Superannuation determination

Case numbers	823489 and 793218
Financial firm	AustralianSuper Pty Ltd (trustee)
Joined financial firm	TAL Life Limited (insurer)

1 Overview

1.1 Complaint

The complaint is about the insurer's decision to decline to pay the complainant an income protection (IP) benefit.

The complainant applied for total and permanent disablement (TPD), death and IP insurance through the fund. The trustee provided him with basic cover up to $250,000 for TPD and death, and IP cover of $5,800 per month. Within two years of the basic cover commencing, the complainant suffered a disability arising from his pre-existing medical conditions and applied for an IP benefit.

The insurer declined to pay the benefit because the complainant's disability arose from a pre-existing condition within two years of cover commencing. The insurer said the complainant's basic cover was limited cover, and he was not covered for claims arising from pre-existing conditions for the first two years.

The complainant says he was unaware he had limited cover when he rolled over his superannuation from the previous fund to the fund. He says the trustee or insurer should have told him when he was deciding whether to join the fund and take out insurance he would have limited cover. He says their failure to tell him this caused him loss, as he would have received an IP benefit if he had stayed with the previous fund.

The insurer decided to decline to pay the IP benefit, and the trustee agreed with the insurer's decision. These are the decisions under review.

1.2 Issues and key findings

Did the complainant have limited cover?

The complainant had limited cover.

Did the trustee or insurer know the complainant was seeking immediate IP cover for his pre-existing conditions?

The trustee and the insurer were not aware the complainant was seeking immediate IP cover for his pre-existing health conditions, and the complainant could not reasonably have expected them to have known this based on the complainant's communications with the trustee.

Did the trustee or insurer mislead or deceive the complainant?

Neither the trustee nor the insurer misled or deceived the complainant about the IP cover.

Did the trustee appropriately deal with the insurance application?

The trustee appropriately dealt with the complainant's insurance application.

Are the decisions of the trustee and the insurer fair and reasonable?

The decisions of the trustee and insurer are fair and reasonable in their operation in relation to the complainant in all the circumstances.

1.3 Determination

The determination affirms the decision of the insurer to decline to pay the IP benefit, and the decision of the trustee to agree with the insurer.

2 Reasons for determination

2.1 What is AFCA's review power and process?

In determining superannuation complaints, AFCA must:

- comply with its rules and the law
- consider whether the trustee's and the insurer's decisions were fair and reasonable in their operation in relation to the complainant in all the circumstances
- not make a determination that is contrary to law, the trust deed or the insurance policy.

This means the issue is not what decisions I would have made, but whether the decisions under review were fair and reasonable.

In reaching my determination, I have reviewed the AFCA file and considered all the material provided by the parties. I am satisfied that the material relied on has been provided to all parties and they have had an opportunity to respond.

2.2 Did the complainant have limited cover?

The complainant had limited cover.

The relevant insurance policy provided that default cover would be limited cover until it had been in force for a period of 24 months.

The complainant does not dispute he had pre-existing conditions, and that his disability, which gave rise to his IP claim, arose from a pre-existing condition.

2.3 Did the trustee or insurer know the complainant was seeking immediate IP cover for his pre-existing conditions?

The trustee and the insurer were not aware the complainant was seeking immediate IP cover for his pre-existing health conditions, and the complainant could not reasonably have expected them to have known this based on the complainant's communications with the trustee.

The complainant initially held a superannuation account with the previous fund. He applied to the previous fund's trustee for it to arrange for his TPD, death and IP cover to be increased, including for his pre-existing health conditions. He disclosed these in his insurance application, which included depression, brain aneurysm and polycystic kidney disease. He attached copies of a radiologist and a specialist report with his application.

The previous insurer rejected his application.

On 12 July 2019 the complainant emailed the trustee seeking for it to arrange IP, TPD and death cover for him with the insurer. In the email he said:

> Hello,
>
> I have attached an application form for your fund.
>
> I am currently with [a] fund though there [sic] underwriter [named] won't increase my insurance to fixed based on medical conditions.

> I have attached my previous [insurance] application with medical documentation from that insurance refusal as I gather your underwriter [the insurer] will want to determine if they will insure me for 250k fixed death and TPD based on my medical history/conditions.
>
> If [the insurer] will insurer [sic] me I will roll over my 200k super to your fund and pay my ongoing super contributions to [the fund].
>
> Look forward to your response with an outcome.

He attached a completed and signed application form to the email.

In response to the complainant's application to join the fund and take insurance, the trustee sent him a letter dated 17 July 2019, in which it said that TPD cover had been provided to him for fixed death cover and TPD cover of $250,000, which is what he had requested in his email. The letter also said in part:

We've received your application for Income Protection cover but, based on your salary of $81,000.00, the maximum amount of Income Protection cover you can apply for is $50,000.00.

This is the amount of cover you've been provided and it started on 12 July 2019.

Your insurance cover is shown below.

Insurance design	Death cover	Total & Permanent Disablement (TPD) cover	Income Protection
Age-based cover	$0	$0	$0 a month
Extra cover (fixed amount)	$0	$0	N/A
Fixed cover	$250,000	$250,000	$5,800 a month
Total cover	**$250,000**	**$250,000**	**$5,800 a month**
Waiting period	N/A	N/A	30 Days
Benefit payment period (maximum)	N/A	N/A	2 Years
Individual work rating	Standard		
Effective date	12/07/2019		

This cover won't start until your employer has made their first contribution into your account. Once your insurance cover starts, we'll write to you to confirm your total cover.

If your salary increases, you may be eligible to apply for additional Income Protection cover.

In addition, the trustee said in the letter: 'More information about your cover, including the terms, conditions and costs that apply, is in our Insurance in your super guide' (the Insurance Guide).

The complainant subsequently asked the trustee of the previous fund to close his account with the previous fund and to roll-over the balance to the fund. In a letter to him dated 7 August 2019, the trustee of the previous fund confirmed the complainant's superannuation benefit had been rolled-over to the trustee in accordance with his instructions.

In a letter to the complainant dated 10 August 2019 the trustee said:

> We've received an employer contribution for you, so you now have Death and Total & Permanent Disablement and Income Protection cover. The cost of this cover will be deducted monthly from your account.

The letter also said the cover was effective from 21 July 2019 and that he was provided death cover of $250,000 and IP cover of $5,800 per month. The letter provided a hyperlink to information about the cover.

The cover provided to the complainant was default cover, which under the terms of clause 20.2.3 of the insurance policy meant he received 'limited cover' for a period of 24 calendar months (see section 3.2 below). This meant he was not covered for pre-existing health conditions for 24 months after the cover commenced.

The complainant suffered a disability on 27 November 2020 preventing him from continuing his work. He applied for IP benefits because of the disability. The insurer, however, declined his claim because it related to a pre-existing medical condition occurring within 24 months of the cover commencing. There is no dispute the disability related to a pre-existing medical condition.

The complainant was unaware he was not covered for his pre-existing conditions

The complainant says he had not realised, at least until the insurer declined his claim, his insurance cover was limited cover.

The complainant was not subject to limited cover under the insurance arranged by the trustee of the previous fund. This meant that if he had not left the previous fund, he would likely have had IP cover for the disability he suffered on 27 November 2020.

After discovering the insurer had declined his application for IP benefits, the complainant emailed the trustee saying:

> I was already covered for these pre existing conditions with [the previous insurer] so I would have not left that fund and rolled into [the fund] if I was advised appropriately.

The complainant says the outcome he is seeking is 'for my insurance not to be "limited cover" so my pre existing conditions are covered and not excluded, so my income protection claim can be accepted'.

The complainant says the trustee or insurer should have realised he was seeking immediate IP cover for his pre-existing conditions

The complainant says:

> … I provided [the trustee] detailed health information including listing my pre existing conditions and requested [the insurer] to consider underwriting me so [the trustee] should have acted on my request and not accepted me under the new member offer as I clearly wanted cover from when I first applied for my pre existing health conditions.

He also says:

> [The trustee] set up my application under this new member offer, ignoring and or overlooking my provided detailed health information and request for [the insurer] to consider underwriting me. Again when I followed up, [the trustee] did not advise me that they did not send to [the insurer] to consider for underwriting and had me believe it had been underwritten and accepted hence I then rolled all my super from [the previous fund] into [the fund] as insurance accepted.

The complainant says the inclusion of his medical history, along with what he says was his (implied) request for cover regarding his pre-existing medical conditions

> … clearly supports and indicates I wanted cover from when becoming a member without being limited cover and [the trustee] has clearly overlooked/ignored my request in processing my application and/or are not fully aware that this was a possible option for [the insurer] to consider as part or the application processes if all that was required was for [the trustee] to

> simply reply to my application email and ask me to complete the change your insurance form to go with my already provided detailed medical history of pre existing conditions for [the insurer] to consider/assess cover.

He also says:

> If I was clearly advised by [the trustee] over the phone when I chased up my application, or they responded to my application email that my [insurer] request for considering insurance was not possible or if they clearly communicated in writing that my request for cover was limited for the first two years I would have stayed with my current fund [named] where I already had cover for my pre-existing conditions in place. I would not have gone to the effort of clearly communicating in my application email that if [the insurer] their insurer will insure me I will roll into their fund as my current super funds insurer [the previous insurer] won't change my insurance based on my medical conditions with also ticking the [fund] application form that I had previously been declined/excluded from insurance cover for a medical condition/injury and provided 32 pages of detailed medical history with my application disclosing my pre-existing conditions for their insurer [the insurer] without not wanting these pre-existing conditions covered by [the insurer] from time of application.

The complainant says the trustee or the insurer should have been aware he was seeking immediate IP cover because:

- of what he wrote in his email to the trustee in which he attached his fund membership application,
- the fact he had included his pre-existing medical history in his application, and
- because of what was said during a phone conversation he had with a fund representative.

In his email (relevant parts of which are extracted above) the complainant made no mention of IP cover, or his desire for immediate cover. Rather, he said he attached his prior medical history because he believed the insurer's underwriter will 'want to determine if they will insure me for 250k fixed death and TPD based on my medical history/conditions'.

The trustee and insurer say that as the complainant was seeking $250,000 TPD cover, the insurer provided him that amount of TPD cover. It was able to do so without requiring his medical history. The $250,000 TPD cover provided by the insurer was higher than the TPD cover the complainant had with the previous insurer, which was $162,500.

I have listened to a recording of the phone conversation the complainant had with a fund representative on 23 July 2019. During that conversation they discuss when his cover would start, amongst other things. There was no discussion about IP cover or the complainant's desire for immediate cover for pre-existing health conditions during the phone conversation.

I am satisfied in the circumstances that neither the trustee nor the insurer knew the complainant was seeking immediate IP cover for his pre-existing health conditions, and it is not reasonable for the complainant to have expected them to have realised this.

2.4 Did the trustee or insurer mislead or deceive the complainant?

Neither the trustee nor the insurer misled or deceived the complainant about the IP cover.

The complainant says the trustee misled him into believing his cover included immediate cover for his pre-existing medical conditions. As he was covered for his pre-existing medical conditions under the insurance cover with the previous fund, he says he suffered a detriment by relying on the misrepresentations made by the trustee and insurer which led him to shift

his fund membership, resulting in him not being covered for pre-existing medical conditions for the first two years of cover.

The complainant says the trustee and insurer made representations in three ways

The trustee and insurer must not engage in conduct in relation to a financial product or service that is misleading or deceptive or is likely to mislead or deceive (see section 1041H Corporations Act, which is set out in section 3.3 below).

In considering whether the written representations are misleading or deceptive, AFCA considers the context and circumstances in which the representations were made.

The representations made by the insurer and trustee were in three contexts:

(i) in the application form, a product disclosure statement (PDS) dated 23 July 2019 and an *Insurance in your super* guide (the Insurance Guide) – (the written representations),

(ii) during a phone call between the complainant and a representative of the trustee, and

(iii) in allegedly being silent about the nature of his cover by not explicitly drawing his attention to the nature and effect of limited cover.

The trustee and insurer made written representations

Written representations were made about the IP cover. Relevant parts of the written representations appear in section 3.2 below.

When considering whether the representations about the IP cover made in the written representations were misleading or deceptive, AFCA considers:

- the impact the representations would have on a hypothetical reasonable fund member or potential fund member who considers the whole of the representations with an open mind (*ACCC v TPG* [2013] HCA 54 at [53], [77]), and
- whether the representations would likely lead that hypothetical member into error.

The complainant does not dispute the written representations were made available to him. In an email to the complainant, the trustee said:

> When completing the join application, you indicated you had read and understood the Product Disclosure Statement (PDS) and the 'Insurance in your super' guide before applying, which provides all the information regarding the type of insurance cover you received when you joined [the fund].

The trustee sent a letter to the complainant dated 10 August 2019 advising him the trustee had received an employer contribution and consequently the cover commenced on 25 July 2019. The trustee also advised the complainant in that letter:

> Cover may be limited. More information about your insurance cover, including the terms, conditions and costs that apply, is in our *Insurance in your super* guide. Download a copy of the guide for your division at [hyperlink]

The Insurance Guide refers on a number of pages to the fact that limited cover may apply regarding basic cover – which was what the complainant received. In each instance the Insurance Guide directs the reader to page 30 of the Guide, which provides details about

when limited cover applies. A screenshot of page 30 appears in section 3.2 below. Relevant parts of page 30 are as follows:

> **Limited cover**
>
> **What does limited cover mean?**
>
> Limited cover means that you won't be covered for any illness or injuries that you already had before you got your cover. Limited cover applies to all cover types, including Death. You will be covered for an illness that becomes apparent or an injury that occurs on or after the date that your cover starts, restarts or increases.
>
> **When will your cover be limited cover**
>
> …
>
> Your basic cover starts (or restarts) more than six months after starting employment with your [fund] employer…
>
> **How long will limited cover last**
>
> Limited cover will last for at least two years….

The complainant started his employment with the employer on 6 August 2012. Consequently, his basic cover provided by the insurer started more than six months after he started employment with the employer.

The complainant has not said that any of the written representations are inaccurate. He did not point to any misleading statements in the written representations. Indeed, the representations are true and accurate.

I am satisfied, taking into account the impact the representations would have on a hypothetical reasonable fund member or potential fund member who considers the whole of the representations with an open mind, the representations in the written representations are not misleading or deceptive. Consequently, they would not lead the hypothetical reasonable fund member or potential fund member into error.

The complainant was not misled during a phone call on 23 July 2019

The complainant says he phoned the trustee on 23 July 2019 about his application for insurance. He also says he was advised during the phone call by a representative of the trustee that his 'application for insurance was accepted and set up'. The complainant says he therefore:

> …believed in conjunction with [his] 12/07/2019 email with requesting cover that their underwriter [the insurer] had accepted my insurance application and I was also covered from this point in time for my pre existing conditions.

I have listened to a recording of the conversation. During the conversation the complainant asked whether his insurance had commenced. He was told his cover would start after the first employer contribution was received. Neither the representative nor the complainant discussed anything about whether or not his pre-existing medical conditions would be covered, nor about his medical information being referred to an underwriter.

In considering whether a conversation was misleading AFCA has regard to the broader context of the conversation (*Butcher v Lachlan Elder Realty Pty Limited* [2004] HCA 60 at [37]). This includes any other information the trustee or insurer provided a complainant about the insurance cover. Although the other information is not decisive, it does have some

significance in determining whether the phone conversation was misleading (*Butcher* at [39]).

I am satisfied, taking into account the broader context of the phone conversation – which included his receipt of the written representations and the availability to him of those representations – and the fact IP cover for pre-existing medical conditions was not discussed, no misleading or deceptive representations were made by the representative during the phone call.

The insurer and trustee did not mislead the complainant through their silence

The complainant says he believed when he made the application to join the fund he was asking it to 'underwrite/cover [him] for [his] pre existing conditions'. He says in effect the trustee or insurer should have realised he was seeking immediate cover for his pre-existing health conditions, and this was evident from:

- the email he sent in which he attached his application form,
- the fact he included his medical history with his application form, and
- the phone conversation of 23 July 2019.

He is saying in effect these factors raised a reasonable expectation on his part that the trustee or insurer would specifically alert him that he would not receive immediate cover for pre-existing medical conditions. He suggests their silence on this matter misled him into believing he would receive the cover.

The question is whether in the circumstances of this complainant a reasonable expectation arose which positively required the insurer or the trustee to inform the complainant (in addition to the written representations), either during the phone call, or by email or in some other way, that if he proceeded with his application to join the fund, he would not receive immediate cover for his pre-existing medical conditions.

A reasonable expectation might be created if, say, a trustee or insurer –

- concealed information from the complainant to gain some benefit or profit,
- kept him in the dark about something it knows would be useful for him to know, or
- led him to believe a statement was complete when it was not (see *Miller & Associates Insurance Broking Pty Ltd v BMW Australian Finance Ltd* [2010] HCA 31 at paragraph [21]).

In considering whether the trustee engaged in misleading or deceptive conduct through silence it is necessary to look at the circumstances as a whole. This requires, for instance, considering the representations the trustee made to the complainant in the written representations.

In the email the complainant sent with the application form attached he made no specific mention of his desire to be covered for his pre-existing medical conditions. He said in the email:

> …I am currently with [a] fund though there [sic] underwriter [named] won't increase my insurance to fixed based on medical conditions.
>
> I have attached my previous [insurance] application with medical documentation from that insurance refusal as I gather your underwriter [the insurer] will want to determine if they will insure me for 250k fixed death and TPD based on my medical history/conditions.

In the email he says his existing insurer will not *increase* his insurance based on his pre-existing medical conditions. He asks whether his cover can be increased to $250,000 for death and TPD. He makes no mention of IP cover. It appears the insurer and trustee

(reasonably) assumed the complainant was seeking to have his death and TPD cover increased to $250,000 from his then existing TPD cover, which was $162,500. The cover the insurer provided him was for the increased amount of $250,000. Under the terms of the group policy the insurer was able to provide him that amount of cover without the need to consider his pre-existing medical conditions.

As for the phone conversation, as mentioned, neither the complainant nor the trustee's representative mentioned the issue of immediate cover for his pre-existing medical conditions.

I am satisfied that neither the trustee nor the insurer kept the complainant in the dark about something it knew would be useful for him to know. I accept they were not aware he was, or might have been, seeking information about immediate cover for his pre-existing health conditions. This is particularly so as he did not raise the issue. The complainant was provided or had made available to him information about the nature of the IP cover, including that it was limited cover. The issue of whether he would be covered for pre-existing medical conditions was not raised during the phone call. His email to the trustee in which he included his fund membership application would not reasonably have alerted the trustee or insurer of anything about his desire to have immediate cover for his pre-existing medical conditions – in fact he said nothing about this in his email.

I am also satisfied neither the trustee nor the insurer concealed information from the complainant to gain some benefit or profit. I am also satisfied neither the insurer nor the trustee led him to believe a statement they made was complete when it was not.

I am therefore satisfied there were no circumstances that would have given rise to a reasonable expectation on the part of the complainant that the insurer or the trustee would specifically alert him to the fact he would not receive immediate IP cover for his pre-existing medical conditions.

2.5 Did the trustee appropriately deal with the insurance application?

The trustee appropriately dealt with the complainant's insurance application.

The complainant says the trustee breached its duty of care to him when it dealt with his insurance application, that it failed to follow its processes when dealing with the application, and the processes are inadequate. He says:

> [The trustee] has a duty of care to adequately service its members and potential new members and to respond to emails and be … clear in communications of members cover for their peace of mind which has not been the case in this matter
>
> …
>
> I also have concerns that [the trustee] do not have processes in place to respond to new member application emails which could also severely impact members like myself that are misled to believe they have adequate insurance cover in place.

The insurer says it:

> … maintains that it reviewed the Claim in accordance with the terms and conditions of the Policy and its decision to decline the Claim based on the Limited Cover provisions under the Policy was fair and reasonable in the circumstances.

AFCA's task is not to engage in ascertaining generally the rights of the parties, nor is it to engage in some form of judicial review of the decision of the trustee or insurer. Rather I am required to form a view as to whether the decision of either was (recognising the overriding framework given by the governing rules and policy terms, respectively) unfair or unreasonable (see *Retail Employees Superannuation Pty Ltd v Crocker; Colonial Mutual Life Assurance Society Ltd v Crocke*r [2001] FCA 1330 at [31] and *Mercer Superannuation (Australia) Limited v Billinghurst* [2016] FCA 1274 at [73]).

The trustee received the complainant's membership application and insurance request and dealt with it in a prompt manner. There is nothing to suggest it departed from its usual processes in dealing with the complainant's application. The insurer declined to pay an IP benefit because the complainant's disability occurred during the first two years of cover and related to a pre-existing medical condition. The complainant does not contest the fact his disability arises from a pre-existing condition within the first two years of cover.

2.6 Are the decisions of the trustee and the insurer fair and reasonable?

The decisions of the trustee and insurer are fair and reasonable in all the circumstances.

The decisions of the trustee and the insurer are fair and reasonable

The complainant says the statements he made in an email to the trustee about him considering joining the fund and taking insurance should have alerted the trustee to the fact he was seeking immediate IP cover for his pre-existing medical conditions. He says his disclosures about his pre-existing medical conditions should also have alerted the trustee, and possibly also the insurer, to the fact he was seeking immediate IP cover for pre-existing conditions. He also says the 23 July 2019 phone conversation ought to have alerted the trustee about this.

The email, however, referred to the amount of TPD and death cover he was seeking, and said nothing about immediate IP cover for pre-existing conditions. The phone conversation did not canvass this issue. The health disclosures and attachment of health records in his application did not alert either the trustee or insurer that he was seeking immediate IP cover.

The insurance information provided or made available to the complainant was not misleading or deceptive about the IP cover. Indeed, it stated in plain language that the insurance was 'limited cover', and this meant an insured would not receive IP cover for pre-existing medical conditions for the first two years of fund membership.

I am satisfied the fact the trustee and insurer did not specifically draw the complainant's attention to the fact he would be receiving limited cover if he joined the fund did not amount to misleading or deceptive conduct through silence.

I am also satisfied the trustee and insurer did not deal with his application or his IP claim in a way that was unfair or unreasonable in the circumstances.

On these bases the insurer's decision to decline the complainant's IP claim, and the trustee's agreement with the decision, are fair and reasonable in their operation in relation to the complainant in all the circumstances. The trustee's decision not to compromise the complainant's express or implied claim for losses he suffered by transferring his membership from the previous fund to the fund is fair and reasonable in all the circumstances.

AFCA cannot make a determination that would be contrary to the insurance policy

Under the Corporations Act 2001, AFCA must not make a determination that is contrary to the terms and conditions of a contract of insurance to which the complaint relates.

See section 3.3 of this determination.

AFCA therefore cannot make a determination that would require the trustee or the insurer to provide cover that is outside the terms of the insurance policy.

2.7 Determination

The determination affirms the decision of the insurer to decline to pay the IP benefit, and the decision of the trustee to agree with the insurer.

3 Supporting information

3.1 We assess available information and circumstances

AFCA is not a court of law. We do not have the power to take or test evidence on oath.

When we assess complaints, we consider:
- available documents
- the recollections of the parties
- all relevant circumstances.

We give more weight to documents created at the time the events occurred. If there are no relevant documents, we will decide what most likely occurred based on the available information.

If there are conflicting recollections and these are evenly weighted, we may find that there are no grounds to set aside the trustee's decision.

3.2 Supporting documents

Insurance policy – effective 1 July 2019

20.2 Limited Cover affecting default cover

20.2.3 If a person's *default cover* commences on or after the *changeover date*, …then unless you and we agree otherwise in writing, that default cover will be limited cover until:

(a) It has been in force in respect of them for a period of 24 calendar months; and

(b) If the person is not in *active employment* on the day after the end of the period described in condition 20.2.3(a), the first date after that on which they have been in *active employment* for two consecutive *calendar months*,

and full cover will commence on the following day.

…

25 GENERAL DEFINITIONS

24.1 General definitions (sic)

25.1.1 The following words or expressions have the meanings set out below where they appear in the policy:

…

changeover date **-** means the commencement of 1 July 2019.

…

default cover - unless varied by a provision in Appendix D, means:

(a) for a member of the Industry Division, …, age-based cover with a:

(i) 60 day waiting period;

(ii) a two year benefit period; and

(iii) a Standard occupation grouping, …

…

limited Cover means the insured member is only covered for claims arising from:

A) An illness which first became apparent; or

B) An injury which first occurred,

on or after the date the insured cover last commenced, recommenced or increased for the insured member as applicable.

…

Product Disclosure Statement effective 1 June 2019

…**Insurance in your super**

When you join us, you automatically receive basic age-based cover (age limits and other conditions apply). If you're eligible, this cover gives you a basic level of protection if you die, or become ill or injured:

…

Read important information about our insurance before making a decision. The *Insurance in your super* guide for your division at [hyperlink] includes terms and conditions about insurance, including costs, your eligibility for cover, how much you can apply for, what you're covered for, when it starts and stops, limited cover and exclusions, and your insurance options.

…

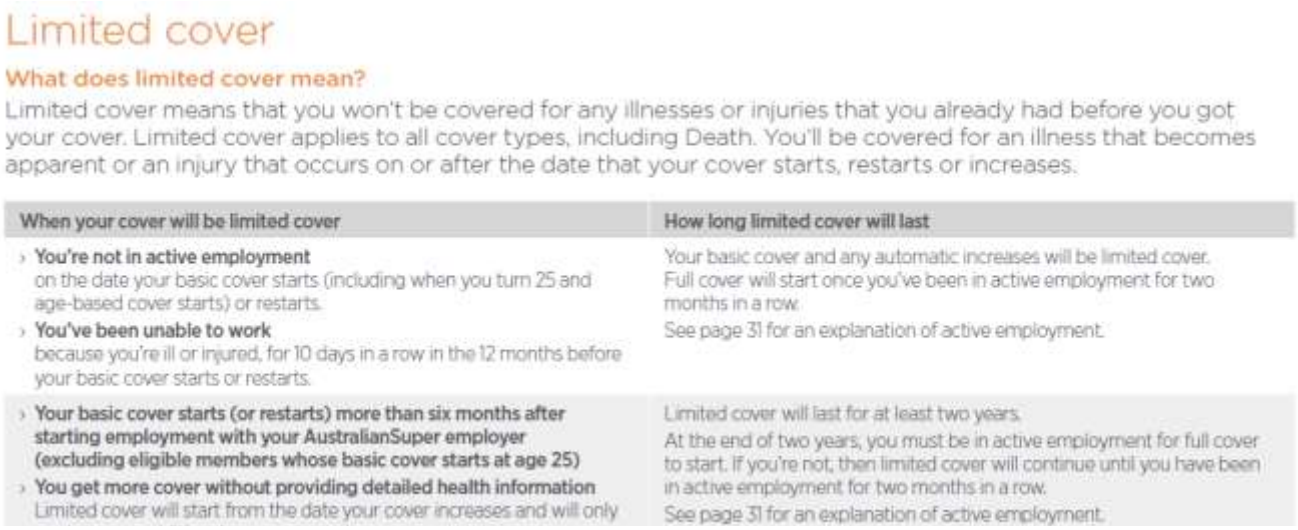
Insurance guide – effective 1 June 2019

Basic cover

When you join the [fund] plan you automatically get age-based Income Protection, TPD and Death cover and you don't need to provide any health information (age limits and other conditions apply).

Age-based cover is designed to provide minimum levels of cover for changing needs as you get older. So the amount of cover you get will change as you get older and the cost generally increases*. Your cover may be limited cover (see page 30 for details).

Page 30 of the Insurance Guide



Limited cover

What does limited cover mean?

Limited cover means that you won't be covered for any illnesses or injuries that you already had before you got your cover. Limited cover applies to all cover types, including Death. You'll be covered for an illness that becomes apparent or an injury that occurs on or after the date that your cover starts, restarts or increases.

When your cover will be limited cover	How long limited cover will last
› **You're not in active employment** on the date your basic cover starts (including when you turn 25 and age-based cover starts) or restarts. › **You've been unable to work** because you're ill or injured, for 10 days in a row in the 12 months before your basic cover starts or restarts.	Your basic cover and any automatic increases will be limited cover. Full cover will start once you've been in active employment for two months in a row. See page 31 for an explanation of active employment.
› **Your basic cover starts (or restarts) more than six months after starting employment with your AustralianSuper employer (excluding eligible members whose basic cover starts at age 25)** › **You get more cover without providing detailed health information** Limited cover will start from the date your cover increases and will only	Limited cover will last for at least two years. At the end of two years, you must be in active employment for full cover to start. If you're not, then limited cover will continue until you have been in active employment for two months in a row. See page 31 for an explanation of active employment.

Trust deed – effective 2 January 2013

4. Management of the Fund and powers of the Trustee

4.2 Subject to the Relevant Requirements, the Trustee has the complete management and control of all proceedings, matters and things in connection with the Fund and, without derogating from any other provision of this Deed, may do all acts and things which it considers necessary, desirable or expedient for the proper application, administration, maintenance and preservation of the Fund or any part of the Fund.

…

4.4 Without limiting the generality of Rule 4.2, and in addition to any other powers conferred on the Trustee by this Deed, the Trustee shall have the following specific powers:

…

> (11) To settle, compromise or submit to arbitration or to a court of law, any doubts, disputes, claims, controversies or difficulties whatsoever arising out of or relating to this Deed or the construction of any provision in this Deed, the Fund or the rights of Members and Beneficiaries and to act on the award or determination of the arbitrator or court or, (where a Member submits a dispute to the Superannuation Complaints Tribunal) on a determination of the Superannuation Complaints Tribunal; …

3.3 Relevant law

Corporations Act 2001

Section 1041H - Misleading or deceptive conduct (civil liability only)

(1) A person must not, in this jurisdiction, engage in conduct, in relation to a financial product or a financial service, that is misleading or deceptive or is likely to mislead or deceive.

…

(2) The reference in subsection (1) to engaging in conduct in relation to a financial product includes (but is not limited to) any of the following:

> (a) dealing in a financial product;

(b) without limiting paragraph (a):

…

(vi) a trustee of a superannuation entity (within the meaning of the *Superannuation Industry (Supervision) Act 1993*) dealing with a beneficiary of that entity as such a beneficiary;

Section 764A – Specific things that are financial products (subject to Subdivision D)

(1) Subject to Subdivision D, the following are ***financial products*** for the purposes of this Chapter:

…

(d) a contract of insurance that is not a life policy, or a sinking fund policy, within the meaning of the *Life Insurance Act 1995*,…

(e) a life policy, or a sinking fund policy, within the meaning of the *Life Insurance Act 1995*, that is a contract of insurance,…

…

(g) a superannuation interest within the meaning of the Superannuation Industry (Supervision) Act 1993;

Section 1055(7) – Limitations on determinations

AFCA must not make a determination of a superannuation complaint that would be contrary to:

…

(c) subject to paragraph (6)(d), the terms and conditions of an annuity policy, contract of insurance or RSA to which the complaint relates.

Superannuation Industry (Supervision) Act 1993

10 Definitions

(1) In this Act, unless the contrary intention appears:

…

beneficiary, in relation to a fund, scheme or trust, means a person (whether described in the governing rules as a member, a depositor or otherwise) who has a beneficial interest in the fund, scheme or trust and includes, in relation to a superannuation fund, a member of the fund despite the express references in this Act to members of such funds.

…

superannuation interest means a beneficial interest in a superannuation entity.

3.4 Table of events

Date	Event
27 December 1976	Complainant's date of birth

Date	Event
6 August 2012	complainant commences employment with the employer
1 July 2019	the 'changeover day' under the group policy
5 July 2019	complainant became a member of the Industry division of the fund via a "New member offer".
12 July 2019	complainant submits a membership application form to the trustee to join the fund
25 July 2019	insurance cover starts
8 August 2019	trustee receives complainant's first employer super contribution from the employer
27 November 2020	complainant is unable to work because of his disability
4 January 2021	insurer received notification of the Complainant's IP claim
12 January 2021	insurer received the IP claim forms
21 January 2021	complainant makes IP claim. In the Initial Medical Attendant's Statement dated 21 January 2021 a medical practitioner indicated the Complainant was claiming IP benefits for Major Depressive Disorder with anxiety
22 April 2021	insurer issued Procedural Fairness to the Complainant, on the basis that the Claimed Condition was pre-existing to the cover commencement date, and so did not meet the Limited Cover provisions under the Policy. On the same date, insurer received correspondence from the Complainant requesting that the decision on the Claim be finalised
27 April 2021	insurer communicated its final decision to the Trustee, stating that the Complainant was ineligible to make the Claim for the Claimed Condition due to the Limited Cover provisions