Australian Financial Complaints Authority

# Determination

| Case number | 674068 |
| --- | --- |
| Financial firm | MLC Limited |

# 1 Determination overview

## 1.1 Complaint

The complainant held a policy with the financial firm (the insurer) which provided critical illness insurance cover. On the complainant's request, the cover was cancelled on 20 February 2018. The complainant was diagnosed with a malignant brain tumour in August 2018 and lodged a critical illness claim under the policy in June 2019.

The insurer declined the claim because her condition was not diagnosed while the cover was in force. The complainant disputes the insurer's decision.

## 1.2 Issues and key findings

### Was the insurer entitled to decline the claim?

I am satisfied the terms and intent of the policy does not allow the insurer to deny the claim. The insurer must pay a critical illness benefit to the complainant.

## 1.3 Determination

This determination is in favour of the complainant. The insurer must pay to the complainant the sum of $500,000 within 14 days of her accepting this determination as full and final settlement of the claim.

# 2 Reasons for determination

## 2.1 Did the complainant suffer a critical condition?

### The complainant held critical illness insurance until February 2018

The complainant commenced a critical illness policy with the insurer on 19 February 2016.

On 12 February 2018 the complainant telephoned the insurer to cancel her critical illness cover due to the cost of the policy. During the telephone call, the complainant agreed to consider a quotation for a reduced level of cover that the insurer offered.

After she had considered the quotations provided, the complainant again telephoned the insurer on 14 February 2018 and confirmed her decision to cancel her critical illness cover.

The insurer advised the critical illness cover would be cancelled in full. The complainant confirmed she understood her policy will be cancelled. The policy cancellation was also confirmed by the insurer in a letter dated 20 February 2018 to the complainant. The complainant does not dispute cancelling her policy.

### The complainant suffered from a critical condition

The complainant is claiming the critical illness benefit for a malignant cancer.

The available information shows the complainant first experienced symptoms in July 2016 and presented to Dr CJ on 12 July 2016 complaining of unusual neurological symptoms with symptoms of leg paraesthesia. This is confirmed in Dr CJ's report of 9 May 2019.

Dr CJ was unable to diagnose the symptoms and provided the complainant with an option to undergo an MRI of the brain and spine to exclude MS. The complainant was referred to Dr KG, a neurologist.

The complainant consulted Dr KG on 20 July 2016. Dr KG reported to Dr CJ on 20 July 2016 stating:

- the doctor was unsure of the cause of the symptoms
- the symptoms were unlikely to be of serious concern
- no further investigation was warranted
- the complainant was requested to return if she developed more persistent symptoms or new neurological symptoms.

Subsequently, the complainant presented to Dr CJ on 20 March 2017 complaining of fatigue. Blood tests were performed and revealed iron deficiency.

She was referred to Dr P, a gynaecologist, for further investigation. The complainant consulted Dr P on 4 April 2017. Dr P's report dated 4 April 2017 indicates that she did not diagnose the complainant's condition and treated the complainant for adenomyosis.

On 1 August 2017 the complainant presented to Dr JR, a general practitioner, complaining of fatigue, iron deficiency, abdominal bloating and shortness of breath. There was no diagnosis of a malignant tumour.

I accept from the evidence the complainant started to experience pins and needles from her right foot to her hip and had a focal seizure on 16 July 2018. A brain scan revealed a lesion in her brain and the complainant underwent surgery to remove this lesion on 30 July 2018.

A histopathology report confirmed the presence of an anaplastic hemangiopericytoma on 2 August 2018. This is a very rare condition, as noted in Dr CJ's report of 5 December 2019:

> [the complainant] has a diagnosis of a hemangiopericytoma. This is a very rare condition…

Dr MT, the insurer's chief medical officer, in her report of 13 June 2019 also confirmed this:

> the insured's diagnosis is an anaplastic hemangiopericytoma which is a rare tumour and part of a group of tumours called solitary fibrous tumours (SFT).

In her report of 5 December 2019, Dr CJ concluded she believed the tumour was the most likely cause of the complainant's symptoms in 2016. She also indicated the complainant's bloating, fatigue and iron deficiency may have been a set of signs and symptoms that is the consequence of the presence of cancer in the body.

On the above evidence, I am satisfied the complainant suffered a malignant cancer – a 'Critical Condition' covered by the policy.

### Critical condition benefit payable if Critical Condition suffered while insurance in force

The insurer's obligation to pay the benefit is subject to the policy requirements. The policy provides in respect to payment:

> **When we will pay**
>
> If the Life Insured suffers a Critical Condition (see below) while this insurance is in force, we will pay you the Critical Illness Benefit or a proportion of the Benefit if indicated below

The policy later provides a section headed **'Critical Conditions'** which lists the conditions. I am satisfied the policy provided cover for malignant cancer, which is defined as:

> the presence of one or more malignant tumours, leukemia or lymphomas.

At the end of the list is the provision:

> The Life Insured first has a Critical Condition
>
> - for surgical conditions when the surgery actually happens and
> - for all other conditions when the condition is first diagnosed as meeting its definition

The policy also states:

> a benefit is not payable until a critical condition meets the terms of its definition. In some cases, a critical condition must progress to a certain point before it satisfies the relevant critical condition definition.
>
> All critical conditions must be diagnosed by a specialist and confirmed by [the insurer's] medical adviser.

The insurer argues that its liability to pay critical illness benefits is by reference to the date of diagnosis. It maintains it does not remain on risk for conditions that may arise during the course of cover but are diagnosed after cover ceased. It says that means the complainant must be first diagnosed (presumably by a treating specialist). The insurer rejects the retrospective diagnosis provided by Dr CJ as this involves a significant degree of speculation.

The question to be determined is whether this interpretation of the insurer's obligations is correct.

### On balance, complainant suffered from Critical Condition while insurance was in force

The insurer has had the opportunity to obtain evidence from a medical practitioner of its choice to rebut the evidence that the condition was malignant cancer prior to the cancellation of this policy, but has not done so.

There is no probative information to indicate the condition was not a malignant cancer and would not have met the policy requirement of 'suffers a Critical Condition while this insurance is in force'. There is also no information to indicate the condition would not have met the policy definition for any other reason while the policy was in force.

There is evidence that the complainant's tumour, a malignant cancer, was on the balance of probabilities present in February 2018. I note there is a report from Dr RJ dated 15 May 2019 that states:

> Although this was first identified in brain scans earlier in July at the time of first imaging it already measured 38 X 25X 25mm. It is almost certain that a scan done in February 2018 would have demonstrated the tumour, although it was not symptomatic at that point.

Dr RJ's report is supported by Dr CJ in her report of 5 December 2019:

> … in hindsight the hemangiopericytoma is the most likely cause of the symptoms that [the complainant] experienced in 2016.

Having considered all the evidence, I am satisfied the complainant suffered from malignant cancer that met the policy definition of a Critical Condition whilst the policy was in force.

## 2.2 Is the insurer entitled to rely on the timing of the formal diagnosis?

### Insurer is declining the claim because of the date of diagnosis

The insurer contends the medical information provided by the complainant shows that although the complainant suffered symptoms while the policy was in force, a diagnosis of her condition was not made by its specialist or any other specialist before her policy was cancelled. The complainant is not disputing this.

The insurer contends, in its post-recommendation submissions, the Critical Illness cover specifically provides for someone who is <u>diagnosed with a Critical Condition</u>, in this instance malignant cancer, whilst the <u>policy is in force</u>. It argues the insured event for the payment of the benefit is the diagnosis of the Critical Condition, not the arising of the condition. It says this is the appropriate characterisation of the insured risk, having regard to the commercial context in which the cover is issued.

The insurer has made a submission that gives the impression the policy payment provisions follow each other. It has submitted:

> **When we will pay**
>
> If the Life Insured suffers a Critical Condition (see below) while this insurance is in force, we will pay you the Critical Illness Benefit or a proportion of the Benefit if indicated below
>
> The Life Insured first has a Critical Condition
>
> - for surgical conditions when the surgery actually happens and
> - for all other conditions when the condition is first diagnosed as meeting its definition

I do not agree with the insurer's position. This is not a fair representation of the policy format. According to the policy provided by the complainant:

> **When we will pay**
>
> If the Life Insured suffers a Critical Condition (see below) while this insurance is in force, we will pay you the Critical Illness Benefit or a proportion of the Benefit if indicated below,
>
> If the Total and Permanent Disability (Extension to Life Cover) insurance is also held which covers the Life Insured, the total of both the Total and Permanent Benefit and Critical Illness Benefit cannot exceed the Life Cover Benefit they are connected to as an Extension

This provision sets out and puts an insured on notice of the limit of the insurer's contractual obligation in respect to the amount payable as the benefit. It does not say the Critical Illness must be diagnosed while the policy is in force, but provides the insured must suffer from the illness.

The '**When we will pay**' provision simply provides for payment when the life insured suffers a Critical Condition whilst the insurance is in force, without any reference to the need for a diagnosis.

The policy provision 'The Life Insured first has a Critical Condition' introduces requirements of 'first has a Critical Condition' and 'when the condition is first diagnosed as meeting its definition'*.* It provides that payment is made after the condition is diagnosed. It does not require the first diagnosis to be during the policy period. It does not determine or modify the words or the intent of the cover for payment 'if an insured suffered a Critical Illness' but fixes when the payment for a Critical Illness first becomes due and payable.

I am satisfied the terms and the intent of the complainant's cover was to pay a benefit for a malignant cancer, that is suffered whilst the policy is in force and not when first diagnosed, as claimed by the insurer.

### The insurer may not refuse to pay claims in certain circumstances

The findings above are sufficient to entitle the complainant to the benefit. I have also considered whether, if the insurer was right about the need for diagnosis before cancellation of the policy, section 54 of the *Insurance Contracts Act 1984* would operate so that the complainant would still be entitled to the benefit.

Section 54 prevents the insurer from refusing to pay claims in certain circumstances. See section 3.2 for the full wording of the section.

The application of section 54 requires a consideration of terms of the policy, and the complainant's conduct, including any acts or omissions of third parties.

### The specified cover was the essential characteristic of the policy

The insurer argues that before section 54 is considered it is necessary to determine the characteristics of the event or the risk insured.

It argues, in short, the requirement that the complainant must be diagnosed with the Critical Condition while the cover is in force is an inherent restriction or limitation on the claim itself. It says that if these requirements are not satisfied there would be no insured event.

The insurer relies on several judicial authorities in support of its position that an essential characteristic of the policy cover for which a benefit was payable was that the complainant's condition had to be diagnosed whilst the policy was in force. One of the authorities was the High Court decision in ***FAI General Insurance Company Ltd v Australian Hospital Care Pty Ltd*** [2001] HCA 38 which considered the application of section 54 in respect to a claim which was made after the expiry of a policy.

The insurer points out the Court said:

> Section 54…. operates to prevent an insurer from relying on certain acts or omissions to refuse to pay that particular that particular claim. In other words, the actual claim made by the insured is one of the premises from which consideration of the application of section 54 must proceed. The section does not relieve the insured of restrictions that are inherent in the claim.

The insurer also relies on Meagher J who said, amongst other things, in ***Prepaid Services Pty Ltd v Atradius Credit Insurance NV*** [2013] NSWCA 252:

> The way in which the provisions of the policy describe and define that event or risk will vary between different types of policy, and sometimes between policies which provide the same type of cover. It is here that matters of form are not to indicate the outcome when considering the effect of the contract: East End at 403-404. It nevertheless remains necessary, in addressing that effect, to have regard to the nature of the risk and subject matter insured as well as the commercial or other context in which the insurance is written, to the extent that evidence of that kind is admissible on the question of construction

In ***Watkins Syndicate 047 at Lloyds v Pantaenius Australia Pty Ltd*** [2016] FCAFC at 41, the Federal Full Court said:

> The process of characterisation and the judgement as to what is the essential character of the policy in a given case will be influenced, but not dictated, by the drafting of the wording of the policy, and will involve the identification of the nature and limits of the risk that are intended to be accepted, paid for and covered.

I understand the insurer's submission that the Critical Illness cover was priced on the basis it would only provide cover for Critical Conditions which occurred while the cover was in force. This removed the uncertainty of determining when a condition first arose, as opposed to when it was first diagnosed.

As set out under Section 2.1 of this determination, I am satisfied the essential character of the policy is to provide a Critical Illness benefit for an insured suffering a malignant cancer whilst the policy is in force. It specifically provides:

> **When we will pay**
>
> If the Life Insured suffers a Critical Condition (see below) while this insurance is in force, we will pay you the Critical Illness Benefit or a proportion of the Benefit if indicated below

This was the nature of the risk insured and was the subject of the actual claim made by the insured. For the reasons outlined above, I find that the provision:

> The Life Insured first has a Critical Condition
>
> - for surgical conditions when the surgery actually happens and
> - for all other conditions when the condition is first diagnosed as meeting its definition

is in relation to the timing of payment and quantification of the benefit. It does not modify the cover for a Critical Illness suffered by an insured whilst the policy was in force. It is not an inherent restriction or limitation on the policy cover or the complainant's claim.

### Section 54 would apply because of the medical practitioners' failure to make the diagnosis

Section 54 is engaged when an insurer seeks to rely on a post-contractual act or omission by an insured or other party to excuse the insurer from an obligation to pay a claim. Unless the act or omission could reasonably be regarded as being capable of causing or contributing to a loss (see section 54(2)) the insurer cannot rely on the act or omission to refuse to pay the claim, but can only reduce the benefit to the extent it is prejudiced.

I find that there has been an omission by an 'other party', namely the complainant's doctors' failure to first diagnose the complainant's condition whilst the policy was in force before the complainant's cancellation of the policy in February 2018. This is a post-contractual omission.

### Omission to diagnose the Condition before policy cancellation did not cause or prejudice insurer

There is no persuasive information that the omission to diagnose the illness could reasonably be regarded as causing or contributing to the loss. That is, there is no persuasive information that the late diagnosis altered the nature of the Critical Illness or, as I have found, that the condition was suffered during the policy period.

I am satisfied that if the complainant's doctors had diagnosed the complainant with the malignant cancer prior to the cancellation date in February 2018, the complainant would have made a claim and the insurer would have been liable to pay the Critical Illness benefit.

The issue is therefore whether and to what extent the insurer may have been prejudiced by the omission.

I understand that the failure to diagnose the Condition had the knock-on effect of the insurer's medical practitioner not being able to assess it whilst the insurance was in force.

I am satisfied, however, that the insurer's medical adviser would have concluded the complainant had a Critical Illness prior to the cancellation of the policy based on the complainant's symptoms from 2016 onwards and the findings after the operation in mid-2018.

Based on these conclusions, I find the complainant would have been entitled to the Critical Illness benefit, and while the insurer has been inconvenienced it has not been prejudiced by the omission.

### The cancellation of the policy does not affect the complainant's entitlement

The insurer's policy provides:

> Your Critical Illness Standard Insurance ends on the earliest of the following:
>
> The date we cancel this insurance following your cancellation request.

I am satisfied this cancellation provision is intended to prevent claims for Critical Illness for Critical Conditions which arise after the cancellation of the insurance. It does not have the effect of preventing claims by life insureds who suffered a Critical Condition whilst the policy was in force.

I find that support is given for this conclusion in ***FAI General Insurance Company Ltd v Australian Hospital Care Pty Ltd*** [2001] HCA 38 where the High Court considered the application of section 54 in respect to a claim which was made after the expiry of a policy.

The joint judgement of Justices McHugh, Gummow and Hayne was considered a relevant guide.

The Justices relevantly said, amongst other things:

> To say of the policy of insurance that it had "expired" at the time that Dr Tampoe's claim was made against the insured is apt to distract attention from the considerations that are relevant under s 54. The section directs attention to the effect of the contract of insurance, and, in particular to whether but for s 54 its effect would be that the insurer may refuse to pay the claim which the insured has

> made. The contract of insurance which is now in question provided for a period what is called a "period of cover" The specification of that period did not however mark out the duration of the contractual rights and duties of the parties. Rather, it provided temporal limits to the operation of certain of the stipulations upon which the parties agreed. Most notably, it marked the temporal limits within which the "claims" referred to in the insuring clause were to be made if that clause was to have application, and the temporal limits in condition 3 to the substance of the policy.
>
> That is not to say, however that the contract of insurance between the parties was discharged and of no further effect at the end of the period of cover. The contract still subsisted and if its terms had been met, the parties continued to be entitled to require performance of relevant obligations under it, notwithstanding that the period of cover had come to an end. Adopting and adapting the language of s 54, if a claim had been made on the insured and notified to the insurer during the period of the insurance, the effect of the contract of insurance would be that the insurer might not refuse to indemnify the insured against that claim, notwithstanding that the time for satisfaction of that indemnity may not arise until some years later. It is not there for not right to say that the ending of the period of cover is itself insufficient reason to conclude that s 54 is not engaged.

It is my view that this authority is applicable to the facts in this matter, and as the complainant is otherwise entitled to the Critical Illness benefit under the policy the cancellation of the policy would not allow the insurer to deny the claim.

### The complainant is entitled to the benefit

I am satisfied the insurer was not prejudiced because of the omission of the complainant's doctors to first diagnose the complainant with the malignant cancer whilst the insurance was in force.

I find the complainant had suffered a malignant cancer whilst the insurance was in force and would have been entitled to the Critical Illness benefit had she been diagnosed before the policy was cancelled.

Accordingly, I am satisfied the insured has proved that no part of the loss that gave rise to the claim was caused by the omission of the complainant and the insurer may not refuse to pay the claim by reason of the omission.

I am satisfied the complainant's claim falls within the policy cover. A diagnosis has been made that she suffered malignant cancer, a Critical Condition, and the evidence establishes she has suffered her Condition whilst the insurance was in force. She is accordingly entitled to the payment of the Benefit which was payable whilst the insurance was in force.

# 3 Supporting information

## 3.1 Process

This complaint has been determined based on what is fair in all the circumstances, having regard to the relevant law, good industry practice, codes of practice and previous decisions of the AFCA or its predecessor schemes (which are not binding).

A full exchange of the relevant information has taken place between the respective parties. Each party has had the opportunity of addressing any issues raised.

All the provided material has been reviewed and considered. The parties have raised numerous issues in their submissions to AFCA. However, commentary in this determination is restricted only to those submissions considered relevant to the outcome.

### How we assess complaints

AFCA is not a court of law. We do not have the power to take or test evidence on oath, or to require third parties to give evidence. When we assess complaints, we consider available documents, the recollections of the parties, and all relevant circumstances. We give more weight to contemporaneous documentary information. If there is no relevant documentation, we will decide what is most likely to have occurred based on the information provided to us. If there are conflicting recollections and these are evenly weighted, we may find that a claim cannot be established.

## 3.2 Relevant law

### Section 54 Insurance Contracts Act 1984

> **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, 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.

## Relevant cases

***FAI General Insurance Company Ltd v Australian Hospital Care Pty Ltd*** [2001] HCA 38

***Prepaid Services Pty Ltd v Atradius Credit Insurance*** 2013 NSWCA 252

***Pantaenius Australia Pty Ltd v Watkins Syndicate 047 at Lloyds*** 2016 FCA

***Watkins Syndicate 047 at Lloyds v Pantaenius Australia Pty Ltd*** [2016] FCAFC at 41