Slater Gordon Lawyers

# Consultation Draft – Life Insurance Code of Practice 2.0

**Submissions to the Financial Services Counsel**

**11 January 2019**

# Contents

## About Us

Slater and Gordon Limited is a leading consumer law firm in Australia. We employ over 800 people in 40 locations across Australia. Slater and Gordon's mission is to give people easier access to world class legal services.

As Australia's leading trade union and labour movement law firm, we also have a proud history of partnering with trade unions to defend workers' rights. The firm provides specialist legal and complementary services in a broad range of areas.

Our Superannuation and Disability Insurance practice has been dedicated to assisting claimants for more than 20 years. The area of disability insurance, whether through a group life policy within a superannuation scheme or retail policy, can be challenging and daunting for people suffering from an injury or illness.

The struggle to cope with the difficulties and frustrations that an illness or injury can bring to them and their families' drives us to support and guide them through this complex area both legally and through our dedicated in house social work services.

## Introduction

Slater and Gordon welcome the opportunity to provide feedback on the FSC's Consultation Draft Life Insurance Code of Practice 2.0 ("FSC Code").

We consider the proposed changes to the FSC Code to be a positive step in the right direction for FSC members to deliver enhanced outcomes to consumers, through improvement of the key promises and objectives of FSC members. This in turn will help to rebuild consumer confidence in the industry and facilitate a greater understanding of and appreciation for the insurance products essential to the protection of workers and their families, in the event of disability or death.

Our submission seeks to address the outstanding issues with the FSC Code as currently drafted. We would welcome the opportunity to provide further clarification or submissions on any of the matters raised within our submissions, if it would be of assistance to the FSC in finalising the amendments to the FSC Code.

In opening, Slater and Gordon strongly advocates for a Code of Practice that requires, as a registration[1] and licensing condition, mandatory participation by all insurers, approval by ASIC[2], and has binding and enforceable consequences for breach, as recommended by the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the Life Insurance Industry ("PJC") report.[3]

It is clear from the voluminous evidence and submissions provided to the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry and to other recent regulatory inquiries[4] that the FSC Code in its current self-regulatory form is insufficient to properly protect consumers.

As at September 2018, the number of self-reported breaches by life insurers since the FSC Code took effect was 23. This is not a reflection of strict adherence by life insurers to the FSC Code but instead supports the conclusion that self-regulation is entirely inadequate. This is particularly so given, during the same period, 747 alleged breaches were referred to the Life Code Compliance Committee ("LCCC"). [5]

We support the Productivity Commission's Draft Recommendation 18, that an Insurance Code Taskforce be established to address and advance the benefits of the Code to insured consumer outcomes,[6] and the recommendations of the ASIC Enforcement Review Taskforce Report of a co-regulatory model to enable consumers to pursue reparation through internal and external dispute resolution processes for non-compliance.[7]

We note the remarks of Mr Peter Kell, Deputy Chairman of ASIC that:

> *The industry has also indicated to us that their intention is to submit the code for our approval. That doesn't necessarily mean that ASIC would enforce all the provisions, but we would only approve it if we were confident that the enforceability was robust.*[8]

Slater and Gordon hope this is in fact the intention of the industry, and that FSC members are taking active steps to bring it to fruition.

---

1 Life Insurance Act 1995 (Cth) s.21.

2 Including through compliance with 'ASIC's 'RG 183 *Approval of financial services sector codes of conduct'.*

3 Parliamentary Joint Committee on Corporations and Financial Services - Report on the Life Insurance Industry (March 2018) "PJC Report on the Life Insurance Industry".

4 PJC Report on the Life Insurance Industry; Productivity Commission Inquiry - Superannuation: Assessing Efficiency and Competitiveness – Draft Report (April 2018); Treasury Proposal Paper on Extending Unfair Contract Terms Protections to Insurance Contracts (June 2018).

5 Life Code Compliance Committee Annual Report FY17 (18 September 2018) page 3.

6 Productivity Commission Inquiry - Superannuation: Assessing Efficiency and Competitiveness – Draft Report (April 2018) page 63.

7 ASIC Enforcement Review Taskforce, Position and Consultation Paper 4 Industry Codes on the Financial Sector, 28 June 2017 pages xi, xv and Chapter 4.

8 Mr Peter Kell, Deputy Chairman, Australian Securities and Investments Commission, Committee Hansard, 8 September 2017, p. 55, in the PJC Report on the Life Insurance Industry page 57.

# Chapter 1 – Obligations your life insurance company has to you

## Clause 2.18

1. It is unclear what the FSC intends to achieve by virtue of clause 2.18 or how it fits with clause 1 objectives.

2. Would it be the case that had the consumer made a complaint to the LCCC, which had not resolved the breach, and subsequently issued legal proceedings in a Court, the LCCC would cease to investigate the alleged breach? What about when the breach alleged by the consumer is separate to the basis for commencement of legal proceedings? We do not support the conclusion that chapter 1 will not apply if a consumer commences proceedings, as any reported breaches prior to this occurring should be investigated to ensure the objectives outlined at clause 1.6 are realised.

3. The term "proceedings" is not defined within the FSC Code, it is likely to lead to consumer confusion.

## Clause 3: Policy design and disclosure

4. There can be no doubt that the affordable life insurance structure offered to working Australians through their superannuation fund in the form of group life insurance has resulted in the majority of Australians having some form of life insurance cover for disability or death.[9] However, also by virtue of such arrangements, consumers have little, if any input or understanding of the different forms and levels of cover available or the definitions to be satisfied to be entitled to claim.

5. Life insurers have increasingly sought to constrict definitions, with some definitions tightening to the extent that they are all but worthless to the beneficiary of the policy, becoming nothing more than junk insurance.

6. In our experience, through assisting injured and ill workers, many claimants do not understand the coverage afforded by their policy,[10] with some being underinsured or unable to claim at all by virtue of the clauses within the policy. This is despite having paid premiums, in some instances for many years, notwithstanding the consumer having no genuine prospect of being able to claim on their policy.

---

[9] Financial Services Council Submission 26 to the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (November 2016), page 20 (referencing Rice Warner Underinsurance in Australia – published in August 2016).

[10] Productivity Commission Inquiry - Superannuation: Assessing Efficiency and Competitiveness Inquiry Report (21 December 2018) page 259.

7. The FSC Code remains silent on providing protection to consumers with old or out-dated polices of insurance, particularly those with policies that they have been paying premiums on for many years, without regular review or redesign where necessary to ensure their suitability.

8. A recent example of this was trauma policies, which the CommInsure scandal revealed the significance of out-dated medical definitions in such policies. This was the experience of Mr Kurthi, whose claim was denied as his medically diagnosed heart attack did not align with his insurance policies restrictive definition.[11]

9. While thankfully, clause 3.2 obliges FSC members to review and update medical definitions at least every three years, it continues to remain silent on the standardisation of definitions across all types of policies, as recommended by the PJC.[12]

10. The 'standard' TPD definition test of 'unlikely ever' is predominantly aligned with the Permanent Incapacity test set by the *Superannuation Industry (Supervision) Act 1993* (Cth) ("SIS Act") and, specifically, regulation 1.03c of the *Superannuation Industry (Supervision) Regulations 1994* (Cth) ("SIS Regulations").

11. The continued evolution of the TPD capacity test burden on claimants is far more strenuous than the standard TPD 'unlikely ever' threshold in the SIS Regulations. The meaning of these terms has been subject to much judicial interpretation, with the Courts consistently concluding that the 'unable ever' test sets a far higher burden on the claimant.[13]

12. An example of policies that provide limited prospect of payment of a benefit for illness or injury include *'Hazardous' and 'Special Risk'* exclusions. A number of employer sponsored superannuation group life policies offer default TPD and life insurance, but widely exclude a number of occupations on the basis that they are 'hazardous' or 'special risk'. We have seen instances where the employer sponsored group life plan excludes a large number of the employees under such plans by virtue of these exclusions.

---

11 https://www.canberratimes.com.au/national/act/canberra-mornings-march-11-2016-20160310-gnfrbz.html

12 Recommendation 10.60 of the PJC Report on the Life Insurance Industry page 167.

13 *Ivkovic v Australian Casualty & Life Ltd* (1994)10 SR (WA) 325, 270; *Davis v Rio Tinto Staff Superannuation Fund Pty Ltd* [2002] FCA 376, 118; *Constantinides v Du Pont Superannuation Fund Pty Ltd* (2002); In Dumitrov v SC Johnson & Son Superannuation Pty Ltd [2006] NSWSC 1372, Gzell J held it was a "harsher test"; In *Manglicmot v Commonwealth Bank Officers Superannuation Corp Pty Ltd* [2011] 282 ALR 167 at 88, it was regarded as "quite emphatic"; *TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68, at 64 – unlikely ever is a lower test than unable ever and at 89 – A person is unlikely ever to engage in employment if there is 'no real chance' that they will ever return to relevant work. A 'remote' or 'speculative' chance will take them outside the definition.

13. This changes the test to be satisfied by the claimant from the standard 'unlikely ever' test to an Activities of Daily Living ("ADL's") definition, which requires the person to be certified by a medical practitioner as being permanently unable to perform at least two ADL's such as bathing, dressing, eating, toileting or transferring.

14. The result is that the majority of injured workers who, under a standard TPD definition, would be entitled and successful in obtaining a TPD benefit, are unable to claim with little or no awareness that the cover they are signed up to is of no benefit to them by virtue of the occupation exclusion therein. The list of occupations is generally not enclosed with any documents provided, and some insurers assert privilege over requests for release of the documents relating to the underwriting.

15. Looking at the TPD insurance definitions of some of Australia's largest industry funds by membership:

    (a) Sun Super[14] has not only changed its capacity test from 'unlikely' to 'unable', but has also introduced the payment of the benefit over a stagnated 5 year period, whereby the claimant needs to annually re-establish permanency. This requirement is completely inconsistent with the requirements of the TPD definition to satisfy initially being the 'unable ever' test.

    (b) AustralianSuper[15] has a policy definition of TPD which requires a member to satisfy an 'incapable ever' test. The definition also allows the insurer to consider any 'retraining, reskilling, or voluntary work' undertaken or that could reasonably be undertaken within a reasonable period following the time the insurer forms its opinion.

    (c) CBUS has the same insurer as AustralianSuper for its group life cover, yet has continued to offer TPD cover based upon the 'unlikely ever' test. But, the definition does allow the insurer to take into account the member's education, training or experience "*up to the time of assessment of the claim".*

    (d) MTAA Super requires its members to be 'unable' to work in any occupation or work for which they are, or may become, reasonably suited by education, training or experience, considering any future retraining or rehabilitation that the member could reasonably undertake or has undertaken.

[14] The sixth largest super fund by membership (as at 16 February 2018)- See https://www.canstar.com.au/superannuation/largest-super-funds/ (accessed 16 October 2018).

[15] The second largest super fund by membership (as at 16 February 2018) - See https://www.canstar.com.au/superannuation/largest-super-funds/ (accessed 16 October 2018).

If a member is successful at procuring their TPD benefit, they will only receive 80% of their insured benefit amount, (despite paying premiums on 100%), unless they are also unable to perform three everyday working activities (such as walking / bending, reading, lifting, manual dexterity or communication) permanently and irreversibly.

16. Yet, other industry super funds, including REST[16] and HostPlus[17] have maintained the 'unlikely ever' standard TPD definition in their group life policies for members, indorsing the value of the standard TPD product to their insured members, and consistency with the SIS Regulations.

17. A final example of an abhorrent policy is a CommInsure stand-alone Accident Policy with a TPD definition that goes one step further and requires the insured to have become permanently incapacitated so as to render it '*impossible'* for the life insured to ever resume or commence *any* work for gain or reward. This policy also sets the lowest of standard for an employment test, and far below 'reasonably qualified by education, training and experience' test in the SIS Regulation. The disabled claimant, who took out this accident policy because he drove trucks and thought it was what he needed if he should be in an accident, had no idea of the severity of the definition he was insured for, nor that he would never theoretically be able to satisfy the definition.

18. Such definition changes in policies are a significant shift away from the test prescribed by the SIS Regulation above, the requirement of Regulation 4.07D and out of line with consumer understanding and expectations of such cover. Slater and Gordon support recommendations in relation to the standardisation of insurance definitions for transparency and consumer protection. In particular, we advocate for TPD definitions to be consistent with the definition of 'permanent incapacity' as prescribed by Regulation 1.03C of the SIS Regulations. This would address concerns raised about complex and problematic policy terms and conditions.[18]

19. In circumstances where the cover afforded is limited or not applicable, the insurance premiums are generally reimbursed. However, the critical issue remains that the disabled member is uninsured, and unable to now procure a different life insurance policy by virtue of their disability. This leaves disabled members and their families' dependent upon Centrelink and the public health system for long term support.

---

16 The third largest super fund by membership (as at 16 February 2018) - See https://www.canstar.com.au/superannuation/largest-super-funds/ (accessed 16 October 2018).

17 The seventh largest super fund by members (as at 16 February 2018) - See https://www.canstar.com.au/superannuation/largest-super-funds/ (accessed 16 October 2018).

18 CHOICE submissions to the Parliamentary Joint Committee on Corporations and Financial Services report on the Life Insurance Industry (March 2018), Submission 71, page. 11.

20. Slater and Gordon are on record[19] as supporting the recommendation by the Australian Lawyers Alliance in its submission to the Productivity Commission[20] of the introduction of a tiered rating system to assist consumers to understand the implications of the varying products of insurance that fall below the standard set by Regulation 1.03C, and make an informed decision on their insurance needs. This should also form part of the Key Fact Sheet ("KFS") requirements under Chapter 2 of the FSC Code.

### Clause 3.3

21. We often see clients who are caught in a dispute between the outgoing insurer and incoming insurer with respect to liability to pay on the claim. The trustee in such circumstances generally remains passive, letting the injured member unilaterally fight the two insurers for resolution of the matter.

22. This clause in its current format does not put any accountability on either life insurer in such circumstances, and again, occurs with little consumer knowledge or understanding. At a minimum, the clause should require that the transaction will be subject to the FSC Guidance Note No.11 *Group Insurance Takeover Terms*.

### Clause 3.5A

23. Slater and Gordon do not consider this clause to be consistent with the stated purpose of the Code, being "*[t]he Code is designed to protect you, the customer" and is "the life insurance industry's commitment to mandatory customer service standards".* Accordingly, it should not be included in the proposed changes to the Code.

### Clause 3.6 - Funeral Insurance

24. Slater and Gordon consider it inappropriate to be targeting or selling insurance to or for persons under the age of 40. We do not consider that this age group should form part of any targeted market or policy promotion by insurers. Accordingly, we consider that the FSC Code should have an expressed age limit of 40, below which FSC members should be unable to promote or sell funeral insurance to or for a person under this age limit.

25. We would also suggest that stepped premium policies require the provision of an examples table to consumers which shows the likely total premiums over the coming 10, 20, 30 years to ensure that consumers are fully aware of the cost of such insurance over the coming decades. The 30 days (or more) cooling off period should not commence before this is received by the consumer.

---

[19] Slater and Gordon submissions to the Productivity Commission - Superannuation: Assessing Competitiveness and Efficiency (18 July 2018) (DR178) https://www.pc.gov.au/inquiries/completed/superannuation/assessment/submissions#post-draft.

[20] Australian Lawyers Alliance submissions to the Productivity Commission - Superannuation: Assessing Competitiveness and Efficiency (11 July 2018) page 8, paragraph 28.

### Clause 3.6B

26. Slater and Gordon support the inclusion of this clause into the FSC Code. We consider that the Code should go one step further and require FSC members to refund premiums for outdated products where such steps were not in place at the time of commencement of the policy, and thus the consumer has been over-insured for a period of time, for which they were never going to be able to claim the amount covered.

### Clause 5.3D

27. Slater and Gordon support the inclusion of this clause into the Code, in line with the PJC Recommendation 10.102. We consider this to be an important step in addressing the issues faced by consumers with prior mental health issues, in obtaining insurance.

28. We also refer to our submissions in relation to clause 5.17 below.

### Clause 5.6

29. The FSC should amend this clause to reflect the wording in clause 8.10(b) that:

    *You can ask us to give you a list of doctors that you can choose from to carry out your medical examination...*

### Clause 5.17

30. This clause has not been amended sufficiently to reflect the concerns raised by numerous consumer organisations or Recommendations 10.101 and 10.102 of the PJC.[21]

31. We continue to see discriminatory practices both at the underwriting stage by way of exclusions, and at the point of claim by way of avoidance of the policy[22], particularly for those with mental health related claims. Statistical data[23] indicates that:

    a. Almost half (of the participants) had their application for income protection insurance declined due to mental illness;

    b. 50 per cent had their had insurance, but either had a mental health exclusion applied, or paid a higher premium;

    c. 67 per cent had difficulty in obtaining life and income protection insurance.

---

[21] PJC Report on the Life Insurance Industry pages 73-74.

[22] Section 29 of the Insurance Contracts Act 1985 (Cth).

[23] Mental Health Council of Australia and beyondblue, *Mental Health, Discrimination & Insurance: A Survey of Consumer Experiences 2011,* page 17.

32. We also often see claimants with full spinal exclusions applied at underwriting stage, or avoidance at claim stage on the basis that a full spinal exclusion would have been applied, despite there being no evidence of injury to the spine, or if there is, it is at one level, with no evidence to support a full spine exclusion.

33. The exemption provided to life insurers by virtue of section 46 of the *Disability Discrimination Act* 1992 (Cth) requires an insurer to base their decision on actuarial or statistical evidence and, in cases where there is no evidence, have regard to other relevant factors. Yet, when a request is made for the data utilised by the life insurer in forming its opinion, it is either refused or very limited information is provided.

34. The FSC Code as currently drafted allows FSC member to continue this practice of denial of such information by virtue of clause 22.5. Our position on this clause is outlined below.

35. We note that the issue has been tested in the matter of *Ingram v QBE Insurance (Australia) Ltd.*[24] However; it should not be incumbent upon a disabled claimant to institute proceedings to obtain full actuarial and statistical data upon which the decision is allegedly based in their claim by virtue of civil procedure disclosure requirements.

36. We would call for the FSC Code to compel its members to produce the relevant actuarial or statistical data utilised in making either underwriting or avoidance decisions when requested, in accordance with section 46.

## Clause 5.20

37. While there is no denying that it is reasonable for an insurer to source medical information as part of its risk assessment against the potential prejudice of non-disclosure at the underwriting stage, and for fraud management at claim stage, there is a clear need for strict parameters and limits to what *is* reasonable in seeking medical information.

38. beyondblue in its submission to the PJC[25] raised concerns, highlighted by ASIC,[26] that in some mental health claims, life insurers were examining the claimant's medical history as far back as two decades. This is clearly an abuse of power and an example of a deliberate attempt to find a reason to avoid payment on the claim. A specific period of time should be established as a mandate for insurers to make reasonable medical history enquiries.

---

[24] *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 1936.

[25] beyondblue submission 18 to the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (November 2016) pages 16-17.

[26] Australian Securities and Investments Commission, Report 498: Life Insurance Claims: An industry review, (October 2016) page 4 ("Report 498").

39. The FSC Code should be amended to reflect Recommendations 8.1 through 8.7 of the PJC[27] in particular that:

- The FSC and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols for requesting and providing medical information; and
- Requests be specifically targeted to the subject matter of the claim.

40. We consider that this approach will remove the practice of life insurers in casting a wide 'medical history' net to see what they can catch to avoid a claim. It will also minimise the risk of patients not fully disclosing the extent of their condition or even avoiding medical assistance for fear of how a life insurer might use that information to assess cover or, a future claim.

### Clause 8.5A

41. We refer to and repeat our submissions in relation to clause 5.20 above.

42. We would seek to have the wording "If you ask us" removed so as to require the FSC member to explain the reasonable grounds.

### Clause 8.8A

43. We refer to and repeat our submissions in relation to clause 5.20 above.

### Clause 8.9

44. We submit that an additional subclause should be added to implement a time limit for FSC members to make payment of the income protection benefit once the claim has been admitted, for example, where offsets are applicable.

45. Too often we see delays in payment of a claim after approval, despite all information and relevant documentation being provided, on the basis that the insurer is still reviewing or 'calculating' the offsets.

### Clause 8.10(c)

46. This clause should be amended, given the limited scenarios whereby there would exist a need to have a claimant examined by the same type of specialist within a six month window. This will remove the proclivity of insurers towards the practice of 'doctor shopping'.

[27] PJC Report on the Life Insurance Industry pages 133 – 135.

47. In reasonable circumstances where a second examination is required within such a short period, we consider that it is only appropriate that the claimant be sent back to the same specialist for a supplementary opinion.

48. This is particularly important for mental illness claims where the claimant is essentially retelling the event or trauma that led to the development of their condition, which can be detrimental to their mental health and wellbeing. This is supported by the submissions of beyondblue to the PJC, which identified that some consumers who participated in the Survey of Consumer Experiences highlighted increased stress by the need to undergo examinations with 'unfamiliar medical professionals working for insurers'. [28]

49. The Courts have taken a dim view of the use of multiple independent examiners of the same specialty by insurers, for example:

    a. In the Queensland Supreme Court decision of Moore,[29] the Court considered the trauma caused to a plaintiff, associated with the defendants request for the plaintiff to be examined by a second psychiatrist and refused the request.

    b. In a Victorian County Court Workers' Compensation serious injury originating motion, Judge Bowman admonished the conduct of the insurer who sent an injured worker to three separate neurosurgeons for independent medical examination. Judge Bowman noted: *"It is not the role of a model litigant to continue to expend [public] monies pursuing medical reports from additional experts in the face of opinions adverse to it from experts already consulted, in the hope that, sooner or later, someone will say something which gives it some comfort."*[30]

    c. The recent decision in Teys[31] is consistent with earlier authorities, specifically citing Cullinane J's comments in the matter of *Woolworths (Qld) Pty Ltd v Berry-Porter:*[32]

---

28 beyondblue to the PJC, page 16 5 Mental Health Council of Australia and beyondblue (2011). Mental health, discrimination and insurance: a survey of consumer experiences 2011. Accessed online 31 March 2016: https://www.beyondblue.org.au/docs/default-source/default-documentlibrary/bw0129-report-mental-health-discrimination-and-insurance.pdf?sfvrsn=2

29 *Moore v Stage Coach Qld Pty Ltd* [2004] QSC 003

30 https://www.heraldsun.com.au/news/judge-slams-victorian-workcover-authority-conduct/news-story/9f9da4613a0839dc978d29c86e4a2521?sv=d55ffbc5b78f9e7844b7c4e183af29cc (accessed 7 January 2019).

31 Teys Australia Meat Group Pty Ltd v Flett [2015] QDC 177.

32 [2002] QSC 360, paragraph 27.

> *…I do not accept that the applicant has an unqualified right to a further examination by a psychiatrist and by an orthopaedic specialist and that earlier examinations are irrelevant to that question. In the absence of any acceptable reason why the applicant should now seek to have examinations by other specialists and given the respondent's readiness to be re-examined by the specialists the applicant chose to have the respondent examined by previously, I am of the view that the examinations sought would not be reasonable and would do no more than provide the applicant with an opportunity to call a multiplicity of specialist witnesses, or to confer upon it a choice to call the most favourable of the specialist witnesses who would have examined the respondent.*

50. The PJC called for the industry to limit the number of independent medical examinations a claimant / applicant was subjected to[33] and this is a prime opportunity for the FSC and its members to do so.

### Clause 8.11

51. The utility of 'interviews' by insurance companies has, in our experience, been employed as a means of obtaining information from the claimant to deny claims. The clause needs to be phrased in such a way as to establish the parameters for the insurer to request an interview be conducted *before* outlining the terms in relation to it.

52. In respect of clause 8.11(c), we consider that the insurer should first explain in writing to the claimant why the interview / investigation is required, and what areas it will cover *prior* to arranging any such interview.

53. In respect of clause 8.11(d), again, we consider that such information should be provided to the claimant, *prior* to arranging any such interview.

54. In respect of clause 8.11(n), we consider that the clause should be amended to provide that an interview will not be recorded *without* the consent of the claimant.

55. We also consider it appropriate to add a clause that the claimant will not be obliged to sign a copy of the recording or any statement derived from the interview.

### Clause 8.12

56. We note the life insurance industries assertions that surveillance is a necessary part of the claims determination process, by affording protection against fake or fraudulent claims.[34]

[33] PJC Report on the Life Insurance Industry pages xii.

57. While there is a place for fraud management in insurance claims,[35] claimants with mental health conditions are particularly vulnerable and this must be an important consideration in such management. The value of this form of fraud management is meritless when compared with the detrimental risk to those with psychiatric or psychological conditions subjected to surveillance activity. The adverse consequences on the mental health of a claimant with a psychological or psychiatric injury by virtue of being subjected to surveillance under the instruction of a life insurer can be significant, as outlined by the submissions of beyondblue.[36]

58. In the decision of *Hellessey v MetLife Insurance Ltd,*[37] the judgement relevantly quoted the position of independent forensic psychiatrist Dr Westmore, who noted:

> *Surveillance type investigations which often occur in psychiatric cases, and which most psychiatrists would agree are effectively useless, add to the patient's mistrust in the objectivity of insurance companies, the defendant and sometimes the defendant's representatives.*

59. The FSC Code does not go far enough to protect those with mental illness from surveillance activity, and thus does not comply with the PJC's Recommendation 10.101[38] that after consultation with relevant medical professionals independent of the life insurance industry and mental health advocacy groups, the FSC establish ….. a dedicated part of its existing Code of Practice, specifically in relation to mental health life insurance claims...

60. We acknowledge the Australian Lawyers Alliance ("ALA") submissions to the Royal Commission[39] and strongly support the recommended amendments to the FSC Code.

61. Clause 8.12(f) of the FSC Code asserts "*we will stop surveillance where there is evidence from an independent medical examiner that it is negatively impacting your recovery."* As currently phrased, the opinion of a treating psychiatrist, psychologist or medical practitioner that surveillance is negatively impacting on a claimant would not compel the life insurer to discontinue the surveillance.

---

34 Report 498, page 63, as noted in the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (March 2018) page 173;

35 Report 498, page 63, paragraph 212.

36 Beyondblue, Submission 18 to the Parliamentary Joint Committee on Corporations and Financial Services Report on the Life Insurance Industry (November 2016) page 16; Dr Michelle Blanchard, General Manager, Research, Policy and Programs, SANE Australia, Committee Hansard, 1 December 2017, p. 3; SANE Australia, Experiences of people with mental illness with regard to life insurance (December 2017).

37 [2017] NSWSC 1284.

38 PJC Report on the Life Insurance Industry pages 73-74.

39 Australian Lawyers Alliance, Submission POL.9006.0001.0116_0001 to the Royal Commission into Misconduct in the Banking, Superannuant and Financial Services Industry (22 October 2018) https://financialservices.royalcommission.gov.au/Submissions/Documents/Round-6-written-submissions/POL.9006.0001.0116.pdf page 25,-26.

62. Further, by use of the word “stop”, the FSC Code leaves it open to life insurers to seemingly ignore independent or treating medical opinion about the detrimental effect of surveillance if the life insurer is yet to commence surveillance. This clause should be amended to the following:

> *(f) Surveillance activity will not be undertaken if we receive evidence from an independent or treating medical practitioner that such activity is having or will have a negative impact on your health.*
>
> *(g) We will stop the surveillance if we receive evidence from an independent or treating medical practitioner that it is having a negative impact on your health.*

### Clause 8.14A

63. This clause needs to establish a time limit for the provision of material by a claimant for transparency and industry consistency. As currently drafted, there is no mandated timeframe after which the insurer can deem it reasonable to close the claim.

64. As drafted, the insurer can utilise this clause as a means of delaying or protracting the matter unnecessarily, by virtue of its ability to the restart the timeframes prescribed by Chapter 1.

65. Claimants should be afforded the same courtesy as FSC members in the Code[40] in that, if a claimant has advised the FSC member that they have taken steps to obtain the requested information but it is taking longer than expected, the claim should remain open.

### Clause 8.15

66. The use of the term “if” should be removed. It is not optional for the insurer to provide to the claimant all the information it considered to form an opinion that leads to the issuing of procedural fairness or to its decision. There is an obligation on FSC members to provide all relevant information considered in the initial assessment of the claim by virtue of procedural fairness and the duty of utmost good faith. [41]

67. The obligation to afford procedural fairness to the claimant is longstanding, with legal authority consistently holding insurers and trustees accountable where this duty is breached:

---

[40] See for example clause 8.8 of the FSC Code.

[41] *Sayseng v Kellogg Superannuation Pty Ltd & Anor* [2003] NSWSC 945 per Bryson J at [82].

- In *Beverley v Tyndall,*[42] Justice Ipp noted:

  *What did fairness, good faith and reasonable conduct require of the respondent after it had obtained the reports …?*

  *In my opinion, fairness required the appellant to be given the opportunity of answering the new material before the respondent made its decision.*

  *In my view, fairness would not tolerate such a transmogrification from adversary to adjudicator while concealing crucial material.*

- In *Erzurumlu v Kellogg Superannuation Pty Limited*[43] Ball J noted:

  *An insurer, when considering a claim, must comply with its obligation of utmost good faith. That obligation requires the Insurer to act reasonably in considering the claim. The obligation to act reasonably includes an obligation to consider and to determine the correct question. It also includes an obligation to give the member an opportunity to answer any material on which the insurer intends to rely.*[44]

- In *Panos v FSS Trustee*[45] Justice Robb held:

  *In my view, … reasonable fairness required that the Insurer would provide the Trustee and [the member] with at least a concise outline of its position in relation to the evidence that it regarded to be significant, including as to the medical evidence that it preferred, the aspects of [the members] statements that it questioned, the extent of [the members] disabilities that it accepted, and the approach it was minded to take concerning the real prospects that [the member] would actually gain employment that was reasonably suitable on the basis of his education, training and experience, and then give [the member] adequate time to make a focused response.*

  *In particular, in my view, the same reasoning that supports a conclusion that an insurer should not rely upon a medical report that it has obtained, without giving the claimant an opportunity to respond to the report, supports the conclusion that the insurer should not act upon the conclusion that it does not believe the evidence personally given by the claimant, without giving the claimant a warning, and an opportunity to respond specifically to the reasons why the insurer is not inclined to accept the claimant's evidence.*

68. We submit that this extends to the opinions from any 'in-house' vocation, rehabilitation or medical practitioners or consultants.

---

42 *Beverley v Tyndall Life Insurance Co Ltd* [1999] WASCA 198 at paragraphs 93 – 94;

43 [2013] NSWSC 1115, at 54.

44 *Hannover Life Re of Australasia Ltd v Sayseng [2005] NSWCA 214;*

45 [2015] NSWSC 1217, at 233

### Clause 8.16

69. Slater and Gordon remain concerned that no hard time-frames have been put in place for a product that by its very nature, is designed to assist consumers when they have no income. The wording of this clause needs to be definitive for the timeframe to have any value to a claimant, who is not receiving any income due to an illness or injury, to support themselves or their family.[46]

70. Allowing FSC members 12 months to make a determination on an income protection product is reprehensible, and we would call for the FSC to require its members to tighten the timeframes for these claims.

71. As a consequence of the claims handling and payment delays, medical treatment is often then also delayed, as the claimant is reliant on the accessibility of treatment through the public health system. This is particularly problematic for claimants with mental health conditions.

72. We often see claimants with physical injuries develop psychological conditions due to delayed treatment and the additional stress of financial hardship, which in turn delays or impedes a return to work.[47] Hard time frames on continuing assessment could reduce these occurrences, which is beneficial to the FSC member as well as the claimant.

73. In circumstances where a determination cannot be made within the timeframe, due to no fault of the claimant, an "ex-gratia" payment should be made in good faith, by the FSC member. Details of the complaints process is of little comfort or utility to claimant who is unable to support themselves or their family.

### Clause 8.17

74. We consider that the reference to "our decision may be to require you to undertake a period of rehabilitation or retraining" in this clause may confuse and potentially mislead consumers, and should be removed.

### Clause 8.21

75. The phrase is too broadly worded and allows an insurer to delay payment based upon its completion of "all reasonable enquiries".

---

[46] Media Release – Parliamentary committee stance does not address income protection delays (April 2018).

[47] See Slater and Gordon case studies which form part of the written document tendered by the Australian Council of Trade Union in its Response to Questions Taken on Notice at the Parliamentary Joint Committee on Corporations and Financial Services - Options for greater involvement by private sector life insurers in worker rehabilitation Hearing (19 June 2018) page 9 of 10.

76. We have witnessed insurers refuse to make a payment for a corresponding period. This generally occurs when the claim has been internally transferred to a new claims assessor / manager, or an internal claim 'anniversary' has been reached, at which point a review of the file is undertaken and it is determined that information is missing (usually from a previous period that the insurer has already paid the claimant for) but has subsequently determined it requires this 'further information' before it can make any more payments. Further information on these case studies can be provided if it would be of assistance to the FSC.

77. The FSC Code should include a clause protecting consumers against such conduct, similar to subclause 8.21 b):

> *We will not stop or withhold your benefit payments during a review of your claim or while awaiting receipt of information relevant to a period for which we have paid you an income-related benefit.*

78. With respect to subclause 8.21 c), we refer to and repeat our submission in paragraph 72.

### Clause 8.26

79. Slater and Gordon are concerned with the connotation of this clause. The FSC proposal on the involvement of life insurers with rehabilitation and medical care of injured workers was neither endorsed nor recommended by the PJC, who were so concerned in relation to some of the statements made by the FSC and its members, that it also recommended ASIC investigate the current use of in house rehabilitation services.[48]

80. We are aware of instances where the insurer, through its independent medical examiner or internal chief medical officer, attempt to contact treating physicians to discuss the claimants treatment. This practice is particularly prevalent in psychiatric cases where, the claim is often put on hold pending the outcome of such discussions, and may constitute a breach of Ethical Guidelines[49] and relevant legislation.[50] Neither the life insurer nor its representatives should be 'collaborating' with treating medical practitioners in relation to the ongoing care and treatment of a patient.

---

[48] Recommendation 3.115 of the Parliamentary Joint Committee on Corporations and Financial Services Options for greater involvement by private sector life insurers in worker rehabilitation report (October 2018) page 39 "FSC Report on Options for greater involvement by private sector life insurers in worker rehabilitation";

[49] Australian Medical Association *Ethical Guidelines for Conducting Independent Medical Assessments* (2010);

Royal Australian & New Zealand College of Psychiatrists *Professional Practice Guideline 11 Developing reports and conducting independent medical examinations in medico-legal settings* (February 2015).

[50] *Life Insurance Act 1995, Private Health Insurance Act 2007, Private Health Insurance (Health Insurance Business) Rules 2013, Health Insurance Act 1973 and Superannuation Industry (Supervision) Regulations 1994 (Cth).*

81. The life insurers, who submitted independent submissions to the PJC on this issue, emphasised the industry's ability to self-regulate through the Code.[51] Yet, as currently drafted, the FSC Code does not set any governing principles nor utilise any of the recommendations raised by the PJC with respect to the provision of internal rehabilitation programs.

82. Along with other consumer organisations and advocates, Slater and Gordon remain concerned about policies that require a claimant to participate in an insurer's occupation rehabilitation program, to thereafter deny a claim.

83. A clear example of this is the TPD Assist policy that SunSuper has with insurer AIA Australia Limited ("AIA"). Part B2 c) (ii) of the policy requires the insured member "*to participate in an Occupational Rehabilitation Program and is fully participating in the Occupational Rehabilitation Program to the satisfaction of the Company."*

'Occupational Rehabilitation Program' is defined in the policy as

> *Any program which, at the Date of Lodgement and each New Assessment Date or any other date the Company deems appropriate, the Company in its sole discretion determines will assist the Insured Member to improve their ability to work in their own occupation or another occupation for which the Insured Member is, or may be at the conclusion of rehabilitation or retraining, reasonably suited by education, training or experience through the skills acquired during any Occupational Rehabilitation Program.*
>
> *In determining these rehabilitation services, the Company may take into account the following criteria and any other criteria the Company considers appropriate*

84. AIA specifically responded to queries raised by the PJC asserting (relevantly):

> *I think there are also concerns around whether this would affect a member who undertook a rehabilitation program, or rather refused to undertake the rehabilitation program …. that was required of them, and how that would affect their benefits. At this stage, I just want to comment that, through our current process for rehabilitation, that's not the case. We have people who start a rehab program, don't finish or say, 'It's not for me, I'm not ready yet.' That does not affect or cut off their benefits. In terms of medical treatment being part of that, we believe that that's the same focus for us, as well.*

---

[51] AIA, Submission 20, p. 3 referenced in the FSC Report on Options for greater involvement by private sector life insurers in worker rehabilitation (October 2018) page 25;

Mr James Connors, Senior Consultant, Government and Policy, MLC Life Insurance, Committee Hansard, 21 August 2018, p. 8, 9 referenced in the FSC Report on Options for greater involvement by private sector life insurers in worker rehabilitation (October 2018) page 30, 31;

Financial Service Council, answers to questions on notice, 6 August 2018 (received 17 August 2018) referenced in the FSC Report on Options for greater involvement by private sector life insurers in worker rehabilitation (October 2018) page 37.

*We would go down the path that we currently do with our rehabilitation process in that regard. I know that is a concern and an objection, but it is not something that we believe is an issue at this stage.*[52]

85. The statement is clearly inaccurate in light of the TPD Assist policy requirements, and flies in the face of the submissions by the FSC to the PJC inquiry.

86. In our experience, upon approval of the initial part payment of the TPD assist benefit, SunSuper immediately demand access to the claimant to discuss rehabilitation. This is often in spite of medical and other evidence before the insurer and fund, that the claimant has exhausted all treatment and rehabilitation processes (including pain management and vocational redirection), and where the condition may be degenerative (ie Arthritis).

87. On this view, the aim of the policy cannot be said to be to 'get a member back to work' but to undertake further 'independent vocational assessment' to identify some role, which may not reasonably be open to anyone in the real world, let alone to the injured claimant, assert the claimant can do it and reject future claim benefits, as it now falls within their education, training or experience.

88. Minimum governing standards should be established within the FSC Code, for the industry to establish credibility for the genuineness of its assertion of 'helping you on the road to recovery', and to govern the use of rehabilitation programs by FSC members. Standards should, at a minimum, include the statements made by the FSC in its submissions[53] and by Mr Hansall on behalf of the FSC[54] that:

    a. Customers and their treating physician would be required to provide consent to the proposed Rehabilitation;

    b. Customers will not be forced to receive rehabilitation that they do not want;

    c. FSC members will not stop Income Protection (IP) or Total and Permanent Disability (TPD) insurance payments of any customer that does not wish to receive rehabilitation.

---

[52] Ms Stephanie Phillips, Chief Group Insurance Officer, AIA Australia, Committee Hansard, 21 August 2018, pp 5–6, referenced in the FSC Report on Options for greater involvement by private sector life insurers in worker rehabilitation (October 2018) page 228-29.

[53] Financial Services Council to the Parliamentary Joint Committee on Corporations and Financial Services Options for greater involvement by private sector life insurers in worker rehabilitation (Submission 1, Supplementary Submission 1.1, Answer to questions posed 18 July 2018 (received 27 July 2018), Answers to questions taken on notice from public hearing 19 June 2018 (received 5 July 2018).

[54] Mr Hansall, Financial Services Council, Committee Hansard, 19 June 2018

## Chapter 2 – Obligations your superannuation trustee has to you if your life insurance is in superannuation

89. The PJC as part of its report recommended that prior to seeking ASIC approval, the FSC Code and the Insurance in Superannuation Voluntary Code of Practice ("Super Code") be combined into a single code of practice.[55]

90. Slater and Gordon recognises the effort of the FSC to combine the codes, but consider there is still room to improve the obligations of FSC members to achieve better consumer outcomes for those with life insurance through super.

### Clause 12.5

91. We note that the timeframe for compliance is consistent with the Super Code, however the clause should carry across the remaining part of the equivalent paragraph – "*to allow for our existing contractual arrangements to be adjusted* " to assist consumers to understand the relevance of the date.

### Clause 12.9

92. We are concerned that the wording of this clause essentially enables a FSC trustee member to alter its commitment to the Code. The commitments and obligations on FSC members are in addition to any that already exist at law. It is the "*industry's commitment to mandatory customer service standards*." As such, where the Code is not consistent with FSC members governing rules, the Code should prevail to ensure that the FSC member is meeting its commitment.

### Clause 12.11

93. We refer to and reiterate our submission in relation to clause 2.18 above.

### Clause 13.9

94. Slater and Gordon's preference is for option 2, subject to consideration being given to flexibility in the cap on premiums when considering the characteristics of a funds memberships, including those outlined in clause 13.5 subparagraph a) through i).

### Clause 13.13

95. We refer to our submissions in relation to Chapter 1, clause 3, and submit that these are relevant to this clause.

[55] Recommendation 4.63 of the PJC Report on the Life Insurance Industry page 64.

### Clause 13.15

96. We refer to our submissions in relation to Chapter 1, clause 3, and submit that these are relevant to this clause.

### Clause 13.22

97. Noting that there is no legal requirement on FSC trustee members to undertake these steps, they should be removed until such time as there is a legal requirement, to avoid any consumer confusion.

98. It is incumbent upon any individual FSC members who have made such policy changes to comply with the FSC Code provisions and requirements at law in relation to notification of members of the changes.

### Clause 13.24

99. Consumers who, within a reasonable time of being notified that their cover has lapsed due to non-payment of contributions, seek to have their default cover reinstated, should be able to do so without being subject to underwriting requirements. The FSC Code should provide that in such circumstances, the consumer would not be subject to underwriting requirements that would otherwise be inapplicable to other members of that group life product with default cover.

100. The term 'heath assessment' used within this clause is not defined, and if it is to remain within the Code, should be defined to avoid misinterpretation.

### Clause 13.25

101. This clause seeks to address the important issue of account erosion through multiple insurance policies. As was found by the Productivity Commission's Superannuation Assessing Efficiency and Competitiveness Inquiry[56] at Finding 5.1, member engagement is a considerable problem, and was lowest for young members and those with relatively low balances. While the Productivity Commission also found that there was considerable information available to members, it was "often overwhelming and complex. Dashboards should be a prime mechanism to allow for product comparison and need to be salient, simple and accessible to be effective — but most are not, and regulators have left this unresolved." [57]

[56] Productivity Commission Inquiry - Superannuation: Assessing Efficiency and Competitiveness – Overview paper (21 December 2018) page 56.

[57] Ibid.

102. Slater and Gordon welcomed the Commission's inquiry relating to the consolidation of lost and inactive accounts as a further proactive step to reduce super balance erosion. However, as outlined in our submission to the Productivity Commission,[58] there are potential consequences with respect to this action that need to be appropriately considered prior to the introduction of any specific legislative requirements on fund trustees regarding inactive accounts.

103. We are concerned by the potential ramifications of this this clause, that the identification of duplicate accounts by a super fund without member engagement with their superannuation entitlement, or the provision of a comparison of the value of the policies, may result in consumers having inferior life insurance products or products less suitable to their needs, or paying higher premiums. Case studies were provided to the Productivity Commission in support of this concern.[59]

104. The clause does not outline any actions that should or should not be taken by an FSC member if insurance cover is identified with another fund. The FSC Code must specify the obligations and restrictions on FSC members with respect to the facilitation of consolidation of member accounts. In doing so, consideration should be given to the recent decision in *ASIC v Westpac Securities Administration Limited & Anor.*[60]

### Clause 14

105. We consider it important for the FSC Code to require FSC members to also explain in plain English the role of a trustee, as compared with the insurer, in respect of an insurance claim, including its obligations to its beneficiaries pursuant to the SIS Act and Regulations, and Prudential Standard SPS 250. It is important for its position on the obligation "to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success".[61]

106. This is particularly relevant given the level of inaction by trustees across the board in engaging in proceedings against an insurer, on behalf of a beneficiary before a tribunal or court (or now, AFCA).

---

[58] Slater and Gordon submissions to the Productivity Commission - Superannuation: Assessing Competitiveness and Efficiency (18 July 2018) (DR178) https://www.pc.gov.au/inquiries/completed/superannuation/assessment/submissions#post-draft page 5.

[59] Slater and Gordon submissions to the Productivity Commission - Superannuation: Assessing Competitiveness and Efficiency (18 July 2018) (DR178) https://www.pc.gov.au/inquiries/completed/superannuation/assessment/submissions#post-draft page 6.

[60] *Australian Securities and Investments Commission v Westpac Securities Administration Limited & Anor.* [2018] FCA 2078

[61] Section 52(7)(d) of the SIS Act.

107. Given the passivity of trustees in pursuing insurance claims for a beneficiary where they have prosects of success, the FSC Code should include a clause requiring FSC members to advise their insured members of their option of seeking independent legal advice, following a rejection of the claim.

108. The involvement of legal representation at the point of rejection of a claim should not be considered reprehensible by FSC members. We have seen specific web campaigns by some FSC members warning member claimants against seeking independent legal advice in relation to pursuing a claim. We are also aware of the conduct of some FSC members who, despite the claimant having legal representation, deliberately contact the member directly, often in an attempt to dissuade or disrupt the involvement of a legal representative. The choice of a claimant to access independent legal representation is a fundamental right that should be respected, and under no circumstances is it appropriate for FSC members to undermine the exercise of that choice.

109. If the obligations on FSC members under the FSC Code and at law have been met, and the claim has legitimately and reasonably been denied, it is most unlikely that the involvement of lawyers with the claim will extend past the provision of the independent legal advice.

### Clause 14.14

110. We do not consider that the grouping of the definitions as they stand in the clause properly articulates the substantial differences in the policies, and are thus misleading. If the FSC Code is to identify 'standard headings', then they must properly articulate *all* differences in the TPD policies offered by FSC members.

111. We refer to our submissions above at clause 3 in respect to policy design, which outlines the significant differences between policy terminology, and the legal treatment of these differences.

### Clause 16.15

112. We recommend the addition of a subclause which addresses the impact of the claim on other insurance entitlements under the policy. For example, the cessation of death cover if TPD is approved.

### Clause 16.16

113. We recommend the addition of a subclause in relation to any time limits or sunset clauses that are relevant to the claim.

### Clause 18.2

114. Reference to financial adviser and dealer group should form part of the 'Authorised representative' definition for consistency of those subject to the FSC Code regulations.

### Clause 22.5(c)/(d)

115. Slater and Gordon are concerned that this clause, as with clause 3.5A above, does not comply with the intended purpose of the Code in providing consumer protection and outlining insurer obligations but instead seeks to protect the behaviour of some FSC members.

116. Specifically, we do not agree with the inclusion of this sub-clause as it is inconsistent with the law in certain respects. If the information or documentation cannot fall into the category of sub clause a), then it is entirely open to provision to the claimant.

117. We refer to and repeat our submissions in relation to clause 5.17 above.

### Clause 26.5(e)

118. We refer to and repeat our submissions in relation to clauses 5.17 and 22.5.

## Chapter 3 – Code governance, Sanctions and Definitions

119. We refer to and repeat our submissions on page 4 in relation to the governance of the FSC Code.

120. We welcome the addition of consumer representatives to the Life Code Compliance Committee in clause 24.5.

### Clause 27

#### *'Exceptional cases'*

121. With respect to subparagraph (a), the term 'so late' is open to exploitation. The use of the 'exceptional cases' clause as defined should be subject to actual genuine prejudice suffered by the FSC member in accordance with the Insurance Contracts Act.[62]

122. With respect to subparagraph (d), we are aware of circumstances where the trustee has requested information from its insurer to assist with its determination of the claim. This often protracts the final determination of the claim unnecessarily. The FSC Code is silent on timeframes for the provision of requested information to a trustee, and a timeframe should be inserted to set the standard required.

[62] Section 54, Insurance Contracts Act.

### *'Unexpected circumstances'*

123. Slater and Gordon are concerned by the use of this term by life insurers in the assessment of claims. In our experience, information and authorities to obtain information are often requested via a drip feed approach by insurers. Initial authorities signed and returned with the initial claim paperwork are not utilised until later in the claim process, at which time, they are often out of date and require updating. Strict compliance with the terms of the FSC Code should resolve this practice.

124. Subclause b) purports to insert an assessment condition which is not relevant to all policies and where not relevant, is inconsistent with legal authority. This should be removed from the definition.

Sarah Snowden

**SLATER AND GORDON LAWYERS**