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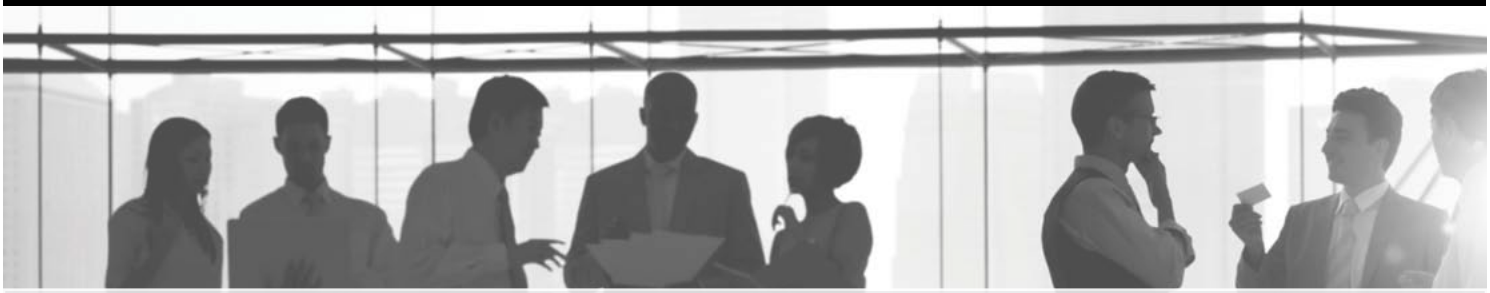

Welcome to the September edition of our Financial Services Bulletin.

This is a busy edition with lots of industry news, some important case law developments and our usual selection of FOS determinations and 'Top Tips'. We hope you enjoy it and find it useful.

The details of the next **'Life Matters'** seminars in Melbourne and Sydney have been confirmed. This seminar series is designed to give our clients a more in depth opportunity to explore recent developments in life insurance and financial services with TurksLegal experts. **Click here** for the seminar program and to RSVP.

INDUSTRY NEWS

ASIC allows broader use of digital disclosure for financial services

On 28 July 2015, ASIC issued 2 new legislative instruments to allow broader use of digital disclosure. It also issued an updated Regulatory Guide 221 (Facilitating digital financial services disclosures) to explain the effect of those instruments, read more

Industry profit levels continue to improve

APRA released the June 2015 Quarterly Life Insurance Performance Statistics on 18 August 2015, read more

Are you ready for the final changes to the ICA?

The *Insurance Contracts Amendment Act 2013* received Royal Assent more than 2 years ago on 28 June 2013. It introduced a number of changes to the *Insurance Contracts Act 1984* which have progressively taken effect since then, read more

FSC takes the lead on risk insurance advice

Assistant Treasurer, Josh Frydenberg took some time out in his speech to the Financial Services Council Annual Conference in August to praise the efforts of the industry to develop a code of self-regulation based upon the recommendations of the Trowbridge Report, read more

CASES AND TRIBUNAL DECISIONS

Large dogs traumatise fire-ant eradicator

Edington v Board of Trustees of the State Public Sector Superannuation Scheme [2015] QSC 245

The Supreme Court of Queensland has looked again at the grounds on which it can reopen the decision of a superannuation trustee in relation to a TPD claim post *Finch v Telstra*, read more

Victorian Court of Appeal rules on fraud

Westpac Life Insurance Services Limited v Thereze Guirgis [2015] VSCA 239

In this case, the VSCA's decision to uphold the trial judge's findings is a reminder of the difficulties a life insurer can face in sustaining a policy avoidance pursuant to section 29(2) of the *Insurance Contracts Act 1984*, read more

Complexities of claim assessment while litigation is on foot

Panos v FSS Trustee Corporation [2015] NSWSC 1217

In this case, the judge dismissed the plaintiff's claim for a total and permanent disablement benefit, finding in favour of MetLife Insurance. The decision demonstrates some practical complexities insurers face while assessing claims after litigation has commenced, and provides further comment with respect to insurers' obligations at the procedural fairness stage, read more

RECENT FOS DECISIONS

- An insured does not need to be asked health questions for a PEC exclusion to apply, read more
- The FOS waters down insurer's claims requirements, read more
- Distinguishing "usual occupation" and "usual employment", read more

TOP TIPS

Offset clauses

Crafting effective offset clauses and applying them effectively can be a challenge for insurers; lump sum settlements and social security payments can cause particular problems. This article explores some key case law around in particular these two issues, read more

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INDUSTRY NEWS

ASIC allows broader use of digital disclosure for financial services

On 28 July 2015 ASIC issued 2 new legislative instruments to allow broader use of digital disclosure. It also issued an updated Regulatory Guide 221 (*Facilitating digital financial services disclosures*) to explain the effect of those instruments. While acknowledging that it is a matter for product providers, ASIC suggests that digital disclosure can be used to make financial services disclosures more effective and efficient.

Instrument 2015/647 (Facilitating Electronic Delivery of Financial Services Disclosure) allows the default option of delivering financial services disclosure documents to be electronic provided the issuer has first sent a notice to the client of its intention to do so and the client has not opted out of receiving electronic disclosure within 7 days.

Instrument 2015/649 (Removing Barriers to Electronic Disclosure) allows more innovative use of electronic media for PDSs, FSGs and SOAs including relief from providing electronic copies on request and the placement of words at or near the front of a disclosure.

The Regulatory Guide gives a number of useful good practice guidelines for the electronic delivery of financial services disclosures. These include:

- Documents should be easy to read and understand
- Disclosures should not distract or divert clients from relevant information
- Clients should be able to clearly identify what type of disclosure it is (eg PDS, FSG, SOA or periodic statement)
- Reasonable efforts should be made to ensure the client receives a copy of the disclosure
- Clients should be able to keep a copy so they can access the disclosure
- Providers must retain all versions of disclosure documents so that clients can prove the version they relied on
- Clients should be able to opt out of digital disclosure
- Disclosure should be delivered in a way that does not unreasonably expose clients to IT security risks

The Appendix to the Regulatory Guide also gives a summary of how providers can use digital disclosure.

INDUSTRY NEWS

Industry profit levels continue to improve

APRA released the June 2015 Quarterly Life Insurance Performance Statistics on 18 August 2015.

The overall net premium income of the life industry was up by around $8 billion, compared to the previous 12 months and net profit after tax was $2.8 billion for the year, compared to $2.2 billion in the previous year, an increase of 27.6 per cent.

The total revenue derived from risk products was $3.4 billion. Of this, individual risk products contributed $2.2 billion and group risk products accounted for the remaining $1.2 billion.

Some of the profit growth was generated through companies achieving better cost control, with total expenses being reduced to $38.8 billion, down from $41.4 billion in 2014, a reduction of 6.3 per cent.

In the same period, net policy payments made by the industry increased to $59.6 billion, considerably more than previous years $47.9 billion in payments. The total assets for the industry nevertheless expanded and were $299.0 billion as at 30 June 2015, up from $282.7 billion a year earlier.

Copies of the June 2015 Quarterly Life Insurance Performance Statistics are available on the APRA website here.

INDUSTRY NEWS

Are you ready for the final changes to the ICA?

The *Insurance Contracts Amendment Act 2013* received Royal Assent more than 2 years ago on 28 June 2013. It introduced a number of changes to the *Insurance Contracts Act 1984* (the ICA) which have progressively taken effect since then.

These changes have included:

- Introduction of unbundling of life insurance contracts when applying remedies for non-disclosure and misrepresentation from 28 June 2013.
- New remedies for non-disclosure and misrepresentation from 28 June 2014.

The final changes introduced by the amending legislation will take effect from **28 December 2015**. These include the following:

- Under section 31A of the ICA, any non-disclosure by a proposed life insured relating to new policies (or increases in cover or additional kinds of cover) will be treated as a non-disclosure by the insured. Accordingly, the life insurer will have the same remedies regardless of whether the non-disclosure is by the insured or the life insured. This brings non-disclosure by the life insured in to line with misrepresentation – section 26 of the ICA already treats misrepresentation by the life insured as a misrepresentation by the insured.
- New notices of the Duty of Disclosure to reflect the above changes must be used from 28 December 2015. These include the obligation for life insurers to remind the proposed insured of the Duty where there is a delay of 2 months in accepting cover or making a counter-offer. We discussed issues relating to these notices in our May Newsletter.

INDUSTRY NEWS

FSC takes the lead on risk insurance advice

Assistant Treasurer, Josh Frydenberg took some time out in his speech to the Financial Services Council (FSC) Annual Conference on 7 August 2015 to praise the efforts of the industry to develop a code of self-regulation based upon the recommendations of the Trowbridge Report.

In the opening plenary of the conference, Chairman of the FSC, Greg Cooper spoke about the creation of a code of conduct for the life insurance industry which would become a standard for FSC member organisations.

Mr Cooper said "This has mainly focused on developing a new remuneration model, improved statements of advice and approved product lists which aim to build a more sustainable advised insurance industry and to develop better outcomes for consumers."

His speech, which was also reported in Money Management as advocating the FSC's support for promoting more education and greater professionalism in the advice industry elaborated that;

"The FSC had been taking proactive steps to pave a way forward through working with the advice industry and broader stakeholders to develop educational requirements, competency standards and a structure for an entity to oversee the requirements for the advice industry as a profession."

The work on the proposed code is on-going. "The FSC is continuing to consult on this process with policy makers and other stakeholders." Mr Cooper said.

CASES AND TRIBUNAL DECISIONS

Large dogs traumatise fire-ant eradicator

Edington v Board of Trustees of the State Public Sector Superannuation Scheme [2015] QSC 245

Link to decision

The plaintiff was a member of the Queensland State Public Sector Superannuation fund known as QSuper.

In 2004, the fund's Board declined a claim which the plaintiff made for a TPD benefit because his disablement was related to a pre-existing medical condition which should have been disclosed by him at the time he applied to join the fund under its rules.

The member disputed this decision but by 2010 had exhausted his rights under the *Superannuation (Resolution of Complaints) Act (1993)* after a complex series of appeals to the Federal Court which ultimately found in favour of the fund.

In 2011, he started fresh proceedings in the Supreme Court of Queensland by bringing a claim under section 8 of the *Trusts Act 1973 (Qld)* as a person who was "aggrieved by any act, omission or decision of a trustee..."

This is a provision of general trust law in Queensland and the Court first had to consider whether it had jurisdiction to hear the plaintiff's claim under the section and whether section 8 applied to the Board because it was properly considered a trustee under the Act of the Queensland Parliament which created it.

Having satisfied himself of this, Justice Bond began to examine the relevant "insurance terms"[1] which applied to the plaintiff. Critically, these included, at clause 6.2, a provision that if the plaintiff had been a member for less than ten years;

> *"No insurance benefit will be paid for a claim unless:*
> …
> *6.2 (b)…*
>
> > *(iii) the board is of the opinion that the total and permanent disablement... was not related to a condition that was disclosed on the personal medical statement or which in the opinion of the board should reasonably to have been disclosed on the personal medical statement;"...*

The Court then examined whether the formation of this opinion by the Board could be reviewed under section 8 and if so, on what grounds.

In doing so, it was necessary to consider if the limited grounds of review that applied to discretionary decisions were relevant, or whether more recent case law[2] had widened the grounds when a court could intervene with the decision of a trustee.

Justice Bond affirmed that the Board was not deciding a "discretionary matter" and also noted the more stringent duty that was placed on superannuation trustees in determining entitlements that members were entitled to as a consequence of their employment.

The Court also recounted that the High Court had made the observation in *Finch v Telstra* that *"the decision of a trustee may be reviewable for want of "properly informed consideration"*.

However, Justice Bond also concluded that there had been no decision since *Finch* to suggest a decision could be overturned simply because it was not *"fair and reasonable"*, or simply because it was not correct, even though the High Court had speculated subsequent cases might possibly go in this direction in *Finch*[3].

Hence, any possible expansion of the grounds upon which a trustee's decision can be reopened based on *Finch* has once more been deferred for a future occasion and the Court concluded that it could only intervene if the Board's decision –

a) *"was not made in good faith; or*

b) *was not made upon a real and genuine consideration of the material before the trustee; or*

c) *was not made in accordance with the purposes for which the power to make the decision was conferred."*

The plaintiff had been employed by the Queensland Department of Primary Industries as a field assistant in a program for the eradication of fire ants. He suffered a series of injuries to his right foot in the course of his work in the first half of 2002, one of which occurred when he was chased off a property by a pack of large dogs.

His treating doctors eventually concluded that apart from the foot injury, the plaintiff may also have been *"suffering from the effects of "post-traumatic syndrome"* in connection with this attack.[4]

Essentially, the problem the Board had to resolve was a dispute in the evidence of two consultant psychiatrists, one of whom concluded the plaintiff was TPD due to post-traumatic stress disorder stemming from the dog attack.

The other considered that the dog incident was not a severely traumatic event and thought the plaintiff was disabled by a pre-existing schizophrenic condition which he should have disclosed at the time he joined the fund.

The Board preferred the latter opinion because it was more consistent with the plaintiff's medical history and it stated that decision clearly in its minutes.

The Court reviewed the medical evidence in depth finding that the conclusion drawn by the Board was reasonably open to it on the available evidence. Justice Bond also dismissed the related complaints that the Board had denied the plaintiff procedural fairness.

[1]There was found to be no intention to create a contract of insurance. The relationship of the parties was purely one of trustee and beneficiary. The judgment contains a detailed review of the differences between the position of a trustee and that of an insurer.

[2]*Finch v Telstra Super Pty Ltd* (2010) 242 CLR 254 as considered in *Alcoa of Australia Retirement Plan Pty Ltd v Frost* (2012) 36 VR 618.

[3]Judgment paragraph 55.

[4]Judgment paragraph 68.

CASES AND TRIBUNAL DECISIONS

Victorian Court of Appeal rules on fraud

Westpac Life Insurance Services Limited v Thereze Guirgis [2015] VSCA 239

Link to decision

In the recent Victorian Supreme Court of Appeal ('VSCA') decision in *Westpac Life Insurance Services Limited v Thereze Guirgis* [2015] VSCA 239 (the summary of the County Court decision was included in our March Financial Services Bulletin), the VSCA's decision to uphold the trial judge's findings is a reminder of the difficulties a life insurer can face in sustaining a policy avoidance pursuant to section 29(2) of the *Insurance Contracts Act 1984* ('ICA').

Partial Non-Disclosure May Put an Insurer on Notice

- The VSCA agreed with the trial judge that, whilst it was likely that the insured's condition of fibromyalgia had been mentioned to her by her treating medical practitioners, it was not definitive that she was actually aware of the diagnosis. Evidence that persuaded both the trial judge and the VSCA on this point was the fact that in the insured's application forms, she disclosed having visited a well renowned rheumatologist. It was determined that had the insured intentionally set out to not disclose her condition of fibromyalgia, she would not have disclosed her attendance to the specialist.

Production of Underwriting Guidelines

- The VSCA's decision emphasised the importance of producing underwriting guidelines in evidence. The VSCA noted (at 56) that whilst the underwriter 'gave evidence that if the respondent had disclosed her fibromyalgia no policy would have been issued, this evidence was based upon a written guideline that was never produced'. The VSCA went further to state that this 'was a gap in the applicant's proof'. The VSCA found that the applicant's failure to produce the underwriting guidelines upon which it relied was 'a failure by the applicant to prove the very thing the applicant sought to prove – namely, that its written guidelines would have prevented the writing of the policy'.
- The VSCA also noted that, if the condition of fibromyalgia was considered to be so serious that a policy would not be entered into if it was a known condition, then the condition ought to have been mentioned specifically in the 'PMAR' questions asked of the treating medical practitioners in the application process.

This decision reinforces the particularly high evidentiary requirement an insurer will face when seeking to establish fraud and sustain a section 29(2) policy avoidance under the ICA. The decision is also a reminder of the importance of being able to produce underwriting guidelines to reinforce an underwriter's evidence at trial.

CASES AND TRIBUNAL DECISIONS

Complexities of claim assessment while litigation is on foot

Panos v FSS Trustee Corporation [2015] NSWSC 1217

Link to decision

Background

Mr Panos (the plaintiff) commenced employment with the South East Sydney Illawarra Area Health Service (SESIAHS) as a Nursing Assistant on 21 August 2006. During his employment with SESIAHS, the plaintiff sustained a number of injuries, including injuries to his lower back while performing tasks involving manual handling. The plaintiff was later involved in 2 motor vehicle accidents occurring on 18 March 2010 and 26 May 2011, during which he was alleged to have suffered further injury to his lower back and injuries to his neck, pelvis, chest, left shoulder, teeth, and reactive depression and insomnia.

On 21 March 2012, the plaintiff lodged a claim for a Total Permanent Disablement (TPD) benefit with FSS Trustee Corporation (FTC) the trustee of the First State Superannuation Scheme, alleging that he had ceased work as a nursing assistant on 26 May 2011 as a result of his various injuries and illnesses. FTC's group life insurer at the relevant time was MetLife Insurance Limited (MetLife). MetLife received the TPD claim from FTC on 13 September 2012.

Initial proceedings

On 19 April 2013, just 7 months after MetLife received the claim, the plaintiff commenced proceedings alleging that MetLife had constructively declined his claim. At that stage, MetLife's investigations into the TPD claim had not concluded.

The proceedings were originally set down for a 3 day hearing before McDougall J commencing on 11 March 2014. Having completed its investigations into the TPD claim, however, on 5 March 2014 MetLife forwarded a procedural fairness letter which identified the material it considered potentially adverse to the plaintiff's claim with an asterisk.

At the commencement of the hearing, MetLife indicated that it had determined to decline the plaintiff's claim and that it would shortly be issuing a letter detailing its reasons. The issues thereby altered from solely constructive declinature to an actual declinature, and McDougall J vacated the hearing so the parties could address this alteration in the factual context.

TPD decision

In its reasons for declining the TPD claim, MetLife noted that the plaintiff had obtained work as a nursing assistant in an aged care facility from October 2012 (after he lodged his TPD claim) to 19 January 2013, which was terminated at his request. The plaintiff described this work as a 'failed rehabilitation attempt'.

MetLife noted the plaintiff's substantial muscle bulk which, in addition to a recent history of weight-loss,

strongly indicated that he continued to work out heavily. MetLife also commented on the security licence that the plaintiff had successfully obtained in 2013, the attainment of which required a certain level of physical function.

MetLife concluded that the plaintiff had not provided evidence to its satisfaction that he was unlikely ever to engage in work for which he was reasonably qualified by his education, training and experience, as required by the Policy.

Adjourned hearing

The adjourned hearing was listed before Robb J commencing on 9 February 2015.

After the proceedings had commenced, the plaintiff 'served' various additional reports of a doctor whose earlier reports had been submitted in support of the claim. Because the plaintiff never responded to MetLife's enquiry whether the later reports were relied upon by the plaintiff solely for the purposes of the proceedings, or also in support of the TPD claim, MetLife assumed they had only been provided for the purposes of the proceedings.

Robb J held that as the earlier evidence of that doctor had been relied on by the plaintiff in support of his claim, MetLife should have concluded that the doctor's later evidence was also to be considered for that purpose. Robb J also found that one piece of evidence (a report from the plaintiff's treating GP) was so obscure and inadequate that 'further elaboration' should have been sought by MetLife.

Robb J considered that procedural fairness should specifically identify the 'parts of the material' that an insurer considers 'adverse' to a TPD claim, and held that the procedural fairness letter in this matter had not done so. He also found that the time for a response to the procedural fairness letter should not have been reduced to factor in the approaching hearing date before McDougall J.

Robb J ultimately set aside MetLife's decision. He then turned to consider whether, on all of the evidence before the Court, the plaintiff was TPD as at the relevant date. This included oral evidence and other material, including subpoenaed material that had not been available to MetLife at the time of its decision.

It had been the plaintiff's position that, despite his muscular physique and calloused hands, he had been unable to attend a gym for over 12 months prior to lodging his claim. The plaintiff alleged that his injuries precluded him from raising his arms above shoulder height, and that his upper body power was so restricted that he even experienced significant difficulty merely setting a table. He provided evidence that his natural muscle bulk was maintained by routine testosterone injections he received following the surgical removal of a testicle. Confusion was expressed by a number of the plaintiff's treating doctors with respect to his weak upper body strength on examination, given the extent of his muscle bulk.

Between the date of MetLife's decision to decline the claim and the hearing before Robb J, surveillance became available which revealed that contrary to the plaintiff's evidence, he had in fact continued to visit a gym and undertake weight training. Notably, that weight training regime clearly included exercises which involved lifting weights above his head and above shoulder height. Having seen the footage, Robb J noted that a number of the exercises performed by the plaintiff were 'inherently difficult'. Robb J considered this one of a number of 'discrepancies' in the plaintiff's claim.

Prior to the hearing, the plaintiff's GP had maintained that he was TPD and had rejected the findings in vocational expert evidence which identified various alternative employment that would be suitable for the plaintiff. During cross-examination, the doctor was shown the surveillance footage. Having seen that footage, the doctor agreed that the plaintiff was in fact capable of performing the majority of the alternative employment roles identified by the vocational assessor. He also agreed with the (previously) conflicting medical opinions that the plaintiff was fit for work.

Robb J concluded that the plaintiff had by some means persuaded his doctor that he was incapable of performing the precise activities demonstrated by the surveillance footage, despite his physique, and that the work that he was reasonably qualified for was contingent on being able to undertake those activities. Robb J found that the doctor's 'change of position' in light of the

surveillance seriously undermined the plaintiff's case.

Other observations were made regarding the plaintiff's credibility as a witness, including his admission in the witness box to having obtained his forklift licence in circumstances of questionable legitimacy. Robb J concluded that the plaintiff had exaggerated his symptoms, and determined not to accept the plaintiff's evidence in respect of the extent of his alleged disability.

Robb J ultimately concluded that the plaintiff had failed to establish that he was TPD within the meaning of the Policy and accordingly, his claim was dismissed.

Robb J made a number of observations regarding the plaintiff's pleadings. He noted that the Statement of Claim did 'not identify, with any specificity, acts undertaken by the Insurer that it should have undertaken, or acts that it ought to have done, but did not do.' Rather, the pleadings did little more than make vague allegations that MetLife had failed to comply with general obligations in dealing with the TPD claim. This included an allegation that MetLife failed to 'seek out' certain information and documents which the plaintiff alleged were 'crucial' to his claim, although the plaintiff did not specify the information and documents in the pleadings.

The plaintiff also did not specifically plead the elements of the TPD definition critical to his entitlement to the relief sought, for example, that he was absent from his employment for a period of 6 consecutive months due to injury. His Honour felt that this complicated the case more than was necessary in an already complicated factual context.

Implications

Panos provides a sound authority for insurers to press for plaintiffs to provide adequate particulars of the case they are expected to meet, beyond making general allegations about an insurer's general duties in the assessment of a claim.

The case also provides some further guidance to insurers with respect to what procedural fairness should entail. Robb J considered that procedural fairness should address (provide a 'concise outline' of) the aspects of the evidence the insurer considers significant, the weight to be accorded to particular parts of the evidence, and the credit to be given to representations made by a claimant. Of course, what is necessary to constitute effective procedural fairness will always depend on the individual circumstances of the claim.

Finally, Robb J noted that an error in MetLife's letter declining the claim (which related to an extension of cover provision, which MetLife did not ultimately rely on in the case) did not on its own necessarily vitiate the decision, where there were other bases for rejecting the claim sufficient to justify the rejection (see paragraph 134).

RECENT FOS AND SCT DECISIONS

An insured does not need to be asked health questions for a PEC exclusion to apply

Link to determination

Background

The applicant made a claim on a mortgage protection insurance policy upon the death of the insured. The policy contained an exclusion regarding pre-existing medical conditions (Policy Exclusion). The cause of death was a pre-existing medical condition as defined in the policy (diabetes) and the claim was denied accordingly.

The applicant argued that the exclusion did not apply because the insured was not asked any questions about his health or verbally informed about the abovementioned Policy Exclusion at the time of application for insurance.

Decision

The FOS determined the matter in favour of the insurer.

The FOS came to the view that the insured was clearly informed of the Policy Exclusion. The policy clearly and unambiguously stated the Policy Exclusion. The insured had signed a declaration that he understood and acknowledged that he had received a copy of the policy. The declaration also referred explicitly to the Policy Exclusion.

The FOS further held that an insurer has the discretion to accept an application for insurance without asking health questions and, even if the insurer did not ask such questions, the Policy Exclusion would apply, provided that the insured was clearly informed of it, which he was in this case.

Implications

The key implications of this determination are that:

- The insurer is not obliged to ask health questions to assess whether it wishes to accept risk.
- If the insured is clearly informed of an exclusion in writing, the insured cannot argue that the exclusion does not apply merely because he or she was not verbally informed.
- Strong indicators that the insured has clearly been informed of the exclusion include signed declarations by an insured of receipt of the policy and/or acknowledgment of the exclusion.

RECENT FOS AND SCT DECISIONS

The FOS waters down insurer's claims requirements

Link to determination

Background

The applicant insured had made a claim for income protection benefits which had initially been paid by the insurer but had ceased. The dispute related to the insured's ongoing benefit entitlements.

In response to a FOS Recommendation, the insurer eventually agreed to continue paying the applicant her benefits. However, it disputed a finding in the Recommendation that the insured was not required to complete a Daily Activity Diary (Diary) as a condition of receiving benefits.

The policy relevantly stated that:

> *"In the event of a claim you agree to provide to us at your expense:*
>
> …
>
> - *Any other information required by us"* …

There was competing evidence from the insured's treating GPs and a psychiatrist that the insurer had retained as to the impact of completing the Diary. The insured's treating GPs believed that forcing the insured to complete the Diary would exacerbate the insured's medical condition.

Decision

A key finding was that the insured was not required to complete the Diary.

The FOS favoured the evidence of the insured's treating GPs over the psychiatrist as the psychiatrist did not ever examine the insured. In contrast, the insured had consulted the GPs on numerous occasions. Furthermore, the psychiatrist's report was based solely on documents provided to him by the insurer and the surveillance evidence.

Implications

This Determination makes it clear that, where a policy contains provisions which empower an insurer to impose requirements upon an insured - but does not specifically spell out what those requirements are – the FOS can release the insured from those requirements where there is evidence to justify that happening.

For insurers to have more certainty regarding compliance with requirements (that is, to make it more difficult for insureds to argue that they are not bound) it may be prudent for the policy to explicitly set out what those requirements are.

RECENT FOS AND SCT DECISIONS

Distinguishing "usual occupation" and "usual employment"

Link to determination

Background

The Applicant insured, who worked as an engine production line inspector (EDU quality inspector), ceased work due to disability in July 2011. She unsuccessfully attempted to return to work in May 2012 because her employer changed her role from EDU quality inspector to trim quality inspector. She alleged that she could not perform the duties of a trim quality inspector. The major issue of the dispute concerned the insured's entitlement to benefits after her failed return to work. The insurer had ceased payments because it considered that the insured was no longer totally disabled.

Relevantly, the insured was subject to an Enterprise Bargaining Agreement that encompassed both roles. However, she never performed the duties of a trim quality inspector.

To qualify for total disability benefits, the insured had to show that she was not able to carry out her "usual occupation". However, to qualify for partial disability benefits, the relevant hurdle was the inability to carry out at least one duty of her "usual employment". The terms "usual occupation" and "usual employment" were not defined in the relevant policy.

Decision

The FOS determined that the insured was entitled to partial disability benefits but not total disability benefits.

With respect to "usual occupation", the FOS made the following observations based on the case law:

- With respect to timing, "usual occupation" refers to an insured's activities at the time of onset of the illness or injury.
- When determining the features and incidents of a person's usual occupation, it is necessary to focus on the nature of the activities.
- Occupation does not mean job or position.
- A person's qualification, skills and employment history are relevant.
- A fair assessment of the normal duties of an insured's usual occupation may be evident from "the broad canvas" painted by insured of the nature of their work history. This could all be part of their normal duties and not tasks only performed in exceptional circumstances or on abnormal occasions.

With respect to "usual employment", the FOS considered that, because the policy distinguished "usual occupation" and "usual employment", "usual employment" referred to her job role and duties as reflected in an Enterprise Bargaining Agreement.

The FOS determined that the insured's usual occupation at the time she became aware of her disabling condition was that of an EDU quality inspector as she had never

worked as a trim quality inspector. The FOS considered the medical evidence and held that she was able to return to her usual occupation as an EDU quality inspector as at May 2012 and, thus, she did not qualify for total disability benefits.

However, the FOS determined that the insured's "usual employment" included the roles of both EDU quality inspector and trim quality inspector due to the Enterprise Bargaining Agreement. As the medical evidence showed that she was unable to perform at least one duty with of her "usual employment" (i.e. one or more duties of a trim quality inspector), the insured qualified for partial disability benefits instead.

Implications

The key implications of this determination are that:

- Where "usual occupation" is not defined in the policy, the primary focus is on the insured's actual work activities at the onset of his or her disabling injury or illness.
- "Usual employment" is not necessarily the same as "usual occupation". Subject to policy wording, "usual employment" focuses on an insured's official position and duties rather than his or her actual work activities.
- A helpful way to view the distinction is that "usual employment" focuses on form and "usual occupation" focuses on substance.
- While the difference in meaning attributed to these two expressions by the FOS on this occasion appears to be justifiable, the policy could have been clearer to everyone. The use of similar but different expressions in a policy is an invitation to lawyers and tribunals to begin to pare away shades of meaning between them. Clear definitions of key expressions help both the customer and the company.

TOP TIPS

Offset Clauses

Life insurers often reserve to themselves the right to reduce amounts payable under Income Protection policies by offsetting certain payments of an Income character.

The purpose of an offset clause is to ensure that a disabled insured does not receive more in "replacement income" than would be the case if he or she was not disabled. The reasons for an insurer doing so should be reasonably clear – by ensuring income from all sources received by an insured person do not exceed pre-disability income, insured persons retain a motivation to return to work. The right to offset must be embodied in the contract; the right does not arise at common law.

Any interpretation of the insurance contract must give effect to the policy's commercial purpose. When he was President of the NSW Court of Appeal, Justice Kirby commented that;

> *"Insurance Policies will be construed in their commercial and social setting and having regard to their purposes. If one construction strikes fundamentally at the purpose of the policy, which is to spread the risk insured against, whilst another construction that is reasonably available would affect that purpose the latter will be preferred"*[1]

Similar comments were made by His Honour from the High Court in a matter of *McCann*[2]. His Honour went on to say in *McCann*;

> *"The meaning to be given to an insurance policy must take into account the commercial and social purposes for which it was written. Under the guise of giving the language of a policy its ordinary and fair meaning, a court is not entitled to make a new contract for the parties at odds with that upon which they have agreed. . . .*

And;

> *". . . Courts now generally regard the contra proferentem rule (as it is called) as one of last resort because it is widely accepted that it is preferable that judges should struggle with the words actually used as applied to the unique circumstances of the case and reach their own conclusions by reference to the logic of the matter, rather than by using mechanical formulae."*

As may be apparent an offset clause will generally stand or fall on the strength of its drafting.

Practical problems often arise in the case of life insurers seeking to offset social security payments and lump sum Workers Compensation payments.

In a recent NSW Court of Appeal decision of *Berzins*[3], the Court grappled with an offset clause in a General Insurer's Group Personal Accident Policy where the benefit payable was;

> ". . . the amount shown in the compensation table in this section of the Policy, or the amount of the insured person's pre-disability earnings which they have actually lost, whichever is less, **and will be reduced by weekly benefits paid or payable from any... statutory workers compensation scheme**." (highlighted text most relevant)

In awarding payments under the Group Income protection policy to the claimant, the trial judge had deducted a sum of $26,000 representing an estimation by the judge of the proportion of a lump sum settlement related to weekly compensation benefits. No evidence had been adduced supporting that approach.

The claimant under the policy contended that approach was wrong because, amongst other reasons, the policy did not permit deduction of lump sum settlements. The Court of Appeal with Sackville AJA delivering the leading judgement, agreed with the claimant's contentions. The offset clause permitted offset of weekly benefits, not lump sum damages payments. There was no evidence as to what component of the settlement represented weekly workers compensation benefits. The insurer could not offset that amount.

Potential problems with respect to social security payments are also illustrated in the case of *Phillips*[4]. In that case, the insurer sought to offset social security payments received by the claimant on the basis it represented "similar State or Federal legislation" within the context of the provision set out below,

> *"...(b) Workers Compensation, Workcare, Accident Compensation or any other similar State or Federal Legislation..."*

The Court, while stating that "the question of construction" was "a close one", ultimately determined that social security payments were not sufficiently "similar" to Workers Compensation benefit schemes to fall within the offset clause.

Einstein J said;

> *"It is necessary to focus upon the meaning of the word 'similar' appearing in clause D19.0. To my mind in the instant context the social security payments do not qualify as relevantly 'similar' within the subject definition. In order to so qualify any relevant benefits would have to arise by reason of accident compensation schemes or statutory accident compensation schemes or the like.*[5]

Offset clauses play an important role in ensuring claimants are properly, but not overly, compensated at times of disability. A well designed offset clause will, in company with other assistance such as rehabilitation (where available), provide an incentive for a disabled person to return to work, which will generally be in the long term interests of a claimant. However, care needs to be taken in drafting such clauses.

While Courts will construe the provisions to give effect to their clear commercial purpose, if there is ambiguity, the clause may not successfully operate. Particular problems might arise in seeking to offset social security payments and lump sum settlements as discussed in this article.

[1]*Legal & General Insurance Australia Limited v Eather* (1986) 6 NSWLR 390.
[2]*McCann v Switzerland Insurance* [2000] HCA 65; 203 CLR 579; 176 ALR 711; 75 ALJR 325 (14 December 2000)
[3]*Berzins v QBE Insurance (Australia) Ltd* [2014] NSWCA 196 (23 June 2014); Case discussed in Enwright WIB and Merkin RM; "Sutton on Insurance Law" Fourth Edition p680 Law Book Co.
[4]*Carolyn Philips (nee Durrand) v Tower Australia Ltd* [2008] NSWSC 1047
[5]*Carolyn Philips (nee Durrand) v Tower Australia Ltd* [2008] NSWSC 1047