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TRANSCRIPT OF PROCEEDINGS

O/N H-919884

THE HONOURABLE K. HAYNE AC QC, Commissioner

**IN THE MATTER OF A ROYAL COMMISSION
INTO MISCONDUCT IN THE BANKING, SUPERANNUATION
AND FINANCIAL SERVICES INDUSTRY**

MELBOURNE

9.46 AM, THURSDAY, 13 SEPTEMBER 2018

Continued from 12.9.18

DAY 53

MS R. ORR QC appears with MR M. COSTELLO as Counsel Assisting with MR M. HOSKING and MS S. ZELEZNIKOW
MR J. KARKAR QC appears with MS Z. HILLMAN for CMLA
MR N. BEAUMONT SC appears for TAL

<HELEN THERESE TROUP, ON FORMER OATH [9.46 am]

<CROSS-EXAMINATION BY MS ORR

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Ms Troup, late yesterday I asked you a series of questions about the product development phases in which consideration was given to changing the definition of heart attack over a multi-year period. Do you recall that?---Yes, I do.

And I put a number of propositions to you, many of which you accepted, which were based on a number of documents that were provided to the Commission by CMLA, and for completeness I want to tender those documents that I was referring to yesterday. So if I could do that first, Commissioner.

THE COMMISSIONER: Yes.

MS ORR: The first document is a heart attack definition updated summary document, CBA.0001.0525.0096.

THE COMMISSIONER: That will become exhibit 6.158.

EXHIBIT #6.158 HEART ATTACK DEFINITION UPDATED SUMMARY DOCUMENT (CBA.0001.0525.0096)

MS ORR: The second is a draft product design description from February 2012, CBA.1002.0004.0010.

THE COMMISSIONER: Becomes exhibit 6.159.

EXHIBIT #6.159 DRAFT PRODUCT DESIGN DESCRIPTION FROM FEBRUARY 2012 (CBA.1002.0004.0010)

MS ORR: A draft product design description from April 2012, CBA.1002.0004.0023.

THE COMMISSIONER: Becomes exhibit 6.160.

EXHIBIT #6.160 DRAFT PRODUCT DESIGN DESCRIPTION FROM APRIL 2012 (CBA.1002.0004.0023)

MS ORR: A draft product design description from September 2012, CBA.1002.0004.0041.

THE COMMISSIONER: Exhibit 6.161.

EXHIBIT #6.161 DRAFT PRODUCT DESIGN DESCRIPTION FROM SEPTEMBER 2012 (CBA.1002.0004.0041)

MS ORR: A draft product design description from March 2013, CBA.1002.0004.0351.

THE COMMISSIONER: Exhibit 6.162.

EXHIBIT #6.162 DRAFT PRODUCT DESIGN DESCRIPTION FROM MARCH 2013 (CBA.1002.0004.0351)

MS ORR: A draft product design description from October 2013, CBA.1002.0004.0274.

THE COMMISSIONER: Exhibit 6.163.

EXHIBIT #6.163 DRAFT PRODUCT DESIGN DESCRIPTION FROM OCTOBER 2013 (CBA.1002.0004.0274)

MS ORR: And finally, a draft product design description from November 2013, CBA.1002.0004.0315.

THE COMMISSIONER: Exhibit 6.164.

EXHIBIT #6.164 DRAFT PRODUCT DESIGN DESCRIPTION FROM NOVEMBER 2013 (CBA.1002.0004.0315)

MS ORR: Now, I want to turn to a new topic, Ms Troup. I said to you yesterday, when I took you to Mr Kell's letter to CMLA from 22 March last year, that I wanted to deal with three of the issues that Mr Kell described in that letter. I want to go to

the second of those issues now. So if I can take you back to that letter, which is ASIC.0066.0001.1134. Now, we've dealt with the first of the issues, which was the use of out of date medical definitions. And the second issue I want to deal with is discussed on pages 15 and 16 of the letter at 1148. 1148 and 1149. If we could have both of those on the screen. Now, this second issue relates to CMLAs advertising and promotion of heart attack cover. And we saw earlier that until March 2016, CommInsure's heart attack definition applied only to some heart attacks, severe heart attacks. You recall that, Ms Troup?---Yes, I do.

And we see from this letter, at paragraph 88 that as part of its investigation, ASIC considered advertisements on CBA and CommInsure's websites as well as information that was made available to consumers through financial advisers?---Yes.

And we see from paragraph 89 that Mr Kell was concerned that those advertisements were misleading and deceptive, and that by those advertisements, CMLA was also breaching its obligation to act in the utmost good faith in section 13 of the Insurance Contracts Act?---Yes.

And in paragraphs 90 to 91, Mr Kell gave some examples of concerning statements in the advertisements, which I will come back to as we look at some of those advertisements, but the essence of the concern was that the statements were not sufficiently qualified or limited to ensure that readers were aware of the specific criteria that they were required to meet to satisfy the heart attack definition?---Yes, that's how I understood it, yes.

And we see from paragraph 92 that Mr Kell told CMLA that ASIC was currently considering enforcement options in relation to these potential contraventions, and would contact CMLA shortly to discuss how the matter may proceed going forward?---Yes.

Now, with that background, could I ask that you look at some of these advertisements. If we could go to ASIC.0066.0001.1097. And if we could turn – that's an email attaching some of the advertisements and providing them to ASIC. If we could turn to 1098.

THE COMMISSIONER: I suspect the attachment will be a new document.

MS ORR: ASIC.0066.0001.1098. I'm told it's coming, Commissioner. I think it is difficult for me to ask you any questions about this document until it is on the screen, Ms Troup?---Thank you.

I'm sorry, Commissioner, I think it might be best if we take just a couple of minutes to ensure that we've got the right document. I'm in your hands as to whether you would prefer to stand down for a few minutes.

THE COMMISSIONER: If I sit here and stare balefully at the screen it will work quicker, won't it, Ms Orr? But there again - - -

MS ORR: We think it may be another few minutes, Commissioner.

THE COMMISSIONER: Rather than my staring at everybody and causing havoc, if I leave and if you let me know - - -

MS ORR: Yes.

THE COMMISSIONER: - - - when we're ready to go.

MS ORR: Thank you, Commissioner.

THE COMMISSIONER: Yes.

MS ORR: I apologise.

THE COMMISSIONER: No, these things happen.

ADJOURNED **[9.58 am]**

RESUMED **[10.04 am]**

MS ORR: Thank you for that time, Commissioner. I apologise for the technical difficulty. We have the document now.

Ms Troup, this is the first advertisement that I want to take you to. It's an extract from the CBA website. Is that right?---Yes, it is.

And we know from correspondence between CBA and ASIC that this advertisement could be accessed from the CBA website from about December 2012 to March 2016. Does that accord with your recollection?---Yes, it does.

Thank you. And if we go to the next two pages of this web capture to 1099 and 1100, we can see that the information about trauma cover runs from the bottom of the first page, across on to the next page. You see that, Ms Troup?---Yes, I do.

And we see that in the right-hand column, the information on the website was:

> *This cover can pay a lump sum to help with medical costs if you suffer any one of our specified trauma conditions, such as cancer, heart attack or stroke. It's part of our tailored insurance range.*

And in the left-hand column under the heading Features it says:

Helps cover the medical costs and lessen the severe lifestyle changes that result from any of 48 major illnesses or injuries such as heart attack, stroke, cancer, or blindness.

Now, there was no indication anywhere in this advertisement that the words "heart attack" covered only some heart attacks, was there?---Not on that page, no.

On any page in this advertisement, Ms Troup?---Not what you're showing here, no.

Would you like to see the other pages of this advertisement?---No.

No. You accept that there was nothing in the pages that dealt with trauma cover on the website at this time that indicated that the references to heart attack were intended to cover only some types of heart attack?---No, not on these pages.

You keep saying that, Ms Troup. What pages would you like to refer to?---Apologies. If you click through to Learn More it takes you to the PDS which explains things further.

I see?---Apologies.

So there was a hyperlink to the product disclosure statement?---Yes.

And the definition was in the product disclosure statement?---Yes, it was.

But there was no indication in the advertisement that the words "heart attack" should be read as "heart attack of specified severity"?---That's correct.

And there was no reference to the particular heart attack definition on the pages of the website, was there?---That's right.

Do you accept that a person reading this advertisement would have been likely to believe that CommInsure's trauma policy covered all heart attacks?---Yes, based on that page, yes.

Well, let's go to the page that you're referring to. I think that's 1104. Perhaps if we could bring up 1103 and 1104 we will see the full four pages containing this advertisement. I think what you may be referring to is something that appears in the information at the bottom of the right page. Is that right?---Yes.

Continuing:

This information has been prepared without considering your personal objectives, financial situation or needs. Before acting on it, please consider its appropriateness to your circumstances. Refer to the relevant product disclosure statement and financial services guide.

And that was a hyperlink. Is that right?---Yes.

Now, is it reasonable for a reader, firstly, to expect that CBA has accurately summarised the key parts of the policy in the advertising material?---Yes.

And is it reasonable for a consumer to expect that CBA has not overstated the coverage available?---Yes.

It is not reasonable, I want to put to you, for CBA to expect a person to scroll much further down the page to click through to a PDS and locate the definition that will explain to them that when you refer to a heart attack, you're really referring to a heart attack of a particular severity?---I think that's fair.

So do you accept that this advertisement was, therefore, misleading to consumers about the coverage of your trauma policies for heart attacks?---Yes.

All right. Thank you. Now, if I could tender that advertisement, Commissioner.

THE COMMISSIONER: CBA website December '12 to March '16 web capture tailored life insurance, ASIC.0066.0001.1098, exhibit 6.165.

EXHIBIT #6.165 CBA WEBSITE DECEMBER '12 TO MARCH '16 WEB CAPTURE TAILORED LIFE INSURANCE (ASIC.0066.0001.1098)

MS ORR: Could I ask that you look at another advertisement that was provided to ASIC. This one is at ASIC.0066.0001.1106. And this is also an extract or a web capture from the CBA website. Now, this could be accessed, we know again from correspondence between CMLA and ASIC, from the CBA website from about June 2013 to March 2016. Does that accord with your recollection?---Yes, it does.

And up the top of this web page under the word Trauma, we see:

> *This cover can pay a lump sum to help with medical costs if you suffer any one of our specified trauma conditions such as cancer, heart attack or stroke. It's part of our tailored insurance range.*

And then we see further down under How It Works – do you see that, Ms Troup?---Yes, I do.

Continuing:

> *This cover can help with medical costs and also help to lessen lifestyle changes that result from any of 48 major illnesses or injuries, including heart attack, stroke, cancer or blindness.*

So, again, there was no indication that the words "heart attack" only included some heart attacks?---That's correct.

No reference to heart attacks of specified severity?---That's correct.

And no reference to the particular definition in the policy?---That's correct.

And, again, do you accept that a person reading this advertisement would have been likely to believe that CommInsure's trauma policy covered all heart attacks?---Yes.

Not just heart attacks of a particular severity?---That's right.

So do you accept as well that this advertisement misled customers?---Yes.

I tender that advertisement, Commissioner.

THE COMMISSIONER: CBA website web capture June '13 to March '16 Trauma, ASIC.0066.0001.1106, exhibit 6.166.

EXHIBIT #6.166 CBA WEBSITE WEB CAPTURE JUNE '13 TO MARCH '16 TRAUMA (ASIC.0066.0001.1106)

MS ORR: Could I ask that you be shown now, Ms Troup, ASIC.0066.0001.1112. Now, this was a two-page pamphlet. Perhaps if we could have the second page brought up on the screen at the same time. It was a pamphlet that was accessible from the CommInsure website from June 2015 to March 2016.

THE COMMISSIONER: Sorry, what dates, Ms Orr?

MS ORR: June 2015 to March 2016.

THE COMMISSIONER: Thank you.

MS ORR: Does that accord with your recollection, Ms Troup?---Yes.

And under the heading What is Trauma Cover, on the left-hand side, it says:

> *Trauma cover pays a one-off lump sum of up to $2 million if you suffer from a specified medical condition, regardless of whether you are prevented from working or not.*

And then under the heading What is Covered, on the left-hand side towards the bottom of the page, what is covered, the first category in the list is heart disorders. And the first item in the list is heart attack. Now, by this time, in June 2015, the policy itself didn't say heart attack, did it?---No.

It said:

Heart attack of specified severity.

?---Yes.

But there's no reference to that qualification here?---No.

And no reference to the definition from the policy?---That's correct.

And there's not even a reference to the product disclosure statement, is there? Perhaps if we can pan back so that you're able to look at the entirety of the document?---No.

Should there have been, Ms Troup?---Yes.

There's no reference to the fact that the benefit would only be payable if the insured met the particular definitions in the policy. We don't even see that sort of statement in this pamphlet?---No.

And do you accept that a person reading this pamphlet would also have been likely to believe that CommInsure's trauma policy covered all heart attacks?---Yes.

Not just heart attacks of particular severity?---That's correct.

Do you accept that this pamphlet was also misleading to consumers?---Yes.

Thank you. I tender that pamphlet, Commissioner.

THE COMMISSIONER: Trauma cover pamphlet June '15 to March '16, ASIC.0066.0001.1112, exhibit 6.167.

EXHIBIT #6.167 TRAUMA COVER PAMPHLET JUNE '15 TO MARCH '16 (ASIC.0066.0001.1112)

THE COMMISSIONER: Just before we leave that, Ms Orr, I see that a number of the items, including coronary artery angioplasty, have an asterisk. I can't – I see, partial trauma cover benefit paid.

MS ORR: Yes.

THE COMMISSIONER: Is where the asterisk leads.

MS ORR: Yes.

THE COMMISSIONER: Yes.

MS ORR: Now, the fourth and final advertisement I want to take you to, Ms Troup, is at ASIC.0066.0001.1114. Now, this was another pamphlet accessible from the CommInsure website from June 2015 to March 2016. Does that accord with your recollection?---Yes. Yes.

And this pamphlet was called The Big Four Trauma Claims. And if we turn to the second page, 1117. If we could turn to 1117 which is page 2 of the pamphlet, under the heading What is Trauma Cover, the pamphlet said:

> *Trauma cover is an insurance product that pays a lump sum benefit for defined traumatic medical conditions or events and should form part of any risk protection portfolio. It covers a wide range of conditions, including the "big four" trauma claims of cancer, stroke, heart attack and coronary artery bypass grafts.*

And then if we turn to 1123 within the document we see that the document addresses heart attack specifically. The first heading on the page is What is a Heart Attack:

> *On average, the human heart beats 70 times per minute to circulate blood around the body. Like other active muscles, the heart needs a steady supply of oxygen-rich blood to remain healthy and function properly. A heart attack happens when one or several of the heart's main arteries are blocked and oxygen-rich blood no longer reaches it, resulting in the death of heart cells. Such blockage is usually caused by a blood clot becoming lodged in an artery, with the clot typically arising after rupture (or tearing) of arterial plaque*

Now, that's not how heart attack was defined in the policy, is it, Ms Troup?---No.

This page doesn't make any reference to the definition of heart attack in the policy, does it?---No.

It doesn't even warn the reader that there is a different definition?---No.

Do you accept that a person reading this document would have been likely to believe that CommInsure's trauma policy covered all heart attacks?---Yes.

Not just heart attacks of particular severity?---Correct.

You accept that this document was misleading to consumers?---Yes.

I tender that document, Commissioner.

THE COMMISSIONER: The Big Four Trauma Claims pamphlet, June '15 to March '16, ASIC.0066.0001.1114, exhibit 6.168.

EXHIBIT #6.168 THE BIG FOUR TRAUMA CLAIMS PAMPHLET, JUNE '15 TO MARCH '16 (ASIC.0066.0001.1114)

MS ORR: Now, we saw from the earlier letter, the 22 March 2017 letter from Mr Kell that Mr Kell advised CMLA that ASIC was considering what enforcement action it would take in respect of the misleading material in these advertisements. Did ASIC take any enforcement action against CommInsure in relation to any of these advertisements?---I'm not sure if enforcement action is the correct term but we did come to an – an agreement in terms of how to close the matter.

You came to an agreement as to how to close the matter?---Yes.

Well, I just want to deal with that in a bit of detail, Ms Troup, and see exactly what we understand happened. Can I start by taking you to some emails that are ASIC.0066.0001.1302. And if we start at 1303 and 1304 on the screen. We can see from the email that commences at the bottom of the left-hand page that on 17 October 2017, Tim Mullaly, the senior executive leader of financial services enforcement at ASIC wrote to James Myerscough, the chief risk officer of wealth management at CBA. Have you seen these emails before, Ms Troup?---Yes, I have.

And Mr Mullaly said that he had set out some wording for the CommInsure advertising matter which would form the basis of a letter as between ASIC and CommInsure formally resolving the matter, and also form the basis of a media release to be issued by ASIC in relation to the matter.

You see that reference in the correspondence from Mr Mullaly to Mr Myerscough?---Yes, I do.

And he then set out ASICs proposed wording for the basis of a media release to be issued by ASIC, and that wording, we can see from the right-hand page, included references to ASICs concern that CommInsure had made misleading and deceptive statements on its websites. You see that reference?---Yes, I do.

It included that, underneath that:

> *The statements may have led a policyholder to believe they would be entitled to a lump sum payment when they suffered a heart attack when, in fact, they would only be paid if they suffered a heart attack which met certain medical criteria.*

?---Yes.

And we see that the proposed form of words also included, a few paragraphs down, a statement that:

CommInsure acknowledged that prior to March 2016 the statements may have been misleading and deceptive.

Do you see that reference, Ms Troup?---Yes, I do.

And the proposed wording also included this statement:

To resolve ASICs concerns, CommInsure has agreed to make a voluntary community benefit payment of $300,000 to –

Blank:

This payment will be made by –

Blank. Do you see that?---Yes, I do.

And there is also a reference to:

...CommInsure commissioning an independent compliance review of its advertising sign-off processes and procedures.

?---Yes.

And finally a statement that:

ASIC has now concluded its investigation into the life insurance business of CommInsure (noting that ASIC will engage on the ongoing reviews).

So that was the form of words for the media release that ASIC proposed to CMLA?---Yes.

And then underneath the proposed words, if we pan out, we will see that Mr Mullaly said to Mr Myerscough:

We will, of course, need to agree with CommInsure the timing of a number of steps, the CBP –

Community benefit payment:

...recipient and the nature and details of the review. Could you please consider and let us know whether this is sufficient for CommInsure to resolve the matter, including by way of payment of the community benefit payment in the absence of infringement notices.

Now, Ms Troup, do you know how the figure of $300,000 for the community benefit payment was arrived at?---No, I – I can't remember.

You don't know. You don't know whether that was proposed by ASIC or by CMLA?---No, I can't – no, I – I'm sorry, I can't remember how that came about.

Are you aware that at this time, in 2017, the maximum penalty for a contravention of section 12DB of the ASIC Act by a body corporate for misleading and deceptive conduct was 10,000 penalty units?---Yes, I recall that, yes.

So that's almost $2 million per contravention?---I – can I trust your maths, yes.

I want to take you back to what happened after this email was received from Mr Mullaly by Mr - - -

THE COMMISSIONER: Before you leave that, what's meant by:

Let us know whether this is sufficient for CommInsure to resolve?

What did you understand by that, Ms Troup?---I – I think it was the two organisations resolving the matter that was satisfactory for both companies.

The regulator asking the regulated whether the proposal was sufficient in the eyes of the party alleged to have broken the law. Is that right?---I guess in terms of we could have taken an approach of continuing to defend our position, and so this was the alternative.

Yes.

MS ORR: There was no need for you to defend your position, was there, Ms Troup, because you were going to be able to consult with ASIC about a mutually agreeable resolution of the matter?---Yes. So the – there could have been other alternatives to resolve the matter.

Was ASIC presenting any other alternatives as ways of resolving the matter?---Well, I think ASIC always reserved the right to continue the enforcement action.

Where do we see that here?---It – maybe not in that correspondence but that's my understanding. ASIC in these correspondence, it doesn't limit their rights or abilities to do other.

No, but the tone of this correspondence is not suggestive of ASIC considering in any active way any enforcement action, is it?---Not in this correspondence.

All right. Well, let's look at what happened after this correspondence was received. If we pan back to the left-hand side of the page. We see that Mr Myerscough said:

Dear Tim, thank you for your letter below. We will consider it and response as soon as possible.

And then a couple of weeks later, having received no response, we see, if we go to the top of the page, that the acknowledgement of the letter by Mr Myerscough was on 17 October, and we will need now to bring up 1302 next to 1303, so that you can see the date of the email at the top of the page. So a couple of weeks after getting that acknowledgement that the letter had been received, Mr Mullaly followed Mr Myerscough up on 2 November. He wrote to Mr Myerscough and said:

> *Dear James, can you please provide an update on your consideration of the below?*

Do you see that?---Yes, I do.

Now, the following day, Mr Myerscough responded. We see this from the left-hand side, 1302, and he copied you on this email. Do you see your name there?---Yes, I do.

And Mr Myerscough attached a different form of wording for the media release to be issued by ASIC, which he said:

> *Would formally resolve the matter between ASIC and CommInsure and form the basis of ASICs media release.*

?---Yes.

So CBA suggested to ASIC what ASIC should say in its media release?---It provided feedback, yes.

With a different form of words for ASIC to use in its media release?---Yes.

And were you involved in the drafting of the alternative wording?---Yes, I believe I was.

Yes. That alternative wording is at ASIC.0066.0001.1306. Now, if we could bring up Mr Mullaly's form of words on one side of the screen and compare that with CBAs proposed form of words, we will need ASIC.0066.0001.1302 at 1304 on one side of the screen and this document on the other. And before we look at the content, I see a comment in the proposed CBA alternative with the initials HT. Are they your initials? Is that your comment there, Ms Troup?---Yes, it is.

Okay. Now, if we compare the text of these two, we can see that they are largely the same, but if we look about halfway down Mr Mullaly's draft, we can see – do you recall I drew your attention to the acknowledgement by CommInsure that prior to March 2016 the statements may have been misleading and deceptive?---Yes.

And if we look at the same line in CBAs draft on the left-hand side, the proposal was:

CommInsure acknowledges that prior to March 2016, ASICs concerns could be reasonably held.

That was the proposed alternative form of wording?---Yes.

Did ASIC accept CBAs form of wording in substitution for its proposal?---I will confess, I'm not sure but I'm sure you have the – sorry, the release that was finalised so.

Let's go to that. I will need to tender both of these documents, Commissioner, the email chain between Mr Myerscough and Mr Mullaly, and the attachment which was the CBA proposed alternative form of wording for the media release.

THE COMMISSIONER: Exhibit 6.169 will be emails October/November '17 between ASIC and CBA concerning CommInsure advertising matter, ASIC.0066.0001.1302.

EXHIBIT #6.169 EMAILS OCTOBER/NOVEMBER '17 BETWEEN ASIC AND CBA CONCERNING COMMINSURE ADVERTISING MATTER (ASIC.0066.0001.1302)

THE COMMISSIONER: Exhibit 6.170 will be CBA draft of ASIC media release to resolve CommInsure advertising matter, ASIC.0066.0001.1306, exhibit 6.170.

EXHIBIT #6.170 CBA DRAFT OF ASIC MEDIA RELEASE TO RESOLVE COMMINSURE ADVERTISING MATTER (ASIC.0066.0001.1306)

MS ORR: Now, that email chain that I've just taken you to was in October and November 2017. Can I ask you now to look at a letter that ASIC sent to you on 28 November which is ASIC.0066.0002.0073. Now, this was a letter from Mr Mullaly to you. I can bring up the last page to show you that, or do you recall that this is a letter from Mr Mullaly?---Yes.

Yes. Dated 28 November 2017. And we see that it dealt with the investigation into the advertising concerns, and set out the background to that investigation. And over the page at 0074, we see in paragraph 9 Mr Mullaly expressing views about the advertisements containing misleading representations. Do you see "ASIC is concerned that"?---Yes.

Continuing:

ASIC considers various representations in the four advertisements gave the impression that CMLA would make a lump sum payment to an insured if they

suffered a heart attack when in fact the insured would only be paid if they suffered a heart attack which met certain specific medical criteria.

Now, if we turn to 0076 in this letter, Mr Mullaly explained in paragraph 22 that:

ASICs concerns extended beyond the four advertisements because substantially similar wording was contained within other advertisements for CMLAs Simple Life product sold directly to consumers, and thereby increasing the number of consumers potentially affected.

And then if we turn to 0077, we see the final – or the penultimate part of the letter is headed Action to be taken by CMLA:

In recognition of ASICs concerns, CMLA will (a) acknowledge that prior to March 2016 ASICs concerns, as set out in this letter in relation to the four advertisements, could be reasonably held.

That was the language we saw from your proposed alternative wording for the media release?---Yes.

Continuing:

(b) make a voluntary community benefit payment of $300,000 to the Insurance Law Service to be paid by no later than close of business –

On a particular date:

(c) commission a compliance review of its advertising sign-off processes and procedures which will be subject to an independent assurance review, and advise ASIC by 15 December 2017 the name of the proposed independent reviewer; and (d) CMLA will report to ASIC by 30 June this year on the results of the review and the changes implemented.

So that was the letter that Mr Mullaly sent to you on 28 November 2017?---Yes.

I tender that letter, Commissioner.

THE COMMISSIONER: Letter ASIC to CMLA, 28 November '17, ASIC.0066.0002.0073, exhibit 6.171.

EXHIBIT #6.171 LETTER ASIC TO CMLA DATED 28/11/2017 (ASIC.0066.0002.0073)

MS ORR: So we see from that page that the first action to be taken by CMLA was an acknowledgement that prior to March 2016 ASICs concerns could be reasonably

held. Now, prior to your evidence today, has ASIC – I'm sorry, has CommInsure ever acknowledged that the advertisements contained misleading representations?---Not in that language, no.

Why not, Ms Troup?---Our position at the time is while we understood ASICs concerns, we didn't entirely agree with them.

What makes you able to make that acknowledgement today, giving evidence in the Royal Commission, that's different from the information that was available to CommInsure at the time that it was negotiating the resolution of this matter with ASIC?---Sorry, could you ask that again?

Well, I don't understand why the difference between CommInsure's position at this time and your position here in evidence in the Royal Commission today?---I – I think at that time we were still defending our position and believed that there was other circumstances around, but sitting here now looking at the way it was positioned, I can see how ASICs concerns were legitimate.

And you can see and you've given evidence that the advertisements were misleading to consumers?---Yes.

But CBA was not prepared to acknowledge that in its dealings with ASIC?---That's correct.

And has not publicly acknowledged that at any time before your evidence today. Is that right?---Yes.

Now, can we go to ASICs media release in relation to this investigation, which is ASIC MR – 17447MR – sorry, that's the name of the media release. It's RCD.0015.0002.2133. Now, this is the media release that ASIC published on 18 December last year?---Yes.

It's a two-page media release. If we could have both of the pages on the screen. We will see that as published, it contained no acknowledgement by CommInsure that the statements in the advertisements may have been misleading or deceptive?---Yes.

It contained no acknowledgement by CommInsure even that ASICs concerns about the advertisements were reasonably held?---That's right.

ASIC elected not to include that form of wording, it seems?---Yes.

And the media release contained no acknowledgement by CommInsure of any form of wrongdoing in connection with these advertisements?---That's right.

Should it have, Ms Troup?---Again, I think that's – given it's ASICs media release I think that's a matter for ASIC.

A poor question on my part because it couldn't have, could it, because you hadn't made any acknowledgement?---That's correct.

Now, the media release records that CommInsure made a voluntary $300,000 community benefit payment?---Yes. I'm not sure I see the word "voluntary" but yes, I see we will make the payment down the bottom.

It was a voluntary payment, is that right?---Well, it was part of the agreement with ASIC, so – if it wasn't for that, we wouldn't have done it.

I see?---Yes.

It also contained a reference to CommInsure commissioning the compliance review of advertising and sign-off processes?---Yes.

And the matter then ended there with this media release issued in December last year?---The matter with ASIC?

Yes?---Yes, but in – we did do the review and provide that report to ASIC.

Yes?---Yes.

So you did what ASIC had asked you to do in terms of the review of your advertising sign-off processes?---Yes, we did.

But the matter ended there in terms of the resolution that you had negotiated with ASIC for the advertising?---Yes.

This was a very good outcome for CBA, wasn't it, Ms Troup?---No, I probably wouldn't characterise it that way. At that time we felt that we did have elements of defence.

THE COMMISSIONER: Can you tell me what they were?---From memory, the two that come to mind was around the context of the advertising, in terms of they're in one element of a broader website and references to advisers. And I think the second element was, in general terms, we think consumers would understand that an insurance policy does have defined terms. They're the two I can recall at this time, Commissioner.

You don't think a consumer reading the website might think that heart attack, a medical term, if the doctor tells me I've had a heart attack, I've had a heart attack. You don't think that would be the chain of reasoning the ordinary consumer would follow?---I think that is reasonable. I guess, as I said earlier, though, our policies do have definitions, and I think a consumer would – may expect that as well.

But at the end of this process with ASIC, is the position this: CommInsure did not acknowledge that it had done anything wrong. Is that right?---A thought that comes

to mind with that question, Commissioner, is yes on that particular advertising matter, but the context was we had addressed the fundamental issue of the heart attack definition, and if any customer had been misled in that time, we – we had corrected that action. So I think there's – we were thinking about it in that – in those terms.

And if CommInsure had done something wrong, had CommInsure been punished for doing something wrong?---I – I think we feel the 300,000 community benefit payment was a form of – form of punishment.

A very small amount, was it not, Ms Troup?---That – that's probably best for other people to judge in the context of other errors of this nature.

300,000 is three times the claim of the particular insured person who forms the foundation of this case study. Is that right?---Yes, that's correct, Commissioner.

And as Ms Orr has said to you, the then punishment for misleading and deceptive conduct was of the order, I think you said, Ms Orr, 2 million.

MS ORR: 2 million for a corporate entity.

THE COMMISSIONER: And there were at least four types of advertisement in issue here?---Yes.

Is that right?---Yes.

Leave aside whether you count each publication as a separate contravention, if we simply take the type of alleged contravention, being singular, for each advertisement, the maximum punishment was of the order of 8 million on this maths. Is that right?---Yes. I – yes, sir.

At the end of the day, Ms Troup, did CommInsure come out of this process thinking that it had been punished or brought to book?---Yes, we did, sir.

Yes. Go on.

MS ORR: I just want to clarify one matter, Commissioner, which is that section 12DB, which I referred to before, relates to false and misleading representations. I said misleading and deceptive. That is the provision we've used to calculate penalty.

THE COMMISSIONER: Yes.

MS ORR: There are multiple sorts of provisions that could have been relied on by ASIC here. I just want to take a moment to summarise the evidence so far in terms of CommInsure's dealings with ASIC over the events that we've been discussing, both today and yesterday. We heard from your evidence yesterday that in March

2017 when ASIC concluded the main part of its investigation into CommInsure, ASIC gave CommInsure, firstly, advance notice of its findings?---Yes.

And when ASIC formally notified CommInsure of its findings, on 22 March, you had conversations with Mr Saadat at ASIC about what would be included in ASICs media release about those findings?---Sorry, which letter are we referring to? The - - -

The 22 March letter, and the media release that came out on 23 March. You had discussions with Mr Saadat about including in ASICs media release the decision that you had made the night before to backdate the medical definition to October 2012?---Yes. Thank you.

And I assume, at your request, ASIC included that piece of information in its media release?---Yes.

And then when FOS notified ASIC that it considered CommInsure had engaged in serious misconduct by misleading FOS, ASIC sent CommInsure a letter?---Yes.

And the letter said that ASIC expected CommInsure not to do that again?---Yes.

But ASIC took no other action?---Not on that matter, no.

And then when ASIC did form the view that CommInsure had engaged in a contravention of the law by misleading and deceptive conduct and made false and misleading representations in its promotional material, it took no enforcement action against CommInsure?---No, not enforcement action, no.

It instead agreed with CommInsure that CommInsure would make the community benefit payment of $300,000?---Yes.

And it gave CommInsure the opportunity to make changes to the media release announcing that decision?---Yes.

With the result that until today, CommInsure has never acknowledged that it engaged in misleading and deceptive conduct in that advertising?---Correct.

I will tender the media release, Commissioner.

THE COMMISSIONER: ASIC media release MR 443, MR of 18 December ’17, RCD.0015.0002.2133, exhibit 6.172.

EXHIBIT #6.172 ASIC MEDIA RELEASE MR 443 DATED 18/12/2017 (RCD.0015.0002.2133)

MS ORR: Now, Ms Troup, we've discussed two of the three issues that I said I wanted to raise with you from Mr Kell's letter of 22 March 2017. The third and final issue that I want to ask you some questions about is ASICs investigation of CMLAs claims handling practices. Now, they were part of the investigation by ASIC. And they were also the subject of a number of external reviews. Is that right?---Yes.

And one of those reviews was conducted by Deloitte?---That's right.

And could I take you to the report that Deloitte produced, which is CBA.0001.0044.0027. Now, I want to take you just briefly to some parts of this report, Ms Troup. If we could turn to 0031, where we see the executive summary of the report. Under the box, the report explains that:

> *The Deloitte Claims Review Program involved two work streams.*

The first was a:

> *Review of a sample of life insurance claims that had been declined between 1 May 2011 and 30 April 2016 to identify whether customers had claims incorrectly declined or there was a poor customer experience in how their claim was managed. This is referred to as the Claims Review.*

And the second work stream was a:

> *Review of the design of the life insurance claims handling processes (both current and planned improvements) to identify any features, factors or processes that, when operated, could systemically deliver poor customer outcomes, either financially because a claim is incorrectly declined, or through a poor customer experience in how a claim is managed.*

That was referred to as the claims handling review?---Yes.

And if we turn to 0039, we see a discussion of the claims review, the first of those work streams. And we can see from this page that Deloitte reviewed a sample of 797 declined claims. Do you see that in the table, Ms Troup?---Yes, I do.

And on 0041 we see that there were four possible outcomes for the review of each claim. Do you see in the bottom part of the page that the four outcomes were that the decision was appropriate, that it was appropriate but there had been a poor customer experience, that there had been a customer financial impact, or an incomplete process?---Yes.

Now, Deloitte identified problems in 41 of the 797 claims that it reviewed?---Yes.

And it referred those to CBA for reassessment?---Yes.

And if we turn to 0043, we can see the results of that reassessment as at the time of this report. We see from the table at the top of the page that there were 12 cases where the decision was correct but there was a poor customer experience, eight cases where the incorrect decision was made leading to a financial impact for the customer, and a further 11 that CommInsure was still reassessing when this report was published?---Yes.

And CommInsure completed its reassessment of those 11 cases?---Yes, it did.

And of those 11, there were a further two where the decision was correct but there was a poor customer experience. Is that right, Ms Troup?---I – I will – it would have been in a document which I assume you have, so yes.

Yes. Are you able to confirm that or would you like me to take you to that document?---If you could take me to the document, that would be appreciated.

Yes. CBA.0001.0395.0687. And if we turn to 0688. You can see that this is a letter first - - -?---Yes.

- - - to Mr Austin from Deloitte on 31 August 2017. And I will ask you to look at the second page, 0688. And we can see that, from the table on that page, there were two cases where the decision was correct but there was a poor customer experience. And eight cases where the incorrect decision was made, leading to a financial impact for the customer?---Yes.

For a total of 14 cases, being 12 from the report, plus two from this document, where the decision was correct but there was a poor customer experience?---Yes.

And 16, eight from the Deloitte report and eight from this document, where the incorrect decision was made leading to a financial impact for the customer?---Yes.

Now, did CommInsure remediate those customers?---Yes.

And Deloitte made a series of recommendations about how CommInsure could improve its claims handling process. Is that right?---That is right.

There were 29 recommendations?---That sounds right, yes.

Now, I want to just take you to a couple of those recommendations, but I'm moving between two documents and it's perhaps best if I tender both of those, Commissioner.

THE COMMISSIONER: Deloitte report to CMLA, 8 February '17 concerning Claims Review Program, CBA.0001.0044.0027 is exhibit 6.173.

EXHIBIT #6.173 DELOITTE REPORT TO CMLA DATED 08/02/2017 CONCERNING CLAIMS REVIEW PROGRAM (CBA.0001.0044.0027)

THE COMMISSIONER: Letter Deloitte to chairman CMLA, 31 August '17, CBA.0001.0395.0687, exhibit 6.174.

EXHIBIT #6.174 LETTER DELOITTE TO CHAIRMAN CMLA DATED 31/08/2017 (CBA.0001.0395.0687)

MS ORR: Are you familiar with the 29 recommendations made by Deloitte - - -?---Yes.

- - - Ms Troup?---Yes, I am.

Let me ask you some questions about them, and if necessary I will take you to the document?---Okay.

But you may be able to answer these questions. Do you accept that they included recommendations about improving staff training?---Yes.

About improving how case managers document their conclusions on the assessment of differing medical evidence?---Yes.

About improving the documents used to communicate with customers in the claims handling process?---Yes.

About how – about the need to improve how CMLA claims handling quality assurance reviews worked?---Yes.

And about improving the processes around the making of ex gratia payments so that where an ex gratia payment is made, consideration is also given to what went wrong and what learnings need to be passed back to the business?---Yes.

They were some of the 29 recommendations made by Deloitte?---Yes.

And has CommInsure implemented each of those 29 recommendations?---Yes, we have.

And what are the key changes that CommInsure has made to its claims handling processes as a result?---There – there were many. I think an overarching one that picked up quite a few of the recommendations is our claims processing system in terms of the checklist a claims manager must do before they complete a claim, and so it's – they're system checks and balances there. For example, they can't proceed to the next step unless they have done the – the step that was necessary. So that picked

up a range of the recommendations, because you want to embed those processing. The – one of the ones that you called out then, obviously claims training. Part of our implementation we use a package system. So every time a change is implemented, we have a training program that's done with testing to ensure that people are learning from – from the improvement in processes or topics. So they – they would be two fairly broad areas.

All right. Now, Ms Troup, I want to turn to a different topic, having dealt with the three issues that I wanted to deal with from Mr Kell's letter to CommInsure in March 2017. I want to take you to the other specific consumer case that you've dealt with in your witness statements?---Yes.

And this case concerned another CommInsure customer whose name is also the subject of a non-publication direction who developed breast cancer. You know which case I'm speaking of?---Yes, I do.

Now, again, I'm just going to refer to her as the insured. Now, the insured took out a total care plan with a company called Legal & General in 1996. Is that right?---Yes, that's right.

And what's the relationship between CommInsure and Legal and General?---So it's another part of our corporate history where Colonial had bought Legal & General.

So it was ultimately acquired into the - - -?---Yes.

- - - CommInsure business?---Yes.

Now, the policy that this insured person had was similar to the one held by the other insured, who I've already asked you questions about. Is that right?---That is correct, yes. Very similar.

And, again, you've exhibited a copy of the customer information booklet for the policy to your statement. And I just want to go to that. It's CBA.0517.0210.3114. And it's the second exhibit to your statement, Ms Troup. Now, if we turn to the third page of the information booklet at 3115. We can see a description of the key features of this policy:

> *Total care plan provides guaranteed renewable life, trauma and disability insurance through to the expiry date of the selected benefits, regardless of any change in your state of health, occupation or pastimes. Cover is available 24 hours per day, seven days per week, anywhere in the world.*

And then under the heading Recuperator, we see:

> *The recuperator benefit guarantees to pay a lump sum upon diagnosis of any one of the following conditions.*

And we see the third of those conditions is cancer?---Yes.

And, again, we have an asterisk which points us to a qualifier that it doesn't cover cancer that occurs within three months of the policy commencing?---Correct.

Now, the insured took recuperator or trauma cover as part of her policy. Is that right?---Yes, she did. Sorry, yes.

And as we saw in relation to heart attacks, each of the conditions on this list were defined in the policy?---Yes.

And if we turn to 0211 to – I'm sorry, 2011 to 2012. I'm sorry, we will come to that. Can I just ask you a few other questions first. The policy definitions, as we saw in the first insured person's case, were updated from time to time. Is that right?---That's right.

And if a definition was updated, again, the insured would be entitled to rely on the definition that applied when she purchased the policy, or any updated definition?---That's - - -

Is that right?---That's correct.

And as you did with your other statement, you provided an annexure setting out the different definitions of cancer that applied under the policy at different times. And that was what I wanted to take you to. It's CBA.9000.0113.2000 at 2012 and 2011. So that's the annexure to your statement dealing with this insured person setting out the different definitions of cancer that applied over time. And we see that the first definition in that list is the definition of cancer that applied when the insured purchased her policy in February 1996. Is that right?---Yes, that's right.

And we see that the definition was updated in April 1996 and again in November 1998?---Yes.

And then it was not updated again until May 2017?---That's right.

Almost 20 years later?---Yes.

And the definition that applied at the time the insured made her claim was the November 1998 definition?---Yes.

The definition that was in force over that 20 year period?---Yes.

Now, if we look at that definition, we see that it defined cancer as meaning:

> *Any malignant tumours characterised by the uncontrolled growth and spread of the malignant cells that requires treatment by surgery, radiotherapy,*

chemotherapy, biological response modifiers, or any other major interventionist treatment and includes cancers that are completely untreatable.

And then the definition has a list of specific inclusions, and under that a list of specific exclusions. And one of those – we will need to bring up the second page to see this exclusion – there we go. One of the exclusions was:

Carcinoma in situ unless leading to radical breast surgery.

?---Yes.

Do you see that, Ms Troup?---Yes, I do.

Okay. So that was the definition in place at the time that this insured person took out her policy – I'm sorry, the time that this insured person made the claim under her policy?---Yes.

That claim was made in August 2016?---Yes.

And by that time, she had held the policy for more than 20 years?---Yes.

And the definition of cancer in the policy at that time was almost 18 years old?---Yes.

Now, you've exhibited a copy of the insured's claim form to your statement. It's the fifth exhibit. CBA.0001.0513.0934. And on the second page of the claim form at 0935, we can see that under details of trauma conditions, the insured person ticked cancer, and explained that the first onset of symptoms was on 7 March 2016, and she was hospitalised on 11 March 2016. You see that, Ms Troup?---Yes, I do.

And over the page, in answer to the question:

What symptoms preceded the diagnosis?

The insured person has given this information:

A regular mammogram through Breast Screen SA identified an abnormality. I had no symptoms prior to diagnosis.

And then on the fourth page at 0937, we can see that the insured had surgery a few days after the first onset of symptoms on 11 March 2016 and again a few days later on 17 March 2016?---Yes.

Now, when the insured provided this claim form, she also provided information from her GP, her surgeon and her radiation oncologist?---Yes.

Now, could I ask that you look at the seventh exhibit to your statement, CBA.0001.0513.0942. And this is the medical certificate provided by the insured's GP?---Yes.

And if we look at question 3, we can see that – question 3 or – question 4, I'm sorry. I'm looking for the part where – here we are – from question 3 we can see that the GP explained that this was a carcinoma in situ. Do you see that?---Yes, I do.

And that then required him to move to question 4, and answer whether or not there was surgical removal of the carcinoma in situ. And whether it involved removal of the entire organ. The question was:

> *Did surgical removal of the carcinoma in situ involve removal of the entire organ.*

And the answer was no. The second question was:

> *Was the surgery performed specifically to arrest the spread of malignancy?*

And the answer was yes. So that was the information provided by the GP. The GP also attached some medical reports to this certificate?---Yes.

And if we go to 0950 within this document, this is one of the reports that the GP provided, and we can see from this report what the two surgeries that the insured had involved. One of the surgeries involved the removal of a portion of breast tissue measuring 33 by 27 by 12 millimetres. Do you see that?---Yes, I do.

And the other surgery involved the removal of a portion of breast tissue measuring 50 by 30 by 8 millimetres?---Yes.

And the same information was provided by the surgeon who also provided a medical certificate?---Yes.

And by the radiation oncologist who also provided a medical certificate?---Yes.

The case manager assigned to this claim referred it to an internal medical consultant. Is that right?---Yes.

And the medical consultant's view was that the policy definition of cancer was not met?---That's right.

And that was because this was a carcinoma in situ. And the treatment had not involved radical breast surgery. Is that right?---Yes.

And on that basis, on 31 August 2016, CommInsure denied the insured's claim?---That's correct.

And on 7 September, a week later, CommInsure wrote to the insured to notify her of this decision?---Yes.

And you've annexed that letter as exhibit 18 to your statement, CBA.1004.0096.1126. This is the letter that was sent to the insured?---Yes.

And it set out the relevant part of the definition of cancer. Do you see that there, above Our Decision?---Yes, I do.

And then under the heading Our Decision:

> *On the basis of the information obtained during the assessment of your claim, it is CommInsure's opinion that the above definition of cancer has not been met. The medical certificate for trauma benefits completed by your GP confirms your condition is carcinoma in situ of the breast. The medical certificate completed by your specialist confirms your diagnosis is carcinoma in situ left breast. In another doctor's letter dated 4 March 2016, he has noted the core biopsy confirms the presence of ductal carcinoma in situ in the left breast. A wide local incision on 11 March 2016 confirms ductal carcinoma in situ and no invasive carcinoma is noted. As such the policy definition for cancer has not been met as carcinoma in situ is excluded unless leading to radical breast surgery. Therefore, it is with regret and without prejudice to any other defences we may have that we have declined your claim for trauma benefits.*

That was the communication with the insured, Ms Troup?---Yes, it was.

The letter didn't explain why the treatment that the insured had had was not radical breast surgery, did it?---No.

It didn't say anything about what CommInsure considered radical breast surgery to be?---No, it did not.

Was the term "radical breast surgery" defined anywhere in the policy that the insured took out?---No, it was not.

Do you think that this letter provided an adequate explanation for the insured of the reason why her claim had been declined?---At the time we thought it did, but I agree we didn't explain what we meant by a radical breast surgery at this point.

Well, how was the insured to understand what did and didn't constitute radical breast surgery when it wasn't even defined in her policy?---I think we believed that the general understanding of what radical breast surgery meant both by us and by the medical fraternity was a mastectomy. But you're right, we did not define that and that did result in confusion for the customer which we've apologised for.

So nowhere in her policy did you explain that the exclusion in relation to carcinoma in situ meant that you would not be covered by a carcinoma in situ unless you had a

mastectomy?---That's right. We used the term radical breast surgery of the understanding that it meant mastectomy.

Well, the insured's medical practitioners took a different view to CommInsure about this, didn't they?---Yes, they did.

All right. I want to take you to that. Later in the month when CommInsure sent this letter to the insured in September 2016, the insured's husband spoke to the case manager and said that he and the insured weren't happy with CommInsure's decision. You tell us that in your statement?---That's true.

And he asked CommInsure not to close the claim because he said that he and his wife were doing some further research?---Yes.

And after this, the insured and her husband sought more information from the GP and from the surgeon?---That's right.

And in February 2017, they wrote to CommInsure and provided that further information from the GP and the surgeon?---Yes.

And if we go to exhibit 19 to your statement, CBA.0001.0505.2573, this is the letter that the insured and her husband sent to CommInsure. And if we look at the second paragraph, we see that they explained that the purpose of the letter was to both outline the reasons they disputed the company's decision and to provide more information:

> *We do not dispute the fact that the cancer my wife is suffering from is classified as a carcinoma in situ. What we do dispute is the fact that CommInsure does not recognise the surgery and follow-up as being radical. The policy covers situations where radical breast surgery is required. At no point does it define "radical". In fact, it seems to us that your company has arbitrarily made a decision of what is radical, perhaps a mastectomy, and has applied that definition to my wife's case.*

So at this point the insured and her husband were still trying to understand what your definition of radical breast surgery meant and were speculating that it might mean a mastectomy?---Yes.

Now, the insured and her husband attached various medical information to this letter. Is that right?---Yes, they did.

And if we go to 2574 in this document we see the information that was provided by the surgeon. Is that right?---Yes.

And the surgeon said in their letter – I'm sorry, this is the surgeon's statement is in handwriting at the bottom of the page:

The treatment received is radical because radiology was required as an alternative to mastectomy.

I'm sorry, radiotherapy. That was the information provided by the surgeon?---That is correct.

And that was provided in response to a letter from the insured which explained that:

The insurance company wished to clarify the nature of her operation, in particular whether the surgery was radical, the definition of radical in the policy is unclear, and the insurance company seemingly arbitrarily have defined radical as requiring a mastectomy. It is my understanding –

I am sorry we don't have this on the screen at the moment:

It is my understanding that in performing the surgery, the ample nature of my breasts meant that I did not require a mastectomy. I believe that you mentioned that had this not been the case and my breasts had been small, I would have required a mastectomy. I would appreciate it if you could confirm this by indicating below if this is the case.

And we see that the surgeon has circled:

I confirm the above statement.

And written the additional portion that I read to you before?---Yes.

And if we turn to 2575, we see the information provided by the GP. The GP said the insured:

... has been a patient of mine for about 30 years and I can confirm that she had had radical breast surgery/treatment in 2016 for breast cancer.

So two medical practitioners who were familiar with the insured's case told CommInsure that she had had radical breast surgery?---Yes.

And the day after this information was sent to CMLA, the claim was assigned to a new case manager within CMLA?---Yes.

And do you know why that occurred?---No.

And the new case manager referred the case to the medical consultant who had previously considered the claim. And the medical consultant again said that radical breast surgery had not been performed, having considered this additional material. Is that right?---That is right.

And the medical consultant recommended that the case be referred to the operational claims committee. What is the operational claims committee, Ms Troup?---It's a forum where claims can be discussed with various members of the claims team.

And when was that committee established?---I think it was in 2016.

Was it established in response to the recommendations arising from the ASIC investigation?---No, I think it was established before – before then.

Okay. And what led to its establishment?---One of the things that we recognise that lots of claims can be quite complex and we wanted to set up forums for – to ensure as much as possible that we make the right decisions. And so sometimes a claims information is unique or – and there's other experts in the team who wanted to have a committee where the claims assessors could discuss that and get further input into making their decisions.

So this particular claim was referred to that committee. And the committee considered her case and endorsed the recommendation to maintain the decision to decline the claim?---That's right.

And then on 15 March 2017, CommInsure again wrote to the insured and told her that it was maintaining its decision to deny the claim?---Yes.

Now, that letter is exhibit 22 to your statement, CBA.0001.0505.2578. And we see from the second page of this letter that the case manager said to the insured, about halfway down the page:

> *We appreciate that "radical" surgery is not defined in the relevant product disclosure statement. However radical surgery pertaining to the breast means radical mastectomy which is defined as removal of the entire affected breast.*

That is what the insured was told?---Yes.

So the insured at this stage had provided letters from two doctors saying that in their view she had had radical breast surgery?---Yes.

But CommInsure had decided, contrary to the view of those doctors, that you could only have radical breast surgery if you had had removal of your entire affected breast?---Yes.

And the claim was denied on that basis?---Yes, it was.

Now, CommInsure was, of course, relying on a definition of cancer at this stage that was more than 15 years old. I think we established before it was about 18 years old by this point?---Yes, that's right.

And it was imposing limitations on that definition that weren't expressed in any of its policy documents?---That's right.

And it did that in a way that didn't account for the way in which the insured had been treated by her doctors or the medical opinions expressed by those doctors?---Yes.

Do you think that that was acceptable, Ms Troup?---No.

What do you think? What observations would you like to make about how these events played out?---I think there were two area – errors that occurred where our processes and procedures should have addressed, and on this particular case they didn't. The first was the emphasis of the medical opinion and the difference in medical opinions should have been considered – should have been reviewed and there should have been a further understanding of why those doctors were saying one thing and our doctors were saying something else, and – and that wasn't addressed. The second one that should have happened is after the OCC, given the circumstances of this claim and how I've understood it, it should have been escalated to the next level of claims review which would have accommodated a broader cross-section of CommInsure and I think if those two things had happened it would have resulted in a different outcome.

Do you think if those two things had happened the claim would have been approved?---Yes, I do.

Do you think that the way CommInsure handled the claim fell short of the standards that the community would expect?---Yes, I do.

And do you accept that by denying the insured's claim on the basis of a requirement that was not contained in the policy, and contrary to the opinion of her two medical practitioners, CommInsure breached its duty to act towards the insured with the utmost good faith?---I think ultimately that is true. But I do feel that the opinion of what radical breast surgery was initially was reasonable and genuine. But the outcome, as we've discussed, the two other errors in that process, did result in us not fulfilling utmost good faith.

So do you accept the proposition that I put to you that this involved a breach of the duty to act towards the insured with the utmost good faith?---Yes, I do.

Now, in April 2017 the insured made a complaint to FOS, didn't she?---Yes, she did.

And she attached a number of documents to her complaint, and one of those was a further letter from her GP?---Yes.

And you've exhibited that as exhibit 34 to your statement, CBA.1004.0097.1611. And we see from the first page of this letter that the GP said, towards the bottom of the page:

I would like to take this opportunity to support –

One of the other medical practitioners:

... in saying that I believe that repeated surgery (lumpectomies) plus radiotherapy in combination constitutes radical surgery.

He went on to say – and if we could have both of the pages on the screen that would assist:

I also believe that if the insured's condition had occurred about 20 years ago when the policy was taken out, that the resultant treatment of two excisions would, in all probability, have resulted in a left breast mastectomy. It is now current practice that the insured's condition, carcinoma in situ of the left breast, would be treated with breast-conserving surgery and radiotherapy.

So medical practice had moved on, hadn't it, Ms Troup?---Yes.

But CommInsure's definition had not?---That's true, but there is some further context which I could expand on.

Yes, please?---Yes. The definition – the carcinoma in situ ..... exclusion when it was first introduced in 1998, we used that term "radical breast surgery" but it was only in operation for three years and I think reflected the language of – of that time. Since then our policy, and the majority of the industry has used the expression "carcinoma in situ" and it would only be paid if removal of the entire breast, and I think that reflects the FSC minimum standard as well. So, yes, treatment had changed but the intent of the policy and the coverage of the policy had not changed throughout that period.

I just want to make sure I understand that. So the definition between 1998 and 2017 excluded carcinoma in situ unless leading to radical breast surgery and CommInsure took the position that that meant carcinoma in situ unless leading to a mastectomy?---Yes, we did.

But medical practice had moved on and carcinoma in situ was wherever possible not treated with a mastectomy. It was treated with breast-conserving surgery?---Yes. And I guess I'm drawing the distinction between treatment versus the coverage of the policy.

But your policy was not covering the way in which carcinoma in situ had come to be dealt with because of medical advances?---Yes. But the intent of the policy was the exclusion was carcinoma in situ unless it resulted in the entire – the removal of the breast.

I see?---That's the distinction.

I understand?---Thank you.

Now, in May 2017 the definition was updated?---Yes, it was.

And if we go back to your annexure to your statement at CBA.9000.0113.2000 at 2011 to 2012. We see the definition that applied from 5 May 2017. The definition of cancer from that time included a number of conditions, including:

> *... carcinoma in situ of the breast which has resulted in the removal of the entire breast or breast-conserving surgery and radiotherapy or breast-conserving surgery and chemotherapy*.

Now, under the new definition, the insured would clearly have been covered?---That is correct.

But when CommInsure amended the definition in May 2017, it did not backdate it?---That's correct.

So it was still the 1998 definition that applied to the insured?---Yes.

Why did CommInsure not backdate that definition?---So this definition was increasing coverage, and – and so the approach is that applies for new claimable events.

But you had backdated the heart attack definition when you made a change to that one?---Yes, that – that was different circumstances. That's because that definition was out of date.

And you didn't accept that this definition was out of date - - -?---No.

- - - the definition that had been in place since 1998?---No.

I see. Now, a week after that definition was amended, on 12 May 2017, group customer relations, who were, again, handling the FOS dispute with the insured, asked the medical consultant who had already provided two opinions by that time to consider further the – further letter from the GP that had been provided by the insured to FOS. Is that right?---That is right.

And the medical consultant, having reviewed that letter said – and you deal with this in paragraph 60 of your statement:

> *While the GP has written a letter in response to the decline letter, no additional clinical information is provided. Based on all the reports provided of the cancer histopathology, plus the treatments offered, I still do not see any evidence of radical breast surgery as per the policy intent.*

That was the position taken by the medical consultant?---Yes, it was.

Referable to the policy intent?---Yes.

But not to the policy wording?---That's correct.

And CommInsure then discussed the matter internally. We see that from paragraph 63 to 65 of your statement. And by 8 June 2017 CommInsure still hadn't provided a response to FOSs original request for information, which had been sent more than a month earlier on 28 April, and asked for a response by 18 May?---That's correct.

And CommInsure hadn't received an extension from FOS?---No.

It just chose not to respond to FOSs request for information?---Yes.

Was that acceptable, Ms Troup?---No.

Do you accept that by not responding to FOS within their required time, or even requesting an extension, CommInsure's conduct in engaging with the external dispute resolution entity fell below what the community would expect of it?---Yes.

And on 8 June, FOS sent another letter giving CMLA seven days to provide the information after which a telephone conciliation would be held?---Yes.

And on 14 June CMLA gave a brief response maintaining that the claim should not be paid because the insured had not had radical breast surgery?---Sorry, what date was that?

14 June. That's the date of the - - -?---Right.

- - - letter that is exhibit 44 to your statement?---Thank you.

And then in July 2017, representatives of CommInsure attended a telephone conciliation conference with the insured?---Yes, we did.

And the CommInsure representatives went to that conciliation conference with authority to settle the dispute for up to $84,650 which was half of the insured sum of $169,305?---That's correct.

Why were they authorised to attempt to settle for this amount?---It was in recognition that we hadn't defined radical breast surgery in the – in the documents.

CommInsure knew, didn't it, that it was problematic to decline a claim based on an interpretation of the term "radical breast surgery" that didn't appear anywhere in the policy documents?---Yes.

The dispute didn't resolve at the conciliation conference?---No, it didn't.

Or in the further discussions between the parties that occurred in the following weeks?---That's correct.

It went to a recommendation by FOS?---That's right.

And the recommendation was made in August last year?---Yes.

And it was in favour of the insured?---Yes, it was.

And if we go to that recommendation, which is your exhibit 54, CBA.0001.0517.0204. We see on the first page that the case manager set out the basis for the recommendation. And it said under the heading Was The Financial Services Provider Entitled To Deny The Claim:

> *The financial services provider was not entitled to deny the claim because the policy does not define the phrase "radical breast surgery" and therefore the financial services provider was not entitled to limit the interpretation to a mastectomy. The applicants have provided medical documents supporting that the insured had suffered a carcinoma in situ which led to her having radical breast surgery.*

Now, that was the recommendation. That recommendation was accepted by CommInsure?---Yes, it was.

And in September 2017 – I'm sorry, that was the time when the recommendation was accepted, in September 2017. After that – I'm not sure how much after that, CommInsure paid the insured's claim?---Yes, we - - -

Is that right?---Yes, we did.

It paid the sum of $169,305, plus interest of just under $5000?---Yes.

And do you agree that FOS made the right decision?---Yes, I do.

And you accept in your statement that the handling of this claim caused the insured distress?---Unfortunately, yes.

Now, the dispute was resolved at this time in September 2017, the FOS dispute. But in March this year FOS wrote to CommInsure again about the dispute?---Yes, they did.

The case manager at FOS who was responsible for the investigation of systemic issues notified CommInsure that he was investigating whether this particular dispute raised a systemic issue in relation to CommInsure's interpretation of "radical breast surgery" as being limited to a mastectomy?---Yes.

And on 9 May this year, CBA responded to that point. Can I take you to your letter to FOS which is FOS.0046.0001.2297. Have you seen this letter before, Ms Troup?---Yes, I have.

And if we turn to the second page at 2298, we can see that FOS had asked CBA about other cases in which CommInsure had declined trauma claims for breast cancer in the previous two years?---That's right.

And CBA provided a table setting out those cases?---Yes.

And there were two cases, including the case that we're discussing, where the claim had been denied on the basis that the policy explicitly required radical breast surgery?---Yes.

And in the other case, CommInsure initially denied the claim but later decided to accept it?---Yes, the processes worked for that claim. Unfortunately it didn't for this – for the insured.

I see. And FOS asked for more information in response to this letter, didn't it?---Yes, they did.

I will tender that letter, Commissioner.

THE COMMISSIONER: Letter CBA to FOS, 9 May '18, FOS.0046.0001.2297, exhibit 6.175.

EXHIBIT #6.175 LETTER CBA TO FOS DATED 09/05/2018 (FOS.0046.0001.2297)

MS ORR: And CBA provided that further information to FOS?---Yes, we did.

And then on 23 July this year, FOS wrote to CommInsure again and said that it found that there was a definite systemic issue in relation to CommInsure's interpretation of "radical breast surgery" as being limited to a mastectomy?---Yes.

And you've said in your statement that CommInsure is still engaging with FOS about that finding?---Yes.

Do you disagree that it's a systemic issue?---Yes, I feel like it was just an isolated event, yes.

In what way do you feel this was an isolated event, Ms Troup?---Well, based on reviewing claims in the last two and a half years we haven't found in other circumstances where we had inappropriately declined a claim.

Does CommInsure plan to review its past claims that have been declined on the basis of its interpretation of "radical breast surgery"?---I must say, that's something that's on my mind, having prepared for – for today, and something that I will discuss with the business on my return.

So there has been no decision made to do that?---Not at this stage.

Should there be a decision made to do that, Ms Troup?---As I said, I think I would like to discuss that with the business. So – and our review so far has indicated in the last two and a half years there has been no other one, but, yes, it is something on reflection I would like to think about further.

But you're not prepared to make a commitment that that will happen?---Not today, no.

What changes has CommInsure made to ensure that issues like this don't arise in the future?---Specifically two things. As you indicated, we have updated our cancer definition, and radical breast surgery was only in our policy for three years. So it is a very small chance that it will happen again. In addition, we have reinforced our guidelines of escalation of – of claims of this nature. And we have also provided training on how – if – if it is a claim for radical breast surgery, although the new definitions apply, we need to consider the circumstances, the actual surgery, the size of the surgery and other elements, not rely on our previous intent.

In your statement you say that:

> *The claims assessment guidance provided to case managers will be updated to state that radical breast surgery should be interpreted by reference to the level of tissue removed, among other considerations.*

Do you recall that?---Yes, I do.

You said that that would happen. Has that now happened?---Yes, it has.

And when did that happen?---I think it was about two weeks ago. I – I would have to confirm.

After you provided your statement?---Yes. Yes.

And finally, in paragraph 91 of your statement dealing with this insured, you made an apology about the handling of this claim. Could you just explain what it is that you or CommInsure are apologising for in connection with this claim?---Well, firstly, the process that she had to go through whilst she was dealing with her health issue didn't meet the standards that we expect. I imagine it caused her additional stress, and I apologise for that. Her claim should have been paid earlier. And I wish – again, I apologise for that as well.

I have no further questions for Ms Troup.

THE COMMISSIONER: Thank you. Mr Karkar.

MR KARKAR: No questions, your Honour.

THE COMMISSIONER: Thank you very much, Ms Troup. You may step down. And you're excused, I think.

<THE WITNESS WITHDREW [11.38 am]

MS ORR: Commissioner, before we take a break and move to the next case study, we would like to say something more about the witness statements that we've received from the 10 life insurers. We've already told you, Commissioner, about what those statements told us about the sale of life insurance products and the handling of life insurance claims. But we also asked those life insurers to tell us about how they design life insurance products, and we asked them, in particular, about their processes for updating medical definitions, an issue that has been raised in this last case study. As you've heard, Commissioner, medical definitions are an important aspect of life insurance policies that provide trauma cover.

Whether a claim is accepted or declined depends in large part on whether the insured person meets one of the specific definitions set out in the policy. In offering insurance, an insurer can use broad or narrow medical definitions to expand or reduce the coverage that it provides. And as we've heard, the breadth of the definition will affect the cost of the policy to the insurer and the reinsurer. ASIC has taken the view that on its own, reliance on an outdated medical definition is not a breach of the law, provided that the applicable definition is clearly disclosed to the insured.

However, ASIC considers, and we agree, that reliance on outdated definitions is clearly out of step with community expectations. The community expects that medical definitions in life insurance policies will appropriately reflect the community's understanding of what constitutes a particular medical definition. As we've heard - - -

THE COMMISSIONER: Well, the community standards or the medical profession's understandings?

MS ORR: Both, we would say, Commissioner.

THE COMMISSIONER: The community may have an understanding of I've got a dose of the flu when in fact they haven't.

MS ORR: Community standards informed by medical practice - - -

THE COMMISSIONER: Yes.

MS ORR: - - - is how we would put it, Commissioner.

THE COMMISSIONER: Yes.

MS ORR: As we've heard in relation to CommInsure, the evidence suggests that those expectations have not always been met. And this issue is not unique to CommInsure. We asked the 10 life insurers whether they had identified any deficiencies in their processes for updating medical definitions in life insurance policies. And eight of the 10 accepted that there had been deficiencies in their processes for reviewing and updating medical definitions. A central theme was the lack of procedures to ensure regular and formal reviews.

TAL told the Commission that it did not have formal processes in place to annually review the currency of medical definitions until 2016. TAL also did not have a formal register recording the dates and revisions made to medical definitions. AIA said that it did not have a formal definition review policy or any documented processes to review definitions for currency and relevance until last year. MLC told the Commission that it did not have a separate definition review policy or documentation of the process for reviewing definitions for currency and relevance until last year. MLC also did not have a register to track definition reviews, any requirements to review definitions on a regular basis, any regular formal review of medical literature, or a system for monitoring triggers for a potential medical definition change.

Zurich said it did not have a formal process in place to review medical definitions for off-sale products until at least 2016, and recognised that it had delayed in updating the definition of severe rheumatoid arthritis in one of its products to reflect contemporary medical treatment and diagnosis. Zurich also identified internal issues concerning which person within Zurich had the power to approve changes to product features. MetLife told the Commission that until at least 2016 it did not have formal reviews of existing products at regular intervals, or regular reviews of medical definitions. MetLife said that it reviewed and upgraded medical definitions in 21 products in 2016, including its definition of heart attack.

AMP told the Commission that it did not have a formal and regular review of medical definitions until last year. Similarly, OnePath said it did not have a formal requirement for reviewing medical definitions prior to June last year. Finally, Suncorp told the Commission that it did not have a structured framework to proactively review medical definitions to identify the need for updates. Instead, it relied on informal processes and ad hoc medical definition updates. Suncorp told the Commission that it now intends to conduct medical definition reviews every three years.

Two of the life insurers did not acknowledge any deficiencies in their processes and procedures for updating medical definitions in their statements. First, Westpac did

not identify any particular deficiencies in its processes and procedures from the period from 1 January 2013. And second, CMLA maintained that there had not been any findings that its processes and procedures for updating medical definitions in life insurance policies were deficient. CMLAs only acknowledgement was that its failure to update its heart attack definition was a commercial misjudgement.

Commissioner, we heard in the last case study that the updating of medical definitions in CommInsure's trauma policies received significant media attention in March 2016. In October that year, the Financial Services Council introduced the Life Insurance Code of Practice which became binding on those who subscribed to it from 1 July last year. Each of the 10 insurers who provided us with witness statements is a subscriber to the code. Could we please show RCD.0021.0023.0001. Now, this is the Life Insurance Code of Practice. And if we turn to 0008, we see that clause 3.2 requires subscribers to review the medical definitions in their on-sale policies at least every three years and to update those definitions where necessary to ensure the definitions remain current. It also requires that this review be undertaken in consultation with relevant medical specialists and that insured persons will be informed of any updates.

We asked the 10 insurers to tell us about their processes for complying with clause 3.2 of the code. Different insurers had different processes for complying with this requirement. TAL, MLC, Suncorp, Westpac, OnePath and AMP told the Commission that they now review the medical definitions in their on-sale policies on an annual basis. MetLife said that it aims to conduct its reviews every 18 months. AIA said that it seeks to review its on-sale definitions at least every three years but in practice these occur more frequently. And CMLA and Zurich indicated that they only aim to comply with the three-year requirement imposed by the code.

Taking each of those entities in turn, TAL said that it has a health service team that reviews its medical definitions annually for currency. This team receives advice from a specialist advisory board comprised of medical specialists. In addition to these review processes, a further review can be conducted if considered necessary. MLC has created a dedicated medical definitions review panel. The panel is tasked with undertaking an annual review of medical definitions, and recommending changes to those definitions. However, the panel does not itself have the authority to approve or make changes to products.

Suncorp entrusts its executive manager of product management for life products to complete an annual review of its on-sale products. Compliance with this requirement is monitored by Suncorp's code compliance committee and compliance team. Suncorp also employs a non-practising medical professional who is scheduled from October this year to conduct six-monthly reviews of medical advances. Westpac conducts an annual medical definitions review which is carried out by a working group led by a product manager within the advised products team. It provides its recommendations for changes to the pricing team, the reinsurer, senior management and the actuarial team before these changes can be implemented. Final sign-off is then given by the insurance, assets and liabilities committee.

AMP established a propositions team which is responsible for its annual medical definitions review. The assigned product owner within that team engages with AMP Life's chief medical officer to review the currency of each medical definition and confirm whether it is aligned with developments in Australian medical practice. The chief medical officer may refer to other medical specialists as required. The product owner also engages the claims policy team to capture feedback and complaints on the applicability and currency of medical definitions, and also considers public debate and other external developments.

OnePath has added additional code compliance measures to its product management guidelines, including a requirement that medical definitions are reviewed on an annual basis, undertaken by the product team, and in consultation with the chief medical officer. MetLife has created a product policy to comply with the code. The product policy establishes the standards by which MetLife's insurance products are developed and managed, and applies to all products across all divisions and business lines within Australia. MetLife also relies on the input of its chief medical officers.

AIA undertakes its reviews in part through the quarterly meeting of its product definitions review committee, established last year as a forum for representatives of departments to consider appropriate updates to medical definitions. It receives recommendations from consulting medical officers, the claims team, the disputes team, and the product and actuarial teams, as well as feedback from policyholders. Zurich has a risk product working group which meets on a quarterly basis to consider product issues, including updating medical definitions. This group is subject to oversight from the executive level risk proposition review group, although it is the board that has the ultimate decision-making power if any change is likely to have a material effect on revenue or profitability.

CMLA has a product management policy that requires all CMLA products to be reviewed annually and medical definitions to be scheduled for review every three years at a minimum. The CMLA teams responsible for product management undertake these reviews. When a review of medical definitions is initiated, a working group is established. That group works with representatives from CMLAs internal medical team, claims team, product, pricing and underwriting. After the working group agrees revised definitions, a CMLA steering committee endorses the preferred wording and minimum standards.

Across the various entities triggers for medical definition changes outside formal review processes included market changes, legislative or regulatory changes, competitor reviews, and feedback from stakeholders, including staff, reinsurers, legal, advisers, industry groups, and policyholders. Although the code introduced requirements for the review of medical definitions in on-sale products, it says nothing about the review of medical definitions in off-sale products. We asked the 10 life insurers to tell us about their process for reviewing and updating medical definitions in their off-sale products. Many of the life insurers said that they have a similar process for updating medical definitions in off-sale products as for on-sale products.

Zurich said it had the same processes. AMP said it had the same processes, although considerations in the internal decision-making process in relation to whether updated definitions are passed back are different. MetLife said it has the same policies except for the fact that on sale products are reviewed at least every 18 months, but off-sale products are reviewed at least every three years. CMLA has the same policies for on and off-sale products. Its practice is to update the medical definitions in its on-sale products and then apply this update to all products to which those medical definitions are relevant, whether such products are on or off-sale.

MLC has the same review process for both products, although its current review of off-sale policies is restricted to those with a guarantee of upgrade. In the future, MLC anticipates reviewing medical definitions across all of its off-sale products. AIA uses the same review process but has not committed to the same three-year review for its off-sale products. It will only implement updates to off-sale products if they are beneficial to customers and if the product terms provide for it. Westpac adopts the same process, except that it only conducts such reviews at least every three years for off-sale products rather than annually.

One path's legacy products are also generally subject to an annual product review, in accordance with the product management guidelines where there is an update to an on-sale medical definition, an assessment will be done to determine whether the change can be passed back to customers of equivalent legacy products. TAL and Suncorp were the only entities that did not have a formal documented process for reviewing and updating medical definitions for off-sale products. TAL relies upon the operation of its guarantee of upgrade clauses to pass back updated medical definitions where it does not affect the level of premiums of pricing for the product.

It also relies upon its obsolete criteria clauses which broadly mean that advancements in medical practice that supersede an existing definition require an equivalent new measure to be applied unless this would materially disadvantage TAL. Suncorp only has informal processes and ad hoc medical definition updates in relation to its off-sale policies, though it completed an internal medical definitions review last year and there are proposals to adopt a similar review every three years. Commissioner, could I tender the Life Code of Practice.

THE COMMISSIONER: The Life Insurance Code of Practice RCD.0021.0023.0001, exhibit 6.176.

EXHIBIT #6.176 THE LIFE INSURANCE CODE OF PRACTICE (RCD.0021.0023.0001)

MS ORR: And could we have a brief break before turning to the next case study which involves a different entity.

THE COMMISSIONER: If I come back at midday is that enough or five past?

MS ORR: Yes. I'm in your hands, Commissioner. I'm not sure how long it will take the people at that end of the bar table to remove many folders and be replaced with many more.

THE COMMISSIONER: If I come back at five past.

MS ORR: Thank you, Commissioner.

ADJOURNED **[11.56 am]**

RESUMED **[12.05 pm]**

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Commissioner, the next case study involves TAL. And the witness will be Ms Loraine van Eeden. Before Ms van Eeden is called, could I tender a final witness statement from TAL. A number are already in evidence, other than Ms van Eeden's statements. Could I tender the statement of Sally Phillips, the general manager of health services for the TAL Group dated 6 September 2018.

THE COMMISSIONER: That statement will be exhibit 6.177.

EXHIBIT #6.177 STATEMENT OF SALLY PHILLIPS DATED 06/09/2018

MS ORR: And the next witness, Commissioner, as I indicated is Ms Loraine van Eeden.

THE COMMISSIONER: Yes.

<LORAINE KAREN VAN EEDEN, SWORN **[12.06 pm]**

<EXAMINATION-IN-CHIEF BY MR BEAUMONT

THE COMMISSIONER: Do sit down. Yes.

MR N. BEAUMONT SC: Thank you, Commissioner. Your full name is Loraine Karen van Eeden. Is that correct?---That's correct.

Your business address is 363 George Street Sydney?---Yes.

That's right?---That's right.

And you are the general manager of claims for the TAL Group. That's right, isn't it?---That's right, yes.

You're attending here today pursuant to a summons addressed to you by the Commission. Is that correct?---That's correct.

Do you have the original of that summons in the pile of material there?---Yes, I do.

Commissioner, I tender that summons.

THE COMMISSIONER: Exhibit 6.178, the summons to Ms van Eeden.

EXHIBIT #6.178 SUMMONS TO MS VAN EEDEN

MR BEAUMONT: Next, do you have before you your original statement made under Rubric 6-45?---Yes, I do.

Dated 31 August and signed by you, Ms van Eeden?---Yes, I do.

Thank you. And you have one correction, is that right, to that statement?---That's right, yes.

And that's in paragraph 74, about five lines down. The word "current" should read "recurrent". Is that correct?---That's right, yes.

Would you kindly make that change and initial it in the margin. Just handwrite it, please, and initial it in the margin. Thank you. Subject to that change, Ms van Eeden, are the contents of that statement true and correct to the best of your knowledge and belief?---Yes, they are.

Commissioner, I tender that statement and the exhibits.

THE COMMISSIONER: The statement in relation to Rubric 6-45 of 31 August '18 is exhibit 6.179.

EXHIBIT #6.179 STATEMENT OF MS VAN EEDEN IN RELATION TO RUBRIC 6-45 DATED 31/08/2018

MR BEAUMONT: Thank you, Commissioner.

Ms van Eeden, do you now have before you your original statement made under Rubric 6-77 of 34 pages and dated 5 September 2018?---Yes.

As – as signed by you?---Yes.

You do. And you have corrections to just two paragraphs of that. That's right, isn't it?---That's right.

First in paragraph 58, if you could please turn that up. The date in line 1 should be 17 July 2017. Correct?---That's right, yes.

Would you kindly handwrite that change and initial it in the margin. And secondly and lastly, in paragraph 61 of the same statement, the year in both lines 1 and 3 of that paragraph should be 2017. Correct?---That's correct, yes.

Would you kindly handwrite and initial those changes in the margin. Thank you. Now, subject to those changes, are the contents of that statement otherwise true and correct to the best of your knowledge and belief?---Yes, they are.

Commissioner, I tender that statement also.

THE COMMISSIONER: Exhibit 6.180 is the statement of Ms van Eeden in relation to Rubric 6-77 of 5 September '18.

EXHIBIT #6.180 STATEMENT OF MS VAN EEDEN IN RELATION TO RUBRIC 6-77 DATED 05/09/2018

MR BEAUMONT: Thank you, Commissioner.

THE COMMISSIONER: Thank you. Yes, Ms Orr.

<CROSS-EXAMINATION BY MS ORR [12.10 pm]

MS ORR: Ms van Eeden we've just heard that you're the general manager of claims for the TAL Group?---That's correct.

And the TAL Group is TAL Life Limited and its associated entities?---Yes.

And you were appointed to that role quite recently in January of this year?---That's correct, yes.

And what are your primary responsibilities in that role?---I'm responsible for the claims area, all – all divisions of the claims teams.

And prior to that role, you were the general manager of International Life Solutions which is a subsidiary of the TAL Group?---That's correct, yes.

And how long were you in that role?---Since October 2016.

And prior to working for TAL, you were the global head of claims at Swiss Re?---That's correct, yes.

So you've worked in the insurance industry for close to 20 years?---Yes, in – I've been in insurance longer than that but in claims since .....

And how long have you been in the insurance industry, Ms van Eeden?---Close to 40 years.

Close to?---40 years.

40. And in claims, how long did you say?---Since 2001.

Now, you've made three statements which deal with the experiences of three different people who made claims on TAL income protection policies. Is that right?---That's right, yes.

And two of those three statements have been tendered, one in response to Rubric 6-45 and one in response to Rubric 6-77?---That's correct, yes.

But the third statement will not be tendered because the person to whom that statement relates did not wish to have their story examined by the Royal Commission. Are you aware of that?---I am, yes.

But TAL has made some admissions in respect of deficiencies with its handling of that person's claim, and I want to ask you some limited questions about those admissions later. Now, before I turn to the other individual cases, I want to ask you some questions about the life insurance policies that are offered by TAL?---Yes.

Firstly, what is TALs share of the life insurance market. Do you know?---I don't know offhand.

Publicly available material suggests that it's about 18 per cent?---Per cent.

Does that sound about right to you?---It sounds about right.

And the life insurance policies that are issued by TAL are sold through three different channels, to superannuation fund trustees and employers as part of group life insurance arrangement. Is that right?---That's right, yes.

And through financial advisers and directly through comparator websites?---That's correct, yes.

Which is called the retail channel. And directly to consumers through an associated entity of TAL, and that's the direct channel?---That's correct, yes.

And which channels are income protection policies sold through?---Through all three channels.

Income protection cover is a significant part of TALs business?---Yes, it is.

We see from the statement of Mr Thorne, the chief distribution officer for the TAL Group which is exhibit 6.7, that in each of the last five years close to half of the life insurance policies sold by TAL have included income protection cover. Are you aware of that?---I've not seen Mr Thorne's statement.

I see. Well, that statement is in evidence, and indicates that it was 44.7 per cent of policies in 2013, 42.5 per cent in 2014, 48.27 per cent in 2015, 48.1 per cent in 2016, and 49.4 per cent in 2017. But I think you accepted my earlier proposition, even without those figures, that income protection cover is a significant part of your business?---Yes, it is.

And Mr Thorne's statement tells us that TAL has received premiums of between 1.6 billion and 2.5 billion in respect of income protection policies in each of the last five years. Are you aware of that?---Once again, I've not seen his statement.

All right. Can I move to asking you some questions, Ms van Eeden, about the current processes for applying for a TAL insurance policy. And these are explained in a fair bit of detail in one of the other TAL statements that has been tendered, a statement of Sally Phillips, the general manager of health services for the TAL Group. For the last five years at least, TAL has used what it refers to as an underwriting rules engine to assess online or telephone applications for underwritten policies?---I – I'm not from the underwriting area and I've also not seen Sally Phillips' statements but as far as I know, yes, that's what they do use.

And do you know that the underwriting rules engine is a software system that receives and analyses information that's provided by a person who applies for a policy?---Yes.

And it applies an algorithm to determine how to deal with the application. Are you aware of that?---Yes.

And the algorithm is derived both from underwriting guidelines provided by the reinsurer and from TALs own underwriting guidelines?---I – I think that is correct.

And are you aware that by using that underwriting rules engine, TAL determines whether to accept an application for a policy, to accept it subject to an exclusion, to accept it with a loading, or to decline the application?---As far as I'm aware, the rules engine wouldn't make those decisions. If anything was not standard, it would go through to the underwriter and the underwriter would be involved in the process.

Are you aware that the underwriting rules engine operates slightly differently across the different channels?---No, I'm not.

Okay. And in some circumstances, I think you would know this, that the underwriting rules engine refers the determination of an application to a human. Is that right?---That's right, yes.

And do you know much about when that happens?---Not – not a lot of detail, but it would normally be a standard policy it would go through. Non-standard would go through to an underwriter.

A standard policy goes through the software system for a decision and a non-standard is referred to a person to assess. Is that right?---As far as I know, yes.

Now, in the three individual cases that your statements deal with, the insurance policies were sold through the retail channel. Is that right?---That's right, yes.

And they were sold in 2009, 2013, and 2014?---That's correct, yes.

And were TALs application processes, to your knowledge, at those times, broadly similar to the process today?---As far as I know, yes.

Now, can I move to the claims handling process. And, again, there is another TAL statement that provides some further detail about that. That's the statement of Justin Delaney, the chief operating officer of the TAL Group which is exhibit 6.123. After a person indicates that they want to make a claim on a life insurance policy, TAL does an initial eligibility check. Is that right?---That's correct, yes.

And is that a relatively cursory check of a number of matters including whether the person has a policy with TAL, whether there are relevant exclusion clauses, and whether there are any waiting periods?---It's – it's very basic in the beginning, just to make sure that the person is covered, that there is coverage.

And if the person decides they want to make a claim, they're sent an initial claims pack or they're asked to participate in a tele claim interview. Is that right?---That's right, yes.

And after the claims pack is returned to TAL or the interview is completed, the claim is then assigned to a claims manager?---That's correct, yes.

And at that point, the claims assessment process commences?---That's correct, yes.

And for straightforward claims, no further information is required to determine the claim?---For straightforward, yes.

But for more complex claims, the approach is tailored to the particular needs of that claim. Is that right?---That's right, yes.

And much of the decision-making about the process to be adopted and the information that will be sought is at the discretion of the relevant case manager. Is that right?---That's right, yes.

And that has been the situation at TAL for a significant period of time?---That's correct, yes.

And if the case manager considers it necessary or desirable, different types of information gathering and investigative actions can be taken?---Yes, but we do have standard guidelines ..... certain processes as well.

Standard guidelines, I am sorry?---Guides dictating our processes.

All right. I want to come back to talk to you about the guidelines that you have as we move through this, but do you agree for now that the types of information gathering and investigative activities that the case manager can undertake include getting an independent medical examination?---Yes.

And getting a further underwriting opinion?---Yes.

Undertaking surveillance of the claimant?---If it needed, yes.

Obtaining information from treating health professionals?---Yes.

Obtaining information from government departments like the Tax Office and the Department of Human Services?---Yes.

And getting information from the person's employer?---Yes, employer based.

I'm sorry?---When it's employer based, yes.

And getting information from credit reference agencies?---I'm not too sure about the credit reference agencies but I would think if we needed from the financials, yes.

THE COMMISSIONER: I'm sorry, you're going to have to keep your voice up a bit?---Okay.

Both I and the transcriber are having difficulties. I can blame the transcriber but not justifiably.

MS ORR: Now, Mr Delaney tells us in his statement that many of those information gathering or investigative steps will only be taken when TAL has obtained a signed authority from the customer. Is that right?---That's right, yes.

So in which circumstances is a signed authority from the customer necessary?---That normally comes attached with the claim pack. So when they – the initial claims pack comes in the authority comes in as well.

I see. So the customer is asked to sign an authority for these sorts of steps to occur at the same time that they complete their claims form?---That's right, yes.

And does that include all the types of steps that I have articulated to you? Would they all be covered by that signed authority?---Yes, they would be.

I see. And then Mr Delaney also says in his statement that those steps or some of those steps are only taken when TAL considers them necessary to assess the claim?---Absolutely, yes.

And how is that judged, Ms van Eeden?---It depends on the type of claim that's coming in, it depends on the medical condition, it depends on the age of the claimant and on the occupation of the claimant. So there's a lot of individual information that goes into that assessment.

I think you said the type of claim, the medical condition?---Yes.

The age and the occupation?---Occupation, yes.

They're the factors that determine what sort of information gathering and investigative steps are appropriate?---That's right, yes.

But the decision is made by the case manager as to which of those steps should be taken for a particular claim?---Yes.

And what oversight does TAL have of those decisions made by individual case managers on whether and when to take those steps?---So the case managers – I can't talk to earlier processes, as I was not around but at the moment we have roundtable conversations and we have discussions in terms of what is needed as part of our investigations.

I just want to make sure, Ms van Eeden, that you're going to be able to answer the questions I have for you, because you have just indicated some difficulty because you weren't around at an earlier point in time. You do appreciate, don't you, that the events that your witness statements cover all predate your time in this position. But I understand that you are going to be able to answer questions about those three individuals and the way their claims were handled. Is that right?---Yes, I will be able to answer that.

All right. Now, Mr Delaney also says in his witness statement that any information sought is sought as soon as possible, and that TAL seeks to avoid multiple requests for information where possible. Do you agree with that?---Yes, I do.

Now, in the three individual cases that I'm going to ask you questions about, the claims were made in 2010, 2014 and 2015. Now, have TALs claims handling processes remained broadly consistent over that period, starting with the claim in 2010?---Some of them.

What are the key changes that have been made over that period, Ms van Eeden?---So there has been a lot of changes made in terms of what institutes surveillance, when we're allowed to call information in terms of surveillance, the kind of medical information that is requested, specifically if we are going out for IMEs. And also trying to be a lot more articulate in the information that you do require and not just going out for general information as could have happened in the past.

Did you say more articulate in the information that you are going after. Is that what you said?---That we are requesting, yes.

What do you mean by that, being more articulate in the information request?---So we – going back to my earlier comment around depending on the claimant, depending on the condition, depending on the age, and depending on the medical condition, trying to be a lot more limited to that condition in terms of the information that we require.

So do you mean the information that's requested is more confined now than it used to be?---Definitely, yes.

And I think you mentioned in that answer as well changes to the kind of medical opinion. Did I hear correctly?---Yes.

What did you mean by that?---So trying to be – making sure that we get specialist reports and really limited in the amount of specialists that we go would out to.

I'm sorry, I just missed the last part of that?---Okay.

Specialists that?---Very limited in the number of specialists that we would request.

The number?---Yes, the information from now.

So is the change that you are seeking information firstly from specialists and from less specialists per claim?---So - - -

Do I understand that correctly?---Yes. So what – what – in the – in the past what you would – what they would do is ..... just go out and call for every kind of report that they could see that the person had seen and now we're trying to be a lot more specific and looking at the medical condition, looking at the treating doctors and really going out in terms of only investigating the areas that we need to investigate in.

Well, why was it the situation that in the past there was a call for every kind of report?---That was the basic process throughout the industry in terms of that. So if a claim is very early or it's very early in terms of the policy duration period, you would go out and get the Medicare records and then you would investigate based on the Medicare records that you've received.

And you would call for every kind of medical report in respect of the claim?---In 2010, yes, that's what they did.

Why?---To – to explore all avenues of investigation.

What avenues of investigation are you exploring by calling for every kind of medical report?---Well, if the information has not been provided in the underwriting – underwriting stage, it's to try to see is there anything that's important that has not been provided and would it impact on the future of the claim.

So you're looking to find a non-disclosure by the claimant?---Well, you're looking to see if there is one, not necessarily just looking to find one.

But that's the purpose of that activity, to call for every kind of medical report so that you can go back and assess whether the claimant has told you about every conceivable type of medical condition. Is that right?---Well, relevant medical condition, yes.

What does relevant mean in that setting?---Relevant in terms of the claim. In terms of the – the ..... around the claim.

What medical – I just want to make sure I understand that, because on the one hand you are saying that you would call for every kind of report. Are you saying that the kinds of reports that would have been called for back at that time were restricted to reports that were relevant to the condition that was the subject of the claim?---Not back at that time.

They weren't, were they?---No. No, they were not. Not back at that time.

So they extended well beyond anything relevant to the claimed condition, to all sorts of irrelevant medical information?---Back at that time, yes.

For the purpose of seeing whether or not the policy could be avoided on the basis of a non-disclosure?---Yes.

How long did that practice continue, Ms van Eeden?---From what I can see, working through these cases, probably about two years, and then the practices started to change.

When do you say that was the practice?---So probably until about 2012, 2013, if I look at the cases.

Until about 2012 or 2013?---Yes.

And you're not able to say when that practice started?---No.

But it was certainly occurring in 2012 and 2013?---Well, I've seen it through the investigation of these cases.

Yes?---That's the only time that I've seen it will.

I see. And what are your views about that practice, Ms van Eeden?---It's not acceptable and that's why we have changed our processes.

I want to ask you some questions about the current process that leads to a claim being denied. It's the case manager who has the discretion to recommend that a claim be denied. Is that right?---That's right, yes.

And if the case manager recommends that a claim be denied, they prepare a submission that goes to a team leader or a senior case manager?---That's right.

Is that correct?---Yes.

And if the senior case manager or team leader supports that recommendation, then it goes to the claims decision committee. Is that right?---That's right, yes.

And they consider whether the claim should be declined?---That's correct, yes.

And it's now the case that any decision to decline a claim has to be approved by TALs senior management. Is that the case?---That's the case, yes.

And when was that requirement introduced?---2016.

And when was the requirement introduced to refer it to the claims decision committee?---At around the same time – well, no, the claims decision committee has been around for – for a long time. But the senior was introduced after - - -

In 2016?---Yes.

And why was that layer introduced in 2016, Ms van Eeden?---Because as TAL – we wanted to make sure that we had a better oversight of our claims when they were being denied.

And if TAL is considering avoiding a contract of insurance because of non-disclosure on the part of the claimant, we know from Mr Delaney's statement that TAL sometimes seeks internal legal advice about that before it goes to the claims decision committee. Is that correct?---That's correct, yes.

All right. Now, to see what that process looks like in the income protection setting, can I ask you to look at TAL.500.071.0001?---Would I have it in the file or - - -

No, I don't – I don't know, Ms van Eeden. I'm not sure what materials you have there?---I have the two claim files.

It's not a document that's annexed to your statement if that assists?---Then, no, I would not – then I would need to see it.

We will wait for it to come up on the screen?---Thank you.

It's a document that I understand will have been drawn to your attention before today. There we have it. So this is a document – I assume you've seen this document, Ms van Eeden. It's a document from 7 December last year and it contains the payment criteria for income protection claims. Have you seen this document?---Yes, I have.

Now, is this document still in use?---Yes, it is.

And if we turn to 0005 within the document. We see the heading Key Initial Payment Criteria. And in the first column we see the heading Establish Evidence. These are the minimum mandatory criteria required for a claim payment. You need to establish evidence. The second column. An initial assessment. And in the third column we see a box saying "withhold payment due to fraud or non-disclosure". Why does that potential part of the process have its own box?---It's just that if there's any fraud or – especially fraud, payment is withheld until the final investigations are done before we start payment.

Is this a stage that's considered to be as significant as establishing the evidence in the initial assessment?---No. The other two are the most important first and if – if anything comes to light within those two processes, then it would go into the next phase.

So your case managers are always on the lookout for any fraud or non-disclosure on the part of the claimant. Is that right?---It is part of the process, yes.

And in a number of your policy documents, TAL describes the non-disclosure or a misrepresentation by a claimant as providing:

> *...an opportunity to apply a remedy under section 29 of the Insurance Contracts Act.*

Have you seen that sort of language, Ms van Eeden?---I have not seen it specifically.

All right. I will tender this document and then show you another?---Okay.

THE COMMISSIONER: TAL retail claims IP claims payment criteria, 7 December '17, TAL.500.0071.0001, exhibit 6.181.

EXHIBIT #6.181 TAL RETAIL CLAIMS IP CLAIMS PAYMENT CRITERIA DATED 07/12/2017 (TAL.500.0071.0001)

MS ORR: Could we bring up TAL.500.009.0209. Are you familiar with this document, Ms van Eeden?---Yes.

Life Insurance Code of Practice – Claims Assessment Guide. Also a recent document dated 22 December last year?---Yes, I have.

Is this document still in use?---Yes, it is.

And if we turn to 0255. Do you see under the heading Overview, underneath 5.20, (a), (b), the paragraph:

> *When non-disclosure or misrepresentation is identified at application for insurance including increases in cover that occurs through an application, there is an opportunity to apply a remedy under section 29 of the Insurance Contracts Act.*

That's the sort of language that I was referring to, Ms van Eeden?---Yes.

What is meant by this language of an opportunity to apply a remedy under section 29 of the Insurance Contracts Act?---So there's various remedies, because you could have an innocent misrepresentation, and then there would be a different remedy for innocent or whether it's negligent misrepresentation as well or fraudulent - - -

What's the remedy for an innocent misrepresentation, Ms van Eeden?---I would need to go back to get all the specifics but innocent is – could, depending on the type of – actually end up being avoided policy but it could also be altered terms where we could alter terms on a policy.

And in what circumstances does an innocent misrepresentation lead to the policy being avoided?---If it's a significant misrepresentation of information and that very, very seldom occurs.

What's an example of an innocent significant misrepresentation?---I don't actually have one at the moment.

And what's an – what are the circumstances in which an innocent misrepresentation leads to the other remedy you identified which I think was different terms for the policy?---So if there is a misrepresentation of an illness that could be ..... to the claim, then there could be altered policy conditions or changes to the policy.

So in those circumstances, the policy would not be avoided?---Not necessarily.

Not necessarily?---No. Well, it would not be avoided – sorry it would be avoided.

It would not be avoided. But instead the terms of the policy – the terms that the policy was offered on is, that right?---May change. May change.

It may change, may not change?---So they may end up placing an exclusion or changing the policy, depending on the type of condition.

Section 29 of the Insurance Contracts Act is about avoiding insurance contracts, isn't it?---Could you please just bring it up for me again?

We haven't had section 29 on the screen before, Ms van Eeden. I think we probably are able to bring it up for you, though. I'm sorry, I don't think we do have that on the system at the moment. I will arrange for that to be - - -?---Or I can go through it later.

- - - made available for you. I assume that's a provision that you, in your role, are fairly familiar with, though?---Yes, I am, but at the moment just sitting I've just got a little bit – sorry, it's a lot of information.

What do you understand – without the benefit of seeing the provision in front of you, what do you understand section 29 of the Insurance Contracts Act to be directed to?---So that's really if we want to change the terms of the policy.

Not about whether you want to avoid the policy?---Not necessarily just avoiding the policy.

You think section 29 is about changing the terms?---Yes. Yes.

Well, let's give you an opportunity to have a look at section 29. I will arrange for that to happen. But in the meantime, could I tender this document, Commissioner.

THE COMMISSIONER: Life Insurance Code of Practice Claims Assessment Guide, 22 December '17, TAL.500.009.0209, exhibit 6.182.

EXHIBIT #6.182 LIFE INSURANCE CODE OF PRACTICE CLAIMS ASSESSMENT GUIDE DATED 22/12/2017 (TAL.500.009.0209)

MS ORR: Now, over the past five years, you tell us in one of your statements that there have been a number of claims in which TAL has avoided the contract of insurance or refused to pay out under the contract because of a non-disclosure by the claimant. Is that right?---That's right, yes.

And you give us some statistics in one of your statements. You tell us that over the five years from 1 July 2013, TAL received 72,351 claims in respect of physical conditions, and that you avoided or refused to pay out under 494 of those on the basis of non-disclosure. That's in paragraph 11(a) and (b) of your statement in response to Rubric 6-45. You see that?---Yes, I do.

And you also tell us in that paragraph that over that five-year period TAL received 8783 claims in respect of mental health conditions, and it avoided or refused to pay out under 95 of those insurance contracts on the basis of alleged non-disclosure?---That's right, yes.

All right. Now, Ms van Eeden, with that background, I want to start by asking you some questions about your statement in response to Rubric 6-77?---Okay.

And I'm going to refer to the person who that statement relates to as the insured because their name is the subject of a non-publication direction. Do you understand which statement I'm directing your attention to? And I'm going to refer to TAL throughout as TAL, even though we see from the documents that it was known as TOWER in some of the documents over this period. So we see from the documents that you've given us in your statement that the insured applied for an income protection policy from TAL in February 2009?---That's correct, yes.

And she did that through an insurance consultant from Lifebroker Proprietary Limited?---That's right, yes.

And Lifebroker is a related body corporate of TAL?---Yes.

Yes. Now, she applied by completing an online application form. Is that right?---That's correct, yes.

And you've exhibited that online application form to your statement as exhibit 1, TAL.005.001.0372. And we can see from this document, Ms van Eeden, that the form of policy that the insured applied for was an accelerated protection policy. That was a form of income protection policy?---That's correct, yes.

And we see from the pages that commence at the following page, 0373, that to complete the online application form, TAL required the insured to provide information about her income, her occupation, and her medical history?---That's correct, yes.

And we see at 0373 that the insured listed her occupation as a registered nurse?---That's - - -

You see that towards the top of the page?---Yes, I do.

And if we could have 0374 and 0375 displayed together. We see the risk assessment questions in the application form, and we see that they included as question Q – do you see question Q on the first page towards the bottom?---Yes, I do.

Do you see that, Ms van Eeden?---Yes, I do.

Continuing:

Do you have or have you ever had –

Do you see that line about halfway down the page before we get to A through to R:

Do you have or have you ever had any of the following medical conditions?

And then one of the very long list is Q:

Depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, attempted suicide, chronic fatigue, postnatal depression or any other mental or nervous disorder?

?---Yes, I see that.

That was one of the many questions posed in this application form and we see that the insured responded no?---That's correct, yes.

And we see also, over the page on the right-hand side, that the insured was also asked as one of those questions:

Do you have or have you ever had any of the following medical conditions, V –

I'm sorry if we're still on 0375 V:

Have you in the last five years been absent from work or your usual duties for a period of more than five days through any illness or injury not previously disclosed in this application?

And the insured again answered no?---That's correct, yes.

And also on that page:

Do you have or have you ever had any of the following medical conditions? (W)
do you have any symptoms of illness, any physical defect or any condition for which you seek medical advice or treatment not already disclosed?

And the insured answered "no"?---That's correct.

Now, the insured disclosed a number of matters in this online application, including that she had had a knee reconstruction. Is that right?---That's right, yes.

And this online application went through the underwriting rules engine that I asked you about before?---That's correct, yes.

And the underwriting rules engine referred it to a human, to an underwriter for a manual assessment?---That's correct, yes.

And in the course of that manual assessment, the underwriter determined that they needed additional information to assess the application, including information about the insured's occupation, her working hours, and the knee reconstruction?---That's correct, yes.

And the insured gave that additional information in a telephone interview with the – via her insurance consultant?---That's correct.

And on 12 February 2009, the underwriter declined the application because the insured wasn't working enough for insurance – income protection insurance?---That's correct.

And then over the next month or so, TAL and the insured corresponded further about the insured's working arrangements and her medical history?---That's correct.

And on 12 March, the underwriter decided to accept the application?---That's correct.

And the decision was made after an internal discussion within TAL about the possibility of exercising some flexibility with respect to the insured's working situation. This was all to do with the number of hours - - -?---Number - - -

- - - that she was working, wasn't it?---That's correct, yes.

Then if I ask you to look at the third exhibit of your statement, TAL.500.057.0393. And if you turn within that document to 0402, we see an entry in TALs internal systems from 5 March 2009. It's the long paragraph towards the top of the page. And part way through that we see:

> *Client is a occ class 3. However, nurse, stable occupationally. We feel we can probably offer something here.*

What do you interpret that to mean, Ms van Eeden?---As I said, I'm not the underwriter but based on this, it's they weren't sure of her occupation, and the amount of hours that she actually worked whether it was in full-time employment.

Whether she was working full time?---That's right, yes.

And if we look further down to the entry underneath we see that someone has responded:

> *Agree. Allow cover.*

?---Yes.

Continuing:

I would allow without restrictions in view of borderline hours/professional role.

?---That's correct, yes.

And there is mention there of some of the medical information that was discussed with the insured after she put the application in about a wrist problem and an ear problem, both of which had been disclosed?---That's correct, yes.

All right. Now, the policy was offered subject to an exclusion?---That's correct.

And the exclusion related to the left knee, the knee that had been the subject of the knee reconstruction?---That's correct, yes.

And the insured accepted the policy on those terms?---Yes.

And her monthly benefit amount under the policy was $2750?---That's correct, yes.

And she had a 30 day waiting period?---Yes.

And her premium was a stepped premium, which commenced at $125 a month?---That's correct, yes.

All right. Now, close to a year later, on 5 February 2010, the insured's insurance consultant contacted TAL and asked for a claim form for the insured?---That's correct, yes.

And the insured returned the claim form a few months later, on 11 May 2010, with accompanying documents?---That's correct, yes.

And you've annexed the claim form to your statement as exhibit 15, TAL.500.052.0936. If we turn to – it's not a very helpful first page, is it – if we turn to 0940. If we could perhaps have 0939 and 0940 on the screen. We will see shortly that on the right-hand side – we're nearly there – 0940 – the insured described her condition that she was claiming for as:

Stress-induced depression and anxiety.

You see that?---Yes.

And she told TAL that the symptoms had begun on 30 June 2009?---That's correct.

And that she had ceased work on 1 January 2010?---That's correct, yes.

And she explained at 0944 that her symptoms had started after a meeting with her nurse unit manager, the NUM. Do you see that?---Yes, I do.

And that she had first been unfit to work due to the symptoms on 1 November 2009, but she continued to work until she saw her GP in January 2010?---That's correct.

And within this document, the insured also disclosed that she had made a workers' compensation claim in relation to the same underlying circumstances?---That's correct.

And that that claim had been denied?---That's correct, yes.

And she said that she strongly disagreed with the outcome of that claim and provided some details about her position?---Yes.

Now, at 0947, she attached a medical certificate from her GP dated 11 May 2010?---That's correct.

And she also attached a document at 0952 headed Initial Attending Doctor's Statement which had been completed by her GP, Dr Sutherland?---That's correct, yes.

And in that document, 0952, Dr Sutherland listed the insured's illness as generalised anxiety disorder?---That's correct, yes.

And Dr Sutherland explained that the insured's symptoms were preventing her from working because she had experienced a loss of confidence in both nursing management and her own skills in dealing with patients?---That's correct, yes.

And at 0957, the insured also attached to the claim form a supplementary letter from Dr Sutherland, the GP, that dealt with the refusal of her workers' compensation claim?---Yes. That's correct.

And in the first paragraph of that letter we see that Dr Sutherland said that she thought the insured had a good case for the workers' compensation claim?---Yes.

In the second paragraph she said that she had known the insured:

> *... for nearly five years and knew her to be an honest and conscientious nurse.*

?---That's correct, yes.

And also in that paragraph she said that when she had seen the insured in January she had been:

> *Extremely and uncharacteristically distressed –*

And that this was something new for her?---That's correct, yes.

And in that paragraph, Dr Sutherland said:

There was evidence of a definite anxiety disorder with some depressive features.

?---That's correct, yes.

And in the third paragraph Dr Sutherland referred to issues the insured had previously had at home through caring for her partner who had a mental illness and some short-term legal involvement. She referred to consultations with the insured in that earlier period and emphasised that in none of those consultations was there any reference to anxiety, depression, or other mental disability and the insured was working her normal working hours?---That's correct, yes.

And in the fourth paragraph, Dr Sutherland referred to an earlier document from the insured which referred to six single days when she was not coping with work stresses and home during 2008 and three in early in 2009. Dr Sutherland said that she had discussed that with the insured who had explained that they were single day events that were responses to her particular situation and that she was otherwise completely well?---That's correct, yes.

And Dr Sutherland said finally that although she had initially thought, based on that document provided by the insured, that her current condition was an exacerbation of a previous anxiety state, she had since reviewed her own medical notes of those consultations which indicated that the current condition was a new onset illness, not an exacerbation of any previous condition?---That's correct, yes.

So this was the information that the insured gave to TAL with her claim?---Yes.

And having received the claim and the supporting material, TAL classified it as a high risk claim. Do you know what that means, Ms van Eeden?---I saw that and I don't know what that means.

Okay. You're unable to assist us with why that was done or what significance it had?---I've got no idea.

All right. Do you think it might have been because TAL takes – or at least at that time took – a harsher stance when assessing cases where the stress or depression was related to work stress?---I think it's more the sensitivity when stress is involved but once again, that's just my opinion on that.

Was it the case that TAL took a harsher stance when assessing cases of stress or depression when they were related to work stress?---No, not at all.

TAL appointed a case manager to manage the claim. Is that right?---Yes.

And the insured gave TAL consent to obtain records about her medical history and about her workers' compensation claim?---That's correct, yes.

That's right? The insured provided that consent to get her medical records?---Yes, she did.

That's an appropriate time if that's convenient to you, Commissioner.

THE COMMISSIONER: Yes. If we come back at 2 o'clock, if you could be good enough to be back in time to begin at 2 and we will adjourn until that time.

ADJOURNED **[12.58 pm]**

RESUMED **[2.00 pm]**

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Ms van Eeden, before the break I had asked you about the appointment of a case manager to oversee the claim of the insured person who I had been asking you questions about. You recall that?---Yes, I do.

And I had asked you about the insured person providing consent for TAL to obtain her records about her medical history and about the workers' compensation claim?---That's right. Yes.

And over the course of the following months, between May and July of 2010, TAL did seek records about the insured from a number of individuals and organisations?---That's correct, yes.

TAL sought medical records from the GP, Dr Sutherland?---That's right.

And from the psychiatrist that the insured had commenced seeing?---Yes.

TAL asked Medicare to provide the insured's Medicare history?---That's right, yes.

And TAL sought details of the insured's private health insurance cover and a copy of her claims history?---That's right, yes.

TAL contacted the Employee Assistance Program of the insured's workplace to seek her treatment file?---That's right.

And TAL sought information about the workers' compensation claim?---Yes.

And TAL also sought the insured's tax records for the recent financial years?---That's right, yes.

Now, why was all of that information sought by TAL?---They – they were trying to understand her medical condition, and also the financials because of the benefit that was payable.

By at least early – by at least – I withdraw that. By at least 2016 – so I want to pause and leave the insured's case for a moment and ask you whether by 2016 it was standard practice within TAL to look for red flags within insurance claims?---Yes.

And do you know when that practice started? Has that been the practice for a long time, to look for red flags with insurance claims?---I don't know when the practice started.

Could I ask that you look at TAL.500.013.3180?---Is that in my Rubric - - -

No, it will come up on the screen. We have it now, Ms van Eeden. It's an underwriting and disclosure review guide for claims, dated 8 September 2016. And we see that it's entitled version 1.0. Do we take from that that TAL didn't have formal guidelines of this sort until 8 September 2016?---That's correct, yes.

And should it have had?---It should have had, yes.

But in 2016, towards the end of 2016, these guidelines were developed. And if we turn to 3189, we see a section entitled Insurance Contracts Act remedies:

> *At time of claim, the claim information (claims forms, reports, etcetera) and the application for insurance, including any additional information provided during the underwriting process should be reviewed to ensure that the customer complied with their duty of disclosure and did not make any misrepresentations.*

That was the practice well before the date of this document in September 2016. Is that right?---That's right, yes.

Continuing:

> *The information that is provided at claims stage, either in the initial claims proofs submitted or within any incoming information received thereafter, may be contrary to and inconsistent with the disclosures that were required to be made on the application. The non-disclosure or misrepresentation may relate to some or all of the following: medical history, occupation and duties, income, hazardous pursuits or pastimes. Where inconsistencies and/or insurance red flags are identified, the case manager must then gather all of the relevant medical, occupational, financial and hazardous pursuit information to ensure a complete history is obtained. Upon receipt of all of the information and where non-disclosure is indicated, the case is referred back to the underwriter (the original underwriter, if available) or to the applicable insurer*

if the policy was not underwritten by TAL to reassess the application with the benefit of full disclosure.

So did these paragraphs formalise the practice that had been in place prior to this time?---Yes, it did.

Thank you. And we see also on this page – I'm sorry, we will go to a different page, 3193, under disclosure assessment at claim and under the heading Disclosure Matters, second paragraph down:

There are two determinants for when extra information may be needed to satisfy there was no material non-disclosure or misrepresentation. When insurance red flags are identified and when a general disclosure review is needed. Insurance red flags, where inconsistencies are identified between underwriting disclosures and claims information, and a general review flag where there are no inconsistencies identified, a general review of disclosures may still be required to ensure there is no adverse non-disclosure. For example, a claim that occurs within close proximity of the risk commencement date may warrant review.

Now, we see from these paragraphs – and can I ask you, again, do these paragraphs formalise the practice that was in place prior to this document being brought into existence in September 2016?---I – I was not there before but I would think yes. It's – it's a standard process, yes.

Yes?---Yes.

It was the practice prior to this document?---Yes.

That there would be these two determinants for when the case manager went off looking for other information?---Information.

Red flags, because of inconsistencies, and when there's no inconsistencies:

...a general review of disclosures may still be required to ensure there is no adverse non-disclosure.

And the example that's given of when that should occur is a claim that occurs within close proximity of the risk commencement date. Now, did TAL have any guidelines about what constituted a claim that was within close proximity of the commencement date?---There is a guide – there's a guideline that states within 12 months.

12 months. So if a claim was made within 12 months, the case manager was, irrespective of any red flags, to conduct a general review to see whether or not there was adverse non-disclosure?---Yes.

Adverse to the insured?---Adverse non-disclosure.

Adverse to the insured because it would provide a basis for TAL to avoid the – avoid the policy?---Yes.

Yes. I tender this document, Commissioner.

THE COMMISSIONER: Underwriting and disclosures review guide for claims version 1, 8 September '16, TAL.500.013.3180, exhibit 6.183.

EXHIBIT #6.183 UNDERWRITING AND DISCLOSURES REVIEW GUIDE FOR CLAIMS VERSION 1 DATED 08/09/2016 (TAL.500.013.3180)

MS ORR: Before we leave that document, Ms van Eeden, there are a number of points in this document, from September 2016, where the author of the document says that case managers should not go fishing for information. But the general review flag that we see on this page was, essentially, a fishing expedition, wasn't it?---The general review flag is generally related to the claim cause. It's not - - -

Related to the claim?---Cause.

Cause?---The cause of claim and it's not generally a fishing – it's not a fishing expedition.

Where do we see that in the general review flag on this page that it's related to the claim cause?---That's not stated in here, you're right.

And what do you mean by that, when you say that it was related to the claim cause?---So when we investigate a claim now, we make sure – we look to see if there's – so, for example, if it's a – an illness we would look to see how long the – the person has been suffering from that illness. So it wouldn't just be a general sending out for all kinds of information. But once again, I can't say what happened early in 2016 – before 2016. Other than what I can see coming from the files.

Well, I would like you to answer my question about whether you accept that the general review flag was a fishing expedition that TALs practices and from this point its policies required case managers to undertake?---I will say yes.

It's correct, isn't it - - -?---Yes.

- - - Ms van Eeden?---Yes.

Despite references in this document to not going fishing?---Yes.

Now, although the insured's claim we know significantly predates this document, her review was what we see called a general review from this document. Is that right?---That's right, yes.

There were no insurance red flags for the insured?---No, not – no.

So the case manager brought in that information as part of a general review to assess whether there was adverse non-disclosure on the part of the insured?---Yes.

Now, before we leave this document, could I ask you to go back to 3193 in the document. The guide says on this page underneath the general review flag point, in the next paragraph, that:

> *TAL employees should ensure that the scale of the potential collective claim costs against the cost and time of reviewing disclosures is treated with a rational approach.*

Do you see that?---Yes, I do.

And:

> *In cases where the claim amount is large and/or for a lengthy duration, TAL should ensure a thorough review is undertaken as part of the ongoing assessment or before admitting the claim, if applicable.*

?---Yes.

So a guiding principle in determining the extent of the investigations to be undertaken was TALs bottom line?---In relation to this, yes.

In relation to when case managers should embark on a general review to see if they could find an adverse non-disclosure?---Yes.

All right. Now, Ms van Eeden, returning to the case of the insured person, by the end of June 2010, TAL had brought in a substantial amount of information from its investigations. Do you agree with that?---Yes, I do.

And the case manager, who at that time was handling the insured's claim, was Ms Holborn?---That's right, yes.

And from the information brought in, Ms Holborn formed the view that the insured may have failed to disclose relevant information when applying for the policy?---That's right, yes.

All right. Could I ask that you look at TAL.004.001.0415. Now, this is a file synopsis prepared by Ms Holborn. It might assist if I show you the last page at the same time, 0417, where we see the signature of Ms Holborn at the bottom of the page. Do you see that, Ms van Eeden?---Yes, I do.

If we stay at that last page, 0417, we see that Ms Holborn expressed the view, about halfway down the page:

There is a certain that there may be medical non-disclosure but no certainty. The only reports to date indicate possibly three consults in 2007 for issues with coping. Await Medicare history and clinical notes of Dr Sutherland. Also await file from Workers Comp (are aware she consulted a psych IME). Treatment appears minimal (seen psychiatrist twice) not initially taking any meds (homeopathic only) but in clinical notes of psychiatrist dated 3/6/10 mentions Seroquel, an antipsychotic. It may be that involvement of Workers Comp has delayed the process as suggested in letter to psych by GP.

And the action items in this document from Ms Holborn were (1):

Request completion of a new claim so have current information re condition; request financials to confirm can justify level of benefit applied for (even though agreed value); and (3) request private health cover claims history.

So why did TAL want to confirm that the level of benefit applied for could be justified in circumstances where the value was agreed?---Because of the – the questions around the employment initially. I think they were just validating the value on that.

But those questions had been resolved by the decision to offer the policy, hadn't they?---Yes, I agree.

They had?---Yes. Yes.

And the policy had been offered on an agreed value basis?---Yes.

Should there have been any investigation of whether the insured can justify the level of benefit applied for?---No.

Now, I will tender that document, Commissioner.

THE COMMISSIONER: File synopsis concerning insured, TAL.004.001.0415, exhibit 6.184.

EXHIBIT #6.184 FILE SYNOPSIS CONCERNING INSURED (TAL.004.001.0415)

MS ORR: So we see from that document that at this point Ms Holborn has a concern that there might be medical non-disclosure. Can I ask that you look now at TAL.004.001.0221. And these are file notes prepared by Ms Holborn on 26 June 2010. Do you see the date on the left-hand side there?---Yes, I do.

And if we turn to 0227 and bring up that page and 0228 we see Ms Holborn's assessment at this date:

Based on financials can justify level of benefit. There is an issue of non-disclosure. Timeline has been prepared for referral to underwriting and for use by claims to follow events. Appears application was borderline standard to begin with.

What does "borderline standard" mean there, Ms van Eeden?---Borderline standard means that based on the information that they now have, they expect there may be some loading.

Based on the information they now have - - -?---They may – sorry, can I just reread that - - -

Yes?--- - - - section? It means that – borderline standard means that it's just very close to a standard rate.

Very close to - - -?---A standard rate.

What does that mean, Ms van Eeden?---So when you say borderline standard, it just means that you – it's just very close to being standard. If there's more information or any other information that had been provided at underwriting stage they may have provided a loading or an exclusion or something like that.

So do I interpret that correctly to mean that at the time she put the application in, it was viewed as a standard application but it was on the verge of being viewed as a non-standard application that might have attracted a premium loading?---That's what that refers to.

Yes. I see. And is that a factor that TAL takes into account in assessing claims?---No. It should have nothing to do with claims.

I see. But here, was Ms Holborn indicating that the claim should be treated with a greater level of scrutiny because TAL had taken that view at the time of the application that this was an application that was close to receiving a premium loading?---I cannot comment on that but it should not have been taken into account.

All right. Thank you. I will tender that document, Commissioner.

THE COMMISSIONER: File notes of 26 June 2010 concerning insured, TAL.004.001.0221, exhibit 6.185.

EXHIBIT #6.185 FILE NOTES OF 26 JUNE 2010 CONCERNING INSURED (TAL.004.001.0221)

MS ORR: And a couple of days after this file note, on 28 June, TAL first told the insured's insurance consultant about its concerns that the insured had failed to disclose relevant information when applying for the policy?---That's correct, yes.

And Ms Holborn said to the insurance consultant in an email, which is exhibited to your statement as exhibit 30:

> *From the information received it appears the insured may have had consultations in relation to a psychological condition prior to the policy start date of 18 March 2009. I'm in the process of placing all the documentation received in a timeline to try and get a sense of what happened when. Once I have done that, I will discuss the insured's claim with my manager.*

So that was the communication to the insured's insurance consultant at that time?---That's correct, yes.

And then a week or so later, on 12 July, the case manager sent the insured a letter directly advising her that there were concerns about what she had disclosed?---That's correct.

And the case manager also said that she had requested further materials, she told the insured she had requested further materials from other people, including Dr Sutherland, and the employee assistance program at her work?---That's correct, yes.

And in the following day, there were phone messages and emails between the case manager and the insured. Do you recall that?---Yes, I do.

And the insured emailed the case manager a document in which she answered questions that had been put to her by the case manager and she explained that she had disclosed all her medical conditions, and she reiterated that she had given TAL permission to get all of her medical records when she applied for the policy?---Do you have reference to that email?

Yes. That's exhibit 32 to your statement, TAL.004.001.0198?---Yes.

You recall that?---Yes. Yes, I do.

So that was the insured's position. She said:

> *I disclosed everything.*

And on top of that:

> *I gave you permission to get all of my medical records when I made the application.*

?---That's correct.

But Ms Holborn decided to refer the matter for a retrospective underwriting opinion?---Yes, that's correct.

And was that standard practice within TAL?---At that stage, yes.

Okay. And after she referred the matter for a further underwriting opinion, she and the insured continued to exchange correspondence in which the insured continued to attempt to explain that she had disclosed everything, and that she had given authority for her medical records to be obtained?---That's correct, yes.

And then on 21 July, the TAL underwriter completed the retrospective underwriting opinion?---That's right, yes.

And the underwriter decided that the information that TAL had received, if it had been known at the time of the application, her application would have been declined due to work-related stress?---That's correct.

And the underwriter's opinion referred to the report from Dr Sutherland that the insured had provided with her claim?---I – I would assume so.

It was the report that I took you to earlier in which Dr Sutherland referred to the document that she had been given by the insured which referred to those six single days when she was not coping with work and home stresses during 2008, and three other days in 2009. Do you recall that?---Yes, I recall that document.

And it was a report in which Dr Sutherland emphasised that those single day incidents were unrelated to the evidence of an anxiety condition that she had now diagnosed?---That's correct, yes.

And after receiving that retrospective underwriting opinion that relied on those matters, it relied on those six days in 2008 and the three days in 2009, TAL brought in two more reports from psychologists who were associated with the employee assistance program at the insured's workplace?---That's right. So according to the underwriting referral, there's a whole list of documentation that was provided.

Yes?---Yes.

The documentation that we've been discussing?---That's right, yes.

Yes. But the focus in the underwriting opinion was, as I've just suggested to you. Do you accept that?---I accept that.

Yes. And the reports that TAL brought in from the employee assistance program, only one of them related to the period prior to the claim, didn't it?---That's right, yes.

One related to the time after the diagnosis which was the subject of the claim?---That's right, yes.

And the one that related to the period prior to the claim confirmed that the psychologist within the employee assistance program had seen the insured on two occasions in 2007, both specifically focused on information and resources regarding her carer role with her partner. She wasn't there seeking treatment of any sort, was she?---No, no.

She was getting information about her rights at work as a carer for her partner?---That's right, yes.

Now, that couldn't reasonably have been characterised as workplace stress, could it?---No.

Then on 29 July 2010, about two and a half weeks after the case manager had first told the insured of her concerns about non-disclosure, TAL sent an email to the insured telling her that the underwriting opinion was that based on a history of work-related stress, her income protection application would have been declined?---That's correct. Could you just also just give me reference of that email, please?

That's paragraph 63 of your statement, Ms van Eeden?---Okay. Okay.

Would you like the time to have a look at that?---Yes, please. Exhibit 42. Okay.

I will take you to the exhibit that you refer to in that paragraph, exhibit 42, which is TAL.004.001.0151. So this is an email from Wana Obaidi to the insured dated 29 July 2010. And we see there that she explained she's in receipt of the underwriting opinion:

> *...and they have confirmed that based on history of work-related stress, income protection application would have been declined. Next step, the matter is now referred to our legal team to advise on our potential remedies. I will be in touch with you mid-next week to advise of the process.*

How do you think the insured was likely to have interpreted the statement that the matter is now referred to our legal team to advise on our potential remedies?---I'm not very happy.

I don't think the insured would have been very happy either. Do you agree, Ms van Eeden?---I – I agree.

What was this person attempting to convey to the insured by telling her that the matter was being referred to the legal team to advise on potential remedies?---I've got no idea.

It was likely to cause the insured considerable distress, wasn't it?---Yes. I agree.

The clear inference was that TAL was considering pursuing some legal remedy against her?---I agree.

The insured responded by asking what TAL meant when it referred to a history of work-related stress, didn't she?---Yes, she did.

That was news to her?---It was news to her.

She seemed confused about why TAL had the impression that she had a history of work-related stress?---Yes.

And what that meant in the context of her disclosure obligations?---Yes.

And she pointed out that she had initially been told that her claim would be processed within five working days, and that after a number of months of dealing with TAL about the claim, the delay was now exacerbating her condition?---That's right, yes.

Then on 18 August 2010, a couple of weeks after this, TAL decided to avoid the insured's policy on the basis that it wouldn't have provided the policy had it known about this history of work-related stress. Is that right?---That's right, yes.

And if we could look at that letter. Exhibit 49 to your statement, TAL.004.001.0079. Now, the letter was annexed to this email at TAL.004.001.0080. So we see on the first page there that the letter directed to the insured recited the question that she had been asked in the online application form about depression, anxiety, panic attacks, stress, psychosis, etcetera. And then the letter noted that TAL had received a medical report from Dr Sutherland, a copy of the clinical notes from Dr Sutherland and a statement the insured had given in connection with the WorkCover claim. That was the one that referred to the six days and the three days:

> *And from a review of those documents, it has come to our attention that your response to the question above was not accurate.*

?--- .....

You smile, Ms van Eeden. What do you think of that?---That's a – I – I don't agree with that.

Okay. Then reference is made, if we go over to 0082 – perhaps if we could bring up 0081 and 0082 so that you can see the remainder of the letter, because 0081 was setting out bits and pieces from Dr Sutherland's report and notes. And then under the heading Duty of Disclosure at the top of the right-hand page, there was reference to the insured's:

> *Duty to disclose to us every matter that you knew or could reasonably be expected to know was relevant to our decision as to whether to accept your application, and if so, on what terms.*

And we see under the heading Non-disclosure Misrepresentation:

In failing to fully outline your medical history in your application, you misrepresented and failed to disclose your medical history, breaching your duty of disclosure. Those matters not disclosed or misrepresented were material to TALs assessment of the risk

And then further down under the policies:

Had the non-disclosure and misrepresentation not occurred, TAL would not have entered into the policies on any terms. TAL hereby avoids both policies from inception pursuant to section 29(3) of the Insurance Contracts Act.

Now, what are your observations about this letter, Ms van Eeden?---There's a number of errors that in my opinion are inappropriate.

Could you explain those?---I think that the claimant was never given an opportunity to provide additional information before a decision was made. I think the fact that a decision was made, already just looking at the non-disclosure misrepresentation, and accusing her of not providing us all the information, is also not appropriate. And cancelling the policy immediately without any additional communication is also not the way that we should be doing business.

Now, the letter refers to section 29(3) of the Insurance Contracts Act. I can now have that brought up for you if you would like to have a look at that, Ms van Eeden. We have it at RCD.0022.0009.0001. And the provision is within 0046 and 0047. Subsection (3) we see on the first page, 0046 – under the heading Insurer May Avoid Contract subsection (2) says:

If the failure –

And this is a failure that's referred to above as a failure to comply with the duty of disclosure:

If the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.

That's subsection (2). Subsection (3):

If the failure was not fraudulent or the misrepresentation was not made fraudulently, the insurer may, within three years after the contract was entered into, avoid the contract.

So three years to avoid the contract for an innocent misrepresentation, but no time limit on avoiding the contract for a fraudulent misrepresentation. Now, it was 29(3) that was invoked here?---Yes.

So it was not suggested that this was a fraudulent misrepresentation?---No.

But nonetheless, the provision was relied on to avoid the contract?---That's right, yes.

Thank you. Now, having received this letter in September 2010, the insured made a complaint to TAL. Do you recall that?---Yes, I do.

She made a complaint about the decision to avoid her policy. And that triggered your internal dispute resolution process?---That's right, yes.

And what's the purpose of an internal dispute resolution process, Ms van Eeden?---It's an independent review of the claim.

Now, TAL provided a response to the complaint about six weeks after it was received in November of 2010. And if we go to exhibit 92 to your statement, TAL.004.001.0063. We see the response. The response was provided by a person who we see from the second page, 0064, was a complaints resolution manager. Do you see that?---Yes, I do.

And if we go back to the first page, we see that this was the response to the complaint:

> *The letter from TAL of 1 September 2010 fully detailed the reasons as to why your policies were avoided. In reaching this decision, TAL claims, legal and underwriting reviewed the following. Based on the above, our underwriters confirmed that had you disclosed on your application your history of anxiety or stress, your income protection application would have been declined. These issues should have been disclosed by you in response to questions Q, V and W on the application. Our legal department confirmed that under these circumstances, TAL is justified in avoiding the policy under 29(3) of the Insurance Contracts Act.*

Now, having read that letter, Ms van Eeden, did the IDR, team, the internal dispute resolution team at TAL, seriously engage with the insured's request that it review the decision to avoid her policy?---No.

Did they review the file and form an independent opinion as to the correctness of the decision by the claims team?---They reviewed the file and they based their decision on the information that they had on file.

The letter does no more than repeat and reiterate the decision of the claims team. Do you accept that?---I accept that.

Was there much point to this internal dispute resolution process for the insured, Ms van Eeden?---No, there was not.

And in your statement, you accept that the file does not reflect the IDR team performing its proper function of conducting a robust analysis and assessment of the

claim decision for itself independent of the claims team. And you accept that that was conduct that fell below community standards and expectations?---Yes, I do.

And having received that response from the internal dispute resolution team, in about February 2011 the insured made a complaint to FOS?---That's - - -

You recall that?---Yes.

About the avoidance of her policy. And in early June 2011, TAL filed its first set of submissions in FOS. I will take you to those. They're exhibit 95 to your statement at TAL.005.001.0364. And we see, if we go to 0365, in paragraph 1, that under the heading Summary of Position TAL said that:

> *The evidence proved that the insured made misrepresentations in the application with respect to her medical history of seeing doctors in relation to depression, anxiety and/or stress, and breached her duty of disclosure by failing to inform TAL of this history prior to the date her policy was accepted.*

Now, this was the first time that TAL had framed the issue as one of a failure to disclose a medical history in relation to depression or anxiety, wasn't it?---Yes.

The previous formulation that TAL had used was work-related stress?---That's right, yes.

And when explaining in this document at 0366 the following page, the questions that should have been answered differently in the insured's application – do you see the table in the middle of the page?---Yes, I do.

TAL referred to the three questions that I took you to earlier on the application form, question Q, V and W?---That's correct.

And TAL recited at 0367 quite similar medical information to what it had relied on internally to avoid the policy?---That's correct, yes.

And at 0368, TAL said, second paragraph:

> *In TALs submission, it's clear from the complainant's pre-application medical history that the complainant breached her duty of disclosure by failing to inform TAL that she had suffered stress, symptoms of depression and anxiety for which she had received counselling. The complainant or a reasonable person in the complainant's circumstances would have known that these were matters relevant to TALs decision whether to accept the policy and the terms upon which TAL would accept the policy.*

So where did these references to depression and anxiety come from, Ms van Eeden?---I've got no idea.

So some months later, in October 2011, the insured's legal representatives provided a bundle of materials to TAL which directly addressed the medical evidence that TAL was relying on in FOS. Do you recall that?---Yes, I do.

And if we go to exhibit 96 within your statement – yes, 96, TAL.500.057.0236, we see the bundle of medical records that the insured provided in response to TALs submissions. And the first of those was the letter from the employee assistance program at – I'm sorry, 237. That's the one I mentioned to you earlier about seeking advice on her rights as a carer for her partner?---That's right, yes.

And the second was a letter from Dr Kang, 0238?---That's correct.

He saw the insured on 12.1.2007:

> *She has never been diagnosed as depression or anxiety disorder at that time. She has never been on any antidepressant medications. She was in for gastroenteritis symptoms and not for counselling. She was having a bad day at that time.*

Further down:

> *She never came back, therefore assumed she recovered. The condition was an isolated incident and, therefore, not associated with any mental illness.*

That was Dr Kang's report?---That's correct, yes.

And then at 0239, the third was another letter from Dr Sutherland, the insured's regular GP?---Yes.

Continuing:

> *This is to confirm that on 22 November 2007 from my notes I did not prescribe Temazepam or any other medication. At this consultation she was noted to be distressed due to an upcoming court case. This is very typical of a large number of patients that I see. I felt in the insured's case that this was an isolated event consistent with the circumstances described and in keeping with my report. I did not consider it constituted a mental condition.*

And the next document provided at 0240 was a letter from Dr Chen who saw the insured on 26 May 2007. He said:

> *Please do not read between the lines for the medical history recorded and make ill-informed decisions. A little knowledge is a dangerous thing. The information recorded refers to the fact that she was suffering from an acute episode of stomach discomfort and feeling the social aspects of this. There is insufficient information to process an empirical diagnosis of true medical anxiety as per DSM III criteria. Her anxiety and stress mentioned relates to*

normal reactive processes that go on in normal coping mechanisms. There is no correlation to mental illness. Thank you.

That was Dr Chen's assessment. And you understand that these reports were all obtained by the insured because these were the doctors whose notes had been relied on by TAL in its submissions to FOS?---That's correct, yes.

And the fifth document that the insured provided was from Dr Dinnen, a psychiatrist who had seen the insured on 21 July 2011, well after the claim was made. That's 0241. And the letter is lengthy and dealt with the insured's condition at that time. But if we turn to 0241 – I'm sorry, 0248, we see at the bottom of 0248, in response to the question recalling that Dr Dinnen was dealing with her current condition, her post claim condition, question 11:

If it is apparent that a pre-existing condition has been aggravated, please comment on the extent to which the aggravation is continuing and the effect of the aggravation on the patient's ability to work and whether that deterioration may occur in the future.

And the answer was:

There is no evidence of any pre-existing condition.

So these materials were all brought together by the insured and provided by the insured to TAL as part of the FOS process?---That's correct, yes.

And with these reports the insured provided a number of medical certificates?---Yes.

And this material was a comprehensive response to the allegations being put by TAL against the insured in FOS, wasn't it?---Yes, it was.

But what did TAL decide to do, having received this information?---They didn't use it.

They decided to press on with their position and defend the FOS dispute?---That's right, yes.

Why, Ms van Eeden?---I really do not know.

What observations do you make about that conduct?---As in my statement, it's conduct that I would not have expected at all from TAL.

You tell us in your statement that TAL and the insured attended a conciliation conference but that didn't resolve the dispute?---That's right, yes.

And then on 14 November 2011, about a month after getting this bundle of material from the insured, TAL told FOS that it had now decided to get some more information from Medicare?---That's correct, yes.

Why did TAL need further information from Medicare?---I really do not understand why.

Was that a delaying tactic, Ms van Eeden?---It was either delaying or they just wanted more information.

Well, what information could they have needed from Medicare?---I've got – really got no idea.

What information did they get from Medicare?---Nothing new.

Nothing new. Medicare advised that it had no information for much of the period, didn't they, because the insured hadn't even received Medicare services in that period?---That's correct.

And TAL, having reached that dead end, then decided to ask for further material from the psychiatrist, Dr Dinnen. Is that right?---That's correct, yes.

And Dr Dinnen refused to release that information without a subpoena?---That's correct, yes.

And having not had any luck with that, TAL wrote to FOS and said that its position remained unchanged?---That's correct.

Do you have any observations to make about that, Ms van Eeden?---Once again, I cannot understand why they did that.

Between May and October 2012, TAL and the insured continued to provide additional information to FOS, including additional submissions. I'm sorry, that should be 2011, I think?---11, yes.

May and October 2011. I apologise for that. No, I'm sorry, it must be that the FOS dispute went on that long?---It went on very long.

May and October 2012?---It took nearly two years.

Yes. And on 4 July 2012, FOS asked for copies of parts of TALs underwriting guidelines?---That's correct.

And that created a bit of internal consternation within TAL?---I can't comment to that.

Well, perhaps if I show you TAL.005.001.0256?---Do you know which – is that in - - -

No, it's not in your statement, I'm afraid, Ms van Eeden. It's a document that I assume has been drawn to your attention. It contains emails between Philip Dobbin and Helen Molloy at TAL on 9 to 11 July 2012. And Mr Dobbin was a service manager in complaints resolution and Helen Molloy was the underwriter who had given the retrospective underwriting opinion. Is that right?---That's right, yes.

Ms Molloy was, in fact, TALs chief underwriter. Is that right?---That's right, yes.

And if we turn to 0257, we see that Mr Dobbin said to Ms Molloy, the chief underwriter:

> *FOS are clearly going to put us to the sword on this. They've sought further submissions from us prior to reaching a decision on the complaint. As you will see, much of it revolves around the underwriting aspect and your statement of 29 June 2012.*

You see that?---Yes, I do.

And Mr Dobbin asked for Ms Molloy's assistance in responding to FOS?---Yes.

And we see that Ms Molloy responded:

> *We will not have guidelines for everything that they are asking for. An underwriter is allowed to apply their judgment and their experience in making an assessment to accept, deny or limit a contract of insurance.*

I will tender that document, Commissioner.

THE COMMISSIONER: Internal TAL emails of 10, 11 July 2012, TAL.005.001.0256, exhibit 6.186.

EXHIBIT #6.186 INTERNAL TAL EMAILS OF 10, 11 JULY 2012, TAL.005.001.0256

MS ORR: The question I had asked before showing you that document, Ms van Eeden, was whether or not the request for TALs underwriting guidelines created some internal consternation at TAL. Do you now accept that proposition?---Yes, I do.

And then some months later – we're now more than two years after the insured made her claim to TAL – on 5 October 2012, FOS delivered a recommendation?---That's correct.

And if we could go to that document. It's exhibit 114 to your statement. TAL.005.001.0002. FOSs recommendation was in favour of the insured, wasn't it, Ms van Eeden?---Yes, it was.

And if we turn to 0005 in the document, we see that at the outset the recommendation outlined in paragraph 16 that:

> *In order for TAL to avoid the policy under 29(3) of the Act, it must establish that the applicant failed to comply with her duty of disclosure or made misrepresentations to it before the policy was entered into and that it would not have been prepared to enter into a contract of life insurance on any terms had the duty of disclosure been complied with or had the misrepresentation not been made.*

The recommendation also set out the medical evidence in some detail. Do you recall that?---Yes, I do.

And if we turn to 0014, we see at paragraph 65 that:

> *Based on the medical evidence on the file –*

The case manager was:

> *...not satisfied that the applicant suffered from the medical conditions of depression, anxiety and/or stress prior to cover commencing under the policy. I am also not satisfied that the applicant sought treatment or counselling for the medical conditions of depression, anxiety or stress, or for symptoms associated with those conditions.*

And at paragraph 71 over the page at 0015, the FOS finding was:

> *On the basis of the medical evidence outlined above, I accept that the applicant was not aware that she suffered from depression, anxiety and/or stress or symptoms of those conditions until she was diagnosed with the generalised anxiety disorder by Dr S on 4 January 2010. Evidence on the file indicates that she first experienced episodes of panic and depression in approximately mid-2009 at which time her stressors were aggravated and her mental health began to deteriorate.*

Now, as a result, the case manager found at paragraph 73 on this page that the insured had not breached her duty of disclosure. And the case manager went on to review the evidence relating to the stress that the insured had experienced at work and at home. And if we turn to 0020, the case manager at paragraph 98 was satisfied that:

> *...the applicant experienced stress at work and at home. And that in 2018 and 2009 prior to cover commencing under the policy, she had taken 10 days of*

leave due to stress at work and at home. However, I am not satisfied that the applicant reduced her hours to part-time as a result of stress and related conditions. I consider that the applicant reduced her working hours for personal reasons and to enable her to spend more time caring for her partner. The question remaining then is whether the applicant knew or a reasonable person in the circumstances could be expected to have known that these matters would be relevant to TALs decision whether to accept the risk and if so on what terms. Based on the evidence on the file, I am not satisfied that the applicant knew that she was required to disclose stress that she had experienced from time to time due to working within a stressful environment and caring for a partner with a mental illness.

And 105:

I therefore find that the applicant did not breach her duty of disclosure under section 21 of the Act by failing to disclose that she had experienced stress.

Now, that was the recommendation made by FOS. What was TALs reaction to that decision?---They did not accept it.

There were a number of internal discussions about whether to accept it, weren't there?---That's right, yes.

And have you seen documents that record that TALs internal legal counsel pointed out that every facet of TALs decision had been rejected. Have you seen those references?---Which document are you referring to?

TAL.500.057.0724?---Do you know which - - -

It will come up on the screen, Ms van Eeden. It's not annexed to your statement. Now, the email from the legal counsel appears in the middle of the page on 23 October 2012. She says that she has read through the recommendation. And she says:

On my reading, it seems that the insured's explanations are accepted without reservation and every facet of TALs decision is rejected. In my view there is nothing to lose by pressing on, but ultimately it must be a decision for the business.

Do you see that?---Yes, I do.

So that was the view expressed by TALs legal counsel?---Yes.

And we see further up the page a response to that:

I was of the opinion we do not accept and go to determination.

That was Megan Garvan just below the part that's expanded at the moment. Do you see that?---Yes, I do.

And then Mr Dobbin, at the top of the page:

> *But I think RS –*

the legal counsel –

> *is saying we are 100/1, which appears close to the mark. It's your call of course but we will have to decide today.*

?---That's right.

And TAL went on, made its decision to reject the recommendation?---That's right.

Do you have any observations about that decision, Ms van Eeden?---Once again, I think it's inappropriate.

And it was a decision that placed the insured in a position where she had to battle further to try and have some success with the claim that she had made well over two years ago by this point?---I agree.

I will tender that document, Commissioner.

THE COMMISSIONER: TAL emails of 23 October 2012, TAL.500.057.0724, exhibit 6.187.

EXHIBIT #6.187 TAL EMAILS OF 23 OCTOBER 2012 (TAL.500.057.0724)

MS ORR: The matter then went to a FOS determination. Is that right?---That's right, yes.

And the FOS determination was also in favour of the insured?---Yes, it was.

For very similar reasons to those contained in the recommendation?---Yes.

The panel found that TAL wasn't entitled to avoid the policy under section 29(3)?---Yes.

And they directed TAL to reinstate the policy?---Yes.

And the panel said that if any benefits were payable to the insured as a result of the reinstatement, they were to be paid with interest in the way that it specified, that FOS specified?---That's correct, yes.

And the panel also made clear that if benefits were payable to the insured, TAL was entitled to offset the costs of any premiums that had already been refunded to the insured when TAL voided the policy?---That's right, yes.

TAL was disappointed by this decision as well?---It seems some individuals were, yes.

Yes. The insured accepted the determination, didn't she?---Yes, she did.

And on 1 March 2013 FOS notified TAL that as a result of that it was required to reinstate the policy and assess the insured's claim for benefits?---That's correct, yes.

And FOS told TAL that it had to undertake the steps necessary to comply with the determination within 21 days. Have you seen that?---Yes, I did.

And on 20 March, just within the 21 day limit, TAL reinstated the policy?---That's correct.

But it took much longer for TAL to assess the insured's claim for benefits, didn't it?---I – I don't know.

Well, let me take you through the sequence. By this time, there was a new case manager for the claim. Is that right?---That's right, yes.

That was someone by the name of Ms Pratt?---Yes.

And Ms Pratt told the insured that before her claim for benefits could be assessed, she needed to pay $2215 in premiums, being the amount of premiums that she had paid before making the claims but which TAL had refunded when it avoided the policy?---I've seen that, yes.

So she has finally got to the point where her policy has been reinstated and she is told she has to find $2215 before TAL will consider her claim. What observations do you have about that, Ms van Eeden?---Once again, I think it's a very inappropriate – inappropriate process.

Well, FOS had already told TAL in its determination that it could offset the refunded premiums against the benefits that it paid out. That would have been the appropriate way to handle it, wouldn't it?---Absolutely.

And that was the way FOS had directed TAL to handle it?---Absolutely.

And FOS was very unhappy when they found out that TAL had told the insured that she needed to pay this $2200 amount before TAL would assess the claim?---I think so. I haven't seen – I don't have that letter.

Would you like to see the email correspondence?---Yes, please.

TAL.005.001.0073?---Is that one of my tabs or - - -

No, it's not one of your tabs, Ms van Eeden. This is an email from Katherine Marchant at FOS. We see that from 0074. Perhaps if we could have 0073 and 0074 on the screen together. Katherine Marchant was the case manager at FOS. And she emailed Mr Dobbin at TAL and she said:

> *I note from TALs correspondence that TAL is seeking that [REDACTED] pay 2215 in outstanding premiums - - -*

THE COMMISSIONER: You've just mentioned a name that should not have been mentioned.

MS ORR: I'm very sorry. I apologise for that.

THE COMMISSIONER: The person's name is the subject of an NPD and is not to be published. Yes.

MS ORR:

> *I note from TALs correspondence that TAL is seeking that the insured pay $2215 in outstanding premiums prior to TAL undertaking its assessment of her claim for benefits. The FOS determination directed TAL to reinstate her policy, assess her claim for benefits and pay interest on any outstanding benefit entitlements as set out in paragraph 22 of the determination. The determination also found that TAL was entitled to offset any premiums refunded against any benefits that are payable. I have confirmed with the ombudsman that the intent of the determination is that TAL completes its assessment of the insured's entitlement to benefits following which TAL may then offset any premiums refunded to the insured against any benefits that are payable.*
>
> *FOS is concerned that TAL, in seeking payment of outstanding premiums prior to its assessment of her claim, is failing to comply with FOSs determination. Please advise FOS whether TAL intends to continue seeking payment of outstanding premiums prior to its assessment of the claim.*

?---I acknowledge - - -

FOS was not happy with TALs position, was it?---Not at all. No.

I tender that communication.

THE COMMISSIONER: Emails between FOS and TAL, 5 and 8 April '13, TAL.005.001.0073, exhibit 6.188.

EXHIBIT #6.188 EMAILS BETWEEN FOS AND TAL, 5 AND 8 APRIL '13 (TAL.005.001.0073)

MS ORR: Now, as a result of FOSs intervention TAL decided not to press for payment of that amount before assessing the claim. Is that right?---That's right, yes.

And Ms Pratt told the insured that she would need to provide updated medical information to allow her claim to be assessed?---That's correct, yes.

And she did that. She provided medical certificates confirming that she remained unfit for work?---That's right.

And in May 2013, about two and a half months after FOS had told TAL that it was required to reinstate the policy and assess the claim within 21 days, the insured raised concerns with TAL about the time it was taking for TAL to make a decision on her claim. Do you recall that? You deal with that in paragraph 81 of your statement?---Okay.

And FOS was concerned about the time it was taking too. You tell us in paragraph 82 that FOS asked TAL to advise as a matter of urgency when it expected to complete its assessment of the insured's claim?---That's right.

And on 22 May 2013 TAL finally told the insured that it had accepted her claim?---That's correct, yes.

And that was just over three years after the insured had lodged her claim. Do you have any observations to make about that, Ms van Eeden?---Once again, in my opinion, it's inappropriate. It should never take so long to make a decision.

And even then, the insured's claim was only accepted for the period up until 10 July 2012, wasn't it?---Yes.

Ms Pratt told the insured that the total amount she would be paid was $89,000, and that included an amount of interest. Do you recall that?---Yes, I do.

And how long after that decision was made to pay that amount was that payment made to the insured?---I – I don't – do you know which tab - - -

No, we're unable to work that out. I wondered if you knew, Ms van Eeden?---I've got no - - -

You can't tell when she was paid that amount?---I've got no idea.

Ms Pratt told the insured that TAL required more information to consider the remaining period, the period from 10 July 2012 and 2 May 2013. Do you recall that?---Yes, I do.

And FOS remained involved at this point?---Yes.

And FOS asked TAL to confirm exactly what further information it needed so that any further unnecessary delay could be avoided?---That's correct.

And the insured also queried how long the review of her claim for that period was going to take, to which TAL said that it was getting more medical information and that once that information was received, then the regular timeframe for the decision was about five to 10 working days?---That's - - -

You recall that?---Yes.

And over a month later, on 5 July 2013, the claim for the remaining period was accepted?---Yes.

And that resulted in a payment of benefits of an additional $35,000?---In back payments, yes.

But that amount didn't include interest, which was required by the FOS determination?---That's correct.

And over the following weeks, there was more dialogue between FOS and TAL about why TAL hadn't paid interest, which the determination had required?---That's right.

TAL then paid interest but only until February, the month of the FOS determination?---That's correct.

Is that right?---That's right, yes.

And it should have paid interest on the sum up until the date when the insured was paid?---That's right, yes.

So FOS got involved again and told TAL of that?---That's right, yes.

And did TAL ultimately pay the insured interest on the amount for the correct period?---Yes.

Why was it such a battle for the insured to get TAL to act in accordance with the FOS determination?---I've really got no idea.

It should not have been such a battle, should it, Ms van Eeden?---It should never be such a battle.

What does this say about FOSs views of and respect for the external dispute resolution body.

THE COMMISSIONER: TALs, I think.

MS ORR: I'm sorry, TALs.

THE COMMISSIONER: Put the question again.

MS ORR: What does that say about TALs views and respect for the external dispute resolution body?---We – we felt especially looking at this case it did not serve the client. We have also made a lot of changes not just because of this case but we have made a lot of changes to our internal dispute review team.

Your internal dispute team?---The IDR team. So we've made a lot of changes and they are now reporting to legal so that we do have legal and the proper oversight.

Do you accept that TAL should have moved quickly to put the insured in the position she would have been in had TAL assessed her claim correctly three years earlier?---Yes. Absolutely.

But the story doesn't end there, does it, Ms van Eeden, because in late April 2013, Ms Pratt decided to conduct a Google search for the insured?---That's correct, yes.

Why did she do that?---Once again, I've got no idea.

And from that Google search, she ascertained that the insured had written a book and that she had attended some public speaking events that year to promote her book?---That's right, yes.

And at the same time, from a review of her tax returns, Ms Pratt identified that over the last three years her business as an author had lost money and the accumulated losses were just over $29,000?---That's right, yes.

Now, some time after that, TAL engaged UHG in connection with the insured's claim. What does UHG do?---UHG facilitates the collection of medical information, but also in this period they provided an external review process.

And what did TAL engage UHG to do with the insured's claim?---From what I can see on the file, they have asked them to do an – an external opinion on the claim.

An external opinion on the claim. Why was that sought?---Once again, I've got no idea.

Should it have been sought?---No, not at all.

And then by late October 2013, the insured's case manager had once again changed?---That's right, yes.

And the name of this case manager is the subject of a non-publication direction. So I'm just going to refer to her as the case manager?---Okay.

On 28 October 2013, the case manager instructed a private investigator to undertake an investigation of the insured?---That's right, yes.

Why did she do that?---Once again, I've got no idea, other than basically maybe she thought there was something she wanted to find out. But I've got no idea why.

It had taken her three years but the insured had been successful in FOS and was now receiving her benefits. That's right?---That's right, yes.

Why was it necessary to have an external investigator conduct an investigation into her circumstances?---I've got no idea.

Was TAL looking for a reason to stop paying the claim?---It seems like it, yes.

Is there any other inference that we can draw from this conduct, Ms van Eeden?---No.

What safeguards were in place at that time to ensure that surveillance was only undertaken where necessary?---There wasn't any.

No safeguards?---No. Doesn't – I couldn't find any.

And what approval processes existed within TAL where a case manager decided that it was a good idea to undertake surveillance to approve that decision?---Looking at the claim, I can't find any approval process.

There was no approval process - - -?---No.

- - - was there?---No.

The case manager decided to do this and went ahead and did it without any approval process and without any safeguards being in place to assess whether that was an appropriate decision?---Exactly, yes.

Could I take you to exhibit 68 to your statement, TAL.500.065.0154. Now, this document contains the instructions that were given to the private investigator. Is that right?---That's right, yes.

And these set out detailed background information about the insured?---Yes.

And at the end of the document at 0165 there was a management plan in the instructions. And the management plan made clear – we will just need to take that document down, Commissioner.

THE COMMISSIONER: Yes. Take it down.

MS ORR: You have this document in your - - -?---Yes.

- - - witness folder there. I apologise for that, Commissioner. We've worked very hard with TAL to try and ensure that redactions were in place, but it appears - - -

THE COMMISSIONER: Well, the primary responsibility for redactions lies with TAL.

MS ORR: I will - - -

THE COMMISSIONER: And I know that the staff of the Commission have spent days checking it and it's not satisfactory. Go on.

MS ORR: I will read the portion headed Management Plan, Ms van Eeden:

> *Review policy for compliance for doctor's recommendation, the life insured states she can't work. However, she is a full-time carer for someone with a mental disorder. Can this be deemed as work? Full backgrounds, surveillance for three days. Obtain update on workers comp. Once all relevant material in, I would like a customer visit, not a full factual.*

So those were – that's what we see under the heading Management Plan. We see that the case manager wanted to try and support her theory that the insured's position as a full -time carer for her partner was work which would disqualify her from continuing to receive payments?---Yes.

And we see underneath Management Plan:

> *Estimated outstanding liability, $792,000.*

What's that a reference to, Ms van Eeden?---That would be her benefit.

That's how much TAL would have paid out under this policy if she continued receiving benefits until age 65?---That's correct, yes.

That's how much money was at stake for TAL if it could not find a way to stop paying out this claim?---Yes.

Now, if we turn to 0167, we see that this page of the document listed a number of different types of background searches that could be done. I'm sorry, I will give the full number. It's TAL.500.065.0167. So all sorts of searches were included in the instructions, including a lot of social media searches, government searches, various websites that could be accessed, property searches, company business searches. We see from 0169 that the instruction given was:

Please complete as many searches as possible. I have enclosed a list of searches. Some are only available if we request from the insured during a factual.

Now, that's a word we see a bit, a factual, Ms van Eeden. Can you explain what that is?---I – I've got no idea what she was referring to.

I see?---It's not something I would use.

She then says:

Please conduct a period of three days surveillance. However, before commencing I would like the searches completed and sent to me and then I can see if we need to alter our instruction.

Do you see that?---Yes, I do.

And then further down the page:

Please complete a pretext at the hospital and maybe discuss with the local police about her. There may be some issues there as well.

What did it mean to do a pretext at the hospital?---Once again, I've got no idea.

The private investigator was being asked to go to the hospital and – under some pretext seek information about the insured, wasn't he? Perhaps posing as a family member or a friend?---I've really - - -

You don't understand what that means?---No, it's not something I've ever seen.

Would it be appropriate to do that, to instruct that to happen?---No.

What about to instruct the private investigator to go to the local police station and see if they had any information about the insured?---This whole – is all inappropriate.

It's all inappropriate and it was all the result of multiple TAL case managers decisions. This wasn't one person responsible for all of this, was it, Ms van Eeden? This was multiple people making multiple, in your words, inappropriate decisions?---That's right. And – you are right, yes.

Now, these instructions to the private investigator were sent under cover of an email that is at the front of your exhibit. It's TAL.500.065.0153?---Is that under a tab?

It's under the same tab. It's the first document. If you turn back to the start. We see that the case manager said to the private investigator:

Hi Mark. OMG. Here is another one for you. I want results.

Do you have any observations about that, Ms van Eeden?---No. I was shocked when I saw this.

You were shocked when you saw that?---Yes, yes.

It's pretty clear what the case manager meant when she said "I want results", isn't it?---Absolutely.

How do you interpret that?---It – once again, I can only say it's not appropriate.

Well, she wanted the investigator to find information that would provide a basis for TAL to cease paying the insured's claim?---Absolutely.

A basis for TAL to avoid paying the $792,000 liability that it would have under this policy?---That's right.

In your statement you acknowledge that this email was reflective of an inappropriate approach - - -?---Yes.

- - - taken by TAL to seek to avoid paying the claim. And you say:

> *It is absolutely contrary to the way that a claim should be handled.*

?---Absolutely.

And you acknowledge that the direction given in the email, the tone of the email, and the information provided in the email instructing the private investigator was totally unprofessional?---That's right, yes.

After these instructions were given, a detailed and sustained surveillance campaign commenced authorised by TAL, didn't it?---That's right, yes.

How long did the surveillance ultimately continue for?---A couple of months.

Well, it was at least four months, on our calculation, from 14 November 2013 when the physical surveillance commenced, to at least 7 March 2014. Do you accept that?---I do, yes.

And one aspect of this was detailed desktop surveillance. Can you explain what that is?---Once again, I don't know what it is because it's not something I've done.

Ms van Eeden, it's somewhat difficult when the person that TAL presents to deal with these case studies is unable to explain so many aspects of them. Can I ask that you look at one of your exhibits, which is TAL.500.052.2148, exhibit 70. We need to bring it down. There's another breach of the non-publication direction. I'm sorry. I'm going to have to ask you, Ms van Eeden, to do this without the document on the screen. You have the document before you. It's one of your exhibits - - -?---Yes.

- - - which ought to have been redacted by TAL. But we will proceed without it on the screen. The document I want to direct you to is entitled Background Investigation Report dated 21 November 2013?---Yes.

And if we turn to the second and third pages of that document, we see a summary of the searches conducted and the findings in relation to the investigations as at this date of the insured?---Yes.

And they include searches for government licences, relevant news text, insurance reference services, searches, white pages entries, Google searches, ABN searches, searches of Facebook, Instagram, Snapchat, Twitter, Tumblr, LinkedIn and CITEC. Do you see all of that?---Yes, I do.

Is that what we would understand the desktop surveillance to involve, the search of all of those sort of sites?---Yes, sitting at the desk. It seems appropriate.

And the next 60 pages of the report were made up of printouts and screenshots of the results of those searches?---That's right, yes.

Now, is this what you refer to in your statement as "the excessive social media research" that was conducted on the insured?---Yes, it is.

And, again, you accept that that research was part of a broader inappropriate approach towards the insured which was that TAL was seeking to avoid paying the claim rather than supporting the insured?---Yes, I do.

Now, the other aspect of TALs surveillance was physical surveillance of the insured, wasn't it?---That's right, yes.

And that physical surveillance involved an investigator observing the insured on and off for about four months at least, on our calculation, and reporting the results of those observations to TAL?---That's right, yes.

And the investigator provided photographs and videos of the insured to TAL?---Yes.

And the information that the investigator provided to TAL about the insured was very detailed and frequently very personal. Do you agree with that?---I agree with that.

Could I take you to exhibit 71 to your statement, TAL.500.052.0037. Now, this was the first surveillance report that TAL received. And it was dated 3 December 2013?---That's right, yes.

And we see at this first page that TALs instructions are listed as:

To conduct observations on the member while she is travelling the country and to ascertain her current activities and the extent of her alleged psychological condition.

?---I see that.

It wasn't an alleged psychological condition, was it, Ms van Eeden?---No, it wasn't.

And we don't see it because it's blanked out, but the front page included a photograph of the insured, so that she could be recognised?---That's right, yes.

And over the page at 0038, we see that there was a description of the insured's home and photographs of her home, as well as her mobile telephone number?---That's right, yes.

All of that was provided to the personal – the private investigator?---Yes.

Is that right?---That's right, yes.

And we then see a section headed Surveillance Summary:

Pursuant to your instructions, a period of surveillance has been conducted on the claimant in an endeavour to ascertain her present activities and the extent of her alleged psychological condition. The surveillance was conducted over a week in –

Particular parts of Australia:

During the surveillance period, the claimant was observed on three separate occasions conducting a presentation and selling her book. The presentations were conducted at the libraries of each country town. She was also observed carrying out her normal day-to-day activities in company with a male person who was in a very close relationship with the claimant, who was observed holding hands, kissing and stroking the body of the male person. The male person and the claimant were also observed bush walking, swimming, attending the three libraries, generally walking about the area and exercising as well as attending a takeaway food store and staying at two hotels and one motor inn.

And further down we see:

The claimant displayed a happy, confident and carefree demeanour as she was observed and videoed during the surveillance period showing no outward signs of her alleged psychological condition.

That was the surveillance summary?---That's right, yes.

And from 0040, the investigator goes into the detail of his surveillance?---Yes.

And we see from this that the insured was surveilled for this report for seven days over a two and a half week period, and video footage was taken on four occasions during the period?---That's right, yes.

And the investigator from 0041 provided detailed notes of what he witnessed on each instance of surveillance?---That's right. Yes.

And on a number of occasions, the investigator referred to having conducted a recognisance or a foot recognisance at the insured's house. Sometimes he was in a static surveillance position?---Yes.

By that language, he is conveying that he went up to the house and inspected what was going on. Is that right?---That's what it implies, yes.

And to take an example of the level of detail that was being conveyed on a daily basis, let's look at the record of the surveillance on Tuesday, 26 November at 0042 to 0043. Now, I want to summarise what appears on these pages. We see that on this day – or we will when they come up on to the screen but you have them there – that the insured was subjected to surveillance from 9 o'clock in the morning when she was located having breakfast at a café, through to late morning when she gave a presentation about her book at a local library, through to the afternoon when she and her partner had a swim at the local pool, through to her dinner at a local pizza and takeaway place, and we see from 0044 that surveillance was terminated at 6 o'clock that night. Yes?---Yes.

And three pages of surveillance notes are made about her activities on that day, including photographs and covert video was taken of her at the café for breakfast, in the library giving her presentation, walking through the streets with her partner, swimming at the pool - - -?---Yes.

- - - and at the takeaway place?---Yes.

Have you read the notes of this day of surveillance, Ms van Eeden?---Yes, I have.

Do you agree with me that the content is very personal and highly intrusive?---Absolutely.

There is commentary about matters such as the insured removing her clothing to reveal her swimwear at the pool?---It's terrible.

Do you agree with that?---I agree with it.

There's commentary about the displays of affection that she showed her partner?---That's right, yes.

The insured had no idea that a private investigator was following her around town taking photos and videos of her and recording her every move?---No. No idea.

The surveillance was, I want to put to you, Ms van Eeden, deeply inappropriate, wasn't it?---Yes, it was.

This is not how an insurance company should treat a person who has qualified for benefits under an income protection policy on the basis of a mental health condition, is it?---It's not how to treat any claimant.

Thank you. No policyholder should ever be subjected to this sort of investigative activity, should they?---No.

How much did TAL pay the private investigator to conduct this surveillance?---In total, about $20,000, I think.

About $20,000?---Yes.

So the insured had income protection payments of $2750 a month?---That's right.

That's what she was entitled to under the policy?---That's right.

But TAL elected to pay $20,000 to a private investigator to try and find a way to stop those payments?---That's correct, yes.

Now, on 3 December 2013, the same date as this surveillance report that I've taken you to, TAL sent a letter to the insured. And you haven't annexed that letter to your statement, but we know that it was sent on that day because it's referred to in an email that the insured sent to TAL on 10 December 2013 which you have annexed to your statement. That's exhibit 71A?---Yes.

And from that email we can see that – we can bring that up, TAL.500.052.1041. We can see from this email that by – we will have to expand it, I'm sorry. We will expand – yes:

> *I received your letter after 3 December 2013.*

Do you see that reference at number 1 there?---Yes, I do.

And we can see from this that TAL had on that date asked the insured to complete a daily activity diary. Do you see the reference to that in point number 2?---Yes, I do.

So TAL asked the insured to complete this daily activity diary from 4 November 2013, which was a month before she received the letter, to 30 December 2013. Do you see that?---Yes.

And in response in this email, the insured expressed concerns about being able to remember back to what she had been doing a month earlier on a daily basis, given that one of her symptoms was short-term memory and forgetfulness?---That's right, yes.

And she also explained that keeping a daily diary would cause her extreme distress and would exacerbate her condition?---Yes.

And in response, the case manager asked the insured to elaborate on how completing the diary would exacerbate her condition. Do you recall that?---Yes, I do.

And she said that she was trying to establish the full extent of the insured's condition and what she was able to do?---Yes, I see that.

And she also told the insured that the majority of TAL claimants had been required to produce a daily diary?---This is not the case.

She said that, didn't she?---She did say that, yes.

And it was not true, was it?---No. No.

The daily activity diary was an entirely inappropriate requirement to impose on the insured, wasn't it?---For this insured, yes.

The use of the diary was again designed to disprove her entitlement to benefits, wasn't it?---In this claim, yes.

So, again, TAL was trying to find a way to cease paying the benefits rather than to support the insured and assist her with her rehabilitation?---That's right, yes.

When is it appropriate to ask a mental health claimant to complete a daily activities diary?---On some claims, because you find claimants with a mental health problem, you can support them through rehabilitation by bringing in some kind of structure into their day. So it might be applicable to certain claims, but very few that you would use it for.

Very few?---Yes.

What sort of claims would suggest that the level of structure brought by the exercise of completing a daily diary would be beneficial?---So it's not the completing of the daily diary, it's to help to bring structure into somebody's life because it's a part of your rehabilitation.

I see. But you accept that this was not - - -?---Not - - -

- - - such a situation?---This was not such a situation.

And this was used for an ulterior motive, wasn't it? It was another attempt to disprove her entitlement?---Yes.

Now, by 6 December 2013, the case manager had asked Dr Phang, a psychiatrist with UHG – I mentioned UHG earlier – to provide an opinion on the insured. Is that right?---That's right, yes.

And if we go to TAL.500.065.0141, we see an email chain between the case manager and one of Dr Phang's colleagues?---Sorry, is this under a tab?

This will come up. This is not in your witness statement, Ms van Eeden. Thank you. Now, if we start at 0142, we see that the case manager told one of Mr Phang's colleagues at the bottom of that page that although it was a big ask, she would love to close this one down –

This one being the insured's file:

> *... before Christmas, if it could get pushed through. If not, that's okay, too.*

?---I see that.

Now, by that do you interpret her as meaning that she wanted the insured – she wanted her claim to cease, she wanted the insured to stop receiving benefits from TAL prior to Christmas?---That's what this says.

Yes?---Yes.

So this is 6 December, and she's corresponding with a colleague, part of the practice of the psychiatrist who has been briefed to give the opinion, and telling him that she wants it closed down, claim ceased, before Christmas?---Yes.

Do you have any observations about that, Ms van Eeden?---Once again, it's totally inappropriate.

And we see that Dr Phang's colleague responded, above the page, that it would assist Dr Phang to get a copy of the surveillance DVD rather than just the surveillance report?---It's also inappropriate.

Yes?---But I see that, yes.

Why is that inappropriate, Ms van Eeden?---First of all, she should not be sharing any kind of information. That's privacy. It's a breach of privacy.

But she did give the surveillance DVD?---Correct.

And the surveillance report to the psychiatrist, didn't she?---She did, yes.

And - - -

THE COMMISSIONER: Go on.

MS ORR: I'm sorry.

THE COMMISSIONER: No, go on.

MS ORR: And I was going to move on from that email so I will tender the email chain.

THE COMMISSIONER: Email chain between TAL and UHG, 6.12.13, TAL.500.065.0141, exhibit 6.189.

EXHIBIT #6.189 EMAIL CHAIN BETWEEN TAL AND UHG DATED 06/12/2013 (TAL.500.065.0141)

MS ORR: So that communication was in December 2013. And also in December 2013 the insured sent TAL a medical certificate explaining the effect that completing the daily activity diary was having on her?---That's right, yes.

And that's exhibited to your statement as exhibit 72?---Yes.

It's TAL.500.052.0065. Sorry, I am losing my documents, Ms van Eeden. I will just pull that document up. Now, this is a letter from the insured's GP dated 11 December 2013. And we see from the letter that the GP says that the insured had presented herself to the GP as her usual GP was absent, and the letter said that she had presented in an:

> *Extremely anxious state which she attributes to your request for a daily activity diary. It is my opinion that this requirement is exacerbating her state of anxiety and potentially having a negative impact on her health.*

And the doctor requested that TAL review its requirement for the diary:

> *As it was likely having a negative impact on health.*

So that was the medical document provided by the insured to TAL at this time?---That's correct, yes.

And the following week, the case manager emailed Dr Pham, the psychiatrist, about the daily activity diary requirement. Now, we need to go to TAL.500.065.0147 to see those emails. Now, if we could go to the second page, 0148, we see - - -?---Is that a – sorry, is that attached to - - -

No, it's not attached to your statement, Ms van Eeden. It will be on the screen. Do you see there an email – perhaps if we could bring the next page up as well, 0419. You will see that the – there's an email chain. I want to direct you first to the email that appears on the page we have at the moment, on 13 December at 8.24 am. This is an email from the case manager. And the case manager says to a colleague of the psychiatrist, part of his practice:

> *I have a question for you. I need medical advice concerning the above, the insured. As you are aware UHG are currently reviewing this claim and I have sent over surveillance to be reviewed as well. To help us manage this claim, I asked the insured to complete a diary from 4 November and her response was not a good one. Below you will see the back and forward emails and now she has lodged a complaint as she is stating that we are going against doctor's advice. Could you please advise how do you think we should handle this? (1) I would love the diary completed. (2) If I keep firm with my request it would be seen as going against doctor's advice. (3) I could ring the doctor, however I believe that this is not the way to go as he/she was only a locum. 4. Help.*

That was the email from the case manager?---Yes, it was.

Who clearly wanted support for her position that the daily activity diary should continue to be completed despite the medical evidence?---That's correct, yes.

And we see from 0147 that the psychiatrist emailed back and he made some suggestions in response, including a suggestion that we see in dot point 3. He says:

> *I am loath to do this over the phone as you need something in writing in order to justify and reinforce the opinion given.*

So one of his suggestions was that the case manager write to the GP who had provided that opinion, and ask him to justify and reinforce the opinion given. Is that how you read that, Ms van Eeden?---Yes.

I will tender that email chain, Commissioner.

THE COMMISSIONER: Emails between TAL and UHG of 13 December '13, TAL.500.065.0147, exhibit 6.190.

EXHIBIT #6.190 EMAILS BETWEEN TAL AND UHG DATED 13/12/2013 (TAL.500.065.0147)

MS ORR: Now, that email that Dr Phang sent was at 8.05 in the morning on 13 December 2013. Can I take you to another email from the psychiatrist to the case manager later that day, TAL.500.065.0001. So at 2.44 that afternoon, the

psychiatrist sent the case manager an email entitled A Picture of Your Favourite Claimant. Do you see that?---Yes, I do.

And the email linked to a photo of the insured which was available on the internet?---Yes.

And it was sent with the tag line from the psychiatrist:

I thought this would make your day.

?---Yes.

Was this an appropriate communication between a case manager and the supposedly independent psychiatrist who had been engaged to review the position of the insured person?---Not at all.

This belittled the insured person, didn't it, Ms van Eeden?---That's right. It's totally inappropriate.

I tender that document, Commissioner.

THE COMMISSIONER: Email from UHG to TAL, 13 December '13, A Picture of Your Favourite Claimant, TAL.500.065.0001, exhibit 6.191.

EXHIBIT #6.191 EMAIL FROM UHG TO TAL DATED 13/12/2013 (TAL.500.065.0001)

MS ORR: And then on 25 December, on Christmas day, the insured provided TAL with her progress claim forms along with a further medical certificate from her regular treating GP. You recall this?---Yes, I do.

And if we go to TAL.500.065.0022?---Is that – is there a tab - - -

No, it will come up on the screen. We see that the insured provided a medical certificate from her regular GP, who noted that her:

...medical condition causes confusion and she is unable to fill out a diary regarding her daily activities. She is getting quite stressed doing this.

That was the medical certificate provided on Christmas Day by the insured?---Yes.

I tender that document.

THE COMMISSIONER: Medical certificate dated 24 December '13, TAL.500.065.0022, exhibit 6.192.

EXHIBIT #6.192 MEDICAL CERTIFICATE DATED 24/12/2013 (TAL.500.065.0022)

MS ORR: And then you tell us at paragraph 103 of your statement that two days later the case manager responded to the insured and she told the insured that the matter had been referred to TALs chief medical officer and that TAL felt that requesting the daily diary was not unreasonable. That communication is exhibit 73 to your statement, Ms van Eeden?---Yes.

Is that correct?---That's right, yes.

And she said that she needed to complete the diary sheets and forward them so that her payments were not delayed. Do you recall that?---Yes, I do.

Was this a threat to stop or pause at least her benefits if she didn't submit the daily diary?---It is, and I refer to it in my statement in terms of bullying and for me this is absolutely bullying.

The case manager bullying the claimant?---That's right, yes.

Now, a few days after that, the insured decided it was necessary to go back to FOS, didn't she?---That's right, yes.

She made a second complaint to FOS about the requirement that she complete the daily diary?---Yes.

She told FOS that she was not able to do it because of her current medical condition?---That's right, yes.

And she told FOS that she had given medical opinions to TAL indicating that this was exacerbating her condition?---That's right, yes.

And a few days after that, the case manager emailed the insured about the daily activities diary. You've annexed that email to your statement as exhibit 74, TAL.003.001.0477. And if we start with 0477, the page on the screen, we can see from the email below that the case manager emphasised – if we could perhaps – are you able to read that? I want to blow up perhaps the part under section 1 firstly. Do you see there:

> *Payment of a benefit is subject to proof of your entitlement in such a manner as we may reasonably request.*

?---Yes.

Continuing:

We have the right to require from time to time proof of continuing entitlement to any benefit and to reduce or terminate payment if you are no longer entitled to the benefit under this policy.

?---That's right, yes.

And we see further down next to 3 that the case manager advised that the diary had to be completed until the end of March 2014?---Yes.

And that TAL – 4(a) – if you look at 4(a):

...would not be accepting responsibility for requesting the daily diary. We are acting under the agreement of our policy conditions. We have also taken all due care and due diligence.

Do you see that?---Yes, I do

And then at 0478, at 11(a), the case manager assured the insured that:

TAL is not deliberately trying to worsen your health and prolong your recovery.

And that TAL was acting under "upmost good faith". Do you see that?---Yes, I do.

And we see on this page that the case manager also explicitly stated at 7(a) that TAL could:

...suspend payments under the policy terms and conditions if the activity forms are not completed as per our request.

?---Yes, I see that.

In your statement, you accept that TAL deployed bullying tactics and offensive communications with the insured and with others acting on her behalf?---Yes, I do.

Is this some of the bullying tactics, Ms van Eeden?---Yes, they are.

You refer to the dogmatic but plainly wrong assertion that it was not TAL requiring the insured to complete the daily activities diary, but a term of the policy itself?---And the – it's not a term of the policy.

It wasn't a term of the policy - - -?---No.

- - - was it?---No, it's not a term of the policy.

So you accept that the assertion in this – in this email to that effect was a lie?---It was incorrect, yes.

It was incorrect?---Yes.

Do you accept that this was a breach of professional standards?---Yes.

I tender this email chain, Commissioner. I'm sorry this is already part of an exhibit. I apologise. And what observations do you have to make, Ms van Eeden, about whether communications such as this one were reflective of compliance with the duty to act with the utmost good faith towards the insured?---Upmost good faith. Utmost anyway. And it's not appropriate. Yes, it's not appropriate.

Did TAL breach its duty to act with the utmost good faith towards the ensured by making communications of this nature?---Yes.

Following this communication, the insured completed the daily activity diary, didn't she?---Yes, she did.

TAL didn't leave her with much choice, did they?---No, they did not.

And you've annexed extracts of that diary to your statement. Have you read those extracts, Ms van Eeden?---Yes, I have.

You've seen that they contain multiple references to feeling anxious, including about TAL, and including about the diary?---Yes, I – I've seen that.

And they include references to self-harm over the diary?---Yes.

You've seen that, Ms van Eeden?---Yes, I've seen that.

And over TALs handling of the claim?---Yes.

Do you have any observations to make about that, Ms van Eeden?---I – I think it just goes all in the inappropriateness of the way this claim was handled.

Are we getting a bit beyond the "inappropriate" stage now - - -?---This is the bullying.

- - - Ms van Eeden. This insured provided you with medical evidence that the requirement to complete a daily activities diary was exacerbating her claim. You agree?---I agree.

And in the face of that medical evidence, TAL persisted requiring her to complete the daily activities diary?---I agree.

And that resulted in harm to the insured, did it not?---I agree.

Now, towards the end of January, Dr Crimston, one of the doctors who had seen the insured, provided another report to TAL, didn't he?---Yes, he did.

And he told TAL in that report that the insured was now suffering severe anxiety attacks, exacerbated by the ongoing requirement of the daily diary, and that she would now need to see a psychologist?---That's right.

Do you recall that?---Yes, I do.

And around that time there was internal discussion within TAL about how to handle the FOS complaint and about the daily activity diary?---That's right, yes.

And if we go to TAL.003.001.0481?---Under tab?

Not one of your exhibits, Ms van Eeden. We see that at 0483 in this email chain, the case manager told the complaints resolution manager at TAL who had been assigned the complaint, at the top of the page, that she:

> *... had a lot of surveillance on the insured and by no means is her condition life threatening.*

That was the case manager's attitude to this medical evidence?---Yes.

And at 0482, the complaints resolution manager suggested that it might be prudent to give consideration to removing or amending the daily diary requirement if the medical evidence was near sufficient to support this. Do you see that in the middle of the page?---Yes, I do.

And the case manager's response at 0481, at the bottom of the page, was that:

> *The medical evidence does support the insured, but the insured's activities do not support her medical evidence.*

She knew better?---It looks like it, yes.

I will tender that email chain, Commissioner.

THE COMMISSIONER: Internal TAL emails of 24 January '14, TAL.003.001.0481, exhibit 6.193.

EXHIBIT #6.193 INTERNAL TAL EMAILS DATED 24/01/2014 (TAL.003.001.0481)

MS ORR: And in February 2014, the case manager decided that the portions of the diary that had been completed by the insured were enough, and that there was no need to ask her to continue it?---Yes.

And as a result in its submissions to FOS, TAL didn't insist that the insured continue to provide the daily activity diary. Is that right?---I – can you refer - - -

The submissions are exhibit 126 to your statement, TAL.003.001.0381. And if we go to 0383 in that document?---Yes.

Do we see there that TAL decided not to insist that the insured continue to provide the daily diary?---Yes.

Do you see that?---Yes, I see that.

But TAL maintained, on this page, that it was entitled to require this under the terms of the policy and that it was standard practice in the industry?---Yes, I see that.

It wasn't standard practice in the industry, was it, Ms van Eeden?---No, it was not.

But it said that in an effort to resolve the matter – do you see that paragraph?---Yes.

Continuing:

> *...it had assessed the medical certificates provided by the insured and taken the decision that a daily activity diary was no longer required for the claim.*

?---That's right, yes.

Now, at the same time that the insured was dealing with this second - - -

THE COMMISSIONER: Just before you go on. You said it's not standard practice in the industry. Is that right?---No.

Why did you tell FOS? Why did TAL tell FOS that it was?---I've got no idea, Commissioner.

What's the – what justification could there be for telling FOS that?---I – I've really got no idea, Commissioner. It's not something that I've seen and do before.

What am I to conclude about it? What's the conclusion do you say that I should draw from just this little aspect of this story?---At this stage, in my opinion the behaviour of the team was inappropriate, in the information they – they stuck to their view, and they continued to support their view, which was not in the interests of the claimant.

Is it in the interests of TAL?---No.

Go on, Ms Orr.

MS ORR: I had suggested to you, Ms van Eeden, that around the time that the insured was prosecuting this second complaint in FOS, TAL was considering its strategy in respect of the claimant more generally. Do you agree with that?---I agree with that, yes.

And shortly before the case manager sent the January email to the insured insisting that the daily diary was a policy requirement, she again enlisted the help of UHGs medical adviser, Dr Phang. Do you recall that?---Yes, I do.

And if we go to exhibit 75 of your statement, TAL.500.052.1051. And if we start at 1052 with an email from the case manager to Dr Phang, on 2 January 2014:

> *Happy new year. I have had quite a few emails from our lovely client. Could you please help answer this one: I agreed to alter the diary so that are simple am and pm activities. I agreed to have them start from 13 January 2014. I agreed to have them online. The insured has sent another letter from her doctor stating she cannot do them, blah, blah, blah. I have now said they are a requirement under the policy. I have answered a few of her questions but I'm stuck on this one, as I stated to her that we request the diary sheets when the disability goes past the duration date. She has replied (1) can you please inform me of the date when, according to TALs assessment in this case, the insured has gone past the normal duration date for this type of disability. Help.*

That was the email from the case manager. And we then see Dr Phang's response over the page. If we could have 1051 and 1052, both on the screen. Dr Phang said:

> *I have received the report for the insured specialist case review which I believe will be coming through to you shortly. I think it sounds like the treating doctors need to see the surveillance.*

What do I interpret that response you've just given to that to be, Ms van Eeden?---It's just so inappropriate.

It's highly inappropriate?---It – it's terrible.

Do you have any observations on behalf of TAL to make about that conduct, Ms van Eeden?---It's definitely not TALs conduct. And I am – I was very surprised to see this when I – when I worked on this claim.

And - - -?---I mean, we pay – we pay over 25,000 claims and I have never seen one handled in this way before.

I see. Over the page at 1052 we see that Dr Phang says:

> *I would suggest that any attempt by TAL to suggest that anxiety is other than persistent would be met with significant opinions to the contrary. Therefore,*

the tack I suggest is that we are not looking at the persistence of the underlying anxiety, but its effect on work capacity.

So Dr Phang was providing strategic advice to the case manager on another means that TAL could use to cease paying the insured?---Yes.

And then a few days later, TAL obtained an opinion from a psychiatrist who had reviewed the insured's file, including the surveillance tapes but who had not had any direct contact with the insured. Is that right?---That's right, yes.

And that report is exhibit 75A to your statement, TAL.500.050.1544. And in that report, amongst other things, we see at 1548 that the psychiatrist opined that there may be specific difficulties – do you see under Conclusion and Summary, a few paragraphs down?---Yes.

Continuing:

There may be specific difficulties with the insured working in her pre-injury capacity as a nurse and particularly in an intensive care setting but there would be apparently no problem with her working in an alternative capacity.

And the psychiatrist also opined that the insured was fit to complete a daily activity diary. And he concluded that:

There was certainly nothing medically to support any argument that completing a diary would exacerbate any anxiety and have a negative impact on her health.

We see that over the page at 1549. Now, how much weight could be placed on that assessment in circumstances where the psychiatrist had not seen the insured and in circumstances where there were two conflicting medical opinions from doctors who had?---Minimal. They should not even have taken it into account.

But instead of giving it minimal weight, the case manager chose to refer the insured's situation to the TAL claims decision committee?---That's right.

On the basis of this report?---Yes.

And that same day, the claims decision committee made a decision on the referral. Who was on the claims decision committee? Was the case manager part of the committee?---Yes, the case manager was part of the committee. And that's something we've also changed.

I just want to understand that, because it did appear that that was the case from the documents?---Yes.

The referral is made by the case manager to a committee of which she is part?---Yes.

And when did you change that at TAL, Ms van Eeden?---It changed already in 2016 and it was implemented even further in 2017.

Was that change made because there was a conflict of interest given that that person made both the recommendation and was involved in the decision on the recommendation?---We – we changed it to ensure that there's impartiality in our decisions going forward.

And there was not at this time, was there?---No, there was not at this time.

And if we go to exhibit 85 in your statement, TAL.003.001.0309. You've read the referral to and decision of – I'm sorry, we need to take that down, Commissioner. I apologise. It appears that there's another redaction problem. Do you have that document in front of you, Ms van Eeden?---Yes. Yes, I do.

Do you agree with me that the tenor of the referral was that the insured's claim was spurious?---Yes.

And do you agree with me that it says at 0309 towards the bottom of the page that it would appear that the insured always intended to write this book and accomplish this?---Yes.

And we see over the page at 0314 – we might try and bring 0314 up on to the screen – that the case manager gave the committee various options?---Yes.

You see that there?---Yes, I do.

And the strategy that was recommended by the case manager was to decline the claim and to reclaim moneys paid?---Yes.

And at this page, 0314, we see that the committee's decision was that:

> *The insured no longer met the definition of total disablement and that TAL was, therefore, entitled to apply section 56(1) of the Insurance Contracts Act to cease paying benefits.*

?---Yes.

Now, section 56 of the Insurance Contracts Act is a section that applies where an insurance claim is made fraudulently, doesn't it?---Yes.

This claim had not been made fraudulently, had it, Ms van Eeden?---No. No.

But this was the decision of the claims decision committee?---That's right, yes.

And on 10 March 2014, about 10 days later, and three days after TAL received its final surveillance report in respect of the insured, TAL sent the insured two letters advising that it would not be making further payments to her?---That's right, yes.

And there were two letters sent because the first letter referred to the wrong legislative provision as the basis for the decision?---That's right, yes.

So I want to take you to the letter that referred to the correct legislative provision. That's exhibit 87 to your statement. TAL.003.002.0239. And at 0239 we see that TAL told the insured that it had:

> *Carefully considered –*

Her claim and:

> *...all the relevant evidence available to us.*

Do you see that in the first line?---Yes, I do.

And that it regretted to say that TAL:

> *...would not be making any further payments –*

To the insured:

> *...as she no longer met the definition for total disability or partial disablement under the terms and conditions of the policy.*

?---Yes.

And on the same page we see:

> *We have declined your claim under section 56 of the Insurance Contracts Act and section 13 of the Insurance Contracts Act.*

Which was the duty – that contains the duty of utmost good faith?---Yes.

And on 0240 onwards, TAL set out an extensive list of all the surveillance that it had conducted in respect of the insured. We see that at 0240, 0241, 0242, 0243, and 0244. And then if we could have 0244 and 0245 on the screen, we see that TAL concluded the letter by saying:

> *We believe that TAL has been more than reasonable with your income protection claim. However, due to the evidence available to us, we will now look to seek recovery of benefits paid from at least 1 June 2012.*

Bearing in mind that this letter is dated 10 March 2014. If – I'm sorry:

...from at least 1 June 2012. If further evidence is located we reserve the right to request the full recovery. Please arrange for recovery of this benefit which totals $68,890.

Do you see that?---Yes, I do.

And by this letter, TAL informed the insured for the first time that she had been under surveillance?---Yes.

And set out extensive details of that surveillance?---Yes.

That would have been a shock to the insured?---Yes.

And by this letter, TAL alleged fraud by the insured?---Yes.

Another shock to her?---Yes.

It told her that she would no longer receive any benefits?---Yes.

Another shock?---Yes.

And told her that it required her to repay the $69,000 in benefits that she had been paid to that date?---Yes.

Perhaps the biggest shock of all?---Yes.

Do you accept, Ms van Eeden, that this letter would have caused considerable distress to the insured?---Absolutely.

Do you have any further observations to make about this communication from TAL to the insured?---No. It's just, once again, I – I was shocked when I saw this.

That may be a convenient time, Commissioner.

THE COMMISSIONER: Yes. How are we travelling for time, Ms Orr?

MS ORR: I think 9.45 would still be a useful time to start, Commissioner.

THE COMMISSIONER: Yes. If I can ask you to be back in time to recommence at 9.45, Ms van Eeden. And we will adjourn until that time.

MS ORR: Thank you, Commissioner.

<THE WITNESS WITHDREW [4.15 pm]

MATTER ADJOURNED at 4.15 pm UNTIL FRIDAY, 14 SEPTEMBER 2018

Index of Witness Events

Index of Exhibits and MFIs