LIFE INSURANCE BULLETIN

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Note from the Editor

Ok, let me get this straight, the regulator is now calling out life insurers for being too generous with its IDII products (APRA on IDII cover)? Hardly consistent with the sharp behaviour a few voices still like to associate with life insurers. Of course what it does demonstrate is that life insurers overwhelmingly are driven to build products which delight their customers. Some reboot is obviously necessary here and that will occur, but in the meantime, let's not forget just how much IDII has done for sick and injured customers to date and how much, IDII done the Australian way, resonates with those who seek to financially protect their loved ones in times of sickness and injury.

Speaking of IDII, we were so thrilled to host a record turn-out at our Spring Life Matters Webinar earlier this month when our life experts, Sandra Nicola and Michael Iacuzzi, broke down the role of offset clauses. We didn't have time to answer all of your great questions but please, reach out to Sandra (sandra.nicola@turkslegal.com.au) or Michael (michael.iacuzzi@turkslegal.com.au) if you have any queries about this topic, which seems to perennially be a source of controversy. Also, stay tuned for details of our final Life Matters Webinar, to be held later this year.

I hope you enjoy our third edition of the Bulletin for 2020. We talk about a recent avoidance case (yes this remedy does still exist!), another AFCA trauma decision as well as decisions touching on those niggling technical issues you may have missed, that I think you may find interesting. Finally, Peter Murray has an interesting piece on the recent Actuaries Institute paper on IDII.

As always, we love your feedback so reach out to your favourite Turks life expert if you have any queries.

See you next time.

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PRODUCT / REGULATORY

Sustainability in Disability Insurance - Actuaries' Taskforce lays bare the challenges ahead…

A recent report from the Actuaries Institute Disability Insurance Taskforce has shone light on the long term sustainability of disability insurance, particularly individual disability income insurance (IDII) product offerings in both the retail and group space, which has for some time now, been of significant concern within the industry.

See link for full report: https://www.actuaries.asn.au/practice-area/individual-disability-income-insurance-in-australia

Of course, in December 2019, APRA had already raised the alarm by way of open letter to life insurers which sought to *'address the poor performance of IDII and move the product to a sustainable state*'[1].

As a result, the AI Taskforce considered it timely to undertake a comprehensive review of issues with IDII in Australia. With an ever increasing claims experience largely due to growing prevalence of mental illness in the community and comparatively rising premiums, the long term viability of IDII in the absence of critical reform or substantial intervention, is reportedly bleak and '*at risk of failure*'[2].

According to the AI Taskforce, IDII has been built on the:

> '*optimistic assumption of continued economic growth as well as rising inflation and interest rates to mitigate any claims deterioration; but unfortunately over the past decade, this has not occurred and low wage growth and interest rates and pressure from changing societal expectations has continued*'.

This has created '*substantial stressors*', particularly for IDII which was described by Taskforce interviewees as a '*broken product*'.

In short, IDII is in desperate need of a reset. The AI Taskforce report provides a series of provisional recommendations and some tools to help the life insurance industry adopt better practices to ensure long term sustainability. Below, we've touched on a few of the key matters arising from the report which are particularly relevant to life insurers.

Product Design Issues

Traditionally, the sale of life insurance has been steeped in distribution targets, aimed at '*optimising the advice/sales process*'. This means that for many life insurers, in order to compete in the market, providing various '*add-ons*' or extra features into their product design has become par for the course. But this has had unintended consequences. The IDII products are now so complex and "*too feature heavy' that they have gradually strayed from attending to the customers 'core' disability insurance needs*'.

Taskforce interviewees also observed that insurers are restricted in their ability to change or adjust the policy terms over the life of the Policy and '*there is little provision made in pricing for future adverse experience*'. These factors combined have resulted in unsustainable financial losses for insurers as the claims experience becomes more difficult to predict in light of ongoing economic uncertainty and a rapidly changing world.

Another glaring issue associated with IDII is the long term nature of the cover (whether that be group or retail) where substantial monthly benefits are paid on the back of increasingly generous policy terms (where claimants need only satisfy '*any one income producing duty*' total disability definitions) for years on end. Claimants can easily find themselves on claim long into the future and in many cases, decades after the commencement of the claim.

Understandably, the flow on effect is that claimants will have very little, if any, incentive to return to work, which is of course one of the key aims of IDII cover. The evolution of '*liberal policy terms*' has long been identified as a problem, with the NSWSC noting more than a decade ago, that IDII policies designed in this way, will result in a '*disincentive to work*' unless the benefits of so doing '*are that good that they outweigh the benefits which would be received whilst the insured remained idle*'.

In an effort to reign in the long-term nature of IDII, the report noted that '*APRA's 2019 proposal to have 5-year contracts with guaranteed renewability on updated terms resonated with many Taskforce interviewees*'. Indeed, APRA expects life insurers to '*have a framework to periodically update policy contract terms, while ensuring policyholders' insurability rights are maintained; and manage their exposure to long benefit periods and have effective controls to manage the associated risks*'.[3]

The AI Taskforce otherwise considers that '*loss minimisation principles*' should be expressly embedded in IDII policies (traditionally limited to policies of general insurance), there being an argument that claimants have a '*clear obligation to take reasonable steps to minimise the period over which benefits are paid to them – and for example, avoid striving to return to work with appropriate treatment and rather continue to claim benefits*'.[4]

Improving the Claims Process

Consistent with the recent 'Hayne Royal Commission' and the Life Insurance Code of Practice, the AI Taskforce has identified a number of shortcomings in relation to claims staff training and qualifications. Claims team members are '*expected to have a wide range of skills and yet there are no formal training requirements, no industry wide professional standards and no qualifications for claims management*'. This inevitably results in a lack of understanding as to how IDII contracts operate resulting in a complicated claims processes which can lead to poor customer outcomes (for example, through misapplication of terms or the inappropriate use of GPs and experts).

The AI Taskforce highlighted the need for an increased focus on rehabilitation noting that:

> *'rehabilitation support can make a difference, particularly early rehabilitation of the right kind. There was strong belief in the health benefits of work. There was an argument that payments should be more frequent than monthly so that there is more frequent interaction, which would help in getting people back to work and setting expectations, mindset etc. about returning to work.'*

An increased focus in this regard, would certainly go some way to offset the '*disincentive to return to work*' borne out of liberal policy terms and significant monthly benefits to retirement age. Early intervention is the key.

Claims assessments would also be better served with a simplified IDII Eco-System where information flows more freely among stakeholders. The AI Taskforce has quite rightly, encouraged increased '*sharing of common information (subject to privacy and consent considerations) particularly when a claimant transitions between different disability support systems,*' because as is often the case, life insurers can often be inhibited in their capacity to offset claim payments due to a lack of understanding as to the nature of other benefits claimants may be receiving. This has been compounded by recent court decisions which have also highlighted the extent to which the matters discussed above (and within the report) overlap, particularly the relationship between product design and the claims assessment processes.

Implications

Whilst the above snapshot does not seek to capture all the issues raised within the report, the issues discussed will not be new to life insurers. Nevertheless, the report certainly gives the industry pause to once again take stock, and consider the direction of IDII going forward into the post COVID-19 world. Put simply, the report suggests things must change if life insurers are going to be in a position to offer a manageable and profitable IDII cover long into the future.

As noted within the report, some insurers have sadly withdrawn from the race, so to speak, and no longer offer Income Protection or Salary Continuance after incurring unsustainable losses year on year. A recent KPMG research paper found that '*life companies lost $3.4 billion over five years*' which has '*threatened the viability of the sector.*'[5] For the sake of consumers and the community more broadly, this unworkable model cannot be the way forward, particularly given the uncertainty presented by COVID-19, the effects of which '*could be profound*'.

The report observes that for too long now, the industry has been focused on competition and distribution of IDII, at the expense of long term sustainability; and if things are to change, and life insurers are to adopt the provisional recommendations and tools suggested by the AI Taskforce, and take action on these matters, it is going to require collective buy-in by all industry participants so as to avoid the inevitable arms race which has led us to this point.

Of course, having started the conversation in 2019, APRA has paved the way for the AI Taskforce report which, for the most part, appears to echo APRA's previously held concerns in relation to IDII and its long term sustainability. Accordingly, for some time now, the life industry has been aware of APRA's desire for insurers to have '*appropriate mechanisms to keep products in step with changing external and consumer circumstances*',[6] noting of course that '*guaranteed renewability for extended periods causes significant difficulty in designing products that will remain sustainable and appropriate for consumers*'.

Nevertheless, life insurers will have concerns about the practical effect of such change. For example, the renewal process (for IDII contracts with fixed terms and conditions not exceeding five years) and the disclosure/underwriting challenges that naturally follow as a consequence. Also, given AFCA's focus on '*fairness*', AFCA's approach to disputes around non-disclosure and policy avoidance in this context is uncertain. Life insurers will be wary of the practical challenges presented by such sweeping product design changes and certainly, APRA has observed that up to this point, '*the fear of first-mover disadvantage has proven to be an insurmountable barrier to (life insurers) making the necessary changes*.'

[1] https://www.apra.gov.au/sustainability-measures-for-individual-disability-income-insurance

[2] Actuaries Institute Disability Insurance Taskforce Report – Provisional Findings and recommended Actions for Individual Disability Income Insurance (September 2020)

[3] https://www.apra.gov.au/sustainability-measures-for-individual-disability-income-insurance

[4] Actuaries Institute Disability Insurance Taskforce Report – Provisional Findings and recommended Actions for Individual Disability Income Insurance (September 2020)

[5] https://riskinfo.com.au/news/2020/09/29/broad-changes-needed-to-sustain-disability-income-market-report

[6] https://www.apra.gov.au/sustainability-measures-for-individual-disability-income-insurance

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LIFE AND SUPERANNUATION CASES

NSWSC confirms s29(2) Avoidance – Court rejects suggestion illicit drug use is akin to drinking alcohol

Catriona Smith v OnePath Life Limited (NSWSC 2020)

Key Takeaways

If an insurer asks about drug use in an application for insurance, it is no defence to an allegation of non-disclosure or misrepresentation to argue that the non-disclosed/misrepresented drug use was recreational or within socially accepted norms, and therefore irrelevant to the insurer's decision.

In spite of the increasing prevalence of widespread recreational use of illicit drugs, the courts remain unwilling to lump such behaviour under the umbrella of recreational alcohol or tobacco use.

Brief Facts

The life insured was a successful fund manager and a recreational user of cocaine (amongst other things). In November 2014, he took out $2.5m of life insurance with the insurer but did not disclose his drug habits in the application for cover. He did tell the insurer about a recent health check he had undergone due to '*age*' but as it turned out, it was actually due to a recent cocaine binge.

The cover was called upon by the life insured's wife and beneficiary after the life insured died in circumstances which suggested he was involved in a string of frauds and other criminal enterprises. The key questions in the application for insurance were:

> *Do you take, or have you ever taken drugs or medications on a regular or ongoing basis?*
>
> *and*
>
> *Have you ever used…any drugs not prescribed for you…or have you ever received advice, counselling or treatment for drug dependence?*

During the course of assessing the claim, the insurer obtained various pieces of evidence which demonstrated that – contrary to his '*No*' answer to the questions about drug use – the life insured in fact had a long and demonstrable history of heavy cocaine use (subsequently described by Hammerschlag J as '*non-trivial*'), as well as '*ice*'.

It also turned out that the life insured was a moderate smoker (contrary to what he told the insurer) although ultimately this played no material role in the avoidance or the proceedings. The insurer's underwriters determined that, had they known about the history of heavy illicit drug use, they wouldn't have offered any cover at all. Accordingly, the insurer avoided the policy for fraudulent non-disclosure/misrepresentation under s29(2) of the *Insurance Contracts Act* 1984 (Cth) (the **ICA**) and this was challenged by the beneficiary in the NSWSC.

Judgment

Hammerschlag J found for the insurer, upheld the avoidance under s29(2) of the ICA and dismissed the summons. There being consensus between the parties as to the insurer's retrospective underwriting position, the key issues revolved around whether the life insured misrepresented or failed to disclose his heavy drug use and – if he did – whether he did so fraudulently.

The theme of the beneficiary's argument was that the life insured's use of illicit drugs prior to the application for insurance was '*recreational, occasional, irregular and sporadic*'. In this context, it was argued that:

> '*…the structure of the Application conveys that the insurer was not materially interested in knowing about a proponent's recreational drug use, or the occasional cigarette, and it was open to a reasonable person in [the life insured's] position to so think*'.

The beneficiary also noted that the application for insurance did not use the word '*recreational*' in the question about drug use, and that the life insured's disclosure of other matters in the application – such as his sister's Multiple Sclerosis (MS) – meant that there was no fraudulent intent in any non-disclosure or misrepresentation.

The insurer's argument was, simply, that the life insured's illicit drug use was far heavier than made out by the beneficiary in her evidence and that his failure to bring these matters to their attention was plainly fraudulent.

Hammerschlag J agreed with the insurer that the life insured's pre-policy illicit drug use was more than '*recreational, occasional, irregular, sporadic or socially acceptable*'. Importantly, his Honour also stated:

> '*But even to give it that description does not mean that he was not a regular or a non-trivial user of illicit drugs. He plainly used illicit drugs on multiple occasions not restricted to when Catriona was there.*'

Noting that the life insured was an '*educated and sophisticated man*', his Honour effectively held that it was '*inconceivable*' that he answered '*No*' to the above two questions in the application for insurance, and was therefore fraudulent. His Honour also considered that the life insured's partial disclosure of his health check (albeit for a false reason) and his sister's MS were '*if anything…consistent with…a person engaging in fraudulent conduct*'.

Implications

This case is a reminder that for a multitude of behavioural reasons, at times, people are deliberately untruthful when they apply for life cover and that accordingly, sometimes it is necessary to invoke the avoidance provisions of the ICA.

Of course determining when non-disclosure and misrepresentation is fraudulent within the meaning of the ICA can be a difficult question that troubles many life insurers, although in the instance of this case, with the stark history of drug use, it may be that the decision to avoid was fairly straightforward. Still, one must also not feel that findings of fraud are only reserved for such extreme cases with salacious facts. The fact of the matter is that the temptation to hide pertinent matters from life insurers so as to avoid embarrassment or obtain cover at a standard price (or at all) is as old as life insurance itself. Fraud comes in many shapes, sizes and intensity and brave life insurers will be prepared to make the call in this regard.

Further, what this case does highlight is that in the eyes of the law (as opposed to say social media), illicit drug use is not yet on par with more accepted vices such as recreational alcohol use. In other words, dismissing drug use as being within accepted social norms and therefore irrelevant to an insurer's decision to provide cover, will not be a valid reason for not disclosing such matters in an application for insurance (assuming the relevant question is asked). Having regard to the firm findings on fraud, this case also suggests that even if the life insured's use of illicit drugs was recreational, it would not be difficult to prove fraud (which of course depends on the evidence).

Life insurers can therefore take comfort in the fact that the courts – notwithstanding the modern, cosmopolitan age – remain willing to enforce underwriting standards about illegal conduct, which are backed up by medical evidence.

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LIFE AND SUPERANNUATION CASES

FCA confirms indemnity costs only ordered in cases where proceedings end by agreement if 'losing' party's case was hopeless

Molnar v Good Mood Food Pty Ltd (FCA 2020)

Key Takeaways

Where litigation resolves when one party essentially gives the other party what they were seeking but an agreement cannot be reached on costs, the court will step in to decide costs if asked. However, it will not usually order indemnity costs because without a full hearing the court will not be able to determine whether a party's case was truly hopeless (although such circumstances may exist in rare cases).

Where this is particularly relevant to life insurers is in situations where an insurer pays a TPD claim in the middle of legal proceedings. In such circumstances, costs will generally be payable by the insurer on the ordinary basis, but unless the insurer was completely without any reasonable argument (which will be rare) then the court should not award indemnity costs.

Brief Facts

Mr Molnar was the 30% shareholder in Good Mood Food Pty Ltd (**GMF**), and Mr Philipsz controlled the remaining shareholding. Following an acrimonious breakdown in his relationship with Mr Philipsz, Mr Molnar commenced proceedings in the FCA against GMF to enforce a direction he gave under the *Corporations Act* to GMF to prepare an audited financial report (the **Substantive Proceedings**).

The Substantive Proceedings were initially defended by GMF but it eventually capitulated, agreeing to provide the requested financial report but costs could not be agreed upon, with Mr Molnar demanding costs on an indemnity basis, resulting in further proceedings (the **Costs Proceedings**).

In the Costs Proceedings, Mr Molnar submitted that he should be entitled to costs of the Substantial Proceedings paid on an indemnity basis because GMF's defence was hopeless.

Judgment

Jackson J held that no party was entitled to indemnity costs in either the Substantive or Costs Proceedings, and no party was entitled to any costs at all in the Costs Proceedings. The only costs order made by his Honour was for GMF to pay Mr Molnar's costs – on the '*ordinary*' basis – of the Substantive Proceedings.

In reaching this decision, his Honour noted that *'where a matter is resolved without a trial, it will not usually be possible or appropriate for the court to award costs on the basis of any firm determination as to who would have succeeded in the issues in dispute'* although clearly an exception was made in this case.

Specifically, quoting principles set out by McHugh J in *Re Minister for Immigration and Ethnic Affairs; Ex parte Lai Qin*, Jackson J stated that the reason for the party-party costs order against GMF in the Substantive Proceedings was that Mr Molnar '*achieved substantial victory*' in those proceedings and '*GMF behaved unreasonably in resisting the application*' (on the basis that the purported costs saving from not complying with the financial report request paled in significance to the legal costs incurred in defending that position).

However, Jackson J did not make any indemnity costs orders at all, as requested by Mr Molnar, for two key related reasons:

- the Substantive Proceedings resolved through compromise, meaning that no adverse findings from a contested trial were made – '*the court does not even have the benefit of hindsight*'; and

- in the absence of a trial on merits, it would be inappropriate for the Court to conclude that GMF's case was hopeless and doomed to fail – i.e. that it acted unreasonably, which is an essential element in making an indemnity costs order. In other words, while GMF's position didn't look hopeful, only a trial on merits could possibly lead to the conclusion that its position was unreasonable to the standard required for an indemnity costs order.

Mr Molnar argued that it was possible to make such a conclusion in this case, because the only real basis for GMF's resistance to the Substantive Proceedings was an abuse of process claim. Mr Molnar tried to demonstrate why that argument was doomed to fail (citing case law in support) however; his Honour canvassed some possible reasons why it was not necessarily doomed to fail. In short, because there was a reasonable possibility of GMF's argument succeeding, then the absence of a trial meant that the argument could not be hopeless.

In terms of the legal costs of the Costs Proceedings, his Honour awarded no costs to either party because a) GMF did not resist the original ordinary costs order; b) the approach by both parties to the costs proceeding was '*disproportionate and misconceived*'; and c) '*so as to mark the court's disapproval of satellite litigation of this kind*.'

Implications

What does this mean for litigated life insurance cases?

If an insurer admits a TPD claim midway through proceedings, and the plaintiff's lawyers claim indemnity costs, *Molnar* suggests that the plaintiff should not be entitled to such costs because the insurer has not had the benefit of a contested trial. No matter how hopeless an insurer's position may seem to be, it is almost always impossible to conclude with certainty that it really is hopeless, until it goes to trial. The lack of hopelessness means an insurer should very rarely agree to an indemnity costs order in these circumstances.

The key takeaway from this case is that – in the vast majority of circumstances – only the benefit of a contested trial can reveal whether an insurer's position was truly, incontrovertibly unreasonable, and therefore give rise to an indemnity costs order.

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LIFE AND SUPERANNUATION CASES

NSWSC confirms insurers must consider all TPD evidence

Long v IS Industry Fund Pty Ltd (NSWSC 2020)

Key Takeaways

Insurers cannot simply choose to disregard, or place unduly little weight upon, evidence which it considers to be deficient – for example, late-in-time medical reports, pro-forma certificates with little underlying rationale, or '*on-the-papers*' medical opinions.

If a claimant suffers from a medical condition or incapacity at a time when their cessation from work is obscured by other reasons – for example, termination for misconduct, resignation etc. – it will not be a strain for a court to find that the initial qualifying period is met unless the terms of the policy explicitly say that the initial absence from work must be caused solely by the claimed condition.

Brief Facts

The life insured was a member of IS Industry Fund (the **Fund**) and accordingly received TPD cover under a group policy held by the trustee of the Fund (the **Trustee**) with the insurer. The TPD definition was as follows:

> *Where an Insured Person is gainfully employed and is working fifteen (15) or more hours on average each week within the six (6) months prior to the Date of Disablement they suffer Total and Permanent Disablement if they;*
>
> > *a) are unable to do any work as a result of Injury or Illness for six (6) consecutive months and in our opinion, at the end of that six (6) months they continue to be so disabled that they are in our opinion unlikely to resume their previous occupation at any time in the future and will be unable at any time in the future to perform any Other Occupation...*

The life insured's employment with BWS was terminated on 14 January 2011 due to misconduct, and he made a brief return to work at a business in Tasmania between 27 October 2014 and 11 December 2014 when he resigned from that employment.

A TPD claim was lodged with the Trustee by the life insured, in respect of bipolar disorder and a back condition. The life insured argued that, although the immediate cause of the termination from his employment was misconduct, he nonetheless met the 6 month qualifying period due to his claimed conditions and was TPD, with the subsequent return to work being a failed attempt.

The insurer argued that the cause of the life insured's inability to work for 6 consecutive months was his termination for misconduct, and his subsequent return to work showed he was not TPD. The insurer declined the TPD claim four times, and an additional time when the life insured attempted to claim with a new date of disablement post-dating the brief return to work in 2014.

The parties to the litigation agreed for the Court to separately determine the question of whether the insurer's decisions were valid, prior to engaging in the further issue of whether the life insured met the TPD definition.

Judgment

Robb J considered that some aspects of the insurer's decisions were reasonable, and others were not, with the net effect of moving the proceedings to the stage 2 enquiry at some date in the future. In reaching these conclusions, his Honour held that:

- The TPD definition did not require that the cause of initial cessation of work to be the claimed condition (as opposed in this case to termination for misconduct) – only that the '*requisite Injury or Illness is present and has the stipulated*

effect' at the beginning of and throughout the qualification period (para 86), i.e. as an '*immediate consequence of the direct cause*' of the termination misconduct. In other words, the Judge found that as long as the relevant illness or injury was a proximate cause of the initial absence from work, it did not need to be the only proximate cause. Accordingly, this aspect of the insurer's decisions were invalid (para 125). Obviously, in this regard the Judge accepted the important *ratio* of *Mabbett*.

- Contemporaneous evidence is not necessarily more reliable than evidence produced at a much later time – *'It is likely to be unreasonable for an insurer to reject out of hand later evidence solely on the ground of its remoteness in time from the Relevant Date'.*
- *'The Court cannot be too exacting in judging the adequacy of the reasoning process displayed by an insurer' in circumstances where an insurer has been 'responding to a series of repeated applications' made with 'a substantial body of incomplete and dissociated medical and other related evidence'* (para 179).
- *'… an insurer considering a TPD claim in the same circumstances as did the insurer is not required to explain its reasoning in the same comprehensive way as would a court deciding the same question. The claims assessor who determines the application may not be legally trained, and is not required to provide an explanation of his or her process of reasoning with the same level of precision as would be expected of a lawyer justifying the decision on legal grounds.'* (para 238)

Despite the above observations, Robb J also held that the insurer breached its duties by rejecting outright certain evidence provided by the claimant rather than allowing the deficiencies in that evidence only to go to the question of weight.

Implications

This case confirms existing authority that insurers' TPD decisions will not be scrutinized with pedantry by the court. It also pleasingly confirms that insurers will be given some latitude when the claims process, through no fault of a claimant, is made difficult to navigate by the insurer due to, for example, frequent tranches of drip-fed evidence.

Having said this, the case is also a warning that insurers cannot simply reject outright evidence, which it deems to have been improperly obtained, or be otherwise irrelevant. Such evidence in this case included pro-forma medical certificates certifying TPD without any explanation, evidence produced many years after the date of disablement making comment on a state of affairs which was present many years prior, and opinions from doctors based solely '*on the papers*'.

Finally, the decision also confirms that the claimed condition need not be the sole or immediate cause for a person ceasing work – so long as it keeps them from working (unless of course the terms of the policy refer to a '*sole cause*'). In this case, the Judge construed the definition of TPD as allowing termination for misconduct to be the immediate cause of unemployment, but considered that termination to result in an immediate exacerbation of the claimed condition – resulting in a concurrent and contemporaneous inability to work from the relevant date, and thereby satisfying the qualifying period.

LIFE AND SUPERANNUATION CASES

Reinsurance: Court rejects request for group insurance takeover material

RGA Reinsurance Company of Australia Ltd v Westpac Life Insurance Services Ltd (NSWSC 2020)

Key Takeaways

The NSWSC has rejected a reinsurer's request to obtain documents related to a Trustees' decision to change group insurers, which resulted in the reinsurer's treaty being terminated.

Whilst the reinsurer was not successful in obtaining material sought in its application, the case nonetheless highlights the importance of an incumbent group insurer being aware of its reinsurance treaty notification obligations in the context of a change in group insurer.

Brief Facts

A group insurer (the **incumbent group insurer**) and a reinsurer were parties to a reinsurance treaty made on 26 October 2017 (the **Treaty**).

The Treaty reinsured certain policies of group insurance referred to as the 'Reinsured Master Policies' (the **Policies**) that were issued by the incumbent group insurer to various Trustees (the **Trustees**) who were part of the same corporate group.

The Trustees informed the incumbent group life insurer of their decision to:

- appoint a new group insurer; and
- terminate the Policies between them with effect from 1 July 2020.

As a result, the incumbent group insurer informed their reinsurer that the Treaty between them would terminate on and from 1 July 2020 given the Trustee's decision to terminate the Policies.

Article 1.5 of the Treaty provided that the incumbent group insurer:

> *'…is not entitled to…sell or transfer or attempt to sell of transfer any of the [Policies]…without [the Reinsurer's] prior written consent…'*

The reinsurer sought documents from the incumbent group insurer to explore whether the life insurer may have acted in breach of Article 1.5 in the context of the Policies.

The incumbent group insurer responded that the termination of the Policies by the Trustees was not a sale or transfer of the Policies by the incumbent group insurer for the purposes of Article 1.5.

The reinsurer subsequently sought orders from the SC that it was entitled to documents directed to the Trustees' decision to appoint a new group insurer under Article 20.2 of the Treaty or, alternatively, by way of preliminary discovery under rule 5.3(1) of the *Uniform Civil Procedure Rules (NSW)*. These documents were said to be likely to cast light on whether the Trustees had appointed a new group insurer in place of the incumbent group insurer or, whether, Article 1.5 of the Treaty regarding selling or transferring the Policies had been breached.

Article 20.2 of the Treaty provided:

> *'…Either Party must, on request, with reasonable Notice, from the other Party, allow that Party and appoints agents such access to its premises and to its Records…as the Party may reasonably require and must, on a reasonable request but subject to any legal obligation to the contrary, provide copies of any Records to the other Party…'*

Prior to the proceedings being heard the incumbent group insurer did provide certain additional material sought by the reinsurer, but did not provide all the material sought.

The proceedings therefore concerned the remaining documents, which the incumbent group insurer had not produced despite the reinsurer's requests.

Judgment

The Court found that the reinsurer had not established an entitlement to the documents sought under Article 20.2 or through preliminary discovery. The Court reached that conclusion primarily on the basis that the Court considered it was not in a position to determine the reasonableness of the reinsurer's requests for documents (the onus essentially being on the reinsurer to establish the requests were reasonable) because it did not have the relevant takeover contractual documents that were to apply between the various parties from 1 July 2020.

The emphasis on the relevant takeover contractual documents was more important in circumstances where the Court considered that there was 'nothing in the evidence' that was before the Court which suggested that the arrangements between the Trustees and the incumbent group insurer involved a sale or transfer by the incumbent group insurer of the Policies. This was also a factor in the Court finding that the reinsurer had not established the preliminary discovery requirements which requires, amongst other things, a party to establish that they '*may be entitled to make a claim*' for relief.

Implications

A trustee deciding to move its group insurance arrangements from one group insurer to another does not, of itself, involve the incumbent group insurer selling or transferring life policies (in the way contemplated by Part 9 of the *Life Act*) and the Court's decision here appears to recognise this in the context of the Treaty wording in question, which referred to obtaining the reinsurer's consent in the context of any selling or transferring of the group policies by the incumbent group insurer.

Nonetheless, the nature of the proceedings underscores the potential importance of notification obligations in a changeover of group insurer scenario. Typically, the reinsurer would be aware of the possibility of a changeover of group insurer during the superannuation trustee's tender process. However, such a process may not always occur in a way which involves the reinsurer and does not, in any case, absolve the group insurer's notification obligations (depending, of course, on how those notification obligations are framed). Notification obligations in reinsurance treaties should be checked when an incumbent group insurer becomes aware of a potential changeover of group insurer.

LIFE AND SUPERANNUATION CASES

AFCA finds trauma event arises when it occurs, not when diagnosed

AFCA Determination 674068

Key Takeaways

What constitutes the occurrence of the insured event in trauma cover, with its heavy focus on scientific diagnostic criteria, has always been the source of much of the controversy that swirls around this product. The additional wrinkle on this controversy arises when regardless of the policy terms, an argument can be made that the relevant condition arose before cover cessation. Here, s54 looms large as a basis on which, regardless of the policy terms, a benefit may still be payable.

Brief Facts

The insured entered into a critical illness policy with the insurer in February 2016 but later cancelled it in February 2018. In the meantime, from July 2016 onwards, symptoms emerged of what would later be diagnosed as a form of malignant cancer that was a critical condition under the policy. Importantly, the formal diagnosis did not occur until August 2018 upon receipt of the relevant histopathology report, six months after the policy was cancelled.

The insured's claim was declined by the insurer on the basis that she did not suffer a critical condition diagnosed during the period of cover.

The insured complained to AFCA.

The Policy Wording

The policy provided:

When we will pay

> *'if the life insured suffers a critical condition (see below) while this insurance is in force, we will pay you the critical illness benefit or a proportion of the benefit if indicated below'.*

Further

> *'a benefit is not payable until a critical condition meets the terms of its definition. In some cases, a critical condition must progress to a certain point before it satisfies the relevant critical condition definition.*
>
> *All critical conditions must be diagnosed by a specialist and confirmed by [the insurer's] medical adviser.'*

And later at the end of the list of **Critical Conditions**

> *'The life insured has a critical condition:*
>
> - *for surgical conditions when the surgery actually happens; and*
> - *for all other conditions, when the condition is first diagnosed as meeting its definition'.*

AFCA's Determination

Contractual Construction

The insured did not dispute that her cover was cancelled prior to the diagnosis of the critical condition. Her position, supported by unchallenged medical evidence, was that although it was not diagnosed until later, she suffered the critical condition while the policy was in force. She argued that the '*When we will pay*' provision of the policy required that she suffer the condition while the policy was in force and not that it be diagnosed while the policy was in force.

The insurer relied upon the later provision specifying that an insured has a critical condition when it is first diagnosed to argue that its liability to pay the benefit was by reference to the date of diagnosis and that the diagnosis must occur during the period of cover for a benefit to be payable.

AFCA considered not only the wording of the policy, but the positioning of particular clauses in the policy. It found, largely by reference to the context in which the extracted clauses sat

within the policy itself, that the contractual obligation to pay a benefit was linked to the suffering of the critical condition, and that the clause requiring the diagnosis simply operated to provide that payment be made after the condition is first diagnosed.

AFCA concluded that the terms and intent of the policy was to pay a benefit if the condition was suffered whilst the policy was in force and not when it was first diagnosed.

S54 of the ICA

AFCA also considered whether the failure to be diagnosed while the policy was in force was a post contractual act or omission within the meaning of s54 of the ICA and therefore could not be relied upon by the insurer to refuse to pay the claim unless it could reasonably be regarded as capable of causing or contributing to the loss.

AFCA found that the date of the diagnosis did not cause or contribute to the loss. It went on to consider the insurer's argument that s54 would not provide relief as it does not operate to restrict or limit the insured risk. The insurer's position was that the insured risk was the suffering of the diagnosed conditions, and with no diagnosis there was no insured event.

AFCA found that the essential character of the policy was to provide a critical illness benefit for an insured suffering a critical condition (in this case malignant cancer) whilst the policy was in force and it was not to provide a critical illness benefit for an insured diagnosed with malignant cancer whilst the policy was in force. The diagnosis was relevant to the timing of payment and quantification of the benefit. It did not modify the cover for critical illness suffered by an insured whilst the policy was in force, and therefore was not an inherent restriction or limitation on the policy cover or the complainant's claim as was argued in *FAI General Insurance Company Ltd v Australian Hospital Care Pty Ltd* (HCA 2001).

Nor did the fact that the claim was made after the cancellation of the policy have the effect of preventing a claim. The period of cover was not found to limit the duration of the contractual rights and duties of the parties and the expiry of the contract of insurance did not discharge the contractual rights. The contract still subsisted and if its terms had been met, the parties continued to be entitled to require performance of relevant obligations under it, notwithstanding that the period of cover had come to an end.

Implications

Unlike the heart attack case reported on in our April bulletin, here AFCA has not relied upon its overarching fairness provisions, but rather has found the claim is payable based upon the terms of the policy itself and s54 of the ICA.

Seeking to narrow critical illness liability to the date of diagnosis rather than date of occurrence is of course a permissible contractual construct and the wording here did make that point, of course although not clearly enough for AFCA's liking. Where the real difficulty lies with diagnosis based triggers in the critical illness product however, is s54 and the fact that moving the date forward to when the critical illness event occurred, rather than when it is formally diagnosed, is really a classic and predictable operation of s54. In such circumstances, absent some dispute about the date of occurrence or the s54 prejudice carve out applying, it is difficult to see AFCA or indeed a court reaching a different decision to the one here in terms of the application of s54.

LIFE AND SUPERANNUATION CASES

NSWSC finds settlement not binding where no executed Deed of Release

MX v FSS Trustee Corporation (NSWSC 2020)

Key Takeaways

In this case, the NSWSC dismissed an application by an insurer to enforce a settlement agreement on the basis that the parties did not intend for the settlement to be binding until a formal deed of release had been entered into.

The decision reinforces the need for parties to be sufficiently clear with offers of settlement to ensure they will be sustainable.

Brief Facts

We previously discussed the TPD decision in *MX v FSS & MetLife* (NSWSC 2018) being a split TPD case, in which Slattery J vitiated the insurer's decision to decline the claim on a Stage 1 hearing, and the decision of *MetLife v MX* (NSWCA 2019), in which the insurer's appeal was dismissed.

In this case, Robb J considered whether a Calderbank offer served by the insurer's solicitor on MX's solicitor's (the **Offer**) and MX's solicitor's acceptance (the **Acceptance Email**) constituted a binding contract.

In the judgment, Robb J subjects the Offer, the Acceptance Email and other relevant settlement communications to an extensive textual analysis and considers the objective interpretation of the words of the relevant documents and the conduct of the parties during the negotiation process.

Judgment

Robb J ultimately concluded that the parties had not entered into a binding agreement. His Honour found that the objective circumstances were such that the parties had only entered into a provisional settlement of MX's claim, which was subject to the negotiation and execution of a formal deed of release so as to bind the parties.

Rights of Other Parties in the Litigation

The Court noted that the First Defendant trustee was not a party to the Offer and that the Offer did not deal with the rights of the trustee. His Honour stated that the absence of any resolution of MX's claims as against the trustee '*may be a practical reason for doubting that the parties had agreed to an immediately binding settlement*'.

The Deed of Release

Robb J found that on its proper construction, the Offer was subject to MX, the insurer and the trustee entering into a formal deed of release, and therefore the settlement process was only intended to be complete at that time. Whilst paragraph one of the Offer was expressly limited to bring to an end the proceedings in their entirety against the insurer, the introductory words or '*chapeau*' of the actual terms in the Offer specified that the proceedings would be resolved in their entirety on the following condition:

> '*MX, [the insurer and the trustee] will enter into a mutually agreed Deed of Release reflecting these terms of settlement and on the basis that such Deed of Release shall contain releases, confidentiality, non-disparagement provisions and such other provisions as are commonly contained in such Deeds of Release*'.

Having made that finding, his Honour found that the settlement agreement contained warranties encompassing tax advice and tax consequences of any payments to be made to MX. His Honour considered these were not obviously provisions commonly contained in such Deeds of Release.

Robb J therefore found that the objective circumstances demonstrated that the negotiation and execution of a deed of release was significant and that there was no binding contract until that stage was reached.

Costs Component of the Offer

His Honour decided that the lack of clarity as to how the Offer was intended to operate as to the costs component of the settlement sum was significant to the question of whether a binding agreement was reached. Briefly:

- The Offer was expressed to be '*inclusive of costs and interest*', objectively meaning all of MX's costs of the proceeding.
- The Acceptance Email restricted acceptance of the offer to '*stage 2*' costs.
- The insurer's solicitors clarified that the offer was inclusive of stage 2 costs and that stage 1 costs would be a matter that remained for determination.
- However, his Honour determined that the explanation of the insurer as to the intended meaning of '*inclusive of costs*' introduced material uncertainty as to '*what was meant by stage 1 and stage 2 and what costs were encompassed within each stage*'.
- This 'element of uncertainty', the Court said, '*may have been significant if MX and the insurer objectively intended to be immediately bound by…the Acceptance Email*' and could not be addressed in the process of agreeing on the final cost components of the Settlement Sum. His Honour concluded that, '*the lack of clarity is therefore consistent with the parties in reality only intending to make a partial in principle settlement of their dispute*'.

Ultimately, the Court concluded that it was objectively improbable that a plaintiff in MX's position would have intended to be immediately contractually bound given that there were issues left to be agreed between MX, the insurer and the trustee that were capable of substantially reducing the settlement money that MX received.

In Principle Settlement

The Court also considered the parties' conduct after the Acceptance Email and found that the parties, in their communications to the Court, expressed that MX and the insurer '*had reached an in principle settlement of the proceedings*' and that '*there remained issues to be agreed upon so as to finalise the question of costs and agree to the terms of the settlement*'. The Court said that the '*very use of the words [in principle settlement] is a definite indication*' that there is no binding settlement until the remaining issues are agreed upon.

The Court therefore dismissed the insurer's application to enforce the settlement.

Implications

This case is a timely reminder that settlement agreements may not be binding in the absence of an executed deed of release.

Whilst the negotiation of further, additional terms, in a more formal agreement is not necessarily inconsistent with an intention to be immediately bound[1], the objective circumstances in this case, in Robb J's view, contained elements of uncertainty as to some of the aspects of the Offer which were considered to be significant and prejudicial to the plaintiff if the parties were immediately bound.

It follows that when preparing offers of settlement, insurers need to ensure that their language in the relevant settlement communications is clear and illuminates their intention as to whether further documentation is required to finalise the dispute.

Terms suggesting that the offer is '*subject to the parties entering into a deed of release*' would generally mean that there is no binding contract before the execution of a deed in final form.

Certainly, as Robb J stated, experience suggests that the general practice and expectation of parties is that a settlement will not be binding until a Deed of Release is negotiated and entered into. A clear indication to the contrary is required where parties wish to be immediately bound.

[1] *Nurisvan Investments Ltd v Anyoption Holdings Ltd* (VSCA 2017)

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LIFE AND SUPERANNUATION CASES

Court dismisses request for discovery of comparable insurance applications in non – disclosure case

Longbottom v Nulis Nominees (Australia) Ltd (WASC 2020)

Key Takeaways

In this case, the WASC has dismissed a plaintiff's application for discovery of comparable insurance applications, which were sought by the plaintiff in order to challenge the insurer's underwriting evidence following avoidance cover pursuant to s29(3) of the ICA.

The decision serves as a useful reminder that such requests can be successfully resisted when they are not relevantly or patently onerous.

Brief Facts

The plaintiff was a former laboratory analysist and took out Life, TPD and IP cover with the insurer in September 2013 (the **Policies**).

The plaintiff ceased employment in May 2015 after suffering a major depressive disorder following which he lodged a TPD and IP claim.

The insurer and trustee avoided the Policies pursuant to s29(3) of the ICA and declined the plaintiff's claim on the grounds that he failed to comply with his duty of disclosure and alternatively, misrepresented his medical history prior to the policies being entered into.

The plaintiff issued proceedings against the insurer and trustee in December 2019, seeking payment of the TPD and IP claim, interest and costs. During the course of the proceeding, the plaintiff made an application to the Court for supplementary discovery alleging that the insurer was required to discover:

> '*applications by other persons for comparable insurance policies (and documents accepting or refusing those applications) on the basis that they are relevant to whether or not the insurer would have entered into the insurance policies with the plaintiff on any terms*'.

Specifically, the application for discovery sought insurance applications sought across a six month period in 2013/14 which:

1. disclosed the proposed life insured had used drugs or suffered depression, gambling addiction or personal, work related, emotional or financial stress; and

2. disclosed the insurer had discovered a proposed life insured applicant had made the disclosures in (1) above and all documents relating to the acceptance, or refusal thereof, avoidance, non-avoidance or variation of any resulting cover or policy.

The plaintiff argued that the documents sought were relevant to the issues in dispute as they went to what the insurer did in practice in relation to other applications similar to that of the plaintiff.

The insurer's position was that whilst they accepted the documents sought were relevant to its practice in dealing with such applications, it had already discovered underwriting manuals and a mental health guiding principle. Additionally, the further applications sought were not relevant as they were not sufficiently similar to the plaintiff's application for insurance.

Further, the issue in dispute in the main proceeding was whether the plaintiff ought to have disclosed *all* of the matters

pleaded by the insurer, not some of them, and as such, discovery of applications that only disclosed one or some of the matters were not relevant to the issues in dispute.

In addition, the relevance of the documents sought was so limited that they would be overly burdened by providing that discovery.

Judgment

The Court accepted the insurer's submissions and ordered that the plaintiff's application be dismissed with the plaintiff to pay the insurer's costs.

In doing so, the Court considered two main issues as follows:

1. whether the comparable insurance applications were relevant to the matters in issue, and if so;

2. whether the production of those documents would be oppressive.

As to the first issue, the Court agreed that applications which disclosed all alleged non-disclosed matters were relevant. However, the plaintiff's application went further than this by seeking applications which disclosed only some, but not all, of such matters (for example, only a mental health issue or only a gambling issue). As the insurer did not put in issue whether it would have been prepared to insure the plaintiff if he had disclosed one or some of the matters, those documents were deemed not relevant.

On the second issue, the Court found that even if the documents were relevant, the request for discovery was oppressive '*given the number of policies the insurer has and the nature of the documents sought*'.

The Court accepted affidavit evidence from the insurer in this regard which, amongst other matters, set out that the insurer would have received some 7,770 applications during the relevant period, which equated to one person taking between 278 and 370 days to complete the review. An equivalent amount of time would be required to consider the claims lodged during the relevant period. Time would also be incurred to redact personal information from the documentation.

The Court therefore found that discovery of the documents sought, even if they were of limited relevance, was oppressive and the utility of the documents did not justify the burden a discovery order would place on the insurer.

The Court also had regard to previous authority of *Bauer Tonkin Insurance Brokers v CIC Insurance*[1] *(Bauer)* which supports the proposition that an insurer's past underwriting practices are relevant to the underwriting issue. However, unlike in *Bauer* where the documents sought disclosed matters similar to those not disclosed by the insured, the documents sought by the plaintiff in this matter were not similar as they did not disclose all matters relevant to the application by the plaintiff. As such, *Bauer* could be distinguished.

Implications

Often retro underwriting evidence given in s29 matters is treated with suspicion by opponents who feel these suspicions can be borne out by examining past accepted applications which show an inconsistent underwriting outcome to that proffered in the retro underwriting evidence. Hence the ubiquitous discovery request for past applications.

There is of course old authority which suggests that an insured is entitled to see such past applications, however, such requests are always subject to a common sense test of practicality. Here the insurer gave evidence that it would have to employ a person working full time for a year solely on this task, to meet this request. Patently such evidence is compelling and the Court did not find such an impost reasonable. Indeed, all courts would likely take a similar view.

The key takeaway here is that when faced with such a request for past applications, the first piece of evidence the insurer needs to collate is just how big a job it is to comply with the request. Once these facts are known and if the impost is clearly unreasonable, the insurer needs to let its opponent know and quote the authority of this decision.

[1] (1996) 9 ANZ Insurance Cases 61-298

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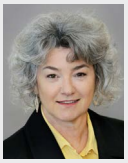

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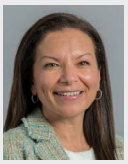

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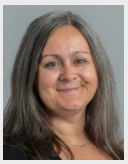

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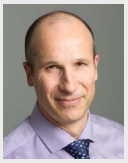

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