INSURANCE ▪ COMMERCIAL ▪ BANKING

Welcome to the Financial Services Bulletin, June 2017

Thank you to the 200 clients who attended our Autumn Life Matters seminars last month in Sydney, Brisbane and Melbourne! Stay tuned for details of our next Life Matters seminars in Spring.

Later this month in conjunction with ALUCA we are hosting the second Life Insurance Future Thinking (LIFT) Alumni Roundtable event. LIFT brings together the past winners and runners up of the ALUCA TurksLegal Scholarship since 2007, a group of 23 passionate and insightful life insurance professionals working at all levels, across all aspects of the life insurance industry. The Alumni will be joined by a panel of experts including a representative from ALUCA and the FSC, a medical specialist and other senior industry executives. This year the group will discuss the very pertinent topic of *Living the Code: Engendering Trust as a Life Insurance Professional*. We will report on the outcomes of the Roundtable event in the next edition of the FSB.

2017 ALUCA TurksLegal Scholarship - Applications will be available in mid-July from the **TurksLegal** and **ALUCA** websites. Stay tuned for details!

Please read on for the latest industry news, important case law developments, our selection of recent FOS and SCT determinations and the answer to a client's question on the Capability Clause in our topical 'Turks Q&A' segment.

We hope you enjoy this edition of the FSB!

CONTENTS

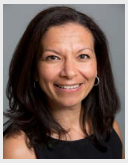
CONTACT US

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

Helen Barnett
Special Counsel
T: 03 8600 5004
Email Helen

Ros Wicks
Special Counsel
T: 02 8257 5779
Email Ros

INDUSTRY NEWS

Important changes to Australian Capital Territory discrimination legislation

The Australian Capital Territory has expanded the number of 'protected attributes' protected by law from discrimination (expanded from 15 to 24) under the *Discrimination Act 1991* (Australian Capital Territory).

Those of most relevance to life insurance are the following:

- Discrimination on the basis of employment status
- Discrimination on the basis of genetic information
- Discrimination on the basis of immigration status

The changes took effect on 3 April 2017 and mean that it is generally unlawful to discriminate on the basis that a person has these protected attributes.

Whilst the new protected attribute of employment status appears to have primarily been added to ensure that employment status is a protected attribute in the context of employment, it also applies to 'services' that includes insurance services.

There are relevant exemptions including:

- the specific insurance exemption applies to these new protected attributes (not unlawful discrimination if the discrimination was reasonable, having regard to any actuarial or statistical data); and
- a specific superannuation exemption (section 29)
- a specific exemption for immigration status where the requirement is reasonable.

The terms of these exemptions will need to be carefully considered by insurers if different coverage is provided on the grounds of any of the new protected attributes.

A copy of the legislation following the amendments can be accessed here.

INDUSTRY NEWS

Changes to the powers of the Australian Human Rights Commission

There was a great deal of focus on the proposed amendments to section 18C of the *Racial Discrimination Act 1975* (Cth).

However, besides section 18C, important changes were also been made to the *Australian Human Rights Commission Act 1986* (Cth) in the recent amendments to the Commonwealth anti-discrimination regime. These changes impact on the powers of the Australian Human Rights Commission (the Commission) and have implications for the way in which insurers may wish to approach complaints made to the Commission.

The changes include:

1. Raising of the threshold for a complaint. The previous threshold only required a complainant to make an allegation that unlawful discrimination had occurred. The changes now require it to be 'reasonably arguable' that the conduct that is the subject of the complaint constitutes unlawful discrimination and the complaint sets out the details of the conduct as 'fully as practicable'.

2. Greater ability for the Commission to terminate unmeritorious complaints. There are four new grounds (one discretionary and three mandatory) on which a complaint could be terminated by the President, namely:

    - the President is satisfied, having regard to all the circumstances, that the complaint is not warranted (discretionary);
    - the President is satisfied that there is no reasonable prospect of the matter being settled by conciliation (mandatory);
    - the President is satisfied the complaint is trivial, vexatious, misconceived, or lacking in substance (mandatory); and
    - the President is satisfied there would be no reasonable prospect that the Federal Court or the Federal Circuit Court would be satisfied that there has been unlawful discrimination (mandatory).

- Introduction of a requirement to seek the leave of the Federal Court or the Federal Circuit Court to make applications alleging unlawful discrimination which were the subject of complaints terminated by the President (except where terminated because no reasonable prospect of settlement by conciliation) as well as provisions relating to costs to discourage unmeritorious complaints progressing to the Federal Court. This could mean a reduction in potential exposure to significant costs in defending complaints that the Commission may have dismissed.

- Allowing the President to terminate complaints lodged more than 6 months after the alleged unlawful discrimination – previously the time limit was 12 months. This amendment is surprising and is a shorter time than most jurisdictions (though we anticipate the Federal Court would generally favour allowing leave in cases that have been terminated only on the basis the complaint was outside the 6 month period).

These changes take effect from 13 April 2017.

The net effect of these changes should be that the Commission will take a more active role in deciding if a complaint should be terminated when it lacks merit.

As a result, consideration should now be given to providing reasons why you consider the complaint should be terminated in any initial response letter to the Commission (if there are potential grounds as to why the complaint should be terminated).

INDUSTRY NEWS

ASIC Proposes Reforms to AFSL Breach Reporting Regime

Over the past decade the self-reporting regime for Australian Financial Services Licensees (Licensees), contained within s912D of the *Corporations Act 2001* (the Act), has come under increasing scrutiny.

As part of its Terms of Reference the ASIC Enforcement Review Taskforce (the Taskforce) was asked to review the adequacy of the breach reporting regime. The Taskforce has produced a consultation paper '*Self-Reporting of contraventions by financial services and credit licensees*' which identifies concerns within the current self-reporting regime and proposes preliminary reforms to address them. The proposed reforms are broadly outlined below.

The significance test

Presently a Licensee is required to self-report to ASIC any significant breaches (or likely breaches) of its obligations as a licensee. The key trigger for the obligation to report being the "significance" of the breach. The subjectivity in determining whether or not a breach is significant has led to inconsistent reporting and uncertainty according to ASIC. For example, the Taskforce noted that while all Licensees have an obligation to self-report, the differing scale, nature and complexity of their respective businesses can mean that larger organisations need to report fewer breaches or less often.

The Taskforce has proposed that the subjective test be amended to provide that significance is to be determined by reference to an objective standard. Effectively a Licensee would be obliged to report to ASIC any breaches "that a reasonable person would regard as significant" and for which "the regulator would reasonably expect notice". Significance is still be determined with regard to the various factors set out in 912D(1)(b) of the Act. However these factors may be supplemented by regulatory guidance from ASIC that specifies certain types of breaches it considers should always be reported.

Obligation to report conduct of Employees and Authorised Representatives

Currently, the reporting obligation applies to breaches by the Licensee. While Licensees are usually responsible for the conduct of employees and representatives there are occasions where ambiguity can arise as to whether a breach by a representative should be reported to ASIC.

The Taskforce has proposed that the obligation to report be extended to specifically require Licensees to report the misconduct of its employees and representatives. Complimentary reforms are to proposed to ensure that in these circumstances Licensees will attract qualified privilege to protect them from liability when making reports to ASIC in good faith and accordance with the regime.

Time to report

Currently, the period by which a Licensee must report a breach to ASIC is 10 business days. This is taken from the point in time that the Licensee has become aware of the breach and determined that it is of sufficient significance to report.

The Taskforce has suggested that the 10 business day timeframe commence from the point in time where the AFS licensee "becomes aware of, or has reason to suspect a breach has occurred, may have occurred or may occur rather than when the licensee determines that the relevant breach has occurred and is significant".

Lack of flexibility for sanctioning

ASIC's current options for sanctioning a failure to report are limited to a criminal offence and a moderate fine. The Taskforce has suggested that both the existing financial and criminal penalties should be increased to deter deliberate non-compliance by Licensees.

Moreover, it was proposed that ASIC should be given additional powers to sanction non-compliance. These include the introduction of a civil penalty and the authority to issue infringement notices for uncomplicated contraventions that do not involve a deliberate failure to not report.

To encourage a co-operative approach between Licensees and ASIC, where breaches are reported at the earliest opportunity, the Taskforce has proposed the creation of a formal provision expressly allowing ASIC to decide not to take action in respect of a Licensee when they self-report and certain additional requirements are satisfied. These may include the breach having been addressed or remedied to ASIC's satisfaction.

Submission and content of reports

While the Act contains an obligation for the Licensee to provide a self-report, there remains no prescribed structure by which to do so. It is recommended by the Taskforce that a "prescribed form" be adopted and to be submitted to ASIC electronically in machine readable forms.

Publication of breach report data

As part of its annual reports, ASIC currently publishes details about breach reports in an aggregate form. In an effort to promote transparency, the Taskforce has proposed that the annual reporting of breach report data include information at a firm or Licensee level. It is proposed that reporting at this level would be subject to a threshold based on the number of significant breach reports provided by the Licensee for the relevant year.

Extension of self-reporting to Credit Licenses

There is no equivalent obligation for self-reporting under the *National Consumer Protection Act 2009* (Cth). Given the significant overlap between financial services and credit services, there is a strong recommendation to introduce self-reporting regime for credit licensees, equivalent to the regime for Licensees. The increased compliance burden would be offset by making the Compliance Certificates required from credit licensees less onerous to complete.

Responsible entities

Responsible entities of managed investment schemes are obliged to report breaches to ASIC under s912D and s601FC(1)(l) of the Act. In general a breach reported under s601FC(1)(l) will need to be reported under s912D however a breach under s912D will not always need to be reported under s601FC(1)(l).

It is proposed that this unnecessarily complex burden be mitigated by removing the self-reporting obligation under s601FC(1)(l) so that all self-reporting for breaches by responsible entities are absorbed by s912D obligation.

CASES AND TRIBUNAL DECISIONS

A Fork in the Road: The two stages of inquiry for litigated life insurance claims

Wild v FSS Trustee Corporation as trustee of the First State Superannuation Scheme [2017] NSWSC 237

Link to decision

It is well-established that in litigated life insurance matters, where the payment of a benefit depends on an insurer reaching an opinion, there are two stages of inquiry for the Court to determine. The first is whether the insurer's decision to decline a claim was reasonable on the material before it. If the plaintiff is successful at the first stage, the second stage requires the Court to decide for itself whether the plaintiff meets the relevant definition. The usual practice is both stages are determined together.

On 10 March 2017, Justice Stevenson delivered an ex tempore judgment in *Wild v FSS Trustee Corporation as trustee of the First State Superannuation Scheme* [2017] NSWSC 237 allowing separate determination of these two stages.

As a member of the First State Superannuation (FSS) Fund, Mr Wild was insured for total and permanent disability (TPD) benefits under an insurance policy between MetLife and FSS. After being medically discharged from the NSW Police Force on 13 October 2011, Mr Wild made a claim under the policy for post-traumatic stress disorder which was declined by MetLife on 1 December 2014.

Proceedings were commenced by Mr Wild on 24 December 2015. MetLife filed a Notice of Motion seeking orders that the first stage of inquiry be heard separately to, and before, the second stage.

MetLife argued that a separate hearing would save time and money. In particular, his Honour noted that:

1. the first stage would be a discrete inquiry based mostly on documentary material;
2. it would not be lengthy or expensive;
3. if the plaintiff fails at the first stage, the proceedings will end.[1]

Balanced against these arguments, his Honour noted the possibility of overlap with material relevant to both stages of inquiry and Mr Wild having to be cross-examined at both hearings (if Mr Wild succeeded at the first stage). His Honour was particularly concerned about the possibility of Mr Wild being cross-examined twice.[2]

In response, Mr Wild's Counsel indicated he would seek to adduce evidence from Mr Wild during a first stage inquiry. Such evidence would relate to psychiatric evidence commenting on surveillance footage of Mr Wild engaging 'various activities at his local surf club and elsewhere'.[3]

In support of the application, MetLife's Counsel informed his Honour that if the application was successful, MetLife would undertake not to cross-examine Mr Wild if he gave admissible evidence on these issues at the final hearing.[4]

The FSS was prepared to provide the same undertaking.

While acknowledging there remained a 'remote possibility' that some medical evidence relevant to both stages of inquiry would have to be adduced by Mr Wild twice if he succeeded the first stage, his Honour allowed MetLife's application.[5] His Honour explained there was a need to balance this in 'remote possibility':

…against the benefit to the parties, and to other litigants in the Court, to adopt a course which may well save time, costs and Court resources.

The undertaking given by the defendants was central to his Honour granting the application.[6]

Conclusion

This decision provides some guidance regarding the circumstances in which the Court may grant separate determination of each stage of inquiry in an opinion-based life insurance dispute.

Earlier cases have demonstrated the Court is generally reluctant to order separate determination. For example, such an application was refused by *Brereton J in Halloran v Harwood Nominees Pty Ltd & Anor* [2006] NSWSC 1355 for reasons including the following:

- No undertaking was given by the defendants that they would not seek leave to appeal on an interlocutory basis from an adverse determination of separate issues.[7]
- On the second stage inquiry, the plaintiff proposed to rely on medical evidence which would be tendered on the first stage inquiry in any event.[8]
- Such applications are effectively for the benefit of the defendants alone – if the plaintiff loses in the application, they lose the proceedings entirely but if they succeed, they must prepare for a second trial.[9]
- The relatively low TPD benefit ($65,000) did not justify a lengthy hearing on the second stage enquiry.

The decision of *Wild* demonstrates the difficulties associated with obtaining an order for separate determination and the wide-ranging discretion of the judicial officer in determining such applications.

[1] *Wild v FSS Trustee Corporation as trustee of the First State Superannuation Scheme* [2017] NSWSC 237 at para 10
[2] Id at para 13
[3] Id at para 14
[4] Id at para 22
[5] Id at para 21
[6] Id at para 23
[7] Id at para 11
[8] Id at para 12
[9] Id at para 13

CASES AND TRIBUNAL DECISIONS

Federal Court finds first breach of best interests duty

Australian Securities and Investments Commission v NSG Services Pty Ltd [2017] FCA 345

Link to decision

Summary

The Federal Court has made the first finding of liability against a financial services licensee for a breach of the Future of Financial Advice (Part 7.7A) provisions of the *Corporations Act 2001* ('the Act').

In the decision of *Australian Securities and Investments Commission v NSG Services Pty Ltd*, the Court found that financial advice firm NSG Services Pty Ltd (NSG) had failed to take reasonable steps to ensure that its advisers acted in the best interests of its clients when providing advice and as a result, on a number of occasions, NSG advisers provided clients with advice that was inappropriate.

Facts

On several occasions between July 2013 and August 2015, representatives of NSG sold to clients insurance products and/or advised them to rollover superannuation accounts.

Prior to the hearing NSG and ASIC reached an agreement in relation to NSG's liability. NSG accepted that on the occasions in question its advisers had failed to act in the best interests of clients and provided inappropriate advice. It further accepted that the contravention of the best interests duty by its representatives (other than its authorised representatives) resulted in a contravention of this duty by NSG under s961K(2) of the Act.

NSG also accepted that it had breached s961L of the Act, as it had failed to take reasonable steps to ensure that its advisers complied with the best interests duty. In this regard the following deficiencies in NSG's processes and procedures were noted:

- NSG's new client advice process was designed to be completed quickly, with little time for clients to reflect on advice provided before it was implemented. As a result insufficient information was obtained from, and given to, the client.
- NSG's training on legal and regulatory obligations failed to provide advisers with sufficient information about their obligations under the Act, including their individual obligations as a result of the Future of Financial Advice reforms.
- NSG did not conduct regular or substantive performance reviews of its advisers. While some internal audits were conducted, no disciplinary action was taken against advisers who were found not to have complied with their obligations under the Act.
- NSG engaged third parties to conduct external audits. The audits conducted identified issues in the provision of advice. However, NSG failed to follow the advice provided by external auditors and recommended changes were not implemented or addressed.

- NSG's compliance policies were inadequate. They did not address representatives' legal or regulatory duties. In any event, despite receiving a number of complaints about the advice provided by representatives, compliance procedures were not followed or enforced by NSG.

The Court made declarations of liability by consent. There will be a hearing in July this year to determine the pecuniary penalty to be imposed on NSG.

Implications

The case represents the first action taken by ASIC alleging breaches of the best interests obligations. It does not set any new legal ground as Moshinsky J was not required to reach a concluded view on any matters of interpretation. However, his Honour did provide some commentary on the operation of the best interest provisions.

1. The steps listed in s961B(2) may be treated as providing a 'safe harbour' for providers accused of breaching the best interests duty. If the provider can prove that they have done each of the steps listed in that section, they will have satisfied the best interests duty in s961B(1). A provider may still be able to satisfy the best interests duty even though they do not fall within s961B(2). However, it was noted that ASIC felt that in a practical sense s961B(2) was likely to cover all the ways of showing a person had complied with the best interests duty.

2. There is support for the view that s961B (which requires advice to be in a client's best interest) is concerned with the process or procedure involved in providing advice, while s961G (duty to provide appropriate advice) is concerned with the content or substance of that advice. Although it was not necessary to reach a conclusion on whether that view was correct.

RECENT FOS DECISIONS

FOS finds blanket mental health exclusion breaches *Disability Discrimination Act* (Cth)

Link to determination

Facts

The Applicant held a Travel Insurance Policy with the financial services provider (FSP). The Applicant lodged a claim after suffering a manic episode during his trip overseas that led to his hospitalization and the subsequent cancellation of his trip.

There was no dispute that the Applicant did not have a history of pre-existing mental illness and the condition for which he was claiming first arose after inception of the policy, whilst he was in the course of his journey.

The FSP denied the claim relying on a general exclusion which provided that the FSP would not pay claims under any circumstances if the claim arose from, or was in any way related to, depression, anxiety, stress, mental or nervous conditions (Mental Health Exclusion).

The Applicant disputed the decision on the basis that the Mental Health Exclusion and denial of the claim was unlawful discrimination under the *Disability and Discrimination Act 1992* (the DD Act).

Issues

1. Did the FSP discriminate against the Applicant when it issued a policy which included the mental illness exclusion and when it refused her indemnity by relying on the terms of that exclusion?
2. If so, can the FSP rely on one of the statutory exceptions to excuse the discrimination?

Held

General exclusion for mental illness was unlawful

FOS found the Mental Health Exclusion was unlawful. Its reasoning included that the FSP discriminated against the Applicant for the purposes of section 5 and 6 of the DDA as it sought to treat a person who developed a mental illness during the period of insurance differently from how it treated a person without a mental illness. There does not appear to have been any consideration given to how a person is treated "less favourably" where the exclusion applies in the same way to all prospective insureds.

Unjustifiable hardship

The FOS considered whether avoiding the discrimination would impose an unjustifiable hardship on the FSP, as section 29A of the Act provides that it is not unlawful to discriminate on such grounds. The FSP argued that to require its entire travel insurance business to cover first presentation mental illness would lead to higher costs, increased difficulties in assessing claims and higher premiums that would ultimately place the FSP in an uncompetitive position.

FOS determined that the FSP had not established it would suffer unjustifiable hardship. In reaching this conclusion, FOS placed emphasis on there not being, in its view, any significant additional costs imposed on the FSP if it were to cover mental illness.

Actuarial or statistical data exception

FOS also considered whether the specific exemption to discrimination for insurers applied.

Section 46 of the DD Act provides that it is not unlawful for a person to discriminate against another person on the grounds of the person's disability in relation to the provision of insurance or superannuation if the discrimination:

- is based on actuarial or statistical data on which it is reasonable for the FSP to rely, and the discrimination is reasonable having regard to the matter of the data and other relevant factors (data limb); or
- where no such data is available and cannot reasonably be obtained - the discrimination is reasonable having regard to other factors (no data limb).

The FSP maintained that it considered relevant statistical and actuarial data including that each year (since at least 2011) it considered publically available data and had prepared a briefing note in September 2011 justifying the exclusion for mental illness. The FSP also referred to studies indicating mental illness is one of the leading causes of disability in Australia.

FOS rejected the FSP's submissions and found that the data did not meet the requirements of the actuarial or statistical data exemption. The main findings were:

- the data was not in existence in 1991 when the exclusion was first applied "being the relevant date under the DD Act";
- the data was mostly about the prevalence, diagnosis and treatment of mental illness, not data required by the DD Act about the assessment of the insurance risk or incidence data with first presentation mental illness;
- as the data relied upon related to all mental illness and not first presentation mental illness, it was "difficult to see how the blanket exclusion including first presentation mental illness is justified."

FOS also found that the discrimination was not reasonable under the no data limb because the Mental Health Exclusion was a blanket exclusion. It is questionable whether FOS should have considered the no data limb in circumstances where the insurer had relied on the data limb as the limbs are not alternatives.

FOS did acknowledge that an exclusion that limits cover for a pre-existing medical condition or mental illness may in certain circumstances be reasonable given the greater likelihood of a claim.

Having found that the Mental Health Exclusion breached the DD Act and no exemption applied, FOS determined that the FSP owed the Applicant the amounts due under the Policy. However, FOS also ordered the FSP to pay the Applicant $1500 compensation on the basis that the denial of the claim was unreasonable and caused an unusual degree of inconvenience and pressure on the Applicant.

Implications

Whilst FOS does not refer specifically to the *Ingram v QBE Insurance (Australia) Ltd*[1] decision, their determination mirrors the Victorian Civil and Administrative Tribunal's (VCAT) reasoning in *Ingram*. In *Ingram* VCAT found an insurer to have engaged in unlawful discrimination where it included a mental illness exclusion in the policy issued to Ms Ingram.

Whilst there were curious aspects of the FOS reasoning, what is certain is that an insurer relying on the data limb of the actuarial or statistical data exemption must produce actuarial or statistical data on which it actually based its decision.

Interestingly, FOS commented on how the FSP should have been aware of decisions regarding discrimination in insurance, how blanket mental health exclusions have been considered and the approach of FOS to that type of exclusion. The implication being that an insurer will face significant difficulties before FOS in defending a blanket mental health exclusion in the context of anti-discrimination legislation.

The implications outlined in our *Ingram* case alert equally apply following the FOS determination and can be found here.

[1] [2015] VCAT 1936

RECENT SCT DECISIONS

Where there's a Will there's not always a way

Link to determination

Facts

The Deceased Member died and was survived by her long-term de facto partner (the Spouse) and three biological children from previous relationships (the Adult Children). When the Deceased Member commenced her membership with the Fund in 2004, nine years before her death, she nominated her elder son as her preferred beneficiary (the Elder Son). She did not, however, make a Binding Nomination. In her will, which she prepared six weeks before her death, the Deceased Member bequeathed the residuary of her estate to her three adult children in equal shares. The Spouse was not named as a beneficiary under the Deceased Member's will.

The decision under review was that of the Trustee to pay the entire benefit arising on the death of the Deceased Member to the Spouse as a dependent.

The Trustee's position was that the Deceased Member's nomination may not have been reflective of her life circumstances as at the date of her death. It noted further that in the Deceased Member's will, she had not elected to formalise to the Fund her wishes regarding disbursement of her superannuation death benefit by way of Binding Nomination, and in fact there was no mention of any wishes regarding her superannuation death benefit.

Absent any binding instruction to the Fund, the Trustee exercised its discretion under the Trust Deed to determine the most appropriate distribution of the benefit. It recognised the priority that a financially dependent and interdependent current Spouse holds over all other dependents. The evidence supported that the Deceased Member and the Spouse had been in a de facto relationship from 1987 until the date of the Deceased Member's death. It also supported that the Deceased Member's financial support was directed solely to supporting herself and the Spouse on an ongoing basis, and also that she was living in a mutually-committed and financially co-dependent and interdependent marriage-like relationship with the Spouse on a genuine and ongoing basis.

The Trustee determined that it would be appropriate and equitable for the benefit to be paid to the Spouse. The Spouse agreed with the Trustee's decision noting further that the Adult Children were all financially independent adults.

The Elder Son, however, argued that the Deceased Member's intentions were for her children to be her beneficiaries which was reflective in her will and her decision to nominate the Elder Son as her preferred beneficiary. His position was that had the Deceased Member been aware of the Binding Death Nomination she would have elected him as the beneficiary but had not been advised on this issue by her lawyer.

Held

The Tribunal held that the Trustee's decision to pay the entire benefit arising on the death of the Deceased Member to the Spouse as a dependent was a fair and reasonable decision.

The Tribunal stated that the purpose of superannuation is to provide income in retirement to a member and his or her dependents. In the event of death before retirement, the Tribunal outlined that its approach is to consider what might have occurred had the Deceased Member not died.

The Tribunal determined that it was clear from the evidence provided that the Spouse was the sole financial dependent and interdependent of the Deceased Member immediately prior to the Deceased Member's death and had an expectation of ongoing financial support, or a right to look to the Deceased Member for ongoing financial support had the Deceased Member not died.

The Tribunal noted further that although the Trustee may have regard to a deceased member's wishes as expressed in their will for the purposes of distributing a death benefit, it is not bound by the terms of a will and under Australian law, superannuation does not form part of a deceased member's estate.

INSURANCE ▪ COMMERCIAL ▪ BANKING

TURKSLEGAL Q&A

"The Capability of the Capability Clause"

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

Q What is the capability of the Capability Clause in IP policies?

A The Capability Clause was introduced in the mid to late 80's in some income protection policies. It is intended to address an insured's capacity for return to work in circumstances where an insured is partially disabled and not working to the extent of their capability as a result of causes other than injury or sickness. For example, redundancy or simply an inability to find work.

Difficulties can arise with the application of capability clauses when terms such as 'partially disabled' are not defined within the Capability Clause or are inconsistent with the policy definition of 'Partial Disability'.

For example, if an insured were to lose their employment through say, redundancy rather than injury or illness, they may not meet a partial disability definition that requires that they have returned to work, albeit in a reduced capacity. They may also not satisfy a total disability definition that may require them to be unable to perform the important duties of their occupation as a result of injury or an illness (not redundancy).

In such circumstances, whether the Capability Clause has any application will depend upon the precise wording of the clause. It must be clear, concise and be linked appropriately with the definition of partial disablement.

Capability clauses usually provide that insurers can take into account available medical and other evidence when making an assessment as to what an insured might earn if they were working to the extent of their capability. The insurer can then increase or decrease the claimant's benefit under the Capability Clause depending on this evidence and subject to the terms of the policy.

To avoid potential for dispute when assessing this evidence, care should be taken to follow the relevant policy terms, not take into account irrelevant considerations when assessing the medical and other evidence going to the insured's capacity and, as always, act with the utmost good faith.