Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry

Round 6 Hearings: Insurance

Submissions on findings concerning case study of second insured and TAL

1. The Public Interest Advocacy Centre (**PIAC**) has been granted leave to appear in the Round 6 hearings on insurance in its own right[1] and on behalf of a consumer, being the individual the subject of the second case study concerning TAL (referred to hereafter as "**the second insured**").

Evidence received by the Commission in relation to the second insured's case study

2. In her oral evidence, Ms Loraine Karen van Eeden, General Manager, Claims for the TAL Group, made the following admissions regarding the second insured's case study:

    a. The second insured was not given sufficient time to consider and reflect on her answers during the forty-minute phone call in which she answered TAL's application questions[2];

    b. TAL's investigation of the second insured's medical history was standard practice because it was an 'early claim', that is, a claim made shortly after the commencement of the policy[3]. However, TAL's investigation of the second insured's medical history should have been confined to the disclosures that were the subject of the second insured's claim[4];

    c. TAL should have notified the second insured that it was investigating her and its failure to do so falls below community standards[5];

    d. TAL's current practice is to only avoid policies in the event of fraud, unlike TAL's conduct in respect of the second insured's policy[6]. TAL accepts there was no fraudulent conduct by the second insured in relation to her policy or claim[7];

    e. TAL's notification to the second insured that it was avoiding her policy was likely to be very upsetting to a self-employed person who was receiving treatment for cervical cancer[8]. The phone call in which the second insured was informed of TAL's decision falls below community standards[9];

    f. TAL did not show sufficient empathy towards the second insured[10];

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[1] PIAC is a specialist community legal centre. For almost five years, PIAC has been working with *beyondblue* and Mental Health Australia to raise systemic problems with the way insurers design, price and offer policies and assess claims for people with a past or current mental health condition or who are imputed to have a mental health condition.
[2] T5765.9
[3] T5766.19-24
[4] T5766.36
[5] T5767.15-22
[6] T5758.35 – T5769.9
[7] Statement of Lorraine Karen van Eeden in relation to Rubric 6-45 dated 31 August 2018 (Exhibit 6.179) ("**Van Eeden Witness Statement**"), paragraph 111.
[88] T5769.33
[9] T5770.16
[10] T5770.5-9

g. The second insured was left with the impression that she may need to refund benefits already paid to her[11];

h. The second insured was not given an opportunity to provide additional information to TAL before it made its decision[12];

i. TAL did not afford the second insured procedural fairness before avoiding her policy[13];

j. TAL inappropriately told the second insured that she had breached her duty of good faith[14];

k. It was inappropriate for TAL to leave the insured with the impression that she would need to refund benefits already paid to her in the amount of $24,649[15]. TAL's conduct in this respect falls below community standards[16];

l. The manner in which TAL handled the second insured's claim was heavy handed[17];

m. TAL subsequently investigated the circumstances of the second insured's diagnosis with cervical cancer and related medical history in order to find a basis to maintain the avoidance of her policy due to a non-disclosure related to her cervical cancer, and move away from reliance on the purported mental health non-disclosure[18];

n. During the above investigation, in which a further underwriting opinion was obtained, TAL's general claims manager expressed concern that TAL was attempting to retrospectively underwrite the application based on information it had not taken into account during the original application process (notwithstanding the disclosures made by the second insured that could have led TAL to make those investigations at the time)[19];

o. Despite the concern expressed by TAL's general claims manager, the claims decision committee relied on the "additional" medical information to maintain the decision to avoid the policy, which was only communicated to the second insured two weeks later on the evening before the FOS conciliation[20] and which was part of a broader pattern of delay in TAL's dealings with FOS in the second insured's matter[21];

p. TAL's internal communications after resolution of the FOS dispute to the effect of "Happy to close that one down" and "That's one success from FOS" were inappropriate[22].

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[11] T5770.12-13
[12] T5770.37
[13] T5771.2
[14] T5771.34-42
[15] T5773.3
[16] T5773.5
[17] T5774.23
[18] T5776.38-40
[19] T5777.18-25
[20] T5778.15
[21] T5778.24
[22] T5779.31-32

3. Ms van Eeden also accepted there were systemic deficiencies in the way TAL avoided policies and communicated with insureds about the avoidance[23], and in TAL's failure to offer insureds an opportunity to provide additional information before their policies were avoided[24].

4. It is somewhat perplexing in view of the above that, at least in Ms van Eeden's witness statement, TAL maintained that the decision itself was appropriate[25]. By this we assume that TAL maintains the decision to avoid the policy was appropriate because, it says, it would not have offered the second insured a policy on any terms due to the purported non-disclosures of the second insured's mental health history.

5. That TAL maintains the decision itself was appropriate is deeply disturbing for a number of reasons:

    a. The second insured has always maintained she did not have a mental health condition and at the time of the original dispute provided a letter from the psychologist she attended to TAL as evidence of this. Ms van Eeden has accepted that TAL's assessment would have been assisted by seeking a report from the psychologist at TAL's cost to better understand her mental health status and treatment.[26] In this respect we also note that at the time of the original dispute TAL accepted that its reliance on a mis-dated clinical record from 2007 was incorrect[27]. The purported non-disclosures are therefore confined to a fifteen-month period over 2008 and early 2009 and not a three year period as might be the impression given from Ms van Eeden's witness statement;

    b. As noted above, TAL now concedes it was looking for reasons not to pay the second insured's claim and maintain its decision to avoid her policy. TAL has not genuinely engaged with the question as to whether its original decision to avoid the policy entirely was reasonable;

    c. TAL's refusal to provide the second insured with a contract of insurance because of the purported non-disclosures of mental health history is very likely to have breached the requirements of State and Federal anti-discrimination legislation. Under that legislation, TAL is required to prove that its decision not to offer an insurance policy at all is based on actuarial and statistical data on which it is reasonable to rely, and that its decision is reasonable based on other relevant factors. It is very apparent the decision to avoid the policy was not based on actuarial or statistical data (that is, on any identified additional risk to the insured) and was not otherwise reasonable based on all of the relevant factors, including nature of the purported non-disclsoures.

    d. As noted above, TAL's current practice is not to avoid policies for innocent non-disclosure.

6. TAL also maintains that the settlement reached with the second insured was reasonable. Ms van Eeden gave evidence that the settlement amount was not substantially less than

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[23] T5770.27-33
[24] T5770.40
[25] Van Eeden Witness Statement, paragraph 112
[26] Van Eeden Witness Statement, paragraph 105(a)
[27] TAL.001.022.0157

what the second insured would have received had she continued to be on the claim[28]. Again, TAL's maintenance of this position is deeply disturbing:

a. The second insured had a policy in place up to the age of 65. TAL's avoidance of the second insured's policy and its refusal to reinstate the policy at the time of the original dispute, resulted in the loss to the second insured of an extremely valuable insurance policy. TAL's avoidance also meant the second insured was unlikely to be able to obtain cover from another insurer for her cervical cancer, and would likely make it difficult or impossible for the second insured to obtain cover from another insurer in relation to any related medical condition in the future. The second insured received no compensation for the lost value of the policy over the second insured's lifetime, which is significantly more than the value of her claim for payment of benefits arising from the diagnosis with cervical cancer;

b. The total value of the second insured's claim for cervical cancer, had the policy stayed in place, would have amounted to approximately $215,666.00[29] in consideration of the 39 months the second insured was unable to return to work as a result of her cervical cancer, and 13 months of partial payments whilst the second insured worked part-time. This is significantly more than the second insured received as an outcome to the FOS complaint, being a payment of $25,000, the equivalent or 5 months at $5,000 per month, and an agreement from TAL not to recover the $25,000 which had already been paid to the second insured prior to TAL's avoidance of the policy;

c. TAL's internal correspondence following the settlement[30] demonstrates that it considered it had achieved a substantial win.

7. There is no doubt that TAL's threats to recover the benefits already paid to the second insured and its raising of additional information on the eve of the conciliation, during a period in which TAL knew the second insured was receiving treatment for cervical cancer, resulted in the second insured accepting a settlement offer that she knew was not satisfactory.

8. The case study of the first insured demonstrates the aggressive and heavy-handed approach that would likely have been taken had the second insured decided not to accept the settlement offer and pursue her claim against TAL in FOS.

Community standards and expectations and misconduct

9. In view of the evidence given by TAL, it appears that TAL does not fully understand and/or accept the degree to which is has engaged in misconduct and conduct that does not meet community standards and expectations.

10. PIAC and the second insured support the submission made by Senior Counsel Assisting the Commission, Ms Rowena Orr QC, that it is open to the Commission to find that TAL has engaged in misconduct in the following respects:

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[28] T5779.35

[29] This figure excludes payment of the Increasing Claims option attached to the second insured's policy, which would have increased the claim payments to the second insured in line with the Indexation Factor on the anniversary of the commencement of continuous benefit payments, capped at 3% per annum.

[30] T5779.20-27

a. In relation to the first insured, that TAL breached its duty of utmost good faith, breached professional standards and engaged in conduct that was misleading[31];

b. In relation to the second insured, that TAL breached its duty of utmost good faith by telling her when it avoided her contract of insurance, that she had breached her duty of utmost good faith[32];

c. Arising from the case study of the second insured and TAL's evidence about its standard practices, that TAL systematically breached its duty of good faith when communicating with policyholders whose policies had been avoided for non-disclosure[33];

d. Arising from the case studies and TAL's evidence about its standard practices, that TAL systematically breached its duty of good faith to policyholders in its approach to investigations of claims, including to obtain medical information well beyond the claimed condition, for the purpose of determining whether TAL might be entitled to avoid the policy on the basis of non-disclosure[34];

e. TAL's minimal training and oversight of its case managers;[35]

f. A systemic lack of independence in TAL's decision-making processes[36];

g. In exacerbating the first insured's mental health condition.[37]

11. PIAC and the second insured also support the submission made by Senior Counsel Assisting the Commission, Ms Rowena Orr QC, that it is open to the Commission to find that TAL's conduct fell below community standards and expectations in the following respects:

a. TAL failed to ensure that it had adequate systems to train its case managers and to oversee the actions of its case managers[38];

b. TAL failed to have in place robust systems to avoid potential conflicts of interest[39];

c. TAL failed to have adequate systems in place to ensure that its internal dispute resolution team conducted a robust analysis of declined claims in a way that was independent of the claims team[40];

d. TAL failed to engage with FOS in a cooperative and frank way[41];

e. TAL failed to accord procedural fairness to policyholders prior to avoiding their policies[42];

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[31] T6481.41
[32] T6482.1
[33] T6482.4
[34] T6482.15
[35] T6483.32
[36] T6484.5
[37] T6485.5
[38] T6482.25
[39] T6482.28
[40] T6482.37
[41] T6482.42
[42] T6483.11

f. In respect of the first, second and third insureds, TAL's communications fell below community standards and expectations, in that the communications were inappropriate, bullying, threatening and misleading[43];

g. In respect of the first, second and third insureds, TAL failed to communicate in a sensitive and empathetic way that recognised the difficult circumstances they were facing[44], including in respect of the second insured by threatening to recover the benefits she had already been paid under the policy;

h. TAL failed to have adequate systems in place to avoid serious administrative errors, such as erroneous notifications of policy cancellation for non-payment of premiums[45].

12. In addition to the findings set out above, PIAC and the second insured submit that the following additional findings of misconduct are open to the Commission in relation to the case study of the second insured.

13. It is open to the Commission to find that TAL engaged in misconduct in its dealings with the second insured in the following respects:

a. By repeatedly threatening to recover benefits already paid to the second insured under her policy, which was both a breach of TAL's duty of utmost good faith and was misleading and/or deceptive;

b. By raising, on the eve of the conciliation, an additional accusation that the second insured had failed to properly disclose symptoms that were related to her diagnosis with cervical cancer. This was a breach of TAL's duty of utmost good faith a number of respects:

i. TAL's delay in providing the information to the second insured such that she only received this information on the eve of the FOS conciliation;

ii. TAL's insistence that the second insured failed to properly disclose all symptoms relevant to the second insured's diagnosis with cervical cancer. The records annexed to Ms van Eeden's statement show that the second insured was proactive in maintaining her health and regularly attended appointments with her GP. At the time of the second insured's application for insurance, neither the second insured nor her GP had any idea of the diagnosis of stage 1 cervical cancer that was to follow a few months later[46];

iii. TAL's insistence that the second insured had failed to properly disclose all symptoms relevant to her diagnosis with cervical cancer in circumstances where the second insured had disclosed mid-cycle menstrual bleeding during the application process, had provided consent for the TAL to obtain further tests and records[47], and where the insurer had declined to review a further blood test obtained by the second insured's GP, before offering

[43] T6483.16
[44] T6483.22
[45] T6483.26
[46] For completeness we also note that the second insured provided TAL with an explanation of her understanding of her weight loss (a change in diet) at the FOS conciliation.
[47] TAL.500.020.1322

the policy to the second insured[48]. We note that line 72 of TAL.500.029.0688_0001 (Exhibit #6.179.65) misquotes the statement of the iSelect representative from the recording of the telephone call and should read '...regarding the blood tests, that that ***wasn't*** an issue'.

c. By avoiding the second insured's policy on the basis of a purported non-disclosure of mental health history when it was availble to TAL to vary the terms of the policy pursuant to section 29 of the *Insurance Contracts Act*. This was a breach of TAL's duty of utmost good faith. In this regard, PIAC and the second insured do not accept TAL's evidence that it would not have offered the second insured a policy on any terms. Further, such a decision would likely have breached State and Federal anti-discrimination legislation;

d. By pursuing a strategy that was designed to leave the second insured with the impression that if she attempted to challenge TAL's decision formally in FOS (that is, outside of the conciliation process and allow FOS to make a formal decision), the financial consequences for her would be significant in that TAL would seek to recover benefits it had already paid to the second insured. This was a breach of TAL's duty of utmost good faith.

14. It is also open to the Commission to find that TAL has not met community standards and expectations in its internal practices and review mechanisms. The documents annexed to Ms van Eeden's statement show that:

a. TAL was committed to investigating the second insured for the purpose of "uncovering" further non-disclosures to entitle it to avoid the second insured's policy and later to maintain the decision to avoid that policy.;

b. The review processes were not sufficiently independent and were not designed to identify and balance those matters that were also in the second insured's favour but rather only to further support TAL's own position. See for example, Exhibit LVE-103 [TAL.500.020.0182] in which TAL's Retain Claims Manager stated "My recommendation is that a further underwriting review is carried out urgently – **however, the original decision is correct**" [emphasis added];

c. The above reflected deeply entrenched cultural issues. These issues are further demonstrated by TAL's failure to take seriously and address concerns raised by one of its directors and its claims manager[49]. This is also reflected in the extremely low number of complaints that have been resolved by TAL's internal dispute resolution process in favour of the policyholder[50] and the even smaller number that resulted in a determination to pay a claim under the policy[51].

Public Interest Advocacy Centre
27 September 2018

[48] Exhibit LVE-061.
[49] Exhibit 6.205 [TAL.001.002.0257], Exhibit 6.206 [TAL.500.022.0017].
[50] Van Eeden Witness Statement, paragraph 21
[51] Van Eeden Witness Statement, paragraph 23