INSURANCE ▪ COMMERCIAL ▪ BANKING

L-R: Jim Welsh, Chair, ALUCA; 1st Runner-up Carola Moore, AMP; John Myatt, Partner, TurksLegal; 2017 Scholarship Winner Jennifer Jackson, CommInsure; 2nd Runner-up Amanda Cruikshank, AIA and Amanda McKernan, CEO ALUCA

Welcome to the October edition of our Financial Services Bulletin

And the winner is...

2017 ALUCA TurksLegal Scholarship

Jennifer Jackson, Rehabilitation Consultant at CommInsure was awarded this year's prestigious ALUCA TurksLegal Scholarship for her outstanding essay on genetic testing.

The 1st runner-up was, **Carola Moore, Claims L&D Manager, AMP** for her paper on Getting the Capabilities Right. The 2nd runner-up was **Amanda Cruikshank, Rehabilitation Consultant, AIA** for her paper on Bringing the Benefits of the Return to Work Philosophy to Superannuation.

For the full details please click here.

Congratulations to Jennifer, Carola and Amanda! Thank you to everyone who submitted an application for this year's ALUCA TurksLegal Scholarship and we look forward to 2018.

Read on for industry news, a whole lot of important case law developments and our selection of a recent FOS and SCT determination.

We hope you enjoy this edition of the FSB!

INSURANCE ▪ COMMERCIAL ▪ BANKING

CONTENTS

INDUSTRY NEWS

Shelf Space Fees for Preferred Product Lists in Regulator's Sights?

In February this year the Federal Parliament passed the Corporations Amendment (Life Insurance Remuneration Arrangements) Bill that removed the exemption from the ban on conflicted remuneration in the Corporations Act for certain life insurance products. Read more

ASIC Reduces Commission Caps

As part of the raft of changes to do with conflicted adviser remuneration that began with the legislation passed by the Federal parliament earlier in the year1 ASIC has launched a new instrument fixing the maximum amount of fees and continuing commissions advisers can charge on life insurance risk products. Read more

CASES AND TRIBUNAL DECISIONS

TPD: Court of Appeal confirms the Jones view on ETE

Hannover Life Re of Australasia Ltd v Jones [2017] NSWCA 233

This decision was of particular concern to life insurers as the notion that an insured must have done a job (or a similar job) in the past, to be 'fitted by ETE' for a job suggested by an insurer (noting that many entry level jobs require no ETE) seemingly created an additional wrinkle on the ETE concept. Read more

Not sure who to pay? Have you considered s215 of the Life Insurance Act 1995?

MLC Limited v Crickitt [2017] FCA 898

This decision is a timely reminder of the option available to insurers to apply under s215 of the *Life Insurance Act* to discharge their liability under a policy of Life Insurance where there is uncertainty as to whom to pay (ie; the Estate or a beneficiary). Read more

Cancellation for Fraudulent Claim

AIA Australia Ltd v Richards (No 3) [2017] FCA 1069

Following the decision of Justice Einstein in *Walton*, it seemed the courts were hesitant to grant insurer's the right to cancel a contract of life insurance on the basis of a fraudulent claim. In *Walton*, Einstein J determined that no such right existed under statute having regard to s56(1) of the *Insurance Contracts Act*. The recent decision in *AIA v Richards* has reversed this approach, with Allsop CJ taking an alternate view. Read more

Federal Court confirms that insurers may withhold reasonable costs from payment into Court

Swiss Re Life & Health Australia Ltd v Public Trustee of Queensland [2017] FCA 963

Where a life insurer can obtain no sufficient discharge with respect to the payment of insurance benefits, it may pay that money into court pursuant to the provisions of s215 of the *Life Insurance Act*. One of the circumstances in which a life insurer cannot obtain a sufficient discharge is where the person to whom the benefit would otherwise be payable is allegedly criminally involved in the death of the life insured. Most recently, this arose in the context of a claim upon a life insurance policy issued by Swiss Re Life & Health. Read more

Group IP: Terms of deed and policy must be paramount in SCT's review

AIA Australia Ltd v Lancaster [2017] FCA 962

On 18 August 2017, Allsop CJ gave judgment on an appeal against a determination of the SCT about an income protection benefit under a group insurance policy. Read more

RECENT FOS & SCT DECISIONS

- You Booze, You Lose, read more
- When You'll Pay for Delay, read more

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

INDUSTRY NEWS

2017 ALUCA TurksLegal Scholarship winner announced

Jennifer Jackson, Rehabilitation Consultant, CommInsure, has been awarded this year's prestigious ALUCA TurksLegal Scholarship for her outstanding essay on genetic testing. In her thoughtful and well researched paper, Jennifer highlighted the strengths and weaknesses of the Australian life insurance industry's current approach to this issue, how other comparable countries are choosing to handle this issue and provided well researched recommendations on how we as an industry should respond.

Jennifer wins an overseas conference package valued up to AU$8,000 including return travel, accommodation, $1,000 cash and registration to one of the following conferences of Jennifer's choice:

- 2018 Eastern Claims Conference in Boston, USA
- 2018 LOMA Life Insurance Conference in Florida, USA
- 2018 Supplemental Health and Protection Forum in San Diego, USA

In addition to the major prize, Jennifer will:

- Be invited to sit on the judging panel for next year's Scholarship; and
- Receive automatic membership to ALUCA and TurksLegal's scholarship alumni program, Life Insurance Future Thinking (LIFT)

"*The judges felt Jennifer's paper on the life industry's approach to genetic testing was concise, well researched and well argued. It looked at the data concerning the increasing availability of genetic testing and analysed the strengths and weaknesses in the current approach of the local life industry to genetic test results, comparing it to several overseas models. Ultimately, Jennifer galvanised readers with a thoughtful argument for change and reform*" said John Myatt, Lead Partner of TurksLegal's Financial Services practice and member of the scholarship's judging panel for the last eleven years.

"*In short, Jennifer ticked all of the boxes the judges look for in a winning paper; mastery of the subject through research, coupled with well-reasoned forward thinking conclusions that give the industry cause to reflect more deeply and take the issue forward productively.*"

The 1st runner-up was, **Carola Moore, Claims L&D Manager, AMP** for her paper on Getting the Capabilities Right. Carola wins an AU$1,000 Visa pre-paid gift card. The 2nd runner-up was **Amanda Cruikshank, Rehabilitation Consultant, AIA** for her paper on Bringing the Benefits of the Return to Work Philosophy to Superannuation. Amanda wins a AU$250 restaurant voucher.

"*ALUCA are very proud to be part of the TurksLegal Scholarship which has seen a high quality standard of papers again this year*", said Devi Uka, Deputy Chairperson of ALUCA and member of the scholarship's judging panel. "*It is really encouraging to see the incredible talent within the Life insurance industry that shone through in the papers submitted and the insights that they all provided.*"

The Scholarship winners were announced at the ALUCA Professional Development Day held in Sydney on 17 October 2017.

The 2018 ALUCA TurksLegal Scholarship will open in July 2018.

INDUSTRY NEWS

Shelf space fees for preferred product lists in regulator's sights?

In February this year the Federal Parliament passed the Corporations Amendment (Life Insurance Remuneration Arrangements) Bill that removed the exemption from the ban on conflicted remuneration in the Corporations Act for certain life insurance products.

The legislation gives effect to the Trowbridge Review's recommendations to limit upfront commissions and the results of the Financial System Inquiry headed by David Murray.

It recently emerged at a Parliamentary inquiry that ASIC thinks that the fees paid to guarantee product placement on advisers' preferred product lists will come within this regime and arrangements will need to satisfy new conflicted remuneration guidelines after 1 January 2018.

ASIC remains highly active in the advice space, having issued a clarification of the use of the term "independently owned" in connection with advice businesses in a statement in June[1] and having just completed its professional-indemnity-insurance-review in August.[2]

[1]See http://asic.gov.au/about-asic/media-centre/find-a-media-release/2017-releases/17-206mr-asic-clarifies-its-position-on-the-use-of-independently-owned-under-s923a/

[2]See http://asic.gov.au/about-asic/media-centre/find-a-media-release/2017-releases/17-286mr-professional-indemnity-insurance-review-completed/

INDUSTRY NEWS

ASIC Reduces Commission Caps

As part of the raft of changes to do with conflicted adviser remuneration that began with the legislation passed by the Federal parliament earlier in the year[1] ASIC has launched a new instrument fixing the maximum amount of fees and continuing commissions advisers can charge on life insurance risk products.

The Instrument will come into operation in January 2018 and will put a lid on the amount of advisers' commissions and the clawback to clients if a policy is cancelled within the first two years.

According to ASIC deputy chair, Peter Kell, these commission caps will reduce the incentives for inappropriate advice, particularly around switching clients into new policies where this is not in their interests.

The instrument, the "ASIC Corporations (Life Insurance Commissions) Instrument 2017/510" sets an "acceptable benefit ratio" for benefits given to a financial services licensee, in relation to a life risk insurance product because of the issue of a product (initial commission) at 60%.

A maximum acceptable ratio of 20% is fixed for trailing commissions.

There will be a transition period, with the initial commission cap set at 80% from 1 January 2018 and 70% from 1 January 2019 before finally dropping to 60% in 2020.

The law extends to the direct sale and marketing of life insurance products.

To view the ASIC Corporations (Life Insurance Commissions) Instrument 2017/510 click here.

[1]*Corporations Amendment (Life Insurance Remuneration Arrangements) Act 2017*

CASES AND TRIBUNAL DECISIONS

TPD: Court of Appeal confirms the *Jones* view on ETE

Hannover Life Re of Australasia v Jones [2017] NSWCA 233

Link to decision

Background

In the first instance decision, Brereton J made findings on some critical TPD concepts which appeared to deviate from accepted principles. In short, he found:

- The 'unlikely ever to be able to engage in' TPD definition was not a pure capacity test at least in NSW despite authorities saying it was in other states including Colella (Victoria) Reynolds and Wilkin (DCT QLD).
- A job which an insured can do without ETE is not necessarily one for which he or she is 'fitted by education, training or experience'. Rather the job must be one for which the insured has been 'prepared or shaped' by past ETE. In other words, the insured must have already worked in the alternative job, or something very similar to it, or have training for it, if it is to fall within the definition.

The decision was of particular concern to life insurers as the notion that an insured must have done a job (or a similar job) in the past, to be 'fitted by ETE' for a job suggested by an insurer (noting that many entry level jobs require no ETE) seemingly created an additional wrinkle on the ETE concept.

Decision

The insurer's appeal was dismissed.

The Court of Appeal confirmed that a stage 1 review of the insurer's decision in an opinion based TPD clause was 'not to assess what is reasonable and thereby conclude that any other view displays error'. It may also be accepted that there can be a range of opinions available to an insurer acting reasonably and fairly on the material before it'. That is, a so called 'merits review' of the insurer's decision was not permissible.

Rather the 'criterion of reasonableness of an insurer's decision is whether the opinion formed by the insurer was not open to an insurer acting reasonably and fairly in the consideration of the claim.

Specifically, the Court rejected the notion that the relevant test was the Wednesbury test i.e. a judicial test applied to administrative decisions that is met when 'no reasonable repository of power could have taken the same decision' – see paragraph 121.

On the critical ETE Issue, the Court of Appeal stated that Brereton J's construction of the ETE clause (as summarised above) was correct. The Court of Appeal said of the lower court observations on this point, 'his Honour correctly observed that the ETE clause requires the insurer to examine the occupations for which the claimant is 'fitted' in the sense of the occupations for which his education, training and experience has prepared him. That naturally is shaped by his vocational history. There is no error in this approach'

On the 'unlikely/unable' issue (the capacity test Issue) the Court of Appeal noted that Brereton J's comments on this point were *obiter* and refrained from providing an 'advisory opinion' on this issue.

The Court made a variety of other findings with no industry wide significance.

Implications

The findings by the Court of Appeal on the nature of the court's stage 1 review, namely that the approach is whether the opinion formed by the insurer was not open to an insurer acting reasonably and fairly in considering and determining the claim, is uncontroversial and would come as little surprise to most observers.

The Court of Appeal did not reject Brereton J's comments that the 'unlikely ever to be able to engage in' TPD definition was not a pure capacity test but it did not endorse them either, and most relevantly confirmed that they were obiter.

Above all however, the critical development in this judgment is the endorsement of the 'Brereton view' on the ETE clause.

The key takeaway from this is that within this ETE clause, a decline based on an assumption that an insured can do a job they have either not done before or have no vocational connection with, is unsound.

This is so regardless of whether they have the capacity and skills to do the job and the job is available and accessible. Such 'job matches', usually made with entry level jobs, invariably find their way into vocational reports as suitable jobs and often form the basis of a decline.

Most life insurers are probably already doing this, but moving forward, they will need to ensure that such TPD declines, based on jobs with no vocational connection to the insured, do not occur. This in turn will require insurers to work closely with their vocational report providers so they know precisely which jobs do and which do not, fall within ETE principles as set down by *Jones*.

Finally, it is important to note that the findings do not end the distinction between 'own' and 'any' occupation TPD products as some have feared. Specifically, an insured will not be TPD under the 'any occupation TPD product, even under the 'Brereton view', simply by being unable do their own job.

That said, the line does seem to be getting closer between these two products given this decision and one would think it would lead to calls for product reform to reaffirm the distinction.

CASES AND TRIBUNAL DECISIONS

Not sure who to pay? Have you considered s215 of the *Life Insurance Act 1995*?

MLC Limited v Crickitt [2017] FCA 898

Link to decision

Background

The recent case of *MLC Limited v Crickitt* [2017] FCA 898 is a timely reminder of the option available to insurers to apply under section 215 of the *Life Insurance Act* to discharge their liability under a policy of Life Insurance where there is uncertainty as to whom to pay (ie; the Estate or a beneficiary).

Section 215 allows a Life insurer to 'pay into court' any money payable in respect of a policy for which, in the insurer's opinion, no 'sufficient discharge can otherwise be obtained.'

The payment made into Court will discharge the insurer from any liability outstanding under the policy in relation to the benefit money. The money paid is then dealt with in accordance with the order of the Court.

While there are costs involved in such an application, the costs of such applications may be recovered out of the benefit funds paid into court.

The following circumstances illustrate the more common situations pursuant to which relief under section 215 has been found:

1. Where there are competing claims as to the proceeds of the policy. This is most often enlivened where there is a dispute between a nominated beneficiary under the policy and a beneficiary or beneficiaries separately identified under the deceased's will;
2. Where there is a beneficiary identified, but their entitlement to the benefit is less than 100% of the proceeds, creating a situation where there is a percentage of the benefit without a nominated recipient;
3. Where the sole nominated beneficiary or beneficiaries have been charged with criminal conduct such as the murder of the life insured.

Decision

The application made in *MLC Limited v Crickitt* was in relation to the third situation identified above.

The Life Insured under the policy, Mrs Crickitt (the deceased), was one of two policy owners. It was determined that her sole co-beneficiary, Mr Crickitt, was ineligible to receive the death benefit as he had been convicted of her murder.

The Court also considered the question of costs. Whilst the Court was prepared to allow the insurer's costs expended in preparing the relevant application, the Court decided to reduce the insurer's costs by approximately 30%.

Implications

In reaching its cost's decision the Court openly acknowledged that applications under section 215 are 'tolerably straightforward' and incidental to the daily business of a life insurer.

In circumstances where a benefit is due and payable and no appropriate beneficiary can be identified, applications under section 215 should be readily considered by insurers.

CASES AND TRIBUNAL DECISIONS

Cancellation for Fraudulent Claim

AIA Australia v Richards (No 3) [2017] FCA 1069

Link to decision

Background

Following the decision of Justice Einstein in *Walton v The Colonial Mutual Life Assurance Society Ltd* [2004], it seemed the courts were hesitant to grant insurer's the right to cancel a contract of life insurance on the basis of a fraudulent claim. In *Walton*, Einstein J determined that no such right existed under statute having regard to section 56(1) of the *Insurance Contracts Act 1984* ('the Act'). The recent decision in *AIA v Richards* has reversed this approach, with his Honour Chief Justice Allsop of the Federal Court taking an alternate view.

The insured, Vincent Richards, applied for disability income benefit cover with AIA ('the Application'). Within the Application, the respondent recorded his occupation as "Anaesthetic Nurse".

In March 2003, Mr Richards made claims under the policy for the payment of IP benefits ('the Claims'). These benefits were paid by AIA on a monthly basis until 10 October 2016.

AIA investigated the claims and took the view that Mr Richards had made misrepresentations to AIA when making the claims. It was discovered that Mr Richards had moved overseas and commenced working in a similar, if not identical, capacity to that of his pre-injury employment. Further investigations revealed that Mr Richards was in fact working and therefore, he was on any view, not totally disabled as he had claimed.

AIA wrote to Mr Richards advising that his claim had been declined on the basis that he failed to satisfy the policy definitions. Further, AIA gave notice that the Policy was to be cancelled 28 days from the date of the letter on the basis that Mr Richards had made a fraudulent claim.

Decision

Chief Justice Allsop of the Federal Court found that Mr Richards was capable of performing his usual occupation. Further, that the representations made by Mr Richards that he was 'Totally Disabled' from January 2016 onwards were in the circumstances, fraudulent. Deviating from Einstein J in *Walton*, his Honour determined that an insurer has the right to cancel a contract prospectively where there is a serious breach of contract such as the commission of fraud against the insurer.

His Honour considered that nothing within the Act abrogates this right and that there is no basis to consider that any common law contractual right has been abolished. Whilst section 56(1) prohibits avoidance from inception, and noting that *Walton* held that an insurer has no option to cancel a policy in the future, Allsop CJ considered that an "avoidance" is not a termination, determining that an insurer has the option to refuse payment and cancel a policy of life insurance.

Furthermore, his Honour took the view that the costs incurred by the insurer during the investigation process were recoverable against Mr Richards as the life insured. In order to recover these costs, AIA had to establish that such costs were incurred outside of the usual course of business and typical claim assessment.

Implications

The decision is of significance, as it clarifies the recourse against an insured in the event of a fraudulent claim. Where a claim is fraudulent, an insurer can not only refuse payment of the claim under section 56, but can also cancel the contract. The judgment also indicates costs incurred by an insurer in investigating the fraudulent conduct may also be recoverable in certain circumstances.

CASES AND TRIBUNAL DECISIONS

Federal Court confirms that insurers may withhold reasonable costs from payment into Court

Swiss Re Life & Health Australia Ltd v Public Trustee of Queensland [2017] FCA 963

Link to decision

Where a life insurer can obtain no sufficient discharge with respect to the payment of insurance benefits, it may pay that money into Court pursuant to the provisions of section 215 of the *Life Insurance Act 1995* (Cth) (the '*Life Act*').

One of the circumstances in which a life insurer cannot obtain a sufficient discharge is where the person to whom the benefit would otherwise be payable is allegedly criminally involved in the death of the life insured.

Most recently, this arose in the context of a claim upon a life insurance policy issued by Swiss Re Life & Health (Swiss Re).

Background

The life insured, referred to in the judgment as "MP", was the mother of "EP" and "AP". The policy issued by Swiss Re to MP provided for the payment of $115,762 to AP and EP in equal shares in the event of MP's death.

It was alleged that, whilst under 18, AP killed his mother and sister on 28 January 2014 by stabbing them to death. That matter was proceeding through the Queensland justice system and in particular, the Mental Health Court. Hence, the parties were anonymised.

The executor of the estate of EP had been paid half the benefits of the policy, being $57,881. The unpaid balance would in normal circumstances have been paid to AP, but in circumstances where he was accused of murdering MP, Swiss Re submitted that it could obtain no sufficient discharge in respect of the payment of the balance of the policy benefit.

Decision

Chief Justice Allsop of the Federal Court held that the opinion of Swiss Re was a reasonable one in the circumstances and provided the requested declaration that it could pay the balance of the policy benefit into Court pursuant to section 215 of the *Life Act*.

This led to the question of costs. Allsop CJ noted that '*the usual order is that the insurer obtains its costs from the sum in question*'. However he also noted that the benefit in issue was modest, and proposed to make '*an order for a modest and appropriate sum in costs to be paid from the proceeds of the policy*'. He directed Swiss Re to make an application for an amount of costs, supported by submissions and a Bill of Costs.

Shortly thereafter, his Honour delivered a further judgment in which he acknowledged (as he had done in previous judgments – see our 2016 December FSB re *Westpac v Mahony*) that '*it must be recognised that an insurer is ultimately put in such a position through no fault of its own and so it is both fair and appropriate that an insurer have some indemnification for its reasonable costs.*'

Swiss Re had incurred costs and disbursements of $20,530 in relation to the application, but recognising the tension between the costs incurred and the modest amount of the insurance proceeds, applied for only $15,000 to be withheld from the proceeds of the policy.

His Honour noted in his judgment on costs (*Swiss Re Life & Health Australia Ltd v Public Trustee of Queensland (No 2)* [2017] FCA 1146) that Swiss Re's application under section 215 had not been straightforward, due to difficulties in locating AP and effecting service upon him within the Queensland mental health system as a result of both the sensitive nature of the alleged offence and the fact that he was alleged to have committed it as a juvenile. Because he was in detention, it had also been necessary for Swiss Re to make an application for interlocutory orders with respect to substituted service.

It was acknowledged by his Honour that Swiss Re had endeavoured to conduct the application as efficiently as possible, and had also agreed that the matter should proceed on the papers to reduce costs.

His Honour was ultimately satisfied that Swiss Re should be allowed to retain $15,000 from the monies paid into Court.

Implications

The judgments of Allsop CJ with respect to this matter emphasise the importance of ensuring proportionality between the amount of costs expended in an application for payment into court and the amount of the insurance proceeds in issue.

CASES AND TRIBUNAL DECISIONS

Group IP: Terms of deed and policy must be paramount in SCT's review

AIA Australia Ltd v Lancaster [2017] FCA 962

Link to decision

Background

On 18 August 2017 Chief Justice Allsop of the Federal Court gave judgment on an appeal against a determination of the Superannuation Complaints Tribunal (the Tribunal) about an income protection benefit under a group insurance policy.

The policy belonged to Maritime Super Pty Ltd as trustee of the Maritime Super Fund (the "Fund") and was issued by AIA Australia Ltd (the "Insurer").

Mr Lancaster commenced work as a stevedore with Patrick Stevedores in 2006. The policy commenced in March 2012 while he was a member of the Fund.

On 2 April 2012, a letter was sent to members with an "Insurance Update". It told members that;

> *"Under the new rules, the premiums for cover are based on occupation and the sum insured, and not on a percentage of contributions….*
>
> *If we don't have a salary recorded for you, a default cover level reflecting a salary of $4,000 per month (which will provide a benefit of $3,000 per month) will be used. It's important to let us know your salary so you don't end up over- or under-insured…."*

The update invited members to contact the Insurer with details of their salary. Mr Lancaster did not do this.

In January 2013, Mr Lancaster suffered a disc prolapse in the course of his work, and in May 2013 he ceased work and lodged a claim for income protection benefits under the policy. The claim was accepted by the Fund and the Insurer.

Up until 3 September 2012 Mr Lancaster was being paid an annual salary of around $45,000, but due to a change in the category of his employment it increased to approximately $97,000. This salary increase was not notified to the Insurer or the Fund by Mr Lancaster or his employer.

The trustee had written to Mr Lancaster on 2 July 2012 and provided him with an opportunity to update his salary details, noting that

> *"that in the event of a claim your Income Protection benefit will be limited to 75% of the Salary we have recorded against your account, therefore it's important you advise the Fund of your correct Salary."*

Shortly after the pay rise in September 2012, Mr Lancaster was also provided with an "Annual Statement" that noted his salary was $44,849.48 and included a reminder that he needed to keep his salary details up to date.

The policy provided that the benefit was 75% of the Insured Member's Income; or the Amount Insured. By a series of interlocking definitions the policy required that where the member's income had increased by 30% or more the member had to apply to the Insurer to increase the Amount Insured.

As Mr Lancaster had not done this the Insurer assessed the benefit using the lower salary amount and the Fund agreed.

Mr Lancaster complained to the Tribunal under section 14 of the *Superannuation (Resolution of Complaints) Act 1993* (Cth) (the "SRC Act"). The Tribunal concluded that the insurer had "correctly" calculated the benefit *"on the*

information available to it at the time by basing it upon the "Amount Insured".

However, the Tribunal went on to say that, as the policy required the member's income as at the date of disablement to be used as part of the formula for calculating the benefit, then it would be reasonable for the Insurer or the Fund to ask members for this information when completing the claim forms.

It consequently found that for the decision to be fair and reasonable in its operation in relation to Mr Lancaster in the circumstances within the terms of section 37(6) the Insurer should have used the higher amount.

Decision

An appeal to the Federal Court is only available under section 46(1) of the SRC Act in relation to a question of law. Chief Justice Allsop concluded that the Insurer's grounds of appeal were that the Tribunal had failed to properly construe the terms of the policy and this was a question of law that met the test in the section.

His Honour then examined the powers of the Tribunal under section 37 of the SRC Act, noting in particular that section 37(5) provides that the Tribunal cannot do anything that would be *"contrary to law, the governing rules of the fund concerned and, if a contract of insurance between an insurer and trustee is involved, to the terms of the contract."*

In its determination, the Tribunal focussed much of its attention on who had the responsibility for notifying the trustee of Mr Lancaster's salary increase in September 2012.

Despite the fact he had several opportunities to do so, it was sympathetic to Mr Lancaster's situation, because a large number of members were changing their employment status at the same time and it may have been reasonable for him to assume that the employer would have notified the Fund and the Insurer of the new salaries.

In Chief Justice Allsop's judgment, this process of reasoning led the Tribunal to set the decisions of the Fund and the Insurer aside, despite acknowledging that the benefit had been calculated in accordance with the policy.

His Honour consequently went on to accept the Insurer's principal submission that, as he had found in *Retail Employees Superannuation Pty Ltd v Crocker*[1], the Tribunal had no power to set aside a decision on a basis that was inconsistent with the terms of the policy.

He repeated the observation in *Crocker* that the question as to whether a decision was unfair or unreasonable *"cannot be judged otherwise than by having regard to the conformity of the decision with the governing rules of the fund and the terms of the policy."*

His Honour consequently concluded that;

> *"If the Tribunal finds that the decision of the trustee or the insurer is in conformity, with and required, by the governing rules or policy terms… it cannot other than find or be satisfied that the decision is fair and reasonable."* [2]

Implications

This judgment is further confirmation of a consistent line of judicial authority that a decision of the Tribunal that fails to properly interpret the trust deed or rules of a superannuation fund, or an insurance policy can be the subject of an appeal to the Federal Court as a matter of law.

It also confirms that a decision of the trustee or insurer that correctly applies them will be a fair and reasonable one in its operation to a member within the remit given to the Tribunal under section 37 of the SRC Act and cannot be set aside.

[1] [2001] FCA 1330.

[2] Par 33

RECENT FOS & SCT DECISIONS

You Booze, You Lose

Link to determination

Facts

Following the death of the Life Insured, the Applicant made a claim for payment of a death benefit (the Claim) pursuant to a life insurance policy (the Policy) issued by the financial services provider (FSP). The direct cause of the Life Insured's death was from injuries sustained as a pedestrian from a motor vehicle collision, which was not disputed by the FSP.

The Policy provided, however, that a benefit would not be paid if the Claim, directly or indirectly, was a result of the consumption of alcohol or drugs other than those prescribed and taken as directed by a registered doctor (the Exclusion). The FSP applied the Exclusion and declined the Claim as it considered that the available evidence showed that the Life Insured's consumption of alcohol and taking cannabis led indirectly to his death.

The Applicant submitted that the FSP had not proven that the Exclusion applied, that section 54 of the *Insurance Contracts Act 1984* (ICA) prevented the FSP from refusing to pay the Claim and that in dealing with the Claim, the FSP had engaged in discrimination.

The Applicant argued that there was no evidence to suggest that the Life Insured's decision to cross the road, and the way he crossed the road, was done because of impairment and any suggestion was speculative. The Applicant also argued that there may have been other causes of the accident such as visibility issues which include that it was a dark night with no moon, there were tree shadows over the road and there was evidence that a street light was malfunctioning.

Alternatively, the Applicant submitted that the Policy was unsuitable for the Life Insured due to his long standing alcohol dependency, and his death would have more likely than not been caused directly or indirectly by consumption of alcohol due to this in any case.

The Applicant claimed compensation for non-financial loss under the Financial Ombudsman Service Australia (FOS) Terms of Reference (ToR) arguing that when providing goods and services, the FSP subjected the Life Insured to direct or indirect discrimination and discriminated against the Life Insured on the ground of his disability, which was alcohol dependence.

Issues

1. Was the death of the Life Insured indirectly caused by his consumption of alcohol and a drug and therefore did the FSP correctly decline the claim in applying the Exclusion?
2. Does section 54 of the ICA prevent the FSP from relying on the exclusion and declining the claim?
3. Was the Policy unsuitable?
4. Has the FSP engaged in discrimination?

Determination

Was the death of the Life Insured indirectly caused by his consumption of alcohol or drugs?

Based on the evidence, the FOS determined that it was more probable than not that the Life Insured's decision to cross the road, and his crossing of the road, was done because of impairment which arose from his consumption of alcohol and a drug which led to poor hazard recognition, judgment, perception and ability to respond in a timely manner. The FOS determined, therefore, that the Claim resulted indirectly from the consumption of alcohol with some drug involvement and that the FSP was entitled to apply the Exclusion and decline the Claim.

While the FOS established that poor visibility would have prevented the driver from seeing the Life Insured in time to avoid colliding with him, it noted that the fact that visibility issues contributed to the death logically, it did not preclude there being other indirect causes of death. Furthermore, it considered that the visibility issues would have had an impact on the driver but would not have had a significant effect on the Life Insured's decision to cross the road.

Does section 54 of the ICA prevent the FSP from refusing to pay the claim?

The FOS held that section 54 of the ICA does not prevent the FSP from relying on the Exclusion and declining the claim because the FSP established that the death of the Life Insured was indirectly caused by his consumption of alcohol or taking drugs. This was an act by the Life Insured which was capable of causing or contributing to the loss and hence under the terms of the section it did not apply in such a case.

Was the Policy unsuitable?

The FOS disagreed with the Applicant's submission that the Policy was unsuitable due to his longstanding alcohol dependence. Had, for example, the Life Insured been a passenger on a bus and died in a bus crash, then despite any alcohol present in his blood, it would not be concluded that alcohol consumption contributed to his death benefit claim. Furthermore, the Applicant could not show that as at the inception of the Policy, the FSP was aware of the Life Insured's long standing alcohol dependence.

Has the FSP engaged in discrimination?

With respect to whether the FSP engaged in discrimination, the FOS determined that the Exclusion and the application of the Exclusion by the FSP did not subject the Life Insured to discrimination and detriment nor to discrimination on the grounds of a disability of which the Life Insured was suffering. The Exclusion applied to any insured person whose claim to be paid a benefit arose directly or indirectly from a specific result. The Exclusion did not require a person to have a condition of substance dependency abuse, or to have a disability or to have a history of injury after consuming alcohol or taking drugs.

The FOS held that the Applicant had not established an entitlement to be paid compensation for nonfinancial loss under the FOS ToR.

RECENT FOS & SCT DECISIONS

When You'll Pay for Delay

Link to determination

Facts

On 23 February 2012, the Complainant suffered a right frontal haemorrhagic contusion, right chronic subdural haemorrhage and left occipital skull fracture after a fall. He subsequently made a claim (the Claim) for a Total and Permanent Disablement (TPD) benefit which was received by the Trustee on 5 July 2012.

The Claim was originally declined by the Insurer as the medical evidence obtained did not suggest that the Complainant was unable to perform at least two of the Activities of Daily Living (ADL's) without physical help from someone else, as was required to satisfy the TPD definition in the Policy. After a report was supplied by the Complainant and further investigations were undertaken by the Insurer, including the Complainant attending an independent medical examination, the Insurer admitted the claim on 21 August 2013.

The Trustee, upon its assessment, required a further Treating Doctor's Report to be completed in order to meet a condition of release so the Complainant's benefit could be paid. The Trustee, after liaising with the Complainant's financial adviser 'continually since August 2013', was provided with all outstanding requirements to roll the Complainant's benefit over to a Self-Managed Superannuation Fund on 13 February 2014 and did so on 14 February 2014, just over 19 months after the Claim was received by the Trustee.

The Complainant submitted that consideration of his Claim for a TPD benefit and payment of the admitted claim were unnecessarily delayed by the Insurer and the Trustee and sought compensation in respect of these delays.

The Complainant alleged that the first period of delay was due to the uncertainty caused by the Insurer as to the applicable definition of TPD under the relevant policy given that the Complainant was over 65 years of age. The Insurer had initially provided the Complainant and treating doctors with claim forms relating to an incorrect definition of TPD and a correct form was provided 105 days after the incorrect forms had been sent.

The Insurer declined to compensate the Complainant for these alleged unnecessary delays arguing that the assessment was not delayed as a result of providing the incorrect forms. The Complainant also argued that there was sufficient medical evidence in support of the claim prior to the date the Insurer approved the Claim on 21 August 2013, and sought compensation for alleged delay caused by the Insurer in not accepting the claim prior to this date.

With respect to the Trustee, the Complainant argued that the Trustee declined to adequately compensate the Complainant for alleged unnecessary delays in processing and paying his TPD benefit. Contrary to this, the Trustee submitted that it had already paid the plaintiff adequate compensation for the delay in the amount of $4,180.06 in interest which had accrued on the benefit while it was held in the cash investment option of the Fund.

Issues

1. Was the Insurer's decision to decline to compensate the Complainant for the alleged unnecessary delays caused the by the initial failure of the Insurer to assess the claim against the correct definition of TPD fair and reasonable?
2. Was the Trustee's decision to refuse to provide the Complainant with additional interest or compensation unfair and unreasonable?

Determination

Alleged delay caused by the initial failure of the Insurer to assess the claim against the correct definition of TPD

The Superannuation Complaints Tribunal (the Tribunal) held that the assessment of the Claim and payment of the benefit by the Insurer was unnecessarily delayed due to the Insurer providing incorrect claim forms to the Applicant. The Tribunal considered that the Insurer's decision not to pay interest in respect of the 105 day period (7 May 2013 to 21 August 2013) from the date the incorrect forms were provided to the date the correct claim forms were provided was unfair and unreasonable. The Tribunal therefore determined to set aside the decision of the Insurer under review and substitute its own decision that the Insurer pay interest on the sum insured from 7 May 2013 to 21 August 2013.

Alleged delay by the Insurer in accepting that there was sufficient medical evidence in support of the claim prior to 21 August 2013 (the date the Insurer approved the claim)

Although the Complainant submitted that the Insurer had sufficient evidence to accept the Claim from either 21 June 2012, which is the day it received a medical report from Dr JT who opined that the Complainant 'Requires constant supervision because of risk of further falls', or at the very latest 13 August 2012, based on a medical report of Dr JMcR, the Tribunal found there to be no unreasonable delay caused by the Insurer in failing to accept the Claim before 21 August 2013.

Alleged delay by the Trustee in processing and paying the Complainant's TPD benefit from the date the claim was accepted by the Trustee to the date the benefit was paid to the complainant

With respect to whether the Trustee caused unnecessary delay in processing and paying the TPD benefit from the date it approved the claim to the date the benefit was paid to the Complainant, the Tribunal affirmed the decision of the Trustee not to pay any additional interest or compensation to the Complainant, aside from the amount of interest it already paid to the plaintiff.