INSURANCE ▪ COMMERCIAL ▪ BANKING

# LIFE INSURANCE BULLETIN

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## Note from the Editor

**The avoidance of** life cover (or the refusal of a claim for that matter) will never be welcome news. Life insurance cover is obviously there for a crisis and when it doesn't respond in such times, this will undoubtedly cause distress. As ASIC acknowledged in its wide ranging 498 report however, there will be some circumstances where despite being a difficult choice to make, avoidance is the only appropriate option for an insurer to take. In this regard, we saw late last year the NSWSC uphold the insurer's decision to avoid, in the case of ***Smith***.

Taking this drastic step is not something life insurers do lightly and that is why the recent decision of the FCA in *ASIC v TAL* will be welcomed by the life industry as providing guidance on how to ensure the process of arriving at an avoidance or variation decision is impeccably fair and humane. Make no mistake, insurers wish to see this as much as anyone else. Additionally it seems that life insurers will also take comfort from the fact that many of the safeguards to ensure fairness in the process are indeed already in place through LICOP. Against this background, we examine the all important implications of this case in our lead story of this quarter's bulletin.

Elsewhere there is plenty of regulatory news around, particularly DI cover in group, and Peter Murray covers this off in his excellent article. We also cover the HCA's call on what is Personal Advice and deal with some interesting court/AFCA decisions on disability issues.

A big thank you to the all those who joined us for our Life Matters webinar last month on the switch to the Duty not to Misrepresent and the flip back to the old s29(3). I know Lisa Norris and Peter Riddell absolutely loved presenting this session for you (in fact we are having trouble dragging Peter away from the camera at the moment just quietly) and they both asked me to thank you all for the lovely feedback they received. Don't hesitate to reach out if you would like a copy of the slides or recording.

Life Matters will return for the Winter session in June where we will examine the role of s54 of the ICA in life claims.

In the meantime enjoy this edition and as always, reach out to your favourite Turks life expert if you have any questions.

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**LIFE AND SUPERANNUATION CASES**

# FCA sets out road map for utmost good faith compliance in non-disclosure/misrepresentation investigations

## *Australian Securities and Investments Commission v TAL Life Limited (No 2)* (FCA 2021)

### Key Takeaways

In what appears to be a first for an Australian court, the FCA has focused on the life insurer's procedure surrounding an avoidance of a life policy under Part IV, Division 3 of the *Insurance Contracts Act* 1984 (**the ICA**).

Whilst life insurer avoidance practices have evolved significantly since the 2014 factual matrix considered in this matter, the judgment provides critical guidance for life insurers contemplating avoidance or variation remedies. Specifically, the judgment makes clear that as well as the substantive elements of an avoidance, there is an additional procedural fairness layer that an insurer must get right in order to comply with its duty of utmost good faith obligations.

### Brief Facts

ASIC brought proceedings against the life insurer in relation to a case study examined in the Financial Services Royal Commission. ASIC alleged that the life insurer had breached the ICA by failing to act towards the insured under an IP policy with the utmost good faith in accordance with the implied duty arising from s13(1) of the ICA. The allegations arose from the way in which the insurer avoided the relevant policy for non-disclosure.

ASIC also alleged that the life insurer had made false and misleading representations in its dealings with the insured.

The life insurer had entered into an IP policy with the insured in October 2013 after the insured had applied for cover through an intermediary in September 2013. In the telephone application, the insured was asked:

> *'Have you ever had or received medical advice or treatment for… Depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, attempted suicide, chronic fatigue, post-natal depression or any other mental or nervous condition?'*

The insured answered '*No*' to this question and the policy commenced shortly thereafter.

In December 2013, the insured lodged an IP claim for cervical cancer. In response to the claim, the life insurer sent the insured a '*claims pack*' containing an Initial Disability Claim Form (containing an authority to obtain medical records), a Medicare and Pharmaceutical Benefits Scheme Authority, a claim payment form and an Attending Doctor's Statement. All of these documents were signed and returned by the insured. The claim form contained the following relevant statement:

> *'Please answer all questions fully to ensure that your claim is assessed as quickly as possible. Answers left blank or not fully completed may delay the assessment of your entitlements to benefits.'*

The medical authority (in the Initial Disability Claim Form) also contained the following relevant statement:

> *'If you do not supply the required information, we may not be able to provide the product or services requested or pay the claim.'*

Shortly after receipt of these claim documents from the insured, the life insurer accepted the claim.

Whilst the claim was initially accepted by the life insurer and payments were made to the insured, material received by it during its assessment of the claim (and during its separate investigation into non-disclosure) alerted it to the possibility that the insured had failed to disclose pertinent matters in relation to her mental health which in turn brought into play a possible avoidance remedy under s29 of the ICA.

Despite these concerns, there was no reference to the insurer investigating non-disclosure/misrepresentation issues in its claims acceptance letter.

The life insurer did eventually determine that the insured had made a material non-disclosure with respect to depression and determined to avoid the policy under s29(3) of the ICA. It informed the insured of this decision via telephone on 30 June 2014, as well as advising her that it may seek to recover the claim amounts it had already paid to her under the policy.

Formal correspondence was sent to the insured by the life insurer on 3 July 2014 advising her of the avoidance and the potential recovery of the amounts it had already paid to her under the policy (it is not clear from the judgment whether the policy was avoided in the initial phone call or in this correspondence). The correspondence stated, amongst other things, that the life insurer considered the insured to have breached her duty of good faith, and that:

> *'At this stage, we won't be requesting the payment of this amount; however we reserve any right to request recovery in the future.'*

This reservation of rights was again expressed by the life insurer to the insured on subsequent occasions.

The insured disputed the avoidance and the potential recovery by the life insurer and brought a complaint to FOS where the matter eventually settled via a deed of release in which the life insurer agreed to pay the insured $25,000 on top of the benefits it had already paid to her. The parties agreed that the policy remained void from inception.

The matter was subsequently included as a case study in the Royal Commission and, as mentioned above, ASIC took proceedings against the life insurer seeking remedies in relation to the life insurer's alleged false and misleading representations and alleged breaches of its duty of utmost good faith and the ICA.

## The Case Against the Life Insurer

### *False and Misleading Representations*

ASIC initially alleged that the life insurer made the following false and misleading representations, pursuant to provisions of the *Australian Securities and Investments Commission Act 2001* (**the ASIC Act**) and the *Corporations Act 2001* (**the Corporations Act**), in the claims pack:

- The life insurer had a right to require the insured to provide authorities enabling it to obtain and access all of her medical records (**the First Representation**); and
- The life insurer had a right to require the insured to provide authorities enabling it to obtain and access all of her other records (e.g. employer records) (**the Second Representation**).

ASIC subsequently amended its case to delete these allegations and in their place, alleged that the claims pack contained the false and misleading representation(s) that the life insurer had a right to delay processing of the insured's claim and to withhold payment of benefits to her until she provided a signed authority for medical records and a signed authority for release of Medicare & PBS records (**the Third Representation**).

### *Breach of the Duty of Utmost Good Faith*

The second part of ASIC's case was that the life insurer breached the ICA (s13(2)) by failing to act towards the insured with the utmost good faith, by:

- making the Third Representation to the insured which was false and misleading; and
- avoiding the policy in circumstances where:
  - the life insurer requested medical records for the purposes of its non-disclosure investigations, as opposed to assessing the claim, without advising the insured of this use;
  - the avoidance of the policy was not '*soundly based in medical opinion*' (because of medical opinion which suggested that the life insurer's underwriter's view about the extent of the insured's pre-policy mental health history was incorrect);

- no notice was given to the insured about the non-disclosure investigation;
- the life insurer alleged in the avoidance letter that the insured had breached her duty of good faith; and
- the life insurer indicated in the avoidance letter that it reserved its rights to recover benefits paid under the policy from the insured.

## Judgment

Judgment was delivered on 9 March 2021 by Allsop CJ, and his Honour relevantly found:

### *False and Misleading Representations*

- The life insurer made the First Representation, but not the Second Representation. His Honour noted that '*It is incumbent upon insurers to ensure that if they wish to be able to require such information, they must found their right to do so with clarity*'. Ultimately however, given ASIC did not press either representation, these findings would appear to be obiter.
- The life insurer did not make the Third Representation in the claims pack, essentially due to the fact that no right was expressed to delay the claim, but rather the life insurer simply stated that the claim '*may*' be delayed as a result of the relevant authorities not being completed. His Honour did note however that if the Third Representation had been made, then the representation about the Medicare and PBS records would have been false and misleading on the basis that no such right to delay payment of the claim existed in the terms of the policy.

### *Breach of the Duty of Utmost Good Faith*

Making the Third Representation to the insured which was false and misleading

- The life insurer did not breach its duty of utmost good faith and consequently the ICA in relation to the Third Representation. His Honour stated:

> *'For the reasons earlier given that allegation must fail. There was no relevant representation. If there were, I have concluded that it was false as to the execution of the Medicare Australia Authority, but not otherwise. In such circumstances, I do not conclude that it would have been a breach of s 13(2) to make that incorrect representation. There was no suggestion that it was deliberately false or other than innocently made. In the context of an entitlement to require the medical authority and to make the representation in relation to that right, I do not consider requiring associated medical records from Medicare breached any community standards of decency or fairness.'*

The avoidance of the policy was not '*soundly based in medical opinion*' (because of medical opinion which suggested that the life insurer's underwriter's view about the extent of the insured's pre-policy mental health history was incorrect)

- The life insurer did not breach its duty of utmost good faith and consequently the ICA in relation to its avoidance not being '*soundly based in medical opinion*' (but see his Honour's comments regarding the failure to consult with the insured on the retrospective underwriting opinion below). His Honour stated:

> *'A decision whether to grant cover was an underwriting decision. It was not a question for a medical professional. [The life insurer] had guidelines derived from its reinsurer to assist it. Underwriters must examine these questions, at least at the time of originally writing the insurance, from their own position and perspective. At the point of consideration of a right under s 29(3) there is another context. The question is: Would the cover have been written on any terms? But the attempt to answer must be approached and undertaken with the utmost good faith. I do not consider that in reaching his views, [the underwriter] was so bereft of information or his approach so unreasonable, capricious or arbitrary as to have exhibited a lack of commercial decency and fairness.'*

The life insurer requested medical records for the purposes of its non-disclosure investigations, as opposed to assessing the claim, without advising the insured of this

- The life insurer had not breached its duty of utmost good faith and consequently the ICA in relation to its request for medical records which it intended to use for its non-disclosure investigations. His Honour formed this view on the basis that ASIC did not make any case about the life insurer's use of the authorities for the purpose of non-disclosure investigations (as opposed to the mere '*requesting*' of material), and ASIC's case in this regard hinged on the Third Representation being made out. His Honour did however suggest that if there was an allegation about the use of the authorities by the life insurer, it would have been made out. Note his Honour's comments:

*'If an insurer wishes to have a contractual right to require an insured to provide it with information or authorities to obtain information to investigate facts which may give it a right or remedy to avoid or vary the contract or refuse to pay an otherwise valid claim because of non-disclosure or misrepresentation, then, subject to the operation of the term implied by s 13(1) of the Insurance Contracts Act, it may well need a specific contractual provision.'*

No notice was given to the insured about the non-disclosure investigation

- The life insurer breached its duty of utmost good faith and consequently the ICA by forming the required retrospective underwriting opinion under s29(3) of the ICA without allowing the insured the opportunity to put an opposing view as to what the underwriting decision would have been had the true facts been known, i.e. the insured '*would have had the opportunity to put all the medical notes into a proper human context*'. It is important to note that his Honour did not find that this failure rendered the underwriting opinion invalid.
- Connected to this failure to consult with the insured on the retrospective underwriting opinion, was the fact that the disclosure investigations were being conducted covertly without the knowledge of the insured. This too represented a breach of the life insurer's duty of utmost good faith and consequently the ICA. Note his Honour's comments:

  *'The difficulty is that this was not some theoretical underwriting decision. It was one, affected by the obligation of the utmost good faith, whereby the underwriter was seeking to identify what would have happened earlier if a question had been answered differently. That involved collecting and assessing, as nearly as possible, the information that would have been brought forth, or information as close to it as possible, at the earlier point of time.*

  …

  *…In these circumstances, a decision to assess what would have been done a year before would begin with getting the most reliable evidence as to what would have happened at that time. This would include informing the Second Insured of the insurer's concerns and giving her an opportunity to put to the insurer what she considered she should, perhaps with relevant advice. This would best mimic what would have happened had disclosure been made in 2013. This was not catered for in fairness and decency by having some internal review function after a considered decision to avoid.'*

The life insurer indicated in the avoidance letter that it reserved its rights to recover benefits paid under the policy from the insured

- The life insurer breached its duty of utmost good faith and consequently the ICA by threatening the possibility of the recovery of benefits it had paid to the insured under the policy after it had commenced its non-disclosure investigation. His Honour stated:

  *'Likewise, there was a lack of decency and fairness in the threat of recovery of over $24,000. The payments were all made after the commencement of an investigation by [the life insurer] into the validity of the policy on the grounds of possible non-disclosure or misrepresentation. In the light of the failure to tell the Second Insured of the investigation (with the possible consequences of obligation to repay, should there be an avoidance) she had no reason to believe that she could not spend these modest sums in sustaining herself. She was given no opportunity to arrange her affairs to protect herself.*

  *In these circumstances, to threaten the possibility of recovery of such a sum against a woman of modest means suffering a catastrophic illness was harsh and unfair and lacked a degree of common decency. The knowledge of a possible future avoidance in circumstances of a possible change of position by expenditure of the payee would, to a reasonable and fair person in the position of [the life insurer], reveal a likely weakness in any right of recovery.'*

The life insurer alleged in the avoidance letter that the insured had breached her duty of good faith

- Finally, the life insurer breached its duty of utmost good faith and consequently the ICA by alleging that the Insured '*acted without good faith*'. In this regard his Honour noted '*there was not the slightest evidence of dishonesty or sharp practice in the conduct*' of the insured. Of course, there is authority to suggest that it is possible to breach the duty of utmost good faith by failing to make proper disclosure notwithstanding the limitations imposed by s12 of the ICA[1]. Presumably '*dishonesty or sharp practice*' in such non-disclosure would make it more likely that a breach of the duty of utmost good faith has occurred in such circumstances but it is not essential.

## Implications

This judgment deals with a factual matrix which occurred in 2014 and insurer non-disclosure related practices have evolved significantly in the intervening years and are now of course subject to LICOP.[2]

Despite its historical nature, the judgment is highly useful in that it provides authoritative guidance to life insurers as to the manner in which they should go about investigating and exercising remedies in relation to pre-contractual non-disclosure in order to comply with their duty of utmost good faith. In other words, not only must the substance of the avoidance be correct but life insurers must also ensure the process is demonstrably fair.

Specifically, the judgment indicates that utmost good faith compliance would require:

- At the earliest possible opportunity, life insurers to inform insureds if they are conducting non-disclosure or misrepresentation investigations.
- The use of Authorities to obtain information which make it clear that the documents sought could also be used to investigate the possibility of pre-contractual non-disclosure or misrepresentation.
- Before making a decision on non-disclosure or misrepresentation and the application of a s29 remedy, life insurers to provide the insured with an outline of their investigations and their preliminary thinking and invite the insured to respond. Such a process is already prescribed in section 5.20 of the LICOP, however, life insurers need to review their section 5.20 letters to ensure they are also compliant with this judgment.
- Traditional '*retro*' s29 underwriting opinions to be preliminary only until such time as any feedback from the insured in response to the section 5.20 letter is obtained and considered.
- Great care to be taken when informing insureds as to rights in relation to the recovery of monies paid under avoided policies. The right of an insurer to recover monies paid under an avoided policy (subject to various defences) is hardly controversial and indeed has long been accepted.[3] It is highly unlikely this judgment should be seen as contradicting this entitlement. Rather, it seems to us that this judgment indicates that in circumstances where a legitimate defence to a potential recovery is evident to the life insurer, such as say a change of position defence or a clear waiver, a life insurer should be highly judicious and considered in the manner in which it asserts a right to recover monies paid under an avoided policy.
- Not making an assertion that the insured has breached the duty of utmost good faith. Whilst as we have indicated above there is authority to suggest that a relevant failure to disclose under s21 of the ICA may also constitute a breach of the duty of utmost good faith, given the findings made in this judgment in relation to this issue, it would be prudent to avoid making such an assertion noting that in any event, the s21 breach is the only breach that needs to be asserted for the purposes of a s29 remedy.

Finally, as far as the false and misleading aspect of the judgment is concerned, some technical features of the judgment and the way that ASIC's case was framed mean there are limited specific takeaways on this point. Having said this, the high-level implication on this point is that care should be taken by life insurers when making assertions about what material they are entitled to require from a claimant. In particular, if an insurer requires a claimant to complete a particular form or authority, then the basis of the requirement must be readily identifiable (whether it is contained in a policy term or elsewhere). That basis must also indicate what use the insurer will put the information to, whether it be to assess the claim, or the alternative purpose of investigating non-disclosure or misrepresentation.

[1] *CIC Insurance Ltd v Barwon Region Water Authority* (VSCA 1998)

[2] For example, s5.20 of the LICOP mandates the use of '*show cause*' letters in circumstances where an insurer is considering an avoidance, a practice which if adopted may have allayed many of the concerns of the Court.

[3] *Dr Gregory Moore v The National Mutual Life Association of Australasia Limited* (NSWSC 2011)

**PRODUCT / REGULATORY**

# APRA progresses Prudential Standard 250 governing insurance in superannuation

In January this year, the Australian Prudential Regulation Authority (**APRA**) commenced its second round of consultations on revisions to Prudential Standard SPS 250 Insurance in Superannuation (**SPS 250**).

The proposed changes to SPS 250 were aimed at improving superannuation member outcomes by helping trustees select the most appropriate insurance policies for their members and monitor their ongoing relationships with insurers. This initially included making it easier for members to opt-out of insurance, and otherwise ensuring that premiums don't inappropriately erode members' retirement income. Since then, further industry consultation has resulted in additional revisions to the draft SPS 250.

## A Brief Re-Cap

SPS 250 was originally devised back in July 2013 to provide guidance for registrable superannuation entities (**RSE's**) on APRA's view of sound practices with respect to *'Insurance management framework'*, '*Insurance strategy*', '*Selection of insurer*' and '*Insurance arrangements*' among other things.

The subsequent Financial Services Royal Commission recommended further improvement to these practices. Specifically, increasing scrutiny of related party engagements for insurers of superannuation members through group life policies (Recommendation 4.14) and ensuring that any status attributed to a beneficiary in connection with the provision of insurance is fair and reasonable (Recommendation 4.15). For example, '*blue-collar*' or another status, such as '*smoker status*', that may affect the premium to be charged for insurance.

In order to reflect these recommendations, APRA sought widespread industry consultation on a proposed draft SPS 250 which begun back in November 2019 and concluded in February 2020. The intention was to update and finalise SPS 250 by mid-2020 in the hope that the revised standard would come into effect on 1 January 2021.

However, the planned roll-out for 1 January 2021 was halted as a number of industry submissions sought further information about particular aspects of the proposed changes to SPS 250. As a result, APRA released a new draft SPS 250 for further consultation in January this year, incorporating new and additional wording aimed at clarifying some of the revised requirements of SPS 250. Submissions on both the further draft SPS 250 and the accompanying prudential practice guide closed on 5 March 2021 with APRA intending to finalise both documents by the middle of this year, with SPS 250 to take effect from 1 January 2022.

## Focus of Further Revisions

Though feedback following the initial consultation in November generally supported the initial proposed revisions, subsequent industry feedback focused on the '*independent certification requirements*' for RSE's and the '*meaning of priority and privilege in non-related party insurance arrangements*'. The idea was to ensure that RSE licensees satisfy APRA that the engagement of an insurer is conducted at arm's length and is in the best interests of beneficiaries.

Under the new revisions, RSE's must undertake a detailed examination of their chosen insurance arrangements and perform the requisite due diligence once an insurer has been appointed. Further, the appropriateness, effectiveness and adequacy of its insurance management framework will be subject to a review by operationally independent, appropriately trained and competent persons at least every three years.

Given the risks associated with conflicts of interest, an independent certification is required for insurance arrangements with connected entities and for arrangements that provide a priority or privilege to an insurer.[1]

Specifically, where an insurer that is a connected entity, or in some way related to an RSE licensee, is party or will be party to an insurance arrangement with the RSE licensee, that RSE

licensee must obtain an independent certification that states:

(a) it is reasonable to form the view that the insurance arrangement is in the best interests of the beneficiaries; and

(b) the insurance arrangement otherwise satisfies all applicable legal and regulatory requirements.

Similarly, where an insurer that is not a connected entity of an RSE licensee, or in no way related, but has been selected to provide insurance cover for the RSE's members and where a contractual term of the insurance arrangement provides the insurer with a '*priority or privilege*', the RSE licensee must obtain an independent certification that states it is reasonable for the RSE licensee to form the view that the insurance arrangement is in the best interests of the beneficiaries.

According to the prudential Practice Guide, '*priority or privilege may occur where the terms of an arrangement provide the insurer with a current or future competitive advantage relative to other insurers, or where the terms of an arrangement favour the insurer relative to the RSE licensee or the beneficiaries of the superannuation entity.*'

Practically speaking, APRA expects that:

> '*a person that provides an independent certification of an insurance arrangement is required to be independent of the RSE licensee and the insurer, and is expected to have suitable expertise, experience and knowledge, to effectively assess and evaluate the terms and conditions of an insurance arrangement. APRA considers that independent certifications will likely be provided by qualified and experienced persons associated with audit firms, actuarial firms, legal firms or other firms recognised in the superannuation and insurance industries, and expects that appropriate external sources of expertise will be sought where relevant.*'

The proposed revisions also set out the various compliance timeframes for RSE licensees, with differing requirements for those insurance arrangements ending after 1 January 2023 (connected entities) and for those ending after 1 January 2025 (non-connected entities). Furthermore, once the required certification is obtained, RSEs must provide APRA with the certification no more than five days after the certification is obtained.

## Implications

At the heart of these further revisions to SPS 250 is the safeguarding of members' interests. This is of course regardless of whether the RSE licensee is connected to the insurer or not.

Clearly, the purpose of these further revisions to SPS 250 is to rebuild consumer confidence and trust in the industry and it would appear that the industry itself has been keen to support the changes providing further input and key submissions in support of the changes.

As for the RSE licensees, the principle takeaway is that they must have their house in order when it comes to their group insurance arrangements, whether that be in relation to the selection process, the ongoing management of the insurance arrangement or the revised certification requirements. It appears that APRA will be looking closely at the arrangements in place and keeping an eye on whether they ultimately benefit superannuation members. RSE licensees must investigate what is required in terms of the expected due diligence and obtaining the necessary certification ahead of the deadlines and timeframes set out in the revised draft SPS 250, expected to commence from 1 January 2022.

[1] *Prudential Practice Guide, Draft SPG 250 – Insurance in Superannuation January 2021*

**LIFE AND SUPERANNUATION CASES**

# HCA delivers key decision – financial product advice given to fund members was personal advice under the *Corporations Act*

## *Westpac Securities Administration Ltd & Anor v Australian Securities and Investments Commission* (HCA 2021)

### Key Takeaways

The *Corporations Act 2001* (**the Act**) imposes more onerous duties and disclosure requirements on financial services licensees providing financial product advice in the nature of personal (rather than general) advice. Accordingly, licensees need to be mindful of the characteristics of personal advice in order to comply with their duties under the Act and avoid breaching the terms of their license. The HCA has now provided welcome guidance on this issue.

Personal advice under the Act will be determined having regard to the context and circumstances in which such advice was given, including the subject matter of the advice, the relationship between the parties and the purpose, tenor, form and content of the advice. Critically, advice given with a warning that personal circumstances are not taken into account in giving the financial product advice may still be personal advice within the meaning of the Act if in substance, the nature and content of the advice is actually personal advice.

### Brief Facts

Westpac (**the bank**) held an Australian Financial Services Licence under the Act. The licence authorised it to provide financial services, including some financial product advice in the course of carrying on a financial services business in Australia. It was not licensed to provide '*personal advice*' in relation to superannuation products within the meaning of s766B of the Act.

The bank contacted a number of existing members of its superannuation funds concerning the rollover of their external superannuation accounts into their bank related superannuation accounts (**the bank related superannuation accounts**). Following a letter inviting members to request that the bank locate any external accounts, the bank's advisers then contacted members by telephone. The primary and common features of these calls were that members were: warned that the discussion was general and would not take into account their personal financial needs, told that the caller wished to help the member, asked what they saw as the main benefits of consolidating their superannuation funds, and told that their beliefs or reasons were commonly held before being offered help to rollover their other accounts into the bank related superannuation accounts.

The issue was whether the bank had given its members financial product advice in the nature of personal advice (rather than general advice) and therefore breached its licence and the Act.

ASIC issued proceedings against the bank for the alleged breaches. The Full Court of the FCA found in favour of ASIC and held that in contacting members regarding the rollover of their superannuation accounts, the bank had given personal advice within the meaning of s766B(3)(b) of the Act.

The bank appealed to the HCA.

### Judgment

The HCA dismissed the appeal and found that the bank had indeed provided personal advice in the calls made to its members about their superannuation accounts. In doing so, the bank had breached the conditions of its licence as well as its

duties to provide financial services '*efficiently, honestly and fairly*' (s912A(a)) and failed to '*act in the best interests of the client in relation to the advice*' (s961B(1)).

'*Financial product advice*' is defined in s766B(1) as a recommendation or statement of opinion that is intended to influence a person in making a decision in relation to a financial product, or could reasonably be regarded as being intended to have such an influence. In the appeal, the bank conceded that it had provided financial product advice within the meaning of the Act in its telephone calls to members. That is, a recommendation was given (that the member should rollover their external accounts into the bank related superannuation accounts) with the intention to influence the member to do so.

In determining whether this was general or personal advice (general advice being advice that is not personal advice), the HCA had regard to s766B(3) of the Act which states that '*personal advice*' is:

> '*financial product advice that is given or directed to a person (including by electronic means) in circumstances where:*
>
> *(a) the provider of the advice has considered one or more of the person's objectives, financial situation and needs ...; or*
>
> *(b) a reasonable person might expect the provider to have considered one or more of those matters.'*

The advisers had not considered one or more of the members' objectives, financial situation and needs so the judgment focussed on whether '*a reasonable person might expect*' the bank to have done so. In reaching its conclusion that the answer is '*yes*', the Court found that:

> '*the subject matter of the advice, the nature of the relationship between Westpac and its members, the purpose and tenor of the calls, and the members' objectives, together with the form, content and context of the financial product advice… compel the conclusion that the… advice was personal advice…*'

Specifically, the Court had regard to the following factors:

- the subject matter of the advice concerned a significant financial decision about consolidating multiple superannuation accounts;
- there was a pre-existing relationship in the nature of trustee and beneficiary between the bank and the members it had contacted;
- given the relationship, a reasonable person would expect the advisor to have access to all of their relevant information known to the bank;
- the tone and tenor of the calls emphasised a desire to help members with their superannuation; and
- in eliciting from members their financial objectives in superannuation which are personal in nature and included things like maximising financial returns and minimising fees, a reasonable person *might expect* that these objectives would be considered by the bank in any subsequent financial product advice.

The Court held that consideration (or reasonable expectation) of only one of the matters listed in the Act – the person's objectives, financial situation or needs – was sufficient to invoke the personal advice provisions of s766B(3). In addition, the requirement that a reasonable person '*might*' expect such consideration is a lower threshold than a requirement that they '*would*' expect such matters to have been considered. That is consistent with the consumer protection objectives of this part of the Act.

The Court rejected the bank's defence that it had issued a general warning at the beginning of each call that personal circumstances were not considered. It did so because firstly, this was inconsistent with subsequent questions specifically asking about the member's personal objectives and secondly, members were not then encouraged to seek personal advice before deciding on whether or not to rollover their accounts.

The fact that the advice was provided without charge did not impact the Court's conclusion of personal advice because the relevant members were already paying fees to the bank and the recommended rollover was clearly in the bank's financial interests. In those circumstances, a reasonable person might expect that a fee for the provision of personal advice was less likely.

Accordingly, the advice given by the bank to each member it had contacted was intended to influence them in making a decision on an important financial product in circumstances where a reasonable person might expect the bank to have considered one or more of the member's objectives, financial situation and needs. It was therefore, personal advice.

## Implications

This decision obviously relevantly provides definitive guidance on the distinction between general and personal advice in the provision of financial product advice and to that extent has been welcomed by the regulator and financial service provider alike.

The provision of personal advice attracts a higher level of responsibility to customers, for example in providing a written statement of advice, and importantly, also attracts duties such as a duty to act in the best interests of the customer in relation to that advice.

It follows that when providing financial product advice, licensees need to ensure that such advice is truly either general or personal advice, having regard to the factors identified in this judgment. In the case of personal advice, providers must be mindful to comply with the more stringent legislative requirements under the Act.

**PRODUCT / REGULATORY**

# Sustainability of Insurance in Superannuation… APRA warns group insurance players

In our Spring 2020 edition of the Life Insurance Bulletin, we covered a report from the Actuaries Institute Disability Insurance Taskforce which shone a light on the long term sustainability of disability insurance, particularly individual disability income insurance product offerings in both the retail and group space, which has for some time now, been of significant concern within the industry.

Since that time, industry concern has also centered on group insurance more specifically, with APRA having identified '*a re-emergence of some concerning developments in group life insurance in superannuation in relation to premium volatility, availability and provision of data, and tender practices*.'[1]

On 9 March 2021, APRA wrote to life insurers and registrable superannuation entity (**RSE**) licensees, urging them to address these concerning trends and practices in the provision of insurance to superannuation members.[2] APRA made note of the fact that between 2012 and 2016, '*insurers experienced significant losses*' which resulted in large premium increases and tighter policy terms. Furthermore, trustees had great difficulty enticing insurers to tender, all of which resulted in a poor outcome for superannuation members.

Recent trends have followed a similar path, with APRA having identified '*a deterioration in group life insurance claims experience*', which has impacted significantly on life insurer profitability. In light of what occurred between 2012 and 2016, APRA has renewed concern that '*members are likely to be adversely impacted through further substantial increases in insurance premiums and/or a reduction in the value and quality of life insurance in superannuation.*'

## Premium Escalation

A key indicator in this regard is the recent APRA data, which confirms that '*insurance premiums per insured member have been escalating during 2020.*' This has resulted in RSE licensees tendering more frequently and being attracted to unsustainable pricing from insurers keen to be selected.

However, APRA considers that this is unmanageable long term and will inevitably '*lead to significant increases in premiums at the end of premium guarantee or contractual periods.*' APRA observes that '*ultimately, members are not best served by such unpredictability and volatility in insurance premiums, with members paying more in future for insurance as a result of unsustainable prices being offered to win tenders in a prior period.*'

## Insufficient Quality Data

Gathering quality data to make informed design decisions and price appropriate insurance arrangements continues to be an issue for insurers and RSE licensees alike. APRA considers:

> *'that this is due to both the varying quality and type of data captured by RSE licensees on members, as well as varying approaches to providing such data to insurers.' APRA believes that this can result in poor outcomes to members through price volatility and may impact availability of insurance through superannuation.'*

## Tender practices

APRA has otherwise observed that there has been an increase in '*undesirable tender practices, including abbreviated timeframes for the tender process, or to respond to revisions in insurance design or other parameters as part of that process, being imposed.*' APRA has identified that some RSE licensees are seeking to have a major role in determining the reinsurers that must be used. Further, the data provided to life insurers is often '*inadequate, out of date and/or not made available to all tender participants.*' APRA considers that the tender assessment criteria should '*align with and reflect the key requirements of an RSE licensee's insurance strategy and include criteria beyond price, such as service levels, claims philosophy, member access to insurance information and member education.*'

## What to expect?

APRA has certain expectations of RSE licensees and insurers going forward in this regard. In short, the expectation is that steps will be taken to '*ensure that insurance offerings and benefits*

*are sustainably designed and priced, provide appropriate value for members, and adequately reflect the underlying risk and expected experience.'*

More specifically, '*RSE licensees should maintain clear insurance strategies that reflect a scheme design for default insurance*' which '*appropriately balances the needs of members and the cost of insurance.*' Further, '*RSE licensees should maintain, and make available to insurers, high quality and sufficiently granular data to support a thorough understanding of fund membership and sound insurance benefit design.*' APRA refers to the soon to be finalised Prudential Standard 250 (also covered in this edition of the Life Insurance Bulletin) which '*requires RSE licensees to maintain sufficient records that can form the basis for insurers to assess and price insured benefits.*'

Regarding tender practices, APRA expects that tenders will be '*conducted in such a way that insurers are given adequate time to consult on scheme designs and appropriately price the risks and benefits. New data that becomes available during the tender process should be provided to all participants.*'

RSE licensees and insurers can expect that APRA will:

> *'actively monitor progress against the expectation set out their letter of 9 March 2021. Through APRA's supervision in this regard, it is hoped that 'RSE licensees and life insurers will take steps that will support the provision of high quality and sustainable insurance outcomes over the medium to long-term for both current and future superannuation members, and reduce the unpredictability and volatility in insurance product design and pricing.'*

APRA has warned that further action will be considered if such steps are not adopted.

[1] https://www.apra.gov.au/sustainability-of-life-insurance-superannuation

[2] Email from APRA to mailing list dated 9 March 2021

**LIFE AND SUPERANNUATION CASES**

# NSWCA confirms flexible approach to TPD qualifying periods based on wording of TPD definition

## *Onepath Life Ltd v Standley* (NSWCA 2021)

### Key Takeaways

If the words of a TPD definition permit, an insured will not be restricted to asserting one particular time period as being the so-called TPD qualifying period. In short, as long as they are insured at the relevant time (and the wording permits) the qualifying period can be a floating concept.

### Brief Facts

Mr Standley, a former Customer Experience Manager, was insured for Own Occupation TPD under a retail policy of life insurance issued to him by the life insurer.

The definition of TPD was relevantly as follows:

> *Own Occupation TPD definition*
>
> *Own Occupation means the occupation in which the life insured was engaged immediately prior to the date of disability.*
>
> …
>
> *Own Occupation TPD means that, as a result of illness or injury, the life insured:*
>
> *1) a) has been absent from work and unable to engage in their Own Occupation for three consecutive months and*
>
> *b) is disabled at the end of the period of three consecutive months to such an extent that they are unlikely ever again to be able to engage in their Own Occupation*

Mr Standley suffered a motorcycle accident in August 2015, resulting in right ankle and left wrist injuries, as well as secondary anxiety and depression. He ceased work and lodged a claim for TPD with the life insurer in September 2016, claiming to have become TPD from 2 February 2016.

The life insurer rejected the claim in November 2017, and Mr Standley commenced proceedings in the NSWSC before Justice Rein shortly thereafter.

Despite agreeing with many aspects of the life insurer's decline including on many credit issues and specifically that Mr Standley was not relevantly TPD from February 2016 being the date continually asserted by him as the start date of his claim (i.e. making the date for assessment three months later in May 2016), Justice Rein still found Mr Standley to be TPD.

His Honour did so on the basis of his finding that Mr Standley had met the qualifying period and was TPD as defined, by the beginning of September 2017.

The September 2017 date was selected despite the fact that by this stage Mr Standley had been off work for over a year and a half and despite the fact that the presumptive start of the qualifying period being June 2017 did not seem on the evidence as a whole, to be a date of any medical significance.

The life insurer appealed this decision to the NSWCA on the basis that (a) the date for assessment could not be later than the end of the three month qualifying period following the initial cessation of work and (b) that Mr Standley was not TPD in any event.

### Judgment

The NSWCA unanimously upheld the decision of the NSWSC.

Crucial to the NSWCA's decision was that:

> *…the first element of Part 1 of the definition is satisfied if the life insured has not worked in their most recent occupation…for a period of three consecutive months because they have been unable to do so as a result*

> *of illness or injury.* ***That will remain so irrespective of whether, between the illness or injury and the commencement of that period, the insured's employment in that occupation has ended for whatever reason.*** (Our emphasis added).

The Court therefore effectively stated that it did not matter that Mr Standley – when he first ceased work – did not cease work because of his claimed condition. It also did not matter that he did not become unable to work immediately after he ceased work, so long as at some point whilst he still had cover under the policy (although unemployed the whole time) he would meet the first limb of the TPD definition by being unable to work.

## Implications

The implications of the NSWCA's findings are very narrow given the nature of the TPD definition in this particular policy of life insurance.

In many any/own occupation TPD policies (particularly in group cover), the sustained cessation of work for reasons other than illness or injury will have the effect of flipping cover to more restrictive ADL or similar types of cover. In such scenarios, the success or failure of a claim will generally be dependent upon the acceptance of the commencement of the claim or '*date of disablement*' as concurrent with the cessation of work.

This decision indicates however, that where full TPD cover continues notwithstanding work cessation, there is no need for alignment between work cessation and the '*date of disablement*' or the '*date for assessment*'. That is, absent cover altering upon work cessation, the qualifying period can be met at any time during coverage and claimants can simply align the start and end of their qualifying period with the medical evidence that best suits their case.

**PRODUCT / REGULATORY**

# Default group life insurance and member value for money – Key findings in ASIC Report 675

ASIC Report 675 *Default insurance in superannuation: Member value for money* shares insights from ASIC's work on measuring the value of default insurance in superannuation.

The report has implications for how trustees and group insurers should approach default cover. It also further underscores ASIC's desire for strengthened data to measure member outcomes.

ASIC found:

1. There is wide variation in the pricing of default insurance.
2. Claims ratios are a good indicator of member value for money and insurers expect to pay about 79 cents in claims, on average, for each dollar of premiums.
3. Some groups of members may be receiving relatively low value for money, particularly younger members.

## Finding 1: Wide variation in pricing

ASIC found wide variation in the pricing and design of default insurance arrangements. It found, for example:

- for two identical 30-year old women, the woman in the product with the highest premiums would be paying a total premium 25 times greater than the woman in the product with the lowest premiums; and
- for two identical 50-year old men, the total premium ranges by a factor of 37.

While some of this variation is due to trustees providing different types and levels of cover as default, ASIC found the unit price of cover also varied widely.

ASIC attributed the range in pricing to factors such as:

- whether IP was included in the default offering, and the waiting period and benefit periods offered;
- death and TPD cover levels (noting the highest amount was 9 to 27 times the lowest amount);
- whether cover level varied based on age (which half of the MySuper products analysed did);
- composition of a MySuper product's membership (such as mainly heavy blue v mainly white-collar membership); and
- generosity of terms and conditions.

Acknowledging that value for money cannot be based on premiums alone (and the most expensive insurance is not necessarily the best value, and the cheapest not necessarily the worst), ASIC urged trustees to take the varied factors driving price into account in considering whether default insurance designs are appropriate for different groups of their members.

## Finding 2: Claims ratios are 79% on average

ASIC considers claims ratios a good indicator of the outcomes members collectively receive, because it is a direct measure of the share of premiums returned through claim payments.

It looked at accrual claims ratios for the largest group insurance policies of 11 superannuation trustees over a six year period to 2018–19.

It found that over this period, on average:

- the accrual claims ratio was 79% (insurers expect to pay about 79 cents in claims, on average, for each dollar of premiums);
- the claims ratio is higher for TPD cover (87%) and death cover (80%), and lower for IP cover (61%) (attributed to the typically increased cost of managing IP claims); and

- a significant share of claims is yet to be paid (and for TPD and IP cover in particular, insurers have so far paid less than half the total amount of claims they expect to pay based on the default insurance arrangements in place over the six year period).

ASIC emphasised the importance of claims ratios in helping trustees monitor the outcomes they are delivering for different cohorts of their members and whether current premium levels are likely to be sustainable over time.

## Finding 3: Some members may be receiving low value for money

In looking at how value for money (measured by the accrual claims ratio) varied across the 11 trustees analysed and across specific groups of their members, ASIC found on average, over the six year period to 2018–19:

- significant variation in the accrual claims ratios across trustees, their individual group insurance policies, and groups of members within them;
- higher accrual claims ratios for death and TPD cover among the not-for-profit trustees compared to the retail trustees;
- larger ranges of claims ratios among the individual group insurance policies held by each trustee (likely explained by the fact different group insurance policies often represent distinct groups of members); and
- members aged under 30 had systematically lower accrual claims ratios than those aged over 50 and are receiving significantly less value for money based on this measure. ASIC noted the difference in claims ratios between age cohorts raised questions of fairness, particularly to the extent it reflects the unintentional result of the degree of risk changing over time without commensurate adjustment in premiums. ASIC noted that a number of trustees had addressed such concerns in their current default arrangements.

ASIC emphasised the importance of trustees measuring and understanding the outcomes they are delivering to different cohorts of their members as measured by claims ratios – and the factors that drive these outcomes, and trustees taking these into account when designing and pricing default insurance arrangements.

## Value for money and claims handling

ASIC urges trustees to look beyond claims ratios in identifying risks of member harm, such as to the way they and insurers handle claims.

It points out, for example, high rates of declined claims could indicate that members do not fully understand when they are eligible to receive a claim payment, and a high number of withdrawn claims or disputes, or long claim processing times, could indicate frictions in the claims process.

## Shortcomings in data and analytics

ASIC noted that most trustees found it challenging to provide all the data it required and ought to improve the standard of data they collect about members.

The report offers specific guidance on how trustees can use data to monitor and review member outcomes and importantly, determine whether they are delivering value for money, and whether groups of members, having different insurance arrangements, are fairly treated.

ASIC advises trustees, for example, to:

- segment their membership by whether or not members have default cover and by demographic characteristics (such as age, gender and occupation category);
- for each cohort, monitor the levels of premiums and consequent balance erosion, claims ratios and other claim-related indicators (such as claim incident rates and claims handling measures);
- compare member outcomes to industry-wide measures (such as claims-related statistics published by APRA);
- consider embedding detailed data-sharing arrangements in service-level agreements with insurers; and
- seek updates on how their insurers are improving their own data management practices.

## Implications

Default group life cover provides significant value to the many Australians who hold life insurance through superannuation. ASIC recognises this within Report 675.

However, Report 675 highlights the continued focus on examining the value of insurance in superannuation. Indeed the report follows on from reports such as ASIC report 633 *Holes in the safety net: A Review of TPD insurance claims* about concerns regarding the value of default cover to certain cohorts and trustees having a better understanding of what value different member groups are receiving.

It is important as such for superannuation trustees to continue to provide access to insurance products that are suitably designed for their members and different cohorts within their membership – and to demonstrate that value, amongst other things, through robust data analysis.

**LIFE AND SUPERANNUATION CASES**

# AFCA interprets '*usual occupation*' to include two unrelated occupations for the purposes of assessing income protection benefits

## AFCA Determination 717312

### Key Takeaways

The fact that an insuring clause refers to '*usual occupation*' (as opposed to '*usual occupations*') does not mean that a life insurer can disregard all pre-injury occupations an insured was performing except for the one it considers to be the 'usual' or '*main*' one.

### Brief Facts

The complainant lodged a claim under a policy of income protection following a work injury to his back on 24 September 2018. The insurer initially accepted the claim and paid benefits from 25 October 2018 to 24 May 2019, on the basis that the complainant was disabled from his '*usual occupation*'.

The complainant's pre-injury work consisted of essentially two occupations – that of carpenter, and that of an internet retailer of tools. There was some factual debate about which of these occupations was the more significant one, if any, however the insurer argued that it was the internet retailer occupation that was relevant to the assessment of entitlement to benefits – i.e. the '*usual occupation*' – on the basis that most of the complainant's pre-injury income came from that job.

The insurer therefore declined the claim on the basis that the complainant – while not being able to work as a carpenter due to his back injury – was nonetheless able to work in his largely sedentary internet retailer job.

The complainant argued that he had barely any involvement in the online tool business, and that it was predominantly operated by his wife.

In its initial Recommendation, AFCA was not convinced by the assertions from the complainant, but nonetheless found that it was '*unfair for the insurer to choose one occupation as the usual occupation where his pre-disability income is generated from both occupations*'.

On this basis, AFCA recommended that the claim be re-opened by the insurer and the complainant assessed for partial disability. The insurer disputed this decision due to its view that the phrase '*usual occupation*' could mean only one occupation because a) the phrase is not pluralised, b) the complainant was performing two separate and distinct occupations at the time the claim arose and c) having regard to a) and b), it falls upon the insurer to determine what the '*usual occupation*' is.

### Determination

In its Determination, AFCA upheld the findings made in the Recommendation about the complainant's '*usual occupation*' being that of '*carpenter/internet retailer*':

> '*… a reasonable person, reading these provisions, would expect to be paid a total disability benefit if there were unable to do at least one important duty and were not working, and a partial disability benefit if they had a limited ability to do at least one important duty and were working. Treating 'usual occupation' as meaning 'main occupation' introduces a significant limitation on the benefits which is inconsistent with the policy read as a whole. I do not accept that such a significant limitation can be fairly achieved by stretching the ordinary meaning of 'usual'.*'

### Implications

According to AFCA at least, this Determination supports the proposition that where an insured is habitually performing two

or more jobs, their '*usual occupation*' will include all such jobs, not just the primary job (however such job is identified).

The net effect is in circumstances where an insured is disabled from one of their jobs, but not the other(s) they will still be disabled for their '*usual occupation*'.

In most IP policies this will mean, provided an insured is still working in one of their jobs they are capable of performing, a resultant claim will be restricted to one of partial disability rather than total disability.

Whilst this principle appears straightforward enough, obviously issues will be raised when for example concurrent job(s) are fleeting and unsustained. In such circumstances, it could be strongly argued that such fleeting employment should not be considered part of the '*usual occupation*' and that some continuity of employment is required.

Critically, it seems to us that the decision will also have relevance to the concept of '*active employment*' as that term is commonly used in the commencement of automatic group cover. That is, an insured in concurrent employment who is fit for one of their jobs but not the other, will arguably not be in '*active employment*' because they can only do some, but not all, of the normal duties of their '*usual occupation*' given the extended definition of that term as used by AFCA in this case.

**PRODUCT / REGULATORY**

# ASIC plans to extend its consumer remediation guidance to all AFS licensees

On 3 December 2020, ASIC published a first round Consultation Paper 335 '*Consumer Remediation: Update to RG 256*' inviting feedback from the industry on its plans to update its 2016 Regulatory Guide 256 '*Client review and remediation conducted by advice licensees*'.

The headline change proposed is that the updated remediation guidance will go beyond financial advice and will apply to all AFS licensees and superannuation trustees. This is likely to have a substantial impact on the design and execution of consumer remediation.

The proposed changes come at a time when a lot of remediation work is continuing and there is a substantial amount of regulatory development. In its guidance review, ASIC noted that although it has seen some positive changes from industry, in its experience licensees are '*still sometimes*' using remediation approaches that are '*not aligned with their stated values about the treatment of consumers and arguably with their legal obligations*'.

The key takeaways from ASIC's guidance review are summarised below.

## Two-tiered approach to initiating a remediation

ASIC has proposed a two-tiered approach to initiating remediation:

- Under Tier 1, ASIC says a remediation '*must*' be initiated when a licensee has engaged in misconduct, an error or compliance failure, and caused actual or potential consumer loss to '*one or more*' consumers, as opposed to '*a number of consumers*' in the current guidance. It proposes the removal of any reference to '*systemic*' issues.
- Under Tier 2, ASIC proposes that a licensee '*should consider*' initiating a remediation where a licensee's failure causing loss '*breaches industry codes or conduct not aligned to a licensee's values or standards (e.g. industry codes, business values or promises made such as doing what is right, or putting the customer first)*'.

The high water mark set by ASIC appears to be founded in a licensee's general obligations under s912A(1)(a) of the *Corporations Act* 2001. ASIC acknowledges that '*some licenses adopt a remediation approach that is not limited to establishing a legal or compliance breach only – it also takes into account what their consumers and the broader community would expect in terms of righting wrongs*'.

Once initiated, ASIC's position is there is '*no one-size-fits-all approach to remediation*' and it can be tailored and scaled as needed, according to the size and scope of the failure.

## Extended review period for a remediation

ASIC recommends that '*as a starting point, the relevant review period for a remediation should begin on the date a licensee reasonably suspects the failure first caused loss to a consumer*'. Additionally, ASIC proposes scrapping the seven-year time-period for remediation in RG 256, noting that '*many remediation issues go back more than seven years by the time they are uncovered*'.

In essence, ASIC expects that insurers and trustees need to go back further than seven years when reviewing remediation issues. The rationale being that increased technology and data management capabilities have enabled robust record keeping. ASIC reiterates that consumers should not be disadvantaged due to poor record keeping or poor systems and governance frameworks.

## Using beneficial assumptions

ASIC has proposed that licensees should only rely on assumptions in remediation if they are beneficial to the consumer. ASIC says that beneficial assumptions are those that are '*evidence based and well documented*', '*aim to return all affected consumers as closely as possible to the position they would have otherwise been in (this may include giving a consumer the benefit of the doubt)*', and are monitored to ensure they continue to deliver to these requirements.

In particular, ASIC expects licensees to use beneficial assumptions to determine affected consumers or to calculate potential loss suffered '*if [licensees] need to make up for absent records, especially if absent records may be considered a breach of their record keeping obligations*'. In these circumstances, ASIC expects:

- licensees to make beneficial assumptions in a consumer's favour if there is evidence to suggest the consumer has been, or may have been, affected by the failure. ASIC says beneficial assumptions '*preference inclusivity rather than exclusivity*' when determining affected consumers.
- licensees to '*err on the side of overcompensation*' in applying assumptions to calculate the amount of loss. '*That is not to say that licensees are obliged to overcompensate*', ASIC continues. '*Rather if they choose to use assumptions to save time and cost or account for absent records, the assumption should equate to actual loss or err towards overcompensation rather than the risk returning less than what consumers are owed*'.

ASIC adds that:

> '*consumers should not be disadvantaged if a licensee fails to keep proper records in line with its record-keeping obligations, or if an authorised representative of the licensee has failed to comply with its obligations to provide records on request. Poor or incomplete records is rarely a justification for a failure to remediate consumers or to limit the scope of a remediation*'.

ASIC recommends that any decision to apply assumptions should be well documented and appropriately justified.

## Implications

The proposals in ASIC's remediation review are preliminary and ultimately may change. Nevertheless, impeding changes to consumer remediation makes the review of existing remediation processes an ever present focus.

Insurers and superannuation funds should consider the potential impact the revised guidance may have on their existing processes including:

- processes for initiating remediation - ASIC makes it clear that it expects financial firms to attend to remediation issues as soon as they develop for '*one or more consumers*', and before a problem festers or becomes systemic;
- processes which enable the detection of a Tier 2 scenario - as some values or standards may be aspirational, firms should also consider what does and does not constitute a Tier 2 scenario that may require remediation;
- decisions around review time periods and a remediation approach in circumstances where accurate data may not be available; and
- assumptions in remediation methodologies.

ASIC is currently reviewing feedback received in relation to the first round consultation. At a future date, the corporate regulator will release a draft-updated guidance for a second round of consultation.

We will keep you up to date with further developments.

**LIFE AND SUPERANNUATION CASES**

# AFCA upholds trustee's decision to distribute death benefit to de facto partner over competing claims

## Case 699515

### Key Takeaways

In this recent determination, AFCA has reminded the industry that when the distribution of a death benefit is contested and a claim is made by multiple dependants, significant weight should be placed on who the deceased member would have financially supported had they not died.

### Brief Facts

The deceased member died and was survived by his wife from whom he was separated (but not divorced), his adult children (a daughter and two sons from his wife), and his de facto partner of 10 years. The deceased's children were all financially independent.

There was no binding death nomination made by the deceased.

The wife, each of the deceased's adult children and his de facto partner qualified as '*dependants*' under the trust deed. Therefore, the trustee had to choose between a number of potential beneficiaries for the distribution of the death benefit.

The trustee determined to pay the entirety of the death benefit to the de facto partner (the trustee's decision) on the basis that she would have held the expectation of ongoing financial support from the deceased.

The wife and adult children lodged a complaint with AFCA with respect to the trustee's decision.

### Determination

AFCA affirmed the trustee's decision finding the decision to pay the death benefit to the de facto partner to be fair and reasonable in the circumstances.

On the issue of who could qualify as a dependent, AFCA acknowledged that:

1. Both the wife and de facto partner satisfied the definition of '*spouse*' as provided by the *Superannuation Industry (Supervision) Act 1993* and therefore could both be considered as dependants.

2. The adult children, as the biological children of the deceased, could also qualify as dependants.

While the wife and adult children also qualified as dependants, AFCA considered that the death benefit should be distributed to the dependants who relied on the deceased for financial support, in line with the very purpose of superannuation, which is to provide income to members and their dependants upon retirement.

The wife and adult children completed statements of interdependence as well as advising AFCA of the following facts:

- the children had a loving and involved relationship with the deceased;
- the deceased provided gifts and made ad hoc financial contributions to the adult children;
- the wife paid for the deceased's health insurance as well as the deceased's funeral expenses;

- the wife supported the deceased when he was establishing his acting career;
- the deceased retained a key to the family home and would continually visit and assist with maintenance; and
- the majority of the deceased member's estate was paid to the wife under an agreement reached between the wife and the de facto partner.

Despite the above, AFCA was not satisfied that they met the interdependence test at law because they did not live with the deceased, and the wife and adult children could not establish they were financially dependent to the extent that the deceased provided constant ongoing financial support.

ACFA turned to consider what might have occurred had the deceased member not died, and who would have had the expectation of ongoing financial support. AFCA found that the trustee's decision to pay the entirety of the death benefit to the de facto was fair and reasonable in light of this consideration.

## Implications

This determination shows that AFCA is more likely to uphold a trustee's death benefit distribution decision as fair and reasonable in the circumstances if it is satisfied that the trustee has made a decision having regard to the degree to which the beneficiaries were financially dependent on the deceased and who the deceased would have supported if they had remained alive.

Trustees should continue to ask themselves in death benefit distribution cases which of the competing parties would have an expectation of future financial support if the deceased remained alive.

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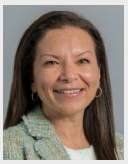

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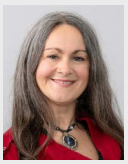

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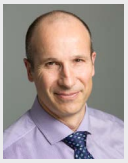

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