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Note from the Editor

Welcome to our final edition of the Life Insurance Bulletin for 2020!

Obviously it has been quite the year. I think we have all learned a bit about ourselves and our work in the process and at the risk of being branded an optimist, I think most of these learnings have been positive. For example, I think to the wonderful paper our 2020 ALUCA Turks Scholarship winner, Honor Grant-Hennessy, wrote on life insurers rising to the challenge in difficult times and note her belief that the life industry has before it tantalising opportunities through technology to both deepen trust levels with customers and also connect with them in more meaningful and immediate ways. As Honor said, '*Any device, anywhere, anytime*'. More power to her and to the power of optimism.

Turning to the Bulletin, Group Occupation Guides are very important documents that often do not get the attention that their contractual significance demands. In this edition, we look at a recent Victorian case where an Occupation Guide was front and centre of the controversy. Many takeaways from this case.

In a similar vein of courts strictly interpreting the words used in policies, we also look at the recent NSWCA decision involving a general insurance exclusion which emphasises the importance of both keeping policy wording up to date and also general enough in scope to do the job intended.

The regulators have been busy of late and we break down for you ASIC's recent survey on member engagement in insurance through super (some work to do there). We also look at ASIC's draft note on the pending legislative change to include claims handling as a financial service.

Building on from our recent webinar on Offset Clauses, we scratch a little deeper on this issue with some key points from important cases as well as analysis of an interesting SCT decision touching upon who has the right to exercise the s29 remedy between the incoming/outgoing group insurer.

I do hope you enjoy the read and as usual, reach out to your favourite Turks life expert if you have any queries (did I mention we love talking shop?).

Hope to catch up with you all soon.

AE

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PRODUCT / REGULATORY

Consumer Engagement Report – ASIC's deep dive into super fund member satisfaction

At the start of the COVID-19 lockdown, ASIC conducted a '*deep dive*' into the experience of super fund members, specifically in relation to group insurance. The recent ASIC Report 673, which is based on findings by Susan Bell Research following 50 face to face qualitative in depth interviews conducted via Zoom, sets about identifying the issues faced by every day super fund members when inquiring about their insurance.

According to the report,

> *'since default insurance is 'group' insurance, it has therefore been designed to meet the needs of large numbers of people and may not suit a particular individual. Potential barriers to a more streamlined customer experience included 'bundling of products, differences in terminology across the industry, and variations in claim processing.'* [1]

Member Inquiry Process

ASIC discovered that there are usually up to four reasons or '*triggers*' for why super fund members will inquire about their group insurance; either because of certain actions taken by the super fund (issuing quarterly statements etc), life stage changes (getting married or travelling), life events (such as illness or death) or exposure to other financial information. For many of the interviewees, their '*journey*' was a fact-finding exercise. They wanted to check what insurance cover they had. Some wanted to find out what policies they had, what they were covered for, and how much it cost. Others wanted to find out what they could change, and how much that would cost.

> *'Typically both superannuation and insurance were back of mind. In general, members were more aware of their superannuation – their balance and the fees – than they were about their insurance.'*

Though most of the interviewees found the process of inquiring about their insurance through their super fund to be easy or straightforward, the research confirms that for many members, very little is actually known about their insurance. Perhaps unsurprisingly,

> *'some members discovered that they had default insurance which did not seem to be adequate for their needs. Some discovered that their cover was much less than they thought it was. Some discovered that they were paying for insurance inside super when they already had some outside super.'*

Generally, super fund members experienced difficulty when inquiring about more complex issues which required advice of some sort. Not all information was readily accessible or easy to find. Accordingly, the research '*highlights potential improvements that could be made to the members' experiences*'. Specifically, helping members understand, among other things, the

> *'differences between the insurance products on offer, the differences between insurance inside and outside super, changes in insurance needs over the course of their lives, whether you can claim on more than one policy, and the implications of pre-existing conditions on switching.'*

> *'The challenge is for the super funds to prioritise a straightforward approach to answering the most common questions and to test the usability of their approach.'*

Practical Steps for Improvement

Some practical suggestions for super funds to improve the member's overall experience in this regard include:

- providing calculators on all super fund websites to help members '*work out how much cover they need and how much it would cost*';
- reminders to check insurance cover when starting a new fund or changing jobs;
- case studies on websites to '*demystify and clarify some often-asked questions*' such as '*what types of insurance do I have in my super?*' or '*what does each type of insurance cover?*';
- support staff to guide members on the phone through the website process; and
- more transparency in gaining access to advice (members did not seem to know what or who to ask for or what the financial or other implications might be).

The report notes that:

> *'many of the problems experienced by members would probably have been avoided if the member had known where to find the information that they needed, in particular on the website, and if it was easy to understand'. Importantly for super funds, 'there is now a fairly general expectation that the super website will contain much information, but the level of accessibility varies with fund.'*

Implications

ASIC Report 673 clearly identifies the need for super funds to increase their engagement with fund members and streamline the information process. As with all things, product offerings and the environment in which they are offered can change rapidly, leaving the onus on fund members to do their own research to better understand their insurance needs over the course of their lives.

This report highlights the extent to which super funds can take additional steps to improve the process and assist their members in this regard, thereby '*reducing the necessity for double contacts and to make members more confident*'. Ideally, super fund members can determine whether they are adequately insured and if not, take the appropriate action to increase their cover inside super or seek cover elsewhere.

Ultimately ASIC Report 673 confirms that which we already knew; that some fund members have little understanding or insight into their insurance (provided through super). Nevertheless, the report provides some specifics around this and identifies those areas in which super funds can meet the expectations of fund members going forward which more often than not, can be remedied through rather inexpensive and simple practical solutions. Again, '*engagement*' with members is the key and as highlighted above, the challenge has been laid down for super funds to '*prioritise a straightforward approach to answering the most common questions and to test the usability of their approach*'.

[1] ASIC Report 673

PRODUCT / REGULATORY

Offset clauses – The essential elements

Offsets clauses are one of the most disputed elements of income protection insurance (**IP**). In a nutshell, these clauses enable the life insurer to reduce the benefits otherwise payable to a claimant under the policy on account of '*other*' concurrent income replacement style benefits received from statutory lines of cover or other life policies and the like. The overarching aim of such clauses is undoubtedly to ensure the totality of money received by a sick or injured claimant during a claim, from all sources (excluding investment income), does not exceed pre-disability income.

The success of offset clauses is wholly dependent on the wording used. Whilst common in IP policies, the wording used in such clauses can vary significantly. There is not one correct way to write an offset clause of course but too often, life insurers can find their offset clauses do not do what they intended them to do. Below, we explore some of the frequent issues that arise from the wording of offset clauses.

The Words are Everything

The words of an offset clause will be treated like the rest of the policy, that is, they will be given a businesslike interpretation with attention to the language used by the parties and the commercial circumstances the policy is intended to secure.

There have been some cases that demonstrate the approach taken by the courts in interpreting offset clauses.

In *Carolyn Philips (nee Durrand) v Tower Australia Ltd* (NSWSC 2008), the insurer sought to offset social security payments received on the basis that they were captured by the offset clause with respect to benefits under '*Workers Compensation, Workcare, Accident Compensation or any other similar State or Federal Legislation*…'. The question was whether the social security payments fell within '*other similar … Federal Legislation*'. Justice Einstein found:

> *'To my mind in the instant context the social security payments do not qualify as relevantly 'similar' within the subject definition. In order to so qualify any relevant benefits would have to arise by reason of accident compensation schemes or statutory accident compensation schemes or the like.'*

In considering a Personal Accident Policy, the NSWCA[1] considered a general insurer's offset clause that specified that benefits were payable pursuant to a compensation table and '…*will be reduced by weekly benefits paid or payable from any... statutory workers compensation scheme.*'

At trial, the judge found an amount of $26,000 could be offset representing an estimate of the proportion of the lump sum settlement that related to weekly compensation benefits. On appeal, the claimant argued the trial judge's approach was wrong as the policy did not operate to allow the apportionment of a lump sum payment. The NSWCA agreed with the claimant's argument and found the policy permitted the offset of weekly benefits, not a lump sum damages payment.

In *Buswell v TAL Life Limited* (NSWSC 2018), the insurer sought to offset '*income*' received by the claimant under a damages claim settled against her employer. Relevantly, 'Other Disability Income' meant '*income*' a person may derive during a month for which a benefit is payable and included '*any benefit under workers compensation, statutory compensation… or other similar State, Federal or Territory Legislation*…'. The applicable offset clause also permitted a lump sum payment to be apportioned over a 60 month period.

Justice White found the meaning of *'income'* was to be given its ordinary meaning and the receipt of damages for personal injury or a settlement sum as a compromise was capital, not income. While the Court accepted that a damages payment could be 'Other Disability Income' if it fell within one of the specified circumstances set out in the offset clause, it was found the entitlement to damages was modified by NSW workers compensation legislation but ultimately arose under common law, not legislation.

In each of these cases, the working approach to the offset clauses adopted by the insurer was found to be unsupported by the words used in their clause. Obviously, the words used are important in any contract but given the crucial work offset clauses are expected to perform and given the intersecting areas of law, statutory schemes and compensation models

which such clauses traverse, it is even more so the case with offset clauses that precision is used in the wording and careful thought is given to the types of payments (and how they are paid) that the clause wishes to capture.

Workers Compensation/Motor Vehicle weekly payments received as Lump Sums

Often times, weekly payments of workers compensation (which would be offsetable under most IP policies when received) are initially disputed and then paid later as a lump sum. Additionally, they may be paid within a bundle of workers compensation rights which are settled for a lump sum pursuant to a settlement agreement which does not break down how the lump sum is apportioned between potentially offsetable amounts and other benefits.

It is crucially important in such circumstances for the offset clause to work as intended, that the clause:

- permits the insurer to deem which part of an undifferentiated combined lump sum is to be considered weekly payments and hence offsetable (noting settlement agreements will never do this);
- allows the breakup of the lump sum to monthly apportionments which can also be attributed to the relevant months in which payments are due under the policy; and
- adopts general language which captures a benefit and does not subsequently lose it because, for example, the mode of the underlying settlement changes the fundamental nature of the payment from income to capital.

A well drafted offset clause should do all these things but many particularly older style clauses, will not always be that robust.

Competing Offsets – Centrelink

In some instances, both Centrelink and an insurer may seek to offset benefits an insured receives from the other (where the IP offset clause does not specifically exclude Centrelink or social security payments).

In these circumstances, insurers should be aware that it is widely considered that Centrelink's right to offset takes precedence over that of the insurer by virtue of Part 3.14 of the *Social Security Act* 1991 (Cth) which allows Centrelink to recover certain benefits where a person receives '*compensation*' from another source for the same period. The AAT has held that payments under a group IP policy are '*compensation*' under the Social Security Act[2].

Offsetting JobKeeper Payments

In the context of the COVID pandemic, life insurers have found themselves grappling with the issue of whether JobKeeper (**JK**) payments fall within the ambit of offset clauses which were not drafted with such unique payments in mind.

Assuming an insured otherwise qualifies for receipt of IP benefits, given that JK payments are essentially a government funded wage subsidy and do not compensate for a work incapacity due to illness or injury, they will generally not be captured by clauses which restrict offsets to payments of the latter nature. Similarly, they will generally not be captured by clauses requiring income to be derived from personal exertion as JK payments are received by persons who are not working.

However, some clauses may potentially allow for the offset of JK payments, if for example, they do not require that the other income be received on account of illness or injury and are broad enough to capture payments received under such a statutory scheme. Again, it will all depend on the wording.

Implications

The non–indemnity nature of life insurance is such that a life insurer's right to offset other income received by an insured as a result of the illness or injury also giving rise to the claim, will arise solely from the wording it chooses to insert in its policy wording.

Offset clauses therefore need to be well thought out and sufficiently broad enough to capture all payments which are intended to be offset. Consistent with recent NSWCA authority on the construction of exclusion clauses[3], there is no room for error here and the words will be construed in their narrowest possible sense without an expansive lens.

[1] *Berzins v QBE Insurance (Australia) Ltd* (NSWCA 2014)
[2] *Macri and Secretary, Department of Family and Community Services* (AATA 2005)
[3] *HDI Global Specialty SE v Wonkana No. 3 Pty Ltd* (NSWCA 2020)

LIFE AND SUPERANNUATION CASES

S29 ICA: SCT finds new insurer becomes 'the insurer' when there is a Part 9 transfer

D20-21\016 (SCTA 2020)

Key Takeaways

A later in time insurer which assumes risk under a group policy pursuant to a *Life Insurance Act* Part 9 transfer, becomes '*the insurer*' of the policy for s29 ICA purposes. This contrasts with the situation where the later in time insurer assumes the earlier in time insurer's risk pursuant to usual group takeover terms. In these cases, there is AFCA authority which suggests that only the earlier in time insurer is '*the insurer*' for s29 purposes and only it can exercise the remedies that flow from that.

Brief Facts

The life insured completed an application for insurance cover in superannuation in July 2014 and was issued life and IP cover via policies owned by the trustee of the superannuation fund.

The insurer that provided this cover subsequently transferred its liabilities and assets (including the policies) to another insurer (**the New Insurer**) on 1 October 2016 pursuant to Part 9 of the *Life Insurance Act*.

In May 2017, the life insured lodged an IP claim in respect of his torn Achilles tendon.

The New Insurer shortly thereafter avoided the insurance cover pursuant to s29(3) of the ICA.

The life insured complained to the SCT.

Determination

The New Insurer primarily relied on misrepresentations instead of non-disclosures as the source of the entitlement to exercise s29 remedies, in light of *Sharma v LGSS Pty Ltd* (FCA 2018) and the SCT agreed with the New Insurer's approach.

Critically, the SCT found that because of the Part 9 transfer of the policies from the earlier insurer to the New Insurer, any misrepresentation that the life insured made to the earlier insurer was made to the New Insurer for the purpose of s25 and s29 of the ICA.

The SCT acknowledged that the financial advisory firm that submitted the insurance application on the life insured's behalf was previously found to have breached their best interests obligations under the *Corporations Act*, and that a FCA judgment describes, among other things, complaints that the firm failed to disclose medical conditions of its clients in insurance applications. As a result of that judgment, the financial advisory firm who submitted the application on behalf of the life insured had been banned from providing financial advice for five years. However, the SCT held that the FCA judgment regarding the financial advisory firm did not negate the New Insurer's and the trustee's entitlements to rely on the life insured's application as submitted to them.

The SCT assessed the insurer's retrospective underwriting evidence based on the underwriting guidelines in force at the time of the application. Ultimately, the SCT found that the life insured made several misrepresentations, and that if they were not made, relevant cover would not have been entered into. The avoidance was upheld.

Implications

The ability of a later in time group insurer which acquires a risk by way of standard takeover terms to exercise the outgoing insurer's s29 remedies, remains highly questionable given AFCA decisions 613562 and 619820.

These issues remain to be dealt with another day, however, this

decision does confirm one aspect which was left unclear by these AFCA decisions, namely, what happens when the transfer of risk from one insurer to another is by way of a Part 9 transfer rather than standard takeover terms.

Thankfully, this SCT decision confirms what most observers assumed would be the case, that is, given standard transfer of title principles, under a Part 9 transfer, the new insurer becomes '*the insurer*' for all purposes under s29. It should be noted that whilst this interpretation seems a given, there is/was a counter view that '*the insurer*' under s29 could only ever be '*the insurer*' which initially wrote the risk.

Additionally, the determination indicates that for insurers looking to exercise s29 remedies in relation to group life cover entered into or varied prior to 28 December 2015, it is best practice to emphasise misrepresentations to EDR decision makers, rather than relying on non-disclosures. The SCT is evidently willing to uphold an avoidance based on a misrepresentation where there was no duty of disclosure owed, so emphasising misrepresentations will enhance the prospects of success before the SCT (and should also do so at AFCA).

LIFE AND SUPERANNUATION CASES

Precision required in TPD Occupational Rating Guides

Abdolhosini v Equity Trustees Superannuation Limited & Anor (VCC 2020)

Key Takeaways

An insured's occupation for the purposes of determining whether they obtain standard or ADL TPD cover in relevant policies will be determined by the factual reality of their occupation not their job title. Occupational Rating Guides which by reference can form part of a relevant policy in this regard can obviously be highly determinative of what type of TPD cover an insured receives, however, they need to be accurately identified by the policy and provide a complete set of consistent rules for dealing with jobs which do not lend themselves to a straightforward rating classification in order to do their intended job.

Brief Facts

The issue in this case was whether the plaintiff's TPD claim fell to be assessed under a standard '*any occupation*' definition or a more onerous ADL definition. In turn, this issue came to be determined by the interpretation of the insurer's group life policies and the plaintiff's occupational classification.

The plaintiff held the position of 'Client Services Officer' at an Immigration Detention Centre. In nominating the plaintiff for cover, his employer classified his occupation category as '***white collar***', which would attract standard cover. At trial, the insurer argued that the plaintiff's occupation, in substance, was either that of a '*security guard*' or a '*prison officer/warden*' which were both '*heavy blue collar*' and attracted ADL cover.

There was also disagreement between the parties as to the version of the policy that should apply to the plaintiff's claim:

- Under the earlier policy, ADL cover was triggered if the plaintiff's occupation was listed in the '*ADL definition list*' (**the ADL List**) which placed jobs into '*occupational categories*' (white collar, blue collar, heavy blue collar).
- Under the subsequent policy, the trigger for less expansive cover was whether the plaintiff's '*primary duties relate to an occupation*', classified as ADL in the Fund's 'Occupations Rating Guide' (**the Rating Guide**). Plaintiff's counsel contended that changes in the subsequent policy '*represent a retrospective re-assessment of eligibility by employment category, and are void and of no effect*'.

Judgment

At the outset, the Court had reservations about whether the subsequent policy amendments applied to this case. Ultimately, however because the Court found that the plaintiff was entitled to standard cover under either policy it did not need to consider the issue in detail nor to determine it.

However, the Court made the obiter comments that:

> *'the retrospective alteration of employment classifications, without notice, which results in the avoidance of claims which would otherwise be honoured, may well breach the insured's duty of utmost good faith.'*

Ultimately the Court made a call on the fact that the plaintiff's occupation was in reality not such to place him in ADL territory under either version of the policy noting that common sense dictates that '*relevant occupation*' should be determined by what the duties were and not the person's job title. In coming to this factual finding the Court noted that the lack of precision in the documents asserted by the insurer as being the relevant occupational list made it difficult to support its contentions on how the plaintiff's actual occupation should be classified.

Implications

This case illustrates two very real legacy issues confronting group life insurers who largely, to keep premium rises sustainable over time, moved from wider TPD cover to narrow the availability of standard TPD cover to those it classified as being in high-risk occupations.

The first issue is determining from when the new restricted cover applied and the second is giving contractual effect and precision to the ubiquitous Occupational Rating Guides, being the documents referred to in the relevant policy and which *inter alia* identified the excluded high-risk occupations.

In terms of the amended cover start date, regardless of policy terms and absent special circumstances, a court will generally not allow an accrued right to a benefit to be expunged by a retrospective contractual amendment. If the right has accrued after the agreed start date of the amended cover between insurer and trustee but before formal documentation has been executed, the insurer can still assert the earlier start date but it will need to produce strong documentary evidence supporting the pre-formal documentation start date. The difficulties in obtaining such evidence (which can often be buried within standard business emails and the like) long after the relevant date, should not be underestimated.

In terms of the Occupational Rating Guides, they must both be precisely identified by the relevant policy and have detailed provisions and guidance notes within them which allow conflicts over which job falls under which rating (such as occurred in this matter) to be resolved one way or another. In short these documents need to cover the field and allow the reader to classify every conceivable job in a consistent way. Ambiguity and imprecision should be avoided. For example there must be a way of categorising a job which either is not identified at all, or neatly fits under multiple definitions.

PRODUCT / REGULATORY

Claims handling and settling as a financial service – A step closer…

Since the Hayne Royal Commission, the insurance industry has waited with baited breath to see what the proposed changes to claims handling might look like. Only last week, the industry moved a step closer to understanding the impact of these changes and preparing accordingly, with ASIC releasing a draft Information Sheet on insurance claims handling and settling, '[How to comply with your AFS licence obligations](#)'; the aim being to provide industry participants as much time as possible to consider whether they need to obtain (or vary) an Australian Financial Services Licence (**AFSL**), and if so, what they will need to do.

A Brief Re-Cap

Currently, insurance claims handling is not included as a '*financial service*' under the *Corporations Act* 2001 (**the Act**) and as such, insurance claims handlers have not before been subject to the obligations of AFSL holders under the Act. Such obligations include '*acting efficiently, honestly and fairly, complying with license conditions and financial services law, ensuring adequate training of staff and complying with IDR and EDR requirements.*'

However, since the Royal Commission, changes have been afoot and the long awaited passing of the *Financial Sector Reform (Hayne Royal Commission Response) Bill* 2020 (**the Bill**) from 1 January 2021 will give effect to Hayne Recommendation 4.8 and ensure that those who provide claims handling and settling services must hold an AFSL and that the claims handling carve out under the Act is removed. Also, a broad definition of claims handling will include '*assessing, settling and assisting in claims*' thereby extending to a great number of industry participants including insurance claims managers, insurance brokers, financial advisors and claimant intermediaries, some of whom may already hold an AFSL but whom may now have to apply for variation.

Claims Handling and Settling Services

The draft Information Sheet, to be issued in final form on the ASIC website once the Bill has passed before the end of the year, provides further clarity around '*claims handling and settling*' services, being an activity that includes, among other things,

> '*making a recommendation or stating an opinion in response to an inquiry about a claim or potential claim, making a recommendation or stating an opinion that could influence a decision about making or continuing with a claim, representing someone in pursuing a claim, assisting another person to make a claim or making a decision to accept or reject all or part of a claim*'.[1]

Applying for AFSL or Variation

Any person performing these functions will be required to have an AFSL authorising the provision of these services or be authorised by a person who holds a claims handling authorisation. This will apply to all persons providing claims handling and settling services in relation to any insurance claim made on or after 1 January 2021, regardless of when the policy of insurance commenced. Table 1 on page 3 of the Information Sheet provides a useful guide.

Those seeking to apply for an AFSL or a variation to their existing AFSL need only select those elements of a claims handling and settling service that apply to them. That is, not every entity will require authorisation for all the elements of a claims handling and settling service under s766G. ASIC will assess each application based on the particular claims handling activities specified by the applicant.

Those persons exempt from requiring an AFSL include loss assessors or loss adjusters, experts providing an opinion to inform the claims assessment, investigators and independent medical examiners. Lawyers providing professional legal services in relation to insurance claims handling and settling are specifically exempt and while registrable superannuation entity

(RSE) licensees (i.e. a superannuation trustee regulated by APRA) fall under the general exemption, their AFSL must provide for a '*superannuation trustee service*' as a '*new financial service*' in accordance with the *Financial Sector Reform Act*. ASIC has provided clear examples within the draft Information Sheet as to what type of entity may require an AFSL with claims handling and settling authorisation.

AFSL Obligations

As an AFSL holder and for those persons performing claims handling and settling services, there are certain obligations with which they must comply under the Act. One of the principal obligations in this regard is to '*do all things necessary to ensure that the financial services covered by the AFSL are provided **efficiently, honestly and fairly***'. This means that claims handling and settling services will need to be provided in a timely way; in the least onerous and intrusive way possible, fairly and transparently and in a way that supports consumers, particularly ones who are experiencing vulnerability and hardship. Importantly, the obligation to provide '*transparency and fairness*' requires that:

- claimants know what to expect from you in the claim process; they know what you will expect of them; they know how long it generally takes for a decision; they know why you need certain information from them and they are regularly told about the progress of their claim;
- you provide the claimant procedural fairness (i.e. you explain any adverse findings to the claimant and give them an opportunity to respond and provide additional information);
- you explain to the claimant why you rejected their claim or part of their claim; and
- you inform the claimant of their right to make a complaint and how to access internal and external dispute resolution.

Both the draft Information Sheet and the Explanatory Memorandum to the Bill give examples of conduct which meets or fails to meet the requirement to handle and settle claims efficiently, honestly and fairly. (See pages 28-29 of the draft Information Sheet). Otherwise, ASIC Commissioner Sean Hughes said in relation to a recent FCA decision that '*ASIC expects those involved in handling insurance claims to act consistently with the commercial standards of decency and fairness, ensuring claims are handled in a fair, transparent and timely manner.*'[2]

Significantly though, the obligations under s912 of the Act extend to notifying AISC of any breach or likely breaches. ASIC can also take enforcement action if there has been a breach and that may include cancelling or suspending your AFSL or imposing conditions, as well as seeking civil penalties.

Transitional Timeframes

1 January 2021	30 June 2021	31 December 2021

• From 1 January 2021, you can apply for a new AFSL with claims handling authorisation or vary your existing AFSL to include claims handling authorisation.
• You can continue to provide claims handling and settling services up to 30 June 2021 without having lodged an application.
• You can continue to provide claims handling and settling services from 1 July 2021, if you have lodged your application before 30 June 2021.
	• Even if you have submitted an application before 30 June 2021, from 1 July 2021, you must stop providing claims handling and settling services if, *inter alia*:
	  • your application is rejected; or
	  • you are not granted an AFSL or variation with a claims handling authorisation by 31 December 2021.
		• The transitional arrangements end on 31 December 2021 unless the Minister extends the end date.
		• From 1 January 2022, you must hold an AFSL with a claims handling authorisation to continue to provide these services.
		• If you only intend to provide claims handling and settling services from 1 January 2022 you can apply for an AFSL or variation at any time before you provide these services.

Implications

ASIC's draft Information Sheet, though not intending to cover the whole of the relevant law, makes it abundantly clear that time is of the essence. For those entities providing claims handling and settling services or intending to do so after 1 January 2021, applications for an AFSL or a variation to their existing AFSL must be lodged as soon as possible.

'*Preparedness*' is the objective here so as to ensure that all industry participants are fully compliant and have their house in order by the time these transitional arrangements expire on 31 December 2021. Therefore, if industry participants have not done so already, now is the time to assess whether you will

require an AFSL or a variation to your existing AFSL providing authorisation for claims handling and settling services. However it doesn't stop there. Industry participants will need to be aware of those entities performing claims handling and settling services on their behalf, e.g. authorised representatives or claims intermediaries, and what, if any, AFSL authorisations they will have in place, thereby guarding against any inadvertent provision of a '*claims handling and settling service*' constituting a '*financial service*' under the Act.

Furthermore, though industry participants will have taken giant leaps in recent years to improve claims handling and settling services, having adapted to the introduction of AFCA and a new regulatory regime focused on '*fairness*' for the consumer; and in particular for life insurers and the need to comply with the Life Insurance Code of Conduct, the inclusion of claims handling and settling as a financial service, though carrying with it increased administrative costs and burdens, makes it all the more important for industry participants to have robust claims handling systems in place to ensure compliance with the Act and the specified obligations.

As foreshadowed by the Hayne Royal Commission, ASIC will have the power to penalise industry participants for any breach (whether self-reported or otherwise) of the obligations and whilst the exact circumstances in which ASIC may take action in this regard remains unclear, these impending changes makes compliance an ever present focus in the post Hayne Royal Commission environment.

[1] Attachment 1 to Media Release (20-300MR): Draft Information Sheet

[2] https://asic.gov.au/about-asic/news-centre/find-a-media-release/2020-releases/20-302mr-youi-breached-duty-of-utmost-good-faith-royal-commission-case-study/

NSWCA confirms scrupulous and inflexible approach to policy interpretation where clear words used

HDI Global Specialty SE v Wonkana No. 3 Pty Ltd (NSWCA 2020)

Key Takeaways

Life insurers must take extreme caution when drafting policies. This NSWCA decision shows that courts will not depart from the clear wording of a policy despite an apparent oversight or error by the insurer in its choice of policy terms. In this case, the Court held the insurer's references in their policies to defunct legislation (which had been repealed and replaced with essentially identical legislation) meant that the exclusion clauses, which should have referred to the new legislation, were ineffective.

In particular, when so much contractual significance turns on a finding or outcome under a specific piece of legislation, policy wording must anticipate and deal with the possibility that such legislation could be repealed and replaced over time and a more generalised wording is probably appropriate here.

Brief Facts

In this general insurance case, the multiple insureds were tourism and hospitality businesses, who held policies of business interruption with two insurers. The two policies issued to the insureds contained cover for disease outbreaks but also contained an exclusion in the following (effectively identical) terms:

> *The cover … does not apply to any circumstances involving 'Highly Pathogenic Avian Influenza in Humans' or other diseases declared to be quarantinable diseases under the Australian Quarantine Act 1908 and subsequent amendments.*

The insureds made COVID-19-related business interruption claims under their policies of insurance, but the claims were declined by both insurers.

The disputed claims were initially lodged at AFCA however, given that the subject controversy affected many other insurers and insureds, it was agreed between the parties (and AFCA) that the controversy should be determined by a superior court.

In this regard, the two insurers commenced proceedings against the insureds, seeking declaratory relief that COVID-19 fell within the above exclusion clause despite the *Quarantine Act* 1908 (Cth) (**the Quarantine Act**) having been repealed on 16 June 2016 – well before cover commenced, and well before the existence of COVID-19. Again, given the significance of the matter, the proceedings were subsequently removed into the NSWCA without having been determined by a lower court, pursuant to r 1.21(1)(b) of the NSW UCPR 2005.

The *Biosecurity Act* 2015 (Cth) (**the Biosecurity Act**) replaced the Quarantine Act on 16 June 2016, and whilst the Quarantine Act provided for '*declarations of quarantinable diseases*', the Biosecurity Act also allowed for the Director of Human Biosecurity to determine a disease to be a '*listed human disease*'.

On 21 January 2020, COVID-19 was in fact determined to be a listed human disease under the Biosecurity Act. It was not declared to be a '*quarantinable disease*' under the Quarantine Act.

The insurers argued that the Biosecurity Act amounted to a '*subsequent amendment*' of the Quarantine Act, as contemplated by the exclusion clause (**the First Argument**). They argued in the alternative that the references to the Quarantine Act in the exclusion clauses were obvious mistakes, and such references should be interpreted to include the Biosecurity Act, as well as any '*listed human diseases*' under that act (**the Second Argument**).

Judgment

The NSWCA held unanimously that the words of the exclusion clause should not be read to include '*listed human diseases under the Biosecurity Act*', and therefore COVID-19.

After a helpful discussion of the principles of construction that apply to contracts of insurance, the NSWCA held in relation to the First Argument, that:

- the phrase '*and subsequent amendments'* is not ambiguous and only describes amendments to the Quarantine Act – *'the repeal and replacements of that legislation with other legislation is not within the ordinary meaning of those words*';
- the word '*subsequent'* in the phrase '*subsequent amendments*' is not redundant (as contested by the insurers, in arguing that the phrase means something more than, for example, '*as amended*', and specifically is intended to capture a '*repeal and replacement*'). Rather, the word '*makes clear that there may be amendments to the Quarantine Act within the policy period*.' In other words, the Court held that '*and subsequent amendments'* has the same meaning as *'as amended*';
- even if the word '*subsequent*' in the phrase '*subsequent amendments*' is redundant, that is not sufficient to give it the expansive meaning of '*encompassing changes that amount to a repeal and replacement of the Quarantine Act with legislation that has the same substantive purpose and function*'; and
- the insurers did not choose to use language which reflected that '*the purpose of the provision in question may be to exclude diseases which are sufficiently serious to attract a public health response*'. Rather, the insurers chose a '*specific mechanism*' under the Quarantine Act and '*to suggest that the words 'and subsequent amendments' include the enactment of the Biosecurity Act is many steps too far'*.

In respect of the Second Argument, the Court reiterated that in cases of contractual '*mistake*', the '*intention against which the literal meaning of contractual language is to be measured must be capable of being discerned objectively from the language itself*'. In other words, it is only '*errors of expressio*n' that can be corrected by construction. Additionally, whereas for cases of contractual mistake there must be absurdity, there was no absurdity in the literal meaning of the exclusion clauses in this case.

The Court held:

> *The difficulty in this case is that nothing has gone wrong in the relevant sense with the provisions of the policies in question: they correctly express the intention they objectively disclose. The mistake was at an anterior stage. It would have been logical, had the insurers realised that the Quarantine Act had been repealed, for the policy wording to have referred instead to 'diseases determined to be listed human diseases under the Biosecurity Act 2015'. But to conclude as much is not to hold that by their language they are to be taken to have conveyed an intention to refer to listed human diseases under the Biosecurity Act. That they did not* ***was not a problem with the language they chose, or a misdescription of the legislation to which they objectively intended to refer****, any more than it would have been had the Quarantine Act been repealed and replaced early in the policy period rather than in 2016. The Court has no power to correct an agreement to reflect what might have been agreed, or even what would have been agreed, had the parties, or the relevant party not assumed the Quarantine Act remained in force.* (Our emphasis added).

Implications

While this is a general insurance case, it clearly has ramifications for life contracts in that it confirms that words will be given their ordinary meaning and effect and when such meaning is clear, there is no need to move to the more nuanced remedial principles of contractual construction.

In other words, courts will not rewrite the clear words of a contract to retrofit it to what one party says was the clear contractual intention of the words in question. If an insurer intends a certain thing to happen in certain circumstances, it needs to say it clearly and unambiguously.

This decision serves as a reminder to life insurers to ensure that critical policy wording is:

- robust enough to achieve its desired purpose regardless of change to legislation and other linked external circumstances; and
- frequently reviewed to ensure it remains fit for its purpose.

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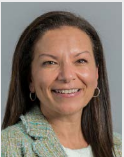

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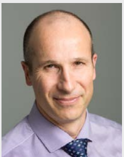

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