METLIFE SUBMISSION TO ROYAL COMMISSION INTO THE BANKING, SUPERANNUATION AND FINANCIAL SERVICES INDUSTRY

About MetLife

Our Profile

MetLife Insurance Limited is an entity regulated by the Australian Prudential Regulatory Authority (**APRA**) that carries on life insurance business within the meaning of the *Life Insurance Act 1995*. It also holds an Australian financial services licence issued in accordance with the *Corporations Act 2001* by the Australian Securities and Investments Commission (**ASIC**).

MetLife first entered the Australian life insurance market in 2005 through the acquisition of Citigroup's life insurance business. We are the 10th largest life insurance provider in Australia[1] with headquarters in New South Wales and an office in Victoria. MetLife employs over 300 highly skilled professionals.

MetLife General Insurance Limited (**MGIL**) is a general insurance entity authorised under the Insurance Act 1973. It is has been in run-off since 2000, which means that it is closed to new business and does not offer new insurance policies.

MetLife and MGIL are ultimately owned by MetLife, Inc., which is listed on the New York Stock Exchange. MetLife, Inc., through its subsidiaries and affiliates, is one of the world's leading financial services companies. Founded in 1868, MetLife, Inc. has operations in more than 40 countries and holds leading market positions in the United States, Japan, Latin America, Asia, Europe and the Middle East.

Our Services and Products

MetLife's primary business in Australia is group insurance. We are the third largest provider of group insurance in the Australian market[2]. We provide the default life insurance coverage members receive through their superannuation funds, or act as an insurer for corporates that provide their employees with protection such as salary continuance insurance.

We are proud of our ability to support Australians whose lives are disrupted by death or disability and our success in this area speaks for itself. Last year, we disbursed approximately $485 million in claims and provided protection to approximately 2.6 million Australians.

Over the last five years, we paid over 95% of all the claims we finalised for Group Insurance, our main line of business.

Our business also includes a small amount of direct life insurance which is sold direct to consumer rather than through a financial adviser, and a small legacy closed book of retail life insurance issued via financial advisers.

[1] Strategic Insight, June 2017
[2] Strategic Insight, June 2017

Our Strategy

At MetLife, our purpose is to ignite the human instinct to protect what matters and provide hope for the future. Our vision is to lead the market by providing the fastest, easiest and most caring life insurance experience. To bring our vision to life, in 2014, we developed a three year strategy and over the past three years, we have implemented a number of new initiatives, including the following:

- Increased capability and expertise across the business by hiring new talent and investing in training and development including introducing quarterly mental health training for all front line staff;
- Developed a number of additional support services to help proactively drive improved health outcomes for our customers. For example, we have invested in developing a set of rehabilitation services;
- Improved our internal systems and processes to make underwriting and claims assessment more efficient. This included implementing a new process management system, and through other initiatives we have significantly improved the time taken to assess claims. For example, we have halved the average assessment time for a Total and Permanent Disability (**TPD**) claim over the last 3 years;
- Implemented all the provisions of the Financial Services Council's Life Insurance Code of Practice which came into effect on 1 July 2017;
- Worked with industry associations, superannuation trustees and other insurers to develop the voluntary Insurance in Superannuation Code of Practice, which was launched in December 2017;
- Conducted extensive consumer research into life insurance in superannuation in order to better understand Australians' knowledge of and attitudes to insurance in superannuation. As a result, we conducted advertising to ensure more working Australians are aware of insurance in superannuation and get more engaged with it;
- Conducted customer satisfaction surveys by means of Net Promoter Score (NPS) surveys and use the insights from the NPS scores to guide process improvement for our customers;
- Developed digital solutions for insurance applications and claims forms (eApply and eClaims);
- Implemented new processes for carrying out surveillance activities and entered into new contracts with surveillance providers;
- Undertaken a significant legacy product rationalisation project designed to streamline our business and cease sale of products to consumers that may not meet current consumer expectations or meet their needs in the same manner as modern products;
- Upgraded trauma definitions for 24 products last year and we expect to upgrade our remaining two legacy products in the first half of this year;

- Appointed a dedicated customer experience officer to drive business process changes in response to customer feedback; and
- Introduced a new health and wellbeing offering aimed at improving the resilience of mental health of working Australians.

Governance

As an APRA regulated entity, we conduct our business in accordance with APRA prudential standards, including those that relate to corporate governance and risk management. We are confident that our business is managed in accordance with sound governance principles. In particular, we are subject to APRA's Prudential Standard *CPS 510 Corporate Governance* which includes the following:

- Board composition obligations including the requirement to have independent directors and an independent chair;
- Obligations to establish and maintain a board audit committee, remuneration committee and risk committee;
- Requirements to adopt governance policies and processes appropriate to our business.

Under APRA *Prudential Standard CPS 220 Risk Management*, the Board of the life company must develop and approve a risk management strategy and a risk appetite statement.

The risk appetite statement sets out what level of risk the company is prepared to take in relation to various aspects of its business. MetLife has a low appetite for risks that threaten MetLife's goal of meeting or exceeding customer expectations and MetLife manages the risks to the extent that is commercially viable.

Regulatory inquiries

To date, MetLife has not been the subject of specific regulatory investigation or sanction.

As the Commission may be aware, the life insurance industry has been the subject of intense regulatory scrutiny over the last two years. MetLife has cooperated fully with relevant regulatory inquiries including:

- Providing information to the Senate Standing Committee on Economics' Inquiry into the Scrutiny of Financial Advice in 2016;
- Following ASIC correspondence to life insurers, including MetLife, in 2016 we engaged external consultants and legal advisers to undertake a risk based review our claims handling processes in relation to denied claims. No systemic or governance issues were identified and our claims management practices were regarded as satisfactory. This review questioned our decision in only three claims. For two claims, this was based on the technical legal interpretation of the particular policy wording. In the third claim, the reviewers found that the supporting evidence was ambiguous but was sufficient to support payment of the

claim. Together with data from other life insurers, this work informed ASIC's 2016 Report 498 Life insurance claims: An industry review;

- Providing detailed claims data to ASIC and APRA as part of their project to improve public reporting on life insurance claims in 2016-208;
- Reporting on claims handling governance, board oversight and remuneration carried out at the request of APRA in 2016;
- Making submissions to the Productivity Commission in 2017 in relation to its review of the effectiveness and competitiveness of the superannuation system; and
- Responding to questions on notice in 2017 from the Parliamentary Joint Committee on Corporations and Financial Services in relation to its inquiry into the life insurance industry.

Our approach to responding to the Royal Commission's questions

As the Commission will appreciate, our business has undergone many changes to personnel, products and processes over the last 10 years. Given the length of time covered by the Commission's questions and the timeframe to produce a response, we have used our best endeavours to interrogate available records to provide as complete a response as possible. Those records are, by their nature, more complete in relation to recent years.

In order to respond to the Commission's questions, we established a project team to collate and review available data. This has included the collation and review of:

- Risk registers and incident reports;
- Minutes and papers of board and relevant board committee meetings;
- Breach reports and other reports to regulators;
- Human resources records; and
- Complaints and disputes data.

Misconduct

Having regard to the definition of 'misconduct' in the Commission's terms of reference, we have interpreted misconduct to infer serious wrongdoing involving some degree of impropriety, intent or reckless disregard. We do not regard operational or administrative errors, which may involve technical breaches of the prevailing law, as 'misconduct', provided that prompt remedial action has occurred.

Findings in litigated matters

In the event that we decline a claim due to ineligibility or failure to meet a policy condition, there may be customers who are unhappy with the decision. While we are confident that our processes

are robust and ensure that each claim assessment is undertaken with utmost integrity, customers sometimes choose to litigate their claims.

It is common in insurance proceedings for a range of conduct to be alleged in pleadings, including breach of contract and breach of the duty of utmost good faith[3]. We have appended (Appendix 1) a list of seven reported judgments where findings have been made against MetLife, one of which was overturned on appeal. We have not provided details of litigated matters that have been resolved via confidential deeds of settlement or which are still underway, due to legal privilege and confidentiality obligations owed to insured members and customers.

While there are a few instances in the past ten years where a court has made findings against MetLife that may constitute 'misconduct' as defined in the Commission's terms of reference, we do not regard these as being systemic, or indicative of governance or cultural failures. The findings in each matter are relevant only to the particular factual circumstances of each case and may relate to events that occurred some years before the judgment. Where reported cases have broader learnings we always seek to address them in our business.

Conduct, practice, behaviour or business activity that has fallen below community standards and expectations

In relation to community standards and expectations, this is inherently a subjective test. Consumer expectations have changed markedly over the period of the Commission's review, however, we have attempted to judge our past conduct by the standards expected today. Complaints by customers and criticism from other sources sometimes reflect expectations which are not reasonably achievable by the industry or commercially viable, so that there may be an expectation gap. We have used the following as guidance in interpreting whether we have met or fallen below those standards and expectations for the purposes of this submission:

- the obligation on all AFSL holders to act "efficiently, honestly and fairly" as required by s 912A of the Corporations Act; and
- ASIC's expectations, as set out in its most recent Corporate Plan[4], that financial service providers will "act professionally, treat consumers fairly and prioritise consumers' interests".

On this basis, we have identified that there are some instances where we may have fallen below community standards and expectations. As outlined below, we do not regard these findings as indicative of systemic or cultural problems within our business. We have outlined these issues below and how we have sought to address concerns and improve our customers' experience.

Mental health issues

There have been concerns raised in a number of forums about the way in which people with mental health conditions are treated by the life insurance industry[5]. Mental health conditions pose challenges for insurers arising from:

[3] s 13 *Insurance Contracts Act* 1984
[4] ASIC *Corporate Plan* August 2017

- The prevalence of mental health conditions is increasing in the community. It is estimated that one in two Australians will suffer a mental health condition in their lifetime[6]. The World Health Organisation has estimated that depression will become the leading cause of the global health burden by 2030[7];

- Mental health is a leading cause of absence from work [8];

- Secondary psychological conditions often develop subsequent to physical conditions, especially where there is a lengthy period of absence from work;

- The symptoms of mental health conditions are generally self-reported as there are no identified biomarkers or clinical tests available, making objective assessment more difficult and the process of assessment more lengthy;

- Mental health claims require great sensitivity in the way that they are handled, and often require access to specialised expertise; and

- Significant learnings and changes in the industry and the mental health profession as more research is undertaken. As an example, the knowledge and understanding of conditions like post-traumatic stress disorder have evolved considerably in recent years.

These challenges have been recognised as a threat to the sustainability of the life insurance industry, meaning the ability to pay claims far into the future without unreasonably increasing the cost of insurance for the customer. In order to manage premium costs, insurers have a responsibility to pay legitimate claims only and to fully investigate each claim on its merits.

The range of criticisms directed at the life insurance industry include denial of mental health claims, delay in considering claims, subjecting claimants to surveillance and discrimination at the underwriting stage[9].

At MetLife, we have had exposure to the complexities of assessing mental health claims through some of our portfolios that covered occupations including police officers and the meat industry. As a result, we have learned that assessment of mental health claims is rarely clear cut and the processes and practices that suit assessment of physical claims are not always appropriate for mental health claims.

In group insurance, MetLife's main business line, there are usually no exclusions for mental health conditions, unlike other areas of insurance such as travel insurance. However, there is a common misconception that 'blanket exclusions' apply in group insurance policies. In the period from 2010-2013, claims for mental health conditions were the third most common kind of claim in the group

[5] For example, submissions made to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into Life Insurance.
[6] Australian Bureau of Statistics 2008, *National Survey of Mental Health and Wellbeing: Summary of Results*, 4326.0, ABS, Canberra
[7] World Health Organisation 2008 *Global Burden of Disease*
[8] Actuaries Institute 2017, *Mental Health and Insurance Green Paper*
[9] For example, Mental Health Council of Australia and beyondblue (2011) *Mental health, discrimination and insurance: a survey of consumer experiences 2011*; ASIC *Report 498: Life Insurance claims: An industry review*

insurance market, the most common being neoplasms/cancer and musculoskeletal conditions[10]. For MetLife, about 15% of our claims in 2017 related to mental health conditions.

The public criticism also has not recognised that life insurers often provide extra support for mental health patients, such as access to specialised rehabilitation services.

MetLife has received some complaints from insured members who have claimed for mental health conditions about our claims-handling processes including complaints about the use of surveillance. Some of these complaints have been the subject of media reporting. Surveillance is a long standing industry practice which had its roots in seeking to identify false claims of physical injury. The practice was extended to mental health claims as mental health claims began to increase. We recognised that this is an area where we may not always have met community expectations. In 2016, as a response to community concerns, we introduced a surveillance policy and procedures which limit the use of surveillance in the assessment of a claim especially for assessment of mental health conditions. We have also established a code of conduct for the companies who provide us with surveillance services, and made compliance with that code a condition of our contract with those parties.

We have also made a number of improvements to the operational and governance aspects of our business. The actions we have taken include:

- Updating our claims philosophy;
- Introducing quarterly training for front-line staff on dealing with mental health issues;
- Improving our procedural fairness processes;
- Introducing telephone support to assist members with completing claims forms and lodging a claim;
- Introducing suicide guidelines to prepare customer-facing staff as to what to do when an individual presents themselves as suicidal;
- Acting as the lead insurance partner to Superfriend in creating "Taking Action: A Life Insurance Best Practice Framework for the Management of Psychological Injury Claims". This framework is now being adopted nationally by Workers' Compensation insurers;
- Developing a claims framework to facilitate earlier intervention and more effective triage based on psychological condition, environment and social situation which provides tailored support for both primary and secondary psychological conditions;
- Establishing a rehabilitation service, designed for people with a psychological injury that focuses on their ability and capability to facilitate a sustainable return to health which may include, where appropriate, access to return to work services and supports;
- Appointing a consulting psychiatrist to support claims and underwriting and provide case conferences on complex matters;

[10] Rice Warner 2016, *Group Life and Disability Insurance Claims*

- Participating in industry forums such as the Financial Services Council's Mental Health Roundtable, which was convened in order for insurers, medical bodies and mental health representative groups to discuss research projects and other initiatives in relation to mental health;

- Ensuring that none of our on-sale products have exclusions for pre-existing mental health conditions; and

- Developing an app to help people track their health and wellbeing and improve their resilience in the face of life's ups and downs. The app is to be launched on a pilot basis in the near future.

Delays in claims handling

The life insurance industry has been subject to criticism[11] that there are delays in determining claims especially in relation to TPD claims. This is potentially an area where the industry as a whole has not lived up to community expectations. MetLife has halved the time it takes to reach decisions on claims since the beginning of 2015. During this time period, the number of claims received has increased by approximately 25%. We have achieved this reduction in claims decision timeframes through the following initiatives:

- Redesigned our core claims processes including the implementation of a new process management system that allows improved tracking, monitoring and reporting;

- Established a continuous improvement team which works to identify areas where there may be inefficiency and duplication and introduce streamlined processes;

- Developed a claims technical competency framework to ensure our claims management and assessment capabilities are market leading and that our staff are caring and empathetic;

- Engaged claims staff with who have psychological or allied health qualifications;

- Established a claims framework and rehabilitation service to identify early intervention opportunities and provide tailored support to help our customers to return to health;

- Appointed a new medical retrieval service provider to improve the time taken to retrieve key medical information;

- Established a process of conducting case conferences with medical experts to help guide our staff in dealing with complex cases;

- Rolled out the use of "tele-claims" which allows claimants to elect to complete claims requirements over the phone, replacing paper forms and enabling the claims officer to explain the process, outline any further requirements and provide assistance directly to the claimant; and

- Provided clearer guidance at the commencement of a claim of our expectations of what material, including medical reports, we will need and how long the process will take.

[11] For example ASIC *Report 498 Life Insurance claims: An industry review*

"Junk Insurance"

The life insurance industry has been subject to criticism in recent years about "junk insurance"[12], that is insurance that has little value to the consumer due to:

- Definitions or exclusions that may make it difficult to claim on the policy;
- Poor sales practices which pressure consumers into acquiring products that are not appropriate for them;
- Low claims ratios (that is, the ratio of claims made to the amount collected in premium expressed as a percentage).

Some of these criticisms have been directed to definitions of TPD which have been updated in recent years in the group life market in order to clarify the intention of TPD and mitigate rising claims costs. MetLife, along with other insurers, has been the subject of criticism in this regard[13]. While MetLife has amended the TPD definition in a number of its group life policies, we do not accept the criticism that TPD is junk insurance, as the vast majority of TPD claims are paid in the first instance - approximately 84% across the industry[14]. MetLife's average acceptance rates for TPD are higher than this statistic. As a life insurer, we are privileged to witness the life-changing effect that a TPD benefit can have for a person is prevented from working by illness or accident.

Criticisms have also been directed at consumer credit insurance (**CCI**). CCI is insurance that provides protection in the event that a person is prevented from paying money owed under a credit facility due to death, disability or unemployment. The amount of the insured benefit is calculated by reference to the amount owed under the credit facility. CCI is often structured so that a life insurer provides the benefits that satisfy the definition of "life insurance" in the *Life Insurance Act 1995*, while a general insurer offers the other components, for example, unemployment benefits.

CCI has been criticised for a number of reasons, one of which is that it may represent poor value to customers as the claims ratio (the proportion of claims paid as a percentage of premium collected) is typically lower than for other lines of business.

MetLife offers only one open CCI product in the form of credit card insurance via an affiliate that is a bank. This product represents a very small percentage (approximately 2%) of MetLife's overall business. In recognition that the product design may not meet community standards or expectations, MetLife has in recent years sought to improve the value to customers of this product by improving the product design and adding additional benefits. We have worked with our affiliate to educate customers so that they are more aware of the benefits they have and to develop communication strategies when there is a customer who is in arrears on their credit card payments.

[12] For example, ASIC 2016 *Report 461 The sale of life insurance through car dealers: Taking consumers for a ride*

[13] For example, Australian Lawyers Alliance submission to Productivity Commission submission to Productivity Commission September 2017

[14] ASIC *Report 498 Life Insurance claims: an industry review*

Regulator reports

Financial services entities are required to report a breach or potential breach of obligations under financial services law to ASIC under s 912D of the *Corporations Act 2001*.

Whether a breach or likely breach is significant is determined having regard to the:

- Number or frequency of similar previous breaches;
- Impact of the breach or likely breach on the licensee's ability to provide the financial services covered by the licence;
- Extent to which the breach or likely breach indicates that the licensee's arrangements to ensure compliance with those obligations is inadequate; and
- Actual or potential financial loss to clients of the licensee, or the licensee itself, arising from the breach or likely breach.

Life insurers are also required to report significant breaches or potential breaches under s132A the Life Insurance Act 1995 and there is a similar test in relation to whether the breach is significant.

MetLife has made a number of reports to ASIC under s912D of the *Corporations Act 2001*. These mainly related to operational incidents. For example, MetLife recently reported a potential breach to ASIC in relation to a policy administration system for a closed book of business which has a number of deficiencies leading to some data being inaccurately recorded. We have conducted a review of the system and are implementing system changes to address the deficiencies. We have undertaken a review of customer impacts and determined that no customers have been adversely affected.

Another example is where, due to an administrative deficiency, a group of customers were not provided with a product disclosure statement prior to the policy commencing.

In these instances our approach is to:

- Identify the root cause of the incident;
- Address any consumer impact and remediate where appropriate; and
- Put in place measures to prevent future recurrence.

We do not regard these matters as being evidence of misconduct or conduct falling below community expectations.

Complaints and determinations of dispute resolution bodies

In compiling this response, we have:

- Reviewed determinations made by the Financial Ombudsman Services and the Superannuation Complaints Tribunal, focusing on those where a decision was made against MetLife. There have been approximately 20 of these in the relevant time period;

- Reviewed historical complaints data over the relevant period, and grouped complaints according to the nature of the complaint, the year received and product type;
- Undertaken a deep-dive analysis of a 10% sample of each type of complaint; and
- Reviewed reports made to relevant board committees about complaints trends.

These investigations have not revealed evidence of systemic issues, misconduct or failure to meet community standards or expectations. In the interests of transparency, some of the themes arising from our review of complaints data are:

- Delays in assessing claims as outlined above. In some instances, this has led to an allegation that MetLife has unreasonably withheld payment within the terms of s57(2) of the Insurance Contracts Act 1984;
- Prior to 2014, MetLife operated a direct call centre which sought to sell life insurance via telephone contact with the customer. This call centre was closed in 2014. During the time it was operating, MetLife received complaints of the kind typically received in relation to a call centre, for example, that the customer service officer had an aggressive or rude manner, that the customer did not intend to purchase a life insurance policy, or that poor customer service was provided. Our deep-dive analysis referred to above did not identify any systemic conduct or instances of misconduct;
- Complaints in relation to surveillance, as outlined above; and
- Complaints in relation to denied claims. As a life insurer has a prudential obligation to run its business sustainably, there will always be some customers who are unhappy with claims outcomes.

The table in the annexure provides responses to your specific questions.

29 January 2018

Annexure - Response to questions from Royal Commission

	Questions	**MetLife response**
1.	Excluding cases of theft from the entity itself, or from an associated entity, has the entity identified any misconduct by the entity (including by its directors, officers or employees, or by anyone otherwise acting on its behalf) which occurred at any time since 1 January 2008? If so, what is the nature extent and effect of that misconduct?	See listing of reported judgments in Appendix where findings against MetLife have been made.
2.	Has the entity identified any conduct, practice, behaviour or business activity it has engaged in (including by its directors, officer or employees, or by anyone otherwise acting on its behalf) since 1 January 2008, which it considers has fallen below community standards and expectations? If so, what is the nature, extent and effect of that conduct, practice, behaviour or activity?	See description in Submission in relation to surveillance, claims handling delays and consumer credit insurance
3.	If yes to either or both of questions one and two: (a) Is the identified conduct, practice, behaviour or activity the subject of another inquiry or investigation, or a criminal or civil proceeding?' (b) Does the entity attribute any of the identified conduct, practice, behaviour or activity to the particular culture or governance practices of the entity? If so, describe that culture or governance practice. (c) Does the entity attribute any of the identified conduct, practice, behaviour or activity to some broader culture or governance practices (including risk management, recruitment or remuneration practices)? If describe those practices. (d) Does the entity consider that the identified conduct, practice, behaviour or activity results from other practices (including risk management, recruitment, or remuneration practices)? If so, describe those practices.	(a) See listing of reported judgments in Appendix 1 (b) No. (c) No. (d) See Submission.

	Questions	**MetLife response**
	(e) What steps has the entity taken to: (i) Remedy the consequences for consumers or other business of the identified conduct, practice, behaviour or activity; (ii) Prevent recurrence of conduct, practice, behaviour or activity of the kind identified?	(e) See Submission.
4.	For an entity that is, or has a connection (other than an incidental connection) to, an RSE licensee of a registrable superannuation entity (as defined in the *Superannuation Industry (Supervision) Act 1993 (Cth)*): (a) During each of the past ten years (according to whatever annual reporting periods the entity has employed in the ordinary course of its operations) to what uses and in what amounts has the entity applied members' fund other than the investment of those funds, the administration of the superannuation fund and the payment of member benefits? (b) In respect of each kind of those other applications of members' funds, why was that application in the best interests of members? (c) What are the cost centres that make up costs attributed to administration in each of those years?	Not applicable. MetLife is not an RSE licensee and does not have a connection to an RSE licensee, other than in relation to being the issuer of group insurance policies as described in our Submission.

Appendix 1

List of MetLife reported judgments with findings against MetLife

Judgment	Outcome in the litigation	Reasons why the matter may be considered to be 'misconduct' as defined in the Commission's terms of reference or failing to meet community standards or expectations
Birdsall v Motor Trades Association of Australia Superannuation Fund Pty Ltd [2014] NSWSC 632	TPD decision. MetLife succeeded in the litigation.	Although the Court ultimately found in its adjudication of the "second stage"[15] that the plaintiff was not TPD, it found in its assessment of the "first stage" that MetLife's decision had unreasonably failed to make specific reference in its decision letter to a number of failed job applications by the plaintiff. The Court also found that it was unreasonable for MetLife to not take into account at the date of its decision that the plaintiff had been out of work for 3 years.
Panos v FSS Trustee Corporation [2015] NSWSC 1217	TPD decision. The plaintiff's proceedings were dismissed and MetLife was ultimately successful in the litigation.	This case concerned a claim for a TPD benefit. While the Court ultimately found that the plaintiff was not TPD and made orders in favour of MetLife, the matter involved an allegation of constructive denial by MetLife. The decision to deny the claim was found to involve a breach of the duty of utmost good faith due to MetLife's treatment of some medical evidence.
Shuetrim v FSS Trustee Corporation [2015] NSWSC 464	TPD decision. Initial decision in favour of the Plaintiff. Judgment overturned on appeal.	The Court found that MetLife erroneously relied on a vocational report that did not address all requisite issues. The Court then found the plaintiff to be TPD on all the evidence. The judgment was overturned on appeal.
Shuetrim v FSS Trustee Corporation [2015] NSWSC 795	Interest judgment. Court found for the plaintiff but	The Court found that it was unreasonable for the purposes of s57 of the *Insurance Contracts Act* for MetLife not to have admitted the

[15] McLelland J (as his Honour then was) set out in *Edwards v Hunter Valley Co-op Dairy Co Ltd* (1992) 7 ANZ Ins Cases 61-113, which the New South Wales Court of Appeal approved in *Hannover Life Re Australasia Ltd v Sayseng* (2005) 13 ANZ Ins Cases 90-123

Judgment	Outcome in the litigation	Reasons why the matter may be considered to be 'misconduct' as defined in the Commission's terms of reference or failing to meet community standards or expectations
	overturned on appeal.	plaintiff's claim by 17 December 2014. The judgment was overturned on appeal.
TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim [2016] NSWCA 68	MetLife succeeded on appeal.	N/A: The NSW Court of Appeal unanimously overturned the findings of the trial judge against MetLife, upheld MetLife's decision, and ordered the plaintiff to pay MetLife's costs.
Gaudiosi v FSS Trustee; *ex tempore* judgement published 16.3.16	Interlocutory ruling on admissibility of evidence. The litigation was ultimately settled on commercial terms.	The judgment concerned the admissibility of surveillance evidence obtained by an operative retained by MetLife. The Court rejected the tender of the surveillance footage as the operative was found to have contravened the provisions of the *Surveillance Devices Act 2007*. NB: the actions the subject of negative comments were those of a third party, not MetLife itself. However MetLife sought to rely on the evidence obtained via those actions.
Ziogos v FSS Trustee Corporation as Trustee of the First State Superannuation Scheme [2015] NSWSC 1385	TPD decision. MetLife's decision was set aside as 'unreasonable'. The plaintiff was found, based on all the evidence, to meet the definition of TPD in the relevant Policy.	It was held that in light of the opinions of the plaintiff's treating doctors and the equivocal nature of the opinion expressed by the independent medical expert, it was unreasonable for MetLife to conclude that the plaintiff had the capacity to work in either a full-time or part-time capacity presently or in the future. It was also found to be unreasonable to rely on certain surveillance evidence. A number of criticisms of MetLife's decision in reality amount to differences of opinion as to the weight to be attributed to certain aspects of the evidence.
Wheeler v FSS Trustee Corporation as trustee for the First State Superannuation Scheme	TPD decision. MetLife's decision was set aside as 'unreasonable'.	The Court found that it was not reasonable for MetLife to discount certain medical evidence, or to rely on certain medical opinions. MetLife was also criticised for not providing material to

Judgment	Outcome in the litigation	Reasons why the matter may be considered to be 'misconduct' as defined in the Commission's terms of reference or failing to meet community standards or expectations
[2016] NSWSC 534	The plaintiff was found to meet the definition of TPD in the relevant Policy.	the plaintiff under "procedural fairness" at an earlier date, although in fact, that material was in the possession of the plaintiff. The decision turns on the Court's view of the weight to be placed on various aspects of the evidence.
Hellessey v MetLife Insurance Limited [2017] NSWSC 1284 Note: This matter is currently the subject of an appeal by MetLife in the NSW Court of Appeal (MetLife Insurance Limited v Hellessey [2017/313493])	MetLife's decision to decline the plaintiff's TPD claim was not "valid or effective", and in coming to its decision, MetLife had breached its duty to act towards the plaintiff with "utmost good faith and fair dealing".	The Court disagreed with that the weight and interpretation given by MetLife to various pieces of medical and factual evidence finding instead they were sufficient to establish that the plaintiff did satisfy the TPD definition.