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Life Insurance Bulletin: Autumn Edition

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Note from the Editor

Welcome to our first edition of the Life Insurance Bulletin for 2022.

There has certainly been a lot of activity since our last issue, with the FCA handing down some highly anticipated decisions in the life insurance space.

AFCA continues to loom large on the life insurance landscape with the FCA affirming its broad jurisdiction to deal with superannuation complaints. We break down the ins and outs of the reasoning behind this decision which has confirmed AFCA's role as a '*one stop shop*' for complaints of this nature.

The importance of clear communication with customers and early breach reporting remains in the spotlight as we take a look at the issue of misleading and deceptive conduct from the perspective of the recent FCA decision in *Statewide* as well as a determination by AFCA. Whilst the two had very different outcomes, each is a timely reminder of the need for Trustees and Insurers to keep a close eye on group and individual insurance arrangements to ensure that customers have accurate information about their cover and premiums.

In other news, the FSC Standard No. 27 has commenced its 12 month transition period before it officially comes into effect on 1 January next year. No doubt already on the radar for those in group life insurance, we discuss the purpose, scope and potential ramifications of the Standard for Trustees and Insurers going forward.

We also analyse a recent AFCA determination on up to date trauma definitions, a topic which remains very much in focus.

A big thank you to our wonderful Turks life experts who have contributed to this edition of the Bulletin – please reach out with any questions and we hope you enjoy the read.

Sandra Nicola

LIFE AND SUPERANNUATION CASES

FCA affirms AFCA's broad jurisdiction to deal with superannuation complaints

MetLife Insurance Limited v Australian Financial Complaints Authority **(FCA 2022)**

Link to decision

Key Takeaways

AFCA's jurisdiction to deal with complaints related to superannuation is not limited to those specifically listed at s1053(1)(a)-(j) of the *Corporations Act* 2001 (Cth) (**the Act**). The Court confirmed that certain complaints related to superannuation - such as an out of time complaint by a fund member against an insurer of a superannuation fund - can be dealt with under the general jurisdiction.

In the factual circumstances of this matter, there was an agreement between the AFCA member (**the Insurer**) and the legal entities of the Financial Ombudsman Service (**FOS**) and AFCA that AFCA would take over the active FOS complaint.

The question of whether AFCA should undertake an active role in court proceedings (as it did here) having regard to its status as an independent decision maker remains open pending further submissions as to costs.

Brief Facts

Mr Edgecombe was the member of a superannuation fund through which he was insured for disability benefits under two policies of insurance. He had made claims under both polices which were declined.

He had an active complaint before FOS in respect of one of the policies (**the 2017 complaint**) at the date AFCA commenced operating. AFCA took over that complaint once its operations commenced.

Mr Edgecombe then lodged a further complaint with AFCA about the decision of the Insurer, in respect of the second policy (**the 2018 complaint**).

Over the objections of the Insurer, by reference to its Operational Guidelines and Rule B.4.3.1, AFCA accepted the 2018 complaint, notwithstanding that it was out of time under the AFCA Rules governing a superannuation complaint. AFCA went on to find for Mr Edgecombe in respect of both complaints.

The Insurer challenged AFCA's authority to determine the complaints and accordingly sought declarations in the FCA that it was not bound by the AFCA determinations in respect of either complaint.

Judgment

The Insurer's position was that, in respect of the 2018 complaint, AFCA's jurisdiction in respect of complaints related to superannuation derived from s1053(1) of the Act, and was therefore limited to the categories of complaints listed in paragraphs (a) to (j) of s1053(1). It followed that if a complaint relating to superannuation did not fall within one of those subparagraphs, AFCA had no jurisdiction to hear it.

It was agreed by the parties that as Mr Edgecombe's complaint was made only against the Insurer, it did not fall within one of those subparagraphs.

AFCA's position was that s1053(1) operated to identify those complaints related to superannuation to which the additional burdens and benefits of the Division, commensurate with those of the Superannuation Claims Tribunal, would apply (i.e. '*superannuation complaints*') and not to identify a class of complaints over which its jurisdiction was restricted.

In dispute was the interpretation of the following part of s1053(1) of the Act:

1. A person may, subject to s1056, make a complaint relating to superannuation under the AFCA scheme only if the complaint is a complaint:

    (a)...

    ...

    (j)...

It fell to the Court to interpret what was meant by the section and more specifically what was meant by the term '*complaint relating to*'.

The principles of statutory interpretation were not in issue. Chappell as executor of the estate of *Hitchcock v Goldspan Investments Pty Ltd* (WASCA 2021) was quoted with approval:

> *'The focus of statutory construction is upon the test of the provisions having regard to their context and purpose'.... The context includes the existing state of the law, the history of the legislative scheme and the mischief to which the statute is directed.....The purpose of legislation must be derived from the statutory text and not from any assumption about the desired*

or desirable reach or operation of the relevant provisions... The intended reach of a legislative provision is to be discerned from the words of the provision and not by making an a prior assumption about its purpose...'

And further in *SZTAL v Minister for Immigration and Border Protection* (HCA 2017):

'Considerations of context and purpose simply recognise that, understood in its statutory, historical and other context, some other meaning of a word may be suggested, and so too, if its ordinary meaning is not consistent with the statutory purpose that meaning must be rejected.'

The context and purpose of s1053(1) included, as recommended by the Ramsey Report, the creation of the '*one stop shop*' for financial services complaints. Prior to AFCA, financial industry complaints could, depending upon the circumstances, be dealt with by three different external dispute resolution bodies, the Credit & Investment Ombudsman, FOS and the SCT.

The *Treasury Laws Amendment (Putting Consumers First Establishment of the Australian Financial Complaints Authority) Act* 2018 provided for changes to the Act with a view to creating that '*one stop shop*'. At the same time maintaining the essential differences between the SCT and the Ombudsman services, including the distinctive nature of its complaints process for handling superannuation complaints. For example: unlimited monetary jurisdiction, the power to join third parties such as the insurer, determinations to give effect to the legal rights of the parties, having the powers, obligations and discretions conferred on an insurer in making determinations, reference of legal questions to the FCA for determination, and the right to seek a review of its determinations in the FCA.

His Honour found that the:

'Provisions in Division 3 of the Corporations Act that were introduced by the AFCA Establishment Act were directed to establishing a one stop shop rather than changing the types of determinations that could be previously be made by the Tribunal and the Ombudsman Service respectively... Therefore the context supports a construction which continues the availability of the kinds of determinations that would be made under the previous regime rather than a construction which identifies a category of complaints that could no longer be brought before external dispute resolution.

It follows that, having regard to the context, the construction advanced by AFCA is to be preferred. The phrase ' a complaint relating to superannuation under the AFCA scheme ' means a complaint that relates to superannuation in the sense that it seeks to invoke the particular statutory authority conferred by Division 3.'

Although the case turned on the above construction issue there were a number of alternative arguments put to and considered by the Court.

AFCA submitted that in any event, there was an ad hoc agreement between the parties by which AFCA was to determine the 2018 complaint outside the AFCA Scheme. Whilst his Honour accepted that AFCA had the power to enter into such an ad hoc agreement, he found no evidence that this was the case as all the dealings of the parties were undertaken on the basis that they were giving effect to the AFCA Rules under the AFCA Scheme. He found therefore that AFCA acquired (and indeed, required) no further authority than that conferred by the AFCA Scheme in dealing with the 2018 complaint.

Provisions in Division 3 of the Corporations Act that were introduced by the AFCA Establishment Act were directed to establishing a one stop shop rather than changing the types of determinations that could be previously be made by the Tribunal and the Ombudsman Service respectively... Therefore the context supports a construction which continues the availability of the kinds of determinations that would be made under the previous regime rather than a construction which identifies a category of complaints that could no longer be brought before external dispute resolution.

In respect of the 2017 complaint, the parties agreed that this was properly brought before FOS. The issue was whether AFCA, rather than FOS, could determine the claim on the basis that there was a novation of the agreement between FOS and the Insurer (to allow AFCA to deal with the 2017 complaint). His Honour found that novation had been established on the evidence. He did so based on the presence of an agreed process for submitting complaints for determination under the AFCA scheme, as well as the fact that the Insurer was required to have such a process in place in order to meet its statutory requirements.

Given his findings on the issue of novation, his Honour did not need to determine whether there was in place an ad hoc agreement between the parties by which AFCA was to determine the 2017 complaint. Nevertheless, his Honour noted that if such an argument were in play, it would face the same evidentiary difficulties as that presented in respect of the 2018 complaint.

The final issue of interest raised by the Insurer was whether it was appropriate for AFCA to undertake such an active role in the proceedings, having regard to its status as the independent decision maker under the AFCA scheme.

It is well established that, where court proceedings are brought that arise out of tribunal proceedings, there are limits to the role that the tribunal may appropriately take in those proceedings. In *R v Australian Broadcasting Tribunal; Ex parte Hardiman* (HCA 1980) the HCA held that:

> *'A tribunal or statutory decision maker entrusted with the responsibility of making an independent decision to determine a dispute between parties should confine its role in the proceedings to the making of submissions addressing the powers and procedures of the tribunal or decision maker.'*

In this case, his Honour noted that the *Hardiman* principle is not limited to administrative decisions, and raised the possibility that it may also apply to decisions of independent statutory decision makers giving effect to the requirements of a statutory scheme. Having said that however, he ultimately deferred further consideration of this issue pending further submissions on costs, which it was said to impact.

Implications

The decision affirms AFCA's position expressed in its Operational Guidelines and Rules B 4.3.1 and E.1. That is, AFCA has jurisdiction to deal with a complaint about an insurer's decision under a group policy held by a trustee as follows:

- if the complaint is lodged within time – it will be dealt with as a superannuation complaint by joining the insurer to a complaint against a trustee; and
- if the complaint is lodged out of time – it will be dealt with as a non-superannuation complaint against the insurer.

It remains to be seen how this judgment may impact when and where superannuation complaints are lodged.

LIFE AND SUPERANNUATION CASES

FCA imposes penalty on trustee for misleading conduct towards fund members

***Australian Securities and Investments Commission v Statewide Superannuation Pty Ltd* (FCA 2021)**

Link to decision

Key Takeaways

The FCA ordered Statewide Superannuation Pty Ltd (**Statewide**) to pay $4 million in penalties for providing misleading communications to members regarding their group life insurance cover, charging premiums for lapsed cover, and failing to report these breaches to ASIC within the statutory timeframe.

Statewide's conduct resulted from system administration errors and was not deliberate.

Brief Facts

The events in question occurred between May 2017 and June 2020. During this period, the group insurance policies held by Statewide on behalf of its members provided that cover for a member would cease on the earliest of various events, including on the date there was insufficient funds in the member's account to cover premium payments or when the member's account balance fell below a certain level.

Statewide started using a new administration system in May 2017, which recorded member data, including insurance status. It also auto-generated correspondence to members and charged premiums and administration fees.

During the relevant period, the insurance cover of many fund members ceased due to the operation of the cover ceasing provisions with respect to nil or low account balances. The administration system however did not record this accurately, instead generating correspondence to members indicating that they had insurance cover when in fact they did not and in some cases, deducting premiums from member accounts for cover that had already lapsed.

The issue impacted several thousand Statewide members and was self-reported by Statewide to ASIC, although outside of the timeframe of 10 business days specified in the *Corporations Act* breach reporting regime as it then was.

Judgment

ASIC's case before the FCA was that Statewide, in sending the misleading communications to members and mistakenly deducting premiums for lapsed cover, had made false and misleading representations to members, or representations which were likely to mislead or deceive. The specific issues of concern to ASIC were as follows:

- misrepresenting to impacted members that they had insurance cover when they did not;
- misrepresenting members' obligations to pay insurance premiums; and
- misrepresenting a right to deduct premiums from member accounts.

In ASIC's view, this situation was troubling because it created a real risk that Fund members may have found themselves without insurance when they needed it.[1]

ASIC further alleged that once Statewide became aware of the breach, it did not report it to ASIC within 10 business days as required by the *Corporations Act*.

In handing down its decision, the Court explicitly noted that Statewide's conduct in incorrectly deducting insurance premiums and representing to members that they had cover when they did not, was not deliberate nor was it motivated by profit. Further, the Court found that Statewide's failure to report the breach to ASIC in a timely fashion was not deliberate, and that at all times Statewide cooperated with ASIC's investigation and with the Court process.

Be that as it may, Besanko J ultimately held that:

> 'The contraventions of s12DB(1)(g) and (i) of the ASIC Act are serious. They affected a large number of members of the Fund and remediation for those members is an ongoing process. The cause of the contravening conduct was an inadequate implementation of the change to the Acurity administration system and then the failure to address adequately and in a timely fashion the problems and errors resulting from that implementation….'

In so finding, the Court ordered that Statewide pay a pecuniary penalty to the Commonwealth amounting to $4 million. This penalty was apportioned as follows:

- $3.5 million on account of the misleading correspondence to members; and
- $500,000 on account of the failure to report the breach to ASIC within the time prescribed by the *Corporations Act*.

The contraventions of s12DB(1)(g) and (i) of the ASIC Act are serious. They affected a large number of members of the Fund and remediation for those members is an ongoing process. The cause of the contravening conduct was an inadequate implementation of the change to the Acurity administration system and then the failure to address adequately and in a timely fashion the problems and errors resulting from that implementation....

Implications

The deduction of premiums and the issue of when cover starts and stops for members in group insurance can be complex due to the sheer volume of insured members and the difficulties faced by trustees in keeping up with individual members' circumstances *vis a vis* cover.

However, this case demonstrates that ASIC is prepared to use enforcement action and seek penalties against superannuation trustees concerning their management of group life insurance, notwithstanding the commencement of appropriate remediation. Accordingly, it is critical that trustees continue to closely monitor their group insurance arrangements to ensure accurate reporting to their members regarding their insurance coverage and the proper deduction of premiums in line with such cover.

The decision also highlights the importance of early breach reporting where required, for which there is likely to be enhanced focus under the new breach reporting regime.

[1] ASIC Media Release '22-001MR Statewide Superannuation to pay $4 million penalty for misleading correspondence to members' dated 18 January 2022.

PRODUCT / REGULATORY

FSC to ban exclusions and restrictive definitions based on occupational classifications

Key Takeaways

In December 2021, the FSC unveiled its enforceable Standard No. 27 (**the Standard**) which requires the removal of exclusions and restrictive disability definitions based on occupation in the design of default cover within group life policies in superannuation.

The Standard will apply to all FSC member trustees and life insurers offering default group life insurance in super. A 12 month transition period applies before the changes come into effect on 1 January 2023.

Background

After stakeholder consultation last year, the FSC Standard is the industry's response to the unintended consequences to default insurance arrangements caused by the *Treasury Laws Amendment (Your Future, Your Super) Act* 2021. Those reforms, which commenced on 1 November 2021, importantly '*staple*' a member to their existing superannuation product so as to prevent the duplication of super accounts and erosion of super with unnecessary fees. However, the consequence is that disengaged members in high risk occupations or members moving to work in higher risk industries may end up '*stapled*' to a Fund with insurance that does not appropriately suit their cover needs.

By introducing the Standard, the FSC hopes to ensure that customers who have default cover in superannuation who would otherwise be able to claim are not prevented from making a valid claim due to the nature of their occupation.

Scope of the FSC Standard

Relevantly, the Standard will:

- be binding on both FSC trustees and life insurers from 1 January 2023;
- apply to default life cover, terminal illness, TPD and IP cover under superannuation group life policies; and
- prohibit the use of exclusions and restrictive disability definitions (being terms which prevent claims under certain definitions of disability) '*due to one or more of the insured member's current or previous occupational duties*'.

'*Occupational duties*' is defined as '*the duties or responsibilities of an insured member's occupation*' and expressly excludes employment status or the hours worked by the insured member.

The change is clearly aimed at protecting members with default cover in high risk and other occupational categories to whom more restrictive definitions have traditionally applied. It does this by removing the use of occupational exclusions and occupation based restrictive disability definitions from default cover.

The initiative aligns broadly with Option 4 of Treasury's review of occupational classifications, but also expands the prohibition by applying to all default group insurance cover including default IP cover. It also applies to members who change occupations, even if they remain with the same employer and are not impacted by '*stapling*'.

> *The change is clearly aimed at protecting members with default cover in high risk and other occupational categories to whom more restrictive definitions have traditionally applied. It does this by removing the use of occupational exclusions and occupation based restrictive disability definitions from default cover.*

That said, the FSC recognises that there are circumstances where occupational exclusions and restrictive disability definitions can continue to apply. For example, the Standard:

- will not preclude FSC insurers from providing default cover with occupational exclusions or occupational based restrictive definitions in a group policy if a non FSC trustee requests them and considers them to be in the best interests of insured members;
- will not prevent trustees from requesting and using a member's occupation to determine whether or not to offer default cover to a fund member;
- will not apply to additional underwritten cover (that is, cover not provided on a default basis);
- will not apply to individuals who are employed in the armed forces as they are typically covered by government-funded schemes outside of life insurance;
- will not apply to non-occupational based exclusions.

Importantly, the Standard only creates obligations between the entities bound by it and the FSC. It does not create rights for any other parties (clause 3.4) and none of the provisions of the Standard can apply to court or tribunal proceedings (clause 3.6).

Implications

The introduction of the Standard will require FSC group life insurers and superannuation trustees to look closely at group insurance arrangements providing default cover for fund members. No doubt many have already launched this process.

Whilst the FSC encourages non FSC trustees to follow the Standard, it recognises that a non FSC trustee may elect to carve out certain occupations where such terms are in the best interests of its members. In those circumstances, the FSC does not prohibit FSC insurers from departing from the Standard.

The FSC also recognises that unaffordable cover remains out of scope as there remains the option of not offering default insurance to certain members due to their occupation. These members will have no default cover but will also not pay for premiums.

FSC insurers and trustees should be prepared to justify any departure from the Standard. Good data collection and retention will therefore be more important than ever in assisting insurers and trustees in this process.

LIFE AND SUPERANNUATION CASES

AFCA finds no misleading or deceptive conduct by insurer and trustee in issuing group life cover with '*Limited Cover*'

Link to determination

Key Takeaways

This decision illustrates the approach taken by AFCA to a recent complaint involving allegations of misleading or deceptive conduct against an Insurer and Trustee in the context of group life insurance.

AFCA concluded that the Trustee and Insurer had not engaged in misleading or deceptive conduct in its communications with the Complainant regarding his default cover under a group life policy which was restricted to Limited Cover.

Brief Facts

After having previously been rejected by another Insurer and Fund for additional underwritten cover due to the disclosure of a number of medical conditions, the Complainant applied to the Trustee for default Death, TPD and IP cover under the Fund's group cover. The Complainant provided his medical information to the Trustee and stated '*I gather your underwriter will want to determine if they will insure me for … fixed death and TPD based on my medical history/conditions.*'

The Trustee advised the Complainant that cover had been issued under the policy with fixed Death, TPD and IP insurance effective from 12 July 2019 and the Complainant was provided with a link to further details regarding his cover.

The Complainant then moved his superannuation account (and cover) from his previous Fund to this Fund.

The cover applied for and obtained by the Complainant with the Trustee was Default cover, and was restricted to '*Limited Cover*' for the first two years. Under the terms of the relevant policy, this meant that the Complainant was not covered for claims arising from any pre-existing health conditions for two years from the date cover commenced.

Within the first two years of cover, the Complainant suffered a disability which arose from a pre-existing medical condition. He lodged a claim for IP benefits, which was declined on the basis of the Limited Cover provisions of the policy.

The Complainant alleged that he was unaware that his cover did not extend to claims arising from any pre-existing condition. He further claimed that the Trustee and Insurer should have been aware that when he applied for cover, he was in fact seeking full cover, including cover for any pre-existing medical conditions. This was because he had sent an email to the Trustee disclosing all of his medical conditions at the time he sought cover.

The Complainant argued that by failing to inform him that his cover was restricted to Limited Cover, the Trustee and the Insurer had misled him. He claimed he had suffered loss because he would have maintained his previous cover had he known that the new cover excluded claims arising from any pre-existing conditions.

The Complainant lodged a complaint with AFCA seeking payment of his benefits under the policy.

Determination

AFCA found that the Trustee and the Insurer had not engaged in misleading or deceptive conduct, either through any of the communications sent to the Complainant or through the absence of communication.

AFCA concluded that the Trustee and Insurer could not reasonably have known that the Complainant was seeking full cover immediately, including cover for his pre-existing health conditions. The mere fact that the Complainant had disclosed these conditions at the time he applied for cover was not sufficient to establish that the Trustee or Insurer should have been aware of his claimed intentions with respect to full cover.

Relevantly, AFCA noted that at the time cover was accepted, the Complainant was provided with accurate information about his cover. This included a hyperlink with details about the Limited Cover provisions in the policy.

When considering the effect of the representations made to the Complainant regarding his cover, AFCA found that a reasonable Fund member who had considered the entirety of the communications with an open mind would not have been misled.

> *AFCA found that the Trustee and the Insurer had not engaged in misleading or deceptive conduct, either through any of the communications sent to the Complainant or through the absence of communication.*

Based on the finding that the Trustee and Insurer could not have known that the Complainant wanted full cover immediately, AFCA was also satisfied that they did not mislead the Complainant by silence or deliberately keep him in the dark about the terms of his cover.

Finally, whilst AFCA noted that the Trustee and Insurer did not specifically draw the Complainant's attention to the Limited Cover provisions in the policy, it was satisfied that this was fair and reasonable in the circumstances.

Implications

AFCA has affirmed that in circumstances such as this, it remains incumbent on a Fund member and insured person to review and consider all the information provided to them via correspondence, including additional policy and coverage details provided through a hyperlink.

In order to avoid any allegation of misleading or deceptive conduct however, Insurers and Trustees must ensure that all relevant information regarding policy terms and coverage is provided to insured members and is clearly expressed, accurate and easily accessible.

AFCA confirms the continued importance of up to date medical definitions in trauma policies

Link to determination

Key Takeaways

AFCA upholds a complaint against an Insurer who relied on an outdated medical definition to reject a trauma claim.

In doing so, AFCA has reinforced that good industry practice requires Insurers to continue to assess trauma claims against medical definitions that reflect current medical practice.

Brief Facts

The Complainant held trauma cover with the Insurer.

The original policy stated that a benefit is paid where the insured is diagnosed with one of a number of conditions, including cancer. The policy excluded '*all tumours which are historically described as pre-malignant or showing the malignant changes of 'carcinoma in situ'*...'(a type of breast cancer).

In 2011, the policy was upgraded. The above exclusion remained, however the Complainant's cover was extended to include '*carcinoma in situ*' if it resulted directly in the removal of the entire breast where such procedure is specifically performed to arrest the spread of malignancy and considered the appropriate and necessary treatment.

In 2019, the Insurer issued a new policy with upgrades that did not apply to the Complainant's cover. The 2019 policy definition paid a full benefit for carcinoma in situ of the breast if an insured had breast conserving surgery and adjuvant therapy (such as radiotherapy) to specifically address the spread of malignance where it is considered appropriate and necessary treatment.

In 2020, the Complainant had surgery for ductal carcinoma in situ and in 2021 she underwent radiotherapy. Removal of the breast was not required as part of her treatment.

Following treatment, the Complainant made a claim on her trauma policy. The Insurer rejected the claim on the basis that her policy (which contained the 2011 cancer definition), specifically excluded the type of cancer suffered by the Complainant – that is, carcinoma in situ which did not result in the removal of the entire breast. The Complainant argued that the claim should be paid because under the upgraded terms of the Insurer's 2019 policy, a benefit would have been paid for her condition.

The Complainant lodged a complaint with AFCA seeking payment of the trauma benefit.

Determination

AFCA found that the medical definition relied on by the Insurer in making the decision to decline the claim was outdated. In addition, AFCA found that relying on a definition based on outdated medical practice was not consistent with good industry practice nor did it meet a customer's reasonable expectations.

Not surprisingly, AFCA drew comparisons between the facts of this complaint and the Royal Commission's examination of outdated heart attack definitions which lead to the introduction of clause 3.2 of the LICOP (which requires that medical definitions be updated where necessary to ensure that they remain current).

In reaching its decision, AFCA noted that a distinction should be drawn between different types of policy upgrades. It observed that there is a difference between on the one hand, an upgrade which provides an insured with a greater benefit or broader scope of cover and on the other hand, an upgrade which simply replaces an outdated medical definition.

AFCA stated that whilst an Insurer is not required to pass on to an insured the benefits of policy upgrades which provide greater benefits or broader cover (unless the terms of the policy require it), an Insurer is required to apply an upgrade which replaces outdated medical definitions. That is because, according to AFCA, an upgrade of that nature simply brings an insured's existing cover into line with current accepted medical definitions and practices. In other words, it does not change the level or scope of the existing cover but rather, is intended to maintain the existing cover.

AFCA found that the medical definition relied on by the Insurer in making the decision to decline the claim was outdated. In addition, AFCA found that relying on a definition based on outdated medical practice was not consistent with good industry practice nor did it meet a customer's reasonable expectations.

For these reasons, AFCA determined that the Insurer should have applied the 2019 policy definition upgrade to the Complainant's policy in order to maintain her level of cover. Had it done so, the Complainant would have been entitled to payment of the full trauma benefit under the policy.

The Insurer was ordered to pay the full trauma benefit plus interest calculated in accordance with s57 of the *Insurance Contracts Act*.

Implications

Based on one of the major findings of the Royal Commission, AFCA continues to hold Insurers to account for relying on outdated medical definitions in trauma policies.

The determination highlights the continued importance of assessing trauma claims against updated medical definitions in order to bring an insured's cover in line with current medical practice and treatment.

AFCA has again shown that it will have no hesitation in finding that a more up to date medical definition applies to a claim, notwithstanding that the definition may not be part of an insured's cover.

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