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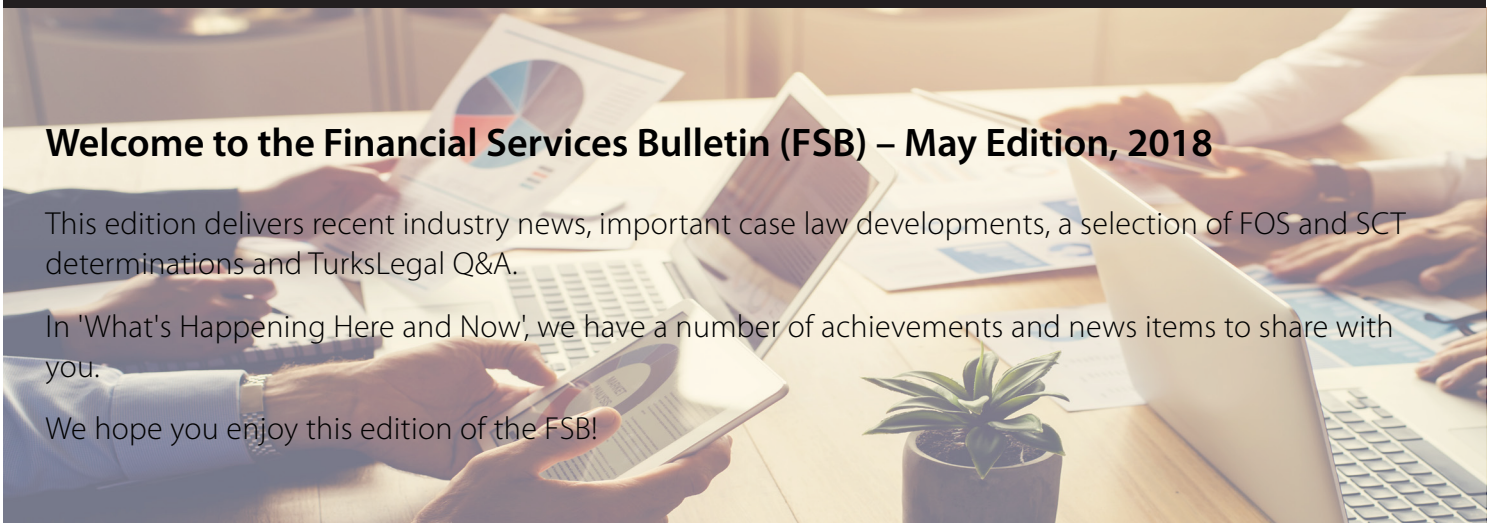

Welcome to the Financial Services Bulletin (FSB) – May Edition, 2018

This edition delivers recent industry news, important case law developments, a selection of FOS and SCT determinations and TurksLegal Q&A.

In 'What's Happening Here and Now', we have a number of achievements and news items to share with you.

We hope you enjoy this edition of the FSB!

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WHAT'S HAPPENING HERE AND NOW

TurksLegal named a finalist in 2018 Australasian Law Awards!

TurksLegal is delighted to announce that we have been named as a finalist in the 2018 Australasian Law Awards in the category of 'Insurance Specialist Firm of the Year'. The Australasian Law Awards recognise excellence and outstanding achievements in the legal industry. This marks the 8th consecutive year of recognition as a finalist in this award category. The winners will be announced at an official awards dinner in Sydney on Thursday 17 May 2018.

Lawyers recognised in the 11th Edition of the 2019 Best Lawyers in Australia

TurksLegal is pleased to announce that both John Myatt, Partner and Doug Vorbach, Special Counsel have been recognised for their achievements in the area of Insurance Law in the 11th Edition of the 2019 Best Lawyers in Australia.

This recognition highlights their exceptional legal expertise and the appreciation held by their peers for their achievements within the Insurance industry. John and Doug have been listed with Best Lawyers since 2014.

Released in partnership with the Australian Financial Review, Best Lawyers is the oldest and most respected peer-review publication in the legal profession, recognising technical excellence and outstanding achievements in the area of Insurance law.

We congratulate John and Doug on this great achievement!

TurksLegal proud sponsor of 2018 FSC Life Insurance Awards

Congratulations to **Ashton Jones**, who won the Young Achiever Award at the 2018 Financial Services Council (FSC) Life Insurance Awards in Sydney on Tuesday, 20 March 2018.

Peter Riddell, Partner at TurksLegal, presented the award to Ashton who is Head of Investments, Retirement and New Propositions from TAL. Ashton currently leads TAL's $1.8bn investments and superannuation business, and manages a team of nine product and actuarial specialists.

In addition to his role at TAL, Ashton regularly writes thought leadership pieces for industry publications on fintech innovation and disruption trends throughout the industry and is actively involved across a number of committees and sub-committees with the FSC.

TurksLegal was proud to sponsor and partner with the FSC for the Young Achiever Award which acknowledges and celebrates the positive achievements of an individual in the early stages of their career within the Australian life insurance industry.



INDUSTRY NEWS

Budget will make significant changes to Insurance in Super

The Government's Protecting Your Super package – announced in the 2018-19 Budget – includes reforms intended to protect members' superannuation savings from erosion.

The Government appears to have accepted that this requires protecting certain categories of superannuation members from fees and insurance premiums by requiring the fund to provide those members with insurance cover on an "opt in" basis only.

Many superannuation trustees currently automatically provide death and total and permanent disablement cover to members upon joining the fund. Indeed, the MySuper settings generally mandates the provision of death and Total and Permanent Disability (TPD) cover to MySuper members on an "opt out" basis.

Income protection cover may also be offered on an "opt out" basis at the trustee's discretion.

The Government has released for public consultation exposure draft legislation which will prevent trustees of superannuation funds from providing default insurance cover to the following membership categories:

1. members with balances below $6,000,
2. new members who are under 25 years old, or
3. all accounts which have not received a contribution for 13 months or longer unless the member has directed otherwise.

Under the proposed legislation insurance cover can only be provided for members in these situations if the member has made a positive election that the fund provides it.

The changes will take effect from 1 July 2019 and trustees must notify the affected members on or before 1 May 2019 of the changes.

The rationale for these changes, as set out in the exposure draft explanatory materials, is that the changes "will better target default insurance cover and prevent inappropriate erosion of retirement savings caused by insurance premiums".

Some commentary has already appeared in the media which is critical of the changes and highlights the risk that younger members will now face and the overall impact on premiums of removing younger lives from the insured pool.

The legislation also makes other significant changes, such as the disallowance of exit fees. Submissions on the exposure draft legislation are due by 29 May 2018.

The exposure draft legislation – the Treasury Laws Amendment (Protecting Superannuation) Bill 2018 can be accessed by clicking here.

INDUSTRY NEWS

Parliamentary Joint Committee on Corporations and Financial Services

Life Insurance Industry Report - March 2018

Link to Report

The Parliamentary Joint Committee recently published the Life Insurance Industry Report. Below are our key findings from this report.

Area	Key Recommendations	TurksLegal Findings
Consumer Protections	▪ **R3.1** Amend s15 of the *Insurance Contracts Act* (ICA) to remove prohibition against Consumer Protection (CP) legislation applying to life contracts. ▪ Amend the ICA generally and *Corporations Law* (CL) to remove other existing carve outs that exempt life insurance from CP legislation. ▪ **R3.2** ASIC to engage with insurers re removing unfair terms from life insurance contracts as soon as possible. ▪ **R3.3** ASIC's product intervention powers extended to include funeral insurance and amended to allow intervention on remuneration and extend time frame of IO beyond 18 months. ▪ **R3.4** Proposed Banking Executive Accountability Regime (BEAR), fin product design and distribution obligations and fin product intervention powers for ASIC should apply to life insurance and life insurers. ▪ **R3.5** BEAR be extended to include consumer related conduct matters and allow ASIC power to act on such matters. ▪ **R3.6** Increase penalties under ASIC administered legislation to equate to 3 x benefits obtained for all parties to transaction (including advisers, licensees and insurers). ▪ **R3.7** ASIC to conduct random adviser audits and results published.	▪ These ICA proposals are not new. Section 15 proposal supported by the Consumer Affairs Minister in August 2017 – currently under regulatory impact assessment. ▪ It is inevitable that CPL (in some form) will eventually apply to life contracts.
Codes of Practice	▪ **R4.1** Implement co-regulation approach for financial services sector as recommended by ASIC Enforcement Review Taskforce. ▪ **R4.2** In addition to co-regulation, ASIC be given power to undertake enforcement action for systemic breaches of Codes of Practice (COP). ▪ **R4.3** COPs to apply to all of life industry participants in order to gain ASIC approval. ▪ **R4.4** Combining the Life Insurance COP and Insurance in Superannuation OP as a prerequisite to ASIC approval.	▪ The current Life Insurance COP is not ASIC approved and breaches are not subject to ASIC enforcement.
Remuneration, commissions, payments and fees	▪ **R5.2** ASIC conduct a gap analysis of all payments and benefits flowing between participants in each sector of life industry and report findings to Government with the Government to then consider further regulation (if required). ▪ **R5.3** ASIC and APRA to immediately audit all super trustees to identify nature, purpose and value of all payments that occur between life insurers and trustees and related parties in connection with default insurance to MySuper members including examination of all monies moving under profit share or like models and payments from insurers to trustees and related parties for various ancillary expenses. ▪ APRA and ASIC publish the audit report as soon as practical.	

Area	Key Recommendations	TurksLegal Findings
Retail life insurance and approved product lists	▪ **R6.1** The life insurance industry have 'as a matter of urgency' a balance of affiliated and non-affiliated products on their approved product lists. ▪ Customer to be provided with information on affiliations when they are recommended an affiliated product. ▪ Customer to be provided with information that compares non-affiliated and affiliated products when they are recommended an affiliated product. ▪ Life insurance industry to transition to open approved products lists. ▪ ASIC and ACCC jointly investigate whether past use of APL's breaches anti-competitive laws. ▪ Investigation report produced by ASIC and the ACCC to inform government whether legislation inappropriately constrains capacity of either ASIC or the ACCC to investigate anti-competitive behaviour.	
Group life insurance	▪ **R7.1** Trustee be given information on, and inform members of low balance and duplicate accounts and accounts at risk of losing insurance coverage. ▪ **R7.2** Trustees inform ATO of insurance status of member accounts. ▪ **R7.3** ATO to provide superannuation and insurance details in Notices of Assessments (subject to cost). ▪ **R7.4** Life insurance industry fund media campaign aimed at lifting member awareness of pitfalls of duplicate cover and premium balance erosion. ▪ **R7.5** APRA/ASIC review compliance of Funds with SIS leg on premium balance erosion - s52(7)(c). ▪ **R7.6** Government consider legislation to protect low account balances from premium balance erosion. ▪ **R7.7** Government consider law to require life insurers and trustees to provide regular updates on level and cost of life insurance.	▪ Series of measures aimed at increasing member awareness of the existence of life cover through super and allowing member choices to me made to halt premium balance erosion and multiple insurance coverage. Regulators to monitor Funds specifically on SIS rules re inappropriate insurance coverage.
Access to medical information	▪ **R8.1** FSC and RACOGP to agree on protocols for requesting and providing medical information and a uniform authority document acceptable to all life insurers on all products (including clear statements on how the information will be used and stored). ▪ **R8.2 & 3** Failing agreement between the FSC and RACOGP within 6 months, request for medical information be limited to the relevant medical condition and life insurers cannot ask for clinical notes. ▪ **R8.4** Absent agreement with RACOGP, fresh consent required from insured each time it seeks medical information from a treater or shares information with a third party. ▪ **R8.5** Life COP be updated to reflect the above. ▪ **R8.6** If CP laws are to apply to life contracts, they should apply to use of authorities ▪ **R8.7** Insurers institute real time disclosure of claims progress.	▪ Strong onus on FSC to come to agreements with RACOGP on protocols for requesting information from treaters and on standard medical authorities. Absent such agreements, insurers face prospect of being prohibited from obtaining clinical notes or commentary on medical conditions beyond relevant conditions. Will also be required to obtain fresh authorisation each time they seek medical records.
Genetic information	▪ **R9.1** FSC and AGNDWG assess the impact of imposing a moratorium on life insurers using predictive genetic information unless consumer provides the information to show that they not at risk of developing the disease. ▪ **R9.2 &3** Predictive genetic information not be used whilst the moratorium is being considered. ▪ **R9.4** If moratorium is adopted, Government consider legislation to support moratorium.	

Area	Key Recommendations	TurksLegal Findings
Claims handling	▪ **R10.1** Government review Reg 7.1.33 of CL (carves out claim handling as a 'financial service') to see if the carve out inhibits ASIC's ability to oversight claim handling. ▪ **R10.2** The ICA and *Disability Discrimination Act* be amended to require insurers to provide written reasons (in plain English) as to why an application for insurance or a claim has been rejected with specific reference to the medical evidence leading to the rejection. The statistical and actuarial evidence behind the rejection should also be provided on request. ▪ **R10.3** Insurers must: - Update all definitions to reflect current medical knowledge. - Standardise all definitions across all types of policies. - Use clear and simple language in definitions. - Clearly explain whether associated conditions (arising from the initial condition) are covered by the policy. ▪ **R10.4 / 10.5** Life COP and Insurance in Superannuation COP be amended to reflect definitional changes above. ▪ **R10.6** The Life COP be amended to prohibit an insurer avoiding cover in relation to a pre-existing condition unless there is 'a direct medical connection between the prognosis of a pre-existing diagnosed condition' and 'the claim'. ▪ The statistical and actuarial evidence 'used to establish a pre-existing condition' as well as a plain English summary of the evidence be provided on request. ▪ **R10.7** The FSC following consultation with relevant groups, establish a new COP or a dedicated part of the existing Life COP, dealing solely with mental illness claims. ▪ The consultations on the Mental Illness COP include: - Applications for cover revealing mental health issues are not automatically declined. - Underwriters dealing with mental health disclosures have appropriate qualifications to deal with same. - An applicant applying for cover with mental health issues being given the opportunity to withdraw the application or provide further information before an underwriting decision is made. - Mental health exclusion or loadings be accompanied by explanation as to how long such non-standard terms will apply and the process to remove such terms. ▪ **R10.8** Insurers be allowed to actively promote best practice preventative health measures. ▪ **R10.9** The FSC consult with other groups (including consumer groups) reamending timeframes for claims decisions in the Life COP. ▪ **R10.10** The FSC consult with other groups (including consumer groups) reamending Life COP and Insurance in Superannuation COP to place upper limit on number of medical assessments that can be placed on insured. ▪ **R10.11** ACCC to monitor concentration of power in the Claims Management and IME industries. ▪ **R10.12** Mechanisms be established to compare draft IME reports with final versions. ▪ **R10.13** Government legislate to allow rationalisation of legacy products subject to an individualised 'no disadvantage' rule. ▪ **R10.14** Government conduct an inquiry before it progresses with any reforms relating to insurers funding rehab services. ▪ **R10.15** FSC consults with groups on Dementia with a view to amending the Life COP to deal specifically with this condition.	▪ ASIC has called for the amendment to Reg 7.1.33 in several reports commencing with R498. ▪ PJC seems to conflate the circumstances of rejected applications for cover with rejected claims on existing cover. Rejected claims are of course always accompanied by detailed reasons and generally prior to that, procedural fairness. In the circumstances this recommendation should be seen perhaps as being restricted to rejected applications for new cover. ▪ Underwriter would need to provide detailed reasons for declines for cover and be prepared to disclose underlying data for rejection. ▪ Life COP already provides undertakings on updating medical definitions. ▪ Standardisation of 'all definitions across all policies' is obviously an impractical and imprecise recommendation. Perhaps it should be taken as meaning key insuring definitions such as 'TPD' or 'Total Disability'. ▪ This is a significant change and would involve a pivot on 150 years of the law of policy avoidance which has always permitted avoidance on the basis of actionable material non-disclosure regardless of whether the non-disclosure is related to a claim or not. Also does not address the situation of avoidance where there is no claim on the policy at all. ▪ Pre-existing conditions are determined according to the facts and the medical evidence not statistical data. PJC may again be conflating underwriting and claims issues ▪ These timeframes are already dealt with extensively in the current Life COP.

INDUSTRY NEWS

FOS approach to section 54 of the *Insurance Contracts Act* (1984)

FOS recently published written guidelines on how it approaches section 54.

Section 54 applies to policies which permit an insurer to refuse a claim because of the "**act**" or "**omission**" of the insured (or another person) after the policy was entered into:

- The effect of section 54(1) is that provided the act/omission could not be reasonably regarded as being capable of causing or contributing to the loss, the insurer may not refuse to pay the claim (in full or part) by reason only of that act/omission. But the insurer may reduce liability to the extent its interests were prejudiced as a result of that act/omission.
- Alternatively, the insurer may refuse to pay the claim if that act/omission could reasonably be regarded as being capable of causing or contributing to the loss (section 54(2)), subject to the exceptions in sections 54(3) - 54(5).

FOS outlines some guides to approaching section 54, stating it will ask:

1. Is there an inherent restriction or limitation in what is covered under the policy?

   Section 54 does not apply to relieve a claimant of restrictions or limitations inherent in the claim.

2. Has the insured (or some other person) done some act/omission after the contract was entered into which permits the insurer to refuse the claim?

   If no, section 54 does not apply.

3. If yes, could that act/omission reasonably be regarded as **capable of causing or contributing to the claimed loss**?

   This does not require the insurer to show the act/omission actually caused the loss.

4. If yes, the insurer can refuse the claim unless the claimant can prove:

   a) The act/omission did not cause the loss (or part of) the loss (section 54(3), section 54(4)). The insurer is liable for the part of the loss that was not caused by the act/omission,

   b) The act/omission was necessary to protect the safety of a person or to preserve property (section 54(5)(a)), or

   c) It was not reasonably possible for the person not to do the act/omission (section 54(5)(b)).

5. If no, the insurer is liable for the claim. But the insurer may reduce its liability to the extent its interests were **prejudiced** as a result of that act/omission.

   The insurer must prove the extent of its actual prejudice in monetary terms (such as the full value of the claim).

FOS provides numerous case studies. Case study 4 deals with a claim for Total Temporary Disability (TTD) benefits. The policy requires TTD to occur within 12 months of the injury. Given the hospital waiting list, the insured did not have surgery until 18 months after injury and became TTD following surgery. It was determined that section 54 applied to prevent the insurer for refusing the claim on the basis of the omission to undergo surgery. The case study recognises that the determination may be different if the claimant had not attended the hospital or sought surgery until after the 12 months had elapsed.

FOS does not provide any guidelines as to the information required to be produced by insurers in disputes involving the application of section 54, noting that it is a question of fact in each dispute. From a practical perspective, insurers should put claimants to the proof to enable an informed assessment of a claim. If a declinature of the claim is disputed pursuant to section 54, insurers should be prepared to produce documents which demonstrate the claims procedures which would have been followed and these steps would have reduced its liability in monetary terms.

CASES AND TRIBUNAL DECISIONS

Total and Permanent Disability (TPD) benefit under the State Public Superannuation Scheme

Board of Trustees of the State Public Sector Superannuation Scheme v Edwin Gomez [2018] QCA 67

Link to decision

Mr Gomez had originally appealed to the Supreme Court of Queensland following a decline of his claim for a Total and Permanent Disability (TPD) benefit under the state public superannuation scheme. His claim had been considered three times by the Board, the first 2 decisions were decline determinations following a full consideration of the merits of the claim and the third was a decision to not further review the claim.

At first instance, His Honour Justice Boddice found that the first 2 decisions were sound, however the third decision of the trustee not to further reconsider the claim on its merits in light of the new material provided, failed the appropriate test. The test was whether, by reason of circumstances occurring since the previous application or by reason of evidence not reasonably available at the time of the previous application there was a reasonable possibility of a different result. If so, having regard to the interests of the applicant and the interest of other members, that possibility justified the expense to the trustee of reconsidering the claim including such other investigations as may be warranted. Having come to that conclusion His Honour returned the matter to the trustee for its re-consideration.

The trustee appealed the finding as to the 3rd decision and Mr Gomez cross-appealed the finding as to the 2nd decision and specific findings as to the validity of the delegation by the Board and orders as to costs.

Both the appeal and cross-appeal were dismissed.

Interestingly, the comments of Boddice J that there was no utility in determining the challenge to the 1st decision once the 2nd decision was made was not the subject of complaint in the appeal.

This suggests that the different approaches to this issue across courts remain to be resolved.

Henry J. in a judgement with which the other members of the Court of Appeal agreed, upheld Boddice J's application of the test set out in *Gilberg v Maritime Super Pty Ltd* [2009] NSWCA 325[22], for determining the circumstances in which the emergence of further information may warrant reconsideration of a previously unsuccessful application for the payment of a TPD benefit. The test propounded for determining whether to reconsider an application – a reasonable possibility of a different result, was said to derive logically from the duty to provide properly informed consideration to an application. "If the further information indicates a reasonable possibility of a different result then, until such time as it is considered in addition to the earlier considered information, it can no longer be said the Board had met its duty of giving properly informed consideration to the application".

In respect of the extent to which the trustee should make further inquiries in order to meet its duty to give properly informed consideration to an application, Henry J. specifically observed that the "duty to give properly informed consideration does not oblige the Board to inquire to the point of factual perfection'. While the extent of those inquiries will vary with the circumstances of the case, the ultimate point of any further inquiry is to enable the Board to meet its duty to give properly informed consideration to an application.

CASES AND TRIBUNAL DECISIONS

The Supreme Court of NSW judgment concerning a claim for a TPD benefit

Carroll v United Super Pty Ltd [2018] NSWSC 403

Link to decision

The Supreme Court of NSW has recently delivered a judgment concerning a claim for a Total and Permanent Disability (TPD) benefit.

Background

The plaintiff was a self-employed building contractor and claimed to be TPD from 9 March 2012 as a result of bilateral hip dysplasia. The plaintiff previously worked as a spray painter and labourer. He operated his own panel beating business between 1989 and 1997, employing up to 5 people. In 1997, the plaintiff commenced work as a building contractor, both self-employed and as an employee.

He underwent a right total hip replacement in early 2015 and subsequently claimed his left hip became symptomatic.

The TPD definition in the Policy was:

> "Unlikely to Return to Work:
>
> The Insured Person is unable to follow their usual occupation by reason of Illness or Injury for 3 consecutive months and in our opinion, after consideration of medical or other evidence satisfactory to us, is unlikely ever to be able to engage in any Regular Remuneration Work for which the Insured Person is reasonably fitted by education, training or experience".
>
> "Regular Remuneration Work" was defined as:
>
> "Regular Remuneration Work means an Insured Person is engaged in regular remunerative work if they are doing work in any employment, business, profession or occupation. They must be doing it for reward, or the hope of reward of any type....".

The Decision

The insurer and the Trustee declined the TPD benefit on the basis the plaintiff could return to lighter work with his education, training or experience – being work as an Estimator or Project Manager. The plaintiff disputed the decisions on the basis the alternative roles required significant retraining and he was physically incapable of performing those roles.

Justice Slattery reviewed the decisions and found they should be vitiated on the following grounds:

- A note in the Trustee's file stated "*a vocational assessment would have made for a more complete assessment*". His Honour found the Trustee "*failed to seek such relevant opinion to complete its assessment… there was no apparent basis for the reason for not pursuing this opinion*".
- The roles of Estimator and Project Manager were not realistically available to the plaintiff.
- The insurer's decline did not refer to all reports from Dr Barnes. His Honour found this demonstrated the insurer did not have regard to all the evidence.
- The insurer ought to have asked the plaintiff to comment on whether he was able to restructure his business to perform the lighter non-manual aspects and delegate the heavier tasks.
- The insurer did not adequately respond to the plaintiff's statement that he could not physically perform work as an Estimator or Project Manager.

Having set aside the decisions, his Honour considered whether the plaintiff:

1. could use his existing vocational experience to work as a Project Manager or Estimator, or
2. could undertake regular remuneration work on a self-employed basis in private business ventures.

His Honour commented on the plaintiff's presentation as a witness by stating:

> "*Whilst the Court did not find Mr Carroll to be an entirely reliable witness and that he was a person prone to exaggeration and overstatement, he was still a witness who attempted to tell the truth*".

The Court accepted the plaintiff's vocational evidence that Estimating and Project Management required "someone physically able to go on site". These roles were not available to the plaintiff as he could not physically perform them.

With respect to the plaintiff's geographical location (Tasmania), his Honour stated:

> "*…it seems difficult to justify assessing a claimant as not being TPD if the cost of relocating to find available work of that kind elsewhere would make accepting that distant work an economically unviable decision. The overall costs of relocation are a logical integer in any finding that a claimant is not TPD due to the availability of work outside the local area*".

Evidence emerged shortly before the hearing that the plaintiff was involved in several businesses. The "Too Easy Distributing" business imported products from China. The plaintiff gave evidence his wife operated that business and he provided occasional assistance.

His Honour accepted the business was not a commercial success and was not capable of providing regular remunerative work.

The plaintiff was also listed as the Australian distributor for agricultural products sold by The Wrangler in NZ. His Honour accepted the plaintiff's evidence that his wife was the distributor for The Wrangler, despite the plaintiff's name and mobile number appearing on The Wrangler's website. The Court also accepted the plaintiff's evidence that his involvement in Nicholas Wines was a "pipe dream" and the business had not progressed from planning and discussion between friends. This was despite evidence showing Nicholas Wines was incorporated and had registered a trademark.

His Honour did not accept the businesses were operated for the "hope of reward" as they were tied to the family and the business responsibility lay with other family members.

His Honour found the plaintiff's involvement in the "*small family businesses*" was "*casual work or other work of an intermittent nature*" (see Dargan) and therefore not regular remunerative work. Accordingly, the plaintiff had successfully challenged the Trustee's and insurer's decisions and had demonstrated an entitlement to the TPD benefit.

Implications

This case is a reminder about the level of detail the Court will use to examine the decision-making process. Where further evidence is identified in a claim, and that evidence is not obtained, the Court may be willing to find a breach results from the failure to obtain relevant evidence. The decision also demonstrates the importance of referring to all relevant evidence and "grappling" with that evidence in a decline letter.

The Court appears to have adopted *Halloran* and found the location of the claimant is relevant when considering whether work is available within the claimant's ETE.

When considering subsequent "self employment", the Court has considered the profitability and success of the businesses, rather than the capacity to perform work.

RECENT FOS & SCT DECISIONS

Compensation Awarded for Non-Financial Loss

Link to determination

Facts

The Applicant was diagnosed with metastatic melanoma and in 2016 claimed terminal illness benefits under a loan protection insurance policy (the Policy) which he had taken out with the financial services provider (FSP) on 2 December 2014.

The Policy excluded claims for benefits where the terminal illness resulted directly or indirectly from an illness for which the Applicant had symptoms, or received professional or medical advice or treatment for within 12 months before the Policy start state. Although the Applicant's illness was not deemed terminal until February 2016, he had undergone several examinations and consultations in the 12 month period prior to the start date of the Policy. As a result, the FSP determined that the Applicant's terminal illness claim was excluded under the Policy.

The Applicant maintained that his illness was not yet terminal at the time the Policy started. He also submitted that the FSP should backdate the Policy to 2009 as he had applied for loan protection at this time and believed his application had been accepted verbally.

The FSP submitted that the Applicant was provided a premium estimate for a loan in 2009 and that while there was an intention to proceed with the application, there was no evidence that the Applicant had accepted the premium estimate and the application had subsequently been closed.

Issues

1. Is the Applicant's claim excluded under the Policy?
2. Is it fair and reasonable for the Insurer to backdate the Policy to 2009?
3. Is the Applicant entitled to compensation in some form?

Determination

The FOS was satisfied that the FSP was entitled to deny the Applicant's claim for a terminal illness benefit by relying on the exclusion.

The medical evidence showed that the Applicant had several examinations and consultations with regard to a diagnosis of metastatic melanoma in the 12 months prior to the Policy start date. The FSP also determined that it was irrelevant that the illness had only become terminal in February 2016 as the Policy wording provided that it was sufficient that the Applicant received professional medical advice or treatment for his illness, within 12 months before the Policy start date.

The FOS did not find any evidence to suggest that the Applicant had accepted the premium estimate in 2009 and it also determined that the onus was on the Applicant to realise that he was not covered. With regard to this, the FOS noted that the Applicant did not receive a welcome letter, policy schedule or policy document in 2009, made no attempt to follow up the application and should have realised that premiums were not being deducted from his account.

Despite the above findings in favour of the FSP, the Applicant was awarded compensation of $3,000 for non-financial loss under the FOS Terms of Reference (the TOR). The TOR allow for compensation to be awarded "for interference with the applicant's expression of enjoyment or piece of mind". As the Applicant had several policies with the FSP, and had multiple dealings with the FSP previously where he was able to accept a premium quote verbally, the FOS was satisfied that there was an interference with the Applicant's expectation of enjoyment or piece of mind.

Implications

The decision provides an example of how compensation may be awarded under the FOS TOR for non-financial loss, even when it is determined that a FSP was entitled to deny an Applicant's claim. In this particular case, even though there was no evidence in writing that the Applicant's application had been accepted in 2009, given the Applicant's prior dealings with the FSP, and their expectation that an application could be accepted verbally, this was sufficient for compensation to be awarded.

RECENT FOS & SCT DECISIONS

Retrospective Underwriting Opinion Key to Avoidance

Link to determination

Facts

On 3 December 2013, the Applicant entered into four policies with the Financial Services Provider (FSP) which included trauma; life, Total and Permanent Disability (TPD), trauma; income protection and life and TPD. The Applicant made a claim in May 2015 against three policies following a diagnosis of prostate cancer. The FSP denied the claim, avoided the policies pursuant to section 29(3) of the *Insurance Contracts Act 1984* (ICA) and refunded all paid premiums on the basis that the Applicant failed to disclose a history of alcohol misuse, gout and tendonitis when he applied for cover.

The Applicant answered 'no' when asked if he 'ever received advice, counselling or treatment for the use of drugs or alcohol'. He answered 'no' to a medical history question which specifically asked if the Applicant had ever had symptoms of, investigation or treatment for, or received a diagnosis for gout or tendonitis. When asked whether he had consulted a health professional for any reason other than a cold/flu, he answered 'yes' and mentioned blood pressure tests, a colonoscopy and 6 monthly blood tests.

The medical evidence revealed, however, that the Applicant had consulted his GP to discuss alcohol, and had been referred to a psychiatrist who treated the Applicant for a diagnosed Alcohol Dependence Disorder between 19 November 2012 and 16 May 2013. The Applicant disagreed with his psychiatrist's diagnosis of Alcohol Dependence Disorder and obtained reports from his GP and an alternate psychiatrist which supported his argument that the diagnosis had been premature, given that the alcohol dependence had not been long term.

Clinical notes in December 2011 confirmed a history of gout and the Applicant's GP had made requests for physiotherapy in September 2013 for the Applicant's tendonitis. The Applicant argued that a failure to disclose the relevant information was an 'honest oversight'.

The FSP avoided the Policies and provided a retrospective underwriting opinion and statement dated 10 June 2015, supported by underwriting guidelines, which confirmed that had the Applicant disclosed his alcohol dependence, he would not have been offered cover on any terms.

Issues

1. Did the Applicant fail to comply with his duty of disclosure prior to entering into the Policies?
2. Is the FSP entitled to avoid the Policies under section 29(3) of the ICA?

Determination

The FOS determined that the FSP was entitled to avoid the policies under section 29(3) of the ICA. It found that the FSP had clearly informed the Applicant of the duty of disclosure. It also found that the Applicant had failed to comply with his duty of disclosure under section 21 of the ICA as he did not disclose his full medical history including advice and treatment he ought reasonably to have known would be relevant to the FSP's decision to enter into the contracts of insurance. Based on the underwriting evidence provided by the FSP, the FOS was satisfied that the FSP would not have entered into the contracts of life insurance with the Applicant on any terms had the Applicant complied with the duty of disclosure or not made the misrepresentation. As a result, the FOS determined that the FSP was entitled to avoid the Policies.

While the FOS did acknowledge the findings of the Applicant's two doctors that the diagnosis of Alcohol Dependence Disorder had been premature, it did not believe that these findings meant the Applicant had not breached his duty of disclosure. This is because the question contained on the application form did not call for a specific diagnosis for alcohol use or misuse but simply asked if the Applicant had ever received advice, counselling, or treatment of the use of alcohol.

Implications

Retrospective underwriting evidence is vital for an FSP to prove that it would not have entered into a contract of life insurance on any terms, had the applicant complied with the duty of disclosure or not made a misrepresentation, in accordance with section 29(3) of the ICA. As a result, FSPs should be diligent in keeping records of their underwriting guidelines which are subject to change over time.

TURKSLEGAL Q&A

Giving Evidence - What to do in these circumstances?

In this edition of TurksLegal Q&A, we respond to a client's question on giving evidence.

Q: In what circumstances might an insurance professional be called to give evidence?

Anyone would be hard-pressed to find a witness who relishes the opportunity to be examined or cross-examined in court. Nonetheless, insurance professionals may be required to justify their position taken on a particular claim and assist in the presentation of an insurer's evidence to a court.

In what circumstances might an insurance professional be called to give evidence?

Due to the contextual nature of the underwriting process, underwriters are commonly called upon to give evidence to particularise their underwriting of the risk. This is typically in instances where there has been alleged non-disclosure by the insured and the insurer has exercised a remedy under s. 29 of the *Insurance Contracts Act 1984*. The underwriter will be required to justify their decision that had there been proper disclosure, they would not have underwritten the risk on the same terms or at all.

Similarly, for claims assessors, evidence may be required in cases involving opinion-based clauses or where there are allegations of breach of the duty of utmost good faith on the part of the insurer. Focus will be placed on steps taken during the claims process, and any alleged flaws in the assessment or decision.

1. Preparing to give evidence

Only evidence relevant to the issues in dispute to help decide the case will be admissible in court. The introduction of that evidence can take several forms. It might be a witness statement or affidavit or given orally by you in court. However, even if you prepare an affidavit or statement you may still be required to attend court to admit that evidence or be cross-examined upon it.

Sound preparation of your case enables you to present yourself as a good witness. You should always assume your file will be produced to a court or a tribunal. Accordingly, hard copy or electronic files should be maintained in good order so that important information is readily accessible. File notes and correspondence (both internal and external) are critically important, as is adopting a professional tone in all forms of communication.

Assessment process and decisions will be examined in hindsight. Therefore, any file notes and internal communications should demonstrate that you have:

- considered the correct question,
- considered all the evidence,
- not considered extraneous or irrelevant evidence,
- had due regard to the interests of the insured, and
- that any decision reached is reasonably open to you on the evidence.

2. What happens in the witness box?

After being sworn in as a witness, your barrister will ask questions to allow you to present your side of the case to the court. This is what is known as 'evidence in chief '. You may be presented with various documents which have been tendered into evidence, for instance an application or underwriting opinion, and asked open questions about your assessment of it.

In evidence in chief you won't be asked leading questions which prompt you to answer in a particular way i.e. when did you form the view that the claimant wasn't credible?

The reason is the court wants to hear your evidence, without manipulation.

You can then be cross-examined by the plaintiff 's barrister. The purpose of this is to test the truth and accuracy of your evidence. Here there can be leading questions – taking you down a particular path. Not surprisingly the barrister will attempt to find flaws in your evidence or the documentation supporting your case.

At the end of the cross-examination your barrister may be able to 're-examine' you so as to clarify any issues arising from the cross-examination. This will provide you with the opportunity to explain any misunderstandings arising out of your cross-examination.

3. Tips for the witness box

Even the most experienced witnesses can find themselves anxious when placed in the witness box, however the following tips may assist in making the process less nerve-racking:

- Try to maintain a calm and professional demeanour,
- Attempt to answer any questions put to you during cross-examination as simply as possible, preferably with a 'yes' or 'no' response. Long rambling responses provide an opportunity for the plaintiff 's barrister to open up a new line of enquiry that may not have otherwise been available to him or her,
- Do not appear evasive by not answering the question put to you, as simply talking around it will not help your case, and
- If you are asked questions about matters you do not recall it is best to simply say so rather than attempting to reconstruct the facts based on other matters known to you.

Generally, if prior to giving evidence you are well prepared and familiar with your file and the sequence of events, and you have conferenced with your counsel as to the type of issues which might arise (without being coached), then you will be well placed to present your evidence in the best possible light.

4. When does ethical preparation turn into unethical coaching?

There exists an assumption that a witness giving evidence for the benefit of one party will be inclined to please that party.

This is precisely why it is important to touch upon the fine line between thoroughly preparing a witness and the unethical coaching of a witness.

In *Re Equiticorp Finance Ltd* (1992) 27 NSWLR 391, Young J emphasised the requirement that solicitors should not advise a witness as to how particular questions should be answered (other than that the question should be answered truthfully) or suggest words which the witness should use.

Ultimately, it is imperative to emphasise the importance of neutrality and independence on the part of any witness. Lawyers should, appropriately, be restricted to preparatory activities which protect the integrity of a witness's evidence. Always keep in mind that, as a witness, your fundamental duty in the adversarial system is to provide evidence honestly and without extrinsic influence from anyone, including your legal practitioner.