



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

# Life Insurance

## Background Paper 29

The views expressed are the author's views and are not to be understood as expressing the views of the Commission.

**Royal Commission**  
**into Misconduct in the Banking, Superannuation and**  
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**Life Insurance Background Paper**

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**Dr Ian Enright**

Adjunct Professor, University of Technology, Sydney

**Peter Mann**

Barrister, Adjunct Lecturer, Faculty of Law, University of Sydney

**Professor Rob Merkin QC**

University of Exeter

**Greg Pynt**

Barrister, Visiting Fellow, School of Law, University of Western Australia

**Samantha Traves**

Visiting Academic, University of Queensland

## CONTENTS

<b>PART ONE – INTRODUCTION.....</b>	<b>1</b>
1. Background.....	1
2. Definition.....	1
3. Investment and risk products – traditional and modern.....	3
<b>PART TWO – REGULATION.....</b>	<b>7</b>
1. Regulatory framework.....	7
2. Role of ASIC and APRA.....	7
3. Registration.....	8
4. Prudential regulation.....	9
5. Consumer protection regulation.....	14
6. Life insurance framework reform package.....	18
<b>PART THREE – RELATIONSHIPS, SALES AND REMUNERATION.....</b>	<b>19</b>
1. Introduction.....	19
2. Life insurance industry sectors.....	19
3. Advisers.....	20
4. Approved product lists.....	21
5. Remuneration.....	23
6. Standards for financial advisers.....	23
<b>PART FOUR – PRE-CONTRACT PROCESSES.....</b>	<b>24</b>
1. Introduction.....	24
2. Genetic testing.....	25
3. Mental health conditions.....	28
4. Gender.....	32
5. HIV.....	33
6. Medical protocols.....	33
7. Insurer processes.....	34
<b>PART FIVE – PRE-CONTRACT DISCLOSURES AND REPRESENTATIONS.....</b>	<b>39</b>
1. Introduction – background and context.....	39
2. Outline summary – legal elements.....	39
3. Group insurance.....	40
4. Non-disclosure.....	41
5. Misrepresentation.....	46
6. Whose misrepresentation or non-disclosure?.....	47
7. Remedies.....	48
8. 2013 amendments.....	54
<b>PART SIX – PARTIES.....</b>	<b>55</b>
1. Introduction – policyowner and insurer.....	55
2. Other claimants.....	55
3. Agent of a policyowner.....	55
4. Trustee.....	56

5.	Beneficiary or third party beneficiary .....	56
6.	Mortgagee of the policy .....	57
7.	Assignee of the policy .....	58
8.	The insurer .....	58
<b>PART SEVEN – DURATION .....</b>		<b>59</b>
1.	Cooling off .....	59
2.	Commencement .....	59
3.	Duration .....	59
4.	Expiry and cancellation .....	60
5.	Renewal .....	63
<b>PART EIGHT – INSURANCE POLICY AND COVER .....</b>		<b>65</b>
1.	Life insurance contract formation .....	65
2.	Anatomy of a life insurance contract or policy .....	66
3.	Disclosure of policy terms .....	69
4.	Types of policies and cover .....	70
5.	Disability insurance: TPD and income protection .....	74
6.	Extensions and options .....	79
7.	Exclusions .....	81
8.	Interpretation .....	85
9.	Utmost good faith .....	87
10.	Section 54 .....	88
<b>PART NINE – CLAIMS .....</b>		<b>93</b>
1.	Introduction .....	93
2.	Notice .....	93
3.	Claim and proof .....	93
4.	Causation .....	94
5.	Claims handling .....	94
6.	Claim denial .....	96
7.	Illegality, fraud and misconduct .....	96
8.	Life Code .....	99
9.	ASIC review of life insurance claims .....	101
10.	APRA expectations for claims handling .....	103
<b>PART TEN – DISPUTES .....</b>		<b>104</b>
1.	Introduction .....	104
2.	Internal Dispute Resolution (IDR) – Life Code .....	104
3.	External Dispute Resolution (EDR) – FOS and AFCA .....	106
<b>GLOSSARY .....</b>		<b>107</b>
<b>APPENDIX A .....</b>		<b>111</b>
<b>APPENDIX B .....</b>		<b>123</b>

# PART ONE – INTRODUCTION

## 1. Background

- 1.1. Life insurance is a type of insurance which provides cover for death, disability, a health condition, some illnesses and injuries.
- 1.2. This Background Paper deals with the specific issues in relation to the four key forms of life insurance cover – term (death) insurance, total and permanent disability (TPD) Insurance, income protection (IP) insurance and critical illness or trauma insurance. It also deals with the special provisions which apply to sickness, accident and consumer credit policies that are classified as life policies and which are eligible and prescribed contracts of insurance under the *Insurance Contracts Act 1984* (IC Act).
- 1.3. The General Insurance Background Paper No.14 (GIBP) discusses the purpose and nature of insurance in Part One. A number of the important legislative provisions are in Appendix A. A number of insurance or unusual words and expressions are described or defined in the Glossary.

## 2. Definition

- 2.1. Life insurance is a contract of insurance in which the policyowner<sup>1</sup> pays a premium to the insurer<sup>2</sup> and the insurer pays the sum insured or provides a benefit<sup>3</sup> to the policyowner, or a person nominated by the policyowner, on the occurrence of the Insured Life Event.<sup>4</sup> The Insured Life Event is a condition, illness, injury, accident, disability or death which entitles the claimant to the relevant and specified amount or benefit. The life insured is the person affected by the Insured Life Event, or to whom the Insured Life Event occurs. The policyowner is often, but not always the life insured.
- 2.2. A policy is a form which sets out the contract of life insurance and the expressions ‘policy’ and ‘contract of life insurance’ (life insurance contract) have the same meaning.

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<sup>1</sup> Sometimes called the insured. In this Background Paper policyowner is used for clarity; it includes proposed insured or proponent.

<sup>2</sup> Insurer includes proposed insurer.

<sup>3</sup> Usually a payment but sometimes a service.

<sup>4</sup> *Sutton*, paras. 21.10–21.50.

- 2.3. All life insurance policies are subject to Commonwealth legislation. The principal legislation that affects life insurance policies is the IC Act,<sup>5</sup> the *Life Insurance Act 1995* (LI Act) and the *Corporations Act 2001* (Corporations Act).<sup>6</sup>
- 2.4. The IC Act applies to contracts of life insurance. It does not define life insurance. It does define a contract of life insurance in terms of a ‘life policy within the meaning of the *Life Insurance Act 1995*’: section 11(1). The LI Act defines life insurance business and life insurance policies that are considered for each life product. The LI Act definitions now also reflect the market distinction between investment products and risk products – see Section 3 below.
- 2.5. A life insurance contract in the LI Act Life Prudential Standard 001 is defined as an insurance contract which is regulated under the LI Act. The LI Act also contains some provisions which affect the terms of the life policy.
- 2.6. The Corporations Act, Chapter 7, Part 7.1, Division 2, contains a number of definitions that affect the application of that Chapter to insurance. An ‘insurance product’ is defined to include a ‘general insurance product’, ‘life risk insurance product’ and ‘investment life insurance product’.
- 2.7. A ‘life risk insurance product’ is defined as a ‘life policy, or a sinking fund policy,<sup>7</sup> within the meaning of the *Life Insurance Act 1995*, that is a contract of insurance’. An ‘investment life insurance product’ is defined as ‘a life policy, or a sinking fund policy, within the meaning of the *Life Insurance Act 1995*, that is not a contract of insurance’. This should be contrasted with the definition of a ‘general insurance product’, which is defined as ‘a contract of insurance that is not a life policy, or a sinking fund policy, within the meaning of the *Life Insurance Act 1995*’.
- 2.8. The categories of ‘life risk insurance product’ and ‘investment life insurance product’ are qualified by a number of exemptions.
- 2.9. Both a ‘life risk insurance product’ and an ‘investment life insurance product’ fall within the category of ‘insurance product’ more generally and are specifically included within the definition of ‘financial product’ for the purposes of the Corporations Act. While a ‘life risk insurance product’ is defined as falling within the category of a ‘risk insurance product’, an ‘investment life insurance product’ is not.

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<sup>5</sup> See the GIBP, Part Seven.

<sup>6</sup> See the GIBP, Part Five.

<sup>7</sup> A sinking fund policy is a type of investment life insurance policy. The life insurance company issuing the policy undertakes to pay money on one or more specified dates and the death of a person is irrelevant to the obligation to pay the money on the due date.

### 3. Investment and risk products – traditional and modern

#### **Traditional products**

- 3.1. Originally and until the 1980s, the life insurance market offered investment products with risk cover included. The person would receive money from the insurance company on an agreed date or on the death or disability of the person.
- 3.2. Three forms of insurance, either alone or in combination, were traditionally the heart of life insurance: endowment insurance, whole of life insurance and term insurance.
- 3.3. Endowment insurance involves the payment by the insurer of a guaranteed or calculated sum conditional on the life insured attaining a certain age or on her or his earlier death. The policy has a maturity date, when the sum insured and any bonuses become payable if the insured has not already died.
- 3.4. Despite their high cost structure, these policies were attractive investments due to the then available tax benefits, including deductibility of premiums. During the 1980s, there were major changes in the market. The withdrawal of tax deductions for ordinary life insurance premiums meant that the high cost structure of traditional life policies and the consequent poor investment returns they provided became apparent and they rapidly fell out of favour.
- 3.5. Whole of life insurance is a contract where the sum insured is payable on the death of the life insured whenever that occurs. Term insurance is insurance under which the sum insured is payable to the policyowner only on the death of the life insured during the term of the contract. These types of cover survive in the modern risk products.

#### **Modern products – types**

- 3.6. The modern life insurance market is almost wholly risk products. The Australian Securities and Investments Commission (ASIC) found that life only and income protection policies were the most common life insurance policies, comprising 32 per cent and 21 per cent respectively of the total life policies in place in June 2013.<sup>8</sup>
- 3.7. Term insurance is a life insurance contract which covers death and is either for a defined period or is ‘guaranteed renewable’ by the policyowner. Term life insurance pays an agreed amount, referred to as the Sum Insured, as a lump sum on the death of the life insured. A term insurance is a life policy under the LI Act. Term insurance is usually sold with a total and permanent disability benefit; some cover partial disability.
- 3.8. A common feature of term insurance is a ‘terminal illness’ benefit which provides cover if the life insured has a terminal illness and is not likely to live more than 12 or 24 months. Terminally ill can be defined in one of three ways: the actuality of the terminal illness; the diagnosis of the terminal illness; or the insurer forming an opinion that the life insured is terminally ill.

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<sup>8</sup> ASIC, Report 413, *Review of retail life insurance advice*, 9 October 2014, p. 19.

- 3.9. There is often considerable delay between the time a proposal for life insurance is lodged with the insurer and its acceptance. Many insurers have adopted the practice of providing temporary or interim cover for varying periods, at least in case of death by accident, pending consideration and acceptance of the proposal.
- 3.10. Disability cover is available under a range of products or through a rider attached to term life insurance. There are two types: TPD, which pays a lump sum, and IP, which pays a monthly income replacement amount.
- 3.11. A TPD life insurance covers the total and permanent disability of the life insured during the period of the policy. The benefit is payable when the life insured is TPD as defined. There are three common definitions of TPD: the 'common form'; activities of daily living; and the 'table of maims'.<sup>9</sup> TPD is sometimes sold on a 'stand alone' basis but is usually combined with life cover. When it is combined with life cover, if the TPD benefit becomes payable, life cover is usually reduced by the amount of the TPD benefit paid; the policy is terminated if the TPD and life covers are for the same amount. However, this is not always the case. Sometimes the policy provides for life cover to continue in full, even though a TPD benefit has been paid. A TPD insurance is a continuous disability policy under the LI Act.
- 3.12. A disability income or IP insurance<sup>10</sup> obliges the life insurance company to pay a monthly benefit, often expressed as the lesser of 75 per cent of the disclosed pre-disability income and a specified amount, if the life insured is disabled during the period of the policy and is unable to work or partially disabled. The monthly payment is for the duration of the disability or the specified benefit period. All of these amounts are calculated on the basis of the amount for which the policyowner applies in the proposal and altered by the insurer's view of the risk. The amounts are fixed and payable on a claim; the amounts are not subject to the indemnity principle nor are they maximums. The sum insured and the monthly benefit are often expressed to increase over time by reference to the increase in a nominated index, usually the consumer price index. An income protection policy is a continuous disability policy under the LI Act.
- 3.13. A trauma, critical illness or crisis cover life insurance product covers the life insured for a defined surgical procedure or a defined illness, for example cancer, stroke, a heart condition or chronic disease like kidney failure during the period of the policy. Trauma insurance will pay a lump sum benefit if the insured person suffers one of a list of specified trauma conditions. A trauma insurance is a continuous disability policy under the LI Act.

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<sup>9</sup> *Sutton*, para. 21.270.

<sup>10</sup> In the group market, 'salary continuance'.

### **Hybrid or bundled products<sup>11</sup>**

- 3.14. A life insurer may issue a policy that contains a ‘package’ of different covers, for example, death, TPD, trauma and IP covers. The policyowner elects which covers he or she will take out.
- 3.15. If a policy contains cover which would be categorised as a life policy and cover which would be categorised as non-life cover, the issue arises as to how it is to be treated for the purposes of regulation. Recently, the Australian Prudential Regulation Authority (APRA) has said that each cover must fall within section 9 of the LI Act for the business in undertaking liability under those contracts to be considered life insurance business. If this is not the case, then it will be regarded as mixed insurance business and the business of offering additional benefits will require a section 12A declaration to deem the whole product to be life insurance business. Otherwise the mixed business will contravene section 234 of the LI Act which prohibits a life insurer carrying on insurance business other than life insurance business.

### **Group insurance**

- 3.16. An important feature of the modern life insurance market is that all products, except trauma or critical illness insurance, are sold both on an individual basis and a group basis. Group life insurance is designed to provide life cover for groups of people who are linked together usually through employment or superannuation. The group market involves a policyowner which is either an employer or a superannuation fund, sometimes in a master trust. The employer group schemes are structured on the basis that the life insured is an employee or a dependant of an employee; the employer is the policyowner and can be the agent of the life insured for the purposes of the insurance. The superannuation fund schemes are structured on the basis that the life insured is a member and beneficiary of a trust fund and these dual capacities shape important features of the law on group schemes. The policyowner is the trustee of the fund.
- 3.17. The available sums insured and benefits are often expressed as a multiple of the life insured’s salary or wage. The group income protection, known as group salary continuance provides an income stream, being a percentage of the life insured’s normal salary, while the life insured is unable to work. The benefit period, during which the payments are made, is usually limited to a maximum of two years.
- 3.18. There is a separate Group Life Insurance Background Paper No 29 (GLIBP).

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<sup>11</sup> See GIBP, Part Two, s. 2.

## **Purpose**

- 3.19. A life policy can be sold on individual lives, sometimes on joint lives (for example, two people in a marriage or life partners) or on multiple lives (for example, partners in a business) and on a group basis: see above. Sometimes a company or a business insures a key person (who could be a director, principal or employee) against death or disability because the loss of that person's services would be expected to have a severe impact upon the fortunes of the company or business. In the event of a claim, the proceeds of the insurance would help the business survive until a replacement could be found. Such a policy is often called 'keyman insurance' but, in reality, it is a normal risk insurance on the life of the key person.
- 3.20. An income protection policy is designed to provide regular benefits, payable monthly or sometimes fortnightly, to replace earned (that is, earned by personal exertion as opposed to investment) income which has been lost by the insured because of disability. However, in practice, it is a very complex contract with a number of variations designed to meet the differing circumstances of potential policyowners and to protect insurers.
- 3.21. An important market for income protection is the self-employed, ranging from manual labourers to professionals: any person who has no employer support on becoming disabled. Premium rates and policy conditions vary widely, particularly by occupation class: a manual worker has a much higher likelihood of disability caused by an injury than does a sedentary worker.

## **Legacy products**

- 3.22. A life insurance contract is long term. A number of investment products provided for a guaranteed minimum return. A number of risk products contain complex definitions of illnesses and conditions but the evolution of medical science can make the definitions out of date. A life insurer might have a right under the policy, to vary unilaterally a life insurance contract.<sup>12</sup> A life insurer cannot cancel a life insurance contract without cause and therefore the life insurer, concerned about a long-term investment guarantee or outdated medical definitions might cease selling the product. It becomes 'closed' to new sales. A life insurance company might sell a closed portfolio to another life insurance company. It becomes known as 'legacy business'.
- 3.23. The changes described in this Section mean that most Australian life insurance companies are now responsible for administering legacy business. But documents, books and records can be lost and staff with experience in dealing with the legacy products become rare. This is a common source of disputes, particularly for disability claims. Insurers often have difficulty accessing original policies and do not use precisely the same definition of what constitutes disability in their own policies.

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<sup>12</sup> IC Act, s. 53, does not apply: r. 37(c) 2017.

## PART TWO – REGULATION

### 1. Regulatory framework

- 1.1. Life insurance is regulated by a number of different laws. They include:
  - a) the *Life Insurance Act 1995* (LI Act) which regulates the registration and prudential conduct of life insurers;
  - b) the *Insurance Contracts Act 1984* (IC Act) which regulates the life insurance contract;<sup>13</sup>
  - c) the *Corporations Act 2001* (Corporations Act) which regulates financial products in relation to licensing, disclosure and conduct matters;<sup>14</sup>
  - d) other statutes dealing with anti-discrimination, trade practices and consumer protection; and
  - e) common law.
- 1.2. The regulatory classification of a life insurance contract is particularly important for the main prudential regulatory statute, the LI Act. The LI Act provides for the protection of the interests of policyowners<sup>15</sup> by the registration of each company which carries on *life insurance business* in Australia<sup>16</sup> and by requiring it to meet prudential regulation<sup>17</sup> standards.<sup>18</sup> The Australian Prudential Regulation Authority (APRA) has the general administration of the LI Act.<sup>19</sup> On prudential regulation generally, see the General Insurance Background Paper 14 (GIBP), Part Six, particularly section 2.
- 1.3. The regulatory classification of a life insurance contract is particularly important for the main consumer protection regulatory statute, the Corporations Act. On consumer protection regulation generally, see GIBP, Part Six, particularly section 3.

### 2. Role of ASIC and APRA

- 2.1. The Australian Securities and Investments Commission (ASIC), the corporate regulator, is responsible for administering the Corporations Act and the IC Act. ASIC's approach is influenced by the key principles of 'market integrity' and 'consumer protection'. Market integrity ensures the development of the market by securing confidence in it by protecting those who participate in it from fraud and other

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<sup>13</sup> See GIBP, Part Seven.

<sup>14</sup> See GIBP, Part Five.

<sup>15</sup> LI Act, s. 3(1).

<sup>16</sup> LI Act, s. 3(2)(a) defined.

<sup>17</sup> LI Act, s. 3(2)(b); See the definition of *prudential matters* in the Dictionary.

<sup>18</sup> LI Act, s. 3(2)(b).

<sup>19</sup> LI Act, s. 7.

unfair practices. Consumer protection is designed to make sure consumers have sufficient information about the financial products they purchase and that they are treated fairly and have appropriate avenues for redress.

- 2.2. APRA, the prudential regulator, is responsible for the prudential supervision of the financial services industry. This involves setting standards with a view to avoiding financial failure and includes those relating to capital and liquidity requirements and the monitoring and reporting of governance and management functions. APRA also sets Prudential Standards for life insurers.

### 3. Registration

#### Introduction

- 3.1. An entity registered as a corporation under the Corporations Act<sup>20</sup> is entitled to carry on business in Australia. A company which is registered as a life insurance corporation under the LI Act is entitled to carry on *life insurance business* as a life insurer in Australia.
- 3.2. APRA's jurisdiction to regulate a corporation depends on the existence of three factors:
  - a) the carrying on of a business;
  - b) the business being *life business* or *life insurance business*; and
  - c) the location of the business is either actually, or deemed to be, in Australia.<sup>21</sup>

#### Carry on business in Australia

- 3.3. There are three elements that the activities and conduct of a corporation must satisfy in order to be characterised as 'carrying on business in Australia':<sup>22</sup>
  - a) a single venture will not normally constitute carrying on a business – some plurality is required;
  - b) there must be 'system, repetition and continuity' although the regulatory context diminishes these criteria as indicia of carrying on business;<sup>23</sup> and
  - c) profit as a motive or outcome is irrelevant.<sup>24</sup>
- 3.4. The Corporations Act, section 21, states some factors which themselves constitute carrying on business in Australia<sup>25</sup> and states limitations on the definition.<sup>26</sup>

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<sup>20</sup> An AFSL not required for carrying on reinsurance business only: excluded by s. 765A(1)(g).

<sup>21</sup> *Sutton*, para. 4.10.

<sup>22</sup> *Sutton*, para. 4.110.

<sup>23</sup> *Sutton*, para. 4.140.

<sup>24</sup> Corporations Act, s. 18.

<sup>25</sup> Corporations Act, s. 21(2).

<sup>26</sup> Corporations Act, s. 21(3).

## **Carry on life insurance business in Australia**

- 3.5. Only a corporation registered under the LI Act is entitled to carry on life insurance business in Australia.<sup>27</sup> Life insurance business means issuing life policies or undertaking liability under life policies.<sup>28</sup>
- 3.6. The meaning of ‘carry on life insurance business in Australia’ is subject to some provisions of the LI Act which expand the definition. Certain marketing and agency activities constitute ‘carrying on life insurance business in Australia’.<sup>29</sup>

### **Illegality issue**

- 3.7. If a company is carrying on life insurance or life business in Australia unlawfully, its life insurance contracts are enforceable by its policyowners.
- 3.8. The LI Act, section 230, provides that: ‘A life company’s failure to comply with this Act does not invalidate any policy issued by the company. Life company means a company that is carrying on life insurance business in Australia.’
- 3.9. The effect of the section is that a policy issued by an unregistered life insurer is valid and enforceable against the life insurer.

## **4. Prudential regulation**

### **LI Act**

#### *Life policy*

- 4.1. The first key definition for the application of the LI Act is a *life policy*. A *life policy* is relevantly for modern risk products:

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<sup>27</sup> LI Act, s. 17.

<sup>28</sup> LI Act, s. 11. There is an expanded meaning which is not relevant here: s. 11(3) and *Sutton*, para. 4.900.

<sup>29</sup> LI Act, ss. 18 and 19; *Sutton*, para. 4.910.

a contract of insurance that provides for the payment of money on the death of a person or on the happening of a contingency dependent on the termination or continuance of human life<sup>30</sup>

- 4.2. A policy is not a *life policy* if the duration is to be not more than a year and payment is made only in the event of death by accident or death from a specified sickness.<sup>31</sup> This provision excludes short term sickness and accident insurance from a *life policy*.
- 4.3. A life policy includes a *continuous disability policy*.<sup>32</sup> A *continuous disability policy* is a contract of insurance:
- a) that is, by its terms, to be of more than 3 years' duration; and
  - b) under which a benefit is payable in the event of:
    - i. the death, by accident or by some other cause stated in the contract, of the person whose life is insured (the **insured**);<sup>33</sup> or
    - ii. injury to, or disability of, the insured as a result of accident or sickness; or
    - iii. the insured being found to have a stated condition or disease.<sup>34</sup>
- 4.4. The duration test is referable to contracts of insurance of the same kind and to the age of the policyowner.<sup>35</sup>
- 4.5. A contract of insurance is not a *continuous disability policy* if the terms of the contract permit alteration by the *life company*; there are qualifications on the alterability test.<sup>36</sup> A consumer credit insurance contract<sup>37</sup> and a health insurance contract are not a *continuous disability policy*.<sup>38</sup>

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<sup>30</sup> LI Act, s. 8, Dictionary in the Schedule and s. 9(1)(a); s. 9(1)(b) refers to a contract of insurance which is subject to payment of premiums for a term dependent on the termination or continuance of human life.

<sup>31</sup> LI Act, s. 9(2).

<sup>32</sup> LI Act, s. 8, Dictionary in the Schedule and ss. 9(1)(e) and 9A; *Bottrell v National Mutual Life Association of Australasia Ltd* [2007] NSWSC 458 at [64] concluded that a policy that provided for the payment of a monthly benefit for an insured suffering total disablement fell within section 9A and 9 of the *Life Insurance Act*.

<sup>33</sup> In this Background Paper, the life insured.

<sup>34</sup> LI Act, s. 8, Dictionary in the Schedule and ss. 9(1)(e) and 9A.

<sup>35</sup> LI Act, s. 9A(2). LI Act, s. 9A(2); *Green v AMP Life Ltd* [2006] NSWSC 370 held that a policy that allowed for termination on three months' notice was not within section 9A for that reason at [78].

<sup>36</sup> LI Act, s. 9A(3)–(5).

<sup>37</sup> LI Act, s. 9A(6): consumer credit insurance contract is defined by reference to the definition in the IC Act.

<sup>38</sup> LI Act, s. 9A(7).

- 4.6. A person, other than a company registered by APRA under the LI Act,<sup>39</sup> must not issue or undertake liability under a *life policy*.<sup>40</sup>

### *Business*

- 4.7. The LI Act refers to business in three different contexts:
- a) *life business*;
  - b) *life insurance business*;
  - c) the business of a statutory fund.<sup>41</sup>
- 4.8. The core definitions of *life business* and *life insurance business* are relevantly the same but *life insurance business*:
- a) includes sinking fund policies but *life business* does not include sinking fund policies;
  - b) does not include superannuation business but *life business* does include superannuation business;<sup>42</sup>
  - c) has some exemptions from *life business*.
- 4.9. The business of a statutory fund is, by definition, *life insurance business*.<sup>43</sup>
- 4.10. The *Life Insurance Act 1945* (1945 Act) also defined life insurance business as life business, continuous disability insurance business and sinking fund business.<sup>44</sup> Life business was defined in the 1945 Act as business of, or in relation to, the issuing of, or the undertaking of liability under, life policies.<sup>45</sup>

### *Life business*

- 4.11. The second key definition for the application of the LI Act is *life business*. The definition of *life business* is:
- life business means business that consists of:
- a) the issuing of life policies or the undertaking of liability under life policies; or
  - b) any business that relates to business referred to in paragraph (a).<sup>46</sup>
- 4.12. Section 19 provides that certain conduct is deemed to be the *carrying on of life business*:

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<sup>39</sup> LI Act, s. 21, which refers to life insurance business.

<sup>40</sup> LI Act, s. 17.

<sup>41</sup> But see the references to 'insurance business' in the LI Act, s. 230AB; it is not defined.

<sup>42</sup> LI Act, s. 8 and the Dictionary in the Schedule.

<sup>43</sup> LI Act, ss. 3(2)(b) and 29; see also Part 6 on financial management of life companies.

<sup>44</sup> *Life Insurance Act 1945* (1945 Act), s.4.

<sup>45</sup> The 1945 Act, s. 4.

<sup>46</sup> LI Act, s. 8, the Dictionary in the Schedule.

1. For the purposes of this Part,<sup>47</sup> a person who publishes or distributes, or procures the publication or distribution of, a statement relating to the willingness of the person to do something that constitutes the carrying on of life business is taken to carry on that business.
2. For the purposes of this Part, a person is taken to carry on life business in Australia if:
  - a) *business that, under this Act, would constitute life business is carried on by another person outside Australia; and*
  - b) the first-mentioned person acts, in Australia, as the agent of that other person in relation to the business carried on outside Australia.

4.13. Section 18 provides:

A person is not taken to be carrying on life business merely because the person:

- a) collects premiums under a policy issued outside Australia to a person who was resident outside Australia at the time of issue of the policy; or
- b) makes payments due under such a policy.

4.14. Both sections 18 and 19 refer to *life business*.

#### *Life insurance business*

4.15. The third key definition for the application of the LI Act is *life insurance business*. The LI Act defines *life insurance business* as including the issuing or undertaking of liability under life policies, sinking fund policies and any related business.<sup>48</sup>

4.16. The LI Act provides that a number of types of business do not constitute *life insurance business* including:

- a) benefits provided by a trade union for its members or their dependants;<sup>49</sup>
- b) any scheme or arrangement under which superannuation benefits, pensions or payments to employees or their dependants (and not to any other persons) on retirement, disability or death are provided by an employer or by employees, or by both, wholly through an organisation established by the employer or employees;<sup>50</sup>
- c) a funeral benefit product and funeral expenses insurance.<sup>51</sup>

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<sup>47</sup> Part 3 of the LI Act deals with the registration of life companies and their non-operating holding companies.

<sup>48</sup> LI Act, ss. 11(1)(a)(i) & (iii) and (b), s. 8 and the Dictionary in the Schedule; related business includes the investment, administration and management of the assets of a statutory fund: s. 11(2).

<sup>49</sup> LI Act, s. 11(3)(a).

<sup>50</sup> LI Act, s. 11(3)(c).

<sup>51</sup> LI Act, s.11(3)(e).

- 4.17. APRA is entitled to declare that insurance business<sup>52</sup> (other than health or property insurance)<sup>53</sup> or the provision of eligible financial benefits<sup>54</sup> is to be treated for the purposes of the LI Act as if it were *life insurance business*. APRA has not made a declaration in relation to any insurance business.
- 4.18. A *life company* providing a *life policy* is carrying on *life insurance business* under the LI Act.
- 4.19. A *life company* providing life insurance is carrying on *life insurance business* under the LI Act. A *life company* is defined to mean a company that is carrying on *life insurance business* in Australia.<sup>55</sup> A friendly society will be a *life company* if it carries on *life insurance business*.<sup>56</sup>
- 4.20. The effect of being *life insurance business* is that the full regulatory provisions of the LI Act apply including:
- a) the prudential standards apply;<sup>57</sup>
  - b) the business must be conducted by a statutory fund;<sup>58</sup>
  - c) a transfer or amalgamation of life insurance business is subject to the LI Act.<sup>59</sup>

### *Life company*

- 4.21. The fourth key definition for the application of the LI Act is a *life company*. A *life company* is defined to mean a company that is carrying on *life insurance business* in Australia. It would seem to follow that once the criterion of carrying on *life insurance business* is met, the entity which carries on that business is a *life company* whether it is registered under the LI Act or not.
- 4.22. There is some drafting in the LI Act which presents an alternative construction:
- a) the definitions are subject to a contrary intention in the context in which the definition is used;<sup>60</sup>

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<sup>52</sup> Not defined in the LI Act.

<sup>53</sup> LI Act, s. 12A.

<sup>54</sup> LI Act, s. 12B.

<sup>55</sup> See paras. 2.24–2.28 below.

<sup>56</sup> LI Act, ss. 16A(2), 8 and the Dictionary in the Schedule; see paras. 2.29–2.30 below.

<sup>57</sup> LI Act, s. 3(2)(b).

<sup>58</sup> LI Act, ss. 3(2)(b), 13 and Part 4.

<sup>59</sup> LI Act, s. 3(2)(f).

<sup>60</sup> LI Act, s. 8(2): ‘Unless the contrary intention appears, an expression defined in the dictionary has the meaning there set out.’

- b) the sections, in relation to registration and applications for registration, refer to ‘companies’ and ‘company’;<sup>61</sup>
  - c) the sections which refer to aspects of regulation under the LI Act all refer to a *life company*.<sup>62</sup>
- 4.23. The conclusion from these elements would be that a *life company* is a company which is registered by APRA to carry on life business.<sup>63</sup> There is no judicial determination of the issue nor any regulatory policy on it.
- 4.24. The classification as a *life company* means that the full regulatory provisions of the LI Act apply<sup>64</sup> including:
- a) APRA’s enforcement rights apply;<sup>65</sup>
  - b) the LI Act provisions about winding up apply.<sup>66</sup>

### *Friendly society*

- 4.25. A friendly society will be a *life company* if it carries on *life insurance business*.<sup>67</sup>
- 4.26. The LI act applies to friendly societies subject to certain modifications.<sup>68</sup> The modifications are in relation to: certain key concepts,<sup>69</sup> statutory funds,<sup>70</sup> and other matters.<sup>71</sup>

## 5. Consumer protection regulation

### **Life insurance contract**

- 5.1. A contract of life insurance (life insurance contract) under the IC Act is defined as a *life policy* under the LI Act.<sup>72</sup> A contract of general insurance (general insurance

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<sup>61</sup> LI Act, ss. 3(2)(a), 21, 22; and s. 248 on offences against the LI Act; but not s. 233 on the LI Act jurisdiction; Part 7 on monitoring and investigation of a life company and Part 8 on judicial management, external administration and windup refer to a body corporate and its ‘business’.

<sup>62</sup> LI Act, ss. 3(2)(b)-(e) and 28AA, Part 4 on statutory funds, Part 6 on financial management of life companies; Part 9, ss. 226, 234, 254; but not s. 23 on a breach of registration conditions and ss. 26–27A on revocation of registration; s. 240 on decision reviews.

<sup>63</sup> LI Act, ss. 3(2)(c), 20 and Part 3, Division 2.

<sup>64</sup> LI Act, ss. 3(2)(b)-(e) and 28AA, Part 4 on statutory funds, Part 6 on financial management of life companies; Part 9 ss. 226, 234, 254; but not s. 23 on a breach of registration conditions and ss. 26-27A on revocation of registration; s. 240 on decision reviews.

<sup>65</sup> LI Act, s. 3(2)(d).

<sup>66</sup> LI Act, s. 3(2)(e).

<sup>67</sup> LI Act, s. 16A(2), s. 8 and the Dictionary in the Schedule;

<sup>68</sup> LI Act, s. 16A(4).

<sup>69</sup> LI Act, Part 2A, Division 3.

<sup>70</sup> LI Act, Part 2A, Division 4.

<sup>71</sup> LI Act, Part 2A, Division 5; and the Life Insurance Regulations 1995, Part 2A.

<sup>72</sup> IC Act, s. 11(1).

contract) under the IC Act is an insurance contract that is not a life insurance contract.<sup>73</sup>

5.2. Under the IC Act some sections apply to life insurance contracts only.<sup>74</sup>

### **Life Insurance Code of Practice**

5.3. A life insurance contract, a *life policy*, is covered by the Life Insurance Code of Practice (the Life Code).<sup>75</sup>

5.4. The Life Code applied from 30 June 2017.<sup>76</sup> The Financial Services Council (FSC) introductory note in the Life Code states:

The Code sets out the life insurance industry's key commitments and obligations to customers on standards of practice, disclosure and principles of conduct for their life insurance services, such as being open, fair and honest.

It also sets out timeframes for insurers to respond to claims, complaints and requests for information from customers.

The Code covers many aspects of a customer's relationship with their insurer, from buying insurance to making a claim, to providing options to those experiencing financial hardship or requiring additional support.

The Code is binding on life insurance companies; in its first iteration it is not intended to put obligations on financial advisers or planners or superannuation trustees. A list of the companies bound by the Code can be found on the FSC website.

The Code is monitored by an independent committee, to ensure effective compliance by life insurers. Insurers can be sanctioned if they do not correct breaches of the Code.

5.5. The FSC states that the 'Key Code Promises' are:

1. We will be honest, fair, respectful, transparent, timely, and where possible we will use plain language in our communications with you.
2. We will monitor sales by our staff and our authorised representatives to ensure sales are appropriate.
3. If we discover that an inappropriate sale has occurred, we will discuss a remedy with you, such as a refund or a replacement policy.

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<sup>73</sup> IC Act, s. 11(6).

<sup>74</sup> IC Act, ss. 25, 27A, 29, 31A, 32, 48AA, 48A, 59A and 70.

<sup>75</sup> Life Insurance Code of Practice (the Life Code), s. 2.10(e) and s. 15, the definition of Life Insurance Policies.

<sup>76</sup> Life Code, s. 2.8.

4. We will provide additional support if you have difficulty with the process of buying insurance or making a claim.
5. When you make a claim, we will explain the claim process to you and keep you informed about our progress in making a decision on your claim.
6. We will make a decision on your claim within the timeframes defined in the Code, and if we cannot meet these timeframes you can access our complaints process.
7. If we deny your claim, we will explain the reasons in writing and let you know the next steps if you disagree with our decision.
8. We will restrict the use of investigators and surveillance, to ensure your legitimate right to privacy.
9. The independent Code Compliance Committee will monitor our compliance with the Code.
10. If we do not correct Code breaches, sanctions can be imposed on us.

### **Financial product**

- 5.6. It is necessary to consider separately the regulation of a life insurance contract in relation to a *financial product* under both the Corporations Act and the *Australian Securities and Investments Commission Act 2001* (ASIC Act). On consumer protection regulation generally, see GIBP, Part Six, particularly section 3.

### **Corporations Act 2001**

- 5.7. The definition of a *financial product* is the fulcrum of regulation under the Corporations Act. A life insurance contract is a *financial product*, subject to exceptions.<sup>77</sup>
- 5.8. A contract of life insurance, a life policy, is a *financial product*.<sup>78</sup>

### **Hawking prohibition**

- 5.9. The inclusion of life insurance contracts and life policies in the financial services licensing and conduct regime contained in the Corporations Act, means that they are included in the prohibition on anti-hawking contained in section 992A of that Act. The effect of the anti-hawking provisions is that if there is an offer to sell or issue a life insurance product to a retail client in the course of an unsolicited telephone call or

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<sup>77</sup> See GIBP, Part Six, particularly s.3.

<sup>78</sup> Corporations Act, s. 764A(1) (d), (e) and (f).

contract, the client has a limited time to return the product and obtain a refund. There are some exceptions, including being given a product disclosure statement (PDS).<sup>79</sup>

- 5.10. ASIC states that in 2004 it obtained Federal Court orders under anti-hawking laws restraining an insurer from selling funeral insurance door-to-door to Indigenous consumers.<sup>80</sup> The ‘scheme or arrangement’ to be assessed was the trust deeds and membership application forms that gave rise to the legal relationship between the insurer and the insured, and did not include other documents such as a policy and procedures manual.<sup>81</sup> The documents did not require payment to be made for the sole purpose of meeting the relevant expenses, but rather simply provided for payment, a ‘specified cash benefit’ to be made; therefore the arrangement was held not to be a ‘funeral expenses policy’ and therefore the anti-hawking provisions applied.<sup>82</sup> ASIC did not argue and the Court did not consider whether the scheme or arrangement was a *life policy* – a funeral life insurance.

### ASIC Act

- 5.11. The ASIC Act has two definitions of *financial product*.
- 5.12. One applies to Part 2, Division 2, and it is set out in section 12BAA. The Part 2, Division 2, definition includes a contract of insurance<sup>83</sup> and a life policy as *financial products*.<sup>84</sup> Part 2, Division 2, provides measures in relation to unconscionable conduct and consumer protection in relation to financial services. These measures do not apply to life policies because of the effect of the IC Act, section 15: see the GIBP, Part Seven.
- 5.13. The other definition applies to the ASIC Act, but not to Part 2, Division 2 (general definition).<sup>85</sup> The general definition adopts the definition of *financial product* in the Corporations Act, Chapter 7. The effect is that a life policy is the subject of ASIC’s powers under the ASIC Act.
- 5.14. On consumer protection regulation generally, see GIBP, Part Six, particularly section 3.

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<sup>79</sup> *Sutton*, paras. 4.770 and 5.150; *Pynt*, para. 4.20.

<sup>80</sup> The ASIC Report refers to Media Release (04-094MR): *ASIC acts to stop illegal door-to-door selling to indigenous communities*, 1 April 2004; the media release is withdrawn from ASIC’s website. The case referred to appears to be *ASIC v Aboriginal Community Benefit Fund Pty Ltd* [2004] FCA 178.

<sup>81</sup> *ASIC v Aboriginal Community Benefit Fund Pty Ltd* [2004] FCA 178 at 59–60.

<sup>82</sup> *ASIC v Aboriginal Community Benefit Fund Pty Ltd* [2004] FCA 178 at 59, 68.

<sup>83</sup> ASIC Act, s. 12BAA (1), (5) and (7)(d) but compare (e).

<sup>84</sup> ASIC Act, s. 12BAA (1), (5) and (7)(d) but compare (e).

<sup>85</sup> ASIC Act, s. 5(2)(a).

## 6. Life insurance framework reform package

- 6.1. The life insurance framework (LIF) reform package is a set of reforms recommended by independent reviews of the industry and supported by the Government<sup>86</sup> and ASIC to improve life insurance customer outcomes. The explanatory memorandum to the Bill<sup>87</sup> cited three reports which identify the need for reform in the life insurance sector and made the case for the LIF package.
- 6.2. The LIF reform package, including the Act,<sup>88</sup> ASIC Regulatory Guidance (CP245), Life Insurance Code of Practice (the Life Code) and Approved Product List Industry Standard (APL Standard), are intended to address a number of issues including those identified by ASIC in Report 413, the Financial System Inquiry and those detailed by the Trowbridge Report on retail life insurance advice.
- 6.3. The primary objectives of the LIF package are to ensure better and fairer outcomes for consumers by:
  - a) improving the quality of life insurance advice;
  - b) reducing the potential for conflicts of interest;
  - c) promoting competition; and
  - d) enhancing professional and ethical standards of financial advisers.

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<sup>86</sup> Kelly O'Dwyer (in the role of Minister for Small Business and Assistant Treasurer), *Government announces significant improvements to life insurance industry*, Media Release, 6 November 2015.

<sup>87</sup> Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016.

<sup>88</sup> *Corporations Amendment (Life Insurance Remuneration Arrangements) Act 2017*.

## PART THREE – RELATIONSHIPS, SALES AND REMUNERATION

### 1. Introduction

- 1.1. The policyowner pays the premium for the life insurance product to the life insurer. The cost (insurance premiums) will vary from individual-to-individual, depending on their type of cover, level of cover and personal circumstances. The premium is then invested by the life insurer.
- 1.2. The premium plus the investment returns are used to pay the costs and expenses of the life insurer. These costs and expenses include:
  - a) reinsurance and claims costs;
  - b) administration, including underwriting;
  - c) advice.
- 1.3. The cost and expenses vary as a percentage of premium among these aspects. The breakdown is about: 50–60 per cent for the life insurer’s reinsurance and claims costs; 15 per cent for administration; and 30 per cent for advice.

### 2. Life insurance industry sectors

- 2.1. The Australian Securities and Investments Commission (ASIC) found that the life insurance industry can be categorised into three sectors based on the three ways in which consumers may purchase life insurance: through an advice provider (retail); directly from an insurer (direct); or through their superannuation fund and the group life cover offered by the fund (group).<sup>89</sup>
- 2.2. The majority of life insurance policies are held within group superannuation. In 2015, there were 14 million group policies, 4 million retail policies, and 3.9 million direct policies.<sup>90</sup>
- 2.3. In each of the three sectors, there are different arrangements for purchasing life insurance, associated with the how the life insurance is sold:
  - a) direct or non-advised – provided directly by insurers or their distributors, partners or affiliates without any personal advice. The life insurance provided through this channel is often a simpler product. Consumers who choose not to seek advice may be able to understand and access this product themselves.
  - b) group – provided as a group policy purchased by the trustee of a superannuation fund or an employer, with fund members ultimately given the benefit of the

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<sup>89</sup> ASIC, Report 413, *Review of retail life insurance advice*, 9 October 2014, p. 4; See GLIBP.

<sup>90</sup> ASIC, Report 498, *Life insurance claims: An industry review*, October 2016, p. 35.

cover under the policy. The default nature of the cover provided through this channel gives access to life insurance to the largest number of consumers, many of whom would not be able to afford premiums if they were individually underwritten or the premiums were not paid from their superannuation fund account. Cover is not tailored to a particular member's circumstances.

- c) retail (advised) – provided by financial advisers. If appropriate personal advice is provided, consumers should be able to source a life insurance product through this channel that is based on their circumstances.<sup>91</sup>

### 3. Advisers

- 3.1. There are two broad categories of adviser in the Australian financial services sector: institutionally-aligned and non-institutionally-aligned.

#### **Institutionally-aligned advisers**

- 3.2. Forty-four per cent of all advisers are employed authorised representatives or aligned to one of the four major Australian banks or AMP. The alignment is as a self-employed authorised representative of an Australian Financial Services Licence (AFSL) subsidiary of one of the five entities, commonly called a dealer group.
- 3.3. Self-employed aligned advisers pay their dealer group fees in exchange for services such as compliance, brokerage, software, research, PI insurance, education and training. The fees charged by institutionally-owned dealer groups deliberately do not cover the cost of providing dealer services. They are heavily discounted to attract advisers.
- 3.4. Typically, in exchange for subsidised dealer fees, advisers are encouraged to recommend related-party products. The main way this is legally done is via restricted approved product lists (APLs) which are populated with in-house product – life insurances issued by a life insurer in the same corporate group as the dealer group.

#### **Non-institutionally aligned advisers**

- 3.5. This category is made up of advisers who either hold their own AFSL or who are authorised by a non-institutionally owned dealer group.
- 3.6. The General Insurance Background Paper No. 14 (GIBP) gave an overview of insurance relationships in Part Five. ASIC Report 498, Part B, contains an overview of the life insurance industry.

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<sup>91</sup> Parliamentary Joint Committee on Corporations and Financial Services, Inquiry into the life insurance industry – Submission by the Australian Securities and Investments Commission (January 2017) Pages 29-30 <<https://download.asic.gov.au/media/4537030/pjc-inquiry-life-insurance-industry.pdf>>.

## 4. Approved product lists

### **Background**

- 4.1. An APL sets out the financial products that an Australian Financial Services (AFS) licensee has approved for recommendation by its authorised representatives. ASIC defined an ‘approved product list’ as a list of financial products, determined by the advice licensee. It sets out the financial products that the licensee considers are suitable for the licensee’s representatives to recommend to customers. APLs will often include deposit products, investment and superannuation products, and life insurance products.<sup>92</sup>
- 4.2. The relevant financial products for the purposes of this Background Paper are life insurance contracts. The AFS licensee is usually a financial advice dealer group (dealer group) and the authorised representatives are individual planners or advisers (advisers) who operate under a corporate structure.
- 4.3. The theory and practice originally was that APLs set out products that the AFS licensee had researched and reviewed. The research and review might be supplied by a research house which professed expertise in the work. The focus of the research and review was on the comparative pricing on life insurance contract terms, but there are more recent examples of other criteria like service capability, claims accountability, underwriting flexibility and premium accountability.
- 4.4. When the authorised representative, after advising the client in accordance with the relevant common law, statutory and regulatory requirements, recommended a life insurance contract from the APL, it would be a professional and careful recommendation to the client to take out the life insurance product as part of the client’s wealth management and protection portfolio.
- 4.5. If an adviser recognised that there was a product that was not on the APL that was in the client's best interests, the adviser could make a special request to have it approved. The relevant committee of the AFS licensee and authorised representatives would consider the product and then either reject it, approve it for use by that adviser only, or put it on the APL for other advisers to use.
- 4.6. Now a material number of dealer groups offer few life insurance products on their APL and the majority are life insurance products issued by a life company within the same corporate group as the dealer group.

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<sup>92</sup> ASIC, Report 562: Financial advice: Vertically integrated institutions and conflicts of interest, January 2018, para. 12, Note 1.

## Open and Closed APLs

- 4.7. The 2015 Trowbridge Report found that AFS licensees operate an APL that contains a selection of life companies from among the life companies<sup>93</sup> in the advised retail life insurance market at the time of the review. The Trowbridge Report<sup>94</sup> stated that it is common for AFS licensees to have very few life companies, in some cases only one, on their APL. Where the ASF licensee is owned by, or in the same corporate group as, a financial institution or life company, the common practice is that the APLs include financial products issued by that financial institution or life company only, and possibly one or two others (Closed APL). Other AFS licensees have an ‘open architecture’ approach that lists all advised retail life companies on the APL (Open APL).<sup>95</sup> There are no publicly available statistics on the number of dealer groups who have Closed APLs and on the numbers of advised retail life companies and products on Closed APLs.

## Regulation

### *Introduction*

- 4.8. ASIC had been tasked by the Government to oversee the effective introduction of the LIF package. The Financial Services Council (FSC) has accepted the responsibility of developing two components of the LIF package: the Life Code and the APL Standard. All material retail advised life companies in the Australian market are members of the FSC and, accordingly, the FSC Life Code and the APL Standard would effectively be binding on the entire market.

### *Life Code*

- 4.9. The Life Code does not refer to APLs.

### *APL Standard*

- 4.10. The FSC APL standard applied from 1 July 2018. The first main criterion for the FSC APL Standard is that the APL is prepared through a fair and reasonable process which gives clients’ (customers and policyowners’) interests priority.<sup>96</sup>
- 4.11. The second main criterion for the FSC APL Standard is that:

The FSC supports principles of competitive access and choice for all advisers and their clients to available life insurance products.

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<sup>93</sup> The number has decreased because of acquisitions: AIA of CommInsure; Zurich of OnePath and the balance of MLC.

<sup>94</sup> John Trowbridge, *Review of Retail Life Insurance Advice* (Trowbridge Report), March 2015, p. 9.

<sup>95</sup> Trowbridge Report, p. 9.

<sup>96</sup> FSC, FSC Standard No. 24: Life Insurance Approved Product List Policy, ss. 3.6, 5 and 7.

In practice this means that an AFSL Member's Life Insurance APL must contain the choice of 3 or more life insurance providers.<sup>97</sup>

4.12. ASIC noted the FSC APL Standard in Report 562.<sup>98</sup>

## 5. Remuneration

- 5.1. The remuneration flows within and between the various components of the life insurance industry are complex. There are a range of commissions – upfront, trailing, hybrid, and level – and various fees and other monetary payments as well as non-monetary payments and ‘soft dollar’ benefits.
- 5.2. The GIBP gave an overview of insurance relationships in Part Five.

## 6. Standards for financial advisers

- 6.1. On 22 February 2017, the *Corporations Amendment (Professional Standards of Financial Advisers) Act 2017* came into force. This Act includes requirements that both new and existing financial advisers satisfy compulsory education standards such as the passing of an examination and ongoing professional development. These requirements will commence from 1 January 2019 and new advisers must hold a relevant degree from this date. Existing advisers will have until 1 January 2021 to pass an examination and until 1 January 2024 to comply with other required education standards.

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<sup>97</sup> *ibid.*, ss. 4.1 and 4.2.

<sup>98</sup> ASIC, Report 562, *Financial advice: Vertically integrated institutions and conflicts of interest*, January 2018, para. 130.

## PART FOUR – PRE-CONTRACT PROCESSES

### 1. Introduction

- 1.1. Life insurance, in contrast to, for example, health insurance, is not an indemnity policy. An indemnity policy insures the policyowner against a loss actually suffered or amounts actually expended.
- 1.2. In the case of life insurance, the amount paid out by the insurer (which is commonly referred to as a benefit) is set by the insurer's determination as to the amount of cover it is willing to sell to a prospective applicant. This determination by the insurer, which would include the amount of cover to be offered and the premium to be paid, is based on the risk profile of the applicant for insurance. The risk profile of the applicant will, in turn, be based on information provided to the insurer through, for example, physical examinations, health records and relevant family history.
- 1.3. Life insurance contracts are generally guaranteed renewable. In practice this means they will only be risk rated once, before the original contract of insurance is entered into. This is in contrast to certain policies issued by general insurers, such as sickness and accident policies, which ordinarily are renewed annually and which require disclosure by the insured before each renewal.
- 1.4. Insurers require an insured to give to the insurer all relevant information to enable the insurer to make a decision as to whether to insure the insured, and if so, on what terms. The *Insurance Contracts Act 1984* (IC Act) protects the position of the insurer by requiring the policyowner to disclose relevant information up to entry into the contract of life insurance as well as dealing with the situation where a policyowner gives the insurer incorrect information in the application for insurance. In each case, whether there has been a failure to disclose or a failure to answer questions in the application correctly, the insurer may have a right to avoid the contract: section 29. If a right to avoid does not exist, or if the insurer elects not to avoid then the insurer may have a right to vary the contract in certain circumstances: section 29(4) and section 29(6). The insurer may also have a right to cancel the contract where the insured has made a fraudulent claim whether under that contract or another contract with the same insurer during the same insurance cover period: section 59A. The remedies in the IC Act for non-disclosure or misrepresentation are exclusive of any right the insurer has otherwise than under the IC Act: section 33.
- 1.5. The General Insurance Background Paper No. 14 (GIBP) gave an overview of insurance processes in Part Five.

## 2. Genetic testing

### **Discrimination and privacy laws<sup>99</sup>**

- 2.1. The issue has arisen as to whether, and if so, to what extent, it is valid for an insurance company to take into account genetic test results. In particular, the extent to which, if any, insurers should be able to require that certain testing take place, or if already undertaken, to compel disclosure of the results. Other issues arise as to whether the results from one person can be used when considering the insurability of others who possess similar genetic traits such as family members and possibly even future descendants.<sup>100</sup>
- 2.2. The use of genetic information is a particularly challenging issue for life insurers and the community generally. There is a tension between, on the one hand, the medical benefits of undertaking genetic testing to discover a pre-disposition to certain diseases with the threat it poses to an individual's privacy and the risk of discrimination. Similar issues arose on the discovery of HIV-AIDS; there was a need to balance the risk of the spread of infection while at the same time safeguarding the individuals who were HIV-positive so as not to stigmatise, discriminate against or unduly breach their right to privacy.
- 2.3. The predictive nature of some forms of genetic testing makes it particularly relevant to life insurers. Indeed, insurers, particularly life insurers, have collected and used family medical histories for over a hundred years.<sup>101</sup> The increasing availability, accuracy and affordability of genetic testing means that issues of access to and appropriate use of such information by insurers will become more important.
- 2.4. At present, the use by life insurers of genetic information is dealt with by internal Industry Standards, namely, the Financial Services Council (FSC) Standard No. 11, *Genetic Testing Policy* (2016), and FSC Standard No. 16, *Family Medical History Policy* (2016).<sup>102</sup>

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<sup>99</sup> AI Green Paper.

<sup>100</sup> Dr Julie-Anne Tarr, 'Regulatory Approaches to Genetic Testing in Insurance', *Sydney Law Review*, vol. 24, 2002, pp.189, 195.

<sup>101</sup> Australian Law Reform Commission (ALRC), *Essentially Yours: The Protection of Human Genetic Information in Australia* (ALRC Report 96), 2003, s. 25.2.

<sup>102</sup> Dated 7 December 2016.

- 2.5. Protection against misuse of that information is provided by legislation including, at the Federal level, the *Sex Discrimination Act 1984* (SDA) and the *Disability Discrimination Act 1992* (DDA) and, at the State level, Anti-Discrimination legislation.
- 2.6. Each Act makes it unlawful to discriminate in the provision of goods and services. 'Services' is defined to include insurance services: SDA section 4(1); DDA section 4(1). Each Act also contains exceptions relating to the provision of insurance, which permit insurers to discriminate in certain circumstances: SDA section 41; DDA section 46. The exceptions reflect the fact that insurance is in some instances mutually rated, as opposed to community rated and depends upon an assessment of risk which takes into account the particular characteristics of applicants which, in the case of life insurance, may include genetic test results.

*What is a genetic test and do the results have to be disclosed?*

- 2.7. Important information affecting our health characteristics is passed down from one generation to the next through our genes. Genes contain information that, for example, dictates our personal attributes, including hair and eye colour, as well as how our bodies function. If a gene is altered, a disease may result. Genes associated with a disease can be inherited just as easily as a gene that determines eye colour. Alterations in genes are called mutations.
- 2.8. Recent medical research has uncovered clear links between particular gene mutations and certain inheritable diseases, for example, breast cancer. Members of a family can be tested for the presence of a mutated gene to help identify their risk of acquiring the disease.
- 2.9. The FSC Standard No 11 Genetic Testing Policy defines genetic testing as:
  - ... a medical test that identifies changes in chromosomes and genes. These tests incorporate pathogenic variants in DNA. The results of a genetic test may confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder, or risk from that disorder.
- 2.10. Genetic information may enable insurers to assess the risk that each applicant brings to the insurance pool. There is concern however about the use of such information by the insurance industry.
- 2.11. To alleviate concerns concerning the use by insurers of genetic testing the life insurance industry has adopted an internal industry standard, FSC Standard No. 11, *Genetic Testing Policy*.
- 2.12. The key elements of the Policy include:
  - a) insurers will not initiate any genetic tests on applicants for insurance;
  - b) insurers may request that all existing genetic test results be made available to the insurer for the purpose of classifying the risk;

- c) insurers should not ask for genetic test results for the purposes of risk classification in circumstances where an Applicant's genetic test results were solely used for the purpose of a medical research study conducted by an accredited university or medical research institution where:
  - i. the test results are not known by an applicant and will not be provided to the applicant; or
  - ii. the applicant has specifically requested not to receive the test results;
- d) members must provide their employees and authorised representatives with sufficient information and training so that they understand the content and meaning of the Standard so far as it relates to their particular jobs and responsibilities;
- e) an insurer, when assessing the cumulative risk associated with a genetic test result, should consider the potentially-beneficial effects of medical screening, early diagnosis and treatment on the applicant's long-term health outlook;
- f) insurers will ensure that results of existing genetic tests are obtained only with the written consent of the tested individual;
- g) the results of a genetic test will be used only in the assessment of an insurance application in respect of the individual on whom the test was conducted;
- h) insurers will ensure that strict standards of confidentiality apply to the handling and storage of the results of genetic tests;
- i) insurers will provide reasons for offering modifications or rejections to applicants in relation to either new applications or requests for increases on existing policies;
- j) insurers will have a competent and efficient internal dispute resolution system to deal with complaints relating to underwriting decisions involving a genetic test result.

2.13. Member companies of the FSC are required to certify compliance with the policy annually in accordance with the terms of the FSC Standard No. 1, *Code of Ethics & Code of Conduct*.

*Privacy law restrictions*

- 2.14. Doctors who conduct genetic testing on an insured will treat this as confidential, as they would any other medical information. The information is protected from disclosure as part of patient/doctor confidentiality. The doctor will not release the test results unless the insured/patient has given written authority to do so.
- 2.15. Insurers who obtain genetic or other medical information about an insured or the insured's family will be subject to the *Privacy Act 1988*. An individual's right to privacy has been reinforced by recent amendments to this Act. The *Privacy Amendment (Enhancing Privacy Protection) Act 2012* sets out 13 Australian Privacy Principles. These principles, which apply to insurers, came into effect on 12 March 2014 and regulate the collection, handling, use, disclosure, transfer and management of 'personal information' which includes medical information.

### 3. Mental health conditions<sup>103</sup>

#### **Underwriting**

- 3.1. The underwriting process is concerned to know if there is a history of mental illness or a mental illness condition. If such a history or condition is disclosed, there will be a mental illness questionnaire. The questionnaire is intended to obtain answers about the severity and nature of illness, number of episodes, the duration of episodes, the amount of time off work, and the time since the last episode.
- 3.2. Mental health conditions may be difficult to underwrite for a number of reasons including:
  - a) each case is different in some way and needs to be assessed on its own merits;
  - b) inconsistency in approach with respect to treatment and diagnosis within the medical profession;
  - c) inappropriate care in terms of up to date treatment and practice;
  - d) poor reporting of medical information.<sup>104</sup>
- 3.3. The underwriter will ask for the relevant medical report from the relevant medical professional. The diagnostic criteria for mental illness do not have the same objective or universally understood clinical presentation compared with physical injuries or illnesses. The underwriter will consider the company and reinsurance guidelines. 'There will be some instances where the underwriter will be unable to offer unrestricted cover and alternatives such as an exclusion or premium extra may be considered. There may be circumstances where the application may be deferred for a period of time or cover may not be offered at all.'<sup>105</sup>
- 3.4. Mental health advocacy groups express concern that underwriting can be uninformed about mental illness and its effects generally or insufficiently precise on those specifics for the applicant. The underwriting may not be evidence based; it may be subjective or biased.<sup>106</sup> Insurers are seen as taking no account or insufficient account of the type of illness, severity, prognosis or its consequences for longevity or income earning capacity.<sup>107</sup>

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<sup>103</sup> This section is based on extracts from the AIDA Paper and the ACFS Paper. Dr Ian Enright is retained by the Australian Government National Mental Health Commission on insurance, including on the Royal Commission.

<sup>104</sup> FSC, *Underwriting Guidelines for Mental Health Conditions*, Guidance Note No. 15, September 2003.

<sup>105</sup> FSC, *Underwriting Guidelines for Mental Health Conditions*, Guidance Note No. 15, September 2003.

<sup>106</sup> MHCA and beyondblue, *Mental Health, Discrimination and Insurance: A Survey of Consumer Experiences 2011*, 2011.

<sup>107</sup> MHCA and beyondblue, *Mental Health, Discrimination and Insurance: A Survey of Consumer Experiences 2011*, 2011.

- 3.5. The Mental Health Council of Australia Survey reports that approximately 80 per cent of people surveyed agreed or strongly agreed that it was difficult to obtain life insurance or income protection insurance due to mental illness. In total about 35 per cent of applications for all insurances (car, home & contents, travel, life and income protection (IP)) (20 per cent for life alone) received insurance without exclusions or increased premium; over 20 per cent were declined due to mental illness (and just under 20 per cent due to other reasons), and about 40 per cent (50 per cent for life alone) received insurance but with exclusions for mental illness or increased premium. Online achieved the best results (55 per cent) compared with in person or through a third party.<sup>108</sup>
- 3.6. The communication of an insurance decision can create greater distress for a person with mental illness. The communication of underwriting decisions increased negative perceptions of the experience of applying for insurance as well as the treatment of mental illness, and the insurance industry in general for some Mental Health Council of Australia Survey respondents.<sup>109</sup>

### **Claims**

- 3.7. An important issue on the categorisation of claims cause is that mental illness can develop from physical injury or illness. Some life companies would characterise a mental illness in these circumstances as a mental illness and some would characterise it as the causative physical injury or illness.
- 3.8. IP mental illness claims usually have a longer duration than most physical injury or illness claims. The longer duration results in higher claims costs.
- 3.9. The FSC said that it is generally recognised that mental illness claims are difficult to assess:
- a) each case is different in some way and is assessed on its individual merits;
  - b) inconsistency of approach, and diagnosis, within the medical profession;
  - c) non-current treatment in terms of up to date best medical practice;
  - d) lack of critical appraisal of claimant symptoms and other mental state activities in addition to their reported complaints;
  - e) lack of understanding of the role of insurance;
  - f) an inclination to certify total disability readily, or even permanent disability, without exploring treatment alternatives or attempting a return to work or rehabilitation plan.<sup>110</sup>

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<sup>108</sup> MHCA and beyondblue, *Mental Health, Discrimination and Insurance: A Survey of Consumer Experiences 2011*, 2011.

<sup>109</sup> MHCA and beyondblue, *Treasury Consultation on 'Unfair terms in insurance contracts': A joint submission by the Mental Health Council of Australia and beyondblue: the national depression initiative*, May 2010.

<sup>110</sup> FSC, *Claims Guidelines for Mental Health Conditions*, FSC Guidance Note No. 14, September 2003, para. 1.1.

- 3.10. The Investment and Financial Services Association's (IFSA, predecessor to the FSC) report on claims data collection<sup>111</sup> found that the 1961 open mental illness claims represented 17 per cent of all IP/group salary continuance (GSC) claims, an increase from the previous report and 21.9 per cent of all IP/GSC claim payments. The higher percentage for claim payments was assumed to be because of the longer duration of these claims. The claim payments were down from 25 per cent in the previous report, but this seems to be because of a data collection anomaly. The 1725 open mental illness total and permanent disability (TPD) claims represented 16 per cent of all TPD claims and 19.6 per cent of all TPD payments, again higher than the previous report. The prevalence of mental illness claims for IP/GSC/TPA all increased with age. Ages 51–65 is the dominant group. About 70 per cent of the IP claims were for males. About 53 per cent of the TPS claims were for males. Depressive disorders accounted for 58 per cent of IP/GSC and about 58 per cent of TPD claims.
- 3.11. In the Mental Health Council of Australia Survey, 41 per cent of claims related to mental illness were accepted 'without problems', 13 per cent were accepted with problems and 12 per cent were partly declined.
- 3.12. Several Mental Health Council of Australia Survey respondents reported difficulties when they made a claim on their life insurance policies and in some cases commented that their experiences exacerbated their mental illness.<sup>112</sup>

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<sup>111</sup> IFSA, *Report on Claims Data Collection*, May 2006, p. 5.

<sup>112</sup> MHCA and beyondblue, *Treasury Consultation on 'Unfair terms in insurance contracts': A joint submission by the Mental Health Council of Australia and beyondblue: the national depression initiative*, May 2010.

## FSC Guidelines and Standard

- 3.13. The FSC has guidelines and a standard for mental health conditions: underwriting,<sup>113</sup> claims<sup>114</sup> and education and training.<sup>115</sup>
- 3.14. The underwriting Guideline is for disability income insurance. It suggests application questions.<sup>116</sup> It recommends protocols for dealing with a disclosed and undisclosed mental health condition during underwriting. The communications should be through the adviser where an adviser is involved.<sup>117</sup>
- 3.15. The claims Guideline is also for disability income insurance. There is guidance about the claims management process,<sup>118</sup> case management,<sup>119</sup> periodic review<sup>120</sup> and claim forms.<sup>121</sup>
- 3.16. The purpose of the FSC education and training Standard is to ensure individual representatives or entities authorised by a life insurer to provide information to consumers in respect of the management of an FSC Member's life insurance products receive an appropriate level of education and training in relation to 'mental health' awareness. The Standard also requires the Member to review the effectiveness of the Member's Mental Health Education Program designed to ensure mental health awareness among such representatives or authorised entities.
- 3.17. The FSC Standard requires that the mental health education and training modules must demonstrate learning objectives that:
- a) increase general awareness and understanding of the causes, signs and symptoms of common *mental health conditions* in the community;
  - b) increase understanding of what it is like to have a *mental health concern*; and

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<sup>113</sup> FSC, *Underwriting Guidelines for Mental Health Conditions*, FSC Guidance Note No. 15, September 2003.

<sup>114</sup> FSC, *Claims Guidelines for Mental Health Conditions*, FSC Guidance Note No. 14, September 2003.

<sup>115</sup> FSC, *Mental Health Education Program and Training*, FSC Standard No. 21, 1 September 2013.

<sup>116</sup> FSC, *Underwriting Guidelines for Mental Health Conditions*, FSC Guidance Note No. 15, September 2003, s. 3.

<sup>117</sup> *ibid.*, s. 4.

<sup>118</sup> FSC, *Claims Guidelines for Mental Health Conditions*, FSC Guidance Note No. 14, September 2003, s. 3.

<sup>119</sup> *ibid.*, s. 4.

<sup>120</sup> *ibid.*, s. 5.

<sup>121</sup> *ibid.*, s. 6.

- c) develop communication skills for interacting with consumers who may have *mental health concerns*.<sup>122</sup>
- 3.18. The FSC Standard sets out a non-exhaustive list of training providers and resources for education and training under the Standard.<sup>123</sup>

## 4. Gender

- 4.1. A person's gender recorded on the birth certificate is determinative of the person's sex under state legislation. The state legislation specifies an administrative process for transgender persons who have undergone gender reassignment to change the sex recorded on their birth certificate. There is no equivalent commonwealth legislation. However, there is case law to support the conclusion that for commonwealth legislation, such as the IC Act, if a person has:
  - a) undergone gender reassignment surgery, the person's sex is the person's non-biological sex (as per the surgery);
  - b) not undergone gender reassignment surgery, the person's sex is the person's biological sex (even if the person has lived and identified as the opposite sex for a number of years).<sup>124</sup>
- 4.2. If a person has undergone gender reassignment and discloses to an insurer the person's non-biological sex, there is no misrepresentation because this is legally the person's sex.
- 4.3. If a person has not undergone gender reassignment surgery and discloses his/her identified sex rather than his/her legal sex, this may still not be misrepresentation if that person held a belief (a belief that they are the identified sex) that a reasonable transgender or intersex person in that position would have held: IC Act, section 26(1).
- 4.4. If an insurer wishes to know a person's biological sex, this would need to be the subject of an express question. However, such a question may be contrary to anti-discrimination legislation if an insurer cannot establish that one of the exceptions in the anti-discrimination legislation applies. There is commonwealth and state anti-discrimination legislation. In New South Wales, the *Anti-Discrimination Act 1977* prohibits discrimination on transgender grounds. The only exceptions to these provisions relate to sports and superannuation (not insurance). As there is no exception for insurance, it is unlawful for an insurer discriminate against a person on transgender

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<sup>122</sup> FSC, *Mental Health Education Program and Training*, FSC Standard No. 21, 1 September 2013, s. 8.1.

<sup>123</sup> *ibid.*, s. 9.1.

<sup>124</sup> *Re Secretary Dept of Social Security and HH* (1991) 23 ALD 58; *Kevin v A-G (Cth)* [2001] FamCA 1074; *Scafe v Secretary, Dept of Families, Housing, Community Services & Indigenous Affairs* [2008]; compare *R v Harris and McGuinness* (1988) 17 NSWLR 158.23 ALD 58; *Kevin v A-G (Cth)* [2001] FamCA 1074; *Scafe v Secretary, Dept of Families, Housing, Community Services & Indigenous Affairs* [2008]; compare *R v Harris and McGuinness* (1988) 17 NSWLR 158.

grounds. It would therefore be unlawful to ask a person in New South Wales to disclose whether the person is transgender in an insurance application.

## 5. HIV

- 5.1. The FSC Guidance Note is to provide background and guidance for FSC Members relating to underwriting in respect of insurance applicants with HIV/AIDs or insurance applicants who engage in activities which can represent a significantly above-average risk of leading to a subsequent infection.<sup>125</sup> The Guidance Note has recommendations about: questions to be included in an application for life insurance; criteria for requesting an HIV screening test; choice of HIV testing arrangements; procedures for tests arranged by the insurer; confidentiality; medical authorities; communication of test results and an example of an exclusion of HIV and AIDS.

## 6. Medical protocols

- 6.1. A life company usually requests an authorization from a life insured to access the person's medical records and health information at the time of applying for a life policy and at the time of making a claim. The life company seeks a broad range of information, documents and tests for the purposes of underwriting the risk: see section 7 below.
- 6.2. A mental health condition may make it difficult to obtain insurance.<sup>126</sup> The fact that a person may have seen a counsellor once, when documented in consultation notes, might have an adverse effect on the access to, terms and pricing of insurance for a person who experiences a mental health condition.
- 6.3. It is not clear what data is used by life insurers to make underwriting decisions that include assessment of mental health information, whether the data is up to date, and if the data reflects the fact that mental illness takes many forms and affects individuals differently.
- 6.4. The access of life insurers to full medical records and health information means that medical practitioners face ethical dilemmas in having to provide information to life insurers that may not be in their patients' best interest.
- 6.5. There is also a concern that a patient may be reluctant to seek necessary treatment, particularly for mental ill health, due to concerns over life insurers having access to their full medical records and health information and then using such information to limit or deny coverage or a claim.<sup>127</sup>

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<sup>125</sup> FSC, Guidance Note No. 32: *HIV/AIDS Underwriting Guidelines*, 19 June 2013.

<sup>126</sup> ACFS Paper.

<sup>127</sup> See generally, ACFS Paper and the AI Green Paper.

## 7. Insurer processes<sup>128</sup>

### **Introduction**

- 7.1. Underwriting for life insurance is a process of assessing the risk in long term contracts. The objective is to ensure those with a similar risk profile pay the same premium.

### **Application and personal statement**

- 7.2. A life company requires an applicant, sometimes called a proponent, for a life risk insurance contract to make a proposal (or application) which usually consists of two documents: an application form and questionnaire in a personal statement. The application form is completed by information about the policyowner and the insurance sought. The personal statement is a form with detailed requests for information about the life insured.
- 7.3. The questionnaire includes questions about the applicant's occupation,<sup>129</sup> financial circumstances, smoking status and medical information, and any high risk activities engaged in by the applicant; the answers supply the standard information needed by the life company. The questions vary in their drafting, clarity and precision. The underwriter in the life company then decides whether he or she requires any medical tests or reports or further information about the applicant to consider the risk presented by that person. These requirements could relate to any of the standard information items. For example, if an applicant's occupation is 'window cleaner', the underwriter would need to know whether the applicant cleans the windows of houses or high-rise buildings. If the applicant includes 'hiking' as a pursuit, the underwriter would need to know whether it is bush walking or mountain climbing. The underwriter also wants to be satisfied that the applicant is financially able to justify the level of cover: is the level so high compared to the applicant's financial situation that the applicant is unlikely to be able to afford the premium or does the discrepancy create a moral hazard for the applicant. All of this information allows the underwriter to profile the applicant and determine the specific level of risk presented by that person. The standard information in the application form is required regardless of the amount of cover sought. There are benefit levels above which further information, beyond the standard information, will be required.
- 7.4. The life company will also usually require a personal medical attendant's report and a medical examination by a doctor nominated or approved by the life company.

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<sup>128</sup> See generally, Productivity Commission, *Data Availability and Use*, Draft Report, October 2016, para. 4.1, pp. 155-157, 542.

<sup>129</sup> Professional, white collar, blue collar, light blue collar and heavy blue collar. The grouping is done within the LIC.

- 7.5. The information from these processes and documents is used by the life company's underwriters to decide whether to reject or accept an application, and if accepted, the premium and terms and whether to include a coverage or benefit exclusion.

### **Pricing and underwriting**

- 7.6. When all relevant information has been gathered and assessed, the underwriter can categorise the risk presented by the applicant as being either 'standard' or 'substandard'.<sup>130</sup> A 'standard' risk describes an applicant who fits the profile of an average policyowner. A 'substandard' risk describes an applicant who is a below average risk profile: a higher risk for the life company.
- 7.7. For 'standard' risks, the rate or premium charged by the life insurer will be the 'standard' premium based on the life company's rating factors, usually for the person's age, sex, smoking status and occupation as set by the life company on advice from the life company's actuaries. There would be no loadings or exclusions. 'Standard' refers to the underwriting assessment basis.<sup>131</sup>
- 7.8. A life company evaluates and sets the premium rates offered to life insurance applicants on advice from its actuaries and the appointed actuary. The life insurance industry actuaries use premium rate tables, prepared, validated and promulgated by the life insurance industry and its experts under the aegis of the Actuaries Institute. The premium rate tables are used to calculate the premium rates. The life company might, after advice from its appointed actuary,<sup>132</sup> adjust a table it uses for marketability of its relevant products. A typical premium rate table includes different rates depending on the age of the life insured, the sex of the life insured, whether the life insured is a smoker or non-smoker, and other rating factors depending on the policy type. Before the premium rates are set (depending upon materiality) the life company will need to seek the advice of the appointed actuary regarding the appropriateness of the premium rates. The appointed actuary when providing this advice will consider the expected cost of the resulting claims. The pricing model and the calculation of the claims costs make various actuarial assumptions which are based on mortality and morbidity statistics and experience and then applies different assumptions based on the characteristics of a risk that might be presented. The rates are typically set as a rate per dollar sum insured. A pricing actuary runs projections that predict future cashflows (premiums and claims) to evaluate the future profitability of the business.

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<sup>130</sup> In the US, this categorisation is subdivided into preferred life categories.

<sup>131</sup> Financial Services Council & KPMG, *2007-2009 Disability Income Industry Experience Investigation Report*, April 2013, para. 1.1.3, p. 1.

<sup>132</sup> The advice must be prepared and provided in accordance with the Actuaries Institute, *Professional Standard 200: Actuarial advice to a Life Insurance Company [or Friendly Society]*, July 2015, and its Explanatory Memorandum; APRA Life Prudential Standard 320.

- 7.9. The rates in a premium rate table are the ones that will apply to life insureds who have gone through underwriting and have been accepted with no additional terms, exclusion or premium loading placed by the underwriters. These risks are 'standard lives'.
- 7.10. A 'substandard' risk describes an applicant who is a below average risk or an impaired insurance risk. This decision would be made because of, for example, the applicant's health status, including family history of disease, occupation or high-risk pastimes. The insurer will use an underwriting manual, often supplied by, or based on advice or a manual from, its reinsurer. The insurer calculates mortality and morbidity ratings from: publicly available data and information; medical studies published in reputable journals; Australian Institute of Health and Welfare and similar sources.
- 7.11. The underwriter would consult with the insurer and the reinsurer's medical officers. The underwriter has to decide what, if any, premium loading should be applied to the 'sub-standard' risk under the life insurance policy. A loading is a percentage or proportional increase of and over the standard risk premium. The underwriter might, depending on the circumstances, apply a mortality/morbidity loading or a per mille loading; see below. Finally, the underwriter will make a decision about the risk. The underwriter may conclude that the risk cannot be insured by the life insurer because the risk is too high to accept and so reject the risk. The underwriter might decide to accept the risk with exclusions or accept with a higher premium.<sup>133</sup>
- 7.12. The mortality/morbidity loading is an additional cost built into the policy. The loading is reasoned or justified on the basis that an unhealthy life is of shorter duration and, without a loading, less premium is earned before a claim is made on the policy. The loading means that the insurer and reinsurer (if any) can achieve the same ratio of premium to claim of a standard life, and recover the same premium that they would recover over the normal expected life of a healthy insured life. A loading is expressed in terms of a percentage. For example, +100% means the standard risk premium is increased by 100%: doubled. A percentage loading is used when there is an additional risk that increases with age, usually a disease.
- 7.13. A premium loading may also be expressed in terms of an additional dollar amount per mille. For every thousand dollars insured, an additional premium is applied. For example, +\$10 per mille means the standard annual risk premium is increased by \$10 for every thousand dollars insured. A per mille loading is used when there is an additional risk that remains constant regardless of age, for example, a dangerous pastime or hobby. The loading may be applied at a higher rate in the early years and then gradually reduced the longer the insured lives. The per mille loading is a function of the condition.
- 7.14. The pricing for a portfolio is based on these precepts above for the pricing and underwriting of an individual life but the processes are different. The pricing work for

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<sup>133</sup> A higher premium is by a 'loading' of the standard premium; the decision might be to offer insurance with exclusions *and* a higher premium.

a current portfolio or product focusses on the 'experience' for standard lives in the insured population for the portfolio or product. The life insurance industry cannot measure the experience of the general population. 'Experience' has a technical meaning. A life company will assess and predict, for a subject range or portfolio of life insurance products, the number and dollar value of 'expected claims'. As the portfolio develops, the life company will calculate the number and dollar value of 'actual claims' and they are compared with the expected claims: this is the 'experience' of the portfolio.

### **Pricing and claims**

- 7.15. Data from the applicant in the personal statement is used by a life company for underwriting, and sometimes in the claim context in relation to misrepresentation and non-disclosure, but ordinarily not used later or otherwise for pricing, incidence or experience.
- 7.16. Where a claim is declined, there will be no experience which can be used for pricing
- 7.17. Claim causes are usually recorded in accordance with the International Classification of Diseases, Ninth Revision. The first level is used most often and the second level is used less often. APRA is encouraging the industry to use the International Classification of Diseases, Tenth Revision. The industry uses the Tenth Revision for reporting for experience studies.

### **Reasons for declining the risk**

- 7.18. Section 75 of the IC Act sets out the situations where an insurer is obliged to give reasons to the policyowner for its decisions in relation to a particular risk or insurance contract.
- 7.19. Under section 75, if an insurer does not accept an offer to enter a contract of insurance, cancels or refuses to renew it, the insurer must give the insured a statement in writing setting out its reasons if the insured makes a written request: section 75(1)(a).
- 7.20. The same applies if the insurer, by reason of some special risk relating to the insured or to the subject-matter of the contract, offers cover on less advantageous terms than it would otherwise offer: section 75(1)(d).
- 7.21. If the policyowner is not the life insured and the health of the life insured was the only reason for not accepting the offer, cancelling, refusing to renew or offering on less advantageous terms than usual, the insurer is not obliged to provide its reasons: section 75(3). Such a statement must be given to the life insured if the life insured makes such a request in writing: section 75(5).

### **Issues**

- 7.22. The processes described in this Part raise community issues involving: access to and affordability of insurance, underinsurance, sustainability, expectation alignment and fairness. These processes raise legal issues involving the categorisation, application

and consequences of: misrepresentation, non-disclosure, privacy and unlawful discrimination.

7.23. APRA released a discussion paper on the role of appointed actuaries within insurers in June 2016. APRA was concerned that appointed actuaries had become increasingly compliance focused, limiting their ability to provide strategic advice to management, particularly for life insurance. APRA also noted an increased turn-over of appointed actuaries within the life insurance industry. APRA proposed reforms which required changed behaviour from insurers, actuaries and APRA including:

- a) introducing a purpose statement for appointed actuaries;
- b) implementing a clear actuarial advice framework;
- c) improving the management of potential conflicts of interest;
- d) improving reporting requirements and simplifying prudential standards.<sup>134</sup>

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<sup>134</sup> APRA, *The role of the Appointed Actuary and actuarial advice within insurers*, Discussion Paper, June 2016, pp. 4–5.

## PART FIVE – PRE-CONTRACT DISCLOSURES AND REPRESENTATIONS

### 1. Introduction – background and context

- 1.1. The proposal (or application) for a life risk insurance product usually consists of two documents: an application and a personal statement. The application form is completed by information about the policyowner and the insurance sought. The personal statement is a form with detailed requests for information about the life insured. The insurer asks about personal and family history in the questions in the personal statement. The questions vary in their drafting, clarity and precision.
- 1.2. The insurer will also usually require a personal medical attendant's report and a medical examination by a doctor nominated or approved by the insurer.
- 1.3. The information from these processes and documents is used by the insurer's underwriters to decide whether to reject or accept an application, and if accepted, at standard premium rates or to apply a premium loading or a coverage or benefit exclusion.
- 1.4. The documents and the processes of each party in dealing with the documents are relevant to a number of important insurance issues which might arise in a dispute.
- 1.5. There is no requirement for a life insurance contract to be in writing. An application for insurance may be made over the internet or by telephone. The process for making the application might affect the disclosure and representation duties.
- 1.6. The General Insurance Background Paper 14 (GIBP) discussed disclosures and representations in relation to insurance generally in Part Eight. This Part discusses those issues for life insurance.

### 2. Outline summary – legal elements<sup>135</sup>

- 2.1. A policyowner, before entering into a contract of insurance, must disclose to the insurer every matter known to the policyowner that the policyowner knows to be relevant, or that a reasonable person in the circumstances could be expected to know is relevant, to the insurer's decision to accept the risk and the terms of the acceptance.<sup>136</sup> A representation by a policyowner must be correct and true. An insurer is entitled to a remedy if the policyowner, life insured, or a person for whom either is vicariously liable, has misrepresented or not disclosed a relevant matter.

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<sup>135</sup> *Sutton*, para. 7.10; Pynt, Chapter 7; Mann, Part IV commentary.

<sup>136</sup> IC Act, s. 21(1); *Sutton*, para. 7.20; Pynt, Chapter 7; Mann, s. 21.10–21.40.

- 2.2. A policyowner's duty of disclosure is not a part of the duty of utmost good faith under the *Insurance Contracts Act 1984* (IC Act).<sup>137</sup> Any breach of the policyowner's duty of disclosure is not a breach of the duty of utmost good faith under the IC Act.
- 2.3. There are three key questions:
  - a) Was there a misrepresentation or non-disclosure at the relevant time?
  - b) Who is responsible and liable for the misrepresentation or non-disclosure?
  - c) What is the remedy?
- 2.4. The IC Act is an exclusive code on the parties' obligations, rights and remedies on misrepresentation and non-disclosure: section 33. The common law before the IC Act is relevant to the interpretation of the provisions of the IC Act. The parties cannot contract out of the disclosure or representation obligations, rights or remedies.

### 3. Group insurance

- 3.1. The obligations, rights and remedies on misrepresentation and non-disclosure do not usually apply in group insurance. The insurer does not underwrite the individual risks or lives insured and does not ask health or medical questions. There is no opportunity for the individual life insured to disclose or represent a matter to the insurer.<sup>138</sup> When the life insured wants life insurance other than the insurance which is automatically available under the group policy, the obligations, rights and remedies on misrepresentation and non-disclosure would usually apply to that life insurance or cover.
- 3.2. The law however makes provision for obligations, rights and remedies on misrepresentation and non-disclosure in group life insurance. An insurer is entitled, in principle, to avoid or vary cover retrospectively in relation to a life insured under a 'group life contract'<sup>139</sup> if the life insured failed in the duty of disclosure, or made a misrepresentation before insurance cover was provided to the life insured under the scheme.<sup>140</sup>
- 3.3. A misrepresentation or non-disclosure might occur *after* the proposed life insured *became a member* of the relevant superannuation, retirement or other group life scheme but *before* the *insurance cover was provided* by the group life contract in respect of the life insured. Then the failure or misrepresentation is taken to have occurred before the proposed life insured became a life insured under the group life contract.<sup>141</sup>

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<sup>137</sup> IC Act, s. 12; *Sutton*, para. 7.10; Pynt, para. 8.30; Mann, s. 12.10.1.

<sup>138</sup> *Sutton*, 7.530; Pynt, Chapter 7; see GLIBP.

<sup>139</sup> Now defined in the IC Act, s. 11.

<sup>140</sup> IC Act, s. 32; Mann, s. 32.10–32.40.

<sup>141</sup> IC Act, s. 32; Mann, s. 32.10–32.40; see GLIBP.

## 4. Non-disclosure

### Introduction

- 4.1. A policyowner, before entering into a contract of insurance, must disclose to the insurer every matter known to the policyowner that the policyowner knows to be relevant, or that a reasonable person in the circumstances could be expected to know is relevant, to the insurer's decision to accept the risk and the terms of the acceptance.<sup>142</sup> There are exceptions.
- 4.2. The duty of disclosure does not require the disclosure of a matter that:
  - a) diminishes the risk to an insurer;<sup>143</sup>
  - b) is common knowledge;<sup>144</sup>
  - c) the insurer knows or in the ordinary course of its business ought to know; or
  - d) where the duty of disclosure is waived by the insurer.<sup>145</sup>
- 4.3. The insurer waives the duty of disclosure:
  - a) under the common law by asking a limited question;<sup>146</sup>
  - b) under the common law by agreement by the insurer;<sup>147</sup>
  - c) under section 21(3), if the policyowner fails to answer a question in a proposal form at all or gives an obviously incomplete or irrelevant answer but the insurer has not asked for further information;<sup>148</sup>
  - d) if section 21A or 21B applies to the contract as an eligible contract.<sup>149</sup>
- 4.4. The method and content of disclosure by the policyowner and life insured are closely related. There must be a fair presentation of the risk.<sup>150</sup>
- 4.5. The IC Act pre-contract duty of disclosure of the policyowner does not include the duty of utmost good faith – IC Act, section 12.<sup>151</sup>
- 4.6. The statutory duty of disclosure ends when the insurance contract is entered into<sup>152</sup> and therefore does not apply to provide for a continuing disclosure duty under the policy. The duty is not qualified by considerations of whether the policyowner had a reasonable opportunity to disclose relevant matters.<sup>153</sup>

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<sup>142</sup> IC Act, s. 21(1); Sutton, para. 7.20; Pynt, Chapter 7; Mann, s. 21.10.1–21.10.9.

<sup>143</sup> Sutton, para. 7.420; Pynt, Chapter 7.

<sup>144</sup> Sutton, paras. 7.430–7.480; Pynt, Chapter 7; Mann, s. 21.20.1.

<sup>145</sup> IC Act, s. 21(2); Sutton, para. 7.110; Pynt, Chapter 7; Mann, s. 21.20.2 and 21.20.3.

<sup>146</sup> Sutton, para. 7.510; Pynt, Chapter 7; Mann, s. 21.30.1–21.30.3.

<sup>147</sup> Sutton, paras. 7.120 and 7.490–7.560; compare s. 52. Pynt, Chapter 7.

<sup>148</sup> IC Act, s. 21(3)(a); Sutton, para. 7.540; Pynt, Chapter 7; Mann s. 21.30.1–21.30.3.

<sup>149</sup> Sutton, para. 7.130; Pynt, Chapter 7; Mann, ss. 21A and 21B commentary.

<sup>150</sup> Sutton, para 7.10, 7.130; Pynt, Chapter 7.

<sup>151</sup> IC Act, s.12.

<sup>152</sup> IC Act, s.21(1); Sutton, para. 7.790; Mann, s. 21 commentary.

<sup>153</sup> *Summerton v SGIC Life Ltd* [1999] SASC 121.

## Notice

- 4.7. The insurer must inform the policyowner and life insured clearly of the general nature and effect of the duty of disclosure including sections 21A, 21B and 31A. The notice must be given before the contract is entered into or if it is not practicable to do so, orally where practicable, and then in either case, in writing within 14 days after the contract is made.<sup>154</sup> An insurer is not obliged to give a notice if the policyowner has a broker or agent arranging the life insurance contract.<sup>155</sup> An insurer who has not complied with section 22 is not entitled to exercise any rights in relation to a non-disclosure unless the non-disclosure was fraudulent.<sup>156</sup>
- 4.8. IC Act amendments to sections 21 and 21A came into effect on 28 December 2015. The IC Act, section 21B came into effect on 28 June 2013 but if there is no information that the insurer supplied the applicant with a section 22 notice which complied with section 21B(2), the section does not come into effect until 28 December 2015.
- 4.9. The section 22 notice must ‘clearly inform’ the policyowner about the duty of disclosure. In *Suncorp General Insurance Ltd v Cheikh*<sup>157</sup> the New South Wales Court of Appeal held that the receipt of a document containing information on the reverse as to the duty of disclosure did not mean that the requirements of section 22(1) had been met. Of the three documents that the insured was assumed to have received one was concerned with the payment of the premium, one was a form letter explaining an increase in the premium but which contained a reference to the duty of disclosure hidden away in the penultimate paragraph and not highlighted, and one was a certificate of insurance, on the reverse side of which was placed a statement of the duty without any highlighting, or any appropriate cross-referencing on the front of the document. In these circumstances, the court found that section 22(1) had not been complied with. Stein JA commented that the adverb ‘clearly’ in ‘clearly inform’ was a plain English word and its ordinary meaning would convey the need for some precision in the making known of the relevant duty, while Giles JA observed that the contents of the note on the back of the certificate had to be made known to the insured, and had to be made known to him clearly. He added:

Clarity was required not only in the contents of the note by which information was conveyed but also by the manner in which the note conveying the information was made known. A note in a document without attention appropriately drawn to it would not suffice, even if

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<sup>154</sup> IC Act, ss. 22 and 69; *Sutton*, para. 7.110 and 7.290–7.410; Pynt, Chapter 7; Mann.

<sup>155</sup> IC Act, s. 71; *Sutton*, para. 7.410; Pynt, Chapter 7; Mann, s. 71.20–71.60.

<sup>156</sup> IC Act, s. 22(5) and (6); *Sutton*, para. 7.110 and 7.290–7.410; Pynt, Chapter 7; Mann s. 22.10–22.90.

<sup>157</sup> (1999) 10 ANZ Insurance Cases 61-442; [1999] NSWCA 238.

the contents of the note were adequate to state the general nature and effect of the duty of disclosure.<sup>158</sup>

- 4.10. The *Cheihk* approach is preferred to the approach in *Wallace*<sup>159</sup> in the context of the Life Insurance Code of Practice standards, the amendments to the IC Act and the Financial Ombudsman Service (FOS) Terms of Reference.

### **Knowledge and relevance**

- 4.11. There are two knowledge elements for non-disclosure. First, the disclosure duty is limited to a matter that is known by the policyowner – see section 6 below. Second, the matter must be relevant to the insurer’s decision – see the following paragraphs.
- 4.12. The common law on materiality is now irrelevant because the test is relevance and relevance to the actual insurer not the ‘prudent insurer’.<sup>160</sup> The filter of the attitude of the reasonable insurer, to avoid the policyowner being capriciously subject to the idiosyncrasies of the actual insurer, is lost. But there is protection for the policyowner in section 21(1)(b) because a reasonable policyowner is unlikely to know the idiosyncrasies of the actual insurer.<sup>161</sup>
- 4.13. But here, the matter must first be objectively relevant for disclosure to be the subject of the disclosure duty.<sup>162</sup>
- 4.14. Relevance is measured by reference to the decision of the insurer whether to accept the risk and, if so, on what terms. Relevance is a much narrower concept than material. It is limited to relevance to the risk being accepted.<sup>163</sup>

### **Disclosure exceptions**

- 4.15. The disclosure duty exceptions are set out in sections 21(2) and 21(3). An issue is whether an insurer can be held to ‘know’ information it can access or which it has in its possession.<sup>164</sup> The fact that computer searches can be made does not necessarily mean that the insurer will be deemed to know everything such a search could reveal. In order for information to come within section 21(2)(c) it must be known to an appropriate officer or agent ordinarily handling the matter, or be contained in current, official records.<sup>165</sup>

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<sup>158</sup> *Sutton*, see paras. 7.320, 7.330 and 7.340.

<sup>159</sup> *GIO General Ltd v Wallace* (2001) 11 ANZ Insurance Cases 61-506; [2001] NSWCA 299 *GIO General Ltd v Wallace*; *Sutton*, para. 7.340.

<sup>160</sup> IC Act, s. 21(1); *Sutton*, paras. 7.200–7.220; Pynt, Chapter 7; Mann.

<sup>161</sup> IC Act, s.21(1); *Sutton*, para. 7.210; Pynt, Chapter 7; Mann.

<sup>162</sup> IC Act, s.21(1); *Sutton*, para. 7.190; Pynt, Chapter 7; Mann.

<sup>163</sup> IC Act, s.21(1); *Sutton*, para. 7.220; Pynt, Chapter 7; Mann.

<sup>164</sup> *Kotku Bread Pty Ltd v Vero Insurance Ltd* [2012] QSC 109.

<sup>165</sup> *Commercial Union Assurance Co of Australia Ltd v Beard* (1999) 47 NSWLR 735.

- 4.16. An insurer might waive its right to disclosure by the policyowner. An insurer might waive disclosure of a matter due to the way in which it has asked a question in the proposal or by the way it responds to an answer given by a policyowner. For example, if a question in a proposal asks whether the life insured experiences a mental condition or illness, the question might be construed to mean that the insurer has waived disclosure about, for example, episodes of minor depression.<sup>166</sup> On the other hand, the provision by an insurer of two alternative ways to give the insurer the life insured's medical history, namely, the completion of a proposal and medical check, was held not to mean the insurer had otherwise waived the policyowner's general duty of disclosure.<sup>167</sup>
- 4.17. Under section 21(3), if a policyowner fails to answer or gives an obviously incomplete or irrelevant answer to a question in the proposal the insurer is deemed to have waived compliance with the duty of disclosure in relation to the matter. Nor will it constitute a misrepresentation: section 27. The reasoning behind the provisions is that the insurer has, by the answer or absence of an answer, been put on inquiry and by failing to undertake further inquiry has relinquished its right to argue that proper disclosure was not made in relation to that matter.
- 4.18. The issue of waiver in the context of non-disclosure was considered in *ABN Amro Bank NV v Bathurst Regional Council*.<sup>168</sup> There it was held that although section 21(3) did not apply, the insurer had nonetheless waived disclosure in relation to a particular matter within the meaning of section 21(2)(d).
- 4.19. The Full Court held that section 21(3) did not apply in relation to the first of the insureds because the questions in the proposal form were not directed to it. The Court said that before section 21(3) is enlivened there must have been a question in a proposal form which the proposed insured has failed to answer or in respect of which the proposed insured has given an obviously incomplete or irrelevant answer. 'Proposal form' is defined in the IC Act section 11 to include, relevantly, a document containing questions to which a person is asked to give answers (whether in the document or not) where the answers are intended (whether by the person who answered them, by the insurer or by some other person) to be used in connection with a proposed contract of insurance. The definition is inclusive in nature. Completion of an online proposal has been held to constitute a proposal for the purposes of section 21(3).<sup>169</sup>
- 4.20. In *Orb Holdings Pty Ltd v Lombard Insurance Company (Australia) Limited*:<sup>170</sup>
- ... The rationale behind those provisions is that obviously incomplete information puts the insurer on inquiry and, if it omits to inquire, it

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<sup>166</sup> *Graham v Colonial Mutual Life Assurance Society Limited (No 2)* [2014] FCA 717.

<sup>167</sup> *Phillips v ING Life Ltd* (2009) 15 ANZ Ins Cas 90-139.

<sup>168</sup> [2014] FCAFC 65 at [1701]-[1712].

<sup>169</sup> *Celik v NRMA* [2000] NSWSC 380 at [10] and [29]-[33].

<sup>170</sup> [1995] 2 Qd R 51, referring to ss. 21(3) and 27, at 53.

has waived its right to rely upon the insured's failure to disclose or misrepresentation.

- 4.21. The requirement for a proposal form under section 21(3) is a positive one. The statutory inquiry is not relevant where no proposal form exists. The questions in the proposal form were directed to a second policyowner, not the first one. It could not be said that the first policyowner failed to answer a question or gave an obviously incomplete or irrelevant answer to a question.
- 4.22. Section 21(3) provides alternative examples of what will be deemed to be a waiver of compliance. This provision is not a codification of circumstances which may constitute a waiver.
- 4.23. The Full Court held in *Orb Holdings* that section 21(2)(d) did apply in relation to one of the policyowners. Section 21(2)(d) provides that the duty of disclosure does not require disclosure of a matter as to which compliance with the duty is waived by the insurer.

The insurer positively stated that it required no information other than what was contained in, relevantly, the financial statements. The insurer therefore waived compliance with the disclosure duty by the first policyowner when it made clear that it did not require a proposal form to be filled in by the first policyowner but required only financial statements.

### **Eligible contracts**

- 4.24. A different regime applies to 'eligible contracts': as defined and specified in the Regulations.<sup>171</sup> Among life insurance contracts, sickness and accident and consumer credit are eligible contracts. All other contracts are not eligible contracts unless adopted by the insurer as an eligible contract.<sup>172</sup>
- 4.25. There is no duty of disclosure for an eligible contract unless a specific question is asked by the insurer. The duty of disclosure for eligible contracts is limited to answering specific questions asked by the insurer. This will apply to contracts entered<sup>173</sup> or renewed<sup>174</sup> on or after 28 December 2015.
- 4.26. There remains a duty of disclosure for other life insurance contracts which might be waived by a limited question but not by asking no questions at all or by asking a general question.<sup>175</sup>

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<sup>171</sup> IC Act Amendment Regulations, (No 1) SR 118/2000.

<sup>172</sup> By a notice under s. 21A.

<sup>173</sup> See s. 21A.

<sup>174</sup> See s. 21B.

<sup>175</sup> *Sutton*, para. 7.120; Pynt, Chapter 7.

## Enter into and renewals

- 4.27. 'Entered into' is a broad term which includes in the case of life insurance the variation, extension or re-instatement of an insurance contract: section 11(9). A policyowner, therefore, who exercises an option to take up additional life cover would be entering a contract of insurance and subject to the duty of disclosure.<sup>176</sup>
- 4.28. The section 21 duty of disclosure applies on renewal.<sup>177</sup>

## Life insured

- 4.29. It is common for contracts of life insurance to be entered into by one person to cover the life of another. A life insured under a contract of insurance may include persons who are not the insured and, therefore, not subject to duty of disclosure obligations under the common law or the IC Act before 28 December 2015. Although not a party to the contract, the person whose life is proposed to be insured will usually provide information to the insurer about matters such as their state of health.
- 4.30. A new section 31A has been introduced to deal with non-disclosures by life insureds. Section 31A imposes a duty of disclosure on life insureds similar to the duty which applies to insureds under section 21 and provides that the IC Act has effect as if the failure to disclose the matter had been a failure by the insured to comply with the duty of disclosure in relation to the matter. This provision applied from 28 December 2015.

## Onus

- 4.31. The onus is on the insurer to establish each element of its entitlement to a remedy for non-disclosure and misrepresentation.<sup>178</sup>

## 5. Misrepresentation

- 5.1. The IC Act contains a scheme and code in relation to misrepresentation and its remedies but the meaning of 'misrepresentation' remains based in the common law.<sup>179</sup>
- 5.2. A misrepresentation is a statement, usually positive but sometimes constituted by silence,<sup>180</sup> which is untrue and which is intended to affect the other party – not a 'mere puff'.<sup>181</sup> The statement might be one of fact, intention or opinion.<sup>182</sup> The IC Act exempts, or modifies the effect of, some representations from its application.

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<sup>176</sup> *Tyndall Life Insurance Co Ltd v Chisholm* (1999) 11 ANZInsCas 90-104.

<sup>177</sup> IC Act, s. 11(9); *Sutton*, para. 7.940; Pynt, para. 8.31.

<sup>178</sup> *Sutton*, para. 7.800; Mann, s. 21.40.

<sup>179</sup> *Sutton*, para. 7.580; Pynt, Chapter 7.

<sup>180</sup> *Sutton*, para. 7.620; Pynt, Chapter 7; Mann, 26.25.

<sup>181</sup> *Sutton*, para. 7.600; Pynt, Chapter 7.

<sup>182</sup> IC Act, s. 26(1); *Sutton*, paras. 7.650–680; Pynt, Chapter 7; Mann.

- 5.3. First, a question – described in the section heading as ambiguous – in relation to a proposed insurance contract or insurance cover under a group scheme will be interpreted in the way the policyowner understood the question if a reasonable person in the circumstances would have understood the question in the same way.<sup>183</sup>
- 5.4. Second, a statement is not a misrepresentation if the policyowner fails to answer a question in a proposal form at all or gives an obviously incomplete or irrelevant answer.<sup>184</sup>
- 5.5. Third, a statement is not a misrepresentation if it is an untrue statement based on its maker's belief, but the belief was one which a reasonable person in the circumstances would have held.<sup>185</sup> The effect is that a statement of an honest and reasonable belief is not a misrepresentation.<sup>186</sup>
- 5.6. Fourth, a statement is not a misrepresentation unless its maker knew that it would have been relevant to the insurer's decision to accept the risk and, if so, on what terms.<sup>187</sup>
- 5.7. Fifth, and if the fourth position above does not apply, a statement is not a misrepresentation unless a reasonable person in the circumstances could be expected to have known that it would have been relevant to the insurer's decision to accept the risk and, if so, on what terms.<sup>188</sup>
- 5.8. A representation 'with respect to the existence of a state of affairs' cannot be turned into a contract term or warranty by a 'basis clause'.<sup>189</sup>
- 5.9. The meaning of 'a reasonable person in the circumstances' is the same as for non-disclosure.<sup>190</sup>
- 5.10. The IC Act, section 22,<sup>191</sup> does not apply in relation to a misrepresentation.

## 6. Whose misrepresentation or non-disclosure?<sup>192</sup>

- 6.1. The disclosure duty is limited to a matter that is known by the policyowner – see paragraph 4.11 above.<sup>193</sup> The policyowner's knowledge would certainly include actual<sup>194</sup> and imputed (attributed from an agent or within a corporation)<sup>195</sup> knowledge.

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<sup>183</sup> IC Act, s. 23; *Sutton*, paras. 7.690–7.700; Pynt, Chapter 7; Mann, s. 23.10–23.50.

<sup>184</sup> IC Act, s. 27; *Sutton*, para. 7.540; Pynt, Chapter 7; Mann, s. 27.10–27.30.

<sup>185</sup> IC Act, s. 26(1).

<sup>186</sup> IC Act, s. 26(1); *Sutton*, paras. 7.650–680; Pynt, Chapter 7; Mann, s. 26.30.

<sup>187</sup> IC Act, s. 26(2).

<sup>188</sup> IC Act, s. 26(2).

<sup>189</sup> IC Act, s. 24; *Sutton*, para. 7.630; Pynt, Chapter 7; Mann, ss. 24.10 and 24.20.

<sup>190</sup> Paras. 4.20–4.26.

<sup>191</sup> Paras. 4.7–4.10.

<sup>192</sup> *Sutton*, para. 7.610; Pynt, Chapter 7.

<sup>193</sup> IC Act, s. 21(1); *Sutton*, para. 7.140; Pynt, Chapter 7; Mann.

<sup>194</sup> IC Act, s. 21(1); *Sutton*, para. 7.150; Pynt, Chapter 7; Mann.

<sup>195</sup> IC Act, s. 21(1); *Sutton*, paras. 7.160–7.190; Pynt, Chapter 7; Mann.

It probably includes constructive knowledge.<sup>196</sup> An agent's fraud is not attributed to the policyowner principal.<sup>197</sup>

- 6.2. The rights and obligations are those of the policyowner – in the IC Act described as the 'insured' – and the insurer. The life insured is entitled to receive a notice under section 22.
- 6.3. The duty of disclosure applies to the person who is to become the life insured under the policy and the policyowner is liable for a breach of that duty by a life insured.<sup>198</sup>
- 6.4. Section 25 makes the policyowner liable for a misrepresentation by the life insured.
- 6.5. The application forms usually contain terms by which the policyowner agrees with the insurer to be liable for the life insured's misrepresentation and non-disclosure.

## 7. Remedies

### Introduction

- 7.1. The insurer is entitled to a remedy under the IC Act, section 29, if the applicant has breached the duty of disclosure under the IC Act and if, for most cases, the insurer supplied a section 22 notice to the applicant in accordance with the IC Act.<sup>199</sup>
- 7.2. An insurer must also establish that the insurer entered into the life insurance contract induced by, or relying on, the policyowner or life insured's non-disclosure or misrepresentation.<sup>200</sup>
- 7.3. There are three different remedy schemes in the IC Act: in relation to misstatements of age; for fraud; and for other circumstances.<sup>201</sup> The available remedies vary depending on the date the contract or variation was entered into – see the table in Appendix B.

### Age – variation

- 7.4. A non-disclosure or misrepresentation about the date of birth of the life insured is given special treatment in section 30. Section 30 applies whether the misstatement is fraudulent or innocent and the remedy is the adjustment of the sum insured (including bonuses) according to the formula set out in section 30(1). If the true age of the life insured is higher than was stated, so that a higher premium should have been paid, the sum insured may be reduced in proportion by the application of the formula. The

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<sup>196</sup> IC Act, s. 21(1); *Sutton*, para. 7.140; Pynt, Chapter 7; Mann.

<sup>197</sup> IC Act, s. 21(1); *Sutton*, paras. 7.160–7.190; Pynt, Chapter 7; Mann.

<sup>198</sup> From 28 December 2015, under ss. 31A and 32.

<sup>199</sup> IC Act, ss. 21(1) and 22(3); Pynt, para. 8.44–8.47.

<sup>200</sup> *Sutton*, paras. 7.80–7.90, 7.580, 7.1150, 7.1180–7.1240; Pynt, paras. 8.16–8.20 refers to the reasonable influence and actual inducement tests; the position for non-disclosure is different before and after 28 December 2015, see para. 6 above.

<sup>201</sup> IC Act, Part IV, Division 3.

insurer can vary the contract retrospectively by substituting the lesser amount. This variation can be done at any time.<sup>202</sup>

- 7.5. If the true age is lower than stated, and accordingly a lower premium should have been payable, the sum insured should be increased. However, under section 30(2)(b) the insurer is given two options, one of which it must adopt. The first option is that the insurer can reduce the premium payable accordingly as from the date of the contract, and refund the excess (with suitable bonus adjustments) together with interest.<sup>203</sup> The second option is that the insurer can vary the contract by substituting the higher sum insured amount. This variation will be retrospective to the time of entry into the contract. This variation can be done at any time as well.<sup>204</sup>
- 7.6. Section 30(3A) applies to a contract of life insurance originally entered into, or certain variations to the extent of the variation, after 28 June 2013.<sup>205</sup> The section applies to remedies for the misstatement of the life insured's date of birth where the expiry date is calculated by reference to the life insured's date of birth. The section gives the insurer the option of varying the contract by changing its expiration date to an expiration date based on the correct date of birth.

### **Fraud – avoidance**

- 7.7. The insurer may avoid the contract if the breach of duty was fraudulent or the misrepresentation was made fraudulently.<sup>206</sup>
- 7.8. An insurer, in order to prove a non-disclosure is fraudulent, must show that the policyowner knowingly failed to disclose a matter which met the relevance test for the decision of the insurer whether to accept the risk and, if so, on what terms.<sup>207</sup>
- 7.9. An insurer, in order to prove a misrepresentation is fraudulent, must show that it was made: knowingly; without belief in its truth; or recklessly, not caring whether it was true or false. Fraud is committed when the policyowner makes a deliberate decision or acts with reckless indifference to mislead or conceal something from the insurer.<sup>208</sup> The policyowner must intend that the statement should be acted upon by the insurer. It is not enough that the policyowner may have acted carelessly. The insurer must show that the policyowner lacked an honest belief in the truth of the answers. If the policyowner was consciously indifferent to the truth of the answers, the policyowner is taken to have been reckless.

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<sup>202</sup> IC Act, s. 30(2)(a) and s. 30(4).

<sup>203</sup> The rate of interest is fixed by a formula set out in s. 57(3) and in the Insurance Contracts Regulations 1985, reg. 32.

<sup>204</sup> IC Act, s. 30(2)(a) and s. 30(4).

<sup>205</sup> *Insurance Contracts Amendment Act 2013*, Sch 5, Pt 3.

<sup>206</sup> IC Act, s. 29(2).

<sup>207</sup> *Tyndall Life Insurance Co Limited v Chisholm* (2000) 11 ANZIC 90-104.

<sup>208</sup> *Graham v Colonial Mutual Life Assurance Society Limited* (No 2) [2014] FCA 717.

## Disregarding avoidance

- 7.10. Section 31 permits the Court to disregard avoidance in cases of fraudulent misrepresentation or non-disclosure where it would be harsh and unfair not to do so in certain circumstances.

## Other circumstances and remedies

### *Avoidance*

- 7.11. The IC Act deals with two other circumstances and remedies. First, the insurer is entitled to avoid the life insurance contract for innocent pre-contractual conduct in certain circumstances. The avoidance for innocent non-disclosure or misrepresentation, where the insurer would not have entered into ‘a’ contract on any terms, for contracts entered into or varied before 28 June 2014, must be within 3 years after the contract was entered into or varied.<sup>209</sup> The avoidance for innocent non-disclosure or misrepresentation, for ‘the’ contract entered into or varied after 28 June 2014, must be within 3 years after the contract was entered into or varied.<sup>210</sup> If there is a fraudulent non-disclosure or misrepresentation, there is no time limit on the insurer’s communication of the avoidance to the policyowner.<sup>211</sup>
- 7.12. It is not sufficient for an insurer to show it would have deferred its decision had proper disclosure been made. The insurer has to show that, following further investigation, it would eventually have declined the offer.<sup>212</sup> In demonstrating this, an insurer is entitled to take into account information it would have obtained through enquiry made after proper disclosure.<sup>213</sup>
- 7.13. The insurer is deprived of a remedy only where it would have entered into the same contract as that which was made.<sup>214</sup> This is implicit in the wording of section 29(1)(c).
- 7.14. The insurer has the onus of proving that it would not have issued the policy had there been disclosure.<sup>215</sup> If the particular underwriter is no longer available, it may be that an inference can be drawn from evidence given by other underwriters with reference to the insurer’s relevant underwriting guidelines, that establishes the probability of inducement or reliance without the particular underwriter’s evidence.<sup>216</sup> It has been

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<sup>209</sup> IC Act, s. 29(3).

<sup>210</sup> IC Act, s. 29(3).

<sup>211</sup> IC Act, s. 29(2).

<sup>212</sup> *Schaffer v Royal & Sun Alliance Life Assurance Australia Ltd* [2003] QCA 182.

<sup>213</sup> *Davis v Westpac Life Insurance* [2007] NSWCA 175.

<sup>214</sup> *Tyndall Life Insurance Co Ltd v Chisholm* [2000] 11 ANZInsCas 90-104.

<sup>215</sup> *Kenan Berk v Westpac Securities Administration Ltd* [2010] NSWSC 28.

<sup>216</sup> *Gould v Vaggelas* [1985] HCA 75.

held that evidence of what a reasonable and competent underwriter employed by the insurer would have done can be relevant and admissible.<sup>217</sup>

- 7.15. In *Phillips*<sup>218</sup> for example, this evidence was given by the Principal Underwriter of the insurer. His duties included preparing guidelines for use by the insurer nationally and conducting audits to ensure consistent underwriting practices were used by the insurer's underwriters.
- 7.16. The evidence from an underwriting expert may be objected to on the basis that the remedy provisions for non-disclosure and misrepresentation adopt the language of the particular insurer, rather than a reasonable or prudent insurer and that the only relevant evidence is that of the particular insurer.<sup>219</sup> Such evidence may, however, be relevant to the exercise of the court's discretion under section 31.

### *Variation*

- 7.17. Second, the insurer is entitled to vary the life insurance contract. There are two separate variation rights. In the event the life insured has died, the notice in writing varying the contract, can be given to the insured's personal representative.<sup>220</sup>

### *Sum insured*

- 7.18. The first variation right is that if the insurer has not avoided the contract, the insurer may, by notice in writing given to the insured, vary the contract. The variation substitutes for the sum insured (including any bonuses) a sum that is not less than the sum ascertained in accordance with the formula in section 29(4). The insurer must first establish that it would not have entered into the contract if there had been non-disclosure or misrepresentation by the policyowner.
- 7.19. The variation, for contracts entered into or varied before 28 June 2014, must be within 3 years after the contract was entered into or varied.<sup>221</sup> The variation for contracts entered into or varied after 28 June 2014, must be communicated to the policyowner within 3 years after the contract was entered into if it is a contract with a surrender value or a death claim<sup>222</sup> and it cannot be made after a section 29(6) election,<sup>223</sup> but otherwise has no time limit.
- 7.20. The variation has effect from the time when the contract was entered into.<sup>224</sup>

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<sup>217</sup> *Davis v Westpac Life Insurance Services Ltd* [2007] NSWCA 175; *Schaffer v Royal Sun Alliance* [2003] QCA 182.

<sup>218</sup> *Phillips v ING Life* (2009) FCA 283.

<sup>219</sup> *Graham v Colonial Mutual Life Assurance Society Ltd* [2014] FCA 717; *McCabe v Royal & Sun Alliance Life Insurance Australia Ltd* [2003] WASCA 162.

<sup>220</sup> *Phillips v ING Life Ltd.* (2009) 15 ANZ Ins Cas 90-139; [2009] FCA 283.

<sup>221</sup> IC Act, s. 29(4).

<sup>222</sup> IC Act, s. 29(10)(a).

<sup>223</sup> IC Act, s. 29(4).

<sup>224</sup> IC Act, s. 29(6) or (9).

## Vary terms

### *Election*

- 7.21. The insurer may elect not to avoid or to vary the contract under section 29(4), but to vary the contract under section 29(6). The election under section 29(6) is not available if the insurer has made an election under section 29(4). The section 29(6) election does not apply to a contract with a surrender value or a death claim.<sup>225</sup>
- 7.22. The insurer must establish that it would not have entered into the contract if there had been disclosure and no misrepresentation.<sup>226</sup>
- 7.23. The variation has effect from the time when the contract was entered into.<sup>227</sup>
- 7.24. The insurer is entitled to a variation which would put it in the same position in which the insurer would have been if the duty of disclosure had been complied with or the misrepresentation had not been made – the same remedy as section 28 for general insurance contracts.
- 7.25. The position of the insurer after the section 29(6) variation must be *consistent* with the position that ‘other reasonable and prudent insurers’ would have been in if there had been no non-disclosure or misrepresentation under a *similar* contract they had entered into. Where section 29(6) applies, the insurer must meet the *consistency* test (section 29(7)) and the *similarity* test section 29(8)).

### *Consistency test*

- 7.26. The insurer must adduce evidence of the position of ‘other reasonable and prudent insurers’. The evidence must be:
- a) by a person who is qualified, through experience, knowledge and familiarity with the practices of insurers, to give an opinion on the conduct of two or more direct retail insurers, acting carefully and rationally, in the same market;
  - b) who may be a qualified person employed by the insurer although less weight might be given to such evidence;
  - c) who may be a qualified person employed by a reinsurer, including a reinsurer of the insurer and the contract, although less weight might be given to such evidence. Evidence based on a reinsurer’s manual should be a manual other than the manual used by the insurer at the time.
- 7.27. The evidence must be about what ‘other’ insurers would have done. The evidence may be from one person but about two or more insurers. Evidence in the form of retro underwriting about what the insurer itself would have done is not relevant.
- 7.28. A difference in practice may not be sufficient if the position is not substantially contradictory.

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<sup>225</sup> IC Act, s. 29(10)(b).

<sup>226</sup> IC Act, s. 29(1)(c).

<sup>227</sup> IC Act, s. 29(9).

### *Similarity test*

- 7.29. The similarity test is that the contracts provide the same or similar cover and the contracts were entered into at, or close to, the same time.<sup>228</sup> The evidence of the expert and the underwriting guidelines and manual must apply at that time.

### **Advice consequences**

- 7.30. A policy that was entered into more than 3 years ago cannot be avoided for an innocent non-disclosure or misrepresentation: section 29(3). Clearly this is a very important consideration when a financial adviser or planner advises a policyowner to cancel one policy in favour of another.<sup>229</sup>
- 7.31. In *Couper*, the Statement of Advice given to the prospective policyowner was a template which did not fully deal with the impact of federal law upon a decision of a policyowner to switch insurer. In circumstances where in truth there was little material difference between the policies, that statutory difference was very material to the decision the policyowner was being asked to make. It was held to be misleading and deceptive to advise the policyowner to do so without drawing it to the policyowner's attention.<sup>230</sup> It was held that CFP by its agent had engaged in conduct in relation to a financial product (the CommInsure policy) or a financial service (the Statement of Advice) which was misleading or deceptive or likely to mislead or deceive contrary to section 1041H of the *Corporations Act 2001* (Corporations Act) which caused loss recoverable pursuant to section 1041I of the Corporations Act. It followed that there was also a contravention of section 12DA of the *Australian and Securities and Investments Commission Act 2011* (ASIC Act) which caused loss recoverable pursuant to section 12GF of that Act.<sup>231</sup>

### **Cancellation**

- 7.32. An insurer has the right to cancel a life insurance contract under the IC Act where the insured has made a fraudulent claim: section 59A. This is in addition to the right to cancel ('forfeiture') for non-payment of premiums which exists under the *Life Insurance Act 1995* (LI Act).<sup>232</sup>

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<sup>228</sup> IC Act, s. 29(8).

<sup>229</sup> *Commonwealth Financial Planning Ltd v Couper* [2013] NSWCA 444.

<sup>230</sup> Couper at [101].

<sup>231</sup> Corporations Act, s. 961G, sets the standard of advice that must be provided to a retail client. It is a higher standard than that previously required by s. 945A. See also ASIC Regulatory Guide 175: Licensing: Financial product advisers – Conduct and disclosure, October 2013, RG 175.343. A person can recover loss because of the contravention from the financial services licensee: s. 961M.

<sup>232</sup> See LI Act, Part Seven.

## **Death and surrender value contracts**

- 7.33. The IC Act, sections 29(2), (3) and (4) apply to death covers and contracts with a surrender value, but not section 29(6).<sup>233</sup> The avoidance under section 29(4) must be within 3 years after the contract was entered into.<sup>234</sup>
- 7.34. Surrender value refers to the cash amount payable by the life company to the policyowner in the event a policy is voluntarily terminated before its maturity or the death of the insured person. They are common in traditional ‘whole of life’ and ‘endowment’ investment-style insurance policies. The minimum standard for the calculation of a surrender value is prescribed by the LI Act.

## **8. 2013 amendments**

- 8.1. The IC Act 2013 amendments usually apply to a contract entered into, or with certain variations, after the specified date. The variations are variations to increase the sum insured or to provide an additional kind of insurance cover but do not include an automatic variation: a variation provided for by the current contract. Appendix B compares the IC Act 2013 amendments with the previous position.

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<sup>233</sup> IC Act, s. 29(10)(b).

<sup>234</sup> IC Act, s. 29(10)(a).

## PART SIX – PARTIES

### 1. Introduction – policyowner and insurer

- 1.1. The two main parties to a life insurance contract are the life insurance corporation (life insurer) and the insured. The *Insurance Contracts Act 1984* (IC Act) refers to the ‘insured’ but the *Life Insurance Act 1995* (LI Act) refers to the policyowner – this Background Paper uses policyowner for clarity. The policyowner can have any legal personality: individual, corporation, partnership or trustee.<sup>235</sup> The policyowner’s capacity can be as: an agent, often an employer in a group life insurance; or as a trustee, often a superannuation trustee in a group life insurance.
- 1.2. The person whose life is insured is the life insured. It is the policyowner, not the life insured, who enters into the contract, is obliged to pay the premium and is entitled to receive the benefit amounts paid by the life insurer. It is the policyowner who is entitled to assign the life insurance contract. It is an Insured Life Event affecting the life insured which triggers an entitlement under the policy.

### 2. Other claimants

- 2.1. There is a range of persons who by common law, but mostly by statute, have rights under a life insurance contract. A person may also have rights under a policy as the nominated beneficiary of the policyowner.
- 2.2. A person might be entitled to make a claim under a life insurance contract as:
  - a) agent of a policyowner;
  - b) trustee of a policyowner;
  - c) beneficiary/third party beneficiary of the policy;
  - d) mortgagee of the policy; or
  - e) assignee of the policy.Each is considered below.
- 2.3. A person entitled to cover under an insurance contract cannot have a claim denied only because he or she is not named in the policy: IC Act, section 20.

### 3. Agent of a policyowner

- 3.1. The policyowner’s broker or planner might be authorised by the policyowner to place the life policy or to make the claim.

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<sup>235</sup> But subject to the FOS TOR, para. 4.1.

#### 4. Trustee<sup>236</sup>

- 4.1. A trust is a familiar structure in life insurance whether for individual or group products. A superannuation trust is considered in the section on group life insurance.
- 4.2. The LI Act, section 201, requires the terms of the trust to be in a document other than the memorandum of transfer. If the life company has express written notice of a trust, sections 200 and 201 do not apply. On a change of trustee, the replacement trustee may give the life company notice of that change.

#### 5. Beneficiary or third party beneficiary<sup>237</sup>

- 5.1. There are two types of beneficiary under a life policy. The first is a beneficiary under a trust – see section 4 above.
- 5.2. The second is a third party beneficiary under the IC Act. A third party beneficiary under the IC Act is a person who is not a party to the contract but who is specified or referred to in the contract by name or otherwise as a person to whom the benefit of the contract extends.<sup>238</sup> The life insured might be a third party beneficiary.
- 5.3. The IC Act provisions about a third party beneficiary were amended in 2013 and apply to life policies originally entered into after 28 June 2014.
- 5.4. The third party beneficiary has a right to recover from the insurer any money that becomes payable under the contract even though the third party beneficiary is not a party to the contract.<sup>239</sup> It follows that the third party beneficiary has a direct claim under the policy without intervention by the policyowner.
- 5.5. If the third party beneficiary is not the life insured, any money paid to the third party beneficiary under the contract does not form part of the estate of the life insured.<sup>240</sup>
- 5.6. Section 48A(1)(a) is extended by section 48(1A), a new provision, to a contract of life insurance that is maintained for the purposes of a superannuation or retirement scheme, subject to: (a) the terms of the contract and the scheme; and (b) any other law, in either case, relating to the payment of money under the contract or the scheme.
- 5.7. The most important change to section 48A by the 2013 Amendment was the introduction of a new provision, section 48A(2), which is in the following terms:

2. Subject to the contract, the third party beneficiary:

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<sup>236</sup> *Sutton*, para. 21.1090.

<sup>237</sup> *Sutton*, para. 21.1070.

<sup>238</sup> IC Act, s. 11(1).

<sup>239</sup> IC Act, s. 48A(1).

<sup>240</sup> IC Act, s. 48A(1)(b).

- a) has, in relation to the third party beneficiary's claim, the same obligations to the insurer as the third party beneficiary would have if the third party beneficiary were the insured; and
  - b) may discharge the insured's obligations in relation to the payment of any money to the third party beneficiary under the contract.
- 5.8. The effect of section 48A(2)(a) is to extend to the third party beneficiary in relation to the claim the same obligations to the insurer as were owed by the insured.
- 5.9. Section 48A(2)(b), a new provision, is designed to confirm that the third party beneficiary may give a valid discharge to the insurers for sums payable under the policy, again confirming that the beneficiary's claim can be made without joining the insured to the proceedings.
- 5.10. Section 48A(3) is in the following terms:
  - 3. Nothing in this section restricts the capacity of a person to exercise any right or power under a contract of life insurance to which the person is a party. In particular, nothing in this section restricts the capacity of a person:
    - a) to surrender a contract of life insurance to which the person is a party; or
    - b) to borrow money on the security of a contract of life insurance; or
    - c) to obtain a variation of a contract of life insurance, including a variation having the result that the contract ceases to be a contract to which this section applies.
- 5.11. Section 48AA is along similar lines to section 48, permitting a third party beneficiary of a contract of life insurance entered into in connection with a Retirement Savings Account (RSA) to recover a benefit from the insurer directly. The section applies where the policyowner is an RSA provider. The specified person would often be an RSA holder.
- 5.12. In the event of a dispute between beneficiaries, the insurer may take advantage of the LI Act section 215 and pay the money into court so that the parties can resolve their dispute without any risk to the insurer of finding that it has paid the wrong person and of facing liability to pay the proper beneficiary.

## 6. Mortgagee of the policy<sup>241</sup>

- 6.1. A policyowner is entitled to mortgage a life policy. This usually applies now only to an investment policy. The LI Act makes provision for the mortgage. The LI Act,

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<sup>241</sup> *Sutton*, para. 21.1100.

section 201, requires the terms of a mortgage of a life policy to be in a document other than the memorandum of transfer. If the life company has express written notice of a mortgage, sections 200 and 201 do not apply.

## 7. Assignee of the policy<sup>242</sup>

- 7.1. A claimant may be entitled to make a claim against the insurer, not by virtue of being party to the contract but by being an assignee. A person will become an assignee as a result of an assignment. The word ‘assignment’ refers to a process by which all or, in some cases, certain rights of one person are transferred to another. As a result of an assignment in relation to a contract, an assignee will be entitled to receive certain benefits under the contract from the person who had contracted with the assignor (the assignor’s counterparty).
- 7.2. The LI Act section 200 sets out a code for the assignment ‘at law’ of a life policy by a policyowner. The section expressly ‘does not prejudice the effect in equity of an assignment of the rights of a person as owner of a policy that is made otherwise than under [the] section’. The section firstly sets out the requirements for an effective assignment at law. The assignment must be by a memorandum of transfer in the prescribed form and registered in a register of assignments kept by the insurer. The transfer must be signed by the transferor and the transferee. It must also be signed by the life company. It follows that the assignment is not one which can be effected by the transferor alone; that is an equitable assignment.
- 7.3. The section sets out the effects at law of the assignment once the requirements are satisfied. A valid assignment confers on the transferee all the rights and powers and is subject to all the liabilities of the transferor under the policy. The transferee can sue in her or his own name on the policy, and, as between the insurer and a third party claimant, the transferee is conclusively presumed to have been the absolute owner of the policy at the time of registration, free of all trusts, rights, equities and interests. The payment to the transferee of money due under the policy discharges the life company from all liability under the policy in respect of the money and the transferee is entitled to receive the money and give a good discharge for it. A surrender of the policy by the transferee is effective. Thus, the transferor effectively ‘drops out’ of the arrangement.
- 7.4. The section expressly preserves an equitable assignment; a life policy can be the subject of an equitable assignment.

## 8. The insurer

- 8.1. The position of the life insurer or *life company* is described in Part Two above.

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<sup>242</sup> *Sutton*, paras. 21.1110–21.1150.

## PART SEVEN – DURATION

### 1. Cooling off<sup>243</sup>

#### **Life policy**

- 1.1. An insured, under a contract of life insurance other than a blanket superannuation contract or Retirement Savings Account (RSA), has a right exercisable at any time before the expiration of 14 days after the insured received the policy document to cancel the contract. If the insured does cancel the contract, he or she is entitled to a refund of all moneys paid to the insurer under the contract, less any tax that has been paid or is payable by the insurer in respect of the transaction and which is not refundable. The subject matter is now dealt with under of the *Corporations Act 2001* (Corporations Act), section 1442B.
- 1.2. Life insurers often provide a longer cooling off period, frequently 30 days.

#### **Investment linked contracts**

- 1.3. There are particular provisions for the cancellation of Investment Linked Contracts in respect to assessing their value. The Corporations Act, section 1019, provides that in exercising a cooling-off period for such a contract, an insured must accept any investment risk prior to cancellation.

### 2. Commencement

- 2.1. The insurer is on risk or liable for an Insured Life Event on and from the commencement date specified in the life insurance contract.<sup>244</sup>

### 3. Duration

- 3.1. A life policy is usually described as ‘guaranteed renewable’. This phrase, often used in selling life insurance, is capable of a number of meanings. It is not often used in the contract itself and the terms of the contract on duration and renewal do not always clarify the meaning of, nor are they always consistent with, the phrase. The phrase can mean either that:
  - a) the contract has a continuous duration until its termination, for example at age 65 or cancellation under the *Insurance Contracts Act 1984* (IC Act); or

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<sup>243</sup> *Sutton*, para. 21.1210.

<sup>244</sup> *Sutton*, paras. 21.1180.

- b) if the policyowner chooses to renew, the life insurer must renew, subject to any terms which apply to or on the renewal. The life insurance industry does not require underwriting for a 'renewal' of a guaranteed renewable contract.
- 3.2. The position depends on the terms of the contract. The terms on payment of premium can require payment monthly or annually which can be factors in raising an inference that the contract duration is annual.
- 3.3. It is likely that the modern life insurances would be structured to be, and contain terms that are, more consistent with 'renewal', the second meaning.<sup>245</sup>

## 4. Expiry and cancellation

### **Expiry**

- 4.1. The insurer is on risk or liable for an Insured Life Event until the expiry date specified in the life insurance contract.<sup>246</sup> An expiry is not a cancellation.<sup>247</sup> The policyowner or insurer is each entitled in some circumstances to cancel the policy before the expiry date.<sup>248</sup>

### **Insured – cancellation**

- 4.2. The insured is entitled to cancel a policy on the terms of the policy or under the common law. The insured must give notice of the cancellation to the insurer.<sup>249</sup>

### **Insurer – cancellation – surrender value policy**

- 4.3. An insurer is entitled to cancel a policy with a surrender value only under the *Life Insurance Act 1995* (LI Act), section 210.<sup>250</sup> It is necessary in each case to apply the section to the circumstances of the cancellation.

### **Insurer – cancellation – policy without surrender value**

#### *Before 28 June 2013*

- 4.4. The insurer was entitled on common law grounds to cancel a policy. The insurer must follow the IC Act, sections 59 and 77. It was necessary in each case to apply the sections to the circumstances of the cancellation.<sup>251</sup>

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<sup>245</sup> *Sutton*, para. 21.1190.

<sup>246</sup> *Sutton*, para. 12.30.

<sup>247</sup> *Sutton*, para. 12.150.

<sup>248</sup> *Sutton*, paras. 12.90–12.270.

<sup>249</sup> *Sutton*, para.12.270.

<sup>250</sup> *Sutton*, para. 12.250.

<sup>251</sup> *Sutton*, paras. 12.250 and 21.1200–21.1320.

## *After 28 June 2013*

### Fraud

- 4.5. Where the insured has committed fraud, the insurer is entitled to cancel a policy only under the IC Act, section 59A and 59. It is necessary in each case to apply the section to the circumstances of the cancellation.<sup>252</sup>
- 4.6. From 28 June 2013, amendments came into effect which now permit a life insurance contract to be cancelled under the Act if the policyowner has made a fraudulent claim under a contract of life insurance with the insurer or has made a fraudulent claim under another contract with the insurer that provides cover during any part of the period during which the life insurance contract provided insurance cover: section 59A. This applies to life insurance contracts originally entered into after 28 June 2013.
- 4.7. If the insurer cancels a life insurance contract because of a fraudulent claim then, in any proceedings in relation to the claim, the court may, if it would be harsh and unfair not to do so:
  - a) disregard the cancellation of the contract;
  - b) order the insurer to pay, in relation to the claim, such amount (if any) as the court considers just and equitable in the circumstances; and
  - c) order the insurer to reinstate the contract: section 59A(2).
- 4.8. If the insurer cancels a life insurance contract because of a fraudulent claim by the policyowner under another contract of insurance with the insurer, then, in any proceedings in relation to the claim, the court may, if it would be harsh and unfair not to do so:
  - a) order the insurer to pay, in relation to the claim, such amount (if any) as the court considers just and equitable in the circumstances; and
  - b) order the insurer to reinstate the cancelled contract: section 59A(3).
- 4.9. If there are proceedings in relation to the cancellation the court may, if it would be harsh and unfair not to do so, order the insurer to reinstate the contract: section 59A(4).
- 4.10. In exercising its power under section 59A(2)(3) or (4), the court:
  - a) must have regard to the need to deter fraudulent conduct in relation to insurance; and
  - b) may also have regard to any other relevant matter: section 59A(5).
- 4.11. Any purported cancellation of a contract of life insurance other than as provided by section 59A or by section 210 of the LI Act is of no effect: section 63(3).
- 4.12. The procedure for cancelling insurance contracts, other than for non-payment of premiums covered by section 210 of the LI Act is set out in section 59. The insurer

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<sup>252</sup> *Sutton*, paras. 12.250 and 21.1330–21.1340.

must give written notice of its intention to do so: section 59(1). The time the cancellation takes effect is governed by section 59(2).

### Other grounds

- 4.13. The law now on other cancellation grounds, including for non-payment of the premium, is very unclear. There are two possibilities. The first possibility is that the insurer is entitled to cancel a policy only under the LI Act, section 210, but this view involves reading down ‘surrender value’ so that it includes a policy without a surrender value.<sup>253</sup>
- 4.14. Section 210 has often been viewed as only applying to life policies with a surrender value. However, the only subsection that refers to such policies is subsection (1) and only where three years premiums have been paid and the surrender value exceeds all monies owed to the insurer under the policy. Subsections (2) – (4) also appear to relate back to the policy and circumstances of subsection (1). However, subsection (5) makes no such explicit connection.
- 4.15. Clearly, if the policy had been a policy with a surrender value and on which three years’ premiums had been paid, then subsection (1) applies to limit the ability of the insurer to forfeit the policy because of non-payment of a premium.
- 4.16. The second possibility is that the insurer is entitled to cancel a policy only under the IC Act sections 59A and 59 but this view involves reading grounds additional to fraud into the section so that it reads the same way as section 60.<sup>254</sup>

### Notice

- 4.17. The insurer must give the policyowner notice of cancellation of a policy under the IC Act, sections 59 and 77, and under the LI Act, section 210. Notice is also required by the common law.<sup>255</sup>
- 4.18. A letter written after the premium was due and had not been paid constitutes a notice of proposed cancellation.<sup>256</sup> A threat or warning of what may occur if a premium was not paid by the due date is not a notice of proposed cancellation. This is because, at the time the notice was given, the premium is not due and unpaid and, therefore, there had not been a breach of the contract of insurance giving rise to a right of cancellation.
- 4.19. There is a general requirement in the law of contract that cancellation of a contract must be communicated to the other party if it is to be effective.<sup>257</sup> However, in circumstances where communication is not possible, an unequivocal act of

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<sup>253</sup> *Sutton*, paras. 12.250 and 21.1330.

<sup>254</sup> *Sutton*, para. 12.250 and 21.1330.

<sup>255</sup> *Sutton*, para. 12.250, 21.1310 and 21.1330.

<sup>256</sup> *MLC Ltd v J & W Management Services Pty Ltd* (2001) 11 ANZ Ins Cas 65-511.

<sup>257</sup> *GA Lovell & Sons Pty Ltd v FML Assurance* (1981) 2 ANZ Ins Cas; *Turner v Metropolitan Life Assurance Co of New Zealand Ltd* (1988) 5 ANZ Ins Cas.

cancellation by the cancelling party is sufficient.<sup>258</sup> If such communication is ambiguous, it is to be construed against the insurer.<sup>259</sup>

- 4.20. Life policies frequently include a term requiring the insurer to give 30 days or one month's notice of cancellation. The insurer must also comply with any such term of a policy.<sup>260</sup>
- 4.21. The legislation and a policy refer to notice to the 'policyowner'. However, a policyowner may specify the adviser's address as the postal address or address for service of notices. If a policyowner fails to update the address when the policyowner changes adviser, then the insurer would appear to have satisfied the requirements of the legislation and the policy if the notice is sent to the adviser.

### **Effect of expiry or cancellation**

- 4.22. A life insurer may cancel a policy in certain circumstances but it must follow certain procedures. Cancellation of a policy by an insurer is an election by it to rescind or terminate the contract of insurance.
- 4.23. The insurer remains on risk and liable for an Insured Life Event which occurs before the effective date of cancellation. A cancellation affects the rights and obligations of each party from its effective date.<sup>261</sup> This is opposed to an avoidance of the contract for misrepresentation or non-disclosure or a breach of a condition precedent to the issue of a policy that would have affected the decision to issue the policy: see Part Five above. Avoidance means that the policy is treated as if it did not come into effect and the parties must put each other back in the same position each was in at the outset.<sup>262</sup>

## **5. Renewal**

- 5.1. A life insurer is required under section 75 of the IC Act to provide written reasons to an insured where it:
  - a) does not accept an offer to enter into a contract of insurance;
  - b) cancels a contract of insurance;
  - c) indicates that it does not propose to renew an insurance policy; or
  - d) offers to the insured a policy on terms that are less advantageous than the insurer would otherwise offer.
- 5.2. There is an exception in subsection (3):

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<sup>258</sup> *Smith v Associated Dominions Assurance Society Pty Ltd* (1956) 95 CLR 381; BC5600390

<sup>259</sup> See *Turner v Metropolitan Life Assurance Co of New Zealand Ltd*.

<sup>260</sup> *Sutton*, para. 12.250.

<sup>261</sup> *Sutton*, paras. 12.90–12.270.

<sup>262</sup> IC Act, s. 11(1); *Sutton*, paras. 12.90–12.270.

In relation to a contract of life insurance where the insured is not the life insured subsection (1) does not apply if the state of health of the life insured was the only reason that the insurer did not accept the offer, cancelled the contract, did not renew the insurance cover or offered insurance cover on less advantageous terms, as the case may be.

Note: A defendant bears an evidential burden in relation to the matters in subsection (3), see subsection 13.3(3) of the Criminal Code.

5.3. And a rider in subsection (4):

In relation to a contract of life insurance where the insured is not the life insured, a statement given under subsection (1) shall not include any reference to the state of health of the life insured.

## PART EIGHT – INSURANCE POLICY AND COVER

### 1. Life insurance contract formation

#### Overview

- 1.1. On formation generally, see the General Insurance Background Paper (GIBP), Part Eleven, section 1.

#### Insurable interest

- 1.2. Since 1995, for insurance contracts to which the *Insurance Contracts Act 1984* (IC Act) applies, there is no longer any requirement for the policyowner of a life insurance contract to have an insurable interest in the life insured.
- 1.3. The IC Act now provides that:

A contract to which this section applies is not void by reason only that the insured did not have, at the time when the contract was entered into, an interest in the subject-matter of the contract.<sup>263</sup>
- 1.4. There is also no requirement to specify ‘the names of the persons who may benefit under the contract’ in the policy document: IC Act, section 20.

#### Formation

- 1.5. The normal principles of the law of contract law are applied to determine when an insurance contract is entered into: an unqualified acceptance by one party of an offer made by the other.
- 1.6. In a life insurance contract, the offer is usually constituted by the proposal and the acceptance by the insurer communicating to the policyowner that it has agreed to undertake the risk at a particular premium and on certain terms. Consideration, also an element of a binding contract, would be met by the policyowner promising or paying the premium and by the insurer in undertaking the risk. The contract would be entered when acceptance had been communicated to the offeror (the policyowner). The parties to a life insurance contract might agree about the time when the contract is entered into.<sup>264</sup>

#### Main terms

- 1.7. On main terms generally, see the GIBP, Part Ten, section 1.

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<sup>263</sup> IC Act, s. 18(2) which applies to life insurance and sickness and accident insurance. The IC Act, s. 19, was repealed by Act 5 of 1995, s.4 and Sch. Item 45.

<sup>264</sup> *Summerton v SGIC Life Ltd* [1999] SASC 121.

- 1.8. A life policy exhibits some important differences from a general insurance policy in relation to its main terms:
- a) the parties include a life insured whose Life Insured Event is the subject matter of the life insurance;<sup>265</sup>
  - b) the premium terms are similar but the premium is calculated differently;<sup>266</sup>
  - c) the subject matter of a life insurance contract or policy is: life, death, terminal illness, total and permanent disability (TPD), trauma or critical illness, disability, illness, injury, a condition or event (together Insured Life Event);<sup>267</sup>
  - d) a life policy pays a specified sum insured or benefit; it does not provide an indemnity and there is no excess or deductible;<sup>268</sup>
  - e) a life policy is usually a long-term insurance contract.<sup>269</sup>

## 2. Anatomy of a life insurance contract or policy

### General

- 2.1. On the anatomy of a policy generally, see the GIBP, Part Eleven, section 2.

### Sources of terms

- 2.2. The purpose of an insurance policy document is to assemble, set out and record the intentions of the parties for their relationship in relation to the subject-matter of the insurance: the Insured Life Event. For modern insurance contracts, most of the terms will be in writing and express.

### Proposal and personal statement

- 2.3. There is a proposal form, or application and personal statement for life insurance, signed by the policyowner and life insured containing various particulars and answers to various questions.
- 2.4. This is often followed by an acknowledgment that each of the policyowner and the life insured has been clearly informed of the persons whose interests are covered and the sum insured or benefit amount recoverable under a claim.
- 2.5. The statements of fact in a proposal or personal statement<sup>270</sup> are no longer, because of the IC Act, section 24, permitted to be incorporated into the insurance policy.<sup>271</sup>

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<sup>265</sup> See Part Six above.

<sup>266</sup> GIBP, Part Ten, s. 1, para. 1.10; see Part Four, s. 7, above.

<sup>267</sup> GIBP, Part Ten, s. 1, paras. 1.11–1.13.

<sup>268</sup> GIBP, Part Ten, s. 1, para. 1.12–1.13; see Part Four above.

<sup>269</sup> GIBP, Part Ten, s. 1, paras. 1.5–1.9; see Part Seven above.

<sup>270</sup> The answers and statements in the personal statement are usually attributable to the policyowner: s. 24.

<sup>271</sup> *Sutton*, para. 10.20.

## Documents

- 2.6. On documents generally see the GIBP, Part Eleven, section 2.
- 2.7. There is no statutory requirement for a life policy to be in writing. The *Life Insurance Act 1995* (LI Act), section 10(1), refers to the 'issue' of a policy in these terms:

For the purposes of this Act:

- a) a life company issues a policy when the company enters into the contract that constitutes the policy;
  - b) a policy is issued to the person with whom the life company enters into the contract.
- 2.8. The policy when issued will usually state that the proposal, declaration and personal statement are incorporated into it and form the basis of the contract of insurance. If the incorporation is effective (see paragraph 2.5 above) then those documents will be read as a part of the policy: *Stone v Tower Australia Ltd.*<sup>272</sup>
- 2.9. In *Stone*, the insurer attempted to argue that a term had been incorporated into its life policy. The relevant term stated that the insurer would not be liable under the policy unless the policyowner first cancelled its policy with a second insurer. The policyowner failed to cancel the policy it held with the second insurer and the issue was whether the cancellation term formed part of the contract and, if it did, whether it was a condition precedent to formation of the contract or a condition that instead relieved the insurer of liability under the contract if it was not fulfilled. The court held that the term had not been incorporated into the contract, and if it had, that it was a condition which was precedent to liability and which would, therefore, have been subject to the operation of section 54; see section 10 below.

## Main insuring clause

### *General*

- 2.10. It is essential in any issue involving a *life policy*, particularly a claim or dispute, to begin with the main insuring clause. It can be difficult to find and it is usually scattered across a number of different clauses. The search is for the terms in the contract which when all put together would read something like this:

The insurer agrees, in consideration of the premium, to pay the Sum Insured or Benefit to the [Policyowner or Beneficiary] if the life insured is [specified Insured Life Event] during the period of this policy.

- 2.11. The main insuring clause contains the main terms of the policy. First, it specifies the relevant parties and their roles. It is the insurer which must make the payment or grant the benefit. It is the life insured who must experience the Insured Life Event. It is the

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<sup>272</sup> (2003) 12 ANZ Ins Cas 61-584.

policyowner or beneficiary who is entitled to receive the amount or benefit. Second, the main insuring clause specifies the Insured Life Event which entitles the claimant to the relevant and specified amount or benefit. Third, it specifies the duration of the life policy. It is axiomatic that the Insured Life Event must occur during the period of the life policy. It is always very difficult to analyse and decide what the Insured Life Event is in a disability, trauma or critical illness policy. If the Insured Life Event occurs before the risk commencement date for the policy or after its expiry, termination or cancellation, the claimant has no entitlement to the amount or benefit. Fourth, the main insuring clause states the obligation to pay the premium.

### *Insurer Opinion*

- 2.12. A policy may define the Insured Life Event in terms of whether in the opinion of the insurer the Insured Life Event has occurred to the life insured. This term means that the insurer must:
- a) consider and determine whether it should form the relevant opinion and in so doing it must direct itself to the consideration and determination of the correct question;
  - b) act fairly and reasonably and in the utmost good faith in determining and considering the matter: a duty of good faith and fair dealing which requires it to have due regard for the interests of the claimant. It is not enough that the insurer honestly held that opinion;
  - c) not limit itself to inadequate information about the claim but must seek more information about the claim and must not take into account an irrelevant consideration;
  - d) supply the policyowner with information it has obtained independently and on which it intends to rely substantially where that information is substantially different from that supplied by the policyowner to the insurer. It is unfair for an insurer to act upon detailed and adverse medical reports obtained by the insurer itself without giving the claimant an opportunity to balance the report by obtaining a detailed report from a treating doctor, or giving the claimant a chance to answer the adverse elements in the report;
  - e) make further inquiries and approach its task with an open mind so that a genuine consideration is given to the claim.
- 2.13. These considerations have led to the development of a life insurance industry practice of ‘procedural fairness’ which sees the claims assessment process include a letter, called a ‘pro-fair’ letter, to the policyowner or life insured which sets out the insurer’s view of the facts, analysis, law and issues for the claim and invites the recipient to put further facts or analysis to the insurer before a decision is made.
- 2.14. A Court might not substitute its own view for that of the insurer unless the view taken by the insurer can be shown to have been unreasonable on the material then before the insurer.

### *Steps*

- 2.15. Once the main insuring clause is identified, it is necessary to consider three matters.
- 2.16. First, it is necessary to identify any definitions in the policy that are definitions of, or related to, the terms of the main insuring clause and to incorporate them into the interpretation of the main insuring clause. The Insured Life Event is almost always defined.
- 2.17. Second, it is necessary to consider whether the main insuring clause and the definitions are affected in any way by legislation, particularly the IC Act and the LI Act.
- 2.18. Third, it is necessary to consider whether the main insuring clause and the definitions are affected in any way (after the effect of legislation, particularly the IC Act and the LI Act) by decided cases.
- 2.19. Once this process is finished it is then possible to analyse and decide what are the elements of the Insured Life Event the occurrence of which means that the claimant is entitled to the amount or benefit. The elements are each and every thing which the claimant must prove for the entitlement to be established and demonstrated. But only one or two of these elements will be the trigger for the insurer's liability. The trigger is the thing which must occur during the period of the policy for the insurer to be obliged as a matter of law, to pay the amount or benefit when the other elements are satisfied but no matter when they are satisfied. It can take years for a claim to be finalised but the insurer is not relieved of liability if the trigger has occurred during the period of the policy.

### *Causation relationships*

- 2.20. The main insuring clause and the terms of the policy will always include words and phrases that require a type of causal relationship between two things – often the Insured Life Event and the sum insured or benefit - for the claimant to be entitled to a sum insured or benefit or for an exclusion to apply to the claim.
- 2.21. The words 'caused by', 'resulting from' or 'brought about by' mean the classic legal doctrines of proximate cause apply.
- 2.22. The words 'contributing to' or 'leading to' mean a looser or more indirect type of causal relationship.
- 2.23. The words 'arising from' mean an even looser or more indirect type of causal relationship.

## 3. Disclosure of policy terms

- 3.1. It is increasingly difficult to find the policy terms. There are a lot of documents and emails that are sent by the insurer and by the policyowner or intermediary.
- 3.2. The policy wording is often in a product disclosure statement (PDS). It can be difficult to discern what parts of the PDS are policy terms and what parts are not. The PDS is

usually many pages. There is advertising material, guidance, information, options and advice about what to do with a complaint or claim.

- 3.3. An insurer is obliged by law to bring the terms of the policy to the mind of the policyowner. There are many sources of the legal obligation of the insurer to disclose fairly the policy terms to the policyowner: see the GIBP, Part Eleven, section 3.
- 3.4. An insurer must comply with the Life Insurance Code of Practice standards in relation to the sale of the policy and disclosure of its terms.
- 3.5. An insurer would not discharge its duty of utmost good faith under the IC Act, section 13, and under the law above in its disclosure of the policy terms unless the insurer clearly informs the policyowner by bringing the policy terms to the mind of the policyowner. A Court or tribunal is entitled, under the IC Act, section 14(3), to have regard to the disclosure of the policy terms by the insurer to the policyowner. Where the disclosure of a policy term is a breach of the insurer's duty of utmost good faith, the insurer is not entitled under the IC Act, section 14(1), to rely on the policy term which is not adequately disclosed.
- 3.6. The Financial System Inquiry proposed a number of reforms to life insurance, including increasing the obligations of product issuers and distributors to act in the interest of consumers by introducing a targeted and principles-based product design and distribution obligation.<sup>273</sup>

## 4. Types of policies and cover

### Introduction

- 4.1. Death – or as the actuaries call it, ‘mortality’, for life policies – presents a dearth of legal concepts for consideration. Continuity of life (‘morbidity’ for actuaries) on the other hand, represents some issues. The meanings given to the words ‘event’, ‘occurrence’, ‘circumstance’, ‘accident’ or ‘loss’, the distinction between these stages or tiers and the impact of such meanings and distinction will depend on the construction of the policy and the facts that arise. Occurrence is a primary trigger for the entitlement of a policyowner under a TPD, disability, trauma or accident policy. A policy under which an entitlement arises because of an injury will require it to be caused by an accident: TPD, disability and accident insurances. Illness and injury are similarly deployed. The definition of disability is the crux of TPD and disability income insurances. Suicide is an important cover, limitation or exclusion from death cover.

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<sup>273</sup> Australian Government, *Financial System Inquiry Final Report*, prepared by David Murray, November 2014.

## **Death**

- 4.2. The insurer must pay the sum insured if the life insured dies within the period of the policy. This is usually a life insurance contract under the IC Act and a life policy under the LI Act. If the duration of the contract is to be not more than one year, and payment is to be made only in the event of death by accident or death resulting from a specified sickness, the contract is not life insurance or a life policy; it cannot be insured with a life insurance company without an APRA declaration to deem it to be life insurance business.

### **Interim or accidental death**

- 4.3. It may be thought that there is no necessity for temporary cover in the case of life insurance, but there is often considerable delay between the time a proposal for life insurance is lodged with the insurer and its acceptance. Some insurers have adopted the practice of providing interim cover for varying periods, at least in case of death by accident, pending consideration and acceptance of the proposal.
- 4.4. The insurer must pay the sum insured if the life insured has an injury or illness caused by an accident within the period of the policy. This is usually not a life insurance contract under the IC Act nor a life policy under the LI Act. If the duration of the contract is to be not more than one year, and payment is only to be made in the event of death by accident or death resulting from a specified sickness, the contract is not life insurance or a life policy; it cannot be insured with a life insurance company without an APRA declaration to deem it to be life insurance business.
- 4.5. The two principal legal questions that arise are: first, whether it is an injury, illness or the accident which must occur during the policy period for the insurer to be liable; and second, whether the causative event is an accident.
- 4.6. The provisions of the IC Act, section 38, apply to both general and life insurance contracts. This temporary cover comes within the ambit of section 38 so that the insurer would remain at risk until such time as the formal contract of life insurance came into existence or the temporary contract was cancelled or the insured withdrew the application for life insurance, whichever first happened. Written notice of cancellation as required by the IC Act, section 59(1), would have to be given except in the case of attempted forfeiture of a life policy for non-payment of premiums coming within the LI Act, section 210(5), which is exempted from the operation of section 59 by section 59(3).<sup>274</sup>

### **Terminal illness**

- 4.7. A term life insurance may include a term which provides that the sum insured becomes payable if the life insured is terminally ill.

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<sup>274</sup> *Sutton*, para. 14.230.

- 4.8. Terminally ill can be defined in one of three ways: the actuality of the terminal illness; the diagnosis of the terminal illness; or the insurer forming an opinion that the life insured is terminally ill. The courts are reluctant to find the third variety of definition because of the uncertainties surrounding the formation of the insurer's opinion.
- 4.9. A life insurance which provided a terminal illness cover defined as 'an illness or condition which is highly likely to result in death within 12 months' entailed an investigation of the anticipated outcome for the particular patient at the date of diagnosis and/or occurrence; and this in turn pointed the inquiry towards the patient's likely response to the diagnosis. The court therefore was entitled to have regard to the availability of medical treatment.<sup>275</sup>

### **Trauma or critical illness**

- 4.10. A trauma or critical illness product pays the sum insured if the life insured has a defined surgical procedure or has a defined illness, for example cancer or a heart condition. The trigger may be the occurrence, manifestation or diagnosis of the condition or the carrying out of the surgical procedure. This is a life insurance contract under the IC Act and a life policy under the LI Act.<sup>276</sup>

### **Disablement – TPD and income protection**

- 4.11. There are two major types of cover for disablement, with some sub-types.
- 4.12. The first is cover for disability which pays one lump sum benefit which terminates the life insured's benefit entitlement for death or disablement: lump sum TPD. For this first type, the lump sum TPD, there are three common sub-types of covers. One common sub-type of lump sum TPD is a definition of TPD which provides a benefit for injury or illness which causes the person to be absent from work for a minimum period, the 'waiting period', and which causes the person's disability – TPD cover.
- 4.13. There is a relatively common form of TPD definition; it is in many policies and it is the form most frequently considered by the courts. The court in *Manglicmot v Commonwealth Bank Officers Superannuation Corporation Pty Ltd*<sup>277</sup> called it the 'common form':

illness or injury which causes the life insured to be incapacitated to such an extent as to render the member unlikely ever to engage in or work for reward in any occupation or work for which [he or she] is reasonably qualified by education, training or experience.<sup>278</sup>

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<sup>275</sup> *Sutton*, paras. 21.230–21.250.

<sup>276</sup> *Sutton*, para. 21.260.

<sup>277</sup> (2011) 282 ALR 167; [2011] NSWCA 204.

<sup>278</sup> *Manglicmot v Commonwealth Bank Officers Superannuation Corporation Pty Ltd* (2011) 282 ALR 167; 17 ANZ Insurance Cases 90-150; [2011] NSWCA 204; it is the wording in *Chammas v Harwood Nominees Pty Ltd* (1993) 7 ANZ Insurance Cases 61–175.

- 4.14. There are common variants. The most frequent is the inclusion of the requirement of the insurer's satisfaction, or forming an opinion, about an element of the definition. Another common sub-type of lump sum TPD is based on an inability to carry out a number of basic activities of daily living which are listed and defined – activities of daily living (ADL) cover.
- 4.15. Another common sub-type of lump sum TPD is a list of conditions or afflictions – based on the macabrely titled ‘table of maims’ – which are defined as constituting disablement.
- 4.16. The second major type of cover for disablement is cover for disability which pays a monthly benefit for a defined benefit period on the total disablement of the life insured – disability income or group salary continuance cover. This type of disability cover also can offer cover for a partial disability. The monthly benefit is either a specified amount or an amount calculated as a portion of the pre-disability income. The monthly benefit will be reduced by amounts from other specified sources.
- 4.17. The definition, at least for the initial period of disability, usually has three requirements, that:
- a) the life insured is not working; and
  - b) the life insured is under regular medical care; and
  - c) the life insured is unable to perform some, or all, or the important, or one of the essential, duties of his or her occupation.
- 4.18. A disability insurance of any of these types may be a life insurance contract under the IC Act and a life policy under the LI Act, only if it is a continuous disability policy. A continuous disability policy is a contract of insurance:
- a) that is, by its terms, to be of more than 3 years’ duration; and
  - b) under which a benefit is payable in the event of:
    - i. the death, by accident or by some other cause stated in the contract, of the person whose life is insured (the insured); or
    - ii. injury to, or disability of, the insured as a result of accident or sickness; or
    - iii. the insured being found to have a stated condition or disease.
- 4.19. If the insurance contract is not a continuous disability policy, it must be entered into and issued by a general insurer, not a life insurer.<sup>279</sup>
- 4.20. A partial disability benefit is payable but only if the partial disability is immediately preceded by the total disability. Such a term is not an exclusion because an exclusion clause is one which purports to limit liability for a breach which would otherwise arise under a contract. This limb of the definition does not constitute an exclusion clause. It forms an essential part of the definition.<sup>280</sup>

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<sup>279</sup> *Sutton*, para. 21.270 and 21.450.

<sup>280</sup> *Sutton*, para. 21.450.

## 5. Disability insurance: TPD and income protection

- 5.1. There are a number of key concepts which are common in these two types of policy.

### **Qualifying period**

- 5.2. There is often a qualifying or waiting period of between one and six months: if the disability occurs within the qualifying period after commencement of the cover, or in the case of an increase in cover, after the commencement of the increase in cover, no benefit is payable.

### **Normal or income producing duties**

- 5.3. A person's 'normal duties' are those which conform to a normal rule: what is normal is something which happens as a rule compared with something which is abnormal or exceptional.
- 5.4. The normal or usual duties or occupation should be identified at the time of the occurrence or onset of the illness or injury said to ground the right to recover under the contract.
- 5.5. The features and incidents of the usual duties, occupation or business focusses on the nature of the activities. The life insured's 'usual business and occupation' embrace the whole scope and compass of the life insured's mode of getting his or her livelihood.<sup>281</sup>
- 5.6. A reference to income includes employment income and income from a business. In this context, the reference to an occupation is not limited to the physical functions involved in the 'occupation' but it includes circumstances in which the function is exercised and the environment in which the work is to be carried out. The circumstance that a contractor's contract for work has come to an end does not mean that the life insured contractor has no occupation.

### **Occupation**

- 5.7. Occupation is determined by considering the person's qualifications, skills and employment history. Occupation does not mean job or position. It is not limited to and can be wider than the person's specific job or position at the relevant time. The concept of 'occupation' is wider than 'employment' or 'job'. A person can have more than one 'occupation'. Occupation also means a 'recognised occupation'. The critical qualification is usually 'gainful'. 'Gainful' excludes a loss making business and voluntary work. A loss-making business is not 'gainful'.
- 5.8. An occupation must be a commercially undertaken occupation, more than a short-term job, not temporary but for a substantial or indefinite period and with some reasonable expectation of continuity: 'the work must be remunerative, that is done for reward or hope of reward and must be regular. The word regular means something occurring at

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<sup>281</sup> *Sutton*, para. 21.300.

fixed times or uniform intervals ... Thus, it would not in the present context include casual work or other work of an intermittent nature'.<sup>282</sup>

- 5.9. The definition of disablement originally was an inability or incapacity in relation to 'any occupation' but now an 'own occupation' definition is much more common. The 'usual occupation' definition sits somewhere between these two and closer to 'own occupation'. With an 'own occupation' definition, if the other elements of the entitlement are met and the life insured is disabled in relation to her own occupation, there is an entitlement even though the life insured could work in another occupation. The definition of 'own occupation' is usually widened to include an occupation for which the life insured is fitted by knowledge, training, status and abilities or the modern formulation of 'education, training or experience' – the ETE clause.
- 5.10. An 'any occupation' definition will be construed literally and not merely by reference to the usual occupation: a life insured who has become a paraplegic will be unable to recover in the absence of evidence that he or she is disabled from engaging in any occupation. A clause requiring the life insured to be wholly disabled from performing any and every kind of occupation, must be understood in the context of the actual circumstances of the life insured. The life insured must be disabled from following not only her or his usual occupation but also any alternative forms of employment reasonably open to her or him.<sup>283</sup>

### **Occupation – part-time**

- 5.11. A capacity for part-time work precludes incapacity or TPD under the insurance. The courts conclude that a person is not totally and permanently disabled within the meaning of that provision in the policy where he or she could undertake part-time work as distinct from the full-time work which that person had previously undertaken. A person who could undertake part-time work was not totally and permanently disabled.<sup>284</sup>

### **Occupation – ETE clause**

- 5.12. The phrase in the TPD definition 'any occupation or work for which [he] is reasonably qualified by education, training or experience' is known as the ETE clause. The court must ascertain what the person is 'actually capable of doing' but the capacity for work must include work in an ETE occupation. It is necessary to inquire, for an ETE clause, as to what work the life insured is suited for. Hobbies that have business potential are very relevant.

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<sup>282</sup> *Sutton*, para. 21.310.

<sup>283</sup> *Sutton*, para. 21.310.

<sup>284</sup> *Sutton*, para. 21.330.

- 5.13. The ETE occupation does include work which the life insured is capable of undertaking with further training which it would be reasonable for her or him to undertake.
- 5.14. The courts treat the ETE occupation as fixed, subject to the ‘reasonable acquisition test’ above, and fixed at the ‘as at’ date for the incapacity or disablement, usually the end of the waiting period. The assessment of ETE must be made at the ‘date of assessment’ which is usually the expiration of six months. The assessment should take into account only work for which the employee was suited at the expiration of that period. Therefore education, training and experience after the end of the waiting period are not relevant.<sup>285</sup>

### **Labour market test**

- 5.15. The court must consider whether it is ‘probable that the insured would actually obtain work for reward’. The context here is that the TPD definition is directed to the realities affecting the capacity of the person, not theory, but the context is the life insured’s physical capacity in a realistic sense; not, for example, the place where work could or should be carried out. This approach has been misunderstood as importing a ‘labour market test’. The ‘labour market test’ is not properly a part of TPD criteria or assessment. It is not supported by the terms of standard TPD insurance, or principle or authority. It is a question of realistic physical capacity not labour market availability.<sup>286</sup>

### **Extent of incapacity**

- 5.16. The various definitions of TPD require varying degrees of disablement: ‘the requirement that the incapacity be ‘for’ further employment, carries with it the requirement that the incapacity be permanent or substantially permanent. Mere temporary incapacity would clearly be insufficient.’ In the same way, an incapacity to such an extent as to render the Insured Member ‘wholly prevented’ required evidence of a very substantial disability.<sup>287</sup>

### **Degree of certainty**

- 5.17. The expression *unlikely ever* sets a very high standard of probability: ‘permanent state of affairs’, ‘no real chance’ or ‘improbable’.<sup>288</sup> The true construction of *unlikely ever* is ‘no real chance or even improbable’. The words ‘look well into the future’ and connote a permanent state of affairs so far as can be seen based on the evidence at the

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<sup>285</sup> *Sutton*, para. 21.340.

<sup>286</sup> *Sutton*, para. 21.360: there are some judicial statements in NSW to the contrary.

<sup>287</sup> *Sutton*, para. 21.370.

<sup>288</sup> See *Wiley v Board of Trustees, State Public Sector Superannuation Scheme* [1997] QSC 46; *Ivkovic v Australian Casualty & Life Ltd* (1994) 10 SR (WA) 325; FOS 13371 at 71; *TAL Life Ltd and MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68, para. 75,81,87-91,190.

time of assessment.<sup>289</sup> A modern and practical rendition of the test would be: ‘very improbable over a working life time’.

- 5.18. It follows that time and therefore age can be factors: a life insured was aged 38 and the length of working life available was relevant because a younger person has a better opportunity to return to an ETE occupation. In the modern Australian context, it might be reasonable to treat a lifetime as between age 65 and 80.<sup>290</sup>

### **Partial disablement**

- 5.19. The distinction between total and partial disablement is between the carrying out of all the normal duties of the insured's usual occupation and the carrying out of the some of the normal duties.<sup>291</sup>

### **Causation**

- 5.20. The TPD definitions require a causal link between the injury or illness and either or both the absence from work and the incapacity. The words ‘resulting from’ and ‘as to render’ are words importing a causation test.
- 5.21. The injury or illness must be the cause of the absence from work: the real, effective and proximate cause. It is not necessary for injury or illness to be the sole cause but there must not be an intervening cause. Where there is an entitlement to a benefit only if a bodily injury, caused solely, directly and independently of any other cause, or resulted in, total and permanent disablement, the claimant must establish that the injury was the sole and direct cause of the disablement.<sup>292</sup>

### **Waiting period**

- 5.22. The insured must be absent from work, or in the industry jargon, ‘off work’, continuously during the waiting period to qualify for assessment as TPD. The usual period is six months but it can be different. If the life insured is incapacitated at the end of the waiting period, this is the first date, and on one view, the only date, as at which the life insured can be assessed to be TPD under the insurance. That is the purpose of the waiting period and its function among the criteria for TPD. If the life insured returns to work during the waiting period, subject to the terms of the insurance, either the waiting period begins again if the injury or illness causes a further day ‘off work’ or there must be a new illness or injury for the waiting period to begin again. A genuine attempted return to work which fails is, on common industry practice, often not counted as ‘at work’.<sup>293</sup>

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<sup>289</sup> *White v Board of Trustees* [1997] 2 Qd R 659 at 673; FOS 19155, at 47, 91, 94.

<sup>290</sup> *Sutton*, para. 21.370.

<sup>291</sup> *Sutton*, para. 21.390.

<sup>292</sup> *Sutton*, para. 21.400.

<sup>293</sup> *Sutton*, para. 21.410.

### **Date of assessment and determination**

- 5.23. It is not, on the terms of the standard TPD definitions, or rationally, necessary for the life insured to be incapacitated or disabled on or from the end of the waiting period until the relevant assessment date. The requirement is that the life insured, during the waiting period, is not at work. The incapacity or disability could occur later, assuming the other definitional criteria are satisfied. Therefore, if the life insured is incapacitated or disabled at the end of the waiting period, the life insured may be TPD under the insurance for the causative illness or injury. If the life insured is not incapacitated or disabled at the end of the waiting period, the life insured may later be TPD under the insurance for the causative illness or injury.<sup>294</sup>

### **Trigger – the insurer’s liability**

- 5.24. The trigger question is: when is the insurer liable, or, what events must occur during the policy period to trigger the insurer, and not a prior or subsequent insurer, to be liable for the claim for a TPD benefit?
- 5.25. There are four possibilities, for any TPD insurance on its terms, for the time the cause of action, or trigger, arises: the injury or illness; the first day of the waiting period or ‘off work’; the end of the waiting period – the assessment date; or the date of TPD determination. The injury or illness may be the trigger because each is causative and because if an injury or illness is not the trigger, an injury or illness prior to the policy period is disclosable to a subsequent insurer and might preclude TPD or be excluded as a cause or as a pre-existing condition. The disclosure point does not arise in group insurance. The first day ‘off work’ is widely accepted by insurers as the trigger. It features as the point which determines, when there is a change of insurer in group insurance, whether the incoming or outgoing insurer is liable for the TPD – it is the insurer which is on risk on the first day ‘off work’. The end of the waiting period as the trigger has the advantage that it is possible for the life insured to be TPD on this date, at the earliest; but it does not have the advantage of being causative, providing continuity between outgoing and incoming insurers or industry acceptance. The date of determination may occur at any time and is therefore too uncertain and open to manipulation. There are authorities which support each of these positions and it is not possible to state a general rule for that reason as well as the determinative importance of the specific wording.<sup>295</sup>

### **Under the regular care and attendance of a medical practitioner**

- 5.26. The purpose of the term of a policy that the life insured will be under the regular care and attendance of a medical practitioner is to ensure that there will be independent proof available from a satisfactory source that satisfies aspects of the definition of

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<sup>294</sup> *Sutton*, para. 21.430.

<sup>295</sup> *Sutton*, para. 21.440.

‘total disability’: for example, that the sickness persists; and that the patient is by reason solely of the sickness unable to work. The term does not require that the life insured is obliged to see the doctor in relation to the relevant conditions every month or every two or three months. Visits of two to three times a year to a general practitioner with a good understanding of the plaintiff’s medical history and the subject problems would be sufficient compliance.

### **Under the continuous direction and professional care of a medical practitioner**

- 5.27. The policy might contain a term that the life insured will be under the continuous direction and professional care of a medical practitioner. The adjective ‘continuous’ which qualifies the nouns ‘direction and professional care’ means ‘ongoing, uninterrupted, unbroken’. The life insured must be under the ongoing or unbroken guidance and management of a medical practitioner. It is not required that there be actual treatment or actual attendances by or upon a medical practitioner.
- 5.28. But if ‘continuous direction and professional care of a medical practitioner ...’ does mean regular attendances by or upon a medical practitioner, it must be the case that the direction and care be necessary and beneficial for the treatment of the life insured’s illness or injury.

## **6. Extensions and options**

### **Automatic upgrades**

#### *Introduction*

- 6.1. As products innovate and medical science advances, a policyowner of a long-term contract taken out in earlier times should not be disadvantaged in comparison with a customer who takes out a new product with better terms. A life insurance company therefore may wish to upgrade a cover, benefit, option, sum insured or periodic payment (*Feature*)<sup>296</sup> under a life insurance contract or policy.
- 6.2. For a life policy which has already been issued, the life insurance contract might contain a term by which the life insurance company promises or has the *obligation* to grant a *Feature Upgrade*. The promise is a contingent one: if the life insurance company upgrades a future life policy in the same series or of the same type to include the *Feature*, the life insurance company would and must grant the same *Feature Upgrade* automatically to all current issued life policies in the same series or of the same type (*Automatic Upgrade* clause). When the contingency – the *Feature Upgrade* – occurs, the life insurance company’s promise ceases to be contingent and the

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<sup>296</sup> A *Feature* is sometimes called a ‘rider’ or a ‘rider benefit’.

promise or obligation in the *Automatic Upgrade* clause must be discharged by performance. The life insurance company must grant the *Feature* automatically to all current issued life policies in the same series or of the same type.

### *Description*

- 6.3. The life insurance company might promise that if the life company improves the benefits under the policy and there is no increase in *premium rates*, the life company will automatically add the *benefit* improvements to the life policy. The benefit improvements are effective either from the date of the next annual statement or from the first date a life policy, with the benefit improvements, could have been purchased from the life insurance company. If a situation arises where the policyowner is *disadvantaged* as a result of the upgrade, the previous policy wording would apply. This is an *Automatic Upgrade* clause.
- 6.4. The clause might also provide that: first, the policyowner/insured may choose to have a claim assessed under the pre-improvement wording; or second, if a policyowner is disadvantaged in any way as a result of an improvement the previous benefit wording will prevail.

### *Benefit*

- 6.5. A ‘benefit’ in this term can mean an *amount* payable under the policy if an insured event, condition, illness or injury occurs. In this sense, a variation to the sum insured or the periodic amount is a part of the calculation of a benefit but not the benefit itself. A ‘benefit’ in this clause can also mean a *promise* to pay an amount if an insured event, condition, illness or injury occurs.

### *Passback*

- 6.6. The combination of an *Automatic Upgrade* clause and a *Feature Upgrade* is usually called a ‘pass-back’. While an insurer is legally permitted, where there is a variation term to that effect, to vary the life insurance contract to the prejudice or disadvantage of the policyowner, a life company may be most unwilling from a customer and adviser relations and market perception perspective to vary the life insurance contract unilaterally with a disadvantageous effect: the removal or diminution of a *Feature* or an increase in premium or premium rate.
- 6.7. The life insurance company will want to grant positive *Features* in the pass-back. A premium increase, for whatever reason, risks the policyowner cancelling the life insurance contract in accordance with a term which permits that cancellation: this is called a lapse. The policyowner might switch to a different product or life company or might cease life insurance completely. The life insurance industry also fears that lapses can be ‘anti-selective’. A life insured with better health and other life risk factors, might wish and be able to find other life insurance with equivalent or better *Features* and at a better premium. A life insured with worse health and other life risk factors, might not have those choices available. If the better life insureds lapse and the worse life insureds remain in the life company’s portfolio, the actual claims are likely to

increase well above the expected claims resulting in various types of losses on the life company's portfolio.

- 6.8. It follows that it would be rare that a life insurance company, depending on the *Feature*, relevant life insurance contract terms and market practice, would charge a premium directly referable to the *Feature* and at the time the *Feature* is issued. Life insurance industry practice is that pass-backs apply only if the life insurance company considers that it can be done without any increase in the premium or at an increase in premium the life company can absorb through reduced profits.

### *Premium*

- 6.9. Whether or not a life insurance company charges a premium directly referable to the *Feature* and at the time the *Feature* is issued, all life companies will review the relevant portfolio over time based on claims experience and will increase the premium or the premium rates based on that reviewed claims experience. If cumulative 'free' pass-backs over time cause changes to the actual experience of the portfolio then experience changes will ultimately be reflected in changed premium rates and premiums. Premium changes result from changes to the premium rates, except in relation to a change in the sum insured or periodic benefit, and would apply to life policies in the portfolio at the next anniversary date. An increase in any factor, including a CPI increase, which applies to a sum insured or a periodic benefit, has the effect that the sum insured or the monthly benefit increases. The premium is higher because the premium rate is applied to a higher sum insured.

### *Annual statement*

- 6.10. The *Feature* should be but is not always included in the annual statement. An annual statement, where there has been an *Automatic Feature Upgrade*, should include specifics about the *Feature*, particularly any variation to the sum insured or amount of periodic benefit. The absence of this information makes it difficult for the policyowner to understand the variation and to exercise the right to 'opt out' and to reject the *Feature*.
- 6.11. The increased premium then appears on and takes effect from the annual statement, summarising the cover, issued to the policyowner. A policyowner, at any time, including on the receipt of the annual statement can ask for a reduction in any a cover, benefit, sum insured or periodic payment or *Feature* for a reduced premium.

## 7. Exclusions

### **Pregnancy**

- 7.1. Some life policies exclude the payment of any benefit for a claim caused (directly or indirectly) or contributed to by normal or uncomplicated pregnancy or childbirth (*pregnancy exclusion clause*).

- 7.2. The *pregnancy exclusion clause* operates to limit the cover of a person who is pregnant or potentially pregnant, which constitutes less favourable treatment on the basis of a person's pregnancy or potential pregnancy. This is discriminatory (as defined by section 7 of the *Sex Discrimination Act 1984* (SDA)) and is unlawful pursuant to section 22 of the SDA. There is no exemption for insurers in respect of discrimination on the grounds of pregnancy or potentially pregnancy, although an exemption from the Human Rights Commission can be applied for.
- 7.3. Other life policies do not exclude benefits completely and will pay a benefit for a pregnancy related condition if total disability continues for a specific period following the date the pregnancy ends. A period of 3 months is not unusual (*delay in payment due to pregnancy clause*).
- 7.4. The *delay in payment due to pregnancy clause* also constitutes unlawful discrimination because it disadvantages persons who are pregnant by delaying payment of benefits until after the end of the pregnancy. This less favourable treatment on the basis of a person's pregnancy is discriminatory (as defined by the SDA, section 7) and is unlawful pursuant to the SDA, section 22.

### **Pre-existing sickness or disability<sup>297</sup>**

#### *Application*

- 7.5. The IC Act, section 47, applies when its first limb is satisfied: 'a claim under a contract of insurance is made in respect of a loss that occurred as a result, in whole or in part, of a sickness or disability to which a person was subject or had at any time been subject.'
- 7.6. The section also requires a second limb to be satisfied for it to apply: 'Where, at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability'. The second limb requires a factual test.

#### *Effect*

- 7.7. The section has the effect, when it applies, that an insurer 'may not rely on a provision included in the contract that has the effect of limiting or excluding the insurer's liability under the contract by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into.'
- 7.8. The courts have puzzled over the meaning of 'loss' in section 47. On one view, it does not have the narrow meaning of financial loss but 'loss' could not refer to the sickness or diagnosis. The rejection of the second part of this approach would make the section impossible to apply. Spigelman CJ considered that the word was 'merely designed to indicate the circumstances, in accordance with the particular insurance contract under

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<sup>297</sup> *Sutton*, paras. 21.90–21.100.

consideration, which can give rise to claims.’ It is submitted that this is the better view.

*Does section 47 apply to an injury?*

- 7.9. Section 47 speaks of illness or disability but not injury. Does section 47 apply to an injury? The Australian Law Reform Commission (ALRC) approach would be consistent with the section’s application to injury but the word ‘injury’ is clearly a distinct idea from disability; not every injury is a disability. The IC Act refers to injury in a number of contexts and disability or cognate terms in a number of contexts. The rules of statutory construction support the construction that disability has its ordinary meaning.
- 7.10. Section 47 is not limited to an illness existing at the time of entering into the contract because the section refers to ‘at any time been subject’ so that if the insured was aware at any time of the subject condition, the illness does not need to be existing but the awareness must be.
- 7.11. Section 47 does not apply to a sickness or disability which occurs after the life insurance is entered into; it is confined to a sickness or disability before the life insurance is entered into. Therefore, the section had no application to a sickness or disability diagnosed during the waiting period but excluded by the waiting period exclusion in the life insurance.
- 7.12. The section does not apply to the core cover or main risk. Section 47 was held not to apply to the ‘waiting period’, an integral part of a TPD definition: a person is not disabled in a period in which the life insured is engaged in an occupation for wage or profit.
- 7.13. If an insured took out insurance cover but was not aware at the time of an existing sickness or disability and a reasonable person in the circumstances could not be expected to have been aware of it, the insurer is not permitted to rely on an exclusion in the policy which has the effect of limiting or excluding the liability of the insurer by reference to that sickness or disability: section 47. The purpose of section 47 is to prevent circumvention of the Act’s provisions dealing with misrepresentation and non-disclosure: *Galaxy Homes Pty Ltd v National Mutual Life Association of Australasia Ltd (No 2)* [2013] SASCF 66.

*Was the injury the result of a pre-existing condition*

- 7.14. Another issue that arises in assessing ‘total and disablement benefit’ claims is determining whether the injury, the subject of the claim, came about independently of any pre-existing condition. Often, the insured will only be entitled to a benefit if he or she has been rendered unable to perform the duties of his or her usual occupation by an injury that ‘resulted solely, directly and independently of a pre-existing condition.’

- 7.15. Three possible scenarios were identified recently in *Preston v AIA Australia Ltd*:<sup>298</sup>
- a) where a dormant or inactive condition creates a propensity in the insured to suffer disabling consequences from what otherwise might be a relatively minor injury;
  - b) where a significant medical or physical condition is aggravated by the injury or combines with the injury so as to result in disability;
  - c) where an insured suffers an accidental physical injury which is sufficient in itself to cause permanent disablement. The accident might also aggravate or activate a pre-existing condition which, independently of the direct consequences of the physical injury, is also sufficient in itself to cause total disablement.
- 7.16. In the first scenario, the accidental injury will ordinarily be regarded as the sole, direct and independent cause of the disability. In the second scenario, a court is likely to conclude that the accidental injury is one of two concurrent causes and is therefore not the sole, direct and independent cause of the disability. With respect to the third scenario, the court gave the example of an accident in which the insured suffers a serious hand injury and also a back injury which aggravates an existing chronic back condition where each injury is sufficient of itself to prevent the insured from working. In this case, the court held that the better view was that the injury to the hand results solely and directly in total disablement and does so independently of the aggravation of the pre-existing back condition.
- 7.17. It is relevant to note section 47(2) which provides that where, at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to be aware of, the sickness or disability, the insurer may not rely on a provision included in the contract of insurance that has the effect of limiting or excluding the insurer's liability by reference to a sickness or disability to which the insured was subject at the time before the contract was entered into. The purpose of the section is to prevent avoidance of the Act's regulation of misrepresentation and non-disclosure: *Galaxy Homes Pty Ltd v National Mutual Life Association of Australasia Ltd (No 2)*.<sup>299</sup>

### **Suicide**

- 7.18. Suicide itself is not now a crime in Australia and therefore the defence that the act is illegal is not a defence in these circumstances. The public policy defence does not apply to deny the life insured's estate to a benefit from the suicide.
- 7.19. A suicide is covered if the insurance contract has an express or implied term that suicide is covered.
- 7.20. But even if there is no such term, the insurer is not entitled to deny the claim for life insurance contracts under the LI Act, section 228, which provides that:

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<sup>298</sup> [2014] NSWCA 165.

<sup>299</sup> [2013] SASCFC 66.

A life company may only avoid a life policy on the ground that the person whose life is insured by the policy committed suicide if the policy expressly excludes liability in case of suicide.

While the section oddly uses avoid, the better view must be that it should be construed as precluding a defence on the stated basis.

- 7.21. A once typical clause in a life policy states that the policy does not cover death where within thirteen calendar months after the commencement date of the policy the life at risk dies by her or his hand or act but these clauses have ceased to be common.<sup>300</sup>

## War

- 7.22. Any term of a life policy is void if it limits, to an amount less than the total of the sum insured and bonuses, the amount payable under the policy if the life insured by the policy dies on war service unless there is written on the policy document an acknowledgment signed by the person to whom the policy was issued that the policy is subject to the term or condition. The acknowledgment must be by the original policyowner.<sup>301</sup>

## 8. Interpretation

- 8.1. A life insurance contract or policy is interpreted or construed according to the following principles.
- 8.2. The contract is read as a harmonious and consistent whole and in the context of other contracts and arrangements between the parties about the insurance.
- 8.3. The contract is interpreted objectively and in the context of the facts known to the parties, the background to the arrangement and the commercial and social purpose of the arrangement.<sup>302</sup> The intentions of a party and the negotiations before the contract are irrelevant.<sup>303</sup>

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<sup>300</sup> *Sutton*, para. 21.170.

<sup>301</sup> *Sutton*, para. 21.210.

<sup>302</sup> *Johnson v American Home Assurance* (1998) 192 CLR 266 at 272; *Botany Fork and Crane Hire v New Zealand Insurance* (1993) 44 FCR 27 at 30-31; *Australian Casualty v Federico* (1986) 160 CLR 513 at 520; *United City Merchants v MGICA* (1985) 3 ANZ Ins Cases 60-603 at 78673; *Wilson v Harvey Trinder* [1973] 2 NSWLR 870 at 874-875; *Charter Reinsurance Co Ltd v Fagan* [1997] AC 313 at 387-388; *Investors Compensation Scheme Ltd v West Bromwich Building Society* [1998] 1 WLR 896.

<sup>303</sup> *Bank of Australia v North German Insurance* (1898) 17 NZLR 387 at 399; *Todaro v Farmers and Graziers Co-Op* [1982] VR 73 at 79; *Nosic v Zurich Australian* [1997] 1 Qd R 67 at 77 & 78.

- 8.4. The words and phrases in the contract have their ordinary meaning<sup>304</sup> or their technical meaning.<sup>305</sup> The meaning is affected by definitions in the contract, legislation and case law. A word or phrase should not be ignored: an interpretation which give a word or phrase no work to do should be avoided.
- 8.5. The contract is interpreted in a fair, reasonable and business-like way taking into account the variety of persons entering an insurance contract and the entitlement of such persons to know the bargain which they have secured.<sup>306</sup>
- 8.6. The contract is not interpreted to give an absurd (irrational or meaningless) result or to deny any cover.<sup>307</sup> It cannot be rewritten to make more commercial sense.<sup>308</sup>

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<sup>304</sup> *Johnson v American Home Assurance* (1998) 192 CLR 266 at 272; *McCann v Switzerland Insurance Australia Ltd* (2000) 176 ALR 711 at 716 and 725-727; *Botany Fork and Crane Hire v New Zealand Insurance* (1993) 44 FCR 27 at 30-31; *Australian Casualty v Federico* (1986) 160 CLR 513 at 520; *United City Merchants v MGICA* (1985) 3 ANZ Ins Cases 60-603 at 78673; *Wilson v Harvey Trinder* [1973] 2 NSWLR 870 at 874-875.

<sup>305</sup> *Johnson v American Home Assurance* (1998) 192 CLR 266 at 272.

<sup>306</sup> *Botany Fork and Crane Hire v New Zealand Insurance* (1993) 44 FCR 27 at 30-31; *Australian Casualty v Federico* (1986) 160 CLR 513 at 520; *United City Merchants v MGICA* (1985) 3 ANZ Ins Cases 60-603 at 78673; *Wilson v Harvey Trinder* [1973] 2 NSWLR 870 at 874-875.

<sup>307</sup> *Johnson v American Home Assurance* (1998) 192 CLR 266 at 272; *Charter Reinsurance Co Ltd v Fagan* [1997] AC 313 at 387-388; *Investors Compensation Scheme Ltd v West Bromwich Building Society* [1998] 1 WLR 896.

<sup>308</sup> *McCann v Switzerland Insurance Australia Ltd* (2000) 176 ALR 711 at 716 and 725-727; *Charter Reinsurance Co Ltd v Fagan* [1997] AC 313 at 387-388; *Investors Compensation Scheme Ltd v West Bromwich Building Society* [1998] 1 WLR 896.

- 8.7. A word or phrase which has two meanings will be interpreted in favour of the policyowner. It is not enough that there is a second arguable meaning: it must be 'intractably ambiguous'.<sup>309</sup>
- 8.8. The High Court in *Wallaby Grip Ltd v QBE (Australia) Limited*<sup>310</sup> has clarified that at least in indemnity policies, if a policy is lost the onus of proving the existence of particular policy exclusions and limitations including the limit of indemnity rests on the insurer.

## 9. Utmost good faith

### Implied term

- 9.1. Utmost good faith generally is discussed in the GIBP, Part Nine.
- 9.2. The IC Act duty involves a continuing duty during the period of the insurance. The High Court stated in *CGU Insurance Ltd v AMP Financial Planning Pty Ltd*<sup>311</sup> that the IC Act, section 13, requires an insurer to act consistently with commercial standards of decency and fairness and with due regard to the interests of the insured. For example, although a term of the contract specified that payment was to be made on a monthly basis, the insurer failed to bring to the plaintiff's attention the fact that he was at risk of losing his disability cover for paying on a yearly, rather than monthly, basis. In circumstances where the insurer was accepting annual payments from the employer and the insurer failed to respond to notice that payment on behalf of the class of members of which the plaintiff was part of would be made on an annual basis, this failure breached the IC Act, section 13 duty.
- 9.3. The insurer's duty to act in good faith and to deal fairly with an insured is not limited to the time the insurer forms its opinion – see Part Nine. It applies to all stages during the gathering of material relevant to the formation of the opinion and it remains a duty at all stages subsequent to the presentation of a claim, being applicable to all aspects of the performance of an insurance contract.

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<sup>309</sup> *Johnson v American Home Assurance* (1998) 192 CLR 266 at 272; *MGICA v United City Merchants* (1986) 4 ANZ Ins Cases 60-729; *CE Heath v Edwards Dunlop* (1993) 176 CLR 535 at 541-542; *Maye v Colonial Mutual Life* (1924) 35 CLR 14; *Darlington v Deko* (1986) 161 CLR 500 at 510-511.

<sup>310</sup> (2010) 240 CLR 444.

<sup>311</sup> (2007) 235 CLR 1.

- 9.4. The duty of utmost good faith under section 13 of the IC Act requires an insurer to make a prompt admission of liability to meet a sound claim and to make a prompt payment.<sup>312</sup>

### **Reliance on a term**

- 9.5. The IC Act, section 14, provides that reliance on a term of the contract can constitute a failure of good faith. The public policy consideration of section 14 of the IC Act included the rationale that, if insurers were prevented from relying on contract provisions in breach of the duty of utmost good faith, this would induce insurers to act fairly in relying on their strict terms. The IC Act, section 14, therefore specifically contemplates that, in some cases, it may be a breach of the duty of utmost good faith for the insurer to rely on the strict terms of the contract.
- 9.6. The courts have decided that in some cases certain terms and conditions could not be relied upon by the insurer because the insurer failed to bring those terms to the policyowner's attention. Examples include the definition of accident, an exclusion and a term that allowed it to reduce benefits by the amount of social service benefits received by the life insured. *Australian Motor Insurers Ltd v Ellis*<sup>313</sup> applied section 14. The Court found that the duty of utmost good faith required the insurer to give the insured adequate warning of the general nature and effect of the policy condition. The Court found that the insurer did not give sufficient warning to the insured in breach of the duty of good utmost faith and as a result, the insurer was prevented from relying on the policy condition to deny liability.<sup>314</sup>

## **10. Section 54<sup>315</sup>**

### **Introduction**

- 10.1. On categories of terms generally see the GIBP, Part Eleven, section 4.

### **General<sup>316</sup>**

- 10.2. The IC Act, section 54, can alter the effect of a term.<sup>317</sup> A breach of or failure to comply with a term which would allow the insurer to deny a claim might, if section 54

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<sup>312</sup> *Wyllie v The National Mutual Life Association of Australasia Ltd*; (unreported, NSW Sup Ct, Hunter J, 18 April 1997); *Beverley v Tyndall Life Insurance Co Ltd* (1999) 10 ANZ Ins Cas 61-453; *McArthur v Mercantile Mutual Life Insurance Company Ltd*. [2002] 2 Qd R 197; 11 ANZ Ins Cas 61-501.

<sup>313</sup> *Australian Motor Insurers Ltd v Ellis* (1990) 54 SASR 61.

<sup>314</sup> Compare *Re Zurich Australian Insurance Ltd* [1999] 2 Qd R 203; *Sutton*, p. 507.

<sup>315</sup> *Sutton*, paras. 3.930–3.1060; See GIBP, Part Twelve.

<sup>316</sup> *Sutton*, para. 7.900.

<sup>317</sup> *Sutton*, paras. 3.930–3.1060.

applies, have no effect or the insurer might be entitled only to reduce the amount it pays or the benefit it grants.<sup>318</sup>

### **Application**

- 10.3. In order for section 54 to apply to a claim the following preliminary matters must be satisfied. First, there is conduct<sup>319</sup> after the life insurance contract is entered into. Second, the conduct is by the policyholder or some other person: it could be conduct by the life insured or a third party beneficiary.<sup>320</sup> The conduct is not by a stranger to the insurance relationship like a third party claimant against a policyholder. Third, the effect of the insurance contract is that the insurer is entitled to deny the claim in whole or in part because of the conduct. These elements are in section 54(1).

### **Causation**

- 10.4. Once the preliminary matters which deal with the application of section 54 are satisfied, the way section 54 applies to the subject claim depends on causation.
- 10.5. First, if the conduct is *reasonably capable* of causing or contributing to the claimed loss, the insurer is entitled to refuse to pay the claim: section 54(2). The loss under section 54(2) is in relation to the policyowner;<sup>321</sup> it is not the loss potentially to the insurer caused by the claim.
- 10.6. But where the claimant proves that all or some part of the loss that gave rise to the claim was not *actually* caused by the conduct, the insurer may not refuse to pay that part of the claim: section 54 (3) and (4).
- 10.7. Second, if the conduct is *not* reasonably capable of causing or contributing to the claimed loss, the insurer is not entitled to refuse to pay the claim but the insurer's liability is reduced by an amount that fairly reflects the prejudice to the insurer caused by the conduct: section 54(1).

### **Exemptions**

- 10.8. The insurer is not entitled to deny the claim because of the conduct if the conduct was: reasonably necessary to protect the safety of a person or to preserve property; or, it was not reasonably possible for the person not to carry out the conduct: section 54(5) of the IC Act.
- 10.9. A reference in section 54 of the IC Act to an 'act' includes a reference to an omission and an act or omission that has the effect of altering the state or condition of the

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<sup>318</sup> *Sutton*, para. 7.900.

<sup>319</sup> IC Act, s. 54 defines act to include an 'act' includes a reference to an omission: section 54(6).

We use 'conduct' to cover the matters in this definition.

<sup>320</sup> *Sutton*, paras 3.930, 3.940, 3.980, 8.100; Mann, para 54.20.

<sup>321</sup> *Sutton*, paras. 3.930, 3.940, 3.980, 8.100; Mann, para. 54.20.

subject matter of the contract or of allowing the state or condition of that subject matter to alter: section 54(6) of the IC Act.

- 10.10. For example, a policyholder who, in breach of a condition of the policy, fails to notify a claim during the relevant policy period may still be covered by the insurance contract if the insurer has suffered no prejudice as a result of the late notification. However, if the relevant breach by the policyholder is the cause of the loss claimed under the policy, for example, causing loss or damage to insured property, then section 54 of the IC Act does not assist the policy owner as the insurer would be entitled to reduce the liability to nil.

### **Contestable or unclear issues**

- 10.11. There are three main issues for section 54 on which the law is not clear.
- 10.12. The first issue is whether the effect of the contract in section 54(1) means the effect as affected by the IC Act.<sup>322</sup>
- 10.13. The second issue is whether the effect of section 54 can affect the scope or definition of the cover under the insurance contract. A series of third party liability cases beginning in the 1990s developed a trend of analysis and results to the effect that the IC Act, section 54, could be deployed to vary the definition of risk that was accepted and underwritten and the scope of the cover. That remains a live and uncertain issue for the application of section 54.<sup>323</sup>
- 10.14. The third issue is whether the reference to conduct in the section includes a state of affairs.<sup>324</sup>

### **Fraud and section 54<sup>325</sup>**

- 10.15. Section 56 deals with the making of fraudulent claims. Section 56(1) of the IC Act provides that an insurer is not permitted to avoid the contract on the basis of a fraudulent claim but is entitled to deny payment of the benefits under the policy. The right to deny payment is modified in section 56(2) and (3) where the fraud applies to only a minimal or insignificant part of the claim and it would be harsh and unfair if the insurer did not pay the balance of the claim.
- 10.16. There may be an overlap between section 54 and section 56. The courts consider that once section 56 applies, section 54 cannot apply.<sup>326</sup>

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<sup>322</sup> See the third criterion in paragraph 10.3 above.

<sup>323</sup> Mann, paras. 54.10.2 and 54.10.5.

<sup>324</sup> Mann, para. 54.10.7; *Allianz Australia Insurance Ltd v Inglis* [2016] WASCA 25.

<sup>325</sup> Mann, para. 54.80.

<sup>326</sup> *Sutton*, para 8.100; Pynt, para 21.17; Mann, para 56.50; *Gugliotti v Commercial Union Assurance Company of Australia* (1992) 7 ANZ Ins. Cases 61-104 (VSC); *Walton v Colonial Mutual Life Assurance Society Ltd.* (2004) 13 ANZ Ins Cases 61–620 (NSWSC).

10.17. Sometimes there is a term in the policy which provides for consequences should an insured make a fraudulent claim. Section 54 may apply to such a situation although section 56 can operate even if there is no relevant term in the contract.

## **Life insurance**

### *Introduction*

10.18. There are a number of important life insurance issues for the application of section 54:

- a) date of IC Act application;
- b) how prejudice and proportion work for a lump sum claim;
- c) protection of the safety of a person: section 54(5)(a).

### *Date of IC Act application*

10.19. The IC Act applies to an insurance contract which has 'Australian' proper law: section 8.

10.20. There are exceptions, the only one of which that is relevant to life insurance is an insurance entered into by a friendly society: section 9(1)(c).

10.21. The IC Act applies to contracts entered into after 1 January 1986: section 4(1). It applies to a cover issued after that date even if the group policy was entered into before that date: section 4(2).

10.22. Therefore, section 54 applies to an individual policy and a life cover issued after 1 January 1986.

### *Lump sum*

10.23. Where section 54(1) applies, its effect is to reduce the insurer's liability by an amount that fairly reflects the prejudice to the insurer caused by the conduct. Where section 54(4) applies, the insurer is entitled to pay a part of the claim or loss. These sections apply clearly to reduce a general insurance claim proportionately to the subject cause. Where the life policy provides for a lump sum insured or benefit, it is difficult to apply section 54 with the effect that the claimant receives a portion of the lump sum insured or benefit amount. The effect might be that the life company pays either all or nothing of the lump sum insured. Different considerations would apply to an income protection policy which paid a monthly benefit calculated on lost income, up to a cap.

### *Safety protection*

10.24. The exception for conduct in relation to the protection of a person's safety has particular relevance for life insurance.

10.25. Section 54(5) provides that the insurer may not refuse to pay a claim by reason only of the conduct described in the section.

10.26. Once the conditions in section 54(1) are met, section 54(5) applies. Section 54(5) becomes an alternative to and overrides sections 54(2)–(4). It also overrides the prejudice limb of section 54(1). The relevant conduct for life insurance is:

- a) protection of the safety of a person: section 54(5)(a);
  - b) it was not reasonably possible for the insured or life insured not to 'do' the conduct: section 54(5)(b).
- 10.27. The section in its application to life insurance raises the following matters for consideration:
- a) a surgery or medical procedure in a trauma cover could involve the 'safety of a person' but safety is an odd word to use where 'health' is more relevant in trauma;
  - b) where a life insured refuses 'reasonable medical assistance' both limbs of section 54(5) would need to be considered.

### **Variation**

- 10.28. A life insurer is entitled to vary the life insurance contract during its period by mutual agreement and this can be done orally.<sup>327</sup> Section 53 which makes void provisions which permit an insurer to vary a contract does not apply to life insurance, superannuation or sickness and accident insurance contracts which are guaranteed renewable or where the insurer guarantees not to cancel the policy due to a change in the risk where such policy has been effected for more than one year.<sup>328</sup>

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<sup>327</sup> *Green v AMP Life Ltd* [2005] NSWSC 370.

<sup>328</sup> Regulation 31 of the Insurance Contracts Regulations 1985.

## PART NINE – CLAIMS

### 1. Introduction

- 1.1. There are a number of elements required for an insured, a third party beneficiary or any category of person or entity considered in section 4 above (the claimant) under a policy to make a successful claim.
- 1.2. On claims generally see the General Insurance Background Paper No. 14 (GIBP), Part Fourteen.

### 2. Notice

- 2.1. Notice of a claim should be given to the insurer, in accordance with the terms of the policy, although failure to give such notice is unlikely to be a proper ground for the insurer to reject the claim or constitute a defence to the claim.

### 3. Claim and proof

- 3.1. The claimant has the obligation to establish an entitlement to the sum insured or a benefit under a life policy. The claimant must prove that:
  - a) the claimed Life Insured Event (condition, illness, injury, accident, disability or death) occurred;
  - b) the relevant consequence (imminent death, disability or inability to work) has resulted;
  - c) the claimed Life Insured Event and the relevant consequence is covered by the insurance policy;
  - d) for an income protection claim, there is evidence of income where that is relevant; and
  - e) the claim otherwise satisfies the policy terms.
- 3.2. The life insurance company will ask the claimant to complete its standard claim form. A death claim requires a death certificate. For other claims, depending on the circumstances, financial, occupational and medical information will be required. The claim form requires the claimant to consent to the life insurance company obtaining information and documents from various entities and people: Medicare, a workers' compensation insurer, an employer, a treating doctor or specialist.

## 4. Causation

- 4.1. The test and description of causation, direct causation, in law is the proximate cause. The legal approach to causation involves the following principles:
- a) insurance law looks to the proximate and not the remote cause of loss or damage;
  - b) the proximate cause is the active, efficient cause that sets in motion a train of events without the intervention of any independent force;
  - c) the proximate cause principle applies when the policy refers to cause, direct cause or result;
  - d) the question of causation is essentially a question of common sense to be determined by the standards of a reasonable non-expert.<sup>329</sup>
- 4.2. On causation generally see the GIBP, Part Thirteen.<sup>330</sup>

## 5. Claims handling

- 5.1. The relevant principles applicable to the assessment of a claim by a life insurer are as follows:<sup>331</sup>
- a) The insurer must consider, and determine, the correct question or questions. This essentially requires the correct interpretation of the policy of insurance.
  - b) If the insurer seeks an opinion from an expert, it must provide the expert with all of the information that is relevant to the expert's opinion.
  - c) Where an expert opinion is sought, the expert must also be asked the right questions.
  - d) Asking the right questions of the expert, however, does not require the insurer to ask the expert to address specific provisions in the policy. The insurer is itself making the ultimate decision, and not delegating the decision making to the expert. The critical enquiry for the court is whether the insurer, ultimately, has addressed the correct questions either directly, or indirectly with the aid of the expert's opinion, and has taken account of the relevant information either directly, or indirectly, in respect of relevant information assessed by the expert.

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<sup>329</sup>*Lasermax Engineering Pty Limited v QBE Insurance (Australia) Limited* [2005] NSWCA 66; See *Ballesteros v Chidlow & Anor* [2005] QSC 280 per White J – (at paras 21–27) applying the dicta of the HCA in *Medlin v SGIO* (1994/5) 182 CLR 1.

<sup>330</sup> Causation is also discussed in Part Eight, ss. 2, 5 and 10.

<sup>331</sup> *Birdsall v. Motor Trades Association of Australia Superannuation Fund Pty Ltd* [2014] NSWSC 632.

- e) The insurer is under a duty to act in good faith and to observe fair dealing in respect of both the trustee and the insured.
- f) As part of this duty, the insurer must have due regard for the interests of the insured. However, this duty is contractual, not fiduciary. This duty is analogous to the duty of a mortgagee exercising a power of sale of mortgage property.
- g) Where a state of affairs governing entitlement of the insured to a benefit is to be determined after a consideration by the insurer, the insurer must act reasonably in considering the matter and in coming to its conclusion.
- h) However, the insurer is not required to undertake the detailed consideration required of a court hearing (*Chammas v Harwood Nominees Pty Ltd* (1993) ANZ Ins Cas 61-175 at p 78,001); *Weber v Tiss Pty Ltd* [2005] NSWSC 67, per Nicholas J, at [8]. It must, however, take account of the relevant information available to it.
- i) The statement of reasons for declining a claim should be understood as a practical document intended to inform the claimant of the basis of the decision rather than detailed reasons with reference to the evidence relied upon comparable to a judgment of a court or tribunal: *Weber v Tiss Pty Ltd*.
- j) If the view taken by the insurer can be shown to have been unreasonable on the material before it, the insurer's decision can be successfully attacked.
- k) If the insurer's decision is successfully attacked, the matter upon which its opinion was required becomes one for determination by the court.

- 5.2. An insurer, when considering a claim, must comply with its obligation of utmost good faith. That obligation requires the Insurer to act reasonably in considering the claim. The obligation to act reasonably includes an obligation to consider and to determine the correct question. It also includes an obligation to give the member an opportunity to answer any material on which the insurer intends to rely.<sup>332</sup>
- 5.3. A policy may define the Insured Life Event in terms of whether in the opinion of the insurer the Insured Life Event has occurred to the life insured. The definition has an effect on the assessment of a claim.<sup>333</sup>
- 5.4. The Life Insurance Code of Practice (Life Code) has terms about claims – see below.<sup>334</sup>
- 5.5. The claims staff and sometimes external consultants will assess the claim using the life insurance company's claims guide or manual which sets out the processes to be

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<sup>332</sup> *Hannover Life Re of Australasia Ltd v Sayseng* [2005] NSWCA 214.

<sup>333</sup> See Part Eight, paras. 2.12–2.14 above.

<sup>334</sup> Life Code, s. 8.

followed and the information and documentation required. For some claims, the life insurance company will make independent enquires (for example Medicare, a workers' compensation insurer, an employer, a treating doctor or specialist) and require the life insured to have an independent medical examination. The independent enquiries might include surveillance.

- 5.6. A life insurance company will usually have a reinsurance arrangement by which it pays premium to another life insurance company, the reinsurer, which then pays a part of the claim. The reinsurer might supply a claims manual or advise on the life insurance company's claims manual. A life insurance company might be required to either consult with the reinsurer about a claim or to obtain its prior approval before admitting a claim.
- 5.7. Once these processes are complete, the life insurance company should make a decision whether to admit the claim, to ask for further information or to deny the claim. The life insurance company then communicates its position to the claimant, the agent or adviser.

## 6. Claim denial

- 6.1. The claimant has the onus of proving the claim.
- 6.2. If an insurer denies liability for the claim on the basis of a breach of a policy term, fraud or a policy exclusion, the insurer has the onus of proving that the term was breached, there was fraud or the exclusion applied.
- 6.3. The IC Act, section 54, might affect the insurer's right to deny the claim: see Part Eight, section 10.

## 7. Illegality, fraud and misconduct

### Introduction

- 7.1. There is a range of conduct: illegality, fraud and misconduct, each of which can entitle an insurer to deny or reduce its liability for a claim under a life insurance policy. The relevant conduct is given effect partly by the terms of the policy and partly by the common law. This part considers the conduct and its consequences.

### Principles

- 7.2. A reference to illegality here is a reference to conduct which would preclude a claim for the sum insured or a benefit under a life insurance contract. The illegality can range from a crime, fraud, a tort, a statutory breach through to misconduct – conduct which is wilful, deliberate or intentional. The most tragic but familiar example for life insurance is suicide, which is dealt with above.
- 7.3. The conduct which is relevant here is the conduct which causes the Insured Life Event of or to the life insured. The terms of the life insurance contract about the Insured Life

Event are determinative and might mean that the policy covers illegality. The common law definition of insurance and the terms, express or implied, of the life insurance would preclude recovery for conduct that is wilful, intentional or deliberate. Public policy precludes recovery for a crime unless the crime is either trivial or has no element of moral wrong to it. The test ultimately calls for a value judgment. The court must balance the gravity of the illegality against the consequences of refusing relief.<sup>335</sup>

- 7.4. The law's response to the conduct varies depending on whether the conduct is by the life insured, policyowner or assignee, in the context of the general public policy that a wrong-doer should not benefit from her or his own wrongful conduct.<sup>336</sup>
- 7.5. Where the insurer alleges illegality as a defence to a claim, the onus is on the insurer to prove it and the presumption is always against illegality.<sup>337</sup>

### **IC Act, section 56**

- 7.6. The IC Act, section 56, may apply to a claim under a life insurance contract.
- 7.7. The principles for section 56 which apply to general insurance claims apply to life insurance claims but there are some characteristics of life insurance which should result in different results.
- 7.8. First, the reference in section 56 to the claim being made fraudulently means that the section does not apply where an honest claim is made under a contract where the conduct of the parties before the contract was entered into was fraudulent and the insurer has a right to avoid the contract: that is the domain of sections 29 and 31.
- 7.9. Second, section 56 is limited to a claim under the life insurance contract and does not apply to a claim or cause of action for damages or to fraudulent evidence in court. Therefore, while the section distinguishes between the payment of a claim and the continuation of the contract, in life insurance the payment of the sum insured or a benefit usually means that, subject to other covers, buy-back options and other terms of the contract, the life insurance contract is cancelled or terminated. Therefore, on the payment of a claim under section 56, those terms of the contract should apply to the same result: it is not the fraud which causes the cancellation or termination but the contractual consequences of paying the claim.
- 7.10. Third, the reference to a claim under the IC Act, section 56(1), refers to a person entitled as a third party beneficiary under sections 48A and 48AA.
- 7.11. Fourth, there are difficulties in identifying the fraudulent part of the claim. The general insurance cases consider that 'part' refers to a severable amount claimed. The issue would arise more subtly in life insurance. The sum insured or benefit for life insurance are either specified or calculated by a formula, because life insurance is not indemnity insurance in the relevant sense, therefore on that basis the section would not apply to

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<sup>335</sup> *Sutton*, para. 21.982.

<sup>336</sup> *Sutton*, para. 21.970.

<sup>337</sup> *Sutton*, para. 21.972.

life insurance. Further as a practical matter, the fraud that is seen in life insurance is about the injury, illness or condition: there are occasional fraudulent death claims and an injury or illness might be invented, imaginary, or fraudulently exaggerated. It is not rationally possible to describe any of these matters as a 'part' of the claim and certainly not as 'minimal or insignificant'.

- 7.12. Fifth, the law that section 54 has no application when section 56 is enlivened should be taken as settled also for life insurance.<sup>338</sup>
- 7.13. Sixth, the insurer is not permitted to avoid the contract simply on the basis of a fraudulent claim but is entitled to deny payment of the benefits pursuant to the claim itself.

## **Consequences**

### *Avoidance*

- 7.14. At common law the insurer is entitled to avoid from inception, or to terminate, an insurance contract for fraud. Where IC Act, section 56, applies, the insurer is not entitled to avoid the insurance contract.<sup>339</sup>

### *Deny or reduce claim*

- 7.15. An insurer is entitled to refuse a life insurance contract for fraud under IC Act, section 56(1). An insurer is entitled, where IC Act, section 56(2), applies, to reduce the payment.<sup>340</sup>

### *Cancellation*

- 7.16. An insurer is entitled to cancel a life insurance contract for fraud either at common law or under IC Act, section 59A, and by notice under IC Act, section 60, in either case.

### *No recovery by or through the wrongdoer*

- 7.17. A person who committed or who has an ancillary culpability or liability for the crime or wilful, intentional or deliberate conduct, cannot benefit under the policy.<sup>341</sup>
- 7.18. Where the *policyowner is the cause* of the life insured's death, illness or injury, the *policyowner cannot benefit* under the policy where the causing conduct is either a crime or it is wilful, intentional or deliberate.<sup>342</sup>
- 7.19. Where the *life insured is the cause* of the life insured's death, illness or injury, and the *policyowner is the life insured alone*, the life insured jointly with another, or the life

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<sup>338</sup> *Sutton*, para. 21.1005

<sup>339</sup> *Sutton*, paras. 15.380–15.640.

<sup>340</sup> *Sutton*, paras. 15.380–15.640.

<sup>341</sup> *Sutton*, para. 21.1000.

<sup>342</sup> *Sutton*, para. 21.1000.

insured's estate, the policyowner cannot benefit under the policy where the causing conduct is either a crime or it is wilful, intentional or deliberate.<sup>343</sup>

- 7.20. Where the *life insured is the cause* of the life insured's death, illness or injury, and the *policyowner is a 'stranger'* where such stranger is the beneficiary under the policy by reason of a trust in his or her favour, a family member of the life insured, a creditor, employer or trustee of the life insured, the law does not preclude the benefit because the policyowner is not culpable and is not benefitting from his or her own wrong.<sup>344</sup>
- 7.21. In the same way, an assignee innocent of any culpability, whether the assignment was effective before or after the relevant conduct, is not precluded from a benefit under the policy because although the assignee's rights may depend on the wrong-doer's rights, the assignee is treated as a stranger to the wrong. The position of the innocent assignee is stronger where the innocent assignee gave value for the assignment: a bona fide third parties for value. Where the assignment is after the relevant conduct and the Life Insured Event, the assignment is, for life insurance, almost always of the right to recover only.
- 7.22. A person who committed or who has an ancillary culpability or liability for the crime cannot benefit under the policy.<sup>345</sup>

## 8. Life Code

### Introduction

- 8.1. This Part discusses the standards in the Life Code in relation to claims and claims handling. The Insurance in Superannuation Code (IIS Code) is relevant.
- 8.2. The superannuation trustee's standards under the IIS Code are for it to assist the claimant with the claim, to monitor the group life insurer's conduct, handling and assessment of the claim and, where the claim is declined but it has reasonable prospects for success, to advocate on the claimant's behalf.
- 8.3. Both the Life Code<sup>346</sup> and the IIS Code have a number of standards which apply to income related claims or income protection policies.<sup>347</sup>

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<sup>343</sup> *Sutton*, para. 21.1000.

<sup>344</sup> *Sutton*, para. 21.1000.

<sup>345</sup> *Sutton*, para. 21.1000.

<sup>346</sup> Life Code, s. 8.26.

<sup>347</sup> IIS Code, ss. 4.25, 4.27 and 7.32–7.35.

## General standards

- 8.4. For a group life claim, it is not clear whether the primary communicator will be the superannuation fund trustee, its service provider or the group life insurance company.<sup>348</sup>
- 8.5. The Life Code provides detail about what type of information might be required to support a claim: financial, occupational and medical information.<sup>349</sup> This detail is mainly explicable by the focus on these matters in life claims and by the large variety of information.
- 8.6. The Life Code provides that:
- a) the insurer may need general or particular authority to obtain information;<sup>350</sup> and
  - b) the insurer should make requests for information as early as possible and avoid multiple requests.<sup>351</sup>
- 8.7. The IIS Code provides for:
- a) the establishment of appropriate governance arrangements;<sup>352</sup> and
  - b) the publication of its claims philosophy.<sup>353</sup>

## Making the claim

- 8.8. The Life Code has a standard which provides that within 10 days of the claim, the insurer will: explain the cover, claim process, requested information, and give contact details.<sup>354</sup>
- 8.9. The Life Code's standards about a timetable for a claims decision are:
- a) once the information and enquiries are complete, including any answer to the 'pro fair' letter, the insurer should notify the decision in 10 days;<sup>355</sup>
  - b) for income related claims, the insurer's initial decision should be no later than two months after notification of the claim or two months after the end of the waiting period,<sup>356</sup> unless Unexpected Circumstances apply.<sup>357</sup> If Unexpected Circumstances, apply, the insurer's decision should be in 12 months;

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<sup>348</sup> Compare the Life Code, s. 8.1, and the IIS Code, s. 7.10.

<sup>349</sup> Life Code, s. 8.5.

<sup>350</sup> *ibid.*, s. 8.6.

<sup>351</sup> *ibid.*, s. 8.7.

<sup>352</sup> IIS Code, s. 7.5.

<sup>353</sup> *ibid.*, s. 7.6.

<sup>354</sup> Life Code, s. 8.3; there is also a reference to explaining any benefit waiting period.

<sup>355</sup> Life Code, s. 8.15.

<sup>356</sup> A life insurance company will usually make a without prejudice payment as soon as it can after the claim is made.

<sup>357</sup> The definition is: late notified claim; a TPD claim taking longer to assess; delay by the claimant or another; or fraud.

- c) for other claims, the periods are 6 and 12 months;<sup>358</sup> and
  - d) the insurer should comply with the timetable (about claims assessment and investigation) unless there are Unexpected Circumstances and, if so, the insurer should notify the claimant about the progress of the claim.<sup>359</sup>
- 8.10. A superannuation trustee may become involved in the claims process and might take responsibility for one or more of the group life insurance company's claims functions.<sup>360</sup> Where that occurs, the superannuation trustee should comply with Life Code.<sup>361</sup>
- 8.11. The Life Code has standards for claim assessors.<sup>362</sup>
- 8.12. The Life Code provides that if an independent services provider report is requested, the report is asked for within 4 weeks of request or the claimant's consultation. If the independent services provider fails to meet the timetable, the insurer should notify the claimant of progress.<sup>363</sup>

### **Urgent financial need**

- 8.13. The Life Code standard provides that:
- a) the urgent need must be caused by the claim condition;<sup>364</sup>
  - b) the insurer will ask for supporting documentation, e.g. Centrelink, financial or bank statements;<sup>365</sup> and
  - c) the claim will be prioritised, not fast tracked.<sup>366</sup>

## **9. ASIC review of life insurance claims**

- 9.1. In October 2016, the Australian Securities and Investments Commission (ASIC) released a review of life insurance claims. ASIC did not find evidence of cross-industry misconduct across the life insurance sector in relation to life insurance claims payments and procedures. However, ASIC did identify concerns in relation to declined claims rates and claims handling procedures associated with some types of insurance, such as TPD policies, some insurers for particular policy types and particular causes for some consumer disputes.<sup>367</sup>

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<sup>358</sup> Life Code., s. 8.17.

<sup>359</sup> *ibid.*, s. 8.14.

<sup>360</sup> *ibid.*, s. 7.11.

<sup>361</sup> *ibid.*, s. 7.11.

<sup>362</sup> *ibid.*, s. 8.20.

<sup>363</sup> *ibid.*, s. 8.8.

<sup>364</sup> *ibid.*, s. 8.27.

<sup>365</sup> Life Code, s. 8.28.

<sup>366</sup> *ibid.*, s. 8.29.

<sup>367</sup> ASIC, Report 498, *Life insurance claims: An industry review* (REP 498), 12 October 2016, p. 6.

9.2. ASIC stated in its review:

Although the considerable majority of claims are paid, we are concerned that in some cases, claims are being declined on technical or contractual grounds that are not in accordance with the 'spirit' or 'intent' of the policy.

We identified that fairness should be given greater consideration by insurers. Not all insurance claims will be successful, but an issue arises when a policyholder's reasonable expectations about policy coverage do not align with the technical wording in the policy.<sup>368</sup>

9.3. In its review, ASIC set out five actions to improve standards in life insurance claims handling:

- a) establishing, with the Australian Prudential Regulation Authority (APRA), a new public reporting requirement for life insurance industry claims data and claims outcomes;
- b) recommending to government the strengthening of the legal framework covering claims handling;
- c) recommending the consumer dispute resolution framework for claims handling be strengthened;
- d) providing targeted, follow-up ASIC reviews on areas of concern including individual insurers with high decline and dispute rates, as well as a new major review of life insurance sold directly to consumers without personal advice; and
- e) strengthening industry standards and practices, including through extension and enhancement of the life insurance code of practice.<sup>369</sup>

9.4. ASIC indicated in March 2017 that it had obtained agreement from life insurers to undertake an independent review of their life insurance claims management practices, procedures, and product design and structure. ASIC noted that as a result of the independent reviews, some insurers intended to improve their claims processes and policy documentation.<sup>370</sup>

9.5. In November 2017, APRA and ASIC released an information paper on industry-aggregate results on a new data collection pilot on life insurance claims. The paper indicated that insurers finalised 103,100 claims during 2016, of which about 92 per cent were admitted and about 8 per cent were declined.<sup>371</sup>

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<sup>368</sup> *ibid.*, pp. 6–7.

<sup>369</sup> *ibid.*, pp. 10–11.

<sup>370</sup> Mr Peter Kell, Deputy Chairman, ASIC, 'Life insurance claims handling', Speech to Money Management's Claims Handling Breakfast, 16 March 2017, pp. 4–5.

<sup>371</sup> APRA, *APRA and ASIC publish key industry data on life insurance claims* (Media Release 17.43), 9 November 2017.

## 10. APRA expectations for claims handling

- 10.1. In October 2016, APRA set expectations for improvements to claims handling, including:
- a) reviewing insurance benefit design and definitions with a stronger focus on delivering benefits appropriate for members at an appropriate level of cost;
  - b) better sharing of information between insurers and trustees;
  - c) closer co-operation and alignment between trustees, insurers and reinsurers to optimise outcomes for beneficiaries; and
  - d) clarifying the approach to claims adopted by both the insurer and trustee to improve claimants' understanding of how claims will be managed.<sup>372</sup>
- 10.2. APRA indicated that where it is not satisfied with progress, it may consider taking supervisory actions such as requiring formal board-approved remediation plans, regular reporting to APRA, or other measures to address deficiencies and mitigate heightened conduct and operational risks.<sup>373</sup>

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<sup>372</sup> APRA, *APRA sets expectations for improvements to claims handling*, media release, 12 October 2016.

<sup>373</sup> *ibid.*

## PART TEN – DISPUTES

### 1. Introduction

- 1.1. On disputes generally see the General Insurance Background Paper No. 14 (GIBP), Part Fifteen.

### 2. Internal Dispute Resolution (IDR) – Life Code

- 2.1. A person can complain about a Life Insurance Code of Insurance (Life Code) participant's decisions or conduct. A person is limited to a policyowner, life insured and a third party beneficiary; and in the Insurance in Superannuation Code (IIS Code), a superannuation fund member who has life cover.<sup>374</sup>
- 2.2. If the complaint is about someone who recommends a Life Code participant's products but is not an AFS licensee, the Life Code participant will inform the complainant how to have the matter addressed.<sup>375</sup> The complaint under the IIS Code can be about the insurer and the superannuation fund trustee will ask for and review the insurer's response.<sup>376</sup>
- 2.3. The Life Code and IIS Code provide that the complaint will be handled by someone different from the person whose decision or conduct is the subject of the complaint.<sup>377</sup>
- 2.4. The Life Code participant should notify the member about: the contact person,<sup>378</sup> the process; and the timeframe.<sup>379</sup> The Life Code participant will make an arrangement to keep the complainant regularly informed about the complaint's progress.<sup>380</sup> The superannuation fund trustee under the IIS Code should update the member on progress every 20 business days unless a different timetable is agreed.<sup>381</sup>
- 2.5. The Life Code provides that the complaint may be resolved in 5 business days except for a complaint about: a declined claim, a claim value or financial hardship.<sup>382</sup> The IIS Code provides that the superannuation fund trustee should provide a final response in

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<sup>374</sup> Life Code, ss. 9.1 and 9.3; IIS Code, ss. 13.8, 13.12 and 13.13.

<sup>375</sup> Life Code, s. 9.2.

<sup>376</sup> IIS Code, s. 13.9.

<sup>377</sup> Life Code, s. 9.4; IIS Code, s. 13.10.

<sup>378</sup> Life Code, s. 9.5.

<sup>379</sup> IIS Code, s. 13.11.

<sup>380</sup> Life Code, s. 9.8.

<sup>381</sup> IIS Code, s. 13.14.

<sup>382</sup> Life Code, s. 9.9.

45 business days after the complaint unless it is an exceptional case, when the time limit is 90 days.<sup>383</sup>

- 2.6. The Life Code provides that where the life policy is owned by a superannuation fund trustee, the life insurance company will respond to the superannuation fund trustee so that it can respond in 90 calendar days. The complainant will be informed about: the reasons; information and documents relied on; and the right to take the complaint to the Superannuation Complaints Tribunal (SCT).<sup>384</sup>
- 2.7. Under the IIS Code, if the superannuation fund trustee does not respond within 90 days, it should give written reasons for the delay.<sup>385</sup>
- 2.8. The IIS Code provides that the superannuation fund trustee should inform the member that the member has a right to External Dispute Resolution (EDR) and independent advice.<sup>386</sup>
- 2.9. Under the Life Code, where the life policy is not owned by a superannuation fund trustee, the life insurance company will respond to the complaint in 45 calendar days. The complainant will be informed about: the reasons; information and documents relied on; and the right to take the complaint to FOS.<sup>387</sup>
- 2.10. A summary of complaints is reported regularly to the superannuation fund trustee board under the IIS Code.<sup>388</sup>
- 2.11. The Life Code standards refer to the availability of EDR.<sup>389</sup>

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<sup>383</sup> IIS Code, s. 13.15.

<sup>384</sup> Life Code, ss. 9.10 and 9.11; see ss. 9.6 and 9.7.

<sup>385</sup> IIS Code, s. 13.16.

<sup>386</sup> IIS Code, s. 13.16–13.20.

<sup>387</sup> Life Code, ss. 9.12 and 9.13; see ss. 9.6 and 9.7.

<sup>388</sup> IIS Code, s. 13.18.

<sup>389</sup> Life Code, ss. 9.14–9.16.

### 3. External Dispute Resolution (EDR) – FOS and AFCA

- 3.1. The Financial Ombudsman Service (FOS) has jurisdiction in relation to a ‘Life Insurance Policy’ which includes any product or service offered by a life company.<sup>390</sup>
- 3.2. There are important exclusions from FOS’s jurisdiction in life insurance, particularly certain aspects of: privacy and confidentiality;<sup>391</sup> the amount of premium;<sup>392</sup> underwriting or actuarial factors in a non-standard offer of a life policy;<sup>393</sup> some decisions to refuse cover;<sup>394</sup> competing beneficiary claims;<sup>395</sup> the value of the claim exceeds \$500,000;<sup>396</sup> the applicant is a large employer.<sup>397</sup>
- 3.3. FOS is not entitled to consider a dispute ‘about underwriting or actuarial factors leading to an offer of a Life Insurance Policy on non-standard terms’.<sup>398</sup> This means that if a life insurer applies its normal approach to rating for a particular condition (say, high blood pressure), then it is not open to FOS to consider a dispute about the rating. However, what FOS can do is to require the insurer to demonstrate that it has applied its normal approach.
- 3.4. The SCT has jurisdiction in relation to disputes involving life insurance where the policyowner is a superannuation fund trustee. It is considered in the Group Life Insurance Background Paper.
- 3.5. As of 1 November 2018, the FOS and SCT schemes will be replaced by a single EDR scheme, the Australian Financial Complaints Authority (AFCA).

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<sup>390</sup> FOS TOR, paras. 4.2b (iii) and 20.1.

<sup>391</sup> *ibid.*, para. 5.1(a).

<sup>392</sup> *ibid.*, para. 5.1(b).

<sup>393</sup> *ibid.*, para. 5.1(d).

<sup>394</sup> *ibid.*, para. 5.1(e).

<sup>395</sup> *ibid.*, para. 5.1(j).

<sup>396</sup> *ibid.*, para. 5.1(o).

<sup>397</sup> *ibid.*, para. 5.1(p).

<sup>398</sup> *ibid.*, para. 5.1(d).

## GLOSSARY

**ACFS Paper:** Ian Enright, 'Data Flows for Life Insurance – Mental Illness Disability Data', commissioned by Monash University, Australian Centre for Financial Studies' Insurance Research Program Committee, ACFS Commission Paper Series.

**ACL:** Australian Consumer Law

**ADL:** activities of daily living cover

**AIDA Paper:** Lachlan Gell and Ian Enright, Conference Paper, 'Insurance Discrimination Law in Australia', presented at AIDA Conference 2014, Rome.

**AI Green Paper:** Actuaries Institute Mental Health and Insurance, Green Paper, October 2017.

**AFS licensee:** Australian Financial Services licensee

**AFSL:** Australian Financial Services Licence

**ALRC:** Australian Law Reform Commission

**APL:** approved product list

**APRA:** Australian Prudential Regulation Authority

**ASIC:** Australian Securities and Investments Commission

**ASIC Act:** *Australian Securities and Investments Commission Act 2001*

**basis clause:** a clause which states that a statement in the proposal form is the basis of the contract. Outside of the IC Act, the effect of the clause was to deem the statement to be material to the insurer. It is now subject to the IC Act, section 24.

**Corporations Act:** *Corporations Act 2001*

**DDA:** *Disability Discrimination Act 1992*

**duration:** in relation to an IP claim, the period during which monthly or other periodical benefits are payable under an IP insurance.

**ETE clause:** 'education, training or experience' clause of the common form of the TPD definition

**experience:** an actuarial term which refers to the criteria and factors which the actuarial profession recognizes as relevant. A life company will assess and predict, for a subject range or portfolio of insurance products, the number and dollar value of 'expected claims'. As the portfolio develops, the life company will calculate the number and dollar value of 'actual claims' and they are compared with the expected claims: this is the 'experience' of the portfolio.

**FOS:** Financial Ombudsman Service

**FOS TOR:** Financial Ombudsman Service Terms of Reference

**FSC:** Financial Services Council

**GIBP:** General Insurance Background Paper No. 14

**GLIBP:** Group Life Insurance Background Paper No 29

**GSC:** group salary continuance insurance, the name for income protection insurance in group insurance

**IC Act:** *Insurance Contracts Act 1984*

**IFSA:** Investment and Financial Services Association

**IIS Code:** Insurance in Superannuation Code

**incidence:** a measure of the number and dollar value of claims paid under the policy. It is expressed as a rate in relation to the subject measure: e.g. the incidence rate is +30% for professional and white collar

**Insurance Act:** *Insurance Act 1973*

**Insured Life Event:** see Part One, section 2.

**Investment Linked Contracts:** any contract, scheme or arrangement that involves the investment of money in property.

**IP:** income protection insurance

**LI Act:** *Life Insurance Act 1995*

**Life Code:** Life Insurance Code of Practice

**life insured:** the person whose life is insured under the life insurance contract – see Part One, section 2.

**loading or premium loading:** a percentage, proportional or specific amount, increase of and over the standard risk premium

**mental health advocacy groups:** including beyondblue and the Mental Health Council of Australia

**MHCA:** Mental Health Council of Australia

**morbidity:** the illness, injury or disability rate

**mortality:** the death rate

**sub (or non)-standard life or risk:** describes an applicant who is a below average risk profile: a higher risk for the life company.

**PDS:** product disclosure statement

**policyowner:** the contractual counterparty to the life insurer under the life insurance contract – see Part One, section 2.

**RSA:** Retirement Savings Account

***SDA: Sex Discrimination Act 1984***

***sinking fund policy:*** a type of investment life insurance policy. The life insurance company issuing the policy undertakes to pay money on one or more specified dates and the death of a person is irrelevant to the obligation to pay the money on the due date.

***standard life:*** describes an applicant who is the average risk profile.

***statutory fund:*** a fund that is established in the records of a life company and relates solely to the life insurance business of the company or a particular part of that business.

***surrender value:*** the cash amount payable by the life company to the policyowner in the event a policy is voluntarily terminated before its maturity or the death of the insured person.

***TPD:*** total and permanent disability – TPD insurance

***Trowbridge Report:*** John Trowbridge, *Review of Retail Life Insurance Advice*, March 2015

***1945 Act: Life Insurance Act 1945***

### **Further Reading**

Ian Enright and Robert Merkin, *Sutton on Insurance Law*, 4<sup>th</sup> Edition (Sutton)

Greg Pynt, *Australian Insurance Law: A First Reference*, 4<sup>th</sup> edition (Pynt)

Peter Mann and Candace Lewis, *Mann's Annotated Insurance Contracts Act*, 7<sup>th</sup> edition (Mann)

## APPENDIX A

### **LIFE INSURANCE ACT 1995 – SECTION 9**

#### **Life policy**

1. Subject to subsection (2), each of the following constitutes a life policy for the purposes of this Act:
  - a) a contract of insurance that provides for the payment of money on the death of a person or on the happening of a contingency dependent on the termination or continuance of human life;
  - b) a contract of insurance that is subject to payment of premiums for a term dependent on the termination or continuance of human life;
  - c) a contract of insurance that provides for the payment of an annuity for a term dependent on the continuance of human life;
  - d) a contract that provides for the payment of an annuity for a term not dependent on the continuance of human life but exceeding the term prescribed by the regulations for the purposes of this paragraph;
  - e) a continuous disability policy;
  - f) a contract (whether or not it is a contract of insurance) that constitutes an investment account contract;
  - g) a contract (whether or not it is a contract of insurance) that constitutes an investment-linked contract.
  
2. A contract that provides for the payment of money on the death of a person is not a life policy if:
  - a) by the terms of the contract, the duration of the contract is to be not more than one year; and
  - b) payment is only to be made in the event of:
    - i. death by accident; or
    - ii. death resulting from a specified sickness.

## LIFE INSURANCE ACT 1995 – SECTION 9A

### Continuous disability policy

1. Subject to this section, a continuous disability policy is a contract of insurance:
  - a) that is, by its terms, to be of more than 3 years' duration; and
  - b) under which a benefit is payable in the event of:
    - i. the death, by accident or by some other cause stated in the contract, of the person whose life is insured (the *insured*); or
    - ii. injury to, or disability of, the insured as a result of accident or sickness; or
    - iii. the insured being found to have a stated condition or disease.
2. A contract of insurance that is, by its terms, to be of a duration of not more than 3 years is taken to comply with paragraph (1)(a) if:
  - a) contracts of insurance of the same kind as the contract are usually of more than 3 years' duration; and
  - b) the contract is of a lesser duration only because of the age of the owner of the policy at the time when it was entered into.
3. A contract of insurance is not a continuous disability policy if the terms of the contract permit alteration, at the instance of the life company concerned, of the benefits provided for by the contract or the premiums payable under the contract.
4. A contract of insurance the terms of which permit alteration, at the instance of the life company concerned, of the benefits provided for by the contract is not thereby excluded by subsection (3) from being a continuous disability policy if, by those terms, the only alterations that are permitted to be made are alterations that improve the benefits and are made following an offer made by the life company and accepted by the owner of the policy.
5. A contract of insurance the terms of which permit alteration, at the instance of the life company concerned, of the premiums payable under the contract is not thereby excluded by subsection (3) from being a continuous disability policy if the terms of all contracts of the same kind as the contract only permit such alterations if they are made on a simultaneous and consistent basis.
6. A contract of consumer credit insurance within the meaning of the *Insurance Contracts Act 1984* is not a continuous disability policy.
7. A contract of insurance entered into in the course of carrying on health insurance business is not a continuous disability policy.

## **LIFE INSURANCE ACT 1995 – SECTION 12A**

### **Declarations that insurance or annuity business is life insurance business**

1. APRA may, on the application of a company, declare, in writing, that insurance business (other than health insurance business or business of insurance against loss of, or damage to, property) or business relating to the payment of annuities:
  - a) that is carried on by the company; or
  - b) that the company proposes to carry on;  
is to be treated, for the purposes of this Act, as if it were life insurance business.
2. The application must comply with any applicable requirements in the prudential standards.
3. APRA must only make the declaration if it is satisfied that:
  - a) the company is a life company; or
  - b) the company is not currently a life company, but the only business it proposes to carry on if the declaration is made is:
    - i. the business in respect of which the declaration is sought; or
    - ii. that business and other business that will be, or is likely to be declared to be, life insurance business.
4. In deciding whether to make the declaration, APRA may also have regard to the following matters:
  - a) whether the business in respect of which the declaration is sought is similar in nature to other life insurance business;
  - b) whether it would be appropriate for the business to be regulated under this Act;
  - c) whether it would be more appropriate for the business to be regulated under some other law (for example, the *Insurance Act 1973*);
  - d) the tax treatment of benefits provided in the course of the business;
  - e) if the company is not registered under section 21—whether the company would be able to be registered under section 21;
  - f) any other matter that APRA considers is relevant.
5. The declaration must also state the class of life insurance business in which the business is to be treated as being included.
6. If APRA makes a declaration:
  - a) this Act has effect accordingly; and
  - b) APRA must give a copy of the declaration to the company.

## **LIFE INSURANCE ACT 1995 – SECTION 234**

### **Prohibition of mixed insurance business**

1. A life company must not intentionally carry on any insurance business other than life insurance business.

Penalty: 300 penalty units.

2. Subsection (1) does not prohibit an existing life company from carrying on general insurance business if the company was carrying on general insurance business immediately before the commencement of this Act.

## **INSURANCE CONTRACTS ACT 1984 – SECTION 21**

### **The insured's duty of disclosure**

1. Subject to this Act, an insured has a duty to disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known to the insured, being a matter that:
  - a) the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms; or
  - b) a reasonable person in the circumstances could be expected to know to be a matter so relevant having regard to factors including, but not limited to:
    - i. the nature and extent of the insurance cover to be provided under the relevant contract of insurance; and
    - ii. the class of persons who would ordinarily be expected to apply for insurance cover of that kind.
2. The duty of disclosure does not require the disclosure of a matter:
  - a) that diminishes the risk;
  - b) that is of common knowledge;
  - c) that the insurer knows or in the ordinary course of the insurer's business as an insurer ought to know; or
  - d) as to which compliance with the duty of disclosure is waived by the insurer.
3. Where a person:
  - a) failed to answer; or
  - b) gave an obviously incomplete or irrelevant answer to;a question included in a proposal form about a matter, the insurer shall be deemed to have waived compliance with the duty of disclosure in relation to the matter.

## INSURANCE CONTRACTS ACT 1984 – SECTION 21A

### **Eligible contracts of insurance—disclosure before contract originally entered into**

#### *Scope*

1. This section applies in relation to the original entering into of an eligible contract of insurance.

Note: This section does not apply in relation to the renewal, extension, reinstatement or variation of an eligible contract of insurance. Section 21B applies in relation to the renewal of an eligible contract of insurance.

#### *Position of the insurer*

2. Before the contract is originally entered into, the insurer may request the insured to answer one or more specific questions that are relevant to the decision of the insurer whether to accept the risk and, if so, on what terms.
3. If the insurer does not make a request in accordance with subsection (2), the insurer is taken to have waived compliance with the duty of disclosure in relation to the contract.
4. If the insurer:
  - a) makes a request in accordance with subsection (2); and
  - b) requests the insured to disclose to the insurer any other matter that would be covered by the duty of disclosure in relation to the contract;then the insurer is taken to have waived compliance with the duty of disclosure in relation to that other matter.

#### *Position of the insured*

5. If:
  - a) the insurer makes a request in accordance with subsection (2); and
  - b) in answer to each specific question included in the request, the insured discloses each matter that:
    - i. is known to the insured; and
    - ii. a reasonable person in the circumstances could be expected to have disclosed in answer to that question;then the insured is taken to have complied with the duty of disclosure in relation to the contract.

#### *Definition*

6. In this section:

***eligible contract of insurance*** means a contract of insurance that is specified in the regulations for the purposes of this section.

## INSURANCE CONTRACTS ACT 1984 – SECTION 29

### Life insurance

#### *Scope*

1. This section applies where the person who became the insured under a contract of life insurance upon the contract being entered into:
  - a) failed to comply with the duty of disclosure; or
  - b) made a misrepresentation to the insurer before the contract was entered into;but does not apply where:
  - c) the insurer would have entered into the contract even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into; or
  - d) the failure or misrepresentation was in respect of the date of birth of one or more of the life insureds.

Note: If subsection 27A(1), (3) or (4) applies to the contract of life insurance, different remedies may be available to the insurer in respect of each separate contract of life insurance that is taken to exist by virtue of the relevant subsection.

#### *Insurer may avoid contract*

2. If the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.
3. If the failure was not fraudulent or the misrepresentation was not made fraudulently, the insurer may, within 3 years after the contract was entered into, avoid the contract.

#### *Insurer may vary contract*

4. If the insurer has not avoided the contract, whether under subsection (2) or (3) or otherwise, the insurer may, by notice in writing given to the insured, vary the contract by substituting for the sum insured (including any bonuses) a sum that is not less than the sum ascertained in accordance with the formula

$$\frac{SP}{Q}$$

where:

‘**S**’ is the number of dollars that is equal to the sum insured (including any bonuses).

‘**P**’ is the number of dollars that is equal to the premium that has, or to the sum of the premiums that have, become payable under the contract; and

'Q' is the number of dollars that is equal to the premium, or to the sum of the premiums, that the insurer would have been likely to have charged if the duty of disclosure had been complied with or the misrepresentation had not been made.

Note: This subsection applies differently in relation to a contract with a surrender value, or a contract that provides insurance cover in respect of the death of a life insured (see subsection (10)).

5. In the application of subsection (4) in relation to a contract that provides for periodic payments, *the sum insured* means each such payment (including any bonuses).
6. If the insurer has not avoided the contract or has not varied the contract under subsection (4), the insurer may, by notice in writing given to the insured, vary the contract in such a way as to place the insurer in the position (subject to subsection (7)) in which the insurer would have been if the duty of disclosure had been complied with or the misrepresentation had not been made.

Note: This subsection does not apply in relation to a contract with a surrender value, or a contract that provides insurance cover in respect of the death of a life insured (see subsection (10)).

7. The position of the insurer under a contract (the *relevant contract*) that is varied under subsection (6) must not be inconsistent with the position in which other reasonable and prudent insurers would have been if:
  - a) they had entered into similar contracts of life insurance to the relevant contract; and
  - b) there had been no failure to comply with the duty of disclosure, and no misrepresentation, by the insureds under the similar contracts before they were entered into.
8. For the purposes of subsection (7), a contract of life insurance (the *similar contract*) is similar to another contract of life insurance (the *relevant contract*) if:
  - a) the similar contract provides insurance cover that is the same as, or similar to, the kind of insurance cover provided by the relevant contract; and
  - b) the similar contract was entered into at, or close to, the time the relevant contract was entered into.

*Date of effect of variation of contract*

9. A variation of a contract under subsection (4) or (6) has effect from the time when the contract was entered into.

*Exception for contracts with a surrender value or that provide cover on death*

10. If the contract is a contract with a surrender value, or a contract that provides insurance cover in respect of the death of a life insured:
  - a) the insurer may vary the contract under subsection (4) before the expiration of 3 years after the contract was entered into, but not after that period; and
  - b) subsections (6), (7) and (8) do not apply in relation to the contract.

**INSURANCE CONTRACTS ACT 1984 – SECTION 31**

**Court may disregard avoidance in certain circumstances**

1. In any proceedings by the insured in respect of a contract of insurance that has been avoided on the ground of fraudulent failure to comply with the duty of disclosure or fraudulent misrepresentation, the court may, if it would be harsh and unfair not to do so, but subject to this section, disregard the avoidance and, if it does so, shall allow the insured to recover the whole, or such part as the court thinks just and equitable in the circumstances, of the amount that would have been payable if the contract had not been avoided.
2. The power conferred by subsection (1) may be exercised only where the court is of the opinion that, in respect of the loss that is the subject of the proceedings before the court, the insurer has not been prejudiced by the failure or misrepresentation or, if the insurer has been so prejudiced, the prejudice is minimal or insignificant.
3. In exercising the power conferred by subsection (1), the court:
  - a) shall have regard to the need to deter fraudulent conduct in relation to insurance; and
  - b) shall weigh the extent of the culpability of the insured in the fraudulent conduct against the magnitude of the loss that would be suffered by the insured if the avoidance were not disregarded;but may also have regard to any other relevant matter.
4. The power conferred by subsection (1) applies only in relation to the loss that is the subject of the proceedings before the court, and any disregard by the court of the avoidance does not otherwise operate to reinstate the contract.

## **INSURANCE CONTRACTS ACT 1984 – SECTION 47**

### **Pre-existing sickness or disability**

1. This section applies where a claim under a contract of insurance is made in respect of a loss that occurred as a result, in whole or in part, of a sickness or disability to which a person was subject or had at any time been subject.
2. Where, at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability, the insurer may not rely on a provision included in the contract that has the effect of limiting or excluding the insurer's liability under the contract by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into.

## **INSURANCE CONTRACTS ACT 1984 – SECTION 54**

### **Insurer may not refuse to pay claims in certain circumstances**

1. Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.
2. Subject to the succeeding provisions of this section, where the act could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract, the insurer may refuse to pay the claim.
3. Where the insured proves that no part of the loss that gave rise to the claim was caused by the act, the insurer may not refuse to pay the claim by reason only of the act.
4. Where the insured proves that some part of the loss that gave rise to the claim was not caused by the act, the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act.
5. Where:
  - a) the act was necessary to protect the safety of a person or to preserve property; or
  - b) it was not reasonably possible for the insured or other person not to do the act;the insurer may not refuse to pay the claim by reason only of the act.

6. A reference in this section to an act includes a reference to:
  - a) an omission; and
  - b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.

## **INSURANCE CONTRACTS ACT 1984 – SECTION 56**

### **Fraudulent claims**

1. Where a claim under a contract of insurance, or a claim made under this Act against an insurer by a person who is not the insured under a contract of insurance, is made fraudulently, the insurer may not avoid the contract but may refuse payment of the claim.
2. In any proceedings in relation to such a claim, the court may, if only a minimal or insignificant part of the claim is made fraudulently and non-payment of the remainder of the claim would be harsh and unfair, order the insurer to pay, in relation to the claim, such amount (if any) as is just and equitable in the circumstances.
3. In exercising the power conferred by subsection (2), the court shall have regard to the need to deter fraudulent conduct in relation to insurance but may also have regard to any other relevant matter.

## **INSURANCE CONTRACTS ACT 1984 – SECTION 75**

### **Reasons for cancellation, &c., to be given**

1. Where an insurer:
  - a) does not accept an offer to enter into a contract of insurance;
  - b) cancels a contract of insurance;
  - c) indicates to the insured that the insurer does not propose to renew the insurance cover provided under a contract of insurance; or
  - d) by reason of some special risk relating to the insured or to the subject-matter of the contract, offers insurance cover to the insured on terms that are less advantageous to the insured than the terms that the insurer would otherwise offer;the insurer shall, if the insured so requests in writing given to the insurer, give to the insured a statement in writing setting out the insurer's reasons for not accepting the offer, for cancelling the contract, for not renewing the insurance cover or for offering insurance cover on less advantageous terms, as the case may be.

Penalty: 300 penalty units.

2. In relation to a contract of general insurance, if the state of health of the insured was the reason, or one of the reasons, that the insurer did not accept the offer, cancelled the contract, did not renew the insurance cover or offered insurance cover on less advantageous terms, as the case may be, the insurer may require the insured to inform the insurer in writing of the name of a legally qualified medical practitioner to whom the statement may be given on behalf of the insured and, where the statement is given to the medical practitioner so nominated, the insurer shall be taken to have complied with subsection (1) in relation to the request.
3. In relation to a contract of life insurance where the insured is not the life insured, subsection (1) does not apply if the state of health of the life insured was the only reason that the insurer did not accept the offer, cancelled the contract, did not renew the insurance cover or offered insurance cover on less advantageous terms, as the case may be.

Note: A defendant bears an evidential burden in relation to the matters in subsection (3), see subsection 13.3(3) of the *Criminal Code*.

4. In relation to a contract of life insurance where the insured is not the life insured, a statement given under subsection (1) shall not include any reference to the state of health of the life insured.
5. Where an insurer:
  - a) does not accept an offer to enter into a contract of life insurance;
  - b) cancels such a contract;
  - c) indicates to the insured that the insurer does not propose to renew the insurance cover provided under such a contract; or
  - d) by reason of some special risk relating to the life insured, offers life insurance cover to the insured on terms that are less advantageous to the insured than the terms that the insurer would otherwise offer;the insurer shall, if the life insured so requests in writing given to the insurer, give to the life insured a statement in writing setting out the insurer's reasons for not accepting the offer, for cancelling the contract, for not renewing the insurance cover or for offering life insurance cover on less advantageous terms, as the case may be, being reasons that relate to the state of health of the life insured.

Penalty: 300 penalty units.

6. The insurer may require the life insured to inform the insurer in writing of the name of a legally qualified medical practitioner to whom the statement may be given on behalf of the life insured and, where the statement is given to the medical practitioner so nominated, the insurer shall be taken to have complied with subsection (5) in relation to the request.

7. It is a defence to a prosecution for an offence arising under this section if the insurer proves that compliance with this section would have unreasonably put at risk the interests of the insurer or of some other person.

Note: A defendant bears a legal burden in relation to a matter mentioned in subsection (7), see section 13.4 of the *Criminal Code*.

## APPENDIX B

### Tabular Comparison of Remedies Pre and Post Amending Act 2013

<b>Cause</b>	<b>Remedy Pre 2014</b>	<b>Remedy Post 2014</b>	<b>Application and Comment</b>
<i>Age</i>	Section 30	Where the contract expiry date is calculated by reference to the life insured's date of birth, the insurer has the option of varying the contract by changing its expiration date to an expiration date based on the correct date of birth.	New section 30(3A). Applies after 28 June 2013.
<i>Fraud</i>	Section 29(2) and section 31.	No change	
<i>Avoidance</i>	If the insurer would not have entered into a contract-of the same type <sup>399</sup> – if there had been disclosure and a correct statement, the insurer is entitled to avoid the contract within 3 years of it being entered into: old 29(3).	For an innocent misrepresentation or non-disclosure, the insurer is entitled to avoid the contract within 3 years of it being entered into: new 29(3)	Applies after 28 June 2014.

<sup>399</sup> See *Sutton*, paras. 21.780, 21.795.

<b>Cause</b>	<b>Remedy Pre 2014</b>	<b>Remedy Post 2014</b>	<b>Application and Comment</b>
<i>Variation of Sum Insured</i>	Section 29(4)	The three-year time limit does not apply.	Applies after 28 June 2014.
<i>Variation of Contract Terms</i>	No remedy	New sections (6)-(8) and (10).	Applies after 28 June 2014.
<i>Unbundling</i>	The IC Act and the common law allowed unbundling	The new section 27A merely declares and clarifies the previous position. <sup>400</sup>	Applies from 28 June 2013

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<sup>400</sup> *Sutton*, para. 21.810.