CASES AND TRIBUNAL DECISIONS

TPD - Delay in Assessing Claims

Sargeant v FSS Trustee Corporation [2018] NSWSC 1997

Link to decision

Background

The TPD claim by the life insured, a former police officer, was brought in relation to both physical and psychiatric injuries. The life insured ceased work in February 2010 and her six months qualification period ended in October of that year. The claim was lodged in June 2011 and a decline decision was issued seven years later, in May 2018 (whilst court proceedings were on foot).

In the meantime, proceedings were commenced firstly in the Industrial Relations Commission in March 2014 but were transferred to the NSWSC by September 2015.

The decline was issued one month before the scheduled hearing date in June 2018 but for reasons unknown, the life insured chose not to challenge this decision but rather continued to assert that the insurer by reasons of its delay, had long since lost the right to make a decision on the opinion based TPD insuring clause and therefore, the May 2018 decision was invalid. Specifically, she urged the Court should make a finding that the failure to make a decision before proceedings were commenced in September 2015 or one year later in September 2016, was a breach under the policy i.e. a breach of its obligations of good faith and reasonableness in handling the claim (first stage).

These issues were determined as a separate preliminary determination by Parker J. The life insured conceded that if she failed on these questions, her claim should be dismissed i.e. the legitimacy of the final 2018 decline was not subject to a challenge.

Findings

The Court found that the insurer had not breached its policy by not making it decision before the 2015 and the 2016 dates. The key reasons were:

- A constructive decline finding is not merely based on the passing of time. There may be acceptable reasons for an insurer taking some time to assess a claim (para 105) per *Hellessey*.
- A life insured or trustee needs to give a clear warning if they are going to deem a claim as constructively declined or 'make time of the essence'. That is, 'it may be difficult for a trustee or a claimant to establish constructive rejection if they have not, so to speak, made time of the essence by giving an appropriate notice' to the insurer (para 105 and 126).
- Questions were raised even in the life insured's own evidence regarding the underlying legitimacy of the claim. Investigation was hence required and the insurer was not obliged to accept her (the life insured's) assertions and the opinions of her doctors at face value. It was entitled to test those assertions and opinions by reference to independent evidence (para 124).
- The insurer received implicit confirmation from both the claimant and trustee that they were satisfied with the progression of the claim when they did not take up the invitation to lodge a complaint with FOS or the internal complaint mechanism about the time taken to determine the claim (para 113).
- The ongoing service of further medical reports by the life insured throughout the proceedings and production of voluminous subpoenaed material (which the parties had

agreed could be used for the purpose of claim assessment) opened up further lines of enquiry which needed to be investigated – '… it was not just a question of reviewing any further material which came forward. Properly addressing the new material might require [the insurer] to reconsider views it had already formed, suggest lines of further enquiry, or require fresh reports from [its experts] (para 115). Further, in this regard the life insured solicitors did not make it clear that the multitude of further reports were only being served for stage 2 (para 121).

Implications

Clearly community and judicial expectations are for life claims to be determined more rapidly than they have in the past. Promises on time frames in this regard have been made in the present Life Code and the draft 2.0 version.

Be that as it may, as this case demonstrates, it is not the headline elapsed time between claim lodgement and claim decision which will be determinative of whether an insurer has delayed to an extent it has breached its policy (or the Code for that matter). Rather, it is underlying claim conduct of the parties to the claim which is determinative.

The facts in this matter are somewhat idiosyncratic and clearly taking seven years to determine a claim is not the norm. Nonetheless, one can draw some conclusions from this decision as to the type of matters which can anchor a defence to a constructive decline allegation in an aged claim context. Namely:

- the absence of a warning from the claimant that 'time is of the essence' in determining the claim;
- a medical matrix which is complex, multi-layered, controversial and warrants further investigation;
- the ongoing service or production via court process of relevant medical reports and material which requires ongoing investigation and absent clear direction that such material is not to be considered in the claim determination;
- the failure to accept an offer to pursue IDR or EDR remedies in relation to the alleged delay ; and
- contributory delay by the claimant in failing to respond to requests for information.

If some or all of these matters are present, then it would seem that an insurer has an arguable case against an assertion of delay in claim assessment.