INSURANCE ▫ COMMERCIAL ▫ BANKING

Welcome to the Financial Services Bulletin (FSB) – September 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 celebrates new appointments

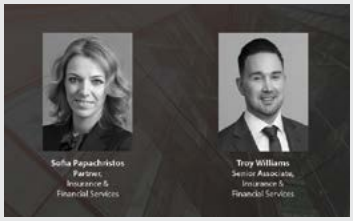
In our December edition of the FSB we announced the welcome return of Sofia Papachristos to TurksLegal as a Partner click here.

We finally got to celebrate Sofia's return with clients at our Melbourne appointments function in August. We were also delighted to announce on the night that Troy Williams, a member of our Financial Services Products, Transactions and Regulatory Team in Melbourne had become a Senior Associate.

Troy was admitted in 2006 and has had extensive experience in private practice and in-house in Australia and overseas in the finance sectors. Immediately before joining TurksLegal in 2017 Troy worked as a legal counsel for the financial services regulator in New Zealand.

We are also proud to announce that Sydney lawyer, Sophie Campbell and Melbourne lawyer, Caitlin Edwards became Associates in July.

These individuals have shown enormous talent, not only as legal specialists, but also as ambassadors for our firm.



2018 ALUCA TurksLegal Scholarship in the Home Strait

The next exciting phase of ALUCA TurksLegal Scholarship began on Monday as entries closed over the weekend. We are currently preparing packs of the top submissions to be reviewed by our expert panel of judges.

The winner and runners up will be announced at the ALUCA bi-annual conference which this year takes place in beautiful Hobart on 11 - 13 October, see item below.

Come and be part of our session

TurksLegal Partners Peter Murray and Sofia Papachristos will be presenting a new perspective on the issues currently driving the life insurance industry in a concurrent session at the ALUCA bi-annual conference on 12 October.

Come along and be part of the discussion as Peter and Sofia explore the thorny issue of Community Expectations and offer a structured solution to Ex-gratia Payments.

INDUSTRY NEWS

Senate Committee recommends no changes to group insurance budget proposals

The Senate Economics Legislation Committee (the Committee) handed down its report on the *Treasury Laws Amendment (Protecting Your Superannuation Package) Bill 2018* (the Bill) on 14 August 2018.

The Bill gives effect to the budget changes. In broad terms, the budget changes as outlined in the Bill will prevent trustees from providing default cover to:

- New members from 1 July 2019 who are under the age of 25;
- Members who have an account balance of less than $6000 and have not been $6000 or more on or after 1 April 2019;
- all inactive accounts after a period of 13 months.

The impacted members will still be able to opt-in to group insurance cover.

The Committee has recommended that the Bill be passed.

There were broadly four key concerns with the Bill raised in submissions to the Committee:

1. The under 25 proposals;
2. Treatment of *active* accounts less than $6,000;
3. Impact on members in high risk occupations; and
4. The proposed start date of 1 July 2019.

The Committee's reasoning on key concerns was:

- The Bill is an important first step in ensuring Australians' superannuation balances are preserved for retirement;
- In terms of the definition of "inactive" account, the Committee argues the more rigorous definition is consistent with the fundamental purpose of the reform to consolidate low-balance accounts;
- In relation to the impact of the bill on insurance premiums, the Committee recognises the changes may result in increased premiums for members who continue to hold default cover. However, the Committee felt this demonstrates the substantial cross-subsidies inherent in the current system; and
- In terms of concerns regarding the removal of default insurance coverage for some cohorts, especially those employed in high-risk occupations, the Committee stated it agreed with the principle highlighted in the Grattan Institute submission that defaults should be set so that they are appropriate for the most people. Plus, the Committee noted impacted members can still opt in; and
- According to the Committee the proposed commencement date of 1 July 2019 is manageable as renegotiating contracts is not an unfamiliar process to superannuation funds.

Overall, the Committee does not appear to have placed enough weight on submissions which demonstrated through case studies and statistics the value of insurance payouts to impacted cohorts as against the balance erosion impact. It is surprising that at the very least there was not a recommendation to introduce a carve out for superannuation funds who could demonstrate the importance of retaining group insurance cover for impacted members on an opt out basis given their demographic composition.

The Committee also appears to have not placed much emphasis on submissions which noted that a longer transition period would benefit members by allowing them further time to consider and address their insurance needs.

The Senate Committee report includes additional comments from Labor Senators in a separate section of the report. Here it is noted that the Labor Senators will

continue to evaluate possible amendments to improve the legislation. The Labor Senators have stated that they are "very cognisant" of the following concerns:

(a) Proposed start date for the insurance arrangements

(b) Potential impacts on high risk occupations

(c) The 13-month definition of inactivity

(d) Insurance cover for people with active accounts with a balance of less than $6000

(e) The age threshold of 25 years

(f) The anti-selection problem raised by opt in arrangements.

Of course, there are also quirks in the Bill which should be ironed out, such as references to the changes not affecting the rights of a member if "the right is a right to insurance cover for a *fixed term*, subject only to the payment of insurance premiums" and the fixed term begins for the changes (see, for example, proposed section 68AAA(8)).

The reference to a member's "fixed term" does not sit easily with how most group insurance contracts are structured. There are a number of possible readings of 'fixed term' including that it means existing members are essentially grandfathered from the changes until their cover expires under relevant end of cover provisions. However, that reading would appear inconsistent with the transitional provisions more generally. Overall, clarity on how such references to "fixed term" should be interpreted would be beneficial.

As it stands, the Bill is currently listed as number 25 in Bills to be voted on by the Senate. The Senate is up to Bill number 5 with their next sitting commencing in the week of 10 September.

INDUSTRY NEWS

Unfair Contracts Protections and Life Insurance

Treasury has recently concluded a consultation process with stakeholders in the general and life insurance industries about extending statutory remedies for unfair contract terms to insurance policies.

The draft model that Treasury has proposed will, if implemented, result in the current exception in *Insurance Contracts Act 1984* (the 'ICA') which prevent other legal remedies for unfair contract terms being applied to insurance contracts, as defined in the ICA, being abolished.

The *Australian Securities and Investments Corporation Act 2001* (the 'ASIC Act') will also be amended under the Treasury model to allow the terms of a life or general insurance policy that are declared to be unfair to be rendered void or to be subject of "other orders" which a court considers appropriate.

Treasury considers that only what it describes as "the main subject matter" of the contract and the "upfront price" will be exempted from scrutiny under the amended ASIC Act provisions.[1]

If you think you have heard all this before, it is because laws regulating unfair contract terms ('UCT') were first introduced in relation to other consumer contracts some time ago and Treasury ran a consultation process with the insurance industry in 2012 with a view to applying them to insurance, which did not result in any changes being made at that time.

The decision to look at the issue again was instigated by the Senate Economics References Committee report but has been reinforced more recently by the recommendations of the Joint Parliamentary Committee on Corporations and Financial Services in its report in relation to the life industry released earlier this year[2] (the 'PJC Report').

Under the law that currently applies to consumer contracts outside the insurance industry[3] a term of a consumer contract is unfair if it;

- would cause a significant imbalance in the parties' rights and obligations arising under the contract;
- is not reasonably necessary to protect the legitimate interests of the party advantaged by the term; and
- would cause financial or other detriment to a party if it were relied on.

In deciding if a term is unfair, a court is to take into account the whole of the contract and the extent to which the term in question is legible, presented clearly and expressed in plain language.

The major concern for the insurance industry in this proposed legislation is not that there are many provisions in policies that would fail this test. Aspects of the proposal are also clearly attractive to everyone, such as the incentive in the legislation to present products clearly and in plain language, which is obviously to everyone's benefit.

However, unlike other consumer contracts that are presently subject to UCT legislation, the distinction between what the contract is about – the core substance of the transaction and the terms on which it is provided, are less easily distinguished when someone purchases insurance, and essentially this issue underlies the industry's major concerns about the proposals.

The difference between the "main subject matter" of an insurance policy and other consumer contracts is well illustrated in the PJC Report, where it lists the kinds of terms that had been eliminated in the telecommunications, fitness and vehicle rental industries, as well as some contracts commonly used by online traders as a result of unfair contracts terms legislation[4].

The eliminated terms all provided an illegitimate advantage to the service provider in relation to the way the contract could be changed or terminated by the service provider, or in relation to agents or the giving of guarantees. They have the common thread of being about how the provider could deal with the consumer over what they had purchased, but not over the essence of what the consumer had agreed to buy or what they agreed to pay for it.

Ironically, where there have been similar problems identified in the context of insurance, they have already been addressed and are part of existing legislative protections.

The insurance industry has pointed out in prior submissions to government that there are already significant safeguards for consumers built into the framework of the legislation it already works within, Government is clearly aware of this, and the consultation paper recently released by Treasury in June 2018 "Extending Unfair Contracts Terms Protections to Insurance" (the " Treasury model") examines them in some detail.

However, evidence of the bad outcomes some consumers have experienced which has been tabled at recent enquries has clearly had an impact on the faith that regulators and legislators are willing to place in existing protections. This has shifted the argument in favour of the need to accept the case for universal consumer protections against unfair contract terms.

The critical question for the insurance industry has therefore ceased to be whether these changes are justified at all, and has turned instead into one about whether changes can be made in a way that prevents every declined claim turning into a legal dispute about the unfairness of the provision of the policy underpinning the insurer's decision not to pay.

A change which would provide a platform for arguments of this nature would undoubtedly be the worst outcome for all the stakeholders, generating uncertainty, rising levels of disputation, creating higher costs for everyone and possibly, in the long run, of significant prudential concerns.

Avoiding this outcome means convincing lawmakers about what the nature of the risk the insurer really underwrites in exchange for premium and the difference between this, which is the true "main subject matter" of an insurance contract and the incidental terms on which cover is provided.

This is not so simple a task as it may appear, when both sets of constructs are just words in a policy document which do not necessarily look that different to one another.

However, the point here is that some of these words contain the commercial core of the bargain into which neither party should want to introduce uncertainty[5] and which ought to be regarded as the "main subject matter' while others are just the machinery that is supposed to facilitate the way the core bargain is delivered, and which should not be allowed to be unfair.

Fortunately, this issue is raised squarely for debate by the current treasury model.[6]

The model initially put forward by Treasury will only exempt specific features of insurance contracts from the UCT regime by exempting the "main subject matter" of a contract which in Treasury's preferred model "will be defined narrowly as terms that describe what is being insured, for example, a house, a person or a motor vehicle".[7]

According to the current Treasury model, all other provisions will be subject to the test of fairness and will be considered unfair unless "reasonably necessary to protect the legitimate interests of an insurer" which will be the case "if it reasonably reflects the underwriting risk accepted by the insurer in relation to the contract and it does not disproportionately or unreasonably disadvantage the insured."[8]

This is the wrong test to apply to provisions which define the boundaries of what the policy covers, which are at the heart of the commercial core of the bargain, because it would mean that every time it denied a claim an insurer would routinely have to establish that the premium it received was a fair reflection of the nature of the risk.

In other words, the narrow approach to what is the "main subject matter" produces an outcome which the Treasury model expressly says it will not permit, saying that "the 'upfront price' will include the premium …. and will not be subject to review ".

The "narrow" view of the contract's subject matter would therefore mean that if it denies a claim, a life insurer might routinely have to prove in court that the contractual terms that describe what it is insuring, including general or specific underwriting exclusions, waiting periods and other conditions that describe when the cover commences or ends are a "reasonable reflection" of the underwriting risk that it accepted.

This looks exactly like the sort of approach which would lead to the proliferation of disputes that was identified earlier as the worst possible outcome for all the stakeholders (outside the legal industry of course) and, one which would generate higher levels of disputation, uncertainty, higher costs and ultimately, lead to prudential concerns.

Fortunately, there are other options canvassed in the current Treasury model which offer an alternative approach to the "main subject matter" based on the model developed in the European Union. This "exempts from the UCT regime terms which 'clearly define or circumscribe the insured risk and the insurer's liability'."[9]

The virtue of this approach is that it treats insurance contracts exactly the same way as the other contracts already regulated by UTC laws and preserves certainty over the essence of what the consumer has agreed to buy and what they agreed to pay for it.

So, what is a better description of the "main subject matter" of what a customer has agreed to buy when they purchase a life insurance policy? The answer is exactly what the EU model suggests, the promises that set out the insured risk and the insurer's liability to pay the agreed benefit.

To enumerate this "main subject matter" in more detail, the customer has purchased a legally enforceable promise by the insurer to pay a benefit of particular type if a particular event occurs within a particular period. So the description of the benefit, the description of the insured event and when cover begins and ends are therefore integral parts of the "main subject matter".

That is not quite all though.

Life policies are issued with conditions that the company's actuaries must take into account in determining if the policy is prudentially acceptable at a given rate of premium, and the Prudential Standards require the Appointed Actuary to give written advice to the company in relation to this[10].

Critical policy conditions will not just be the ones in relation to the description of the benefit, or the description of the insured event, but will also include provisions within the policy which have the effect of modifying either or both by, for example, excluding certain medical conditions (a general pre-existing conditions exclusion would be a typical example) or imposing a waiting period or other temporal exclusion calculated to defeat anti-selection.

The Appointed Actuary's advice will also be premised on the assumption the company's underwriters will only be permitted to issue cover within its underwriting guidelines, and also, more relevantly, that they may require other exclusions or conditions that are individually negotiated with the person applying for cover that render an otherwise unacceptable risk permissible within them.

The conditions and exclusions negotiated during the process of underwriting also modify the insured risk and the insurer's liability to pay the agreed benefit. The sum total of these prudentially critical terms which describe the risk insured by the policy and define when the insurer is liable to pay truly form the "main subject matter" of a life policy.

Like other contracts currently covered by UCT laws, the core elements of the bargain with the customer represented by the "main subject matter" should not be rendered uncertain for either party under the new UTC laws by routinely requiring the insurer to prove they are reasonably necessary to protect its legitimate interests.

How broadly the "main subject matter" is defined in relation to life policies is one of the critical issues Treasury is seeking to resolve in the current consultation and exactly what solution is arrived at potentially has immense consequences for the future shape of the industry for life companies and customers alike.

However, it is only one of a number of issues that the industry needs to engage with. The Treasury model raises questions about the form the changes should take and to what extent they will apply to the group market which is characterised by bespoke policies negotiated by parties with equivalent bargaining power.

The closing date for submissions was 24 August 2018.

[1] To see Treasury's summary of its proposed model, click here. The changes will only apply a "consumer contract" or "small business" contract but the extent that either expression applies to group business is unclear.

[2] Report of the Parliamentary Joint Committee on Corporations and Financial Services in relation to Life Insurance, 28March 2018. https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

[3] Meaning of Unfair - section 12BG the Australian Securities and Investments Commission Act 2001

[4] PJC Report paragraph 3.26.

[5] Or at least where uncertainty has established parameters under the ICA, such as policy conditions in relation to increased post-contractual risk affected by section 54 ICA.

[6] Treasury model page 14.

[7] Treasury model page 2.

[8] Treasury model page 2.

[9] Treasury model page 14.

[10] LPG 320 Actuarial and related Matters. Paragraph 24.

BOX 1: SUMMARY OF THE PROPOSED MODEL

The proposed model seeks to ensure that insureds are provided with the same UCT protections already available to consumers in relation to other financial products and services, while ensuring the laws are appropriate in light of the specific features of insurance contracts.

It is proposed that the existing UCT regime in the ASIC Act apply to insurance contracts regulated by the IC Act. The key elements of the model are:

- Amending section 15 of the IC Act to allow the current UCT laws in the ASIC Act to apply to insurance contracts regulated by the IC Act.
- The UCT provisions in the ASIC Act being tailored in their application to contracts of insurance to accommodate specific features of these contracts, in particular:
  - the 'main subject matter' of an insurance contract will be defined narrowly as terms that describe what is being insured, for example, a house, a person or a motor vehicle;
  - clarification will be provided that the 'upfront price' will include the premium and the excess payable and that these will not be subject to review;
  - a contract will be considered as standard form even if the consumer or small business can choose from various options of policy coverage;
  - when determining whether a term is unfair, a term will be reasonably necessary to protect the legitimate interests of an insurer if it reasonably reflects the underwriting risk accepted by the insurer in relation to the contract and it does not disproportionately or unreasonably disadvantage the insured;
  - examples specific to insurance will be added to the list of examples of kinds of terms that may be unfair, which could include terms that permit the insurer to pay a claim based on the cost of repair or replacement that may be achieved by the insurer, but could not be reasonably achieved by the policyholder;
  - where a term is found to be unfair, as an alternative to the term being declared void, a court will be able to make other orders if it deems that more appropriate;
  - the definition of 'consumer contract' and 'small business contract' will include contracts that are expressed to be for the benefit of an individual or small business, but who are not a party to the contract;
  - for life policies, as defined by the *Life Insurance Act 1995*, which are guaranteed renewable, it will be made clear that a term which provides a life insurer with the ability to unilaterally increase premiums will not be considered unfair in circumstances in which the premium increase is within the limits and under the circumstances specified in the policy.

CASES AND TRIBUNAL DECISIONS

TPD: Reinsurer in the Spotlight

MX v FSS Trustee Corporation as Trustee of the First State Superannuation Scheme & Anor [2018] NSWSC 923

Link to decision

The NSWSC has recently delivered a TPD decision in *MX v FSS & MetLife* (plaintiff's name supressed) which may have an impact on the way you engage with your reinsurance stakeholders in the management of 'opinion' based claims (obviously, mainly TPD claims).

Background

The plaintiff was a former police officer who alleged that a work related PTSD condition had rendered him TPD. He was insured for this event under a group policy effected between the two defendants as trustee and insurer respectively. The coverage was a conventional opinion based 'unlikely' ETE clause.

His claim was lodged in 2012 and rejected by the insurer in 2014 and again in 2017.

Proceedings were brought challenging the decisions of the insurer and consent orders were made splitting the hearing into separate stage 1 and stage 2 hearings.

This decision deals only with stage 1 which was whether the insurer's two decisions to decline the claim should be vitiated.

The trustee took no active part in the hearing which was determined by Justice Slattery.

The judgment

The Court vitiated the insurer's first decision on several grounds all flowing from the way the insurer was seen to evaluate the medical, vocational and other evidence in the decline letter.

Specifically, the Court found flaws with the way the insurer expressed its decision in the decline letter noting that it left *'pertinent questions unanswered'* and that *'the gaps in this reasoning are such that they do not satisfy the test stated by Ball J in* Ziogos *… and one cannot discern why…* the insurer*… reached the conclusion that it did'.*

Additionally the Court felt that the insurer failed to 'get to grips' with underlying inconsistencies in the information before it which could have been resolved by seeking out further information from a treating doctor (as to why he did not feel the surveillance footage contradicted his findings) and from a Surf Lifesaving Club (as to whether the plaintiff's volunteer work there had the flavour of paid employment).

The second decision was also set aside by the Court on the primary basis that when making this second decision, the insurer did not start *de novo* but rather approached it on the basis as to whether it should change its mind from its first decision to decline. This according to the Court, was a basis for the decision to be set aside.

The reinsurance issue

Those who follow TPD case law will be all too familiar with the above stage 1 vitiation reasons which have featured in many TPD decisions (which also in technical terms, are probably *obiter* in this judgment). The most novel aspect of this judgment however is the primary basis on which the insurer's first decision was vacated, being a seemingly new ground to vitiate, that being, the insurer was influenced by its reinsurer in exercising its opinion.

In coming to a view on this issue, the Court extensively reviewed both the reinsurance treaty and the reinsurer's '*close involvement*' in the management of the claim. The critical provision of the treaty was a claim approval provision as follows:

'For any Sum Insured above the Claim Handling Limit…the Cedant must before accepting liability for a claim under that Reinsured Policy, obtain [the reinsurer's] *prior approval…'*

Additionally, the critical claim fact was that the reinsurer had made it clear to the insurer that such approval was not being given in this instance.

The Court embarked on a detailed assessment of the impact of the clause on the insurer's obligation to form a reasonable decision under its policy and eventually came to this conclusion at paragraph 269:

'In the absence of any internal evidence that any positive steps were taken to ring fence the decision from such clearly asserted influence, the inference that the decision maker took this consideration (i.e. the reinsurer's refusal to grant approval to pay the claim) *into account is strong, because of the potential commercial consequences for* [the insurer] *of proceeding to decide in the plaintiff's favour without* [the reinsurer's] *approval in breach of Article 18.8.. I infer from all of these matters that* [the insurer] *took into account* [the reinsurer's] *refusal to grant prior approval to an outcome favourable to the plaintiff.'*

This amounted to an *'irrelevant consideration'* which *'breached its obligations of utmost good faith and of acting reasonably in forming an opinion'.* On this basis, the first decision of the insurer was set aside.

Additionally, the failure to disclose the reinsurance arrangement to the plaintiff *'placed the plaintiff at a procedural disadvantage'* (he could have made submissions on it had he known) and was also a basis on which the first decision was vitiated.

Implications

The findings that essentially the insurer failed to spell out clearly why the claim was being refused in the respective decline letters are hardly novel and simply serve to further illustrate the intense judicial scrutiny that such letters are placed under. Whilst the courts are at pains to point out that they do not expect such letters to be of the nature of judgments, their actual criticisms of such letters suggest otherwise.

Care should also be had to ensure that requests for a review of a declined claim when accompanied by fresh information, should be of the nature of a *de novo* review.

Of more wider significance however, are the findings in relation to the reinsurance arrangements.

Specifically, the judgment suggests that, in relation to opinion based decisions by insurers:

- the presence of a reinsurer approval clause in the relevant treaty similar to the one in this case; and
- heavy reinsurer involvement in the claim process culminating in an express desire that the claim should not be accepted; coupled with
- a lack of affirmation that the insurer is acting independently of the reinsurer's views and possible treaty consequences

will place stage 1 opinion clause decisions at risk of being vitiated for taking into account an irrelevant consideration.

It may be that the unique reinsurance factors at play in this case are not replicated in the wider life market. Be that as it may however, as things presently stand and against this background, clearly it is timely to review your reinsurance treaties, reinsurer claim engagement practices and your claim communications to ensure the relevant reinsurance factors which led to the vitiation in this case are not present in your claims book.

The key things to note are that,

- The intense judicial scrutiny of TPD decline letters continues. Such letters need to have the look, flow, comprehensiveness and rigour you would expect from a judgment.
- Reviews of declined TPD decisions need to be carried out on a *de novo* basis.
- In opinion based cases involving high reinsurer involvement, insurers need to be careful that as a matter of impression, perception and fact they are not outsourcing the exercise of their opinion to the reinsurer on the basis that this can be a ground for opinion vitiation.

CASES AND TRIBUNAL DECISIONS

Indemnity Costs and section 52(7)(d) of the SIS Act

Carroll v United Super Pty Ltd (No. 2) [2018] NSWSC 1101 (18 July 2018)

Link to decision

The matter of *Carroll v United Super*[1] returned before Slattery J in relation to Mr Carroll's application the insurer and trustee pay indemnity costs of the proceedings. Mr Carroll claimed an entitlement to indemnity costs based on:

- two Offers of Compromise served on the defendants dated 5 February 2015 and 5 October 2016; and
- an argument the trustee was obliged under s.52(7)(d) of the *Superannuation Industry (Supervision) Act 1993* (the SIS Act) to commence the proceedings against the insurer, for the benefit of the plaintiff, as it was required to "*do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has reasonable prosects of success*".

The trustee and insurer opposed Mr Carroll's cost application. The defendants also argued that Mr Carroll should be disentitled to recovering part of his costs due to his conduct in the proceedings.

Offers of Compromise

His Honour considered the late service of Mr Carroll's evidence was relevant to an application based on the Offers of Compromise.

It was noted Mr Carroll served an affidavit outlining his "*various work related activities*" on 4 November 2016. This was (effectively) the day before the commencement of the hearing. The affidavit was the first time Mr Carroll had explained the nature of his commercial activities and his claimed limitations in conducting those activities. His Honour found:

> *Without the 4 November 2016 affidavit, the defendants were not able to adequately assess the real strengths and weaknesses of the plaintiff's case, and consequently, their own prospects of success in the proceedings.*

His Honour found the plaintiff was not entitled to indemnity costs on either Offer of Compromise.

SIS Act Claim

The Statement of Claim filed in the proceedings included an allegation the trustee had failed "*to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success*: Section 52(7)(d) [SIS Act]". Although this allegation against the trustee was not abandoned, it was not advanced by Mr Carroll in the main hearing.

Mr Carroll's argument against the Trustee was it had failed to commence proceedings against the insurer on his behalf, despite requesting the trustee do so on two occasions. As a consequence, Mr Carroll claimed he was required to commence the proceedings in his name and the Trustee ought to bear the costs of the proceedings on an indemnity basis.

[1] *Carroll v United Super Pty Ltd* [2018] NSWSC 403

RECENT FOS & SCT DECISIONS

Section 54 of the Act prevents a FSP from relying on a technical breach of the policy

Link to determination

Facts

On 18 January 2000, the Applicant entered into an income protection policy with the Financial Services Provider (FSP). The Applicant worked as a commercial pilot. On 24 February 2016, the Applicant made a claim for total disability benefits as a result of suffering from chronic fatigue syndrome, symptoms of which he claimed commenced two years prior.

The Applicant submitted that he had been unable to work since January 2014 and sought the payment of benefits from 24 February 2014 to 23 September 2016.

The FSP accepted the Applicant's claim from 23 September 2016 however, refused to pay benefits from 24 September 2014 on the basis that the waiting period (as defined in the policy) did not commence until 23 September 2016 and that in any event, the applicant did not satisfy the three part definition of 'totally disabled' under the policy namely:

1. Unable to perform at least one income producing duty of his… occupation;
2. Not working, and
3. Under the regular care and attendance of a medical practitioner.

Issues

1. Did the Applicant meet the three parts of the total disability definition from 24 September 2014?
2. Could the FSP rely on a technical breach of the policy in order to refuse to pay benefits prior to 23 September 2016?
3. Did section 54 of the *Insurance Contracts Act* limit the FSP's right to not pay benefits?

Determination

In dealing with the dispute, the Financial Ombudsman Service Australia (FOS) first considered whether the three parts of the policy definition had been met by the Applicant prior to 23 September 2016. It then turned its mind to whether the FSP could rely upon a technical breach of the policy in relation to the commencement of the waiting period in the context of section 54 of the *Insurance Contracts Act* 1984 (the Act).

With reference to the first part of the definition, the FSP submitted that there was conflicting information regarding when the Applicant ceased all work. The Applicant submitted that he was unable to work since January 2014. In support of his submission, the Applicant provided medical evidence that his class one medical certificate had lapsed (this medical certificate is a requirement for a commercial pilot) and that according to a Designated Aviation Medical Examiner, anyone presenting with symptoms of fatigue and depression (such as the Applicant) would be automatically disqualified from holding a class one medical certificate and would be precluded from working as a commercial pilot. The FOS accepted that the medical evidence demonstrated that the Applicant had a history of symptoms supporting a diagnosis of chronic fatigue syndrome and that from 24 January 2014, the Applicant was unable to perform at least one income producing duty of his occupation.

In relation to the second part of the total disability definition, the Applicant claimed that he had not worked or been paid money for working since January 2014 and relied upon copies of his log book which detailed that he was only flying on a private basis from January 2013 and his tax return from 1 July 2014 showing that his income stream was only from his investment income as a beneficiary of NAF Trust. The FOS accepted that the Applicant was not working as a commercial pilot from 24 January 2014.

With reference to the third part of the definition, the FSP argued that clinical notes confirmed that the Applicant had not been under the regular care and attendance of a medical practitioner because any attendance had been intermittent. The Applicant submitted a number of reasons for why his attendance on a medical practitioner had been irregular including that he believed that his symptoms would abate, that due to his rural location in Western Australia, it was difficult to see the same medical practitioner and, he became disillusioned by the lack of improvement in his symptoms. The FOS accepted the reasons advanced by the Applicant in consideration of the evidence and the Applicant's circumstances. The FOS therefore accepted that the Applicant met the third part of the definition.

Having determined that the Applicant met all three parts of the definition for total disability from 24 January 2014, the FOS considered whether section 54 of the Act limited the rights of the FSP to refuse to pay benefits on the basis of a technical breach of the policy. In this case, the technical breach relied upon related to a clause setting out the commencement of the waiting period:

> The waiting period begins on the date a *medical practitioner* first examines the person insured and certifies that he or she is totally disabled.

As the Applicant was not certified by a medical practitioner as being totally disabled until 23 September 2016, the FSP asserted the Applicant was prevented from seeking benefits at any date prior to 23 September 2016.

The FOS determined that in consideration of the whole of the evidence, it was fair and reasonable to accept that the Applicant was totally disabled from 2014. Further, the FOS asserted that section 54 of the Act did not permit the FSP to refuse to pay benefits from 2014 by relying on a technical breach of the policy.

The FOS determined that the FSP was required to pay the Applicant the income protection benefits from 2014 to 2016 and interest calculated in accordance to section 57 of the Act.

Implications

This decision demonstrates that the FOS will consider all of the evidence before it in determining whether section 54 of the Act prevents a FSP from relying on a technical breach of the policy in refusing to pay benefits.

In this case, the FOS considered the whole of the evidence and the circumstances of the Applicant, including rural location, in determining when the waiting period under the policy commenced, notwithstanding the relevant clause in the policy and whether the breach asserted by the FSP could reasonably be said to have caused or contributed to the loss. Further, the Tribunal detailed that Chronic Fatigue Syndrome can be difficult to diagnose because it involves a series of tests to exclude common causes of tiredness.

RECENT FOS & SCT DECISIONS

Working at reduced capacity and limited medical involvement leads to a decline in TPD Claims

Link to determination

Facts

On 1 July 1988, the Complainant became a member of a Fund. The Complainant worked as a senior teacher and Head of his Department. On about 1 July 2013, the Complainant made a claim for a TPD benefit under the relevant policy on the basis that he ceased full time employment due to a back injury which he suffered at his workplace in 2006. The Complainant ceased his full time employment in 2011 but continued to work as a casual teacher in a regular casual capacity, at the same workplace at the time of his claim.

The Complainant's claim was declined by both the Insurer and the Trustee on the basis that the Complainant's ongoing employment as a casual teacher precluded him from satisfying the definition of TPD under the policy. The Complainant submitted that his casual employment did not utilise his training, education or experience and that the inclusion of 'any occupation' in the TPD definition of TPD was unreasonable.

Issue

1. Whether the decision of the Insurer and Trustee to decline the Complainant's claim for a TPD benefit was fair and reasonable.

Determination

In considering the evidence before it, the Tribunal made clear that its role in reviewing the decisions of the Insurer and Trustee under section 37(2)(a) of the *Complaints Act* (the Act) was not to determine what decision it would have made on the material before the Insurer and Trustee but rather whether the decisions by the Insurer and Trustee were fair and reasonable.

The Tribunal accepted that the medical evidence and claim forms did not demonstrate that the Complainant had any difficulty engaging in work up until 2011, noting that he had suffered the claimed injury in 2006. Further, the Complainant's condition did not require ongoing treatment, rehabilitation or physiotherapy and there was also no specialist care, ongoing therapies or formal diagnosis. The Tribunal also accepted that the Complainant's decision to cease work was not on the direction of a medical practitioner.

On review of the medical evidence, claim documents, policy documents and the parties' submissions, the Tribunal affirmed the decisions of the Insurer and the Trustee to decline the Complainant's claim for a TPD benefit under the policy.

Implications

This case demonstrates that a claimant will not satisfy an 'any occupation' definition of TPD where they have continued to engage in work, albeit on a casual basis, for years after ceasing full time employment due to an injury, especially where there is no clear evidence of increasing difficulties associated with that injury.

TURKSLEGAL Q&A

Involvement in criminal acts – moving the goal posts of public policy

Australian Executor Trustee Ltd v Suncorp Life & Superannuation Ltd [2016] SADC89

In our first "Life Matters" seminar series earlier this year we received a lot of questions from clients about the sad case of Mr and Mrs Humby and Mr Humby's death in a house fire he caused as part of a conspiracy he and his wife had devised to fraudulently claim on their household insurance.

The plan went disastrously wrong and not only did the house and contents insurers refuse to pay, but so did the insurer of Mr Humby's life cover.

The legal principle considered in the case was a very old one, often associated with the English jurist Lord Mansfield, who famously also framed the legal principle at the heart of the duty of disclosure.

In *Holman v Johnson*, decided in 1775, Lord Mansfield had to adjudicate a case between the plaintiff, who sold some tea in Dunkirk on the other side of the English Channel, to a Mr Johnson, the defendant, who refused to pay for it when the debt fell due.

The fact which raised the issue which still gets the case talked about was that both men knew Mr Johnson was a smuggler and that he intended to illegally import the tea to England and evade customs duty.

The case clearly wasn't an easy one, as the judgment shows that in terms of doing justice between the two men, Lord Mansfield thought Johnson should pay up. But there was a larger issue at stake; Holman was seeking to use the judicial system to enforce a debt contracted between two people in the course of committing a crime.

Lord Mansfield concluded the law could not be used in that way and Mr Holman's case failed.

There are wider applications of the principle that law will not support a cause of action which is based in a morally wrong or criminal act in the context of insurance and the recent decision concerning the Humbys is one of them.

The insurer rightly took note of the fact that the policy over Mr Humby's life was owned by Mrs Humby, who was the other half of the arson conspiracy. Consequently any payment to Mrs Humby as a result of her husband's death would be using the law of contract to enable her to profit from her crime. So, many clients asked after the brief presentation on the Humby case why was the insurer ordered to pay?

Legally, the fact that the claim was by that point being brought by Mrs Humby's estate (she having also passed away some time after the fire from other causes) cannot be the answer. The cause of action her estate had could be no more or less than she had when she was alive. It arose from a criminal conspiracy gone wrong and was tainted in just the same way as if she had brought the claim herself.

The answer lies in the fact that this type of a defence to a claim made under a contract, generally known as "public policy" is, at least in the 21st century, flexible. In particular, the courts will take into account whether permitting enforcement of the contract would encourage the commission of a crime.

The beneficiaries of Mrs Humby's estate were her children who were not part of the conspiracy and the Court thought no harm would be done if they were paid. This means the principle will operate differently when the crime is different or the parties seeking to enforce the policy have a different relationship to it, so the goalposts of public policy keep moving.

Subscribers to TurksLegals' Life Guide can look at the background facts and read about the principles in detail at http://turkspublicationhub.turkslegal.com.au/lifeguide/public

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