INSURANCE ▫ COMMERCIAL ▫ BANKING

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

This is our first FSB for the year, delivering recent industry news, an important case law development, a selection of FOS and SCT determinations and TurksLegal Q&A.

In 'What's Happening Here and Now', we are delighted to tell you about our upcoming launch of the interactive online TurksLegal Life Guide. The Guide will be launched at our 'Life Matters' seminars in Sydney, Melbourne and Brisbane, the dates for which have just been announced (sorry, Sydney is now waitlist only!)

We hope you enjoy this edition of the FSB!

CONTENTS

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WHAT'S HAPPENING HERE AND NOW

AUTUMN 'LIFE MATTERS' SEMINARS

TurksLegal is excited to announce the release of the next generation of the Life Guide in a unique new format and jam-packed with new material.

The next 'Life Matters' seminar series will take place in **Sydney on 15 March**, **Brisbane on 11 April and Melbourne on 12 April 2018**. You can register below for the Melbourne and Brisbane seminars.

TurksLegal's '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 our experts.

This year the first of our annual Life Matters seminar series coincides with the release of the next generation of TurksLegal's popular Life Guide. The Life Guide has been re-imagined in a new design concept, which builds on the cases and concepts that changed the law with new cases from 2017 and insightful commentary.

Join us for a light lunch as our life insurance experts explore the major case concepts of 2017 and give you a preview of the new online version of the Life Guide.

SYDNEY SEMINAR

Date	**Thurs, 15 March 2018**
Time	12.15pm light lunch / registration 12.30pm - 2pm seminar
Venue	TurksLegal Level 44, 2 Park St Sydney
Cost	Free

REACHED CAPACITY

Please note places are limited.

BRISBANE SEMINAR

Date	**Wed, 11 April 2018**
Time	12.15pm light lunch / registration 12.30pm - 2pm seminar
Venue	The Sofitel 249 Turbot St Brisbane
Cost	Free
RSVP	Monday, 9 April 2018

REGISTER FOR **BRISBANE**

Please note places are limited.

MELBOURNE SEMINAR

Date	**Thurs, 12 April 2018**
Time	12.15pm light lunch / registration 12.30pm - 2pm seminar
Venue	TurksLegal The Rialto Towers Level 8, South Tower 525 Collins St, Melbourne
Cost	Free
RSVP	Monday, 9 April 2018

REGISTER FOR **MELBOURNE**

Please note places are limited.

INDUSTRY NEWS

Banking Royal Commission

Public hearings in the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry will re-commence on 13 March 2018.

This round of hearings will take place in Melbourne, focusing on consumer lending practices in connection with home loans, car loans and credit cards.

The Royal Commission is known to have written to life insurers seeking details of matters that may fall within its terms of reference shortly after Letters Patent were issued to the Commissioner in December 2017.

The Commissioner is authorised under the terms of reference to inquire into three principal matters:

- Whether financial services entities and their directors, officers or employees have committed "misconduct" and, if so, whether the criminal or other legal proceedings should be referred for prosecution.
- Whether conduct, practices, behaviour or business activities by financial services entities fall below "community standards and expectations".
- Whether the use to which superannuation fund members' retirement savings have been put does not meet "community standards and expectations" or is "not in the best interests of those members".

The terms of reference also require the Commissioner to make findings concerning whether any bad behaviour observed by the Royal Commission was caused by the "culture and governance practices of an entity or broader cultural or governance practices in the finance sector, such as risk management, recruitment and remuneration practices".

The Royal Commission will also make recommendations about the mechanisms for redress for consumers who suffer detriment as a result of misconduct, as well as the adequacy of laws and of industry codes of self-regulation.

Commissioner, the Honourable Kenneth Hayne AC QC, who was a judge of the High Court of Australia from 1997 to 2015, will submit an interim report no later than 30 September 2018 and a final report by 1 February 2019.

Though the Royal Commission has already published several background papers about the Australian banking and mortgage broking industries, it has not yet released any papers in relation to the life insurance industry.

INDUSTRY NEWS

Australian Financial Complaints Authority update

The Bill establishing the Australian Financial Complaints Authority (AFCA) passed both Houses of Federal Parliament on 14 February 2018.

We previously covered the transitional arrangements for the new authority in the December FSB which included higher monetary limits and compensation caps.

The AFCA, which originated from the review of the dispute resolution framework by an independent panel led by Melbourne University Law School Professor, Ian Ramsay, will combine the operations of the Financial Ombudsman Service (FOS), the Credit and Investments Ombudsman (CIO) and the Superannuation Complaints Tribunal (SCT).

ASIC welcomed the passage of the legislation with an announcement on its website saying that it will:

> *"work with Government and scheme stakeholders to ensure that the transition to the commencement of AFCA is as smooth as possible. In the interim, ASIC will retain direct oversight of the two ASIC-approved schemes - FOS and CIO - which will continue to provide high levels of service to consumers and firms".*

Separate arrangements have been put in place in place for the ongoing operation of the SCT to enable it to deal with existing complaints, though the press has recently been critical of backlogs and has questioned whether funding arrangements are in place to adequately resource the SCT.

ASIC Deputy Chair Peter Kell said, in the ASIC announcement that:

> *"Fair, timely and effective dispute resolution is a cornerstone of the financial services consumer protection framework. The combination of firms' internal dispute resolution procedures and access to a free independent external scheme currently provides redress for many tens of thousands of Australians each year".*

In a separate announcement on 5 March, the Minister for Revenue and Financial Services, Kelly O'Dwyer, said the AFCA would be ready to start to receive disputes by 1 November 2018.

The Hon Helen Coonan, a former Barrister and Howard Government Minister, will be the inaugural Chair of AFCA.

Draft Regulatory Guide 139, *Oversight of the AFCA*, was released on 5 March 2018 and will be open for consultation with interested stakeholders until 6 April 2018. It seeks feedback on whether financial firms need transitional relief from external dispute resolution disclosure obligations in the lead up to commencement of the AFCA, and is available on the ASIC website.

INDUSTRY NEWS

Increase in FOS compensation caps from January 2018

From 1 January 2018, FOS will be able to award increased remedies for claims in a dispute.

The new compensation caps (not including interest or costs) which apply to each claim in disputes lodged from 1 January 2018 are:

- $8,700 per month for income stream risk or advice claims[1]
- $5,000 for third party claims for property loss or motor vehicle claims
- $174,000 for general insurance broking claims
- Up to $323,500 for all other claims (e.g. death, total and permanent disability or trauma claims)

There is no change to the monetary limit of $500,000 in relation to each claim in a dispute. Accordingly the $500,000 monetary limit and the compensation caps continue to apply to each claim in a dispute[2].

For disputes lodged on 31 December 2017, compensation caps are limited to $8,300 per month for income stream claims and a standard compensation cap of $309,000 applies.

Please refer to the comparison table overleaf for further details of FOS compensation caps.

In addition to the overall cap on the compensation that can be awarded, there are specific limits on some types of compensation:

- for consequential financial loss, the limit is $3,500 per claim[3]
- for non-financial loss, the limit is $3,000 per claim

For a full copy of the current Terms of Reference which were released on 1 January 2018, click here.

Table 1: Comparison table of FOS compensation cap that apply to each claim in a dispute lodged 2010 to date

Timeframe New Dispute Lodged with FOS		**01.01.2010 – 31.12.2011**	**01.01.2012 – 31.12.2014**	**01.01.2015 – 31.12.2017**	**On or after 01.01.2018**
Type of Claim[4]	1. Claim on a Life Insurance Policy or a General Insurance Policy dealing with income stream risk or advice about such a contract. If the claim is in Excess of this monthly limit, the monthly limit will apply unless: • The total amount payable under the policy can be calculated with certainty by reference to the expiry date of the policy and/or age of the insured; and • That total amount is less than the amount specified in row 2. If this is the case, then the limit will be the amount in the row 2.	$6,700 per month	$7,500 per month	$8,300 per month	$8,700 per month
	2. Other	$280,000	$280,000	$309,000	$323,500

[1] Refer to table 1 for full details.
[2] I.e. FOS cannot consider a dispute if the value of a claim is over $500,000. However, FOS can consider a dispute lodged on or after 1 January 2018, if the value of a claim is say over $323,500, but can only award a maximum of $323,500 inclusive of costs and interest. Exceptions apply. See the FOS Terms of Reference for full details.
[3] Previously $3,300 per claim for disputes lodged with FOS between 1 January 2015 and 31 December 2017 and $3000 per claim for disputes lodged between January 2010 and 31 December 2014.
[4] In any dispute, one claim or multiple claims can be raised by an applicant. The compensation caps shown and the $500,000 monetary limit apply to each claim in a dispute.

CASES AND TRIBUNAL DECISIONS

Group Cover - The Duty of Disclosure and the Remedy of Avoidance

Sharma v LGSS Pty Ltd [2018] FCA 167

Link to decision

Summary

On 1 March 2018 the Federal Court delivered judgment in *Sharma v LGSS Pty Ltd* [2018] FCA 167 being an appeal from the Superannuation Complaints Tribunal (SCT) which had affirmed the insurer's right to avoid the "voluntary" portion of the cover of a member under a group policy.

Background

The insured member became a member of the Super Fund in April 2005 and completed an application for additional TPD and SC cover, known as Voluntary Insurance Cover, in March 2007.

In 2012, the insured member lodged a claim for a TPD benefit arising from a major depressive disorder from May 2007 and schizophrenia from March 2008.

Based on his health records which were obtained by the insurer, the insured member was diagnosed with major depression in 2003 and treated with a variety of antidepressants following the sudden death of his wife in 2001.

He continued to receive treatment in the form of counselling and medication throughout 2003 and 2004 until he ceased in January 2005. At that point in time he was advised to continue to take his medication despite no longer feeling depressed.

The insurer assessed the claim and admitted that insured member was entitled to his automatic TPD benefit but ultimately declined the "voluntary" benefit.

It elected to treat that cover as void under s 29(2) of the *Insurance Contracts Act 1984* (ICA) due to his intentional misrepresentation and non-disclosure of his history of tachycardia and depression.

The SCT upheld the insurer's decision and agreed it was fair and reasonable.

Decision

The SCT noted that the form included questions asking whether the insured member had ever had heart disease, any mental disorder, depression, stress, anxiety or any ear disorder. The SCT also noted that notice of his duty of disclosure was detailed on the form.

The SCT determined that the insured member should have been aware that he was required to disclose to the insurer any matters that he knew, or could reasonably have been expected to know, were relevant to the insurers' decision whether or not to accept the insurance risk and found that he had breached that duty in circumstances where the omission was deliberate. This included the matters relied on by the insurer.

An appeal from a decision of the SCT to the Federal Court can only be brought under section 46(1) of the *Superannuation Complaints Act 1993* in relation to a question of law. Mr Sharma's amended notice of appeal ultimately identified six questions of law, though the Court came to a substantive view about only one of them in reaching its judgment.

The ability of group life insurers to avoid individual cover based on non-disclosure prior to the 2013 amendments to the ICA was always problematic due to historic deficiencies in the key provisions of the original legislation. These problems were identified in the process which led to the passing of the *Insurance Contracts Amendments Act 2013* and led to the introduction of section 31A which expressly extends the duty of disclosure to the life insured.

Her Honour Justice Gleeson's grounds for upholding the insured's appeal are principally found in paragraph 48 where she said:

> *'I accept that it (the SCT) probably assumed or considered that the duty arose from section 21, which it had cited as a relevant provision of the ICA. In doing so, it erred as to the proper construction of section 21. Properly construed, section 21 did not impose such a duty on Mr Sharma.'*

Her Honour consequently found that a life insured in an insured member situation does not have a duty of disclosure under section 21 of the ICA. Having found that no such duty existed, the remainder of the SCT's decision fell away and the matter was remitted back to it for redetermination by the SCT in accordance with law.

While the insurer argued that even if there was no duty of disclosure under section 21, it was still entitled to avoid the cover on the basis of misrepresentations using the combination of sections 25 and 32 of the ICA. Her Honour did not attempt to reach a final determination on those issues because the SCT did not consider them in its determination.

Consequently, these questions will be among those left for the SCT to consider now that the matter has been remitted to it.

Implications

Those who were involved in the consultation process around the 2013 ICA amendments will recall that the way the duty of disclosure was originally expressed in the ICA, led to sufficient doubt about how it would apply in a group situation to make reform in this area desirable.

Section 31A, which expressly extends the duty of disclosure to the life insured, was inserted in the ICA to remove any doubt that the duty of disclosure was intended to apply to lives insured, even when they were not also the policy owner.

The need for there to be a legally enforceable duty to give proper disclosure to the insurer in this situation is, of course, self-evident; bearing in mind the life insured's unique knowledge of their own state of health.

The current decision consequently merely serves to confirm that the reforms reflected in section 31A of the ICA were warranted.

Other important issues relating to the ability of group insurers to avoid voluntary cover that predates the commencement of section 31A on 28 December 2015 were raised, but not determined by the Court. Those issues will remain at large to be resolved in the subsequent phases of the matter before the SCT.

Of course, most voluntary cover will, like the cover obtained by the insured member, be the subject of at least a questionnaire which, if not correctly answered, will give rise to a misrepresentation that will trigger a right to a remedy, such as avoidance in the insurer.

Insurers should be mindful (particularly in matters currently progressing through the SCT) that the tribunal has paid due regard to the misrepresentation aspect in its final determination and that they also do so when framing their correspondence avoiding cover.

RECENT FOS & SCT DECISIONS

Manifestation and disclosure – what and when?

Link to determination

Facts

In August 2010, the Applicant took out income secure professional cover, including trauma recovery cover and business expense cover with the financial services provider (FSP). The Applicant made a claim under the Policy for both types of cover in April 2016 as a result of 'severe aortic stenosis' which required surgery.

In order to qualify for the benefits, the Applicant was required to meet the definition of 'totally disabled' under the Policy, which required the disability to be 'due to an illness or injury'. There was no dispute that aortic stenosis was not an 'injury'.

'Illness' was defined in the Policy as follows:

> 'an illness or disease which first manifests itself during the period of the policy unless it was fully disclosed to us and accepted by us as part of the application for cover, or an application to extend, vary or reinstate cover'.

In January 2007, which was prior to the commencement date of the Policy, the Applicant was diagnosed with a bicuspid aortic valve with mild aortic stenosis however no symptoms were present at that time.

The FSP did not assert that the Applicant breached his duty of disclosure under section 21 of the ICA; rather, while the FSP agreed that the severity of the diagnosis manifested itself once the Policy was in force, it denied both claims on the basis that the Applicant's condition did not meet the definition of 'illness' under the policy as it first manifested itself via a routine test in 2007, prior to the period of the Policy, and that this was not 'fully disclosed to' the FSP or accepted by the FSP for the purposes of the definition of 'Illness'.

The Applicant's position was that the condition first manifested in late 2015 and early 2016 when he first suffered symptoms that led to him requiring surgery, and was therefore an Illness as defined. He also understood that the FSP had a copy of his file from a previous insurer which contained the diagnostic 2007 echocardiogram, so that he was not required to fully disclose it.

Issues

1. When did the aortic stenosis first manifest itself?
2. Was the aortic stenosis fully disclosed to the FSP or accepted by the FSP as part of the Applicant's application for cover so as to have been an Illness, even if it first manifested before commencement?
3. Was the FSP entitled to deny the trauma recovery claim and business expense claim?

Determination

The FOS ruled in favour of the FSP.

While the FOS accepted that the Applicant's condition had deteriorated over time resulting in a more severe diagnosis in January 2016, the FOS agreed with the FSP that the Applicant's condition first manifested itself in 2007 when it was diagnosed. As the condition first manifested itself prior to the period of the Policy, it was not an 'Illness' as defined in the Policy unless fully disclosed.

The FOS noted that the Applicant was an endocrinologist, and would have understood the diagnosis and its implications. It also considered that he would have been aware of his disclosure obligations when he applied for the policy. This should have led to the diagnosis of

bicuspid aortic valve and mild aortic stenosis and the 2007 echocardiogram being disclosed. As they were not fully disclosed, and because his condition first manifested before the policy commenced, it was not an Illness as defined.

The FOS therefore determined that the FSP was not required to pay the claims.

Implications

The words 'first manifests' were regarded as unambiguous, and so were given their ordinary meaning.

In this case, a condition was found to have 'first manifested itself' when it was diagnosed, even though no symptoms were present at that time.

RECENT FOS & SCT DECISIONS

Tribunal determines that Insurer and Trustee's decisions to decline claims for TPD and IP benefits were fair and reasonable

Link to determination

Facts

On 30 September 2011, the Complainant completed an online application for Death and Total and Permanent Disablement (TPD) cover, and income protection (IP). The Trustee wrote to the Complainant on 26 June 2014 to advise her that cover would be cancelled effective 1 August 2014 as her last 'on-time employer contribution' made was for the period ending 27 June 2013. The Complainant ceased work on 31 July 2014 due to ill health. Following this on 9 August 2014, the Complainant was hospitalised after suffering a seizure and was diagnosed with a subarachnoid haemorrhage secondary to a ruptured aneurysm.

The Complainant's son notified the Trustee of the Complainant's claim for TPD and IP cover on 15 August 2014 however the Trustee and Insurer denied the claims on the basis that the Complainant did not hold cover at the time of the seizure on 9 August 2014, as her cover had ceased on 31 July 2014. This was on the basis that on 31 July 2014, the Complainant's superannuation account balance was below $10,000 and it was more than 13 months from the end of the month for which her last on-time employer contribution was made, in accordance with the policy terms and conditions.

The Complainant submitted that she had cover on the date she ceased work, that being on 31 July 2014, due to unknowingly suffering a ruptured aneurism arguing that her cover was paid up until 14 August 2014. Alternatively, the Complainant submitted that she had cover up until at least the end of September 2014 as her last on-time employer contribution was received by the Trustee on 8 August 2013, within the prescribed 13 month lapsing period contained in the 'end of cover' provision of the policy.

The Insurer accepted that the Complainant's last day at work was 31 July 2014, however, it did not consider that the medical evidence supported a 'date of disablement' prior to 9 August 2014, or that the Complainant consulted with a medical practitioner prior to this date. Therefore, the Insurer's position was that the Complainant was ineligible to claim a benefit as she was not insured as at the 'date of disablement', according to the policy definition.

Issues

1. Was the decision of the Trustee to cancel the Complainant's life and income protection cover on 31 July 2014 fair and reasonable?
2. Was the decision of the Insurer, with the Trustee's concurrence, to decline the Complainant's claim for IP benefits fair and reasonable?
3. Was the decision of the Insurer, with the Trustee's concurrence, to decline the Complainant's claim for a TPD benefit fair and reasonable?

Determination

What date did cover cease?

The Tribunal affirmed the decisions of the Trustee and the Insurer.

The key issue was assessing the time at which the Complainant's cover ceased.

The Tribunal held that the last 'on-time employer contribution' must be applied to the period it relates to, not the date which it was received, as specified in the policy.

With respect to the cessation of the IP cover, the Tribunal determined that the last 'on-time employer contribution' that was received on 8 August 2013 related to the period 29 March 2013 to 27 June 2017. As a result, the Tribunal was satisfied that the IP cover ceased thirteen months after the period to which the contribution relates, which was 31 July 2014.

With respect to the TPD cover, the Tribunal held that based on the wording of the policy, the Complainant's cover would end both thirteen months from the end of the month in respect of which an 'on-time employer contribution' was last received and where the balance of the Complainant's superannuation account was less than $10,000, as at the end of that thirteen month period. The Tribunal was satisfied that the Complainant's superannuation account balance was less than $10,000 as at 31 July 2014 and for the same reasons as set out above, the TPD cover ceased on 31 July 2014.

The Tribunal, therefore, held that the Trustee had acted fairly and reasonably in cancelling the Complainant's life and IP cover on 31 July 2014.

Decision to decline claim for IP benefits

The Tribunal was satisfied that the Trustee's and Insurer's decisions to decline the Complainant's claim for IP benefits was fair and reasonable. The Policy provided that a 'waiting period' started on the date a medical practitioner examined the Complainant and certified her to be totally and partially disabled (TTD). The Tribunal was satisfied that the Complainant could only have been certified TTD on 9 August 2014 given that she had worked until 31 July 2014 and had not consulted a doctor between 31 July 2014 and 9 August 2014. Furthermore, the Tribunal was satisfied that the 'waiting period' could not have commenced before the cover ended.

Decision to decline claim for TPD benefit

The Tribunal held that the Trustee and Insurer's decision to decline the Complainant's claim for TPD benefits was fair and reasonable. In order to be eligible for a TPD benefit, the Complainant was required to be absent from her employment for 3 months, as a 'result of injury or illness' following the 'date of disablement'. The Tribunal held that the 'date of disablement' was the later of the date the Complainant ceased work on 31 July 2014 or the date upon which a medical practitioner examined the Complainant in relation to the illness that was the principal cause of the TPD, which was 9 August 2014. The Tribunal was satisfied that the Complainant was not eligible to obtain a TPD benefit under the Policy as her cover was not in effect on 9 August 2014.

The Tribunal also determined that the 'date of disablement' did not commence whilst the Complainant held cover and as a result, she did not satisfy clause 19.5.3 of the policy which provided that where cover has ended and the person becomes TPD, they are still entitled to a benefit provided their date of disablement precedes the date that cover ended.

TURKSLEGAL Q&A

Fraud - can a life insurer cancel the policy?

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

Q: Can life insurers cancel a policy as a result of a fraudulent claim?

The *Insurance Contracts Act 1984* (ICA) specifically says that insurers cannot treat a policy as void from inception because the insured has made a fraudulent claim under the policy.

But what about eliminating the risk of subsequent fraudulent claims by cancelling the future cover under the policy?

An insured may be fraudulent by seeking to claim a benefit they know they are not entitled to. For instance, providing an IP insurer a progress claim form that states the claimant is totally disabled while in reality they are working.

It is also fraudulent if a claimant deliberately provides misleading information to an insurer in relation to a claim to induce an insurer to pay a claim that would otherwise be valid.

In either case, section 56(1) of the ICA says the insurer is not obliged to pay the claim and section 60(1)(a) always gave an insurer under a policy of general insurance the right to cancel the policy. However, prior to the 2013 amendments to the ICA it said nothing about what a life insurer could do in this situation.

Section 59A of the ICA, which was part of the reforms made by the Insurance Contracts Amendment Act 2013, now makes it clear that a life policy can be cancelled in this situation.

But what about policies entered into prior to 28 June 2013 when the new Sections came into force?

The law in this area has a chequered history.

In the 2004 decision in *Walton v The Colonial Mutual Life Assurance Society Limited*[1] *(Walton)* the Court held that because section 56(1) only said an insurer could refuse payment of the claim, this was the only remedy available to a life insurer in the event of a fraudulent claim and the insurer had no right to cancel the policy.

The decision in *Walton* was the cause of section 59A being added to the ICA in 2013. However, the Federal Court recently had cause to consider the issue again and has expressly refused to follow that aspect of the decision in *Walton*.

In the case of *AIA Australia Ltd v Richards*[2], the Chief Justice of the Federal Court, Justice Allsop, reached the opposite conclusion, saying that there was "no basis" to consider that the common law right to cancel the policy as a result of the insured's fraud had been abolished by section 56(1).

Utmost good faith is a fundamental term of every policy of insurance and a fraudulent claim is consequently a serious breach of the policy conditions. The reasoning in *Richards* was, that consistent with general principles of contract law, this confers on the innocent party a right to terminate the contract if they choose to. *Richards* is, for this reason, in our view the preferable decision.

Clients will be able to read more about the decision in *Richards* in the updated Life Guide which will be released in March 2018.

[1] *Alexander Raymond Walton v The Colonial Mutual Life Assurance Society Limited* [2004] NSWSC 616

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