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TRANSCRIPT OF PROCEEDINGS

O/N H-919885

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

9.45 AM, FRIDAY, 14 SEPTEMBER 2018

Continued from 13.9.18

DAY 54

MS R. ORR QC appears with MR M. COSTELLO as Counsel Assisting with MR M. HOSKING and MS S. ZELEZNIKOW
MR N. BEAUMONT SC appears for TAL
MR J. STOLJAR SC appears with MR T.W. MARSKELL for REST

<LORAINE KAREN VAN EEDEN, ON FORMER OATH [9.45 am]

<CROSS-EXAMINATION BY MS ORR

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Ms van Eeden, late yesterday I took you to a letter from March 2014 by which TAL informed the insured person, who we were speaking of yesterday, that she had been under surveillance, that there was an allegation of fraud against her, that she would no longer receive benefits, and that she would be required to repay the $69,000 in benefits that had been paid to date. Do you recall that?---Yes, I do.

Now, the day after the insured received that letter, she sent an email to FOS explaining what had happened?---Yes. Can you just - - -

Yes. It's an exhibit to your statement. It's exhibit 128, TAL.003.001.0333. Do you have that, Ms van Eeden?---I've got a different one under 128. Yes, I've got that email. Yes, I do.

Yes?---Yes.

An email from the insured to FOS on 11 March 2014, in which the insured said to FOS:

> *TAL has now declined my claim again. No more benefit payments will be made and TAL seeks to recover $68,890 from me. I don't know what to do and I need your help.*

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

From the insured to FOS. And the TAL complaints resolution manager who was handling the second complaint with FOS this was the complaint that was about the daily activities diary. You recall that?---Yes, I do.

So the person within TAL who was handling this complaint, didn't hear about this development, about this communication from TAL to the insured until she was told by FOS?---That's correct.

THE COMMISSIONER: Sorry, I think you need to go back. You have said the person within TAL who was handling this complaint. You meant, did you, the person within TAL or FOS?

MS ORR: I meant the person within TAL, Commissioner. So there was - - -

THE COMMISSIONER: I will go back in my box. You ask your questions.

MS ORR: No, no, I clearly haven't articulated that clearly. There was a separate process within FOS that the case manager was involved in which was an assessment of whether or not to continue paying benefits which led to the decision of the claims decision committee and the letter that we saw yesterday?---That's right. Yes.

And then there was a separate part of TAL who handles complaints with FOS. Now, the person assigned to handle this complaint with FOS didn't know about the decision to stop the benefits being paid to the insured until she was told by FOS?---That's correct, yes.

Yes. Now, if we go to TAL.003.001.0215?---Which tab is that?

It's not an annexure to your statement, Ms van Eeden. It will come up on the screen. We see an email chain here. And if I could take you, firstly, to 0220, we see from this page that Ms Kim, who was the complaints resolution manager within TAL, the person handling the complaint, requested an update from the case manager on the status of the claim. Do you see that?---Yes, I do.

You see she said:

> *It appears from the complainant's response that we have denied further benefits and are seeking to recover an overpayment. Can you please provide an update on the status of the claim.*

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

And then if we go back to 0219 in the email chain. We see that the case manager down the bottom of the page told the complaints resolution manager – she attached the decline letter and said:

> *We have not requested that she repay all the money. We have requested that she repay the money that she received from TAL whilst we have evidence to support that she was working.*

To which the complaints resolution manager said, at the top of the page:

> *Would you mind sending me the supporting documentation for the decline? Also, do you know what steps will be taken to seek recovery of the overpayment?*

You see that?---Yes, I do.

And then if we go to 0218, we see that the case manager provided an explanation, in the course of which she said:

Also, at this point in time –

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

Continuing:

> *We put the recovery clause in there. Basically, we were waiting for the response. We could waive. Can you please send me the actual complaint. I will review and see exactly what you need.*

So we see from this that TAL was intending to use the threat of recovery of benefits paid solely as a bargaining tool which could be waived so that it could be seen as compromising if it gave up that threat?---That's what this indicates, yes.

That was an entirely inappropriate way to treat an insured person, wasn't it, Ms van Eeden?---Yes.

We see from 0217 that Ms Kim, the complaints resolution manager, tried to confirm – do you see in the first email:

> *Can I just confirm that we are not seeking to recover the overpayment?*

Now, she asked that first in the email at the bottom of the page on Monday, 17 March. And the following day she followed up again, asking for that confirmation, to which the case manager said at 0216, the email in the bottom half of the page:

> *We will not at this stage say we will not seek recovery. This woman has defrauded TAL for years. We reserve our right to recovery is the best I can do at this point in time.*

That was the communication from the case manager?---Yes.

This woman had not defrauded TAL for years had she?---No, no.

She had never defrauded TAL?---No. There's no evidence.

There's no evidence of that?---Yes.

Do you know why the case manager gave that indication to the complaints resolution manager?---I've got no idea.

It's very apparent from what we've seen, I want to put to you, Ms van Eeden, that the case manager had no regard for the insured?---I agree.

For her wellbeing?---I agree.

She was on a mission, was she not, to stop the insured from receiving benefits under her insurance policy?---Yes.

Why?---I've got no idea.

She had a KPI connected with not paying claims, didn't she?---No, she did not.

She did not?---No.

What were her KPIs?---Our standard KPIs are effective case management, but we don't reward case managers for stopping or closing claims at all.

At this time was a KPI involved for closing claims?---Closing claims is not the same thing. Closing claims is effectively managing a claim within a timeline. And closing could be payment, a lot of – sometimes a lot of early payment as well. So it's not necessarily just a decline of a claim or an avoidance of a claim but it's payments as well.

Do you say that KPIs for closing claims are KPIs for effectively managing claims. Is that how we should read KPIs for closing claims?---That's how the KPIs of closing claims is intended. Absolutely for managing claims. So it's really managing within effective times.

Are you familiar with the KPIs that were in place at this point, in 2014, Ms van Eeden?---Yes, I have seen them.

And was there a financial component to those KPIs for claims handlers?---Not that I recall.

I see. What about the KPIs that were applicable to people moving up the chain for claims handling? TAL case managers, what KPIs did they have?---The case managers would not have claims closure. That would only be for the general manager, it would be for the closing of claims management because that's – and it's not specific. It's looking at the entire portfolio within a timeframe.

What about senior case managers?---I've not seen the senior case manager.

You haven't seen those KPIs?---Not for a senior case manager in those days.

Do you know what their KPIs are?---I know what they are now.

Do you know what they were at this time?---I haven't seen at that time. It's not .....
- - -

You're unable to tell us what the KPIs were?---That's right.

At the time of this claim?---That's right. For a senior case manager.

Ms van Eeden, we've been assured by TAL that you are the person who is able to deal with these matters, despite only being in your position for a short period of time. Are you unable to tell the Commission what the KPIs were for senior case managers in the period when this case manager was conducting herself in this way?---I have not seen any financial for a senior case manager.

What about team managers? Do you know what their KPIs were?---There would also be no financials in for team managers.

What about the head of claims? What KPIs would the head of claims, your predecessor, have had at this time?---She would have had the general claims closure comment in there.

The general claims closure comment?---Yes. So - - -

So she would have had a KPI about the closure of claims across the whole claims handling team?---That's right, yes.

But you say we should interpret that as a KPI that was about effectively managing claims?---That's exactly what it is.

Was there a minimum expectation as to percentage of claims that should be closed within any particular period of time?---Well, it's – it's managing within timeframes. It's not – it's not denying claims. There's no mention to denying or not paying a claim.

It's about closing the claim. Is that right?---That's right, yes.

And you say that closing the claim might amount to a denial, it might amount to an approval?---It's an approval. It's an early payment.

I see. Do you think that the KPIs that TAL had in place in this period were in any way drivers of the poor conduct that we've seen yesterday and already today?---No.

So what do you put the conduct of the case managers that we've been looking at down to?---I think it's just the – the process that those case managers brought in. It's not specific to TAL. We had contractors working for us at that stage, and I put it down to more that kind of – the way that they worked. And not a general TAL philosophy.

Sorry, so I want to understand that. You say that it was because individuals were doing the wrong thing, not TAL?---Certain individuals within certain teams, yes.

Do you accept that TALs culture encouraged these individuals to do the wrong thing?---I can't talk about TALs culture at that stage, but definitely not the culture at the moment.

So, again, you're unable to assist the Commission with the culture of your organisation in the period with which we are concerned?---That's right, yes.

All right. I tender this email chain, Commissioner.

THE COMMISSIONER: Email internal TAL emails between 14 and 18 March '14 between complaints resolution manager and case manager, TAL.003.001.0215, exhibit 6.194.

EXHIBIT #6.194 INTERNAL TAL EMAILS BETWEEN 14 AND 18 MARCH '14 BETWEEN COMPLAINTS RESOLUTION MANAGER AND CASE MANAGER (TAL.003.001.0215)

MS ORR: I just want to put to you before we move on, Ms van Eeden, you've reviewed the three particular cases that the Commission asked TAL to deal with. That's right?---Yes, I have.

And you know that there were multiple employees of TAL involved in extremely poor conduct across those three files over different periods of time. Do you accept that?---Yes, I do.

And what does that say to you about the culture at TAL?---It was – in terms of those case managers, it was really not appropriate .....

Multiple case managers over multiple cases over multiple years?---Yes.

Does it concern you, Ms van Eeden?---Yes, it does, definitely. And that's why we're doing a lot of changes.

Now, in the weeks that followed this email chain, TAL filed further submissions with FOS. Is that right?---That's right, yes.

In relation to the second FOS complaint about the daily activities diary?---That's right, yes.

THE COMMISSIONER: Ms Orr, I'm sorry but there's apparently some issue either happening or has happened about the transcript.

MS ORR: Should we take a break while that is addressed, Commissioner?

THE COMMISSIONER: I think it's probably better that we try and solve it now. Come back at five past 10, or thereabouts.

MS ORR: Thank you, Commissioner.

THE COMMISSIONER: I'm sorry.

ADJOURNED **[10.00 am]**

THE COMMISSIONER: Sorry about that but I gather we're back up and running, or at least I hope we are. Yes, Ms Orr.

MS ORR: Ms van Eeden, before I return to TALs handling of the second FOS complaint, I just want to come back to this topic of KPIs and see if I can assist you. Can I ask that you be shown TAL.500.060.0004, which is an exhibit to a statement from Mr Justin Delaney, another TAL representative that has been tendered in the hearings. Now, Mr Delaney has provided us with a spreadsheet. This spreadsheet relates to 2015. And the KPIs for various people within the business in 2015. 2015 was the period within which the claims of the second and the third insured people that we will deal with were being dealt with. Is that right?---That's right, yes.

At the moment we're in 2014 for this particular insured. Could we bring up the team manager tab in this spreadsheet. And we see that there was a scorecard listing the KPIs?---That's correct, yes.

Yes. And we see that the first scorecard matter – the first scorecard category was business matters. Do you see that there?---Yes, I see that.

And there are three rows within Business Matters. And together those rows make up 50 per cent of the weighting in the scorecard. Do you see that?---Yes, I see that.

So there was a 30 per cent weighting in the scorecard for a profit target?---I see that.

These are the team managers of claims handlers?---I see that, yes. Yes.

Yes. So 30 per cent of their scorecard was directed to a profit target. What is the profit target for the team manager of a claims handler?---I've got no idea what's underlying that.

What's profit when you're in claims handling, Ms van Eeden?---It – I would think related to the overall profit of the company.

Is - - -?---But it wouldn't be something just for claims. I don't know. I – I really can't comment.

I see?---I've got no idea.

Well, of this 50 per cent related to business matters, we see 30 per cent for a profit target, 15 per cent for the goal of individual team result. Do you see the 15 per cent, the goal is listed as:

Achieve budgeted profit targets by managing claims to outcomes in line with assumptions underpinning loss ratio targets. Individual team result.

?---I see that, yes.

What does that say to you, Ms van Eeden?---There's normally a lot that goes into loss ratios. It's not only on the claim. So it's expenses – so it's much broader than just a claims number normally. But once again, I – I really can't comment on what that relates to.

But it's another 15 per cent - - -?---I see that.

- - - of the KPIs that related to a budgeted profit target - - -?---Yes.

Continuing:

by managing claims to outcomes in line with assumptions underpinning loss ratio targets.

?---So the actuaries would have an expected number of claims.

An expected number of claims approved/denied?---No, just based on - - -

A total number of claims?---A total number of claims that they would expect on the portfolio.

Yes?---So a lot of this is related to the actuarial and claims would not normally be given individual targets.

But we see there is a team loss ratio target?---Yes, I see that but I really don't – it's the first time I've ever seen it.

Is it a matter that disturbs you, Ms van Eeden, that this is how team managers of claims handlers were having their performance assessed by your organisation in 2015?---Without a deep understanding of it, yes. But, I mean, I would need to know the understanding because I've never seen a case manager be rewarded on claims that they've closed.

Well, we see there's still another five per cent of the scorecard that's directed to achieving budgeted profit targets by managing claims to outcomes in line with assumptions underpinning loss ratio targets. That's a collective claims result?---Yes and that's looking at the broader organisation.

So do you accept from this spreadsheet that 50 per cent of TALs scorecard for team managers, team managers of claims handlers in 2015, depended upon financial matters, profit targets?---Yes. That's what it's here.

Yes?---Yes.

Do you – have you seen Mr Delaney's statement? Have you looked at this spreadsheet before?---No, I have not seen this statement at all.

I want to just show you briefly the case manager tab in this same spreadsheet. And we see there for the case manager, there was also 50 per cent of the scorecard directed to business matters, 30 per cent directed to a profit target, and 20 per cent directed to achieving budgeted profit targets, again by managing claims to outcomes in line with assumptions underpinning loss ratio targets?---I see that.

Now, I want to ask you again, now that you've seen these documents, whether you think that the KPIs that were in place for case managers and their superiors were a driver of the poor conduct that we've observed already in relation to the first insured, and which you are familiar with in the cases of the second and the third insured?---I can't comment on that, because I do not see any rewarding or any benefits paid to people based on this. So unfortunately I can't comment on that.

You can't comment on it?---No.

THE COMMISSIONER: Well, what am I to make of the last column G? If you look at the first two entries in column G, which are the Exceed Expectations columns. Both of them are:

> *Demonstrate significant contribution to achieving more than annual team finalisation target, demonstrate significant contribution to supporting performance across the wider claims business.*

Why should I not read that as bringing claims to an end as soon as possible?---It's – but it is finalising, it's not necessarily denying. So a claim – a decision has to be made on a claim as fast – as fast as we can, Commissioner, and we shouldn't be extending the duration of our – our decision-making processes.

And a decision was made on this claim following the first FOS proceeding. Is that right?---No. Unfortunately this claim is not a very good example of our processes.

What the claims manager was doing in the emails that were last tendered was trying to bring this claim to an end. Is that right?---That's right, Commissioner.

That is, to achieve finalisation of the claim?---In this respect, yes.

Something for which the claims manager likely would be rewarded?---That I cannot comment on.

Well, the fact that you can't comment on it may simply lead me to infer, you being the witness put forward by TAL, that that is the expectation when I see, in the 2015

documents, that that is the way in which people were rewarded after these events. Go on, Ms Orr.

MS ORR: I want to come back to the case of the insured, Ms van Eeden. And I had put to you earlier that after the email chain that we had seen, the email chain between the case manager and the complaints resolution manager at TAL, TAL filed further submissions with FOS addressing both the daily diary issue and now its denial of the insured's claim. You recall that?---Yes, I do.

And TAL told FOS that it had obtained extensive evidence from surveillance footage, internet and background searches, that it said showed that the complainant had engaged in work-based activities while in receipt of her benefits?---That's right, yes.

And TAL said that it was entitled to cease paying the benefits on that basis and that it reserved its right to recover the benefits that had been paid so far. That was the position that TAL expressed to FOS?---That's right, yes.

And in April 2014, FOS asked TAL to participate in a conciliation call with a view to resolving that complaint?---Do you have the relevant tab - - -

You refer to this in paragraph 164 of your statement?---Okay. Yes. Yes.

And TAL declined that invitation. TAL said it did not wish to participate in the conciliation conference?---That's correct, yes.

Why was that decision made, Ms van Eeden?---I don't know why they would not want to participate.

Was it because TAL wasn't prepared to offer the insured anything to settle the dispute?---That's what it looks like, yes.

And do you consider that the refusal to participate in the conciliation process was conduct that fell below what the community would expect of TAL engaging with FOS in that proceeding?---Yes, I do.

And over the following six months, FOS continued to liaise with TAL and the insured to and to receive further information from both the insured and TAL?---That's right, yes.

The insured provided FOS with further medical reports in support of her position?---Yes.

And TAL continued to maintain that she was not entitled to benefits?---That's right, yes.

And in October 2014, TAL finally told FOS that it did not intend to attempt to recover the benefits that had already been paid to the insured?---Yes.

And in November 2014 FOS delivered its recommendation in that dispute. The recommendation is annexed to your statement as exhibit 140. It's TAL.003.002.0140. And if we turn to 0143, the first page of that recommendation, we see that the recommendation, like the recommendation and determination in the first dispute, was in favour of the insured?---That's right, yes.

We see on this page, under Issues and Key Findings, that FOS found:

> *The applicant has not made a fraudulent claim. The applicant made the proper disclosures to TAL with regard to her self-published book and home business. She continues to be unable to perform one or more of the important duties of a nurse due to her sickness.*

And under the heading Is It Fair And Reasonable To Require The Applicant To Complete A Daily Activity Diary:

> *Dr H and Dr C have stated that the completion of a daily activity diary causes the applicant stress and exacerbates her medical condition. Therefore, it is not fair and reasonable to require the applicant to complete a daily activity diary.*

Those were the findings in those paragraphs?---That's right, yes.

And then under Is The Applicant Entitled To Benefits:

> *The applicant is entitled to benefits from 4 February 2014.*

Now, that was when you had ceased paying the benefits. Is that right?---That's right, yes.

Continuing:

> *Whether the benefit is for total disability or partial disability would depend on whether she generated monthly earnings from the home business from that date.*

Now, the recommendation required TAL to reassess the insured's claim and to pay her either total or partial benefits from that date. And as with the previous recommendation, the insured accepted the recommendation. Is that right?---That's right, yes.

And TAL had reasonably quickly after this formed the view that it would challenge the aspect of the recommendation dealing with the daily activity diary. Is that right?---Yes, I – I think so.

But TAL spent more time considering whether there was a basis to challenge the finding that the insured was entitled to benefits. Is that right?---Do you have the – our correspondence on that?

Yes. Could I show you TAL.003.002.0132. It will come up on the screen, Ms van Eeden. Now, this is a two-page email chain. If we could have both pages on the screen. We see that it's an internal email chain between the external dispute resolution manager at TAL and a number of other people within TAL. Do you see on the left-hand side that a person called Monique Saunders says:

> *We believe there is basis to reject the recommendation to continue payments with the claim but will have a definitive answer for you tomorrow. The one recommendation we can confirm that we will not be accepting is the insured's not having to complete daily activity diaries.*

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

All right. I will tender that email chain, Commissioner.

THE COMMISSIONER: Emails November and December to and from EDR manager TAL, TAL.003.002.0132, exhibit 6.195.

EXHIBIT #6.195 EMAILS NOVEMBER AND DECEMBER TO AND FROM EDR MANAGER TAL (TAL.003.002.0132)

MS ORR: Now, to make that assessment of whether to challenge the recommendation insofar as it related to the payment of benefits, TAL sought external assistance. Is that right?---That's right, yes.

TAL engaged a strategic consultancy firm, Whyburns Strategic?---That's right, yes.

And had Anthony Whyburn, the principal consultant of that firm, had previous involvement in the insured's matter?---I don't – no, I don't think he had.

All right. Now, did you refer to the involvement of Whyburns Strategic in your statement?---I don't – I – I should – did I? I don't know if I did.

You don't know if you did?---No, I can't remember. I don't think I did. Did I?

Is there a reason you would have left that out, Ms van Eeden?---No. No specific reason.

Well, why did TAL seek Mr Whyburn's assistance?---They – apparently they wanted an external opinion on how to proceed.

And what qualifications did Mr Whyburn have to assist with this consideration?---He provided – he provided support in terms of complex claims.

I see. What are the qualifications he has?---I don't have his - - -

You don't know?---No.

Does TAL generally seek the assistance of a strategic consultancy firm when it loses in FOS?---No. They generally use him to help with support with letters and communication with claimants.

He supports with letters?---Yes.

And communications with claimants?---Yes. So this is unusual in kind of – this kind of review.

And you're unable to say why that happened here?---I'm unable to say why.

Can I ask you to look at TAL.500.057.0674?---Is that in – it's not in my pack?

No, I will tell you when it's an exhibit to your statement, Ms van Eeden. This one is not. TAL.500.057.0674. Now, if we could turn to 0678 in this email chain. We see at the top of the page that Monique Saunders, retail claims manager, said to Mr Whyburn:

> *We would really like your thoughts on the recommendation made by FOS. Would you mind having a look at this when you get a moment?*

And then if we bring up 0674 and 0675. We see that having reviewed the recommendation, Mr Whyburn sent the email that starts at the bottom of the left-hand side of the screen. He provided an executive summary of his views. The executive summary said:

> *I believe that we should challenge the FOS recommendation but do not expect that will be successful in respect of the denial of the claim, but potentially will be in terms of activity diaries. The reason for the challenge is that (a) the recommendation is inaccurate in many respects and understates the evidence; (b) I do believe that with more work there should be a sound basis to decline this claim in the future, and so maintaining our position at FOS will be important in that ongoing assessment; (c) as part of that I would want to push for completion of activity diaries.*

You see that in the executive summary provided by Mr Whyburn?---Yes, I do.

And we see that Mr Whyburn also offered to assist with drafting a response to the recommendation?---Yes, I see that.

And at 0674, we see from the email above that in the chain that Ms Saunders asked Mr Whyburn to prepare a draft. She said:

> *Because having a chat to Emlyn he is just querying whether we should challenge the denial given our case is not that strong.*

Who was Emlyn?---He was the head of retail at that stage.

He was the – I'm sorry?---The head of retail.

The head of retail?---Yes.

So he queried whether it was appropriate to challenge the FOS recommendation, given that TAL did not have a strong case?---That's right, yes.

What observations do you make, Ms van Eeden, about the strategic consultant saying to TAL:

> *I do believe with more work there should be a sound basis to decline this claim in the future. And so maintaining our position at FOS will be important in that ongoing assessment.*

?---Once again, it's inappropriate.

It's, again, evidence of a plan at any point possible to find a way to stop paying this insured benefits, is it not?---That's right, yes.

I will tender that email chain, Commissioner.

THE COMMISSIONER: Emails of December 2014 to and from Anthony Whyburn, TAL.500.057.0674, exhibit 6.196.

EXHIBIT #6.196 EMAILS OF DECEMBER 2014 TO AND FROM ANTHONY WHYBURN (TAL.500.057.0674)

MS ORR: Now, ultimately, TAL decided to accept the recommendation that it accept the claim. Is that right?---That's right, yes.

But it challenged the recommendation that the completion of the daily activity diary was not fair and reasonable?---That's correct, yes.

Is that right?---Yes.

Now, if we could go to exhibit 142 of your statement, TAL.003.002.0129. We can see that TAL provided FOS with detailed reasons for its position. This is a letter that TAL sent to FOS?---Yes, it is.

And TAL was at pains to make sure that FOS understood that although it was not rejecting the finding that it should pay the claim, it had grave concerns about FOSs analysis on that point. You recall that?---Yes, I do.

And it was at pains to point out that despite its misgivings about the claim – we see this on 0131 – under the heading Recommencement of Claim - - -?---Yes, I see that.

Despite its misgivings about the claim it accepted that:

> *...benefits were to be reinstated from 4 February 2014, with interest, subject to receiving further information from the insured*

?---Yes.

But TAL took the position that:

> *Completion of the diaries was not unfair or unreasonable, and that it was a legitimate and proper claims assessment requirement to enable the insurer to undertake a prudent and balanced assessment of the claim, and, in particular, the claimant's functional capacity.*

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

Now, for another six months after this FOS continued to liaise with TAL and the insured to receive further information from TAL and the insured before making a determination. Is that right?---That's right, yes.

And during that period, TAL appointed a new case manager to the insured's claim?---Yes.

Do you know what happened to the previous case manager?---She was on contract and her contract expired.

Did she receive any disciplinary consequences for her conduct in relation to the handling of this claim?---No.

No disciplinary consequences?---No.

Why not, Ms van Eeden?---I – I really don't know.

What does that say to you about the culture within TAL?---Yes. It was not great, looking at this claim.

In June 2015 FOS delivered its determination in relation to the second dispute. Is that right?---Yes.

And the only issue in dispute from the recommendation stage was whether it was fair to require the insured to complete the diary?---That's correct, yes.

And if we go to exhibit 154 to your statement, TAL.003.003.0105, we see that the determination, which starts at 0106, was in favour of the insured?---Yes.

And FOS again found that it was not fair to require the insured to complete the diary in circumstances where doing so caused her stress and exacerbated her medical condition?---Yes.

And it also pointed to the fact that the insured was already completing a monthly claims form which provided similar information?---Yes.

And at 0107, we see that FOS found, towards the top of the page, that TAL should reimburse the insured for the legal costs that she incurred, and pay her $1000 for non-financial loss?---Yes.

Now, in your statement you accept that the daily activities diary was used by TAL as a tool to disprove the insured's entitlements?---In this claim, yes.

And you accept that TALs insistence upon completion of the daily activities diary was another reflection of the inappropriate approach that was being taken by TAL more generally in respect of the claim?---For this claim, yes.

Yes?---Absolutely.

That approach being an approach that was designed to stop the payment of benefits?---In this claim, yes.

Now, that was particularly so in circumstances where TALs insistence upon the daily activities diary was at odds with the opinions of the external medical advisers. Do you accept that?---Yes, I do.

And it was at odds with the position of FOS?---I agree.

And it was increasingly evident from the communications with the insured that it was having a significant detrimental impact on her wellbeing?---Yes.

Now, you acknowledge in your statement that TALs actions with respect to the daily activity diary constituted misconduct, don't you?---Yes, I do.

And you accept that it was a breach of professional standards, which we now see reflected in the Life Insurance Code?---Yes, I do.

And it was a breach of the utmost – the duty of utmost good faith in respect of the insured?---Yes.

And telling the insured that she was required to complete the diary as a term of the policy was, at best, misleading?---Yes.

But I think you accepted yesterday it was a lie?---Yes.

MR BEAUMONT: I object to that, Commissioner. I am not sure – I am not sure that it's fair to put to the witness that she accepted yesterday it was a lie. I don't recall that evidence being given yesterday.

THE WITNESS: It was misleading.

THE COMMISSIONER: Just a moment. Yes.

MR BEAUMONT: I remember it being put and I thought the answer – I don't think the witness agreed yesterday that it was a lie. I think she – I don't remember her precise answer but I believe - - -

THE COMMISSIONER: Well, do you accept, Ms van Eeden, that it was a lie?---It was definitely misleading.

Yes. Do you accept the word "lie"?---I can't actually comment on that, based on I don't know the reason why they put it in.

Can I just - - -?---No.

- - - so that there's no misunderstanding about this, Ms van Eeden. To accept that it is misleading but to hesitate or reject the notion that it is a lie is, I think, perhaps, to draw a distinction that may be without difference?---I would not say that it was a lie.

Yes. Very well.

MS ORR: Well, was it the truth, Ms van Eeden?---It was – it was misquoted.

It was an untruth, was it not?---It was not quoted appropriately, yes.

You know, don't you, Ms van Eeden, that it was not permitted by the policy – I should – I withdraw that – required by the policy that the insured complete the daily activity diary. You accept that?---I accept that.

And I will just refer you to the transcript from yesterday at 5712, line 20. I put to you:

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?

And you said no. So that was the matter you accepted - - -?---That was not true.

- - - was not true yesterday?---Yes, yes.

And you accept still that that was not true?---That was not true.

Okay. But you want to draw a distinction when it comes to what was said about it being a requirement of the policy to complete the daily activities diary, you want to say that was misleading?---Yes.

But you're not prepared it was not true?---Yes, I – yes.

You're not prepared to say that? All right. Now, after the determination of the first FOS dispute that we looked at yesterday, we saw that TAL didn't get the payment of the interest to the insured right. Do you recall that?---Yes.

It took a number of attempts and the intervention of FOS for interest to be paid and then for interest to be paid for the right period. Do you recall that?---Yes, I do.

Now, after this determination, did TAL get the payment of interest to the insured right?---No.

It got it wrong again?---Yes.

How did it get it wrong?---It didn't calculate it correctly.

And I said to you yesterday – I asked you yesterday why it was such a battle for the insured to get TAL to comply with FOSs first determination. It was a battle again in respect of the interest to get TAL to comply with the second FOS determination, wasn't it?---It was an administrative error, yes, on the - - -

It was an administrative error?---Yes.

Which had to be drawn to the attention of TAL before it was rectified?---That's right, yes.

I see. Now, TAL accepted that determination?---Yes.

That's right?---Yes.

And as at the date of your statement, the insured continues to receive income protection benefits from TAL?---Yes.

And your statement doesn't say anything further about TALs interactions with the insured after the second FOS determination?---Yes.

Could I ask that you look at TAL.500.052.1357. Now, in October 2015, some months after the determination, another case manager was brought on to the handling of the claim. Is that right?---That's right, yes.

Now, her name is also subject to a non-publication direction. So I'm going to refer to her by her position, which was senior case manager?---Yes.

Now, we see that this email relates to the engagement of that new case manager but you accept that proposition, that she was engaged at that time on the claim?---Yes, I do.

Yes. I don't need to take you further to the content of this email. I will tender it for completeness, Commissioner.

THE COMMISSIONER: Exhibit 6.197, email 20 October '15 concerning appointment of senior case manager.

MS ORR: Yes, thank you, Commissioner.

THE COMMISSIONER: Exhibit 6.197, TAL.500.052.1357.

EXHIBIT #6.197 EMAIL DATED 20/10/2015 CONCERNING APPOINTMENT OF SENIOR CASE MANAGER (TAL.500.052.1357)

MS ORR: Now, that case manager, the senior case manager, you've just agreed was brought in in October 2015. I want to take you forward to April 2016 when TAL and the senior case manager, in particular, were continuing to consider the strategy in respect of the insured. Do you understand?---Yes, I understand.

And can I ask that you look at TAL.500.052.1921. This is a file note headed Benefit Payment that relates to the insured?---That's right, yes.

And the metadata tells us that this document is from 6 April 2016. And if we look at the box headed Strategy, down the bottom of the page, we see that the case manager has written a number of dot points that were being considered by TAL at this time. The final of which was to:

> *Advise claimant she has not declared TAL benefits as income in 2015 returns and is therefore in breach of tax law.*

?---That's – yes. I see that.

What's your immediate reaction to that, Ms van Eeden?---It doesn't really have anything to do with the case manager.

Well, why did TAL consider it appropriate to advise the insured that she was breaching tax laws?---I've got no idea.

It was another heavy-handed tactic to intimidate the insured, wasn't it, Ms van Eeden?---I can't comment but it's not appropriate. It has got nothing to do with the case.

Well, do you accept my characterisation of it as a heavy-handed tactic to intimidate the insured?---I don't know if it's heavy-handed but it's a tactic.

To intimidate her?---Yes.

And it was orchestrated by yet another more senior case manager?---Yes.

And TAL proceeded to communicate this to the insured, didn't it?---I have not seen the communication.

All right. I will show you that. So I will tender this document.

THE COMMISSIONER: File note benefit payment concerning insured, 6 April '16, TAL.500.052.1921, exhibit 6.198.

EXHIBIT #6.198 FILE NOTE BENEFIT PAYMENT CONCERNING INSURED DATED 06/04/2016 (TAL.500.052.1921)

MS ORR: And if I could ask that you be shown TAL.500.057.0730. I will ask that you be shown this two-page email which is an email from the insured to TAL in which she thanks TAL on the second page for informing her about TALs finding and:

> *...information regarding the missing declaration of TAL benefits in my tax return.*

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

So you accept that TAL did in fact say to the insured that she was breaching tax laws by not declaring the benefits?---Yes, I do.

And do you see that the insured said to TAL:

I need to request TAL –

This is the second page:

...to please refrain from making any assumptions that I am in breach of the law while it is yet again, and as many times before, TALs mishandling of my claim that has created unnecessary problems and avoidable difficulties and stresses for the ATO, my accountant, Centrelink, and me.

?---Yes.

I tender that email, Commissioner.

THE COMMISSIONER: Email from insured to TAL, 12 April '16, TAL.500.057.0730, exhibit 6.199.

EXHIBIT #6.199 EMAIL FROM INSURED TO TAL DATED 12/04/2016 (TAL.500.057.0730)

MS ORR: So this is April 2016. By August 2016 TAL was beginning to have serious concerns with the approach that was being taken by the senior case manager to the insured. Have you seen documents that reflect that?---No, I have not.

All right. Could I ask that you be shown TAL.500.057.0158. And if we start at 0159, we see that on 19 August 2016, Mr Kay, TALs retail claims manager, asked the senior case manager what her future management plans were in respect of the insured. Do you see that?---Yes, I do.

And at 0158, we see that the case manager, the senior case manager, responded, down the bottom that:

This was an old protracted complicated claim.

You see that?---Yes, I do.

And she agreed with Mr Kay's assessment that the strategy in respect of the insured should have been articulated more clearly, but said that:

There are time constraints on everyone.

?---In terms of processing.

She then said that the strategy was:

Continue with benefits –

We see this from 0158 through to 159:

> *Continue with benefits until the reinsurer advises otherwise, and await to hear from the reinsurer regarding the investigation approach.*

So further investigation into the insured's case was being considered at this time?---It appears so, yes.

Why, Ms van Eeden?---I've got no idea.

And this prompted Mr Kay, we see from the email on the top left-hand side, to email Sandra Hill. Who is Sandra Hill?---She's the new retail – head of retail.

The head of retail claims?---Yes.

And Mr Kay told Ms Hill that the senior case manager's behaviour was wholly inappropriate, especially from a senior?---Yes.

He said that his review of the senior case manager's portfolio was:

> *... really concerning and pretty much followed a similar theme to the comments below, in the email below*.

?---That's correct.

Do you see that?---Yes, that's correct.

And he said that he would have concerns with her being a case manager, let alone a senior?---Yes.

And he recommended that her whole portfolio be reviewed by quality assurance as he had significant concerns and considered it to be a big risk for the team?---That's correct, yes.

This is the person who was entrusted to handle the insured's claim after all that TAL had put the insured through?---That's correct, yes.

I tender that email chain, Commissioner.

THE COMMISSIONER: Emails to and from retail claims manager concerning senior case manager, August '16, TAL.500.057.0158, exhibit 6.200.

EXHIBIT #6.200 EMAILS TO AND FROM RETAIL CLAIMS MANAGER CONCERNING SENIOR CASE MANAGER, AUGUST '16 (TAL.500.057.0158)

MS ORR: And if we turn to TAL.500.057.0684, we see that despite the concerns expressed by Mr Kay, a few weeks later the senior case manager remained in charge of the file. Do you see that?---I think - - -

Do you see from the email that starts part way down the page that she is dealing on 7 September 2016 with the insured's claim?---Yes. Her name is blanked out so I assume that it is her, yes.

Well, we provided - - -?---Yes.

- - - these documents to you ahead of giving evidence so you could satisfy yourself as to who these documents related to - - -?---Yes.

- - - Ms van Eeden. Do you need assistance or are you able to accept from me that this is an email from the senior case manager?---I will accept it.

So we see that in September 2016, the senior case manager is still in charge of the file and she decides to email Mr Whyburn, the strategic consultant, for some more advice?---I see that, yes.

So he had remained involved with the file?---It looks like it, yes.

And at 0685, we see that a question posed by the senior case manager for Mr Whyburn was – question 2:

> *Are we in a position to decline her claim for not following medical advice? It is unclear what that advice is.*

TAL was still, in September 2016, looking for a basis to deny the insured's claim. Do you agree, Ms van Eeden?---Yes, it appears so.

Is this case manager, this senior case manager still employed by TAL?---Yes.

Have any disciplinary consequences been imposed on this senior case manager in relation to her handling of the insured's claim?---No, but we have provided training.

No disciplinary consequences?---No.

So she remains in your employ and you've provided her with some training?---Yes.

Despite all of the concerns expressed by Mr Kay about her conduct not just in relation to this claim, but in relation to her other files?---I can't comment on the eventual QA results. I have not seen them.

I see. You didn't look into that matter in preparation for today?---This was really in the last two days that I received this information so I really haven't had a chance to look into it yet.

Well, the information was made available – this is information that was provided under a notice to produce by TAL and identified by the Commission for your review before you gave evidence many days ago, last week?---Yes. I have not looked into it yet.

All right. I tender that email chain, Commissioner.

THE COMMISSIONER: Email between senior case manager and Whyburn, September '16, TAL.500.057.0684, exhibit 6.201.

EXHIBIT #6.201 EMAIL BETWEEN SENIOR CASE MANAGER AND WHYBURN, SEPTEMBER '16 (TAL.500.057.0684)

MS ORR: Now, in July last year Dr Dinnen the insured's psychiatrist provided a further report to TAL about the insured's condition. Have you seen that?---Yes, I have.

That is TAL.500.052.2312. Now, you recall that Dr Dinnen had previously given a report about the insured in 2011?---That's right, yes.

And we see at 2312 that Dr Dinnen made some observations under the heading At Interview about the insured's presentation at an interview with him prior to the preparation of this report last year. He referred to the insured's:

> *Fearfulness and anger which was directed towards the insurance processes.*

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

And over the page – I will take you a few pages in, I'm sorry, to 2318. We see that Dr Dinnen said under the heading Comment:

> *It is clear from the patient's current condition that there has been progressive deterioration since I first examined her just on six years ago. The level of suspiciousness, feelings of oppression, loss of trust and social withdrawal have all worsened considerably. Further, her aversion to any form of treatment is a reflection of her suspiciousness and lack of trust and is almost of delusional intensity. In other words, it is not amenable to logical discussion. While I think that a range of treatments would have been and are now appropriate and may slow the progression of this insidious and malignant psychiatric illness, the prospects of such treatment now or in the future are very poor. I do not think it would cause any major recovery, however.*

And then over the page at 2320, Dr Dinnen answered some specific questions that were raised by TAL, because this was a report produced at TALs request. And in relation to diagnosis, Dr Dinnen said:

Adjustment disorder with anxiety and depressed mood. This was triggered by workplace problems as described in the original report but has now a life of its own.

And in relation to the insured's capacity to return to work, Dr Dinnen said:

I see no reasonable prospect of the patient returning to work in her usual occupation or, indeed, in any other significant occupation for more than a handful of hours a month. Her psychiatric condition is the barrier to any employment with suspiciousness, lack of trust, social withdrawal and isolation, and therefore very difficult interpersonal relationships, panic attacks, anxiety and difficulties with memory and concentration and so forth.

And in response to a question about fitness for work, Dr Dinnen said:

In my opinion, she is permanently unfit for any employment.

You see all of that - - -?---Yes, I do.

- - - Ms van Eeden. I will tender that report, Commissioner.

THE COMMISSIONER: Report of Dr Anthony Dinnen, 13 July '17, TAL.500.052.2320, exhibit 6.202.

EXHIBIT #6.202 REPORT OF DR ANTHONY DINNEN DATED 13/07/2017 (TAL.500.052.2320)

MS ORR: TAL also brought in a report from the insured's GP last year who certified that her illness rendered her incapable of working in her trained occupation as a nurse with no expectation that she would ever recover enough to return to that occupation. Do you recall that?---Yes, I do.

Do you accept that TALs treatment of the insured over the past eight years caused her considerable distress and has significantly exacerbated her mental health condition?---I can agree to us causing her stress but I cannot comment on the exacerbation of her medical condition as there could be many other factors as well.

Do you think that the matters that I've taken you through yesterday and this morning are matters that are likely to have exacerbated her mental health condition?---They can have caused her a lot of stress, yes and - - -

And exacerbated her mental health condition?---I can't comment on that.

Throughout the period that followed the FOS determination, TAL continued to inflict various systems errors and administrative errors on the insured, didn't it?---Yes, it did.

For several months she didn't get her monthly statements. She had to make several requests to TAL before the information was finally provided. Do you accept that?---Yes, I do.

On a number of occasions, she has had to contact TAL about TAL failing to pay her benefits in a timely manner?---That's right, yes.

And on at least four occasions, TAL sent her a letter suggesting that she was required to pay premiums to TAL, despite being on claim?---Yes.

And that happened as recently as May this year?---Yes. Administrative errors, yes.

And that followed an earlier occasion when the insured had received a letter from TAL telling her that her policy had lapsed because she hadn't paid premiums?---That's correct, yes.

And in April 2018 – April this year – we see from documents produced to the Royal Commission that a TAL staff member commented that her policy was paid until 18 September this year?---Yes.

What does that mean, Ms van Eeden?---So there's normally a review of all our claimants depending on their condition. So there's a regular review. It's a standard procedure.

So there will be a review of her claim in September this year?---Yes.

That's a week or so from now?---Yes.

Now, Ms van Eeden, you accept, I think, that TALs handling of this claim was deficient in many respects. Is that right?---That's right, yes.

You accept that TAL engaged in misconduct by breaching its duty of utmost good faith?---That's right, yes.

And you accept that the approach taken by TAL was to seek to avoid paying out the claim rather than supporting the insured with her claim?---In this instance, yes.

I want to put to you that the way TAL handled this claim was a deeply troubling response to a legitimate mental health claim that led to a series of wrong decisions and extremely poor behaviour, including misleading the insured, misleading FOS, and authorising conduct that involved very troubling breaches of the insured's privacy?

MR BEAUMONT: I'm sorry, I object to that question, Commissioner. That's - - -

THE COMMISSIONER: Yes?

MR BEAUMONT: There are a number of propositions rolled up in that.

THE COMMISSIONER: Well, take it one by one then.

MR BEAUMONT: The witness ..... - - -

MS ORR: I will do it one by one, Commissioner.

THE COMMISSIONER: Yes. All right.

MS ORR: Do you firstly accept, Ms van Eeden, that this was a deeply troubling response to a legitimate mental health claim?---I don't have enough – yes, I will – yes.

You do?---Yes.

Do you accept that it led to a series of wrong decisions?---Yes.

Do you accept that it led to extremely poor behaviour by a number of TALs representatives?---Poor behaviour, yes.

Do you accept that the insured was misled?---Yes.

Do you accept that FOS was misled?---That one I can't comment on. I think some of the information in there was, yes, was misleading.

The Commissioner asked you questions - - -?---Yes.

- - - about TALs statements to FOS yesterday. Again, I can bring up the transcript but I understood that yesterday you had conceded - - -?---There were comments in there that were misleading, yes.

Thank you. And do you accept that TAL authorised conduct that involved very troubling breaches of the insured's privacy?---Yes.

And that conduct extended over a significant number of years?---Yes.

And was engaged in by numerous TAL employees?---Yes.

The insured's claim went through a number of case managers. It went to the TAL claims decision committee. It went to the TAL internal dispute resolution team. And it went to the TAL external dispute resolution team. Is that right?---That's right, yes.

And none of them took steps to change the approach that was being taken?---That's correct, yes.

And was that because no one was paying due regard to TALs duty of utmost good faith to its policyholders?---I cannot explain why it happened. It's troubling that it did but I don't know why it happened.

What does it say to you, again, about the culture at TAL?---In terms of this case, absolutely not acceptable.

You say in your statement that there was a lack of oversight of and guidance given to the first unnamed case manager. Do you recall that?---Yes.

And you say that that happened because she came to TAL with extensive claims management experience?---Yes.

She was a senior case manager?---Yes.

So this was the case manager who engaged the private investigator, corresponded with the psychiatrist in the way we saw yesterday, and recommended to the claims decision committee of which she was part that the policy be avoided and that the insured be told she needed to repay the benefits already paid?---Yes. She came in as a contractor.

And you accept in your statement that there was minimal oversight within TAL of senior level case managers?---At that stage, yes.

And there were no structured ongoing training programs in relation to TALs processes and procedures?---There – the – there's much better structured programs at the moment. I can't comment on exactly what training they received but we have structured training in place now.

Could I ask you to look at paragraph 194 of your statement. On page 30 of your statement, Ms van Eeden?---Yes.

You tell us that there was no - - -?---Just to - - -

- - - structured – do you see - - -?---Yes, I see it.

So you accept there were no structured ongoing training programs in relation to TALs processes and procedures?---Well, this is relating to the philosophy. So I would assume there was training in processes and procedures but not sufficient on philosophy.

I see. Do we take from your statement that TAL didn't have mandatory induction training for all new employees at the time that the first case manager joined TAL?---Yes.

You didn't?---We didn't have.

That's a pretty serious flaw in TALs systems, isn't it?---Yes.

And were TALs representatives, in your view, adequately trained to provide the financial services that were covered by its Australian financial services licence?---Yes. There was a lot of on the job training but we've now structured it that there's a formal two-week induction training program as well.

When did the two-week induction training program commence, Ms van Eeden?---In 2017.

And prior to that time there was no such requirement?---No, it was on the job training.

You accept that TAL breached professional standards in your statement?---Yes.

And in what ways do you accept that TAL breached professional standards in the handling of this claim?---We did not consider the claimants and the claimant's position.

You also accept in your statement that several aspects of the dispute resolution process fell below community standards and expectations?---Yes.

You accepted yesterday that TALs IDR team didn't perform its proper function of conducting a robust analysis and independent analysis of the complaint?---Yes.

And in your statement you tell us that you're unaware of why that occurred, but at the time it occurred, the IDR team was embedded within the operational functions of TAL and the EDR team was part of the risk team?---That's right, yes and now we've moved them into our legal environment.

So they've both been moved to the dispute resolution area now - - -?---That's right, yes.

- - - you say with a view to enhancing their independence and expertise?---That's right, yes.

So you accept that at the time of this conduct, structurally those teams were not located in a way that enhanced any independence?---That's right, yes.

Do you accept that the IDR team was not sufficiently independent of the business at the time of this claim?---It appears not to be, based on their processes.

Now, you also accept that there were serious issues with the way in which the EDR team engaged with FOS?---Yes.

TAL was not frank with FOS?---Yes. And they should not – TAL should have accepted the FOS decisions.

Yes. And - - -?---Yes.

- - - was TAL frank with FOS?---I'm not sure what you mean by that.

Was TAL – I'm not sure how else to put that. Was TAL frank with FOS? Were they open and transparent and truthful in their dealings with FOS?---They provided FOS the information that they had on file, yes, but some of it, as you said, it previously was misleading.

I see. And the community would expect better from TAL in its engagement with the external dispute resolution body, wouldn't it?---In those years, yes.

And you have just said that TAL should have accepted FOSs determinations and its recommendations?---Yes.

At the time. Is that right?---That's right, yes.

And if that had happened, the insured's matter wouldn't have needed to proceed to determination stage on either occasion, and that likely would have saved the insured a lot of mental anguish. Do you accept that?---I accept that, yes.

And you also accept that TAL failed to properly acknowledge the insured's distress in relation to a number of matters, including the daily activities diary?---Yes, I do.

And that the refusal to participate in the FOS conciliation conference in the second dispute and continuing to maintain an allegation of fraud against the insured was also conduct that fell below community standards and expectations?---Yes.

And finally, you acknowledge the many administrative and system errors throughout the history of this claim as falling below community standards and expectations?---Yes.

And do you accept that for someone in the insured's condition, that those administrative and system errors were likely to be significant stressors and could have impacted on her health?---Definitely stressors, yes.

And again you're unable to explain why those things occurred?---No. I can't explain that.

Now, before I leave the case of this insured, I just want to put to you squarely that the misconduct that you have admitted in connection with this claim is attributable to a culture within TAL that endorses and encourages attempts to limit TALs liability to pay out under claims?---No, I can't comment. That – this is one individual claim. And it does not happen to all our claims.

Well, you say it's one individual claim, Ms van Eeden. It's a claim that was handled over numerous years by numerous case managers and numerous other parts of the TAL business, including the IDR and EDR and the claims dispute committee. None of them, as I put to you earlier, did anything to change the approach that was being taken. In those circumstances, do you accept that this misconduct was attributable to a culture that endorsed and encouraged attempts to stop paying out claims?---On this one claim, yes, but I – I don't want to make that comment broader than that.

Are you aware - - -?---Because its ..... - - -

- - - Ms van Eeden, that holders of Australian financial services licences have an obligation to do all things necessary to ensure that their services that are covered by the licence are provided efficiently, honestly and fairly?---Yes.

Now, leaving to one side the question of whether that obligation extends presently to the process of handling a policyholder's claim, do you think that TALs conduct in relation to this claim was efficient?---No.

Do you think it was honest?---No.

Do you think it was fair?---No.

All right. I want to now move, Ms van Eeden to asking you some questions about your statement in response to Rubric 6-45?---Yes.

And that relates to a different insured person. And again, I'm just going to refer to her as the insured?---Okay.

If necessary, I will refer to her as the second insured. Now, the Commission provided TAL with an outline of proposed evidence from this insured person. And you respond to that outline of proposed evidence in your statement. Is that right, Ms van Eeden?---Yes.

Commissioner, I want to tender the outline of evidence of the second insured, provided to TAL on 7 August 2018.

THE COMMISSIONER: Does it have a doc ID, Ms Orr, or is it sufficient to describe it as outline of evidence provided to TAL on what date?

MS ORR: On 7 August 2018. We will have it assigned a document ID, Commissioner.

THE COMMISSIONER: Yes. Exhibit 6.203.

EXHIBIT #6.203 OUTLINE OF EVIDENCE PROVIDED TO TAL ON 7 AUGUST 2018 (RCD.0014.0052.0001)

MS ORR: Now, Ms van Eeden, this insured also took out an income protection policy from TAL?---That's correct, yes.

And she was a self-employed health professional?---That's correct, yes.

And she obtained her policy from TAL in October 2013?---Yes.

And in mid-December 2013 she was diagnosed with cervical cancer?---Yes.

And she made a claim on the policy in January 2014?---Yes.

And from January to May 2014 TAL paid the insured's claim?---Yes.

Then at the end of June 2014 TAL avoided the insured's contract of insurance?---That's correct, yes.

And TAL did this because it considered that the insured had failed to disclose a prior history of depression?---Yes.

An unrelated condition to the condition that was the subject of the claim being cervical cancer?---That's correct, yes.

The insured disputed that decision in FOS?---Yes.

And after a conciliation conference, TAL and the insured settled the dispute?---Yes.

Now, I want to take you back to some points in that time line in a little more detail. You tell us in your statement that the insured applied for her policy with the assistance of a representative of iSelect?---That's right, yes.

And the iSelect representative conducted a telephone interview with the assured to obtain answers to the questions listed in TALs accelerated protection application summary?---That's right, yes.

And that telephone call, which took place on 26 September 2013, went for just over 40 minutes. Is that right?---That's right.

And in that call, the iSelect representative completed an application form containing the answers given by the insured. And that was then submitted to TAL and that document is exhibited to your statement?---That's right, yes.

Now, if we could go to that document. It's exhibit 62 to your statement, TAL.500.020.1322. Now, Ms van Eeden, we see from this document, if we go to 1324 and 1325 at the same time, that TAL required the insured to answer a series of questions about her occupation. Quite a long series of questions on the left-hand side?---Yes.

And questions about her income?---Yes.

And then if we go to 1325 and bring up 1326 as well. We see the first two of four pages of questions about the insured's health and medical history. You see that?---Yes, I do.

And if we look at 1325, we see that all of the medical history questions, at the bottom of the page, were prefaced with:

> *Have you ever had or received medical advice or treatment for any of the following?*

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

And we then see a list of 27 matters?---Yes.

Now, have you listened to the telephone call in which the iSelect representative takes the insured through these 27 questions?---Yes, I have.

And you know that the words:

> *Have you ever had or received medical advice or treatment for any of the following?*

Was not repeated before each of those 27 questions were asked?---Yes.

It was said once at the start of the 27 questions?---That's right, yes.

And one of those 27 questions, question 16 was about – the insured needed to put question 16 together with the words that were said to her much earlier:

> *Have you ever had or received medical advice or treatment for any of the following: depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, attempted suicide, chronic fatigue, postnatal depression or any other mental or nervous condition?*

And we see that the insured's response to this question was no?---Yes.

And it was the insured's response to this question that led to TALs avoidance of her policy?---Yes.

And if we turn to 1328, we see that the questions asked also included a question under the heading Seeking Treatment. Do you see there:

> *Apart from any condition already disclosed, do you plan to seek medical advice, investigation or treatment for any other current health condition?*

?---Yes.

And the insured disclosed that she had been referred to have some blood tests in relation to mid-menstrual cycle bleeding, checking hormone thyroid levels, etcetera. Do you see that?---Yes.

Now, having listened to that call conducted by the iSelect representative, do you think that the insured was given sufficient time to consider and reflect upon each of the questions that she was asked in that call?---No.

No. You heard from that call the quick-fire way the questions were put to the insured?---Yes.

Now, in your view, is that a difficulty for insured – for people who are applying to receive an insurance policy that exists generally with the sale of underwritten policies by telephone?---I can't comment on that. That – each underwriter is different.

Which sorry?---Which tele underwriter could do it differently.

I see. You don't have a view on that?---No, I don't have a view on that.

Now on the day of the telephone interview later in the day the application form that had been completed by the iSelect representative in the course of the call was provided to the insured, and then it was submitted on that day to TAL?---That's right, yes.

And on 9 October 2013, TAL notified the insured that her application had been accepted?---That's right, yes.

But it was subject to a spinal exclusion as a result of a previous whiplash injury which was disclosed by the insured in the telephone interview and which is recorded in this application form?---Yes.

Then on 16 December, the insured was diagnosed with cervical cancer?---Yes.

And as I indicated earlier, she lodged a claim in January, on 3 January?---Yes.

And on 7 January TAL completed an initial assessment of her claim and approved the claim?---That's right, yes.

The day before, TAL had completed an initial assessment and strategy document in which the case manager had said – now, you deal with this in paragraph 55 of your statement. You extract what was said:

> *At application, the insured disclosed that she had mid-cycle menstrual bleeding and was awaiting blood test results. It does not appear that the underwriter*

requested a copy of the insured's clinical notes. They have only obtained a spinal questionnaire which was directed to the insured and not the GP. The insured has also provided her investigation results which show that she had clear results and ultrasounds prior to policy application. We will need to investigate the full history to confirm there were no earlier abnormalities which were not disclosed. Suggest that we accept the claim at this stage.

So that was the initial assessment that led to acceptance of the claim in January 2014?---That's correct, yes.

And over the next few months to May 2014, TAL made monthly payments to the insured of about $5000?---Well, 5000 per month, yes.

Yes?---Yes.

$5000 per month?---Yes.

And throughout that period while the claim was being paid, TAL conducted an investigation into the insured's medical history?---Yes.

Why did that happen?---Because it was an early claim, and so it was a – it's a standard process.

A standard process, you say?---On early claims.

Now, you describe the circumstances in which that would happen in your statement as being circumstances that involved a general review of disclosures made at the time the policy was issued because the claim was within close proximity of the risk commencement date. Is that right?---That's right, yes.

But the review wasn't confined to disclosures that were relevant to the condition that was the subject of the claim, was it?---No, it wasn't.

Why not?---I don't know.

Should it have been?---Yes. But – yes, generally, though, they – when you call for Medicare records you would get more information as well.

TAL didn't tell the insured that it was undertaking those investigations, did it?---No.

We saw in the case of the first insured that TAL had kept her notified because it wasn't paying the claim at that point. Is that right?---That's right, yes.

Why didn't TAL tell this insured that although it was paying the claim, it was investigating whether or not there was a basis to cease paying the claim?---The process had changed and on – if there is an investigation, the claimants are not

always informed because most of the time there's nothing that comes out of the investigations.

What's the current practice? Is an insured person to whom claims are being paid told if they are under investigation?---In some instances, yes, but in some instances they may still not be told.

When are they not told, Ms van Eeden?---Often if there's a mental illness or some kind of illness that could cause distress, so it's – the – the feeling at the moment is there's no point in distressing the claimant, especially if there's going to be nothing coming out of the investigation.

What about the distress that's caused if the result of that investigation is a decision to avoid the claim?---The – the process is how you engage with the claimant, you are right, across the time of the claim – during the period of the claim. So as soon as information does become apparent, we should have that conversation with the claimant which didn't happen in this case.

But do you accept that TALs failure to tell this insured that it was investigating the validity of her policy was unacceptable?---Yes, in this case.

And that it fell below community standards?---Yes.

Now, on 30 June 2014 the TAL claims decision committee decided to avoid the policy on the grounds of non-disclosure?---That's right, yes.

And if we go to your exhibit 89, TAL.500.020.2163. We see here a recommendation that was put to the claims decision committee:

> *Policy validity investigation was undertaken and clinical notes were referred for re-underwriting. Clinical notes indicate the insured had pre-existing depression in 2007, '08 and '09. Based on the medical evidence obtained underwriting would have declined cover due to the insured's prior history of depression. Based on the cervical spine exclusion and depression decline, the overall decision would have resulted in the application being declined. TAL would not have entered into a policy on any terms. Therefore, the recommendation is to avoid the policy based on the remedy in section 29(3) of the Insurance Contracts Act.*

So TAL cited the cervical spine exclusion and the alleged history of depression as the basis for saying that it wouldn't have offered any cover to the insured?---That's correct, yes.

And it relied on those matters to avoid the insured's policy under which she was claiming for cervical cancer?---That's correct, yes.

And at the time that decision was made in 2014, the claims decision committee could decide to avoid a policy where the claimed condition was unrelated to the matter that was allegedly not disclosed. Is that right?---If the condition would have resulted in a policy not being issued, that - - -

Yes. Even if that condition was unrelated to the condition that was the subject of the claim?---That's correct, yes.

And since that time, has the situation changed?---No.

Has TAL put in place any further level of scrutiny in relation to decisions to avoid policies for non-disclosure of an unrelated condition?---Yes. Yes.

What is that additional scrutiny?---I have to sign off on all of those cases, and the head of the legal team has to sign off on those claims.

Why was that change made?---To make sure that it only happens in the cases where there is real and true non-disclosure. So the - - -

Real - - -?---The serious cases.

What are the serious cases, Ms van Eeden?---Well, sometimes you do get non-disclosures that are advised or people mislead at – at application stage. And there could be a valid reason for doing that.

So what are the serious cases that warrant the policy being avoided where there's a non-disclosure of an unrelated condition?---Do you want me to go into some examples?

Yes?---So you could have somebody that was not employed and actually have told us that they were employed. We've had people that are already receiving disability benefits that take out insurance and tell us that they're working, and when the claim comes in you actually find out that they are working.

So are we talking about fraudulent cases?---More fraudulent cases, yes.

And beyond fraudulent cases, is it appropriate to avoid a contract of insurance for non-disclosure - - -?---No.

- - - of an unrelated condition?---No, we wouldn't do it unless it's fraudulent.

So an innocent non-disclosure of an unrelated condition ought never lead to avoidance of the claim?---I don't – I'm not the underwriter so I can't tell you what they all base it on but it shouldn't.

Well, I understood that you were the decision-maker - - -?---So when - - -

- - - about whether or not this was to occur?---So when this information comes to us, yes, you are right so I would - - -

You are the decision-maker?---Yes, I am.

And you would not decide to avoid a policy on the basis of an innocent non-disclosure of an unrelated condition?---No, not innocent non-disclosure.

But that was what happened in this case?---In this case, yes.

Now, the same day as the claims decision committee decided to avoid the policy, the insured's case manager called the insured?---That's right.

You are familiar with that?---Yes, I am.

And the case manager told the insured that her policy would be voided from inception due to her failure to disclose an alleged history of depression. Have you listened to that phone call, Ms van Eeden?---Yes, I have.

I want to play a short excerpt from that call, Commissioner. It's TAL.500.026.0221B.

RECORDING PLAYED

MS ORR: Ms van Eeden, in your view, was that an appropriate way to communicate to the insured, after her claim had been being paid for five months, that her policy was now, without notice, going to be avoided and the payments would cease?---No.

It was likely to be very upsetting news to a self-employed person who was recovering from treatment for cervical cancer, wasn't it?---Yes.

And do you accept that the handling of this call demonstrates a lack of empathy towards the situation of the insured?---The case manager, I think, was empathetic but I do think the process was inappropriate.

You say in your statement at paragraph 108:

> *I do not believe there was sufficient empathy shown towards the insured, given the lack of notice to her that the claim was being investigated, the manner in which the unwelcome news that her benefits would cease was conveyed and leaving her with the impression –*

Which we didn't hear but was in a later part of the call:

... that she may need to refund the benefits already paid to her by TAL.

?---That's right. So it's the process was absolutely not appropriate.

And you accept that it demonstrates a lack of empathy?---In the process, yes.

And a lack of sensitivity?---In the process, yes.

To someone who was recovering from cervical cancer?---Yes.

And it was made worse by the fact that the case manager left her with the impression that she might also need to pay back the benefits that she had been paid?---That's right, yes.

And you accept that the way that phone call was handled fell below the standards that the community would expect?---Yes.

You accept also that the way that call was conducted was part of a systemic deficiency within TAL both in terms of insufficient empathy and in terms of keeping the customer informed?---Systemic?

Yes?---I don't know if I agreed to systemic.

I will direct you to paragraph 113 of your statement?---So there were deficiencies, yes.

Systemic deficiencies?---Yes, in terms of how these cases were handled.

Yes?---Yes.

In terms of communications with claimants?---On – when their policies were voided.

Yes?---Yes.

And until this phone call, the insured hadn't known that her case was being investigated. So she wasn't given any opportunity to provide any information in relation to the alleged non-disclosure, was she?---No, she wasn't.

And you accept that that was also a systemic deficiency within TAL at the time?---At that time, yes.

TAL generally didn't give a policyholder an opportunity to provide information prior to their policy being avoided for a non-disclosure?---Not generally.

Why not?---It was not part of their process.

Should it have been, Ms van Eeden?---Yes, and we have changed that.

Do you accept that the insured was not given any procedural fairness before this decision was made to avoid her policy?---Yes.

And TAL sent a formal letter to the insured a few days after the phone call in which the case manager reiterated that TAL considered that she had breached her duty of good faith - - -?---That's right.

- - - to TAL. You recall that?---Yes, I do.

And you've exhibited that as exhibit 81, TAL.001.001.0175. And we see from that letter that TAL recited for the insured the mental health question and her response?---Yes.

And then set out seven dot points relating to medical information that TAL said was not disclosed to it?---Yes.

And said that this information rendered her response to the mental health question inaccurate. Do you see that?---Yes.

And over the page under the heading Misrepresenting or Failing to Disclose Relevant Information, TAL said:

> *In failing to correctly and completely provide your medical history in the application, you failed to disclose and/or misrepresented your medical history, thereby breaching your duty of disclosure pursuant to section 21 of the Insurance Contracts Act. We are also of the opinion that you also breached your duty of good faith as set out under section 13 of the Act. As such, pursuant to section 29(3), TAL hereby avoids the policy from inception on the basis that had the non-disclosure and/or misrepresentation not occurred, TAL would not have entered into a policy.*

?---Yes. That's correct.

Does TAL now accept that it was not appropriate to have informed the insured in this letter that she had breached her duty of good faith?---Yes.

Why was that inappropriate, Ms van Eeden?---Because they could not actually state that she had done it intentionally.

They hadn't even given her - - -?---No.

- - - an opportunity to defend herself, had they?---No.

In your statement you tell us that a review of TALs communications took place around the middle of last year?---That's right, yes.

But prior to that time when claims were declined for non-disclosure, did the communication to the policyholder generally include a statement that TAL was of the opinion that there had been a breach by the insured of the duty of good faith?---Yes.

Was this in itself, this form of communication, Ms van Eeden, a breach of TALs duty to act with utmost good faith towards the insured?---Yes.

There would have been many cases of innocent non-disclosure in which this allegation was made which would have been very unfair to the policyholder, wouldn't there?---That's right, yes.

And you say that following your review of communications, a decision was made to cease that practice?---Yes.

And you say that TAL is continuing to implement that decision?---Yes.

So TAL has not fully eradicated this practice?---So we've changed all our letters. However, sometimes you always get one that might slip out but we're trying to make sure that it never, ever happens. So at this stage I did not want to say 100 per cent but 99.9 per cent.

In – back to the letter to the insured, we see at 0176, if we pan back, that TAL also reserved – do you see:

At this stage –

About two-thirds of the way down the page:

TAL reserved the right to seek repayment of the benefits from the insured.

?---Yes.

And under the heading Benefits Paid Under Your Claim, we see that TAL said:

As we would have not offered a policy on any terms, you were not eligible for any benefit payments made under the policy. As such, we are entitled to recover any benefit payments made to you. In this instance, we are prepared to refund all of the premiums that you have paid (minus any premiums already refunded). We have listed these amounts below.

And the amount to be recovered was $24,649?---That's correct, yes.

Now, TAL also took this position in other correspondence that it sent to the insured. Have you seen that?---Yes, I have.

And in your statement, you accept that it was inappropriate for TAL to have left the insured with the impression that she would need to refund the benefits that already had been paid to her?---That's correct, yes.

Do you accept that that fell below community standards?---Yes, I did.

And what is TALs practice in this respect now?---We do not get the – request the claimant to pay the money back.

And when was that change to practice made?---It has been in since before I came so I would think January '17. I don't know the exact - - -

Some time last year?---I don't have a date.

Now, can I take you back to the handling of this claim. This letter to the insured was July 2014. Now, in March 2015, about nine months after the decision to avoid the policy, did Brett Clark become involved in the insured's file?---Yes, he did.

And he was, at that time, the deputy group CEO at TAL?---Yes.

And what is his position now?---The CEO of TAL.

The CEO of TAL. How did Mr Clark become involved in this file?---Somebody from the PIAC contacted him.

All right. Could we have a look at TAL.001.002.0257. Now, if we turn to 0259, we see an email in the second half of the page entitled inquiry from Ralph Pliner, TAL director. Do you see that?---Yes, I do.

This is an email from Mr Clark to Mary Maini. Was she your predecessor?---Yes, she was.

And Cathy Duloy. Who was Cathy Duloy?---I don't know who Cathy was.

Mr Clark said:

> *I've had a couple of conversations with Ralph about a claim that he had described to him. It involves an income protection claimant who has had a claim denied which may be cancer-related. There is a view from Ralph that the way the claim has been described to him that the insurer is being heavy-handed. The Public Interest Advocacy Centre (Ralph is the chair) are involved in the claim dispute. Ralph is unable to provide too much information but he asked me if it was a TAL claim. I said I would check but with limited information it would be difficult to track it down. If this note triggers any claim files you are aware of, please let me know.*

Now, it related to this file, didn't it - - -?---After the - - -

- - - Ms van Eeden?---After the investigation, yes.

Yes. It was this insured's case that had been raised by Mr Pliner with Mr Clark?---That's right, yes.

And he became involved because he was concerned that TAL was acting in a way which was heavy-handed?---That's right, yes.

Do you agree with that characterisation of the way that TAL handled this claim?---I think it was inappropriate. I don't know whether it was heavy-handed. I can't comment. But it was inappropriate.

Why don't you know that, Ms van Eeden?---The heavy-handed? I can't comment on - - -

Yes. I'm asking for your view on whether from what you've seen in the handling of this claim, TAL handled it in a heavy-handed way?---I think the communication with the claimant was inappropriate, in the way that it was done.

You don't accept it was heavy-handed?---I – I don't want to comment on that.

THE COMMISSIONER: Well, that's not the way the system works. What's your view? Was it or was it not heavy-handed?---I think it was heavy-handed. Inappropriate.

MS ORR: Now, Mr Clark indicated that he wanted a briefing note on the matter, didn't he?---Yes.

All right. Now, I will tender, first, this email chain.

THE COMMISSIONER: What are we doing about the audio of the phone call, Ms Orr?

MS ORR: I'm sorry, Commissioner. We do need to tender that. I apologise.

THE COMMISSIONER: Exhibit 6.204 will be audio of phone call to insured, TAL.500.026.0221B.

EXHIBIT #6.204 AUDIO OF PHONE CALL TO INSURED (TAL.500.026.0221B)

THE COMMISSIONER: Emails March '15 to and from Brett Clark concerning insured's claim, TAL.001.002.0257, exhibit 6.205.

EXHIBIT #6.205 EMAILS MARCH '15 TO AND FROM BRETT CLARK CONCERNING INSURED'S CLAIM (TAL.001.002.0257)

MS ORR: So Mr Clark asked for a briefing note. Now could I ask you to look at TAL.500.022.0017. We can see that after reviewing that briefing note in the email at the top of the page, Mr Clark said to Mary Maini, your predecessor:

> *Thanks, Mary. This is tricky. The application and claim events are quite separate. We would have declined the application if accurate disclosures had been made. That is technically correct. We do need to be mindful of the bigger picture in this case and that is not straightforward either, as you say.*

Now, what do you think Mr Clark meant by needing to be mindful of the bigger picture here?---I've got no idea.

Well, do you think the bigger picture was that it was deeply unfair to be relying upon an alleged non-disclosure that was completely unrelated to the claim that was being made?---I – I cannot comment on what Brett meant in his email.

Or is it possible that the bigger picture was that TAL didn't want to disappoint one of its directors who was also involved with PIAC?---I've got no idea.

You don't know?---No, I don't know.

I will tender that email communication, Commissioner.

THE COMMISSIONER: Email 17 March '15 concerning briefing note to and from Brett Clark, TAL.500.022.0017, exhibit 6.206.

EXHIBIT #6.206 EMAIL DATED 17/03/2015 CONCERNING BRIEFING NOTE TO AND FROM BRETT CLARK (TAL.500.022.0017)

MS ORR: Could I ask that you look at TAL.001.002.0238. Now, this is an email from Joanna Kalouche, external dispute resolution manager, to another EDR manager at TAL, Francis Ferla and Mr Dobbin who we saw from the previous insured's case was also part of the external dispute resolution team. It's from March 2015. And Ms Kalouche says, when referring to this insured's matter, middle of the email:

> *The thing with this matter is that it came to light that a TAL director who is on the board for the Public Interest Advocacy Centre (PIAC) has raised concerns over the handling of the claim due to the insured's diagnosis of cervical cancer. Initially, we weren't aware (I don't think) that she was being represented by PIAC but when FOS forwarded the material below there were letters from*

PIAC to FOS. I am not sure at this stage whether this has changed TALs position.

Now, why would the discovery that the insured was being represented by PIAC have changed TALs position?---It should not have.

I will tender that email, Commissioner.

THE COMMISSIONER: Email from EDR manager, 20 March '15, TAL.001.002.0238, exhibit 6.207.

EXHIBIT #6.207 EMAIL FROM EDR MANAGER DATED 20/03/2015 (TAL.001.002.0238)

MS ORR: Now, I want to ask you, Ms van Eeden, about TALs conduct prior to the conciliation conference that I mentioned earlier was held in FOS. Between June 2014 and March 2015 TALs concerns around non-disclosure related to the non-disclosure of the alleged pre-existing depression. Is that right?---That's right, yes.

But in mid-March 2015 TAL also began considering whether there was a separate non-disclosure issue?---That's right, yes.

And that issue related to the insured having experienced some symptoms which may have been indicative of cervical cancer prior to applying for the policy?---That's correct, yes.

But you will recall that the insured disclosed when applying for the policy that she was undertaking some blood tests in connection with some gynaecological issues that she had been experiencing?---That's correct, yes.

But TAL began a further investigation into those disclosures, and I want to put it to you that that happened because it wanted to find a basis on which the insured's contract could be avoided that was directly related to the claimed condition, and moved away from the concerns that were being expressed in the emails we've just looked at, about the fact that the non-disclosure related to an unrelated condition?---That's how it appears, yes.

You agree with that?---Yes.

And TAL decided to get a retrospective underwriting opinion on this issue in March 2015, many, many months after it had avoided the policy on the basis of the non-disclosure of depression?---That's right, yes.

And if we go to TAL.500.020.0200. We see in the email at the middle of the page, which is an email from your predecessor, Mary Maini, general manager of claims, to

Mr Kay who we saw in the first insured's case – can you remind us what his position was?---He was a team manager.

And Emlyn Pugh, can you remind us who Emlyn Pugh was?---At that stage he was the head of retail.

So a few days after getting the retrospective underwriting opinion, Mary Maini, the general manager of claims, said to the retail claims manager:

> *Let's discuss as I can't help feeling that we are now trying to make retrospective decisions when the facts at the time were different. Just a healthy challenge.*

You see that?---Yes, I do.

So the retrospective underwriting opinion had come in but your predecessor was worried that this was about making retrospective decisions when the facts at the time were different. What do you interpret her as meaning by that?---I think that she feels as well that additional information has been added, I think, reading her email.

Additional information added where?---So taking into account the – the new medical information that wasn't taken into account from the first retrospective underwriting.

And she is expressing concern about that?---And she is expressing concern about that.

And – I will tender that email.

THE COMMISSIONER: Emails to and from general manager claims, March 2015, TAL.500.020.0200, exhibit 6.208.

EXHIBIT #6.208 EMAILS TO AND FROM GENERAL MANAGER CLAIMS, MARCH 2015 (TAL.500.020.0200)

MS ORR: On the – on the same day as that email, 23 March, there was an email at the top of the page from 23 March, the claims decision committee considered the additional point, and said:

> *Upon review, additional medical evidence/information has come to slight. The insured had recent deteriorating weight loss, mood change and fatigue. Underwriting would have declined based on this. TAL would not have entered into a policy on any terms. Therefore, the recommendation is to maintain the decision to avoid the policy based on the remedy in section 29(3) of the Insurance Contracts Act.*

We know that from paragraph 93 of your witness statement?---Yes.

You recall that?---Yes.

And the claims decision committee formalised its decision the following day?---Yes.

But despite that TAL waited for two weeks until the day before the FOS conciliation conference to communicate that it would be also supporting its position, its avoidance of the policy, on this new additional basis?---Yes, but I think reading the file the dates changed a lot on the – the conciliation meeting. There were a number of changes to the dates.

I see?---So – but it's still very late to provide the information.

It was very late, given when it had been received, wasn't it?---That's right, yes.

And did TAL do that, keep that information until that time, because it wanted to use the information to its strategic advantage in the conciliation conference?---I don't know.

You don't know?---No.

It was part of a broader pattern of delay in the dealings with FOS in this matter, wasn't it?---Yes.

And following that FOS conciliation conference, as I indicated earlier, TAL and the insured settled the complaint?---That's right, yes.

And under the terms of settlement, TAL waived its right to recover the 25,000 that had already been paid under the policy and paid the insured a further $25,000?---That's right, yes.

And the additional $25,000 was substantially less than what the insured would have received from TAL by that time if she had continued to be on claim?---I – I don't think so.

You don't think so?---No, because she would have been on claim until this date, which would have been the 5000 for the 10 months.

Well, could I ask that you - - -?---It wouldn't have been much less.

I'm sorry?---I don't think it would have been much less.

Could I ask that you look at TAL.500.020.0200?---Is that in my statement or - - -

No, it's not. It's the – it's the email, I think, that we still have on the screen. Yes, it is. Now, if we go to the bottom of the page, we see – and perhaps we could bring up

the second page as well so that you can see that this is an email from John Kay to Mary Maini. And he tells Mary Maini, as of 20 March 2015, that:

To bring the policy benefit up to date would amount to $45,000.

?---Yes, I see that.

That's in addition to the $25,000 that was already paid?---I thought that included the $25,000 that had already been paid.

Why do you say that, Ms van Eeden?---I thought she had only been on claim for nine months and 5000 per month for the nine months is 45,000.

I see?---If I remember correctly.

Well, we see from the internal communications that have been provided that the general manager of claims, Mary Maini, regarded this FOS outcome as a great outcome. Have you seen those communications?---Yes, I have.

And upon receiving notification that TAL had closed the file, Mr Kay, the retail claims manager, said to the case manager:

Happy to close that one down.

To which the case manager responded:

That's one success from FOS.

You've seen those communications?---Yes, I have.

Do you have any observations to make about those communications?---It's not appropriate.

In your statement you describe the outcome for the insured as a fair and balanced outcome?---Yes.

Unlike your colleagues who were in charge of the file at the time who characterised it as a great outcome?---No, I don't think – I think it's fair. It was just - - -

You think it's fair. All right. Now, can I move, Ms van Eeden, to asking you some questions about the third statement that you provided. And as I indicated to you yesterday, that statement has not been tendered because the person to whom it relates doesn't wish to have the details of their case examined in these hearings. But in your statement about that person's case, you admitted that TALs claims handling conduct fell below community standards and expectations in a number of ways. And I want to ask you some questions about those admissions?---Okay. I don't have – you will put them up on the screen because I don't have - - -

No, I won't put that up on the screen. We will need you to have a copy of your statement there?---Could I please have a copy of my statement?

THE COMMISSIONER: I think a copy is about to be made available.

MR BEAUMONT: Yes, certainly.

THE WITNESS: Thank you.

MS ORR: Now, as with the first insured, TAL admits that there were significant difficulties with the behaviour of the case manager in this case. Do you agree with that?---Yes, I do.

And more specifically, the claims decision committee had made a determination to avoid the policy and before that decision was communicated to the insured, the case manager added in some additional grounds for avoidance, namely, alleged non-disclosure of a mental health condition. Is that right?---That's right, yes.

And alleged non-disclosure of a physical condition?---That's right.

And the case manager appears to have added in this information based on the contents of an underwriting opinion, but that underwriting opinion was inconsistent with the decision of the claims decision committee. Do you accept that?---Yes, I – I don't have all the information in front of me so I'm just going to - - -

Perhaps if you direct your attention to 156, subparagraph (a) of your statement, Ms van Eeden?---Yes.

Do you accept that proposition, that the information was added in based on the contents of the underwriting opinion but the underwriting opinion was inconsistent with the decision of the claims decision committee?---That's right, yes.

And the case manager then communicated the content of the underwriting opinion rather than the decision of the claims decision committee to the insured?---That's right, yes.

And that should not have occurred?---No, that should not have occurred.

And you attribute that in your statement to a lack of rigour by the case manager?---Yes.

So you assume that the conduct was not deliberate?---I assume it was not deliberate.

And on what basis do you make that assumption?---Just looking at all the information on the file. It's the only assumption I could make.

You also attribute the conduct to a lack of oversight by a more senior case manager?---Yes.

Or a team leader?---Yes.

So much like the situation with the first insured, there was a failure by TAL to step in when a case manager was behaving inappropriately?---In this instance, yes.

In this instance. This is another instance, isn't it, Ms van Eeden?---Yes.

Another indication that there was insufficient oversight of the behaviour of case managers within TAL?---Yes.

And after TAL told the insured that her policy would be avoided, she applied for TALs decision to be internally reviewed?---That's right, yes.

And after that internal review, the file went back to the original case manager?---Yes, it did.

And the case manager did not confine herself to conducting a review in accordance with the recommendations arising from the internal dispute resolution process?---That's right.

She decided to undertake a review that extended beyond that recommendation, and undertook her own further inquiries?---That's right.

And in the statement that you've prepared, you say that TAL can't establish what caused that to occur?---No.

It looks quite similar, does it not, to what we saw from a different case manager in the case of the first insured?---Yes, it does.

And TAL accepts that both of those matters, the communication of information that was inconsistent with the claims decision committee's decision and the failure to conduct a review in accordance with the IDR team's recommendations, are matters that fell below what the community would expect?---Yes.

And TAL has since recognised that it's appropriate to change what you describe as its controls and risk management on disputed claims, so that decisions from the IDR team are not remitted back to the original case manager, but rather to a case manager who hasn't been involved in the claim before?---Yes.

When did TAL change that practice?---That practice is in the process of being changed. So it's relatively new.

It hasn't yet been changed?---It's changed on some cases but it's not on all cases at the moment. We're busy employing a claims compliance person to make sure that it's consistent across all cases.

In paragraph 173 of your statement you say:

> *Today decisions from the IDR team are no longer remitted to the original claims manager but, rather, to a claims manager not previously involved in the claim.*

?---Yes.

Is that not quite accurate, Ms van Eeden?---No, that's – that's what's happening but what I want to do is actually cement it further in the business that it's totally independent. And we're employing a claims – a claims specialist that will be involved in these cases going forward.

So there's - - -?---So we're going to move it out of the team even further.

So there's not yet total independence?---Well, it doesn't go to the same claims manager any more but I want to remove it even further than that.

And why do you want to do that, Ms van Eeden?---To make sure that I've got total independence, obviously.

And you accept that there has not been independence in the past?---That's right, yes.

And do you accept that remitting a decision of the internal dispute resolution body to the person who has been found by them to have engaged in poor conduct in the first place, was an inappropriate process?---Yes.

That's likely to have led to poor customer outcomes?---It could have led, yes.

Now, this presents a similar issue to one we discussed yesterday, which related to TAL permitting the claims managers to sit on the claims decision committee - - -?---That's right.

- - - in circumstances where they had been the one that referred the matter to that committee?---That's right.

So those two matters, I want to suggest to you, show that TAL has permitted a number of systemic conflicts of interest to persist within its processes for a significant period of time?---It's a – it's a process that was followed. Most of the time it worked. So I don't think it was systemic - - -

How do you know that, Ms van Eeden? How can you possibly know that?---Well, I – I would think in terms of the – the valid claims that have paid and the number of

disputes that we get, I would hope the process is working. But as a result of the Royal Commission, and what I have seen in these cases, I am going to be reviewing all of the past claims just - - -

All of the?---Past claims that we have declined for non-disclosure, just to make sure that the appropriate processes have been followed.

Precisely which claims are you going to be reviewing. Declined claims?---As a result of non-disclosure. So all the ones that have been - - -

Any form of non-disclosure?---Yes.

Over what period?---Going back to 2013, the period of these claims.

And when do you anticipate that review will be complete?---As – well, as soon as I get back into the office I will be starting that.

All right. Well, coming back to the third insured person, you accept in your statement that against the backdrop of the case manager having communicated inconsistent information, inconsistent to the claims decision committee's decision and her failure to conduct a review in accordance with the IDR team's recommendations, the decision to defend that insured's matter at FOS was also a decision that fell below community standards and expectations?---Yes.

And you say that TAL should have accepted the view of its IDR team, which would have led to the insured's policy being reinstated subject to some immaterial exclusions?---Subject to exclusions, yes.

In your statement you say that TAL became aware of the matters canvassed in the IDR review and the EDR process culminating in the FOS review and determination progressively as they occurred. That's paragraph 167 of your statement?---Yes.

But as in the case of the first insured, TAL did nothing to stop the inappropriate action at the time?---I wasn't aware of this at the time.

Well, someone was, because you've explained that these were matters that TAL became aware of progressively as they occurred?---And there were changed – that's why the teams were moved out, the IDR and EDR teams were moved into legal.

As a result of this particular case?---Well, as a result of the process. They just wanted to make sure that the process was a solid process going forward.

But do you accept my proposition that despite these problems being drawn to the attention of people within the organisation as they emerged, no one did anything to stop the inappropriate approach to this insured's claim?---No.

You accept that proposition?---Yes.

Was TAL just relieved, as it appears to have been in the other two cases, to have found a basis to avoid paying out the insured's policy?---I don't think relieved is the word, but there is a basis not to pay. I don't know if they were relieved to find a way.

What do you think they were, Ms van Eeden?---I think it was just part of their processes at that stage.

I don't – I'm sorry, I don't understand that answer?---Well, relieved makes me feel like I'm happy to decline a claim and I'm never happy to decline a claim, so I would not use the word "relieved".

I see. Before I leave the topic of this particular case manager, you acknowledge that the way in which the claim was managed by the case manager reflected a rigid approach to the collection of information which led to protracted assessment times?---That's right, yes.

Which, again, fell below community standards?---That's right, yes.

And more broadly, as with the case of the second insured, you admit that the way TAL communicated its decision to avoid the policy fell below community standards?---That's right, yes.

In this case, for 11 months, TAL had been making payments to the insured and had been arranging rehabilitation support for her?---That's right, yes.

And without prior notice, TAL told her that it was going to avoid the policy for non-disclosure?---That's right.

And you accept that the claim should have been handled with greater sensitivity and empathy?---Absolutely.

And you accept that the failure to give her notice of the adverse decision was part of the general processes?---Yes.

Which you have told us this morning have now changed?---That's right.

Is that right?---That's right, yes.

But prior to those changes those processes, I want to put to you, detrimentally affected a number of TAL claimants?---Potentially, yes.

And you also accept that there was no internally consistent approach when investigating claims that were made in close proximity to policy inception?---In – at that stage, yes. That has now changed.

And TAL should have had a structured and targeted approach to the collection of information?---Yes.

But it didn't do so, it didn't start doing so until September 2016 when a guideline was introduced in anticipation of the Life Insurance Code of Practice coming into effect?---That's right, yes.

All right. Now, to finish off, Ms van Eeden, I want to ask you about some of the themes that were common across all three of these cases. I want to start with the conduct of the case managers involved in those cases. You accept that their conduct in the first and third cases was inappropriate?---Yes.

You accept that the approach taken by the principal case manager in the first case was to seek to avoid paying the claim, and this led to conduct that breached TALs duty of utmost good faith?---Yes.

And conduct that breached professional standards and conduct that was misleading?---Yes.

In respect of the case manager in the third case, you accept that there were at least two points in time when the case manager acted against the advice or direction of other teams within TAL, on the first occasion, the claims decision committee and on the second occasion, the internal dispute resolution team?---Yes.

And in both instances, you accept that there was a lack of oversight over the claims managers?---That's right, yes.

And in both instances, you also accept that there were numerous TAL employees and committees that were broadly aware of what was going on and that they failed to step in to prevent the poor conduct?---Yes.

That was because the culture in TAL, as I put to you earlier, encouraged and supported active attempts to find reasons not to pay out claims?---I can't comment on that. Sorry, no, I – I don't know the culture but relating to this it was definitely not an appropriate way to manage claims.

And do you accept that we see so many problems with so many people involved over such a lengthy period of time that it is quite telling as to TALs culture?---Yes.

Turning next to the conduct of TAL in relation to the external dispute resolution body, you accept that in the first case and the third case, TAL continued to defend those matters when it shouldn't have done so?---Yes.

And in the case of the first insured, TAL failed to accept FOS recommendations on two occasions when it should have done so?---Yes.

And in the case of the first insured, TAL had gone against FOSs specific directions in a number of respects, including by requiring the insured to repay premiums that had earlier been refunded before it would assess the claim?---Yes.

In relation to internal dispute resolution processes, do you accept that in the case of the first and the third insured, those processes were ineffective?---Yes.

And in the case of the first insured, you accept that the review conducted by the internal dispute resolution team didn't seriously engage with the complaint?---Yes.

In the case of the third insured, the case manager had complete disregard for the IDR team's recommendations?---Yes.

Now, you accepted yesterday that the medical reports that TAL called in in this earlier period extended well beyond medical reports that were relevant to the claimed condition and included all sorts of irrelevant medical information?---Yes.

And that that information was brought in to see whether a policy could be avoided on the basis of non-disclosure?---They ..... non-disclosure, yes.

You told the Commission that practice existed you said yesterday until 2012 or 2013?---I – I'm not 100 per cent sure of the dates but I think it's the right – yes, I think it's about the right date. I think it's a bit later. No, it was later than that. Yes.

Yes. Well, we saw from the handling of the second insured's complaint today that TAL took a very similar approach at that time. Do you agree with that?---That's right, yes.

In 2014. And do you agree that TAL took a similar approach in 2015 and '16 in the case of the third insured?---Yes.

Each insured was designated with what TAL now calls a general review, weren't they? A general review to bring information in?---Yes, but the general review now is very specific. We've done a lot of training to the staff in terms of IMEs and we've also changed our approach to them as well. So up until last year, the medical officer had to sign off on every one that we needed, and now we provided training to the claims teams as well in terms of that as per my statement.

I want to put to you finally, Ms van Eeden, that what we see when we look at all three claims and the way they were handled is that there have been serious systemic issues with claims handling within TAL for many years. Do you accept that?---I don't know if it's systemic – I think in certain practices, yes. In terms of some of the processes, yes.

You don't accept that there have been serious systemic issues with claims handling within TAL?---I think it's only relative to certain types of claims and I wouldn't put it to all claims.

Which claims would you put it to, Ms van Eeden?---Well, it seems to be claims when there was some kind of anticipated non-disclosure, but I – I can't say that it's systemic. I'm across all of them without doing the review that I have planned.

How can we be sure that the issues that these three cases have revealed, whether or not you accept them as systemic, have been addressed and resolved by TAL?---That's going to be part of my audit process. I'm going to be reviewing all of them and if there is anything we will rectify that.

I have no further questions, Commissioner.

THE COMMISSIONER: Thank you, Ms Orr. Yes, Mr Beaumont.

MR BEAUMONT: No re-examination, thank you.

THE COMMISSIONER: Yes. Thank you, Ms van Eeden. You may step down.

<THE WITNESS WITHDREW [12.24 pm]

THE COMMISSIONER: Yes, Ms Orr.

MS ORR: Commissioner, in the course of this last case study, we've looked at surveillance practices used by insurers to monitor the activities of claimants. We sought information and data from the 10 life insurers about their surveillance practices from 1 July 2013 to 30 June this year. Some of that information and data was provided as part of the general claims handling statements that we tendered on Wednesday, and we sought more specific information about some entities' surveillance practices in statements which have not yet been tendered. We want to say something about the statements and before we do, we make some general observations about the data provided by them.

The data indicates that throughout the relevant period of the last five years, insurers more regularly engaged in surveillance activities in connection with mental health claims than in connection with physical health claims. Of the 10 entities from which the Commission sought statements, surveillance activities occurred in mental health claims more than twice as frequently as in physical claims. Surveillance activities were undertaken in an average of 1.29 per cent of physical claims, and 3.9 per cent of mental health claims throughout the five-year period.

The data obtained by the Commission indicates that since 1 July 2016, the number of claims in which surveillance has been used has decreased significantly. This is likely due to the influence of the Life Insurance Code of Practice, which was released in October 2016, and became binding on subscribers on 30 June last year. Under clause 8.12 of the code, insurers are obliged to utilise alternative methods of verifying information before arranging surveillance. Surveillance may be arranged only when

there is a reasonable belief that a claim appears to be inconsistent with the available information, and the reasons are documented.

Requests for surveillance must be internally reviewed and approved by a senior claims manager. Surveillance is not to be conducted in any court or other judicial facility, in any medical or health facility, in any bathroom, change room, lactation room or inside a claimant's house. Investigators must avoid filming people who are not the claimant. Surveillance must be discontinued where there is evidence from an independent medical examiner that is negatively impacting the claimant's recovery. And surveillance investigators must not communicate with the claimant's neighbours or work colleagues in ways which may reveal that surveillance is being, will be, or has been conducted.

Between 1 July 2016 and 30 July this year, surveillance activities occurred in an average of .39 per cent of physical claims and .66 per cent of mental health claims. During this period, MetLife and Zurich did not engage in any surveillance with respect to mental health claims, and AMP, MLC and Suncorp each referred only one mental health claim to surveillance. We want to say something about each of the statements provided to the Commission. AIA provided a statement were Mr Michael Thornton, the chief risk officer of AIA which is exhibit 6.124. Over the last five years, AIA engaged in surveillance activities in .69 per cent of physical health claims and 1.04 per cent of mental health claims.

In the 2014, '15 and '16 financial years, AIA engaged in surveillance activities in 1.11 per cent of physical health claims, and 1.7 per cent of mental health claims. In 2017, AIA adopted a policy that specifies that for mental health claims surveillance may only be used if the claimant is claiming for a benefit because they are unable to work, and AIA has information that indicates that the claimant is working or is able to work. AIA may not use surveillance to verify a claimant's mental health condition. Following this development, in the 2017 and '18 financial years, AIA engaged in surveillance activities in .1 per cent of physical health claims and .17 per cent of mental health claims.

AMP Life Limited provided a statement from Ms Megan Beer, managing director, which is exhibit 6.135. Over the last five years AMP used surveillance in .77 per cent of physical health claims, and 2.98 per cent of mental health claims. AMPs use of surveillance significantly decreased in the 2017 financial year. In the 2014, '15 and '16 financial years, AMP engaged in surveillance in 1.16 per cent of physical health claims and 5.08 per cent of mental health claims. In contrast, in 2017 and '18 it engaged in surveillance in .1 per cent of physical claims and .05 per cent of mental health claims.

BT Financial Group as you've heard offers life insurance and income protection insurance through Westpac Life Insurance Services Limited. We received a statement from Ms Susan Houghton general manager of insurance at BT Financial Group which is exhibit 6.128. Over the last five years Westpac used surveillance in 1.7 per cent of physical health claims and surveillance activity in 5.38 per cent of

mental health claims. Prior to the implementation of the code, Westpac's life insurance claims philosophy required requests for surveillance to be approved by a senior employee and to set out clear reasons for why surveillance was appropriate and necessary.

Between 1 July 2013 and 30 June 2016, Westpac conducted surveillance activity in respect of 2.96 per cent of physical health claims and 9.1 per cent of mental health claims. Following the implementation of the code, Westpac implemented a code guide which requires surveillance to be used in exceptional circumstances and to not be considered unless there is a specific trigger to do so. This includes where there is inconsistent evidence of earnings or financial activity, and determination of the customer's position cannot be made by other means. Between 1 July 2016 and 30 June 2018, use of surveillance activity dropped to .39 per cent of physical health claims and 1.72 per cent of mental health claims.

CMLA provided a statement from Helen Troup, the executive manager of CommInsure which is exhibit 6.137. Over the last five years, surveillance was used by CMLA in .92 per cent of physical claims and in 4.39 per cent of mental health claims. Between 1 July 2013 and 30 June 2016, CMLA used surveillance in 1.3 per cent of physical claims and seven per cent of mental health claims. Between 1 July 2016 and 30 June this year, the use of surveillance dropped to .23 per cent of physical health claims and .71 per cent of mental health claims.

MLC provided a statement from Natalie Cameron, MLCs chief claims officer, which is exhibit 6.126. Over the last five years, MLC used surveillance in .75 per cent of physical health claims and 1.54 per cent of mental health claims. In the 2014, '15 and '16 financial years, MLC used surveillance in 1.17 per cent of physical health claims and 2.58 per cent of mental health claims. In the 2017 and '18 financial years, surveillance use dropped to .15 per cent of physical health claims and .08 per cent of mental health claims.

MetLife provided two statements to the Commission that addressed the use of surveillance. A statement of Mr Mark Raberger chief claims officer which is exhibit 6.132 and a further statement of Mr Raberger which I will tender dated 28 August 2018.

THE COMMISSIONER: That statement will become exhibit 6.209.

EXHIBIT #6.209 FURTHER STATEMENT OF MR RABERGER DATED 28/08/2018

MS ORR: In our opening address we explained that MetLife acknowledged in its submission to the Commission that it had engaged in conduct that fell below community standards and expectations in relation to claims handling processes for claimants with mental health conditions, including through the use of surveillance.

In his second statement to the Commission, Mr Raberger admitted that MetLife had engaged in misconduct through the actions of one of its surveillance operatives in June 2012. In 2016, a court found that the actions of this surveillance operative contravened provisions of the Surveillance Devices Act 2007 of New South Wales.

Mr Raberger told the Commission that MetLife otherwise did not consider that it or any third party engaged on its behalf had engaged in misconduct as the use of surveillance is not legally prohibited and can be, and legitimately is, used by insurers as an investigative tool. However, Mr Raberger did acknowledge that for activities undertaken from 1 January 2013 until July 2016, the routine use of surveillance was not appropriate in all circumstances, and in some cases may have resulted in MetLife or a third party engaging in conduct that fell below community standards and expectations. MetLife told the Commission that over the last five years, nine complaints relating to surveillance activities had been received, eight of which came from complainants whose claim was for a mental health condition.

MetLife told the Commission that over the last five years it used surveillance in .46 per cent of physical health claims and 1.07 per cent of mental health claims. In the 2014, '15 and '16 financial years, MetLife engaged in surveillance activity in .73 per cent of physical health claims and 1.66 per cent of mental health claims. MetLife told the Commission that it implemented new surveillance policies and procedures in July 2016, under which surveillance may occur only in exceptional circumstances and after approval by the chief operating officer. MetLife surveillance policy provides that surveillance is not to be used in the assessment of a claim where diagnosed mental illness is known to be a factor in the claim. In the 2017 and '18 financial years, MetLife did not engage in any surveillance activity.

OnePath provided a statement from Mr Gerard Kerr, the head of life insurance at ANZ Wealth Australia which is exhibit 6.133. Over the last five years, OnePath used surveillance in 1.42 per cent of physical health claims and 3.85 per cent of mental health claims. In the 2014, '15 and '16 financial years, OnePath engaged in surveillance activity in 1.39 per cent of physical health claims and 4.3 per cent of mental health claims. Of all of the entities that provided data to the Commission regarding their surveillance activities, OnePath most frequently undertook surveillance activities, both for physical and mental health claims in the 2017 and '18 financial years. During this period, OnePath conducted surveillance in 1.48 per cent of physical health claims and 3.2 per cent of mental health claims.

We turn to Suncorp. The Commission received two statements from Suncorp in respect of its surveillance processes. The statement of Mr Christopher McHugh, executive manager of life claims in the personal injury claims division of Suncorp, which is exhibit 6.134, and the statement of Mr Andrew Morrison, executive manager life claims in the personal injury claims division. Suncorp accepted that there were isolated instances where it or an investigator acting on its behalf had engaged in conduct which may have fallen below community standards and expectations in relation to the use of surveillance. These included an investigator causing a policyholder distress by driving his car erratically in order to follow the

policyholder. Instances of investigators falsely denying that they were investigating a policyholder after being asked by the policyholder whether they were doing so.

And an investigator accepting a surveillance engagement despite personally knowing the policyholder. Suncorp also accepted that there were two occasions where it elected to recommence surveillance of a policyholder in circumstances where the policyholder had notified Suncorp that surveillance was causing them distress or was otherwise adversely affecting their mental health. Suncorp stated that this conduct was allowed to occur and was not properly internally investigated because Suncorp had insufficiently robust procedures governing surveillance activities at this time. Suncorp also recognised that under its policies and procedures at the time, the relevant conduct was not prohibited.

Over the last five years, Suncorp life used surveillance in 4.03 per cent of physical health claims and 11.27 per cent of mental health claims. This was the highest level of surveillance across both physical and mental health claims of all the 10 insurers over the five-year period. In the 2014, '15 and '16 financial years, Suncorp Life used surveillance in 5.84 per cent of physical health claims and 17.2 per cent of mental health claims. This was the highest level of surveillance across both physical and mental health claims of all the 10 insurers over the three-year period prior to the introduction of the Life Insurance Code of Practice.

Suncorp implemented revised surveillance policies in December 2016, and has used surveillance significantly less frequently since this time. In the 2017 and '18 financial years, Suncorp used surveillance in .84 per cent of physical health claims and in .19 per cent of mental health claims. Commissioner, I tender the statement of Andrew Morrison, dated 3 September 2018.

THE COMMISSIONER: That statement becomes exhibit 6.210.

EXHIBIT #6.210 STATEMENT OF ANDREW MORRISON DATED 03/09/2018

MS ORR: We turn to TAL. In addition to the statements provided by Ms van Eeden relating to the individuals whose circumstances we've examined, TAL provided a statement from Mr Justin Delaney, chief operating officer, which is exhibit 6.123. Over the last five years, TAL used surveillance in .62 per cent of physical health claims and in 1.61 per cent of mental health claims. In the 2014, '15 and '16 financial years, TAL used surveillance in .95 per cent of physical health claims, and 2.51 per cent of mental health claims.

TAL told the Commission that it had introduced a new surveillance guideline in November 2016 which contained some restrictions upon approval for surveillance activities. The guideline also provides that surveillance may only be requested when deemed absolutely necessary to progress the claim, and that must be – and that it

must be discontinued if TAL receives evidence from a doctor or specialist that it is negatively impacting the customer's recovery. In the 2017 and 18 financial years TAL used surveillance in .2 per cent of physical health claims and .42 per cent of mental health claims.

The final entity from which the Commission received a statement was Zurich. Zurich provided a statement from Mr Sheriff Hamza, Zurich's head of life claims and investments which is exhibit 6.130. Over the last five years Zurich used surveillance 1.26 per cent of physical health claims and 5.39 per cent of mental health claims. Between 1 July 2013 and 30 June 2016 Zurich used surveillance in 2.42 per cent of physical health claims and 11.37 per cent of mental health claims. In the 2017 and '18 financial years Zurich used surveillance in .35 per cent of physical health claims and as I have already indicated, did not engage in surveillance in any of its mental health claims.

Commissioner, that concludes what we want to say about surveillance. Could I also, Commissioner, provide you with the document ID for the outline of evidence that I provided earlier which was tendered as exhibit 6.203. That was the outline of evidence provided to TAL on 7 August 2018.

THE COMMISSIONER: Yes.

MS ORR: The document ID is RCD.0014.0052.0001.

THE COMMISSIONER: Thank you.

MS ORR: Commissioner, if we could have a brief break before commencing - - -

THE COMMISSIONER: Well - - -

MS ORR: Or you may prefer - - -

THE COMMISSIONER: I think if we adjourn over until 2, is there – is that going to leave enough time in the afternoon if we begin again at 2?

MS ORR: We would be grateful, Commissioner, if we could commence in an hour's time. It's a matter for you.

THE COMMISSIONER: Yes. Quarter to two it is.

MS ORR: Thank you, Commissioner.

ADJOURNED **[12.45 pm]**

RESUMED **[1.45 pm]**

THE COMMISSIONER: Yes, Mr Costello.

MR COSTELLO: Commissioner, we now move to the final topic in this part of the life insurance section of the module, which is group life insurance. Before moving to the next case study, there are some statements that need to be tendered and some explanation given of the work that has been done by the Commission in the lead-up to these hearings. Commissioner, an important feature of the Australian life insurance market is that life, total and permanent disability, and income protection insurance are sold on both an individual and a group basis.

The majority of life insurance policies are held within superannuation funds. In its recent draft report, Superannuation: Assessing Efficiency and Competitiveness, the Productivity Commission stated that 12 million Australians have one or more forms of life insurance through their superannuation. By way of contrast, ASIC report 498, Life Insurance Claims: An Industry Review, states that in 2015 there were four million retail policies and 3.9 million direct or non-advised policies of life insurance. A 2016 report prepared by Rice Warner states that the proportion of total life insurance held within superannuation funds at that time was 71 per cent for death cover, 88 per cent for total and permanent disability cover, and 59 per cent for income protection cover.

In 2016/2017 Australians paid a total of more than $9 billion in group life premiums. Yet the recent Productivity Commission draft report states that about a quarter of members do not know if they have, or if they are paying for a policy of group life insurance. The structure for group life insurance involves a policyholder owning a policy on behalf of a defined group of individuals. The most common group schemes are employer schemes and superannuation schemes. In this part of the hearing block we will deal only with superannuation group schemes.

Superannuation fund schemes are structured on the basis that the life insured is a member and beneficiary of a trust fund and the policy owner is the trustee of the fund. It is the policy owner in group schemes, not the life insured, who enters into the contract, is obliged to pay the premium, has standing to claim and is entitled to receive the benefit amounts paid by the life insurer. The Commission requested information in connection with group life insurance from 15 superannuation trustees. In effect, those entities represent the five largest retail trustees measured by number of members, some of whom conduct their operations through more than one legal entity, and the five largest industry funds.

The 15 selected entities include the 10 largest funds by member in the country. Information was sought for a five-year period from 1 July 2013 to 30 June 2018, which I will refer to as the relevant period. Two entities, REST and AMP will the subject of case studies in this round of hearings. The solicitors and Counsel Assisting have carefully reviewed all of the responses received from superannuation trustees, and I will now give an overview of the responses of some of the entities that will not form part of the case study.

We begin by making some general observations about insurance management frameworks, selection of insurers and the roles of third parties in connection with group life policies and claims. The Superannuation Industry Supervision Act requires the trustee of a superannuation fund to formulate, review regularly and give effect to an insurance strategy for the benefit of beneficiaries. The insurance strategy must address the kinds, levels, basis and method for insurance to be offered or acquired on behalf of beneficiaries, the cost of offering or acquiring insurance and to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary if that claim has a reasonable prospect of success.

Since 1 July 2013, APRA has required superannuation trustees to have an insurance management framework that includes an insurance strategy under prudential standard SPS 250, Insurance and Superannuation, a prudential standard that has the force of law. Each entity examined by the Commission had in place an insurance management framework which included an insurance strategy, as required by prudential standard SPS 250. Each of the entities confirmed in statements to the Commission that their respective insurance management frameworks have been reviewed internally on an annual basis, the entities also confirmed that their respective insurance management frameworks undergo or have undergone an independent review at least every three years.

The Commission requested that for any group life policy entered into for members during the relevant period, each entity identify the insurer, when the insurer was chosen, any other insurers considered, to explain the process by which the insurer was chosen and explain the reasons the insurer was selected. In general terms, for entities that hold insurance through related parties, the selection and review processes explained in the statements to the Commission appear less rigorous than those described by entities that hold insurance through non-related parties.

Most related party insurers do not involve a tender process, although some involved external review of some kind. An example of a more rigorous process was set out in the statement provided by Sunsuper which describes the process of selecting the group life insurance provider for its Sunsuper for Life product which accounts for 82 per cent of Sunsuper members. The current insurer was selected through a full market tender in 2010 with the assistance of an independent external actuary. Seven insurers were considered. Each insurer presented a tender document responding to selection criteria with each insurer then scored against the criteria. Sunsuper conducted site visits to a short list of four insurers and received revised tender documents. An insurer was then selected. Sunsuper has since conducted two pricing reviews in relation to group life insurance with that insurer.

The Commission also put questions to each entity concerning the types of insurance offered to members, the extent life insurance was taken up by members, the extent of any rebates received from insurers, and the extent to which the trustee had misinformed members in relation to the group life policy. The Commission also put questions to each entity about two types of clause sometimes found in life, TPD or income protection insurance. The first such clause is where coverage discontinues if

a member's superannuation balance falls below a minimum level. We refer to these as prescribed minimum balance clauses.

The second type of clause is one that requires a particular employment type or a minimum number of hours to be worked to maintain one or more forms of life insurance coverage. We refer to these clauses as prescribed employment status clauses. I will now outline some of the responses to the Commission's questions about those issues from particular entities, commencing with the retail funds. Melinda Howes provided a statement on behalf of three entities, BT Funds Management Limited, BT Funds Management Number 2 Limited and Westpac Securities Administration Limited. The percentage of fund members who paid for group life premiums varied between the three funds.

The highest take-up was in the Retirement Wrap Fund in which 54.2 per cent of members had funds deducted for group life premiums. The lowest was the Beacon Superannuation Plan where only 4.3 per cent of members took up group life insurance. As to the specific types of clause I have already mentioned, Ms Howes stated that during the relevant period she was not aware of any members that have been denied an insurance death or TPD benefit claim by reason of the fact that the member's account balance was below a prescribed minimum balance. Ms Howes noted that with limited exceptions, when a balance is not enough to pay premiums, members are not provided with insurance cover.

Ms Howes was also not aware of any circumstances where members or beneficiaries have been denied a benefit under a life insurance or TPD policy or have received a reduced benefit by reason of the fact that the member did not have a prescribed employment status. Having said that, a member's entitlement to a TPD benefit within one of the BT funds will be affected by their ability to engage in activities of daily living. In general terms, a TPD benefit will be payable where, in the opinion of the insurer, the member is unlikely to ever follow their usual occupation or an occupation they are suited for by reason of their education, training and experience. In addition to this, the member must satisfy one of the further list of criteria. For example, a member must be continuously and totally unable to perform at least two of the following activities: bathing, dressing, eating, toileting in order to be eligible to claim.

In relation to income protection insurance, Ms Howes was not aware of any circumstance where a member or beneficiary was denied a benefit under an IP insurance policy by reason that the person did not meet a prescribed employment status requirement. Ms Howes does note in her statement that to be eligible for income protection insurance a member must work at least 15 hours per week on an initial assessment. At a latter point any income benefit paid will relate to the income a member is earning prior to their illness or injury. Finally, part-time employees, casual employees and contractors may be covered for income protection insurance but only for a period of two years.

In regards to rebates and profit-sharing Ms Howes also disclosed that BT was party to an arrangement with a third party insurer pursuant to which it receives payments described as a variable profit share and a fixed profit share. As examples, in 2017 BT received over $9 million with respect to the arrangement and in 2018 over $4 million. Ms Howes stated that the trustees received administration payments from the insurer AIA from 1 July 2013 until 31 December 2017, and from Westpac Life Insurance Services Limited from 1 January 2018. Ms Howes stated that the trustees received these payments for their own benefit. The value of the arrangements has not been disclosed to the Commission.

Ms Howes also identified various instances where the trustees had communicated with members in a way that did not accurately reflect the terms of the group life policy. Many of the disclosed instances involve large groups of members being misinformed. For example, in September 2017, 18,027 members were incorrectly advised about premium payments. Investigation and remediation in relation to this and other incidents is ongoing. Commissioner, I tender the statement of Melinda Suzanne Howes dated 31 August 2018 in response to Rubrics 6-32, 6-33 and 6-34.

THE COMMISSIONER: That will become exhibit 6.211.

EXHIBIT #6.211 MELINDA SUZANNE HOWES DATED 31/08/2018 IN RESPONSE TO RUBRICS 6-32, 6-33 AND 6-34

MR COSTELLO: Thank you, Commissioner. I turn now to the Commonwealth Bank of Australia. Witness statements were provided by three entities ultimately owned by the Commonwealth Bank of Australia. Colonial First State Investments Limited, Colonial Mutual Superannuation Limited and Avanteos Investments Limited. I will outline the response from Colonial First State only. Mr Peter Chun, general manager distribution, provided a statement on behalf of Colonial First State Investments Limited. Colonial is the trustee of four funds which offer 12 products of which two are MySuper products. Mr Chun gave evidence that none of the Colonial funds require members to have a prescribed minimum balance.

Accordingly, no members or beneficiaries of CFSs funds have been denied a TPD or death benefit claim for that reason. However, if a member's balance is too low to make payments for two months in a row, their policy will lapse. With regard to total and permanent disability, Mr Chun informed the Commission that during the relevant period, 85 members had their TPD claims rejected as they did not meet the definition of TPD applicable to their employment type at the time of disablement under the terms of the policy.

There were no members who received reduced benefits under a TPD or life insurance policy because they did not have a prescribed employment status. A prescribed employment status did not result in any life insurance policy benefits being denied to members during the relevant period. And that in addition to the 85 members

previously mentioned whose TPD claims were rejected, a further six claims were rejected because members did not satisfy an activities of daily living test or similar requirement. In May 2018, a change was implemented to the effect that all members, regardless of employment type, are assessed against a full TPD definition rather than some being assessed against an activities of daily living TPD definition.

With regard to income protection insurance, Mr Chun identified eight members whose income protection cover claims were declined owing to them not meeting the relevant policy's prescribed employment status requirements. In regards to member communications, Mr Chun identified 33 incidents where communications with members did not reflect the terms of a group life policy. These included advising members of incorrect premium amounts, advising members that they were entitled to a higher level of cover than they were actually entitled to, paying incorrect benefits to members, and members receiving confirmation that they were covered despite not being eligible to receive cover. Of the 33 communicated incidents identified six of those incidents were identified as occurring within 2018. Commissioner, I tender the statement of Peter Chun, dated 31 August 2018 in response to Rubric 6-35.

THE COMMISSIONER: Exhibit 6.212.

EXHIBIT #6.212 STATEMENT OF PETER CHUN, DATED 31/08/2018 IN RESPONSE TO RUBRIC 6-35

MR COSTELLO: I also tender the statement of Peter Chun dated 31 August 2018 in respect of Avanteos Investments Limited in response to Rubric 6-37.

THE COMMISSIONER: Exhibit 6.213.

EXHIBIT #6.213 STATEMENT OF PETER CHUN DATED 31/08/2018 IN RESPECT OF AVANTEOS INVESTMENTS LIMITED IN RESPONSE TO RUBRIC 6-37

MR COSTELLO: I tender the statement of Dr Lisa Maree Butler Beatty dated 21 August 2018 in respect of Colonial Mutual Superannuation Limited in response to Rubric 6-36.

THE COMMISSIONER: 6.214.

EXHIBIT #6.214 STATEMENT OF DR LISA MAREE BUTLER BEATTY DATED 21/08/2018 IN RESPECT OF COLONIAL MUTUAL SUPERANNUATION LIMITED IN RESPONSE TO RUBRIC 6-36

MR COSTELLO: Turning now to NULIS Nominees Limited. Mr Thomas Garde, general manager of wealth product and platform enablement, provided a statement on behalf of NULIS. NULIS does not hold group life insurance policies through its MLC Superannuation Fund and MLC Super Fund. Sorry, it does hold group life insurance policies through those two funds. In 2018, the MLC Superannuation Fund deducted amounts from 131 member accounts for income protection cover, 738 accounts for life insurance cover, and 738 accounts for TPD insurance cover. This amounts to only .2 per cent, one per cent and one per cent of member accounts respectively.

On the other hand, the MLC Super Fund deducted amounts from 159,177 member accounts for income protection cover, 632,800 member accounts for life insurance cover, and 618,510 accounts for TPD insurance cover, being 18 per cent, 70 per cent and 69 per cent respectively. NULIS has informed the Commission that there is no prescribed minimum balance condition for its life insurance and TPD policies and that no members have been denied an insurance, death or TPD claim owing to their account balance being below a prescribed minimum.

Mr Garde identified one significance where a NULIS member was denied a benefit under a TPD insurance policy because a member did not meet a prescribed employment status requirement although that was not the ultimate basis for denying the claim. The basis for denying that specific claim was a failure to meet the activities of a daily living test. As recently as 12 July 2018, consideration was ongoing as to whether or not the activities of a daily living test should be replaced with an experience, training, education and rehabilitation test, so as to reduce the number of declined claims of members engaged in casual employment.

Mr Garde stated that in the relevant period, 24 members were denied a benefit under an income protection policy by reason that they did not meet the prescribed employment status requirements of that policy. Mr Garde also acknowledged that members are only eligible to make a claim on an income protection insurance policy if they are permanently employed at the time that they make the claim, although income protection premiums will continue to be deducted while a member is unemployed or employed in a capacity other than permanently unless advised by the member.

NULIS identified four events where its communication with members did not accurately reflect the terms of the group life policy during the relevant period, and an additional event which involved miscommunication by a predecessor trustee. NULIS also noted one event where it was involved in remediation for miscommunication by MLC Nominees. The Commission requested further information in connection with one of these reported breaches. NULIS reported a breach to ASIC on 23 May 2016. It acknowledged that certain members in the MLC MasterKey Business Superannuation Fund had their date of birth amended and were subsequently provided with inaccurate information regarding the level of insurance cover they had, or the level of premiums that had been charged.

Remediation activities were completed and ASIC was notified of the completion of those activities on 17 May 2017. Commissioner, I tender the statement of Thomas Lee Garde, dated 31 August 2018 in response to Rubric 6-38.

THE COMMISSIONER: Exhibit 6.215.

EXHIBIT #6.215 STATEMENT OF THOMAS LEE GARDE, DATED 31/08/2018 IN RESPONSE TO RUBRIC 6-38

MR COSTELLO: Turning to OnePath Custodians, Caroline James, head of assurance and compliance at the trustee benefit review team pensions and investments for ANZ Wealth Australia made a statement on behalf of OnePath Custodians. Between 2014 and 2018 five per cent of members had income protection premiums deducted from their superannuation balances, 35.8 per cent of members for life insurance cover and 28.8 per cent for TPD insurance cover. For the Retirement Portfolio Service Fund, the highest percentage was for life insurance at only 1.4 per cent. OnePath did not have a prescribed minimum balance requirement.

If premiums cannot be paid within a certain period, described as typically 60 days, the member's policy will lapse. Ms James gave evidence both that no claim for death or TPD benefits had been denied by reason of a member's account balance being below a prescribed minimum balance but that in some cases where members had failed to pay their premiums and their insurance had lapsed, their later claims have been denied. During the relevant period, OnePath Group life policies have contained reference to two elements of prescribed employment status: the type of employment, and the minimum number of hours worked in a particular period.

These elements are used to determine a member's entitlement to claim benefits under OnePath's Group life insurance policies. OnePath disclosed that 30 members have been denied claims under one income protection insurance policy because of a prescribed employment status clause. Aside from the operation of this policy, OnePath has not provided the Commission with information about other claims potentially denied due to prescribed employment status. In regards to member communications, OnePath has disclosed 82 incidents where communications with members did not accurately reflect the terms of a group life policy.

OnePath limited its list of incidents to those with a $10,000 actual gain or loss that represent actual or potential compliance events with regulatory obligations. The miscommunications disclosed to the Commission include members being incorrectly informed that cover was active when it was not, members being provided with inaccurate information about the relationship between age and premiums and incorrect verbal advice given by telephone. Commissioner, I tender the statement of Caroline Michelle James dated 31 August 2018 provided in response to Rubric 6-39.

THE COMMISSIONER: Exhibit 6.216.

EXHIBIT #6.216 CAROLINE MICHELLE JAMES DATED 31/08/2018 PROVIDED IN RESPONSE TO RUBRIC 6-39

MR COSTELLO: Turning now to the industry funds, Mr Paul Schroder, group executive product brand reputation, provided a statement on behalf of AustralianSuper. The percentage of AustralianSuper fund members that had accounts where insurance premiums were deducted between 2013 and 2018 was on average 37.6 per cent for income protection cover, 61.6 per cent for life insurance cover, and 58.5 per cent for TPD insurance. During the relevant period, 126 members were denied an insured death or TPD benefit by reason of the fact that the member's account balance was below a prescribed minimum balance. The account had not received employer contribution for 13 months and the member was no longer paying insurance premiums.

AustralianSuper stated that it has considered the operation of clauses of insurance policies which make prescribed minimum balances relevant to coverage or to the extent of a benefit payable as part of the overall insurance benefit design. AustralianSuper explained that these clauses have been inserted into its policies to prevent erosion of member account balances. Mr Schroder has not identified any members or beneficiaries who have been denied a benefit under a life insurance or TPD insurance policy or have received a reduced benefit by reason of the fact that the member did not have a prescribed employment status. However, members are not covered by AustralianSuper's insurance policies if they meet certain definitions of pre-existing illness or injury.

Mr Schroder states that no member has been denied an income protection benefit or received a reduced benefit by reason of the fact that the member did not have a prescribed employment status. As to rebates and profit sharing, AustralianSuper disclosed that it has been party to arrangements with a number of insurers and two administrators in the relevant period. Mr Schroder states that none of these arrangements involve profit sharing. In one case, Mr Schroder identified that although an arrangement with CommInsure was described as a profit sharing arrangement, payments received by AustralianSuper were paid into the administration reserve and used entirely for the benefit of insured members.

Commissioner, I tender the statement of Paul Johan Schroder dated 30 August 2018 and provided in response to Rubric 6-40.

THE COMMISSIONER: Exhibit 6.217.

EXHIBIT #6.217 STATEMENT OF PAUL JOHAN SCHRODER DATED 30/08/2018 AND PROVIDED IN RESPONSE TO RUBRIC 6-40

MR COSTELLO: Mr Jason Sommer, S-o-m-m-e-r, provided two statements on behalf of Sunsuper. During the relevant period, insurance was offered by Sunsuper through its Sunsuper Superannuation Fund. Sunsuper informed the Commission that no Sunsuper members have been denied an insured death or TPD benefit claim by reason of the fact that the member's account balance was below a prescribed minimum balance. Sunsuper ceases deducting premiums and a member's cover ceases when a member's account falls below $1500 balance and employer contributions have not been received for 12 months.

Members are notified on multiple occasions that their cover will cease if they fall into both of these categories. Mr Sommer confirmed that a member can claim for death and TPD insurance benefits regardless of their balance if they have paid the relevant insurance premium. For example, a Sunsuper member can receive insurance cover where their balance remains below $1500 if they also receive employer superannuation contributions. Mr Sommer reported that there were no Sunsuper members who had been denied a benefit under a death or TPD policy by reason of the fact that the member did not have a prescribed employment status.

He stated that Sunsuper had no prescribed minimum employment status requirements for the payment of death or TPD benefits. Sunsuper identified 29 members who had been denied a benefit under an income protection insurance policy by reason that the person did not meet the prescribed employment status requirements of the policy. The prescribed employment status definition requires employees to be working at least 15 hours per week and be classified as permanent part-time or full-time when they commence their employment.

Sunsuper also disclosed that it was party to two arrangements with third parties, Suncorp and AIA Insurance Limited. Sunsuper has submitted to the Commission that they have not received rebates in its personal capacity under the arrangements. It is entitled to a rebate under the profit share arrangements and those rebates have been used to subsidise members' insurance premiums, invest in improving its claims management processes, and to cover administrative costs. In respect of member communications, Sunsuper disclosed 12 instances where it had communicated with members in a way that did not accurately reflect the terms of the group life policy.

These instances include issuing an insurance guide which contained incorrect insurance premiums, and issuing a corporate plan guide that contained an incorrect definition of permanent employment. Commissioner, I tender two statements of Jason Brett Sommer. The first dated 12 September in answer to Rubric 5-73.

THE COMMISSIONER: Exhibit 6.218.

EXHIBIT #6.218 STATEMENT OF JASON BRETT SOMMER DATED 12/09/2018 IN ANSWER TO RUBRIC 5-73

MR COSTELLO: The second dated 12 September in answer to Rubric 6-42.

THE COMMISSIONER: Exhibit 6.219.

EXHIBIT #6.219 STATEMENT OF JASON BRETT SOMMER DATED 12/09/2018 IN ANSWER TO RUBRIC 6-42

MR COSTELLO: Mr Noel Lacey, the head of insurance complaints and compliance, provided two statements on behalf of United Super Proprietary Limited more commonly referred to as CBUS. No members of United Super have been denied an insurance, death or TPD benefit claim by reason of the fact that the member's account balance was below a prescribed minimum balance. Where there have been no employer contributions to a member's account for six months and a member's account balance falls below $1200, premiums will stop being deducted and the insurance coverage will cease. Mr Lacey states that CBUS does not include a prescribed employment status requirement in its life and TPD insurance policies and as such no members have been denied a benefit for that reason.

During the relevant period, Mr Lacey identified denials of benefits under income protection insurance policies by reason of the operation of a prescribed employment status requirement. United Super also disclosed that it was party to two agreements with third parties pursuant to which it receives rebates in respect of coverage offered under group life policies. Those arrangements were as follows: during the relevant period, United Super had two profit sharing arrangements that applied within the fund's policies, one with Hannover Life and the other with TAL.

These arrangements were described by United Super as reconciliation arrangements, meaning that if the premiums paid by the fund over a given period were too high, the fund would be reimbursed the difference between the premiums paid and what should in fact have been paid. Conversely, if the premiums paid by the insurer are too low over the given period, the fund is obliged to pay the insurer the difference. CBUS made one disclosure of a major incident during the relevant period where communications with members did not accurately reflect the terms of the group policy. Its external administrator, Super Partners, informed the fund of errors in the administration of member accounts between 2010 and 2013.

These errors included incorrect administration of premium deductions, incorrect calculation of members' level of cover and incorrect commencement and cessation dates for insurance cover. As a result of these errors, members' annual statements may have contained incorrect information regarding premium deductions and insurance cover over a number of reporting periods. APRA and ASIC were informed of the issue. CBUS engaged in a remediation program and implemented measures to ensure members had not been disadvantaged by the error. ASIC finished its investigation into the matter and notified United Super in February 2017 that no enforcement action would be taken.

Commissioner, I tender two statements of Noel Lacey. The first in answer to Rubric 5-74 and dated 12 September 2018.

THE COMMISSIONER: Exhibit 6.220.

EXHIBIT #6.220 STATEMENT OF NOEL LACEY DATED 12/09/2018 IN ANSWER TO RUBRIC 5-74

MR COSTELLO: The second in answer to Rubric 6-43 and dated 31 September.

THE COMMISSIONER: 6.221.

EXHIBIT #6.221 STATEMENT OF NOEL LACEY DATED 31/09/2018 IN ANSWER TO RUBRIC 6-43

MR COSTELLO: Finally, Commissioner, Hostplus. Mr Colin Cassidy, national insurance manager, provided a statement on behalf of Hostplus. During the relevant period, Hostplus provided default death insurance and combined death and TPD insurance to members. The amount of coverage offered was determined by the kind of employment the member engaged in and was stepped by member age. Hostplus also offered members voluntary income protection cover with members able to select the amount of coverage. On average, group life insurance premiums were deducted from 994,380 member accounts in each year from 30 June 2013 to 30 June 2017. By way of example, on 30 June 2018, 82.6 per cent of member accounts had amounts deducted for death insurance, 81.2 per cent for TPD insurance, and 3.1 per cent for income protection insurance.

Hostplus does not have prescribed minimum balances or prescribed employment status clauses in its group life policies. Hostplus stated that it has not considered introducing clauses imposing prescribed minimum balance or prescribed employment status. Mr Cassidy disclosed that during the relevant period Hostplus was party to arrangements with two insurers, OnePath Life Limited and MetLife, and two external administrators. None of those arrangements involved profit sharing. Hostplus identified an issue in respect of member communications in its 29 January 2018 submission to the Commission which involved an error in the calculation of insurance premiums in 2013.

Mr Cassidy gave evidence by way of his statement that Hostplus considers that to be the sole instance in the relevant period where it has communicated with its members in a way that did not accurately reflect the terms of a group life policy. Commissioner, I tender the statement of Colin Cassidy, dated 31 August 2018, provided in response to Rubric 6-44.

THE COMMISSIONER: Exhibit 6.222.

EXHIBIT #6.222 STATEMENT OF COLIN CASSIDY, DATED 31/08/2018 IN RESPONSE TO RUBRIC 6-44

MR COSTELLO: Commissioner, that brings us to the next case study which involves REST. The witness is Lachlan Ross.

THE COMMISSIONER: Yes.

<LACHLAN GAMBIA ROSS, SWORN [2.21 pm]

<EXAMINATION-IN-CHIEF BY MR STOLJAR

THE COMMISSIONER: Do sit down, Mr Ross. Yes, Mr Stoljar.

MR STOLJAR: Now, your full name is Lachlan Gambia Ross?---Yes.

And your business address is level 5, 321 Kent Street, Sydney?---Yes.

And you're attending today to give evidence pursuant to a summons served upon you by the Commission?---That's right.

Do you have a copy of that there with you, the summons?---I do.

I tender the summons to Mr Ross.

THE COMMISSIONER: Exhibit 6.223, the summons to Mr Ross.

EXHIBIT #6.223 SUMMONS TO MR ROSS

MR STOLJAR: Now, Mr Ross, you've prepared two witness statements, and I will deal with them in order. The first is in respect of Rubric 6-41, and in particular part F of that Rubric. You prepared a witness statement in that regard on 31 August 2018?---I did.

And that has, I note for the record, number WIT.001.0144.001. Now, is the content of that statement true and correct to the best of your knowledge and belief?---It is.

I tender Mr Ross' statement in respect of Rubric 6-41 of 31 August 2018.

THE COMMISSIONER: That statement and its exhibits becomes exhibit 6.224.

EXHIBIT #6.224 STATEMENT AND EXHIBITS OF MR ROSS DATED 31/08/218 IN RESPECT OF RUBRIC 6-41 (WIT.001.0144.001)

MR STOLJAR: Now, your second statement, Mr Ross, is in respect of Rubric 6-65. And in particular, questions 1 to 10 inclusive and 15 of that Rubric. And that's dated 7 September 2018?---That's correct.

And I note for the record that that has ID number WIT.001.0154.001. Now, is the content of that statement true and correct to the best of your knowledge and belief?---It is.

I tender Mr Ross' statement in respect of Rubric 6-65 dated 7 September 2018.

THE COMMISSIONER: That statement becomes exhibit 6.225.

EXHIBIT #6.225 STATEMENT OF MR ROSS IN RESPECT OF RUBRIC 6-65 DATED 07/09/2018 (WIT.001.0154.001)

MR STOLJAR: Now, Mr Ross, Counsel Assisting has some questions for you?---Thank you.

THE COMMISSIONER: Yes, Mr Costello.

<CROSS-EXAMINATION BY MR COSTELLO [2.23 pm]

MR COSTELLO: Mr Ross, approximately how many members does REST have?---Around two million.

And how many of those members have life insurance through REST?---Between 1.4 and 1.5 million.

You're the service delivery manager insurance?---That's correct.

And you say in your statement that – or your statements that your role includes review of every claim declined by an insurer?---The team that I manage review the denied claims, yes.

And when you say by an insurer, do you mean AIA?---I do.

Are there other insurers?---There are.

And who are they?--- Hannover and also we have had insurers prior to AIA, and we do from time to time still have claims made on those policies which we would review any declines of them as well.

Is AIA the current group life insurer for REST?---Yes.

And for how long has AIA been the group life insurer?---I believe they were appointed in 2004.

And approximately how many claims are made against the REST group life policies each year?---I expect it would be in the vicinity of 6000 this year.

6000 this year?---Yes.

And how many of those do you expect would be declined?---In total, REST pays around – over nine out of 10 claims. So this year I would expect we would decline in the vicinity of 400. That's not quite 10 per cent because there's a delay in receiving claims as well.

I see. And what's the annual premium bill that REST pays to AIA, in general terms?---750 to 800 million this year.

And is that variable on anything other than the number of members in the fund?---REST has had two million members for quite some time. The driver is the level of premium more than the number of members, I would say.

And how often are premiums reviewed under the group life policy?---It varies, but between two to three years there is a pricing review.

That's a – that's a right of the insurer to have a pricing review every two to three years under the policy?---I'm not sure if it's a right of the insurer. That's not my specific area of policy but a - - -

In practice that's what you understand to have happened?---Yes.

Thank you. Does REST understand part of its role as being to assist members with their life insurance?---What do you mean by "assist members with their life insurance"?

Provide them with information about cover?---Yes.

Yes. Assist in the making of a claim against the policy?---Yes.

Has REST agreed to comply with the insurance in super voluntary Code of Practice?---I believe we have expressed our intent to comply with that, yes.

And do you know when you intend to comply with it?---I believe by the end of 2019.

Is that a document you've had any involvement with?---No.

Are you familiar with its terms?---Broadly.

I imagine that parts of it will affect your role?---Correct. There is a section on claims handling.

And are you aware of any internal debate within REST about whether the voluntary code should be adhered to?---No, I'm not.

All right. Can I just take you to the voluntary code. It's RCD.0025.0005.0606. This is the code, Mr Ross. You can see at the top there are three bodies noted. AIST, ASFA and FSC?---Yes.

Is REST a member of any of those bodies?---I believe we are a member of AIST and ASFA, yes.

The first two?---Yes. I'm not sure if we're a member of the FSC.

Thank you. If I could take you to 0615 of that document. Mr Ross, you might not be in a position to answer all of these questions but I just want to put them to you to understand the extent to which the code differs from RESTs current practice. You can see there clause 5.17, which is headed Communications During the Term of Your Cover. And it says that:

> *We will provide you with an annual statement which includes the following information.*

And that information includes the types of cover you hold and how much you are insured for, your current premium, an explanation for any changes in your premiums, the policy's standard exclusions and the benefit limitation terms that may impact your entitlement to insurance benefits:

> *If we have not received any eligible contributions in the previous year or if your eligible contributions are less than $1800 for the previous year, a warning that your premiums may be inappropriately eroding your account balance.*

Now, just pausing there for a moment, are you familiar with RESTs annual statements to its members?---Broadly, yes.

Are you a member of the REST fund yourself?---I am.

And you receive an annual statement?---I do.

All right. From your own experience and perhaps that – at work, are you aware which of those from (a) to (e) REST is currently complying with?---I believe we comply with (a) to (d). I'm not sure if we have the specific wording included in (e).

All right. And then what about (f) to (j):

> *information about how to contact us to discuss options if you want to change the terms, how you can increase, decrease or cancel your cover, information about the code.*

You obviously don't comply with now:

> *Our rules for automatic cessation of cover and what to do in the event of a claim.*

Do you comply with those?---I would believe we do.

Do you think you comply with (i):

> *Our rules for automatic cessation of cover.*

?---I believe we have disclosure around what is required for REST to know in order for cover to be in place.

What are the rules for automatic cessation of cover that currently exist within RESTs policy? Perhaps I will put it a little bit more specifically to help you. If you were in the hearing room when I just delivered that rather long address, you would have heard me speak of two types of clauses, and these are two clauses that you deal with in one of your witness statements?---Yes.

The first was a prescribed minimum balance clause?---Yes.

Does REST currently have a prescribed minimum balance clause?---There is no prescribed minimum balance clause in our policy, no.

There has been historically, though?---Historically, there has been part of the policy, which is dependent on having a minimum balance but that works in tandem with another part of the policy as well.

And what's that other part?---That the member needs to be still employed by an employer who is making contributions to REST on their behalf.

All right. We will come back to that. If I could then take you, perhaps, to the part of the code that will be more readily applicable to you. At 0617 of that document. This is clause 7, Handling Claims. And perhaps if we could bring up 0618 as well on the screen. Have you looked at this before?---It has been some time but I have seen it before, yes.

All right. Perhaps before we get to the detail of the clause, could you explain to me what the role of the superannuation trustee is in connection with claims under group life policies?---Yes. The – as you spoke to earlier, the trustee is the policyholder. I think of particular importance, if a claim is declined, the trustee will review the decline to make an assessment about whether it is fair and reasonable. The trustee also has a role in the payment of benefits, because most benefits are released into the member's superannuation account, and then the trustee must make a determination about whether that meets a condition of release and can be released to a member.

All right. So for, say, an injured member who wants to claim, say a seriously injured member who wants to make a claim on a total and permanent disability policy - - -?---Yes.

- - - is the role of REST to assist – is it any role of REST to assist the member in making that claim?---In my experience, REST certainly takes its role very seriously to make members aware they have an insured benefit and it is very interested that they receive any benefit they're entitled to, yes.

I just want to understand the role a little bit, because in a normal policy, say a TPD policy, that is outside of superannuation, the policyholder is the individual and the policyholder makes a claim and to the extent there is a dispute, it is a dispute as between the policyholder and the insurance company?---Yes.

Group life is substantially different from that because of the interposition of the superannuation trustee, somewhere in the middle between the policy – sorry, between the superannuation fund member and the insurance company?---Yes.

And what I'm trying to understand is what REST conceives its role as being. Are you an intermediary between the two, are you there to fight for the member, or are you there to defend the insurance policy on behalf of the insurer?---You know, RESTs view is that insurance is very valuable to its membership. And ultimately, it's REST that has made the decision to provide this benefit to its members. And it works very hard to make sure that any benefits that a member is entitled to are paid to the member.

And how does it do that?---It works with the insurer and in RESTs case we have an administrator, an external administrator to design the claims process and monitor claims, make sure that any benefits members are entitled to are paid.

All right. Well, understanding that let me now try and relate it to the terms of the code. You will see there at 7.3 it says "We" – that's for relevant purposes REST:

> *will oversee the claims process and help you navigate the process.*

Is that something you would describe REST as doing now?---Yes.

And 7.4:

We will be responsible for overseeing the conduct of the insurer and any service provider we engage in the claims process, in line with the standards in section 12 of the code.

Are you aware of the standards in section 12?---No.

Okay. Well, I will ask you the question without reference to section 12 for now. Do you see RESTs role as overseeing the conduct of the insurer and any service provider that you engage?---I think that's a fair statement, yes.

All right. And while we're in 7.4, there's talk of service providers and you've already mentioned, I think, a service provider. What service provider did you have in mind when you spoke of one a few moments ago?---Sorry, our external administrator is AAS.

Did you say AAS?---Yes. That's part of Link Group.

And what's their role?---Their role as it pertains to what, sorry, Mr Costello?

What is the role that you have engaged – you've contracted with AAS. You, sorry, being REST, have contracted with AAS. And what have you asked them to do?---Do you mean specifically around claims?

Yes?---Yes. When a member wants to make a claim, they call REST. And the person they will be speaking to works at administrator SS. They will be provided claims forms documents to help them navigate the claims process. That will be done by SS as well. The initial information will be gathered by our administrator. It will then be passed to our insurer. They are also involved with the payment of insured benefits as well, TPD and death benefits. As the insurer, when there is a benefit passes it back to our administrator SS who then puts it into the member's account.

Does AAS do functions separate from insurance?---Yes, they do.

So correct me if I'm wrong, it sounds to me like the role of AAS is in some respects an outsourcing by REST of at least parts of the insurance claims handling process in the insurance administration?---Yes.

And other parts of the process are done internally by you and your staff?---Yes.

All right. Just while we're in clause 7 there, if that box could come done, please, and I could direct your attention to 7.12. And you may or may not have noticed there is a screen next to you there if it's easier for you to look at but it's a matter for you. 7.12 is on 0618. Can you see it there? It's the first under – the first paragraph under the heading Making a Claim on the second page?---Yes.

Continuing:

If you tell us that you wish to make a claim we will help you provide the information for your claim or direct you to the appropriate forms or information online or email these to you.

Do you do that now?---We do.

And then it says:

If we receive a completed claim form from you within five business days we will acknowledge receipt, assess whether you have provided all information, provide you with a summary of the claims process, and either provide the claim to the insurer or tell you that you are not eligible to make a claim.

Do you do that now?---We do. I – I don't have information about whether we do that in five business days or not.

Do you benchmark it internally, how long it takes you to process a claim once it's received by REST?---We do monitor it, yes.

Do you have an idea what it might be?---Not off the top of my head, no.

Is that the sort of metric that your team's performance might be assessed by?---It's an important metric for us but it's not a KPI if that's what you're driving at.

Do you have any understanding of what it might be, how many days it might be?---We're doing a lot of work on our claims process at the moment. We would have some claims where it's happening on the same day. We would have other claims where it takes longer. I don't have an average that I could give you, though.

All right. There's just one more clause that I want to take you to in this code. It's on page 0613. Can you see there 4.31, Duplicate Insurance Cover?---Yes.

It says:

When you become a member of our fund we will ask your permission to help you to determine whether you have any other insurance cover in a superannuation fund. The purpose of this is to ensure you do not unintentionally pay premiums for multiple insurance covers or for any cover on which you may be unable to claim. If we identify that you have other insurance cover, we will let you know.

Do you know how many REST members have duplicate funds?---No, I do not.

Do you know if that's something that REST monitors at the moment?---I'm sure we do as much as that information is available to us.

Again, this might not be something that you can speak to, but are you aware that under the Superannuation Industry Supervision Act there is an obligation in some circumstances for trustees to consolidate duplicate accounts? Is that something you're aware of?---No, not specifically.

All right. What you may be more aware of, though, is that in the current group life policy by REST, there is an exclusion clause based on multiple policies. Are you familiar with that clause? I can take you to it if - - -?---That would be helpful.

Of course. It's exhibit LGR-3 to your witness statement, 6-41, which is RST.0006.0001.0658. Mr Ross, is this the current policy document for REST group life?---Yes, it is.

All right. And then if I could take you, please, to page 0673. Can you see here the clause is entitled Duplicate Accounts and it says:

> *An insured member will only be eligible to claim a death, terminal illness or TPD benefit under the REST super product of the trust under one member account.*

?---Yes.

Continuing:

> *Where duplication of insurance cover is identified, the member's accounts will be merged –*

by you –

> *and only one death, terminal illness or TPD benefit will be payable.*

?---Yes.

Continuing:

> *If the amount of cover differs between the accounts we will pay the higher amount. And any duplicate cover will be cancelled from the date it commenced and any insurance premiums paid with respect to the duplicate cover will be refunded by us to you for payment to the member's account.*

?---Yes.

All right. Are you aware that those types of clauses have received some public attention in recent times?---Just – is the premise of your question, Mr Costello, that this clause refers to accounts other than REST accounts?

No, that's not the premise of my question?---So - - -

You understand the clause as applying to superannuation accounts held outside of REST?---No, this clause only applies if unknown to REST, we hold multiple accounts - - -

Yes?--- - - - on behalf of a member.

Yes. That's as I understood it?---Okay.

Are you aware that these types of clauses have received some public attention recently?---No.

All right. Are you aware of whether this clause has been enforced by AIA in recent times?---No, I'm not.

Do you think that the presence of this clause makes it all the more important that REST identify if there are members with duplicate accounts with REST?---I totally agree, and we do.

And how do you do that?---I mean, REST is a – is a very large fund.

Yes?---And from time to time we will have accounts set up and when accounts are set up, we sometimes receive very limited information from an employer. So we could receive an account which has a different surname and different date of birth, but unbeknownst to us it is a duplicate account. So if we can identify a duplicate accounts we merge them and refund insurance premiums immediately.

And are you aware of whether or not this duplicate account clause has existed in policies issued to REST by AIA before 2017?---I'm not aware, no.

All right. But you would agree, wouldn't you, that having members paying insurance premiums for – in circumstances where they would not be entitled to the cover, is something that REST is obliged to avoid?---I would agree, yes.

Yes. Thank you. All right. I want to – that document can come off the screen. Thank you. Commissioner, I should just tender the voluntary code.

THE COMMISSIONER: Insurance in Superannuation Voluntary Code of Practice, RCD.0025.0005.0606, exhibit 6.226.

EXHIBIT #6.226 INSURANCE IN SUPERANNUATION VOLUNTARY CODE OF PRACTICE (RCD.0025.0005.0606)

MR COSTELLO: Thank you, Commissioner.

Mr Ross, we've already mentioned prescribed minimum balance clauses?---Yes.

And you said that REST no longer has a prescribed minimum balance clause, I think. Was that your evidence?---My evidence was there is no prescribed minimum balance clause currently.

And there has been in the past, working in combination with another – I think in fairness to you you said working in combination with another requirement or another definition?---Correct. There were two parts of the policy that worked in tandem, one of them related to account balance, yes.

Yes. All right. Perhaps the easiest way to do it is if I take you to the paragraph of your witness statement in answer to Rubric 6-41 where you deal with the history of prescribed minimum balance clauses in the AIA group life policies. Sorry, Commissioner, the document ID for the 6-41 witness statement is, I hope, WIT.0011.0144.0001 – 001.0144.0001. And if we could go to the second page. Perhaps have the second and third pages on the screen. You will recall, Mr Ross, in paragraph 6 here you gave some explanation of the history of prescribed minimum balance clauses in the AIA policies?---Yes.

You remember that? And you started answering it by reference to the period that we put to you which was 1 July 2013 to 31 December – sorry, 1 July 2013 to date was the period that we asked you for?---Yes.

And you explained that from 1 July 2013 the relevant policy was a 2008 policy that had been – I think I am right in saying retrospectively varied by an agreement in March 2011. Is that what you remember saying? Feel free to have a look at 6(a) of your statement?---Did you say "retrospectively varied" in your question to me?

I did?---I don't think it has been varied. I think that's when the agreement came into effect but it had been in force until that point.

Right. I'm not sure that I understand that, but it might not be important. I was just taking your words:

> *By agreement dated 4 March 2011 and with retrospective effect from 5 December 2008.*

?---Yes.

Did the 4 March 2011 agreement vary an earlier agreement or did it just have force as of an earlier date?---I'm getting into muddy sort of legal waters here, Mr Costello. I think what happened was the policy was in force. I think the final legal signatures may have happened in 2011 but this is - - -

Okay?--- - - - well before my time.

All right. No, that's fine. The more important part is the second part of 6(a) where you say:

The REST super 2008 death and TPD policy provided continued cover for death for members who ceased employment with a contributing employer, subject to a prescribed minimum balance of $1200.

?---Yes.

So in more simple terms, under this policy, a member with a balance of $1000 did not have coverage for death?---No. As in no, that's not correct.

Sorry?---What happened – all REST members who have insurance cover is – what begins the insurance cover is a contribution from an employer.

Yes?---At that point they continue to have cover. However, if they stop working for the employer who has paid the – paying contributions to REST they continue to have cover for 71 days.

Yes?---In order to keep it after that point, they would have needed to have an account balance of more than $1200.

Yes. So if they – I think perhaps what I had failed to put in my question to you was an unemployed member who had been unemployed for more than 71 days and had a balance of less than $1200 would not have cover. Is that right?---More or less, yes. Just that – not necessarily unemployed. Not receiving - - -

It wouldn't be limited to people who were unemployed?---It's specific to an employer who is making contributions to REST.

Does that mean then that a person who was employed but whose employer was not making compulsory contributions could be caught by this clause?---They would not be covered by the clause, yes.

Yes. Well, when you say they wouldn't be covered by the clause, would they have insurance coverage?---Well, it would depend. Employer is a defined term in our policy. So where employer is referenced in our policy, it is referenced as an employer who is making compulsory superannuation contributions to REST on behalf of that member.

All right. And you go on to say there in addition, the 2008 policy introduced continued cover for TPD with a prescribed minimum balance requirement of $3000?---Correct.

Could you explain "continued cover"?---So that was what I was referring to before. When members join and get a compulsory contribution, their insurance cover starts. So the principle at REST is cover for as many people as possible. And they will have that cover until they are no longer employed by that employer making contributions to REST. But they will continue to have that cover for 71 days. I believe the principle being, you know, time to find a new job. And then they will

continue to have cover after that but as long as they have an account balance over either the $1200 for that particular period there or the $3000 for the period I'm referring to there too.

I see. So there was a change made to that clause that you set out in (b) which we can probably skip over because there was a further change made and from 1 December 2017, which is the policy that I have already taken you to - - -?---Yes.

- - - the position is what in respect of prescribed minimum balances?---Well, this clause is not in the current policy.

Right. And why was that change made?---From what I've reviewed, the change was made to align with principles of clarity and simplicity.

From 1 July 2013 to 30 June 2018 you say 11 death benefits claims were declined because of the application of the clauses we've been talking about?---Yes.

And 36 TPD claims were denied?---Yes.

And do you agree that it's important that members have an awareness of their level of cover?---I think it is important, yes.

And it's important that REST communicates accurately with members about their level of cover?---Yes, it is.

And these types of clauses make it difficult to communicate with members about their level of cover in some respects because they are necessarily complicated in their factual application. Do you agree with that?---I would agree that these types of clauses do make it more complicated and hence why in 2017 we removed it. But there is a balance to be struck as well.

Between?---Between members with low balances who may not be working, being charged insurance premiums, and also having simple clear cover. So what REST had for that five-year period and has now removed, those high level principles are what has been proposed by the government to come back into force, essentially this idea of a account balance under which premiums don't get charged, and a period of time after unemployment in which premiums don't get charged either.

And - - -?---It is a difficult question.

Yes?---And a balance needs to be struck.

And it's a contested question in some respects of public policy?---Yes.

And what needs to be weighed is, on the one hand, the benefit to a member of having continued insurance cover?---Yes.

Versus, what, sometimes described as erosion of balance?---Yes. I think it's a difficult question.

Yes?---And you're correct, a contested one at the moment.

And does REST have a view about that, about that question, whether insurance coverage should continue for as long as it can, or whether it is better for it to stop in order to cease the erosion of a low balance account?---Well, I think it's – you can see from our policies that it has been a question that has been weighed and considered over the period. I can't speak for what, you know, the position might be in regards to the public policy debate at the moment.

Are you aware of REST making any contribution to that debate?---I believe we may have, yes.

And how was that done?---I believe we may have appeared at a Senate Committee.

All right?---We may or may not have - - -

You don't need to tell me anything more about that. Thank you. That's not a - - -

THE COMMISSIONER: The Parliamentary Privileges Act cuts in at some point.

MR COSTELLO: It is a risk and I could see the Commissioner glaring at me?---Better you than me, Mr Costello.

Do you agree that - - -

THE COMMISSIONER: No promise, Mr Ross. No promises.

MR COSTELLO: Do you agree that one of the most important documents for communicating levels of insurance cover to members is annual statements?---It's one of the important ones, yes.

It's the type of communication a member might be more inclined to have regard to?---I mean, it's certainly an important communication for a superannuation fund, yes.

Do you think it's more likely that a member would read an annual statement that tells them what their superannuation balance is than, say, a letter setting out changes to a complicated policy of insurance?---I'm not sure I can answer that question. When you say a complicated – a letter outlining complicated changes to insurance, I think members are interested in their annual statements, yes.

Yes. Thank you. Are you aware of whether in the period that REST had prescribed minimum balance requirements in its group life policies, it had systems that set the

amount of coverage of members caught by that clause at zero in their annual statement?---Sorry, I don't – I don't understand the question.

Well, imagine a person who by operation of one of the clauses that you have explained in paragraph 6(a) and 6(b) of your statement, a person comes within the exclusion and does not have coverage. On that person's annual statement, would the statement display their coverage as zero, or would it display their coverage as another amount?---Well, as long as REST is aware or had been aware of their employment status, it would display a zero, yes.

It would?---Yes.

REST had those policies in place?---Yes.

And how does REST become aware of the person's employment status?---We would rely upon the employer, or also we would rely upon the member to let us know.

That is, if the – if the member has ceased work with an employer, either the employer or the member tell REST?---Yes.

And if that has happened, REST is then able to look at what the person's balance is and if the balance is below the prescribed minimum in the annual statement, REST would set the person's coverage at zero?---Correct.

And you've seen that happen in statements?---Yes.

And in your experience, how promptly are notifications made to REST by employers?---It's not something that I'm close to.

Are you aware of the extent to which these clauses operated to deny coverage in circumstances where RESTs information was wrong because it hadn't been notified by an employer or an employee?---So there have been cases where a claim has been declined where REST has subsequently found out that a member was not employed.

Is that a common occurrence?---I wouldn't say it's common and hence the quite low numbers of declines.

Right?---In my witness statement.

In your statement at paragraph 14, you've set out the various ways that members were advised of prescribed minimum balances. Perhaps we could go – thank you. And you informed members of the terms of their insurance cover and the circumstances in which cover would cease and provided members with information to make them aware of the importance of notifying REST of changes to their employment status. How are changes of employment status notified to REST? Is there a form that needs to be used?---Generally, that would come from the employer when they make their contributions to REST on behalf of their employees.

When they make – when they make the final contribution, do you mean?---Yes. So REST has some very large employers who contribute. And they would generally pay monthly. And we would typically receive a file that would have new members, existing members, and exited members or members that were no longer employed by them.

And in your witness statement, you use a few times the term a REST employer?---Yes.

What's a REST employer?---Well, I think that gets back to what I was talking about with a policy. In terms of claims, employer is a defined term in our policy, and without referencing my witness statement, I believe what I'm referring to is employers who are contributing to REST.

That's any employer who's paying contributions to a REST member's fund – account?---Yes.

Thank you. Now, if a REST member was caught by a prescribed minimum balance clause and no longer had coverage, when did REST stop charging premiums?---Just – when you say "caught", it was quite intentional to stop charging premiums to protect the balance from going down. So I wouldn't use the word "caught" - - -

Well, I don't mean it pejoratively. I just mean the clause has an effect and you say it was an effect that was intended?---Yes.

And my question was when did you stop charging premiums when that clause came into effect?---As soon as we became aware.

In some cases you never became aware except by reason of the fact that a claim was made?---Yes.

And in those circumstances the premiums were refunded when?---As soon as we became aware. So when we became aware a date would have been entered into our administration system and that would have automatically triggered the refund of premiums.

All right. I just want to take you quickly to an example of one of these clauses in operation. I think it's an example of one of these clauses in operation. Can I take you, please, to RST.0011.0001.0137. Now, this is a type of letter that I imagine you're very familiar with?---Yes.

Is this what is referred to sometimes as a procedural fairness letter?---Yes, that's correct.

All right. And so this is a letter that AIA issues to a REST member who has made a claim when they formed a preliminary view of how they intend to deal with the claim. Is that right?---Yes.

And are these typically copied to REST as well?---No, we're not copied in on these.

Right. So you don't have any involvement in the process, at least at this point in the claims process, REST isn't involved?---No.

This is just between the REST member and the super fund – sorry, and the insurer?---Yes.

All right. So this is a TPD claim. And you can see there that the insurer has reached the preliminary view that the claim should be declined?---Yes.

Continuing:

...on the basis that your insurance cover had already ceased.

Can you see there that the date of injury that caused the injury – sorry, the date of the injury that caused the total and permanent disablement was 1 August 2016. See in the box there under the heading claim?---Yes.

And then if we go over the page to 0138, the insurer sets out its reasons for the preliminary view that it has formed. I will just give you a moment to read that. All right. So I think that in general terms, without going to all of the detail, what happened here was coverage commenced on 9 March 2015. And the member ceased work with his then employer on 17 May 2016?---Yes.

And as you explained before, coverage then continued for 71 days from that date?---Yes.

Which meant that it stopped on 27 July 2016?---Yes.

And then the member became totally and permanently incapacitated on 1 August 2016?---Yes.

And at the time, this member had a – a balance that was below the prescribed minimum threshold?---Yes.

And so the reason for the insurer declining this claim has nothing to do with the extent of the member's injury. It's the operation of the clauses that you and I have been discussing already?---Yes.

And the way those clauses operated in this case was the person was about five days outside of cover?---Yes.

When they suffered their injury. And the letter goes on to say that REST did not become aware of the fact that the member had ceased work until 28 August 2017?---Yes.

So this is one of those cases where neither the employer nor the employee has promptly notified REST of the change in employment status?---Yes.

Why would it occur to an employee to notify REST that they had stopped working at their current job?---It could be because they have read the disclosure material that was provided to them when they joined REST or they've read their annual statement.

Does the annual statement tell them to do that?---It talks to the importance of notifying REST if they're no longer employed, yes.

The first option that you just gave is not a realistic one, is it?---What do you mean it's not a realistic one?

That the person would notify you because they've read – what was the document you said?---Well, it was – in this period it would have been the insurance guide, I imagine.

Is that something that many of RESTs two million members do in your experience?---I don't know what they read that we send them, Mr Costello.

Are you aware of how effective your communications with your own members about key insurance terms are?---We hope they are very effective.

My question wasn't one directed to hope. It was do you do any work within REST to ascertain whether or not members understand important insurance terms?---We try and be as clear as possible in all our communications to our members, and we highlight areas we think are of particular importance when we communicate with them.

The – I can show you a document if I need to, but you can take it from me that the preliminary view the insurer had here had expressed here became the final view?---Yes.

And this claim was - - -?---Yes.

- - - declined. Is this the sort of declined claim that REST took into account when negotiating for the new terms that do not include a prescribed minimum balance clause?---Sorry, I don't really understand the question. Took into account when we negotiated our new policy.

Yes. When you negotiated the new policy, the 2017 policy - - -?---Yes.

- - - that we've been to, the prescribed minimum balance clause that were in the older policies were removed?---Yes.

And they were removed, I think you said, for clarity?---Yes.

And for ease of understanding of members, perhaps?---Yes.

Were they also removed because a case like this where somebody misses out on a claim, not for any reason to do with the injury the person has suffered but because they are five days outside of a clause in an insurance policy, was that something that REST took into account in doing away with prescribed minimum balance clauses?---I wasn't involved in the writing of our new policy. But in answer to your question I would say that I doubt the issue of five days or not had any effect on the considerations.

Well, in this case, REST was unaware that the person's employment had ceased?---Yes.

And one consequence of that would be that the person continued to pay premiums?---Yes.

And at the time this person was injured, they were paying premiums for a policy of TPD insurance?---Yes.

And notwithstanding the fact that they were paying for that policy– paying premiums for that policy, because of the operation of a rather technical rule they fell out of the terms of the policy for five days and instead of being entitled to insurance coverage were entitled to a partial refund of their premiums. Is that the sort of circumstance that would concern REST?---Well, I think when the policy was changed, one of the reasons was because of complaints we had received from members.

Complaints received from members?---Yes.

About this type of operation of the clause?---Yes.

THE COMMISSIONER: According to the procedures that then obtained, would this declining of cover have been reviewed by REST?---Absolutely.

In the course of that review, one can only wonder whether attention was given to the notion that PTSD has a specific start date of 1 August, which is the date on which the doctor issued a certificate, but I just wonder what that may say, if anything, about the nature of the review that's undertaken?---What I would say is when they – without having the – the claim file, they would have looked for the earliest date possible under the policy.

No, the premise of my question is one that you rightly test. The premise for my question unstated which needs to be brought to the surface is a challenge to the notion that PTSD, in effect, starts on a day. That's at least not something that intuitively seems immediately apparent?---I would agree with that.

Yes.

MR COSTELLO: Mr Ross, just let me ask you one more question in that connection: once the insurer has made their decision – REST is not informed of this procedural fairness letter?---So this is a preliminary.

That's right?---This is pre the actual decision.

Pre the decision. You're not involved at this point?---No.

A decision is then made, it confirms the preliminary view and that notification is typically made to REST, not directly to the member?---So in this case the notification – sorry, the notification is always made to REST.

As the policy owner?---Yes.

And REST communicates that to its member?---Not until it has conducted – well, sorry, yes, it does communicate that to the member, yes.

Immediately?---I'm not sure in what time period but I would – more or less, yes.

And this is when your team becomes involved because this is a declined claim and your team is responsible for the review of every declined claim?---Yes.

So what then happens within REST? You receive the letter from AIA that declines the claim on the basis set out in the letter, which we can assume is the same basis set out here. What do your team then do?---So it actually doesn't start at our team – my team. It actually goes to RESTs administrator who conduct a first review. It is then forwarded to the trustee and the team will receive a copy of the decline letter plus a copy of the claim file, and they will conduct a thorough view of the claim to see if the decline, they believe, is fair and reasonable.

Is fair and reasonable?---Yes.

And do you know why fair and reasonable is the test?---No, not off the top of my head.

It might be that that's the basis that the superannuation complaints tribunal will - - -?---Yes.

- - - review decisions. So your team will then assess it to determine if it's fair and reasonable. And in a case like this where it's the operation of a clause in a policy, what does that mean? Does that just mean checking the accuracy of the material in the decline letter and the insurer's view as to the operation of the clause?---Yes, they want to check to see that the policy has been correctly applied.

Right. Can I just take you to another document, please. It's RCD.0025.0003.0334. Mr Ross this is ASIC report 529 Member Experience of Superannuation from June last year. Have you seen this report before?---Not that I can remember.

All right. If we could go, please, to page 0349. Which is on page 16 of that document. Can you see there there's the heading changes to or cessation of cover?---Yes.

This is directed, specifically, this part, to insurance within superannuation, and you can see that from the opening words of paragraph 60:

> *One of the specific features of insurance in superannuation is that it's not guaranteed renewable.*

See that?---Yes, I do.

If you could then focus on paragraph 61. It says:

> *Within insurance in superannuation changes may be made to the policy or cover may cease without the member's active consent and in some cases with no timely disclosure about the change at all.*

Do you see that?---I can, yes.

Do you think that one circumstance that would fit within ASICs description there is the operation of the type of clause that we've been talking about, in a case like the one I just took you to?---Well, I certainly think the – in the case we've been talking about, cover may cease without the member's active consent - - -

Well, it absolutely does, doesn't it?---Yes. In the other clause there would be no timely disclosure about the change at all. As soon as REST becomes aware, it will communicate with the member that their cover has ceased.

But part of this is a process issue, isn't it? True it is that when REST becomes aware you will let them know, but that just begs the question of how REST becomes aware. And in this case, which is not an isolated incident, I'm sure you will agree, REST wasn't aware?---No, we were not.

And the reason REST wasn't aware was because it hadn't been told by the employer or the member?---Correct.

And it might be that some fault lies with the employer or the member for that if they had an obligation to let REST know. Or it might be that in circumstances where it's RESTs policy that has that effect, that the onus is on REST to ensure that its information is accurate. Do you accept that?---Well, I certainly think, from what I have seen, REST certainly attempted to ensure its information was accurate.

Can you see in 62 there it says:

We found that members were vulnerable in these situations because the consequences of changes to insurance could have significant ramifications and yet the member may be unaware of these changes.

?---I can see that, yes.

That's, by definition, what happens in a prescribed minimum balance clause, isn't it?---Do you mean specifically in RESTs policy when you say prescribed minimum account clause? I think I would agree that there are ramifications to the member and they may have been unaware of the changes, yes.

It's unlikely that a member with a low balance who ceases employment sets their stop clock for 71 days to know the period they retain in continued cover?---I would agree with that proposition, yes.

It's not realistic, is it? It's the sort of – it's the sort of clause that people involved with the policy, insurers and superannuation administrators, would be familiar with, but it would be unlikely, in most cases, that a consumer, a fund member, would have an awareness of the detailed operation of a clause like that. Do you agree?---I think it's fair that most members probably don't have a detailed understanding of our insurance policy, yes.

And these types of clauses have very significant effects on the cover available to the member?---They determine whether there is cover or there is not cover.

That's right. If I could take you to the next page of the ASIC document. Can you see there at 63 ASIC give an example:

For example, to avoid eroding member benefits unnecessarily, trustees may have nominated a particular threshold for accounts so that if a member's account drops below this amount cover will cease and premiums will no longer be deducted. This means that there is a designated point at which cover will cease without a member doing anything further.

And then if we go further down to 67:

Disclosure about cover ceasing should occur at an appropriate time and in an appropriate way to have the best chance of being useful to the consumer in making decisions about their next steps in light of the change.

See that?---Yes.

Do you agree with that?---I'm not sure the context it's in in this document – I - - -

THE COMMISSIONER: Well, it's cast in terms it's impossible to disagree with, isn't it, Mr Ross, and the real bite in the proposition is to know what's meant by appropriate, appropriate, useful, etcetera. It's the loaded terms in there that do all the

work and you don't quite know what work they're doing, do you?---Not without turning my mind to it a bit more, no.

Well, I think that may be what Mr Costello is asking you to do?---I think that's a fair proposition, yes.

MR COSTELLO: Thank you. At 67 to 70 ASIC give some suggestions. The first suggestion is that trustees trial different approaches to notifying members. How are members notified – assume for present purposes in the example we discussed you were notified by the employer or the member that they had ceased employment. How then would you communicate the operation of the insurance policy to the member?---Because we're going back to when this was in force. As soon as REST is notified that – was notified that a member was no longer employed, it would write them a letter telling them as such, and also to maintain their insurance cover they would need to maintain their account balance over the required threshold.

How would you communicate that? By letter?---By letter, yes.

In the mail? By post?---Yes.

Yes. And ASIC there suggest in 68 that trustees:

> *... trial different approaches to notifying members (using emails or text messages) and consider the use of reminders to nudge behaviour.*

Has REST given any consideration to communicating with members in any way other than by post?---We communicate with our members in lots of ways, yes.

Okay. In about important changes to insurance status?---Yes.

How else do you do it?---Well, if you're – if you're referring again to the minimum account balance we're going back quite a way in time. If we're talking about the death cover, back to 2013, and for TPD and IP up to the end of 2017. We may have communicated this to members by email at the time as well. I'm not sure, though, Mr Costello.

All right. If we could go to the next page of that document, please. There's just one final paragraph I would like to take you to. Can you see paragraph 72 there and the table below it:

> *If trustees cannot be confident that they have timely and accurate information from employers or that disclosure can be provided to warn the member that cover will cease, they should consider whether defaults that rely on data from employers are appropriate, given the needs of the membership base.*

?---Yes.

Now, this is a point that I was putting to you before, that the obligation might be one on the employer or the employee, or it might ultimately be an obligation on REST as the owner of the policy and as the protector of the interests of the members of the fund. Are you aware of whether REST has given any consideration to whether – sorry, are you aware at the time these clauses existed whether REST gave any consideration as to whether or not they were appropriate, given the risk of having incorrect information about employment?---I think, clearly, they did, because the clause was removed.

Is that one of the reasons the clause was removed?---I was not involved in removing the clause but I think – I've seen the principles of certainty of cover and clarity.

Are you aware whether or not the removal of these types of clauses had a price effect on premiums?---I am not aware, no.

All right. Thank you. Commissioner, I tender that document.

THE COMMISSIONER: We should also, I think, perhaps have the AIA procedural fairness letter about declining TPD, 10 November '17 RST.0011.0001.0137 as exhibit 6.227.

EXHIBIT #6.227 AIA PROCEDURAL FAIRNESS LETTER ABOUT DECLINING TPD DATED 10/11/2017 (RST.0011.0001.0137)

THE COMMISSIONER: Exhibit 6.228 becomes ASIC report 529 Member Experience of Superannuation, June '17 RCD.0025.0003.0334, exhibit 6.228.

EXHIBIT #6.228 ASIC REPORT 529 MEMBER EXPERIENCE OF SUPERANNUATION, JUNE '17 (RCD.0025.0003.0334)

MR COSTELLO: Mr Ross, I want to discuss the particular circumstances of a claim with you now. It is a claim that you – it's the claim of a REST member that you've addressed in one of your witness statements, that is the one in answer to Rubric 6-65?---Yes.

It is a REST member who became a paraplegic?---Yes.

You know who I'm speaking of?---Yes.

Now, you would appreciate that there is a confidentiality – a confidentiality order has been made that protects the name of that individual. So I will just refer to that person as the member?---Yes.

But you know the case that I'm speaking of?---I do.

Thank you. You explain – you explain in your witness statement that the member became a member of REST on 14 June 2005. And that was when the employer first made a contribution on the member's behalf?---Yes.

And from that date, the member had basic insurance cover?---Yes.

And then in December 2008, REST entered into a new group life policy with AIA. Do you recall that from your earlier witness statement. And under that new policy the member's coverage for both life and TPD increased?---It did increase by a small amount, yes.

Yes. And the maximum amount potentially payable to the member under the 2008 policy at the time that the member became injured was $108,000. Do you recall that?---Yes.

And the 2008 policy, as we've already seen, required a minimum balance of $3000 to be maintained in order for continued cover?---Yes.

And REST sent communications to members before the 2008 policy came into effect, and one of those policies was the REST superannuation booklet?---Yes.

All right. I might just take you to that booklet quickly. It's LGR-17 to your witness statement, 6-65. It's document ID is RST.0006.0001.0037. Do you remember exhibiting this to your statement?---Yes, I do.

So this is a communication that was sent to REST members before the changes came into effect?---Yes.

Advising them that a new policy would be in place and explaining what the insurance cover would be under the new policy?---Yes.

And is this the type of document that REST does whenever a new policy is entered into?---There were particularly significant changes at the time to RESTs insurance offering.

All right. If we just move through that booklet, you will see on the front there that the changes were effective from 5 December 2008?---Yes.

And then if we move to the third page, there's some introductory words, 0039, which explains why REST is communicating with the member?---Yes.

And then if we move two pages forward to 0041, there's a table about important features of RESTs insurance cover?---Yes.

And can you see third from the bottom in the table:

Automatic transition to the new cover: members who currently hold insurance will automatically be transferred to our new cover on 5 December 2008.

?---Yes.

And that's what happened to this member?---Yes.

And then there are many pages that explain different aspects of the coverage. If we go to 0045, there is the definition in the right-hand column of total and permanent disablement cover?---Yes.

And it explains there that it will guard against the financial costs associated with the occurrence of a serious permanent disability. And then it speaks of the TPD benefit being changed to a flat $50,000 for most ages?---Yes.

In the second paragraph. This member didn't have $50,000 cover, though?---No.

Did – at this point in time she had 100?---So members who had cover under different policy prior to 2008, when REST brought in this – like significant changes to its insurance offering, there was a no worse off test for members. So if members had higher than $50,000 coverage prior to 2008, their cover was, essentially, matched and rounded up in 2008.

I see. Now, there's then explanation of the cost of the levels of cover of additional voluntary cover that members could take out, of the weekly rates for the voluntary cover, and how the changes will affect particular members. And Ms – the member that we're speaking about here didn't have voluntary cover, it was just - - -?---She did not have voluntary cover prior to 2008. She was, essentially, on our systems given voluntary cover although she did not have to apply for it in order to bring her coverage up to the level she had - - -

I see. If I could take you to 0060. This is – this is the second page of section 3 which is entitled how the new changes affect you. And there's an example at the top there:

Jennifer is 19 years old and is currently insured for basic cover. She does not have any voluntary cover. On 5 December 2008 she will automatically move to our new insurance arrangements. As Jennifer's current death and TPD cover is higher than the new basic cover scale she will receive top up cover in the form of voluntary units of death and total and permanent disablement cover to ensure her current benefit level is not reduced.

That's what happened here?---That's correct, yes.

Thank you. There's then further explanation of the cover and inactive members. And when we get to page 29 of the document, section 4 terms and conditions, and if we could go to 0067, which is the 31st page of the document. The right-hand column

under the heading Ceasing Insurance is where we get to an explanation of continued cover and the prescribed minimum balance requirement?---Yes, I can see that.

And you can see in (g):

> *In the case of continued cover for members with TPD and/or IP continued cover the date your account balance falls below $3000 –*

That's when insurance ceases?---Yes.

Now, I just want to ask you some questions about RESTs membership base. You're the default fund for a particular industry?---That has been the history of REST, yes.

It's the retail industry?---Yes.

And a large number of your members are young members?---Yes, that's fair.

Each year you would have a reasonable inflow of new members entering the workforce for the first time?---Yes.

And they are people who, by definition, are likely to have low account balances?---Yes.

And not just in their first year, for some time, because these are people that are often working part-time. You agree with that?---Part-time or casual, yes.

Or casual. Who are being paid hourly rates that aren't particularly high in many cases?---Yes.

And so REST would have a reasonably high number of low balance accounts, I imagine?---I think when compared to other funds we probably do, yes.

Yes. And so a clause like the one we've been discussing might have greater scope for operation in a membership base like RESTs where account balances might be low and where people might be more inclined to switch between employers or to have periods where they're no longer working for many and varied reasons. Do you agree with that?---I mean, I think the clause was specifically written for REST because it was by REST. Your question being - - -

You say it's by REST?---Well, sorry, I mean the specific insurance clause you're referring to only applies to REST. It was the REST policy. And REST does have, I would say, a reasonably high proportion of low account balances. Sorry. You might have to repeat your question to me, Mr Costello.

And do you agree that it might also have members who are more likely than the general population to change jobs or to have periods outside of work?---Yes.

Thank you. So there's at least a reasonable amount of scope for a clause like this to operate in relation to a REST membership base, and if this clause was replicated for another fund, it might not be as likely to have as common an operation?---Possibly.

And do you know – did this clause come in at RESTs request or is this an AIA clause?---I – I wasn't around back in 2008.

Right?---But I – from what I've reviewed and from what I know about REST, the principle would have been to give as much coverage as possible, to as many members as possible, and to be able to cover casual and part-time employees who can have a lot of difficulty getting cover outside of their superannuation, and in fact outside of REST.

All right. Do you agree that for a young person entering the workforce for the first time, perhaps in a casual or part-time job, that a 39 page booklet on superannuation is a lot to take in?---Probably is, yes.

And to get to page 31, and to learn at the foot of that page, of the operation of a clause involving something called "continued cover" is at least possibly, likely, to be confusing?---It's possible, yes.

This member that you and I have been discussing worked for McDonald's between June 2005 and September 2010?---Yes.

And that's again a not uncommon sort of a demographic for a new REST member?---Not at all.

And the member then commenced work with another company called Swan Services sometime after September 2010?---Yes.

And on 18 May 2012 the member suffered a very serious injury by falling from the fifth floor of a building?---Yes.

And was rendered a paraplegic?---Yes.

And at the time of the member's injury, that is 18 May 2012, the member's most recent annual statement was the statement for the 2011 financial year?---Yes.

And you have exhibited a number of statements – a number of annual statements for this member. I will take you to one. It's LGR-21 to your witness statement, which is RST.0013.0001.0047. So this in fact is the 2012 statement, which is a couple of months after the injury?---Yes.

And you can see there that it explains that it's the annual statement and it gives some comparison on returns in the first page. And then if we go to the third page there's the member's withdrawal benefit stated there, $1550?---Yes.

And then if we go to 0052, there's the statement of insurance cover. And you can see the TPD benefit is stated as being $108,000, plus the withdrawal benefit, for a total of $109,550.43?---Yes.

So this member would have received this statement about three months – three and a half months after suffering the injury?---Probably – probably in September.

All right. Perhaps four months after suffering the injury. And this is what the member would have understood to be the insurance coverage based on the statement. Do you agree with that?---I – I don't know what the member would have understood, but it's certainly the statement they received.

This is what was conveyed by REST to the member as to the extent of insurance coverage?---This was the statement we sent them, yes.

Thank you. And are you aware if, within this statement, there is any reference to the minimum balance requirement?---I don't believe there's a specific reference to dollar amounts, no.

Can I take you to 0055. Can you see there in blue, in the middle of the first column, it says Insured Benefits?---Yes.

And it says:

> *The insured benefit shown on your statement reflects RESTs records and is not a representation that you are insured.*

And then it has the statement about receiving contributions from your employer. And it then says, in the second paragraph:

> *REST relies on you and your employer to keep us up to date on your employment status at all times. If you or your employer do not notify us of your employment status or changes to your employment status, your statement may reflect a level or type of cover to which you are not entitled.*

?---Yes.

So that's the warning about the earlier statement made about $108,000-odd worth of coverage. It's conditioned by that warning a few pages later?---Yes.

But there's nothing in the paragraphs there under Insured Benefits about a prescribed minimum balance?---No, there is not.

And why was that the case?---I don't know, Mr Costello.

Should there have been?---Possibly. I think it's a balance. You know, the more information you put in there, the more information the member needs to absorb, so

it's some – you need to strike a balance and give what you think is the relevant information. So the answer to your question: possibly.

Well, RESTs position was ultimately that this member had no TPD insurance at the time of the injury, wasn't it?---I think it's a – yes, but I think it's slightly more nuanced in that the claim was eventually paid, and REST supported that position as well.

Yes. But, for some time at least, both REST and AIA was of the view that there was no coverage at the time?---Yes.

And in those circumstances the bare statement of $108,000 worth of TPD coverage, if taken alone and not read together with these paragraphs later on in the document, would be misleading to the member. If the member didn't pay careful attention to the document the member would fall into error and think that 108,000 was the amount of cover?---Quite possibly.

Thank you. The member couldn't find out, even by reading this policy diligently, about the prescribed minimum balance clause. How would the member know about that?---It would be disclosed – I'm just thinking the time period here – it would be disclosed in the product disclosure statement. I believe it was disclosed in that document you took me to earlier.

Yes, it was?---Yes.

When is a product disclosure statement sent to a member?---When they join.

So the member could either have had regard to a document that would have been sent in June 2005, when membership first commenced, or could have had regard to the document that I took you to from 2008?---Yes.

So, if the member had excellent record keeping, could go back to either of those two documents, but otherwise wouldn't be aware of this clause; is that right?---Not if we were under the belief that they were still employed, which is the case here, I accept. If an employer had let us know – or the member had let us know – the employer had let us know, we would have communicated with the member that there was an important account balance that they should be aware of.

Do you think it was unrealistic – would it have been unrealistic to expect that a member would have retained the booklet from 2008?---I don't know.

You don't know?---No, I - - -

Do you know how old this member was at the time?---I believe she was in her mid-20s.

At the time of the injury?---Yes.

Yes?---Yes.

On 18 July 2014, REST submitted the member's claim to AIA for assessment?---Yes.

Do you recall when the member submitted the claim to REST?---I don't believe the member did submit it, I think it was submitted by lawyers representing the member. From memory, in January, but I stand to be corrected there, Mr Costello.

No, you're quite right. The member – the member's claim, whether submitted directly by the member or by somebody on the member's behalf, was submitted to REST in January 2014. Why did it take until 18 July 2014 for REST to send the member's claim to AIA?---So our administrators were collecting the relevant information for AIA to be able to make their assessment.

What sort of information?---I think they were waiting for – quite some time for employment records.

Right. Is that sort of a delay, in excess of six months, acceptable?---Sorry, in excess of six months? I – I think it took too long.

I took you to the Insurance Code earlier?---Yes.

And there was a reference to five days?---Yes.

And I asked you if you were complying with that at the moment, and I think your answer was you're not, but you try and do these things as quickly as you can. Would – is six months an outlier?---So we're – I mean, this is quite some time ago. I don't know what the time periods were back in – 2014, I think we're in, aren't we, Mr Costello?

Yes?---Yes.

Would six months be unusual now?---Absolutely.

The claim, in any event, eventually got to AIA on – in July 2014, and AIA then took some months to assess the claim?---Yes.

And it sought information from REST at various times. Do you recall that?---Yes.

And do you recall that AIA had to follow up REST on a couple of occasions to get information that it was seeking to use in assessing the claim?---At that – at that point in time the administrator basically managed the collection of information, so typically, AIA would follow them up if there was outstanding information.

The administrator here is AAS?---That's correct, yes.

And eventually that information was provided to the insurer. And on 21 November AAI – sorry, AIA - - -?---AIA.

- - - emailed REST?---Yes.

And I will just take you to that document. You've annexed it to your statement LGR 38. Document ID is RST.0010.0003.0099. So this is a communication from AIA to, I think, AAS on behalf of REST, because – can you see there in the To line - - -?---Yes.

- - - it says AAS.com.au?---That's correct.

But in any event it's addressed to REST. It says:

> *Dear REST, in regards to the above claim, please note the assessment has been completed and based on this assessment we have made the decision to admit liability on the claim.*

?---Yes.

Continuing:

> *The assessment decision was based on the following information –*

and there's reference to two medical reports:

> *The assessment decision was based on the relevant date of 18 May 2012.*

Which is when TPD was certified by one of the doctors?---Yes.

And:

> *If you have any queries please don't hesitate to contact me.*

It also says:

> *Based on the above we have remitted a TPD benefit of $108,000.*

?---Yes

And that was the fact: REST in fact received $108,000 into its account?---Correct.

And that's the usual process that you explained before, that REST receives claims paid out by the insurer, and that claim is then – that amount is then deposited to the member's superannuation account and there is then a decision taken by REST about whether it's appropriate to release those funds from the superannuation account; is that right?---Correct.

Thank you. But that didn't happen here, did it?---No. It was not released in this case, no.

Can I take you, please, to exhibit 41 to your statement which is RST.0010.0003.0105. Now, this is an email by RESTs administrator to the insurer on 4 December, so a couple of weeks after the $108,000 has been sent to REST?---Yes.

And it says:

> *Good afternoon. Due to continued cover rules from 5 December 2010, member's TPD and IP insurance ceased, as balance was less than $3000. Please review claim and determine if decline claim. Refund of $108,000 will be organised and a separate email will be sent.*

?---Yes.

Why would RESTs administrator consider it appropriate to form a view about whether or not an exclusion within the policy operated?---I don't believe – I don't know if this was the first communication. They realised there had been an administration mistake.

By?---By themselves.

Sorry, do you mean AAS formed the view there had been an administration mistake?---Yes.

And what was that mistake?---That employment records that had been sent to AAS had not been correctly entered into the system.

Where were those employment records from?---This member's employer.

But which employer?---McDonald's.

And because – and, relevantly, it was information about the date the member had ceased working for McDonald's?---That's correct.

So AAS became aware of that, that there had been an error, and it then took it upon itself to refund the money that had been paid and to call upon the insurer to review the claim to see whether or not the prescribed minimum balance clause operated to preclude the member from being paid?---Seemingly, yes.

And is it ordinarily part of RESTs administrator's role to try and ascertain whether or not a member falls within an exclusion?---I'm not familiar with the – all the procedures at the time.

Are you aware that under the Superannuation Industry (Supervision) Act, REST has an obligation to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary if the claim has a reasonable prospect of success?---Yes.

That's RESTs obligation?---Yes.

And it is an obligation that it performs in part through the appointment of its administrator?---Yes.

And in this circumstance the administrator, rather than doing the work of pursuing the claim for the member has identified an error to the possible advantage of the insurer and refunded the money without notice to the member. Is that correct?---I – the money has been refunded without notice to the member, yes.

And the member hadn't been informed that the insurer had formed the view that the claim should be accepted?---I do not believe they were, no.

And was that an appropriate way for AAS to behave?---I believe it was, yes.

Without notice to the member?---Yes, I do.

But let me just test that a little bit. You explained that the error that AAS had made was an error concerning the date employment with McDonald's had ceased. Is that correct?---Correct.

And let me take you to – this is exhibit 27 to your statement, which is RST.0005.0001.4676. The claim form that was submitted on the member's behalf?---Yes.

And it's submitted to REST?---Yes.

And that claim form, if we go to 4679, section (e):

occupation details, name of current or last employer, Swan Services.

?---Yes.

Do you see that?---Yes.

So this was a document in RESTs possession at the time?---Yes.

And would this have been a document in AASs possession at the time?---Yes.

And the member has stated that their employer is Swan Services, not McDonald's?---Yes.

So why would the date that employment ceased with McDonald's be determinative of whether the member's claim should be accepted?---This goes back to the issue we were talking about some time ago with a REST employer. So what is important in the policy is who is the employer that was making contributions on behalf of the member to REST. And I do not believe any contributions were ever received from Swan Services for this member.

But shouldn't AAS have investigated why that was the case?---And I believe they did. Hence, the – we were talking before about why it may have taken some period of time for the claim to be presented to the insurer and my understanding is quite a period of that was trying to follow up information about Swan Services.

If we skip forward a little bit, it's the case, isn't it, that this member was employed by Swan Services?---Yes.

But what had happened was Swan Services was not paying the compulsory contributions that they were required by law to have paid?---I don't know that.

You don't know that?---No.

Are you aware that Swan Services went into liquidation?---Yes.

And you're aware that this member was employed by Swan Services?---Yes.

And did work for Swan Services?---I believe so.

And was paid by Swan Services?---I believe so.

Would you understand that to create an obligation on Swan Services to pay compulsory contributions?---Yes.

And you're aware those compulsory contributions were not paid?---No, I'm not. They were not paid to REST. They may have been paid, they may not have been paid. I don't think we ever got any payslips from Swan Services even.

Yes. So what REST knew definitely was that it did not receive contributions on this member's behalf from Swan Services?---Yes.

And you say now what REST still doesn't know is whether or not Swan Services in fact paid another fund?---Yes.

And is there anyway that REST could have ascertained that?---Well, I believe they did try their best. They – they talked – they tried to follow up Swan Services on multiple occasions. They sent communications to the member's representative asking for information on Swan Services.

Can I take you, please, to exhibit 28 to your witness statement, which is RST.0005.0001.4913. Do you remember exhibiting this to your witness statement?---Yes.

And you've read this statement?---I have but not recently.

Sorry, this – I called it a statement. I meant this article?---Yes.

And this article explains that the member's employer was placed into liquidation?---Yes.

And it owed $1.6 million to 2466 employees for wages alone?---Yes.

And there is discussion there of the expectation of the liquidator about whether or not those claims could be paid and how they would be paid. Given that and given that you know that, it would be unsurprising wouldn't it if this member had not been paid her compulsory superannuation contributions by this employer who owed millions of dollars to its staff?---I – I just didn't think there's anyway I can know that, Mr Costello.

Do you ever have – does REST ever have the experience of an employer failing to pay compulsory contributions?---Yes.

Does that experience include sometimes circumstances where a company ultimately goes into liquidation?---Yes.

And does that experience extend to being aware of circumstances where companies in financial difficulty cease paying compulsory contributions as one of the first payments that they stop making - - -?---I would - - -

- - - to improve their own cash flow?---I would agree with that, yes.

None of that would be surprising to, would it?---No, it would not.

Why do you constantly resist my characterisation that it would not be unlikely that this member was not paid what she was entitled to?---I think it's quite possible.

And you don't have – REST has no evidence to suggest that there was any amount paid to this member to any other superannuation fund?---No.

No. So why then, when AAS determined that the employer had finished working at McDonald's at an earlier point in time, but when REST knew that the employer – that there was a new employer and knew the name of that employer?---Yes.

Why would it be assumed that the clause would operate so that the 71 days counted from the day that she – that the member stopped working at McDonald's?---I don't think it was assumed. REST – I will get back to the definition of an employer in the

policy. It's an employer that makes – this is from memory – compulsory contributions on behalf of a member to REST. So unless REST has received a compulsory contribution, I can't understand how the employer would be characterised as a REST employer.

And that's a clause that creates a double detriment to RESTs member because not only does the REST member forgo a compulsory contribution to which there's a legal entitlement, insurance coverage is also forgone?---I don't agree with that proposition because like I say it's possible no superannuation guarantee contributions were paid for this employer but I have no way to know that or not.

You know none were paid to you?---This is correct, yes.

And you've got an obligation to know about multiple accounts?---As far as we can tell, yes.

And none of the information that you have available to you suggests that this member had multiple superannuation accounts?---I am aware that this member did have other superannuation – I have become aware in preparing for this that they did, yes.

At the date?---At which date?

Well, at the relevant date for claiming under the policy?---Yes.

And who was that fund with?---I can remember one of them. I believe it was AustralianSuper. I cannot remember the other one.

It couldn't have been easier then to find out whether or not this member had been paid, could it?---This became apparent at a much later stage during litigation.

I see. As a consequence of RESTs or AASs correspondence to the insurer, AIA gave further consideration to the claim?---Yes.

And ultimately determined that the claim should be declined?---Yes.

And that decline had nothing to do with the extent of the injury suffered by the member?---Correct.

It was the operation of prescribed minimum balance clause and continued cover?---Yes.

And then in April 2015, REST wrote to the member's solicitors and advised of the insurer's decision?---Yes.

And I might just take you to that document. It's exhibit 43 to your statement, which is RST.0010.0003.0175. You might recall that it was in January that AIA determined the claim should be declined. Do you recall that?---Yes.

And then in April this letter was sent by REST. And what happens in the gap between AIA notifying REST and REST notifying the member?---So what happens in the gap between – did you say AIA notifying REST and REST notifying the member of - - -

The fact that the claim had been declined?---So this isn't actually the final notice that the claim has been declined. This is a letter informing the member that AA has declined the claim. I don't believe REST had conducted its review by this point.

THE COMMISSIONER: The document needs to come down. It's not redacted properly.

MR COSTELLO: Thank you, Commissioner. That document – that document informs the member of the fact that the insurer has come to a view - - -?---The insurer has declined the claim at that point, yes.

And that there is an opportunity for a review process?---That the trustee will review the claim, yes.

And I will just read the relevant paragraph to you that you're referring to:

> *Please note that this decision is not the final outcome of your client's claim. We will now refer the claim to the trustee for an independent review. In doing so, your client's claim will undergo a full and independent assessment and all evidence provided will be considered. Following this review the trustee may disagree with AIAs decision and refer the claim back for further assessment.*

?---Yes.

That's the process?---Yes.

Do you think there's something a little contradictory in telling the member's solicitors that the trustees will review the decision in circumstances where the insurer's decision has been made at the suggestion of the trustee?---No. I don't believe the insurer's decision was made at the suggestion of the trustee.

The insurer had made a decision and had paid the claim. The trustee then drew the insurer's attention to facts and to a particular clause and asked to advise whether or not it would be declined and refunded the money?---The insurer's decision was made with their preliminary – the initial decision was made with incorrect information.

But that's not my question. My question to you was is it a little contradictory to suggest that the trustee will review the claim in circumstances where it was the

trustee that identified the basis on which the claim should be denied?---Well, it was the administrator that communicated with the insurer. The trustee's review of the claim would encompass everything that had taken place. So I don't think it was contradictory, no.

You don't think it was contradictory?---No.

The administrator is the agent of the trustee?---Yes.

What the administrator does, it does in the name of the trustee?---Yes.

And it was because of the intervention of the administrator that the claim was denied. Do you agree with that?---Yes.

But you don't think it was contradictory then in those circumstances to suggest that the trustee would disagree with the decision that had been come to by the insurer at the trustee's suggestion?---Sorry, can you rephrase that for me?

The insurer came to a decision that was suggested to it by the trustee?---No. I think the insurer came to a decision after reviewing the additional information that was provided to it.

That was suggested to it by the trustee?---I think the trustee had explained to the insurer their view but the insurer would have come to their own decision.

No, the trustee was sufficiently confident about it that it didn't just say would you like to have another look at it, it refunded the money that had been paid for the benefit of the member?---Yes.

Are you seriously suggesting that this trustee would look at that conduct and then engage in an argument with the insurer about the correctness of the decision that was taken at the suggestion of the trustee?---If they thought it was an incorrect decision they would.

And why would they think it was an incorrect decision?---After reviewing all the evidence, the trustee comes to an independent view.

And the trustee got it wrong again, didn't it?---No, I don't believe they did.

You don't think the trustee did get it wrong?---At what point?

At this point when it did the review?---No.

You think the trustee was right in affirming the decision of the insurer to decline the claim?---I think on the evidence available to the trustee at that point in time, yes.

All right. And do you think that the trustee ultimately came to the correct decision?---What decision do you refer to?

Paying the member's claim?---Yes.

And why was that the correct decision?---New medical evidence was presented to the trustee – well, the insurer during the course of litigation.

And save for that, you think the decision would have been right?---Yes.

All right. The initial – the further medical evidence that came to the attention of the trustee was medical evidence concerning a mental health condition?---Yes.

And that mental health condition had been present in the member for – from an earlier point in time?---Yes.

And that fact is stated in the member's claim form that I've already taken you to?---Yes.

So that fact was known to the trustee at all times?---Which particular fact?

The fact that the person suffered from a mental health condition from an earlier date?---Yes.

So why did it take litigation in the Supreme Court of New South Wales before the trustee recognised that that might be a basis for a claim?---I think this is a very unusual case in that the member has been deemed to be totally and permanently disabled prior to them ceasing work. So as we've already agreed, the member worked for Swan Services. That was ultimately after the date that the insurer decided the trustee – the member was totally and permanently disabled which is very unusual.

Commissioner, I see the time. I think - - -

THE COMMISSIONER: How long do you expect to require?

MR COSTELLO: I think I have another half an hour.

THE COMMISSIONER: We will have to bring you back on Monday morning, I'm sorry about that but it has been a long week. If we were to begin at, what, 9.30?

MR COSTELLO: Thank you, Commissioner. That would be very helpful.

THE COMMISSIONER: Is that going to be unduly inconvenient to everybody? I know it's not convenient but is it going to be unduly inconvenient if I say 9.30 Monday morning?---Not to me, Commissioner.

Well, you're the one who matters. Counsel don't get a look in at that point. 9.30 Monday morning.

<THE WITNESS WITHDREW [4.19 pm]

MATTER ADJOURNED at 4.19 pm UNTIL MONDAY, 17 SEPTEMBER 2018

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