INSURANCE ▫ COMMERCIAL ▫ BANKING

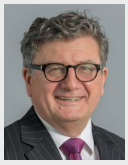
Welcome to the December edition of our Financial Services Bulletin

With the end of the year practically in sight this is our last edition of the Financial Services Bulletin for 2017. Read on for industry news, case law developments, our selection of FOS and SCT determinations and our topical "Turks Q&A".

The FSB has been another huge success in 2017 and we would like to thank you, our readers, for being part of it. We wish you all the very best for the festive season and a bright and prosperous New Year!

CONTENTS

CONTACT US



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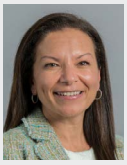

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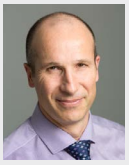

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2017 HIGHLIGHTS

This year has been one full of innovation and excitement. From launching a range of innovative publications, to being named a finalist in the professional services firm of the year, 2017 has been full of highlights. Thanks for coming along for the ride – we couldn't have done it without you!

FIRM NEWS

NEW MANAGING PARTNER

Pieter Oomens took the reins as Managing Partner from January 2017 after the firm's founder Peter Turk retired at the end of 2016 after 35 years.

Read more

FIRM NEWS

SENIOR APPOINTMENTS

We appointed three new partners, a special counsel and five senior associates.

Read more

SEMINARS

LIFE MATTERS SEMINAR SERIES

In 2017, 490 clients attended 10 '*Life Matters*' seminars in Sydney, Melbourne and Brisbane. The '*Life Matters*' seminar series is designed to give our clients a more in-depth opportunity to explore recent developments in life insurance and financial services with TurksLegal experts.

PUBLICATIONS

LIFE GUIDE UPDATE

We released an update to the TurksLegal Life Guide, our innovative and user-friendly digital publication that allows clients to navigate life insurance case law and related concepts through a unique on-line interface.

Register for The Life Guide

PUBLICATIONS

LIFE CODE SERIES

We launched a four part publication series translating the main elements of the Code from the perspective of the insurer, focused on Claims Complaints and Governance, Product Design and Marketing and New Business and Underwriting.

View publications

OTHER INNOVATIONS

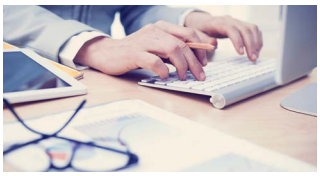
LIFE INSURANCE FUTURE THINKING (LIFT)

TurksLegal and ALUCA hosted its second LIFT Roundtable event attended by industry leaders and TurksLegal Scholarship Alumni. We then proudly launched the whitepaper - "Living the Code- Engendering Trust as a Life Insurance Professional"

View whitepaper

2017 HIGHLIGHTS

OTHER INNOVATIONS



TURKS HIGHRES

We launched a HighRes advice which is a new, unique short form- advice focused on providing a high level synopsis to clients of a case.

SCHOLARSHIPS

ALUCA TURKSLEGAL SCHOLARSHIP (11TH YEAR)

Jennifer Jackson, Rehabilitation Consultant, CommInsure, was awarded this year's ALUCA TurksLegal Scholarship for her outstanding essay on genetic testing. Jennifer won an overseas conference package valued up to AU$8,000 to an international insurance conference.

Read more

SCHOLARSHIPS

ANZIIF TURKSLEGAL SCHOLARSHIP (10TH YEAR)

Fiona Fong, Senior Claims Consultant, Marsh, was awarded this year's ANZIIF TurksLegal Scholarship for her outstanding essay on cyber claims. For her prize, Fiona chose to receive $5,000 cash and registration to attend the 2018 AICLA/ ANZIIF Claims Convention in Australia.

Read more

SCHOLARSHIPS

WIBF TURKSLEGAL SCHOLARSHIP (4TH YEAR)

Deborah Beeck, Director, Australia and New Zealand Banking Group was announced the 2017 TurksLegal WiBF Scholarship winner. Deborah will travel to the United States in April 2018 to participate in The Women's Leadership Program; at the Darden School of Business at the University of Virginia.

Read more

AWARDS

AUSTRALIAN INSURANCE INDUSTRY AWARDS
2017 FINALIST
Professional Services Firm of the Year

FINALIST PROFESSIONAL SERVICES FIRM OF THE YEAR

We were selected as one of six finalists in the Australian Insurance Industry Awards in the category of Professional Services Firm of the Year.

Read more

AWARDS

2017 AUSTRALASIAN LAW AWARDS FINALIST
INSURANCE SPECIALIST FIRM OF THE YEAR

FINALIST AUSTRALASIAN LAW AWARDS

We were selected as a finalist in the Australasian Law Awards in the category of Insurance Specialist Firm of the Year.

Read more

AWARDS

TURKSLEGAL 2018
RECOGNIZED BY
Best Lawyers

2017 BEST LAWYERS IN AUSTRALIA

We received recognition in the 2017 Edition of The Best Lawyers in Australia in the practice area of Insurance Law.

Read more

INDUSTRY NEWS

Insurance in Superannuation Voluntary Code of Practice

The Insurance in Superannuation Working Group (ISWG) released the Insurance in Superannuation Voluntary Code of Practice ('the Code') for superannuation trustees on Monday, 18 December 2017.

In a statement, ISWG Chairman Mr Jim Minto, endorsed the value proposition of life Insurance through superannuation saying;

"It delivers enormous benefits without underwriting and must be preserved as a unique aspect of our superannuation system."

The Code, which will come into effect from 1 July 2018, sets standards that the ISWG also says will *"provide greater understanding, clearer accountability and consistency of delivery across the superannuation industry".*

However, adherence to the Code will be voluntary which has predictably aroused criticism in quarters that seek greater regulation of the industry and threats of government intervention.

The ISWG said that despite the voluntary nature of the Code it expects there will be strong support for trustees to sign up to it.

For a full copy of the media release click here.

INDUSTRY NEWS

PJC inquiry findings postponed… again

On 15 November 2017, the Senate extended the reporting date for the Joint Parliamentary Committee on Corporations and Financial Services ("PJC") from 7 December 2017 to 31 March 2018.

This is the third time the delivery of the Committee's report has been deferred. The inquiry was originally set up in September 2016, when the Senate asked the PJC to look into the life insurance industry. A wide cross section of the industry and interested parties subsequently gave evidence and made submissions to the PJC.

It is unclear what the end result of the inquiry will be following the Prime Minister's reluctant announcement of a Royal Commission into the banks and wider financial services sector on Thursday 30 November 2017.

INDUSTRY NEWS

Australian Financial Complaints Authority

The Federal Government's new "one stop shop" to deal with financial services complaints has come one step closer to reality.

A Bill to establish the new body, which will be known as the "Australian Financial Complaints Authority" ('AFCA') has been introduced and was read for the first time in the House of Representatives on 7 December 2017. Relevantly, from the perspective of the life insurance industry, the AFCA will replace both the FOS and Superannuation Complaints Tribunal.

The AFCA Board will have equal numbers of industry and consumer directors, with the Federal government initially appointing a minority of the AFCA board, including the independent chair.

A transition team was appointed in July 2017 headed by former Reserve Bank Assistant Governor Dr Malcolm Edey, to settle the terms of reference. Consultation on key aspects of AFCA's operations, including monetary limits, concluded on 20 November 2017.

The Government has decided that AFCA will commence operations with a monetary limit of $1 million and a compensation cap of $500,000 for most non-superannuation disputes.

The Bill sets out standards that AFCA must meet, confers powers in relation to superannuation disputes and gives ASIC additional regulatory powers, including the power to issue directions. AFCA's terms of reference will set out how legislative and policy requirements will be met.

INDUSTRY NEWS

ANZIIF Life Insurance Breakfast

Sold out for the second year in a row, the ANZIIF Life Insurance Breakfast held on 18 October this year showcased global insights and local changes in a fast evolving and dynamic industry.

Dr Monique Esterhuizen, who joined the Sydney office of Hannover Re in 2017 as Chief Medical Officer, presented on the paradigm shifts in underwriting caused by recent medical advancements in treatment and early diagnosis.

With recent experience in the South African market, Dr Esterhuizen was uniquely positioned to explain how the global underwriting environment is evolving particularly in relation to HIV, mental health and cancer and how this is likely to impact on both local underwriters and on the design of Australian life products.

Tim Tez, Chief Strategy Officer, AIA Australia, was interviewed by TurksLegal Partner, John Myatt, about the work of the Insurance in Super Working Group and the proposed Code of Practice.

Tim provided the audience with key perspectives on the draft Code, including why the Working Group continues to endorse an opt–out rather than an opt-in preference. He also provided a detailed outline of the main consumer benefits from the proposed Code and where things would be going next in the progress toward a new Code.

The breakfast ended with a presentation from Tim on key elements of the success of AIA's exciting and engaging "Vitality" program.

The Insurance in Superannuation Voluntary Code of Practice was released yesterday and will come into effect on 1 July 2018 (see article in this FSB).

ANZIIF is planning another Life Insurance Breakfast in 2018. If readers have ideas for the topics they would like to hear about, please email us with your suggestions and we will pass them on.

CASES AND TRIBUNAL DECISIONS

Intermittently TPD

Williams v Mercer Superannuation (Australia) Limited & Ors (2017) QDC 289

Link to decision

Background

The plaintiff was an administrative assistant, employed by a merchant bank who conducted her work primarily from her home by telephone and computer. She was diagnosed with fibromyalgia (although this was contentious) and stopped work citing ill health, subsequently accepting a redundancy.

She lodged a Total and Permanent Disability claim under a policy of insurance held by her superannuation fund in which a continuous absence from work through "injury or illness" for a period of six consecutive months (i.e. the waiting period) was a condition for payment of a TPD benefit.

The evidence before the Insurer tended to indicate that the plaintiff could work a full day or even for several days, but that the plaintiff's symptoms could strike at unpredictable times and could disable her from working at all for a day or a number of days.

Nevertheless, whilst awaiting a decision on her TPD claim, the plaintiff commenced studying a law degree in 2012 which she ultimately successfully completed, at an accelerated rate, by early 2015. She graduated with Honours class IIA.

Both the Insurer and the Fund declined the plaintiff's TPD claim.

Decision

Whilst finding that the underlying injury or illness would *'probably… have prevented her working in her former position until the end of the waiting period',* the Court also found that the fact that her position was coincidentally made redundant at that same time, meant that the redundancy was the cause of the absence from work, not the injury or illness. The plaintiff had therefore failed to satisfy a threshold requirement.

The plaintiff also failed in her claim that the Insurer had breached its duty of good faith and fair dealing by failing to consider certain pieces of relevant medical evidence which were not mentioned in the decline letter.

The Court accepted that a failure to consider the particular documents would have resulted in breach but inferred that it was probable that the insurer had considered those documents in forming its decision. This inference was made because the insurer's reasons included analysis that reflected the content of one of the particular reports and because the reports had otherwise been referred to by the insurer in earlier correspondence.

The plaintiff's allegations that the trustee had failed to consider information and make relevant enquiries in determining whether the plaintiff was TPD also failed. The Court found that the rules of the fund did not impose on the trustee an obligation to form an opinion as to a member's entitlement to a TPD benefit in circumstances where, if there was a policy of insurance, the trustee was to defer to the insurer's determination about whether the member was TPD.

In ruling against the plaintiff on stage 2, the Court determined that once it was demonstrated that the plaintiff had a capacity to do relevant part-time work or even casual work of an intermittent nature she was disentitled to the benefit under the policy.

The plaintiff's General Practitioner gave evidence that she suffered unpredictable fluctuations in energy, concentration and physical capabilities and the plaintiff gave evidence that her illness made her too unreliable to undertake permanent employment.

The Court found that given the tenacious resilience she had demonstrated for three years in completing her law degree in spite of her symptoms, she was unduly pessimistic about her unreliability and it was likely that she could "summon the same tenacious resilience if called upon to do part-time administrative work."

Implications

With its treatment of the waiting period, this judgment seems to contradict what appears to have been a relatively settled area of TPD law as expressed in the NSW decision of Mabbett (*Mabbett v Watson Wyatt Superannuation* [2008] NSWSC365), namely that where the TPD definition speaks of an absence from work due to illness or injury, all that needs to be shown is that illness or injury was a cause of absence, not the only cause.

Similarly, the judgment appears to fly in the face of *Birdsall (Birdsall v Motor Trades Association of Australasia Superannuation Fund Pty Ltd* [2014] NSWSC 632) in which it was considered that the relevant enquiry was limited to "regular employment for reward other than casual work of an intermittent nature." Whereas here the Court accepted a capacity for work of an intermittent nature was sufficient to disentitle the plaintiff. If correct, this is significant, particularly in the context of claims relating to degenerative conditions and conditions which fluctuate in severity.

However, it is worth remembering that a Queensland District Court judgment will not be binding in all courts and jurisdictions.

CASES AND TRIBUNAL DECISIONS

Fishy argument rejected by Court of Appeal

Fenton v AIA Australia Ltd [2017] VSCA 331

Link to decision

Background

The Life Insured had been in receipt of monthly disability benefits claiming that she was unable to work after contracting ciguatera poisoning (the Sickness) in October 2009.

Ciguatera is a foodborne illness caused by eating fish that is contaminated by the ciguatera toxin.

The Insurer paid her disability benefits pursuant to an Income Protection policy. The Insurer later determined that the Life Insured was no longer suffering from the Sickness.

During her claim and at trial the Life Insured said that the ciguatera poisoning had rendered her totally disabled due to a number of symptoms including chronic fatigue.

Judge Kings of the County Court (*Fenton v AIA Australia Ltd* [2017] VCC 438) dismissed the Life Insured's claim, finding that she was not a convincing or reliable witness and that when considered as a whole, the medical evidence did not support her argument that she was continuing to suffer from ciguatera poisoning at the time the Insurer determined to cease payment of benefits. Accordingly, Judge Kings found that the plaintiff did not satisfy the policy definition of Total Disablement.

The Life Insured sought leave to appeal this decision. She relied on many proposed grounds of appeal including:

a) That the Trial Judge erred in failing to consider whether the plaintiff's disablement was solely due to ciguatera poisoning when evidence established that her symptom of chronic fatigue was a continuing symptom of or precipitated by ciguatera poisoning;

b) That the Trial Judge erred in preferring the opinions of a medico-legal infectious disease physician over that of the Life Insured's treating infectious disease physician.

Decision

The Court of Appeal refused to grant leave to the Life Insured to appeal the County Court decision stating that the proposed appeal did not have a real prospect of success.

In respect of point a), the Court of Appeal reviewed the evidence led and submissions put on behalf of the Life Insured at trial and ultimately found that it was clear that the Life Insured did not advance at trial a case that chronic fatigue or chronic fatigue syndrome was the 'Sickness' giving rise to an entitlement to indemnity under the policy.

The Court of Appeal held that the Life Insured ought not to be permitted to advance a case on appeal that was markedly different to what she advanced at trial. The Court also accepted the Insurer's submission that it would have run a very different case at trial to rebut those arguments.

In respect of point b), the Court of Appeal noted that the plaintiff's credit and reliability of her evidence was critical to the medical opinions expressed by the treating and expert medical witnesses who gave evidence at trial. The Court of Appeal noted that as in *Whisprun*[1] the medical opinions expressed were underpinned by the Life Insured's self-reported symptoms and complaints.

Importantly, the Court of Appeal noted that there was a distinction between assessing medical causation (in this

instance whether the ciguatera poisoning was still a cause of the plaintiff's alleged disability) and assessing the extent of any disability.

The Court of Appeal noted that a treating doctor who has a number of consultations over a sustained period of time may be able to provide a more reliable opinion about the extent of any disability.

However, a medical opinion on an issue of causation may not necessarily be strengthened by the fact that the medical expert has had multiple opportunities to examine the patient. This is because issues of medical causation often turn more on the analysis of scientific criteria used to arrive at the diagnosis, rather than whether an examining patient presents as genuine.

Implications

Whilst this case was largely confined to a unique set of facts and the primary focus at trial was a sustained and ultimately successful attack on the plaintiff's credit, the Court of Appeal decision provides some comfort and guidance to life insurers.

Life Insureds often argue that the evidence of treating doctors is to be preferred over and above any IME evidence. The Court of Appeal has noted an important distinction can be drawn when there is a dispute over the medical cause of a disability rather than the extent of that disability. This is particularly so when faced with a Life Insured whose evidence about the extent of her disability was ultimately not accepted by the trial judge.

Further, the Court of Appeal was critical of the attempt to re-cast the Life Insured's case as effectively one of 'chronic fatigue' and noted that it is not sufficient to simply include a syndrome such as Chronic Fatigue as a symptom of the claimed Sickness in the particulars of pleading, without adducing evidence at trial addressing that issue.

[1] *Whisprun v Dixon* [2003] HCA 48

CASES AND TRIBUNAL DECISIONS

Longitudinal evidence from a treating medical practitioner preferred

Hellessey v Metlife Insurance Limited [2017] NSWSC 1284

Link to decision

Background

The plaintiff was a member of the NSW police force. During the course of her employment, she was subjected to a number of traumatic incidences As a result of the incidences, the plaintiff claimed to have developed Post Traumatic Stress Disorder ('PTSD'), Major Depressive Disorder and Anxiety and subsequently ceased work due to her symptoms.

The plaintiff was a member of the First State Superannuation Scheme. The trustee of the Scheme, FSS Trustee Corporation, held two policies of group life insurance with the insurer, being the 'Blue Ribbon' Group Life Insurance Policy and the 'MetLife Insurance' Group Life Insurance Policy. The plaintiff made a claim for Total and Permanent Disablement ('TPD') under both policies. MetLife first received the claim documents in January 2012. It provided procedural fairness in respect of the claim on 17 April 2014. MetLife proceeded to decline the claim on 22 December 2014, and two times thereafter, on the basis that the plaintiff did not satisfy the relevant TPD definition.

Decision

Justice Robb conducted a thorough consideration of the evidence as well as the insurer's procedural fairness and decline letters. He observed the insurer's focus on medical opinions which were expressed on about, or shortly after, the relevant assessment date.

His Honour noted that:

'…where there are prospects of the claimant recovering from the incapacity in a manner that will defeat the satisfaction of the ETE clause, the evidence available as at the assessment date may be an unsound basis for determining whether the TPD clause has been satisfied, and the consequences of later and particularly longitudinal evidence may be a more reliable guide to the true nature of the claimant's incapacity as at the assessment date'.

In this regard, Justice Robb found the reports of the plaintiff's treating psychiatrist, Dr Durrell, to be informative. Dr Durrell had started treating the plaintiff on 5 October 2010 and was still treating her at the time of the hearing, some six years later. Justice Robb found that 'Dr Durrell had far more exposure to Ms Hellessey's psychological injuries in a longitudinal sense than any of the other medical professionals'.

Justice Robb ultimately found that:

'… the evidence establishes that Ms Hellessey has suffered from serious PTSD and depression… for at least about six years and possibly longer. This is an important consideration in determining whether or not, as at the assessment date of 1 March 2012, the incapacity caused by Ms Hellessey's psychological injury was of such an extent as to render her unlikely ever to engage in any gainful profession, trade or occupation for which she was

reasonably qualified by reason of her education, training or experience'.

He noted that MetLife had correctly pleaded that, at the assessment date, the plaintiff had a further 31 years of her nominal working life ahead of her. However, at least six of the projected 31 years had expired by the date of the hearing without the plaintiff recovering the capacity to undertake any employment.

Justice Robb found that the evidence in this particular case did not establish that there was a 'real chance' the plaintiff would return to relevant work.

Implications

Justice Robb's judgment is a reminder that longitudinal evidence from a treating medical practitioner may be insightful and persuasive in determining whether an insured has a 'real chance' of returning to relevant work (even if this evidence does not specifically address the insured's capacity at the relevant time for assessment) because it can be informative as to the prospect of the insured's future recovery.

RECENT FOS & SCT DECISIONS

Insurer's decision not to proceed with assessment of claim deemed fair and reasonable

Link to determination

Facts

On 5 March 2012, the Complainant applied for Death, TPD and IP cover. The application included the Complainant's Duty of Disclosure under the *Insurance Contracts Act 1984* (the ICA) and details about when the Insurer could avoid the contract for non-disclosure. The Complainant was asked whether he had ever had, or been told he had, or ever sought advice or treatment from a doctor, counsellor or other health professional for stress, anxiety, depression, post-traumatic stress disorder or any other mental health disorder. The Complainant answered 'Yes' to this question, disclosed a history of Anxiety and Asthma and was subsequently granted Death, TPD and IP cover.

On 5 November 2015, the Complainant was involved in an incident which triggered several medical conditions and on 23 February 2016 he was diagnosed with, amongst other conditions, Adjustment disorder, depression, anxiety and Asperger's syndrome. The Complainant ceased work on 15 April 2016 and lodged a claim for TPD and IP benefits on 14 February 2017. The Medical Reports obtained during the claim's process indicated that some of these conditions had been present for a long period even if they had only been formally diagnosed in early 2016.

As a result, the Insurer believed that the Complainant had failed to make full and complete disclosures on his application and requested that the plaintiff complete an authority so that it could obtain further evidence and make a decision regarding the claim. The Complainant withdrew his consent for the collection of any further information arguing that he had already disclosed everything he knew, was under no obligation to allow the Insurer to intrude further into his privacy and submitted that he had no duty to disclose what the Insurer should have known, ought to have researched or should have obtained evidence about before accepting his application. The Complainant sought payment of the TPD and IP benefits with interest.

The Trustee's position was that the Complainant had not received a decision from the Insurer and therefore was not in a position to form an opinion regarding the claim.

Issues

1. Was the decision of the Insurer to maintain that it was unable to determine the Complainant's entitlement to a TPD and/or IP benefit until it had received the Complainant's authority to obtain further medical information fair and reasonable?

2. Was the decision of the Trustee to affirm the Insurer's decision fair and reasonable?

Determination

The Tribunal held that the decision of the Insurer not to proceed with the assessment of the Complainant's claims until the Complainant provided the Insurer with his authority to obtain further medical evidence was fair and reasonable. The Tribunal was also satisfied that the Trustee could not make a decision on the claims until it received notification that the Insurer had made a decision following receipt of further evidence.

The Tribunal was of the opinion that the Insurer had the right to request further information it considered relevant to its liability under Policy and in order to determine the

Complainant's entitlement to both TPD and IP benefits where it was of the opinion that it did not have sufficient evidence to make a decision. In coming to this decision, the Tribunal acknowledged that the Policy stated that a benefit would be paid 'when we have proof satisfactory to us that all events entitling the trustee to payment of the benefit have happened' and that the Insurer 'may ask for further proof or information to be satisfied that the trustee is entitled to the benefit.' The Tribunal held that this extended to information required by the Insurer to allow it to determine whether a condition was pre-existing at the time of application (whether disclosed or not) as well as information related to assessment of the Complainant's claims under the TPD and IP definitions. Finally, the Tribunal held that the Complainant had an obligation under the Policy to provide the relevant requested information to the Insurer.

RECENT FOS & SCT DECISIONS

Total disability claim found to be continuous claim

Link to determination

Facts

The Complainant submitted a claim for partial disability benefits which was accepted by the Financial Service Provider (FSP). Under the Policy, the Complainant was entitled to partial disability benefits for a maximum of two years (the Maximum Benefit Period) however the Complainant only received benefit payments from the FSP from 7 June 2013 up until the date he returned to work on 13 August 2013. The Complainant maintained that, upon his return to work, he was unable to perform at full capacity due to his illness, and therefore claimed to be eligible for benefit payments for the Maximum Benefit Period.

The Complainant submitted that since he returned to work in August 2013, he was unable to work at full capacity due to his illness and as a result his earnings never approached the level they were in the 2012 financial year or before. The FSP submitted that the Complainant was not entitled to additional partial disability benefits from August 2013 as he had returned to full time employment and was able to perform the usual duties of his regular occupation.

On 4 November 2015, the Complainant submitted a further claim for total disability benefits due to the same illness stated on his previous claim. A dispute arose over whether the total disability claim was a new, recurring or continuous claim and also regarding the date up to which the Complainant should be required to pay premiums.

Issues

1. Did the Complainant remain partially disabled after his return to work in August 2013 and was he therefore entitled to partial disability benefits for the Maximum Benefit Period?
2. Was the total disability claim submitted by the Complainant in 2015 a new, recurring or continuous claim?

Determination

The Financial Ombudsmen Service (FOS) determined that the Complainant remained partially disabled under the partial disability claim and was entitled to receive benefits for the Maximum Benefit Period of two years, i.e. up until 6 June 2015. In coming to this conclusion, the FOS held that the medical information provided supported the conclusion that the Complainant remained partially disabled as a result of the same condition or illness under the previous claim from 14 August 2013 until 3 November 2015, despite having returned to work. The FOS did not accept the FSP's submission that the plaintiff had remained in full time employment, performing regular duties from August 2013.

The FOS also held that the FSP had sufficient information from approximately 18 March 2016 to assess that the Complainant was entitled to at least ongoing partial disability benefits from 14 August 2013 to 6 June 2015. The FOS ordered the FSP to pay interest on the benefit payments pursuant to section 57 of the *Insurance Contracts Act 1984* from 18 March 2016 to the date payment was made under the determination.

Although the Complainant lodged his claim for total disability from 4 November 2013, the FOS was persuaded that this was a continuation of the same condition or illness which was the subject of the Complainant's partial disability claim. The FSP was not required, therefore, to accept the Complainant's total disability claim as either a separate or a recurring claim and was liable to pay benefits under the policy for any one illness or injury for a maximum of two years only.

As there was no practical prospect, in the FOS's opinion, of the Complainant obtaining future benefits from the policy caused by any new injury or illness due to the applicants age, health issues and business situation, it was determined that there was no value in the Complainant paying premiums after 6 June 2015. As a result, the FSP was ordered to refund all premiums paid by the Complainant from the expiry of the benefit period of the first claim, that being 6 June 2015.

TURKSLEGAL Q&A

Murder by a co-insured

In this edition of TurksLegal Q&A, we respond to a client's question on how payments into court work.

Q: How does section 215 of the Life Insurance Act apply when a life insured is murdered by the beneficiary under the policy?

The case note about the recent Federal Court decision in *MLC Limited v Crickitt* "Not sure who to pay?[1]" has prompted a number of questions about the way section 215 of the *Life Insurance Act 1995* ('the Act') is intended to work.

The insurer in *Crickitt* grappled with the problem of who to pay when the surviving beneficiary was convicted of the murder of the other policy owner.

There have been several instances of murder by co-insureds recently, including the case featured in the December 2016 edition of the FSB; *Westpac Life Insurance Services Limited v Mahony*[2]. *Mahony* was eventually convicted by a Supreme Court jury in Toowoomba of the murder of his long term partner and co-insured in November this year.

The Federal Court accepted in both *Crickett* and *Mahony* that section 215 of the Act enabled it to give the insurer a discharge of its liability under the respective policies, because the section is engaged when "in the company's opinion, no sufficient discharge can otherwise be obtained"[3].

Section 215 therefore applies when a company has formed the view that it will pay a benefit under a policy but is unsure who is legally able to give it a release in relation to that benefit payment. In other words, when there are competing claims to the benefit that is payable under the policy.

The section should not be used when the insurer has concerns it is not liable under the policy in the first place.

One common feature of cases where one co-insured kills another is that the perpetrator may have taken out policies of life insurance on the life of the victim in advance of the murder to obtain a financial benefit. This frequently occurs without the victim's involvement, knowledge or consent and may involve fraudulent misrepresentation and forged documentation.

In a case such as this, the insurer should not be concerned about getting a valid discharge, because the policy in question will be unenforceable because it was obtained without the other party's knowledge and through dishonest means.

Seeking to pay into court under section 215 is not the appropriate way of dealing with a policy that may be void on the above grounds and arguably might actually amount to a waiver of the insurer's right to avoid.

In a case where the insurer suspects the policy may have been obtained to gain a financial benefit as part of a criminal scheme, it should (if it has sufficient evidence) refuse payment of the benefit and seek to avoid the policy.

[1] December 2016 FSB.

[2] [2016] FCA 1071. See also *Swiss Re Life & Health Australia Ltd v Public Trustee of Queensland* [2017] FCA 963 (featured in the October 2017 FSB).

[3] Section 215(1).