INSURANCE · COMMERCIAL · BANKING

Welcome to the Financial Services Bulletin (FSB) – February Edition, 2019

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CONTACT US

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

Alph Edwards
Partner
T: 02 8257 5703
Email Alph

Fiona Hanlon
Partner
T: 07 3212 6703
Email Fiona

Michael Iacuzzi
Partner
T: 02 8257 5769
Email Michael

Sandra Nicola
Partner
T: 02 8257 5752
Email Sandra

Lisa Norris
Partner
T: 02 8257 5764
Email Lisa

Darryl Pereira
Partner
T: 02 8257 5718
Email Darryl

Peter Riddell
Partner
T: 03 8600 5005
Email Peter

Peter Murray
Partner
T: 03 8600 5031
Email Peter

Sofia Papachristos
Partner
T: 03 8600 5049
Email Sofia

Ros Wicks
Special Counsel
T: 02 8257 5779
Email Ros

WHAT'S HAPPENING HERE AND NOW

Life Matters Seminar - March 2019

Join us for a light lunch as our life insurance experts explore the major case law developments of 2018. Please register your interest below:

7 March Sydney **12 March Brisbane** **14 March Melbourne**

TurksInduct Training Session - April 2019

TurksInduct is a 3 hour introductory workshop on the Basics of Life Insurance Claims. Each session provides an ideal foundation for those new to the industry or those who need a refresher on the basics of Life Insurance Claims. The content covered within the session includes Products, Non-Disclosure, Avoidance & Variation of Policies and Code of Conduct. Please register your interest below:

7 April Melbourne **11 April Sydney**

WHAT'S HAPPENING HERE AND NOW

And the winner of the 2018 ALUCA TurksLegal Scholarship is… Evgeney Schkola, Case Manager, CommInsure!

Evgeney has been awarded this year's prestigious ALUCA TurksLegal Scholarship for his paper on 'How will "Insure Tec" shape the future of the Life Industry'. In his thought-provoking and well researched paper, Evgeney highlighted the challenges of data analytics for the Life Insurance industry and how InsureTech applications can play a beneficial role in this. He also looked at the potential social challenges that the industry could face in the future with the adaptation of InsureTech in the workplace.

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

"Evgeney's paper began with a Peter Drucker quote 'The best way to predict the future is to create it', and developed an insightful and compelling account of the benefits InsureTech will bring to the industry. The paper tackled challenges for the industry in relation to data collection, use and protection and as well as its many benefits, such as the power of data to create better customer experience and its applications in streamlining underwriting and claims" said John Myatt, Lead Partner of TurksLegal's Financial Services practice and member of the scholarship's judging panel for the last twelve years.

The 1st runner-up is Christine Gan, Senior Manager, Underwriting Technical & Capability, CommInsure for her paper on 'How will the insurance industry adapt to a future where periods of mental ill-health and inability to work may become the norm for its customers'. Christine wins a $1,000 Visa pre-paid gift card. The 2nd runner-up is Aimee Kelly, Senior Claims Assessor, CommInsure for her paper on 'Has the Community lost sight of the good our Industry does?'. Aimee wins a $250 restaurant voucher.

"It is always pleasing to see the depth of talent within the Life Insurance industry, and the ALUCA TurksLegal Scholarship entries have once again shown this", said Devi Uka, Deputy Chairperson of ALUCA and member of the scholarship's judging panel.

The Scholarship winners were announced at the ALUCA Biennial Conference held in Hobart on 13 October 2018.

Entries were received from a broad cross section of the major insurers but this year, the winning papers all came from CommInsure. Congratulations to CommInsure for its long term support of the scholarship and the high quality of the entries they submitted.

The 2019 ALUCA TurksLegal Scholarship will open in July 2019.

LIFT "Life Insurance Future Thinking" Roundtable event held in Sydney highlighting 'Mental Health: Working together to build better outcomes…'

Late in 2018 we hosted our third LIFT "Life Insurance Future Thinking" Roundtable event in Sydney. LIFT brings together the 20+ past winners and runners up of the ALUCA TurksLegal Scholarship and an expert panel to brainstorm solutions to issues affecting the future of the life insurance industry.

The focus was on 'Mental Health: Working together to build better outcomes…'. From the roundtable event we will be creating a White Paper on the key issues raised and what the way forward could be. Stay tuned for the copy of the White Paper to be released early in 2019!

INDUSTRY NEWS

Parliamentary Committee rejects Industry's submissions to offer rehab

The industry's proposal that life insurers should be permitted to have greater involvement in rehabilitation processes, so that sick and injured claimants can get back to work sooner was the subject of a report from the Parliamentary Joint Committee on Corporations and Financial Services on 20 September 2018.

The Committee received over twenty submissions from interested parties including a body representing the private healthcare industry, the ATCU, individual unions and plaintiff law firms who opposed the move.

The Committee rejected the proposal and recommended that ASIC undertake a thorough investigation of the use of in-house rehabilitation services in the life insurance industry. The object of that inquiry will be to determine whether all concerns, (including inappropriate financial incentives) have been resolved for the current non-medical rehabilitation services.

The Committee also recommended that the life insurance industry be required to disclose all of its discretionary, off-contract arrangements to ASIC and that these arrangements be examined.

The details of the report and the submissions are available here.

ASIC Report - Mandatory claims and disputes reporting - commissions set to stay a little longer

Life insurers are now required to report on claims and disputes data to APRA with the release of new compulsory standards.

The requirements for claims include measured variables such as insurance type, on-sale status, advice type, cover type, product type, and various sub-categories for specific products or cover types. The reporting form includes 3 additional claims data sheets that provide totals or sub-totals.

The compulsory collection of a more comprehensive range of industry statistics is a key recommendation of a series of Parliamentary and regulatory enquiries, and has many potential benefits for the industry in reinforcing the support it provides to customers and the community more generally.

Both APRA and ASIC have been involved in extensive data gathering in relation to life insurance claims and disputes in recent years, through voluntary participation by the industry, but with the release of Life Insurance Reporting Standard LRS750.0 in October 2018, both regulators consider they have achieved a new critical milestone in delivering accountability and transparency.

Claims professionals can become more familiar with the requirements on the APRA website.

In other regulatory news, ASIC in a submission to the Banking Royal Commission while continuing to express its ongoing reservations about the effects of commission based remuneration, said it is willing to allow the LIF implementation process to run its course and would not be seeking the removal of commission based remuneration before 2021.

INDUSTRY NEWS

Product Design and Distribution Obligations Bill update

On 20 September 2018, the Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Powers) Bill 2018 was referred by the Senate to the Economics Legislation Committee for inquiry. On 9 November 2018, the Committee released its report recommending the Bill be passed, with no changes suggested.

The Bill amends the Corporations Act by inserting a new Part 7.8A, which imposes design and distribution obligations on the providers of financial products. The products covered by the regime are those for which a product disclosure statement (PDS) is required under the Corporations Act, although there are some exceptions.

The Committee noted that the reforms represented a shift away from the traditional reliance on disclosure as the chief protection for consumers, towards a more 'product safety' approach whereby issuers and distributors of products were required to take responsibility for marketing appropriate products. However, overall the Committee felt the draft Bill struck an appropriate balance between consumer protection and consumer benefit.

The Committee did appreciate that industry had limited information as to the requirements of target market determinations, but observed that ASIC could not publish guidance before the legislation was in place. It further considered that the implementation period of 2 years was adequate to enable guidance to be produced and given effect to by industry, noting the long time that had elapsed since the government first indicated that it would legislate along these lines.

On 23 October 2018, draft regulations were also released to support the Bill. These further defined the products and persons to which the regime would and would not apply.

CASES AND TRIBUNAL DECISIONS

TPD: Stage 1 in the post-Jones era

Newling v FSS Trustee Corporation (No 2) [2018] NSWSC 1405

Link to decision

Background

The plaintiff was a former police officer whose TPD claim was declined. She commenced proceedings and the NSW Supreme Court made orders for the separate determination of questions with respect to, in essence, whether the insurer breached duties including the duty to act reasonably in forming its opinion.

The judgment

It was held that the clear effect of the Court of Appeal decision in *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233 is that *'if the decision is one which could have been made by an insurer acting reasonably, then it must be sustained',* even if the insurer's expressed method and process of reaching that decision was in some way flawed. Justice Parker considered that Jones overruled the earlier comments to the contrary in *Ziogos v FSS Trustee Corporation* [2015] NSWSC 1385.

Consequently, an inability to understand a particular insurer's process of reasoning does not necessarily mean a breach is established, as long as the result is *'within the permissible range'* of a decision that could have been made by an insurer acting reasonably.

The trial judge noted that the policy did not expressly oblige the insurer to provide reasons. However, if it did not, it may be unclear what evidence was considered and hence whether it gave proper consideration to the relevant matters. Further, any obligation to give reasons requires only that the insurer's *'actual path of reasoning'* be evident. If the rationale was clear enough from the context, there is no actionable failure to give adequate reasons.

An insurer is not obliged to prefer the opinions of a treating doctor to a medicolegal specialist. It is entitled to be doubtful or sceptical if the facts make this '*reasonably open'* (e.g. if the doctor's opinion is outside expertise, or entails advocacy).

The claimant must prove entitlement to the benefit, so it is not sufficient to defensively 'pick holes' in an insurer's vocational evidence. The best evidence the plaintiff could have advanced that she was TPD would have been unsuccessful attempts to obtain work.

His Honour stressed that separate questions should be dispositive of the entire proceedings, and result in a saving of time/costs. Ultimately, each of the separate questions formulated for determination was answered in favour of the insurer, and the Court dismissed the proceedings.

His Honour indicated that had he found a breach by the insurer, it may have been possible to deviate from the traditional stage two approach (hearing evidence from witnesses) depending on the character of the breach. Because he concluded that there had been no breaches in this case, these comments were obiter in this case.

Implications

The approach taken in *Newling* focused on whether the end result was reasonable, not whether there are any flaws in the process of reaching that result. This could be described as the *'top down'* approach rejected by Justice Robb in Hellessey [link], and contrasted with the *'bottom up'* approach taken in Hellessey.

Newling is a useful and practical post-Jones example of the stage one reasonableness test. If adopted by other judges, insurers' decisions will no longer be subjected to the traditional level of scrutiny in considering unreasonableness. This is a welcome development from the perspective of efficient claims management and effective, succinct communication of TPD decisions.

CASES AND TRIBUNAL DECISIONS

Fraud - A Conscious Indifference to the Truth

Denise Finadri v Westpac Life Insurance Services Limited [2018] VCC 1636

Link to decision

Summary

In this case the Court considered the issue of fraudulent misrepresentation, and whether the insurer was entitled to avoid contracts of life insurance pursuant to section 29(2) of the Insurance Contracts Act 1984 (the Act).

The Court also considered the concept of continuing representations in circumstances where Ms Finadri's alleged fraudulent misrepresentations had been contained in an earlier, unrelated insurance proposal. This earlier proposal was ultimately relied upon by the insurer when it accepted the unrelated application and issued the policies it later sought to avoid.

Background

Ms Finadri had been employed in a family owned business, Finadri Windows Pty Ltd as an office manager/booker. In or around June 2009, an insurance agent of the insurer, Mr Campbell (the agent), met with Ms Finadri and her brothers to review the policies of insurance that were held by the business.

Following this meeting, Ms Finadri subsequently met with the agent again and signed a personal information statement, which included a number of questions and answers pertaining to her health. The personal information statement formed part of an insurance proposal (the June proposal) relating to insurance policies for the benefit of the business. Later, in August 2009, Ms Finadri met with the agent again and completed a further insurance proposal, this time for the purposes of individual insurance cover (the August proposal).

At trial, Ms Finadri submitted that she had not agreed to the insurer using the information from the earlier June proposal, as part of its assessment of the August proposal. However, evidence was given by the agent, that at the time of the August proposal, he would have explained to Ms Finadri that because she had completed the personal statement in the June proposal, it wasn't necessary for her to complete it again.

His Honour Judge Murphy found the evidence of the agent persuasive, particularly in light of the covering letter that had been sent with the August proposal, asking that the personal statement from the June proposal be referred to for the purposes of the subsequent application.

Murphy J found that the earlier June proposal remained an "**unwithdrawn continuing representation**" by Ms Finadri as to the matters contained therein. Accordingly, the insurer was entitled to rely on Ms Finadri's representations in the June proposal when it determined to avoid the policies that had been issued in response to the August proposal.

On the question of fraudulent misrepresentation, Murphy J referred to and followed the *Briginshaw* standard, but he also went further to uphold the commentary in *Prepaid Services Pty Ltd & Ors v Atradius Credit Insurance NV* (2013) 302 ALR 732, noting that:

> "*a finding of fraud could be made in the face of conscious indifference to the truth*".

In *Prepaid Services*, the Court stated that:

> "*conscious indifference means more than carelessness. It must be shown that, before and at the time that the insured signed the proposal form, he or she did not care whether the answers were true or false. It is not necessary, however, to show that the insured knew that there was a substantial prospect that the answers were not true*".

Murphy J was prepared to find that if the insured was willfully apathetic as to the veracity of his or her answers in an insurance application, this was sufficient to satisfy the threshold of fraud for the purposes of section 29(2) of the *Insurance Contracts Act 1984*.

Murphy J considered that Ms Finadri had been "consciously indifferent to the truth" in completing the June proposal. He found the "mountain of contemporaneous medical material" was in direct contrast to the "blanket negative answers to the questions" in the June proposal.

Together with Ms Finadri's responses to cross-examination which impacted on her credibility, he found that Ms Finadri's answers in the June proposal could "only be characterized as answers proffered with a state of mind that meets the requirements set out in *Prepaid Services*".

Accordingly, Murphy J found that the insurer was entitled to avoid the policies under s 29(2) of the Act. Further, because the avoidance of the policies were rendered void from inception, he formed the view that the insurer was entitled to recover any money paid under the policies.

Implications

This case is a good reminder that whilst insurers still have the onus of discharging the burden of proof when alleging fraud, the third limb in the Derry v Peek test remains (that fraud can be proved when it is shown that a false representation was made without caring whether it be true or false). In this matter, Murphy J was satisfied that the threshold for fraud had been met due to the combination of the written misrepresentations in the June proposal, together with Ms Finadri's credibility issues which became apparent in cross-examination at trial.

CASES AND TRIBUNAL DECISIONS

Court Rules on Offset Provisions

Susan Buswell v TAL Life Limited [2018] NSWSC 1507 (10 October 2018)

Link to decision

Summary

Justice White of the NSWSC recently handed down a decision dealing with an 'offset' clause in a group salary continuance (**GSC**) policy. Bearing in mind both the prevalence of such clauses in group and retail IP policies and the commonality of the wording of such clauses, the decision has industry wide implications.

Background

The plaintiff received payments under the GSC policy and also made a claim against her employer seeking damages arising from the injuries sustained in the course of her employment. This damages claim was settled via a deed for $350,000 (the Damages Sum).

The group life insurer sought to reduce the monthly payment due under the GSC policy on account of the Damages Sum pursuant to an 'offset' clause under the policy. Because so much turned on the precise wording of the 'offset' clause, it is worthwhile noting the wording in full. The important words are highlighted:

1.9.1. The amount of any Benefit payable in respect of an Insured Person for a month will be reduced by any Other Disability Income which accrues to that person during that month.…

Other Disability Income means any income (other than Return To Employment Income) which an Insured Person may derive during a month for which the Benefit is payable and includes;

a) any benefit payable under other income protection insurance policies; and

b) any benefit under any workers compensation, statutory compensation, pension, social security or similar schemes or other similar State, Federal or Territory legislation; and

c) any benefit paid under state or federal legislation such as the Department of Veteran Affairs; and

d) any other income payments including Employer funded sick leave entitlements.

Any Other Disability Income which is in the form of a lump sum or is commuted for a lump sum, has a monthly equivalent of one sixtieth (1/60) of the lump sum over a period of sixty (60) months.

If it can be shown that a portion of the lump sum represents compensation for pain and suffering; or the loss of use of a part of the body, we will not take that portion into account as Other Disability Income."

The plaintiff challenged the group insurer's right to 'offset' the Damages Sum and matter proceeded to judgment before Justice White.

The Decision

The Court found that the Damages Sum was not 'Other Disability Income' as defined under the policy and that accordingly it could not be used to reduce monthly payments due under the policy (see paragraph 48). It did so for two critical reasons:

- The word 'income' in the opening line or 'the chapeau' of the '*Other Disability Income*' definition is to be '*given its ordinary meaning*' noting that '*the receipt of damages for personal injury, or a settlement sum in compromise of a claim for damages for personal injury, is capital and not income*'. In this regard the Court did '*not accept that paragraphs (a)-(d) have the effect of allowing the word "income" where it is used in the chapeau to the definition to be read as "benefit" or "monetary benefit", whether capital or income*' (see paragraphs 22 and 23).
- Notwithstanding the above, the Court accepted that the Damages Sum could still be '*Other Disability Income*' if it fell within one of the sub paragraphs of the definition. Here the insurer argued that it fell under sub paragraph (b), being payments '*under any workers compensation*' legislation. Despite cogent and forceful arguments to support this position, the Court rejected this argument on the basis that the underlying entitlement to damages (which formed the basis of the Damages Sum) whilst heavily modified by NSW WC Act, arose 'under' the common law and not 'under' the WC legislation (see paragraph 48).

Implications

This is obviously a single judge decision on the construction of the specific wording of a particular policy and the wider precedent value of the decision must accordingly be viewed through than lens. The judgment may also be appealed.

That said, there are some important takeaways as follows:

- A life insurer's right to 'offset' other income arising from the subject disability, arises solely from its policy wording. There is for example, no common law concept of set-off which allows it to make an adjustment to monies payable under the policy on account of other monies which may be received.
- Further, because such clauses seek to limit the value of a benefit which would otherwise be payable, like exclusion clauses, they will be construed strictly even pedantically against the insurer. On this basis, particular precision needs to be applied in the wording of such 'offset' clauses to ensure that all benefits which are intended to be caught, are indeed caught. An insurer cannot expect a court to do it any construction favours in this regard and employ an expansive construction approach even if such an approach accords with the underlying intentions behind the clause and just plain good sense.
- In this case, the Court found that defining the benefit sought to be offset by reference to the Act that modifies the benefit rather than the underlying source of the benefit i.e. the common law, was an ineffective basis on which to anchor an offset. Our concern is that the relevant wording used in this case is not uncommon in many IP policies on the market. Additionally the issue is not just restricted to how WC offset sub clauses are framed. Motor Accident benefits, which also have as their source the common law, are defined in a similar fashion in many offset sub clauses. It follows that offset clauses which do not reference the underlying source of the benefit (particularly WC and MVA benefits) may be open to challenges similar to the one in this case.
- Against this background it would be timely to review the wording of all relevant offset clauses and at least in the first instance, identify whether such clauses are likely to operate in the manner intended.

CASES AND TRIBUNAL DECISIONS

Court Scrutinises Insurer's Decision

Folmer v VicSuper Pty Ltd & Anor [2018] NSWSC 1503

Link to decision

Summary

The Supreme Court of New South Wales has recently delivered a judgment concerning a claim for a Total and Permanent Disablement (TPD) benefit. The proceedings were heard by Justice Hallen.

Background

The plaintiff, Ms Susan Folmer, commenced work with Aspire Mental Health Services as a community development officer and counsellor in late 2007. She was a member of the Victorian Superannuation Fund (the Fund). VicSuper Pty Ltd was the trustee of the Fund.

The plaintiff was tertiary qualified and had experience working as a counsellor, youth support worker, disability support worker, case/social worker and researcher.

It was claimed the plaintiff ceased work on or about 25 January 2008 as a result of suffering psychological conditions. The plaintiff claimed a TPD benefit under a group life policy (the Policy) issued by the Insurer to the trustee.

The plaintiff's claim condition appears (in part) to arise from a motor vehicle accident in March 2006, in which it was alleged she was driving under the influence of alcohol. It was claimed the plaintiff's subsequent dealings with the Police caused a worsening of her symptoms. In July 2008, the plaintiff was charged and convicted of making a false statement about injuries she claimed the Police had inflicted on her. The Court noted that the precise details of the plaintiff's cessation of work were not outlined in the evidence.

The plaintiff also suffered an injury to her back in September 2009 following an assault by her partner, which (it was claimed) also affected her psychological conditions. An arachnoid mass was also discovered on her thoracic spine. The plaintiff claimed her psychological conditions and back condition caused her to withdraw from further university courses she had commenced after ceasing work.

The trustee and insurer declined the TPD claim (including confirming the decisions on reconsiderations).

The TPD Definition

The Policy contained the following TPD definition:

> *"... in relation to an Insured Member who has been in gainful work at any time*
>
> *during the two years immediately preceding the Date of Disablement:*
>
> > *(a) (i) the Insured Member has been continuously unable to work because of injury or illness for the TPD Waiting Period; and*
> >
> > *(ii) in the Insurer's opinion (after considering medical and other evidence satisfactory to the Insurer) the Insured Member is unable ever again to work for reward in any business, occupation or regular duties for which he or she is reasonably qualified by education, training or experience;"*

The "*TPD Waiting Period*" under the Policy was 6 months. The Policy (relevantly) defined "business, occupation or regular duties" to mean full-time business, occupation or regular duties.

The Dispute

The insurer declined the TPD claim on the basis that:

- The plaintiff had not shown, on the medical evidence, that she ceased work because of an injury or illness; and
- The evidence did not show the plaintiff's condition prevented her from performing work with her education, training or experience.

The plaintiff alleged the insurer had breached its duties in forming the opinion and sought declarations that she satisfied the definition of TPD in the Policy.

The allegations against the Trustee were abandoned at the hearing and the matter proceeded against the insurer only.

The Decision

In relation to the reasonableness of the insurer's decisions (referred to as the 'first stage' enquiry by his Honour), the Court carefully analysed the insurer's reasons in light of the evidence.

His Honour found the insurer's decisions should be set aside on the following bases:

- Evidence to the insurer had found that Dr Stillger's report (the plaintiff's GP) had not described the symptoms the plaintiff was suffering in 2008 and that report did not explain why the contemporaneous clinical notes did not record significant symptoms at the relevant time. His Honour found the view formed by the insurer was not open to it as "*the symptoms from which the Plaintiff had been suffering for a significant period were adequately identified in the Patient Progress Notes and other medical records to which reference has been made*".
- There was little evidence showing the Insurer had given real consideration to the ongoing consequences of the plaintiff's medication. The evidence showed the plaintiff was taking medication to treat her psychological condition before and through the 6 month period from January 2008.
- The Insurer had not given detailed consideration to the definition of "*business, occupation or regular duties*" to be performed on a "*full- time*" basis, as required by the Policy. It was found the Insurer had no basis to reject a Job Capacity Assessment Report (obtained on behalf of the plaintiff) which found the plaintiff was only likely to be able to work a maximum of 14 hours per week. His Honour found the Insurer did not obtain any vocational evidence in response or identify any full time business, occupation or regular duties that she could fulfill with her education, training or experience.

His Honour concluded his analysis of the reasonableness of the insurer's decision by stating:

> *"Taken overall, the decision in the TPD Final Claim Summary reflected a failure by the Insurer to consider whether, in the real world, "full-time business, occupation or regular duties" for a person suffering from the psychological condition from which the Plaintiff was suffering, and who was taking both anti-depressant, and anxiolytic, medication, was reasonably available. In this regard, the opinion formed by the Insurer was not open to it acting reasonably and fairly in the consideration of the claim."*

Having set aside the Insurer's decision, his Honour went on to decide whether the plaintiff satisfied the definition of TPD in the Policy. His Honour found the plaintiff had satisfied the TPD definition in light of the evidence. The Court therefore made declarations the plaintiff was entitled to the TPD benefit under the Policy.

Implications

This decision is a reminder about the high level of detail and analysis the Court will apply to an insurer's decision. The Court will expect an insurer to obtain evidence regarding each relevant part of the TPD definition and consider a claimant's condition and restrictions as a whole, to including any medication that may affect a claimant's capacity to return to the type of work defined in the Policy.

FOS & SCT DECISIONS

Circumstantial Silence by Trustee Deemed Misleading and Deceptive Conduct

Link to determination

Facts

The Member was 21 when he died interstate and was survived by his mother and father. He joined the Fund through his casual employment with the Employer and default cover of Death (Death Cover) plus Total and Permanent Disablement and Income Protection, collectively basic cover (Basic Cover) was applied to his account. The Member's account was set up without listing his home address.

The Member's parents sought payment of the insured death benefit originally on the basis that the Member was covered by the Policy and therefore entitled to the payment upon the happening of his death. Subsequently, they sought payment of the benefit on the basis that the Trustee had failed to discharge its legal and fiduciary duties which resulted in the insurance cover being cancelled without the Member being notified of this.

The position of the Trustee and Insurer was that in accordance with the Policy, the Member's Basic Cover (including Death Cover) ceased on 5 February 2011, 71 days after his last day of work with the Employer. As the Member's account balance was below $1,200 at the end of the 71 day period he was not provided with Continued Cover, was no longer an Insured Member and therefore held no Death Cover.

The Trustee declined the claim and paid the balance of the account in equal shares to the mother and father as non-financial dependants, and not as dependants by virtue of interdependency.

Issues

- Was there an insured death benefit at the date of death?
- In the absence of entitlement to a death benefit, should the Trustee have compromised the claim in the amount equivalent to the insured death benefit?
- Did an interdependency relationship arise between the Member and his parents, which would allow them to receive the death benefit?

Determination

Insured death benefit?

The Tribunal agreed with the Insurer and Trustee that at the date of death, the Member did not have Basic Cover (including Death Cover). The Tribunal held that the decisions of the Insurer and Trustee were fair and reasonable, in this regard.

Should the Trustee have compromised the claim?

Although the Tribunal concluded that the Trustee and Insurer were fair and reasonable in their decision that there was no insured death benefit, it considered whether the Trustee was under an obligation to compromise the claim, as per the Trust Deed, after considering all aspects of the claim.

The Tribunal outlined a number of 'Failures' by the Trustee which it was satisfied resulted in the Member not knowing he had Basic Cover or how to maintain Continued Cover if he ceased working for the Employer. These included a failure to:

1. issue any correspondence to the Member while he was a member of the Fund including a welcome letter, PDS or member booklets;
2. upload the address of the Member to his account so that these documents could be sent to him;
3. advise the Member that he was a member of the Fund and had Basic Cover;
4. provide the Member with information about the cost of insurance and the option to elect what component of insurance he wanted;
5. advise the Member that there were insufficient monies in his account for Continued Cover to be maintained; and
6. inform the Member that his Basic Cover had ceased.

The Tribunal was not satisfied that the Member could have known, or been reasonably expected to know, that he had Basic Cover, that his Basic Cover had ceased or how to maintain Continued Cover.

Furthermore, it found that the Member would have had a reasonable expectation that this information would have been communicated to him. Ultimately, the Trustee's failure to keep him informed was to his detriment and caused him to suffer loss.

In its reasoning the Tribunal stated that the Trustee, which owed fiduciary obligations to the Member, had engaged in circumstantial silence. This is where a failure to communicate a relevant matter affecting a person constitutes conduct which is misleading or deceptive.

As a result, the Tribunal did not consider that it was fair and reasonable for the Trustee to conclude that payment of the Balance only, and not the death benefit, was fair and reasonable in the circumstances. It determined that the Trustee should have realised that its circumstantial silence denied the Member access to Death Cover which was a detriment it must rectify.

The Tribunal determined that it was fair and reasonable for the Trustee to compound the Claim. The Tribunal substituted its own decision for that of the Trustee and compromised the Claim in the sum of $105,000, being an amount equal to the death benefit.

Potential Beneficiaries - Interdependency Relationship

The Tribunal disagreed with the Trustee's view that as at the date of death, there was not an interdependency relationship between the Member and his parents. The Tribunal was of the view that the Trustee had not considered the totality of the circumstances in the definition of interdependency, as defined in the Trust Deed or the relevant legislation.

The Tribunal determined that the relationship between the deceased member and his parents was above that of 'a normal parent-child' due to the severity of the Member's psychiatric condition, which was the only reason he was not living at home with his parents at the time of his death, on the advice of his Doctors. Furthermore, the Tribunal was satisfied that the mother and father continued to support the Member by providing medication, personal equipment and extra health cover.

The Tribunal determined it fair and reasonable that the Claim together with the Balance be distributed equally to the father and mother as dependants by virtue of interdependency.

Implications

- Even where there is an absence of entitlement to a death benefit, if the Trust Deed gives it the power to do so, the Trustee must consider the whole of the claim and decide whether to compromise the claim.
- The obligation not to engage in misleading and deceptive conduct goes to the core of fiduciary duties owed by the Trustee to the Member. A Trustee may be found to have engaged in misleading or deceptive conduct where they have failed to communicate a relevant matter affecting a member.
- In assessing the nature of an interdependency relationship, the Trustee must look at the totality of the circumstances in the definition of interdependence as defined in the Trust Deed and relevant legislation, and not limit their assessment to one consideration.

FOS & SCT DECISIONS

Binding Death Benefit Nomination Deemed Valid Despite Allegation of Duress and Coercion

Link to determination

Facts

The Member passed away at the age of 54 and was survived by the adult son and the adult daughter (together the Adult Children), whom he had with the First Spouse, and three minor children (the Minor Children), whom he had with the Second Spouse.

The Member had prepared a will which stated that all but 10% of his estate should be left to his second spouse.

After the diagnosis of a terminal illness and six months prior to his death, the Member signed a new will and Binding Death Benefit Nomination (BDBN) in favour of his two adult children. The Second Spouse made a complaint to the Tribunal on behalf of the Minor Children that the decision of the Trustee to equally divide the Member's death benefit between his Adult Children, in accordance with his BDBN, was unfair and unreasonable and sought that it be divided between all five children. She stated that the Minor Children were dependants for the purposes of the fund's trust deed, and that they had been left without adequate provision for their maintenance and support.

The Second Spouse argued that the Member's BDBN was invalid because one of the witnesses to its signing was the mother of the beneficiaries. She also alleged that the Member was subject to undue influence amounting to coercion by the First Spouse and the adult daughter with respect to the BDBN and will. Finally, the Second Spouse disputed that the Adult Children were entitled to the benefit, as they were not dependants for the purpose of the *Superannuation Industry (Supervision) Regulation* (SIS Regulation) and the Trust Deed.

Issues

- Is a BDBN invalid where a Member nominates his two adult children as "dependants" despite not being under the age of 18?
- Was the BDBN invalid as a result of duress, coercion, undue influence, unconscionable conduct and/or the capacity of a member at the time of signing?
- Was the Trustee's decision to pay the death benefit in equal shares to the adult son and adult daughter, in accordance with the Member's BDBN, fair and reasonable in its operation in relation to the Minor Children?

Determinations

The Tribunal found that in accordance with section 10A of the *Superannuation Industry (Supervision) Act 1993* (SIS Act), a dependant of a deceased member includes a child of the deceased member, whether or not that child is under the age of 18. Hence the adult children were both dependents of the Member, each being his child at the time of the execution of the BDBN and at the date of the Member's death.

The Tribunal relied on extensive submissions from the Member's mother, doctors and lawyer to determine whether the BDBN was invalid as a result of duress, coercion, undue influence, unconscionable conduct and/or capacity at the time of signing. The Tribunal placed significant weight on the submissions from the lawyer including that the Member had clearly expressed his intentions when he came to change the BDBN and that he had displayed "independent thought and clear instructions".

The Tribunal found that given the extensive amount of evidence in favour of the Member's capacity, no objective evidence was provided to support the claim of coercion, duress and/or undue influence by the First Spouse or the Adult Children. The tribunal noted that in accordance with *Thorne v Kennedy* [2017] HCA 49, direct or inferential evidence is invariably required to substantiate claims of this kind. In this case, it found that there was no evidence nor any merit to the fraudulent allegations submitted by the Second Spouse. Thus the submissions of the

Second Spouse failed to establish that the deceased member had lost his free and independent will to make his BDBN.

The tribunal affirmed the Trustee's decision to pay the Adult Children the death benefit in equal shares, in accordance with the Member's BDBN.

Implications

- A dependant of a deceased member includes a child of the deceased member, whether or not that child is under 18 years of age.
- Evidence to substantiate claims of duress or undue influence must be provided to prove this claim.