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☐ INSURANCE

# New Insurance Brokers Code of Practice

The National Insurance Brokers Association (NIBA) has introduced a new Insurance Brokers Code of Practice (the Code) which came into effect on 1 January 2007.

The Code was developed by NIBA as part of a national self-regulatory scheme, and covers all insurance intermediary services. The Code is compulsory for all members of NIBA, and can be adopted by non NIBA members by entering into a Deed of Adoption with NIBA.

The Code principally applies to general insurance services (other than reinsurance) and life insurance services. It also applies, to a limited extent, to services provided in association with them, such as risk management, inspection, valuation and the arrangement of premium funding.

## Objectives

The Code is intended to promote good relations between insurance intermediaries that are members of the Code and their clients, insurers and others involved in the insurance industry.

The Code clarifies what members should do to comply with relevant legislation. Further, the Code provides for a system of review to minimise non-compliance and maintain high standards of compliance by members.

## Standards contained in the Code

The Code provides that brokers will:

- discharge their duties competently and with integrity and honesty;
- exercise reasonable care and skill; and
- comply with all of the IR legal obligations, in particular but not limited to, those that apply to them as an Australian Financial Services Licensee relating to the provision of advice, conflicts of interest and the maintenance of written records.

The Code requires brokers to act in the best interest of their clients and provide advice as appropriate, as well as providing clients with necessary information regarding changes in coverage and variation in policies, amongst other things. The Code requires brokers to tell clients if they are acting for the insurer, whether in arranging the policy or handling a claim. Brokers must ensure that they do not authorise representatives to provide insurance services that they are not competant to provide.

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## introduction

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**Welcome** to a bumper issue of our *Financial Services Law Bulletin*. This issue covers matters relating to general insurance (including an article on Insurance Act schemes or portfolio transfers), life insurance, superannuation and health insurance. We also look at the Treasury's proposals for streamlining prudential regulation. We covered the Corporate and Financial Services Regulation Review proposals in our December 2006 issue and we sent an update on the proposed Insurance Contract Act reforms in February. Finally, we are pleased to announce an update of our Self Managed Superannuation Fund package – details on page 7.

☐ GENERAL INSURANCE

# The Insurance Act and Portfolio Transfers

The addition of Division 3A of Part III in 2001 to the *Insurance Act 1973* altered the manner in which a general insurer could transfer its business or one of its portfolios to another general insurer. Division 3A of Part III prohibits any part of the insurance business of a general insurer being transferred to or amalgamated with the business of another general insurer, except under a scheme or Portfolio Transfer confirmed by the Federal Court. The amendment permits general insurers now to transfer portfolios in the same manner that life insurers have for the past 60 years.

Prior to the introduction of Division 3A, if a general insurer wished to transfer a portfolio of policies it was obliged to do one of the following:

- enter into novation agreements in respect to the policies; and
- assign the policies pursuant to the relevant state conveyancing act or property statute; or
- in some circumstances, the transfer might be in the context of a solvent scheme of arrangement which complied with the provisions of the Corporations Act that govern arrangements and reconstructions.

All of the foregoing options were administratively and commercially problematic. To some degree, each involved a third party, the policyholder, in the process.

Furthermore, there is another method of transferring policies contained within Section 17 of the Insurance Act. Section 17 schemes, or assignments as they are sometimes labelled, are where APRA directs an insurer to transfer its portfolio to another insurer prior to the revocation of the transferring insurer's licence. This article does not deal with, or address, Section 17 transfers except to note that an assignment under Section 17 applies to the insurer's entire business but a transfer under Division 3A can apply to individual books of the business of the general insurer.

While there have been relatively few applications to approve transfers pursuant to Division 3A since its inception, the process has been efficiently used within the life insurance industry since the 1950's.

Like any transfer of shares or assets, a Portfolio Transfer under the Insurance Act must be documented in a manner similar to any other sale transaction. The transferring parties must negotiate and take into account the traditional issues of any transaction such as pricing, stamp duty considerations and what level of indemnity, based on the representations and warranties, is required.

In addition, the parties to the transaction should be aware of the potential application of the provisions of the *Insurance Acquisitions and Takeovers Act (1991)*. If the value of the line or business being transferred amounts to 15% or more of the insurer's premiums or outstanding claims liability, an insurer must notify the Treasurer and comply with terms of the Insurance Acquisitions and Takeovers Act in respect to the transfer.

Another matter to be taken into account is whether the transfer involves foreign investors as that may require that the Foreign Investment Review Board (FIRB) to review the transactions. A FIRB review and approval is generally required when a transaction involves a foreign individual or entity investing greater than $50 million dollars in Australian assets. Although, depending on the nationality of the individual investor and/or the Australian industry involved, the amount of the permitted investment may be different.

## Steps of a Portfolio Transfer

After a general insurer has negotiated a business agreement for the transfer of a portfolio and the parties have reached agreement on the terms, the transfer must proceed pursuant to the procedure set out in the Insurance Act and those contained in Prudential Standard GPS 410 – Transfer and Amalgamation of Insurance Business for General Insurers (the Standard). It is advisable that during the negotiations, and prior to the formal commencement of the steps listed below, the parties to the transaction meet informally with the Australian Prudential Regulation Authority (APRA). The purpose of the meeting would be to inform APRA of the transaction and to elicit any concerns or issues APRA would need to see addressed in the scheme summary and actuarial reports.

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### Step 1: prepare and deliver a copy of the scheme summary and any actuarial reports to APRA

Once the parties agree to a transfer of a part of the insurance business they must then prepare a scheme summary and an actuarial report on the proposed scheme.

The actuarial report, upon which the scheme is based, usually seeks to establish that sufficient assets are being transferred to the transferee company to actuarially match the value of the liabilities being transferred.

The actuarial report will need to address the affect of the scheme on the policyholders by taking into account the protections in place in respect to the policyholders.

To protect the policyholder, APRA has the right to request, at the expense of the applying insurer, a second independent actuarial report. Often the second actuarial report will be prepared to provide guidance to APRA on the interpretation of the first report and confirm that the assumptions and calculations in respect to the first report were appropriate.

### Step 2: seek and receive APRA's approval in relation to the notice of intention and approved summary

Unlike schemes of arrangement permitted by the Corporations Act, policyholders have no direct standing in an Insurance Act portfolio transfer. The Insurance Act requires that the general insurer deliver the scheme summary and notification to policyholders.

A summary, to be approved by APRA for delivery to the policyholders, will contain, at minimum, the following information:

- that the insurer proposes to transfer the policyholder's policy or policies to another insurer, on or after a specified date;
- the full name and contact details of the purchaser;
- the effect of the transfer on the policyholder;
- any action the policyholder will need to take before or as a result of the transfer, including advising the policyholder if no action is required;
- how the policyholder can obtain further information and inspect related transaction documents; and
- the policyholder has the right to attend the Federal Court application.

### Step 3: publish notice of intention to transfer the portfolio

The Insurer must distribute the approved summary to policyholders and make it available for public inspection.

### Step 4: public inspection

A copy of the scheme must be open for public inspection for a period of at least 15 days prior to the application to court.

### Step 5: make an application to the court

An application to the court for confirmation of a scheme may be made no earlier than:

- the day after the day on which the public inspection ends; and
- unless the court dispenses with the need for compliance with Section 17C(2)(c) of the Insurance Act, 15 days after the approved summary of the scheme has been given to every affected policyholder under that paragraph, whichever is the later.

While the policyholder has the right to attend the application, the policyholder has no standing or right to be heard at the application. Notwithstanding the foregoing, the court has exercised discretion in previous applications and permitted policyholders to make submissions.

### Step 6: court confirms the scheme

The decision to proceed and approve with the application is at the court's discretion. The Federal Court has the right to:

- confirm a scheme without modification; and
- confirm the scheme subject to such modifications as it thinks appropriate; or
- refuse to confirm the scheme.

How the court will exercise its discretion is based on the application itself and the protection of the policyholders provided in the scheme summary. The Act contains no specific criteria which the court is to apply. The court stated in the Reward case:

> *Obviously a prime consideration would be the nature of the actual or potential claims to which the transferor insurer is subject and the financial viability of the transferee insurer.*

The court's primary concern in relation to an application is to ensure that the affected policyholders are protected. The court has reviewed the issue as to who is an "affected policy holder" and the jurisprudence provides that the court has the discretion to look at how the transfer affects the policyholders of both the purchaser and the vendor.

Not only are the policyholders affected but certain third party contracts may be affected, for example re-insurance purchased to back the policies to be transferred may be affected.

The Act provides the Federal Court the power to make such orders as it thinks fit in relation to reinsurance contracts that apply to the transferred portfolio. To ensure that there is no confusion the court will often make an order, in addition to the normal order confirming the portfolio transfer, binding the re-insurers to the scheme.

### Step 7: if the scheme is confirmed by the court, then certain documents must be provided to APRA by the transferee

Once the court approves the scheme, there is an obligation on the insurer that received the new line of business to provide to APRA within 30 days of the completion of the transfer or amalgamation of the

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following materials:

- a statement of the nature and terms of the transfer or amalgamation;
- a certified copy of:
  - the scheme providing for the transfer or amalgamation;
  - an actuarial report, or other report, on which the scheme, and the agreement or deed, are founded;
  - the agreement or deed under which the transfer or amalgamation is affected;
  - the court order confirming the scheme;
  - a statement of the assets and liabilities of each insurer associated with the transfer or amalgamation, before and after the transfer or amalgamation;
- a statutory declaration by a Director:
  - setting out, in relation to the transfer or amalgamation: each payment made; and a reasonable estimate of each payment to be made; and
  - stating that he or she reasonably believes that no other payment has been made, or will be made, by, or with the knowledge of, a party to the transfer or amalgamation.

The conclusion is that Division 3A of Part III of the Act provides an efficient mechanism that permits a general insurer to transfer a portion of its business or portfolio, yet it also ensures that the affected policyholders' rights are taken into account and protected.

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The Code contains additional provisions for managing insurance placed with overseas insurers not authorised in Australia. Under the Code, brokers must inform all consumers of the risk of dealing with a foreign general insurer who is not authorised under the Insurance Act, and seek written acknowledgment before placing any insurance with such an insurer. This represents pro-active regulation by NIBA, placing a higher standard of regulation on Code members than is currently required under the legislation (although the requirements reflect the old provisions under the now repealed Insurance (Agents and Brokers) Act).

## Payment for services

Brokers are remunerated for providing insurance services by commission, remuneration, benefits and rewards from insurers, fees paid by consumers, or a combination of both. The Code requires that brokers disclose how a service is to be paid for before providing the service, and what will happen to the commission fee if the policy is cancelled before it expires.

## Dispute resolution and Code breaches

Of particular interest are the new provisions for resolving complaints, and disputes handling. These provisions are quite extensive, and cover access to information, as well as emphasising transparency and the prompt resolution of complaints. The Code provides for an internal dispute resolution manager to resolve complaints which cannot be resolved by other means. This extends the legislative requirement for retail clients to all clients of a broker, retail or wholesale.

## Sanctions for breaching the Code

The Code standards are monitored by Insurance Brokers Disputes Ltd (IBD), which is able to impose binding orders or sanctions for any breach of the Code, such as reporting breaches of the Code to ASIC, requiring the broker to take corrective action, or to undertake a compliance audit. IBD cannot impose any monetary penalties.

## Commentary

Commenting on the release of the new Code, Parliamentary Secretary to the Federal treasurer Chris Pearce said "I am confident the NIBA Code will be an effective tool in the self-regulation of insurance brokers and will assist in increasing consumer confidence in the insurance broking industry". Further, he said that in launching the Code, brokers are one of a growing number of financial services groups embracing the need to go beyond legislation by laying down rules for dealing with customers.

This marks an interesting trend within financial services industries that are regulated by legislation, but who recognises that increasing demands for improved customer service sometimes requires higher service standards than those mandated by legislation.

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☐ REGULATORY

# Streamlining Prudential Regulation Proposals paper December 2006

The Treasury is working with the Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Authority (APRA) to identify ways to reduce the regulatory burden on entities regulated by ASIC and APRA.

## Reducing duplication and overlap

The Streamlining Prudential Regulation Response to Rethinking Regulation proposals paper was released for public comment on 4 December 2006 and is the Government's response to the report of the Taskforce on Reducing Regulatory Burdens on Business – Rethinking Regulation, outstanding recommendations from the HIH Commission and other prudential regulation proposals. Further, guidance on legislative amendments proposed in the paper will be provided once the changes have been finalised (following the period for public comments, which closed on 15 February 2007).

## Responsible persons and officers

Both ASIC and APRA use the concept of "responsible" individual although the obligations of such people differ. The working group found that a number of people who are responsible "officers" for ASIC purposes are also responsible "persons" for APRA purposes, highlighting the overlapping in responsible individual reporting requirements.

## Streamlining breach reporting obligations

Presently under the Prudential Acts (prudential regulation frameworks for banking, general and life insurance and superannuation), APRA must be informed of all breaches of prudential requirements. However, pursuant to section 912D of the Corporations Act, only material breaches need to be reported by Australian Financial Services Licensees to ASIC. To improve the breach obligation requirements under both regulators and ease compliance burdens, it is proposed that a materiality test akin to the one in the Corporations Act be introduced into the Prudential Acts. The test will focus on:

- the number or frequency of similar previous breaches;
- the impact of the breach on the entity's ability to meet its obligations to depositors, policyholders and beneficiaries (including actual or potential loss); and
- whether the breach indicates that the entity's compliance systems are inadequate to meet their obligations.

Under the prudential Acts, there are several reporting timeframes. It is proposed that all material breaches be reported to APRA as soon as possible and otherwise within 10 business days after the person responsible for the compliance becomes aware of the breach (this may be before the materiality of the breach has even been established). Where it appears that an entity in breach is not able or is likely to be unable to meet its obligations to depositors, policyholders or beneficiaries, APRA must be notified immediately.

If a breach relates to a prudential Act or Standard and an ASIC regulated Act, the breach need only be reported to APRA (who will pass on the information to ASIC).

At present there is an overlap in reporting obligations between responsible persons and officers, actuaries and auditors. It has been proposed that where the actuary or auditor notifies APRA and the supervised entity of a breach, the entity (ADI, general or life insurer or superannuation trustee) will not be required to notify APRA. Life insurers who are presently not required to report material breaches to APRA will be obliged to do so.

## Whistle-blowing proposals

The proposals also considered the lack of consistency in the prudential Acts with respect to whistle-blowing provisions for example; voluntary whistle blowing is not always protected under the Acts or only granted protection on request. Therefore, to encourage good practice amongst regulated entities it is proposed that the

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☐ PRIVATE HEALTH INSURANCE

# Proposed private health insurance legislation

Currently health insurance is regulated by two main pieces of legislation – the *National Health Act 1954* (NHA) and the *Health Insurance Act 1973* (HIA). Various key provisions regarding the requirement for registration, definition of carrying on health insurance business, administration and certain prohibitions are contained in these two pieces of legislation.

However, the Private Health Insurance Bill 2006, introduced into Federal Parliament on 7 December 2006, and Rules 2007 (PHI legislation) are proposed to consolidate provisions concerning the activities of private health insurers into one primary legislative source. The PHI Bill, if passed, is intended to commence on 1 April 2007. Nevertheless, to the extent that some provisions in the NHA and HIA will remain in force, these two pieces of legislation will also continue to be a part of the health insurance legislative framework.

The PHI legislation essentially intends to simplify the regulation of the private health insurance industry and provide greater clarity as to health insurers' obligations. The proposed legislation will give effect to the current health insurance laws and are not intended to substantially alter the current regulation under the main provisions of the NHA and the relevant provisions in the HIA.

## General insurance aspects

One key difference is the rewording of the definition for the type of medical treatment caught by the definition of health insurance business. Under the NHA, it consists of "hospital treatment" and "ancillary health benefit". Under the PHI legislation, it is proposed that "hospital treatment" and "general treatment" are the main parts of the definition. Nevertheless, overall, the kind of medical treatment that only health insurers can cover appears to remain similar in effect to that allowed under the current legislation.

The PHI legislation does not significantly alter the position of general insurers currently under the NHA and HIA. Under the NHA and the National Health Regulations 1954 (NHR) only registered health insurers can provide cover in relation to medical services that fall within the ambit of "health insurance business". General insurers may only provide insurance for medical services that are not caught by the health insurance business definition or to certain persons who are specifically excluded. However this is limited to the extent that the kind of medical service covered does not breach the HIA section 126 prohibition against undertaking liability in relation to a medical service for which a Medicare benefit is available. The PHI Rules specifically state that health insurers are intended to be excluded from this prohibition where they provide a complying health insurance policy or cover people who are covered by reciprocal health agreements. The position of general insurers remains unchanged. Therefore the section 126 prohibition still applies to general insurers.

## Duties and liabilities of directors

Lastly, the PHI legislation adopts prudential regulatory standards similar to those found in relation to other prudentially supervised entities. For example, provisions in the PHI Bill regarding duties and liabilities of directors to health benefits funds reflect current obligations imposed in relation to life insurers.

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☐ SUPERANNUATION

# Self Managed Superannuation Fund Package

We have recently completed the most comprehensive reviewing and updating exercise of the Self Managed Superannuation Fund Package since it was first released in 1995 and are now proud to announce its relaunch.

A primary motivation for this exercise has been to accommodate the superannuation simplification proposals announced in last year's Federal Budget, although the opportunity has been taken to generally improve and simplify the package.
The full package (an abbreviated package is available for existing funds) provides the following:

- the deed;
- advice notes relating to the deed;
- the draft declaration and consent to act for each proposed trustee director or individual trustee;
- the draft application for membership form for each proposed member;
- an example of draft minutes relating to the establishment and initial operation of the fund;
- an example of a binding death benefit nomination form;
- an example product disclosure statement for new members;
- an example draft letter from the trustee to an employer confirming the complying status of the fund for superannuation guarantee purposes; and
- an example draft letter from the trustee to the trustee of another fund to enable a benefit rollover to be received.

Whilst the package has been updated to accommodate the superannuation simplification proposals, it should be noted that some aspects of those proposals have not yet been finalised and therefore further updates may become necessary.

The following questions and answers may assist you in deciding whether now is the right time to proceed with the new package:

- **should I establish a Self Managed Superannuation Fund now or should I defer?** While there can be no guarantee, you should be reasonably confident that if you go ahead now, the documents will not need any further work to accommodate the superannuation simplification proposals. Therefore, it is unlikely that it is worth putting off establishing a new fund if commercial considerations warrant it being established now; and
- **should I update my existing fund's deed?** There are no hard and fast rules. The answer depends on what is in your current deed, including how old it is, and what you are proposing to do (for example, commence a new style pension after 1 July 2007). Updating may be worthwhile, particularly if you have an old deed, but it might also be worth waiting a short time until all aspects of the superannuation simplification proposals have been finalised.

For further information about this package, please contact:

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☐ SUPERANNUATION

# Late superannuation applications

It is interesting to consider and compare the current and previous regulatory requirements applicable where a superannuation trustee receives an application taken from an out of date disclosure document. For present purposes, the assumption is that a prospective member makes an application on his or her own behalf to become a member of a public offer superannuation fund.

## The Superannuation Industry (Supervision) Act

Previously, the section 153 Determination (Determination), issued under the Superannuation Industry (Supervision) Act (SIS) by the Australian Prudential Regulation Authority (APRA), expressly contemplated a trustee accepting an application after the expiry of the Key Features Statement (KFS).

Under clause 39 of the Determination, a KFS generally expired one year after its issue date. However, clause 148 of the Determination allowed a trustee to issue a superannuation interest as long as the application was received within 21 days of the expiry of the old KFS. In those circumstances, the trustee was simply required to give the applicant a new KFS.

APRA stated that this process was permitted because if there had been a material change in, for example, fees or investment strategies, the member could take advantage of the cooling off period to withdraw from the fund. APRA also stated that clause 148 was intended to avoid difficulties that may be experienced by trustees each time a KFS was replaced, enabling a trustee to issue a new superannuation interest immediately rather than either returning the application and contribution to the member or placing the contribution in an application monies account pending receipt of a new application.

Clearly, APRA's approach under the Determination for late applications provided a level of certainty and simplicity for trustees, although it may have been preferable in addition for trustees to have been required to provide some explanation of the changes from the old KFS to the new KFS and to remind the applicant of the availability of the cooling off period.

## The Corporations Act

In contrast to the KFS regime, there is no specific expiry date for a Product Disclosure Statement (PDS) under the Corporations Act. A trustee must not, however, admit a person to membership of a fund unless the person has completed an eligible application and in turn that requires the relevant PDS not to have been defective at the time the application was made. For this purpose, "defective" includes the PDS containing misleading or deceptive statements or omitting certain required material (being statements or omissions) that would be materially adverse from the point of view of a reasonable person considering whether to acquire the superannuation interest.

It is worth noting that the issue of a new PDS is not necessarily conclusive either way as to whether an old PDS is defective. Rather, it is quite possible that the old PDS will be defective before the issue of the new PDS, or will not be defective after the issue of the new PDS, depending on the circumstances. This leaves open the possibility that an application, received after the issue of a new PDS, may be accepted by the trustee as long as the old PDS was not defective.

Effectively, this means there could be two PDSs in circulation at a given time, with neither being defective. Still, it will often be the case that the old PDS will be defective following the issue of the new PDS and that is assumed to be the outcome for present purposes.

In contrast to the "black and white" position under the KFS regime, the Corporations Act places the onus on trustees to make qualitative judgements on what to do where an application is made after the issue date of the new PDS, depending on whether or not the old PDS was defective when the application was made.

## Section 1016E approach

A trustee may be able to accept an application, despite the old PDS having been defective when an application was

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made, under section 1016E of the Corporations Act.

In addition to permitting a trustee to simply repay application money to the applicant, section 1016E allows the trustee to:

- give the applicant a new PDS and an additional statement that identifies the respects in which the new PDS is materially different from the old PDS, and one month to withdraw the application and be repaid; or
- issue the superannuation interest to the applicant and give the applicant a new PDS and an additional statement that identifies the respects in which the new PDS is materially different from the old PDS, and one month to withdraw from the fund and be repaid.

In the first scenario, the trustee can issue the superannuation interest if the applicant makes a decision to proceed with the application or if the period of one month elapses without the applicant withdrawing the application. This seems a reasonable outcome, although it does not result in the immediate issue of the superannuation interest (something that APRA had seen as desirable under the KFS regime).

In the second scenario, there is no scope to adjust the refunded amount, meaning that the trustee bears the investment risk during a period of up to one month. The explanatory memorandum to the amendments that introduced section 1016E made clear that this was the intended outcome, on the basis that the applicant may have received something different from what was described in the PDS.

Therefore, it seems unlikely that trustees will favour this approach in view of the investment risk being with them, in contrast to the first scenario under section 1016E where the application money is simply held in the trustee's application money account (and APRA's previous approach for the KFS regime where investment risk was carried by the applicant if cooling off rights were exercised).

For completeness, it is worth noting that regulation 7.9.13A purports to modify section 1016E by inserting paragraphs (2)(aa) and (2)(ab). However, as regulation 7.9.13A commenced on 11 March 2003 and section 1016E was subsequently amended relevantly (by the inclusion of paragraphs (2)(aa) and (2)(ba)) with effect on 18 December 2003, presumably the changes made by regulation 7.19.13A are redundant and should be removed.

## Alternative approach

Rather than relying on section 1016E, a trustee could notify the applicant that the application is from an out of date PDS. In so doing, the trustee could send the new PDS to the applicant along with a request that he or she complete the application form which accompanies the new PDS. The trustee could also provide a brief explanation of the differences between the old PDS and the new PDS.

Effectively, if the applicant completes and submits the new application form, the old application form is treated as having been withdrawn. Arguably, in this situation, section 1016E does not apply because the original application is not actually made (if the applicant does not submit a new application form, the trustee would need to repay the application money under section 1016E).

If this approach is followed, a concern for trustees may be that it is only if there is a positive act by the applicant (completion and return of the new application form within a period of, say, one month set by the trustee) that the interest will be issued. The first approach under section 1016E may be preferred on the basis that the trustee can issue an interest if no response is forthcoming from the applicant within the specified period of one month.

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☐ INCOME PROTECTION

# Defining the term "usual occupation"

The term "usual occupation" in an income protection policy comes into question when the claimant returns to the company but not in his former capacity as the managing director.

- Case note: *Kon v AMP Life Ltd* [2006] NSWSC 1304.

## The facts

The claimant, under his income continuation insurance policy, was paid monthly benefits due to a depressive mental illness, which caused him to resign from the position of managing director of a small business.

Under the supervision of his doctor, the claimant continued to perform clerical duties for the business. The claimant received a monthly amount loaned to him by the business in addition to superannuation contributions continuing.

The insurer stopped paying monthly benefits in August 2002 stating that the claimant was no longer considered to be "totally disabled" from performing his "usual occupation" under the policy.

The claimant then sought payment of monthly benefits for the period from 7 August 2002.

## Analysis

The court considered the following two main issues:

- at what point in time, is the relevant party's "usual occupation" to be identified; and
- how to characterise the relevant party's "usual occupation" (including performance of any remunerative work).

Citing both New Zealand and English cases, Barrett J held that the relevant time at which to pinpoint the claimant's "usual occupation" is at the time the illness or injury began, rather than at the time of entering into the contract.

The claimant, at the time his mental illness began, was a managing director who was recognised for his strong client relationship building, organisational and leadership skills. Due to his illness, the claimant could no longer manage these duties and agreed to continue in a clerical capacity. Therefore, the claimant could no longer perform his "usual occupation" due to his mental illness, i.e. he could no longer deal with clients, acquire new business or handle leadership responsibilities.

The court also stated that another factor in determining whether the claimant had returned to his "usual occupation" was to consider if he had undertaken any remunerative work since the onset of his illness. Though the claimant received financial benefits in the form of loans and superannuation contributions, it was held that these were not in payment for the services he performed after his illness began. The board of the company stated that they would have provided these benefits even if the claimant had not returned to work due to his illness.

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☐ LIFE INSURANCE

# Definitions mean what they say

**Only a "heart attack" that met the requirements of the policy definition will provide payment of the benefit.**

- Case note: *Larwint Pty Ltd v Norwich Union Life Australia Ltd* [2007] VSCA 21.

## The facts

Larwint Pty Ltd owned a policy which provided a "critical illness benefit" if the life insured suffered a heart attack as defined. The definition of heart attack was stated as follows:

> *Heart attack means death of a portion of heart muscle as a result of inadequate blood supply to a relevant area. The basis for diagnosis shall include:*
> *(i) electrocardiographic changes associated with the Myocardial infarction, and*
> *(ii) elevation of cardiac enzymes consistent with the Myocardial infarction.*

If in the policyowners' opinion the above tests are inconclusive we will, at our own discretion, consider other appropriate tests.

The life insured suffered death of a portion of heart muscle due to inadequate blood supply but an electrocardiogram failed to show any associated electrocardiographic changes.

As there were no electrocardiographic changes, the insurer refused to pay the benefit. Larwint commenced proceedings in the Supreme Court against the insurer.

## Supreme Court decision

Larwint argued that it was not essential for the life insured to satisfy both (i) and (ii) for it to be eligible to receive a critical illness benefit. Further it argued that if it was necessary to establish both limbs to be eligible for the benefit, the policy could have an extraordinary meaning which would exclude the payment of a benefit for a heart attack properly diagnosed but otherwise not in accordance with (i) and (ii).

It was also argued that the policy should be interpreted against the insurer contra proferentem as it was ambiguous and that an interpretation requiring the insured to satisfy both (i) and (ii) was not in accordance with the purpose of the policy – that is to provide benefits in the event of a heart attack.

The insurer argued that it was not necessary for the court to consider whether the life insured had suffered a heart attack but whether he had suffered a heart attack in the terms as defined in the policy. It was argued by the insurer that the list of test results contained in the definition of a heart attack was not exhaustive, in that other test results could be used but it was mandatory for any benefit payment for both limbs to be satisfied.

The court found that for an insured event, in this case a heart attack, to occur it required both (i) and (ii). The court found no ambiguity. It was held that the words were clear and should be given their ordinary meaning.

## Court of Appeal

The insurer was again successful on appeal. The Court of Appeal discussed the correct approach to take when interpreting contracts of insurance. The Court of Appeal noted that a court's duty when considering the construction of an insurance policy is to judge from the "language, structure and apparent purpose" what the policy means. This normally involves giving the words used in the policy their ordinary meaning.

Larwint argued that rather than giving the words of the policy their ordinary meaning, the court should have regard to other considerations including the commercial and social purposes of the insurance policy. It was also suggested that a court should not permit an unjust result. The unjust result would be denying benefits for a "heart attack" that was not a heart attack as defined in the policy. It was also argued that the policy was ambiguous.

The Court of Appeal rejected these arguments. It held that the policy was unambiguous and that the denial of a benefit was not an unjust result. The Court of Appeal noted when construing policies every part of a clause in a policy must be given "work to do". It is not appropriate to ignore particular parts of a clause.

## Implications

The decision supports the view that when construing insurance policies courts will look to ensure that every clause in the policy must be considered when determining what the policy means. This decision also lends further support for the proposition that words in policies will be given their natural and ordinary meaning when the policies are being interpreted. Further, courts should generally only interpret policies contra proferentem the insurer if the policies are ambiguous.

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☐ SUPERANNUATION

# Good faith and medical reports

When obtaining medical opinion on whether someone is disabled, an insurer should provide the doctor with the policy definition of disability.

- Case note: *Dumitrov v SC Johnson & Son Superannuation Pty Ltd & anor* [2006] NSWSC 1372.

## The facts

Atilla Dumitrov (the plaintiff) worked as a process worker and line setter. He was a member of the SC Johnson Superannuation Fund which was insured with Hannover Life Re of Australasia Ltd (the insurer).

The plaintiff migrated to Australia from Romania where he had been in the Army and worked as a motor mechanic. He commenced work at SC Johnson & Son Pty Ltd (the employer). His work at the time involved the repetitive lifting of 25 kilogram bags of chemicals and at times supervision of other workers on the line.

In 1996 he was injured at work and was diagnosed as suffering De Quervains Tendo Vaginitis in his right wrist. After surgery he returned to work on light duties. Shortly thereafter he developed similar symptoms in his left hand which led to him ceasing work in March 1997. His employment was terminated in November 1997.

He was unsuccessful at obtaining other employment and in TAFE studies. A claim was made on his behalf by the trustee in 2001. This claim was rejected and the plaintiff did not seek to challenge this rejection in the legal proceedings.
A further medical was provided on the plaintiff's behalf in May 2002. The insurer again denied the plaintiff a benefit. This denial was made after the insurer had instructed a Senior Claims Consultant to review that material on file. This review involved the consultant looking at the file and reviewing the medical reports and other material before writing a report. The consultant was not instructed to investigate the claim. The consultant did not inform the plaintiff of the details of his review of the file nor did the consultant inform the plaintiff of what was necessary for him to show that he satisfied the policy definition.

The plaintiff commenced proceedings against the insurer alleging that in its consideration of the second claim the insurer acted unreasonably, failed to act in good faith and failed to act fairly to the plaintiff. He did not commence proceedings against the trustee as it was deregistered.

The plaintiff also alleged that the relevant definition of total and permanent disability (TPD) was an unusual one which required him to be notified of it for the insurer to be able to rely upon it.

## The decision

It was necessary as part of the court's decision to determine whether the definition of TPD was an unusual term and then once that was determined whether the plaintiff fell within the definition to be eligible for policy benefits. TPD was defined in the Hannover Policy as:

Total and Permanent Disablement means:

- suffering the loss of two limbs or the sight of both eyes or the loss of one limb and the sight of one eye (where limb means the whole hand or the whole foot); or
- having been absent from work through injury or illness for an initial period of six (6) consecutive months and in any opinion being incapacitated to such an extent as to render the Insured Person unable ever to engage in or work for reward in any occupation or work which he or she is reasonably capable of performing by reason of education, training or experience.

The court rejected the plaintiff's claim that the insurer should not be able to rely on the definition of TPD as it was unusual. The court noted that other authorities indicated that a definition such as the above containing a requirement of "unable" to return to employment

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provides a harsher test for a plaintiff to meet than a definition that contained the word "unlikely" however this was not sufficient for the plaintiff to be able to claim it was unusual.

The court then considered the legal obligations the insurer owed to the plaintiff. It was held that when considering the plaintiff's claim, the insurer had to have due regard to the plaintiff's interest when forming its opinion. The insurer owed an obligation to act in good faith and to act fairly. In addition, the insurer was under a legal obligation to consider the correct question when forming it's opinion as to the plaintiff's eligibility for policy benefits. The obligation to act in good faith and to act fairly was owed in all stages of the gathering of the material relevant to the claim and at all stages after the claim is made.

From a review of the conduct of the claims consultant it was concluded by the court that the claims consultant and thus the insurer did not fairly assess whether the plaintiff satisfied the policy definition. The court concluded that by just reviewing what was on the file was not enough. It was necessary to consider fairly whether the plaintiff actually satisfied the policy definition.

In addition to the above the court found that the insurer had breached it's legal obligations by not informing the plaintiff what was needed to be shown by the plaintiff for him to meet the policy definition. The insurer was also found to be in breach as it failed to permit the plaintiff the opportunity to respond to the claims consultant's report.

As part of the claims process, the insurer sought opinions from a number of medical specialists, each of whom was not provided with the policy definition. The plaintiff claimed that the failure to instruct the specialists with the correct policy definition should lead the court to conclude that the insurer acted unreasonably as it was not considering the correct question. The failure by the insurer to ask doctors who had provided reports whether the plaintiff fell within the definition contained in the policy was deemed to be a failure to act reasonably.

The court found further that the insurer should have conducted further investigations. The court as a result of determining the insurer acted unreasonably then moved to the next step and considered whether the plaintiff satisfied the policy definition. The court concluded, based on the medical evidence that the plaintiff was totally and permanently disabled and thus made a declaration to that effect.

## Implications

This decision again demonstrates that if an insurer relies on medical reports where doctors have not addressed the applicable policy definition a court is likely to find that the insurer has acted unreasonably and the court will then substitute its decision in place of the insurer's decision.

This case also highlights that if insurers are presented with reports from medical specialists that indicate that a claimant has disability, an insurer could be deemed to act unreasonably by not asking the specialists if a claimant satisfies the correct policy definition.

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## NEWS IN BRIEF

### New APRA outsourcing standards

- The implementation date of APRA's new prudential standards on outsourcing has been moved from 1 January 2007 to 1 April 2007.
- APRA released its new "outsourcing package" in October 2006, which includes three sets of prudential standards for authorised deposit-taking institutions, general insurers and life companies, an overall prudential practice guide, and a prudential practice guide in relation to custody arrangements for general insurers. The new framework deals with risk management issues in the outsourcing of material business activities, including matters to consider when entering into outsourcing agreements, offshoring and management of outsourcing relationships. The standards and guides can be accessed on the APRA website (www.apra.gov.au).
- Source: APRA (www.apra.gov.au), APRA Media Release 06.48, APRA Prudential Practice Guide.

### Federal Government reviews of corporate sanctions and infringement notice

- On 5 March 2006 the Treasurer publicly released its Review of Sanctions in Corporate Law. The Review was issued in response to a recommendation made by the Taskforce on Reducing the Regulatory Burden on Business and seeks to establish the extent to which sanctions under corporate law may be unduly influencing business decisions. The Treasurer stated that the Government had not formed a view and was seeking comment.
- The Review outlines two possible types of reform. The first is an examination of the types of penalties available and when they should be used. The second is to refine the penalty provisions themselves to make the circumstances that attract a sanction clearer.
- The available types of sanctions include criminal, civil and administrative. The Review seeks comment on when criminal sanctions should apply. It also raises issues in relation to strict liability offences. It asks whether greater use should be made of civil sanctions for breaches of corporate law and for comment on whether the amount of civil pecuniary penalties is sufficient. It also asks whether there is scope for administrative sanctions to apply to breaches of low level record keeping and reporting provisions.
- The second part of the Review raises the question of whether a general defence would improve the balance between discouraging undesirable conduct and promoting responsible risk taking. It invites comments on the elements of any such general defence and whether it should apply to all duties of a director or only some. It also raises the potential for confusion where there is inconsistency, or potential inconsistency, between the requirements of the Corporations

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Acts be amended to include protection from self-incrimination and civil action (for example defamation actions, breach of employment contracts and confidentiality agreements) for mandated or voluntary whistle blowing (based on section 29JE of the *Superannuation Industry (Supervision) Act 1993*). In addition, it will be an offence to threaten or harm a person because they disclosed information that would be protected under the Prudential Acts (based on section 1317AC of the Corporations Act).

### APRA's discretionary powers

It is proposed that to improve APRA's ability to tailor prudential regulation to supervised entities, APRA should have the power to make discretionary decisions in relation to approving, imposing, adjusting or excluding certain prudential requirements.

### APRA appointment of actuaries and auditors

Presently APRA can, under the Prudential Acts, grant, vary or revoke appointments of actuaries and auditors of a regulated entity. However, in light of feedback that such a power is contrary to general prudential principles that primary responsibility for the good management of regulated entities lies with their Board of Directors, it is proposed that APRA's power be revoked. Rather APRA should have the power to direct the Board of an entity to remove an auditor, actuary, senior manager or director who does not meet the fitness and propriety prudential requirements.

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## NEWS IN BRIEF (CONTINUED)

Act and the requirements under the Criminal Code.

- The paper poses a large number of consultation issues, and invites written submission from the public. The closing date for submissions is 1 June 2007. An advisory board will be established and it is expected that a proposals paper will be given to the Treasurer in November 2007.
- At the same time the Treasurer announced the release of a separate paper, Review of the Operation of the Infringement Notice Provisions of the *Corporations Act 2001*. This review seeks comments on the use and effectiveness of infringement notices issued by ASIC for breaches of the continuous disclosure provisions. The paper seeks comment on experience of the infringement notice process, whether the availability of infringement notices has resulted in greater compliance with the continuous disclosure provisions and whether the provisions should be amended to improve the usefulness, or the fairness, of the infringement notice mechanism.
- Again, the closing date for submissions is 1 June 2007.
- For further details of both Reviews, please see the Treasurer's media release No. 008, 05/03/07, and the paper at: www.treasurer.gov.au.

### ASIC amends policy statement on time sharing schemes

- ASIC has revised its policy statement 160 on time sharing schemes. The key amendments are:
  - to allow certain time sharing operators with ASIC relief to have internal dispute resolution arrangements that meet section 912 of the Corporate Act rather than external dispute resolution arrangement;
  - ensuring the cooling off period for purchases is 14 days for everyone;
  - granting licensing relief for certain time sharing schemes for the resale of time sharing interests;
  - removing the concept of an industry supervisory body; and
  - the updated policy can be downloaded at: www.asic.gov.au/ps.

### Benchmarking regulatory burdens on business

- On 6 March 2007, the Australian Government Productivity Commission issued its research report "Performance Benchmarking of Australian Business Regulation", together with a summary of the key points. The commission suggests a limited and targeted program over three years, that would allow "learning by doing". Financial services regulation is one of the suggested priorities for the first three year program, along with business registration, land development assessments, occupational health and safety, environmental approvals, stamp duty, payroll taxes and food safety.
- A full copy of the report can be found at: www.pc.gov.au/study/regulationsbenchmarkgin/finalreport.

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