Transparency in Australian insurance law and regulation

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1 Introduction

This chapter examines the extent to which transparency is achieved in Australian insurance law. Part 1 focuses on the contractual relationship insurance between insurers and insured clients as set out in the *Insurance Contracts Act* 1984 (Cth) (the *ICA*), and Part 2 focuses on the regulation of insurers and intermediaries by the Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Authority (APRA). The analysis in both parts is structured under the four "quadrants" of the duty of utmost good faith[1] – the first quadrant being the insured's pre-contractual obligations; the second being the insurer's pre-contractual obligations; the third the insured's post-contractual obligations after the inception of the policy and the fourth being the insurer's post-contractual obligations.

Whilst 'transparency' is not directly used in the legislation governing insurance in Australia, the term appears in other Australian legislation dealing with unfair terms in consumer and small business contracts. Nevertheless, this chapter shows that the meanings commonly attributed to the term, including frank, open, candid; easily seen through, recognised, understood or detected; and manifest, evident, obvious, clear[2] are key underlying themes throughout both the *ICA* and the related case law, and in the regulation of insurers and intermediaries. For this reason, this chapter examines transparency in a wide sense to refer not only to the clarity and comprehensibility of terms within insurance contracts, but also to the frankness, openness and candour in the conduct between insurers, insureds and intermediaries throughout the life cycle of insurance contracts.[3]

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[1] These 'four quadrants' of utmost good faith were first conceptualised by Peter Mann 'The elusive second quadrant of utmost good faith: What is the scope of an insurer's pre-contractual duty of utmost of good faith?' (2016) 27 *Insurance Law Journal* 176

[2] *Oxford Concise Australian Dictionary* 6th Edition (Oxford University Press, 2017); *Macquarie Dictionary : Australia's National Dictionary* 7th Edition (Macquarie University, 2017)

[3] This chapter is necessarily selective in the cases it discusses. For a more comprehensive examination of the principles of Australian insurance law, the leading texts include Ian Enright and Rob Merkin *Sutton on Insurance Law* 4th Edition (Thomson Reuters, 2015); Greg Pynt *Australian Insurance Law: A first reference* 4th Edition (LexisNexis, 2017); and Peter Mann *Mann's Annotated Insurance Contracts Act* 7th Edition (Thomson Reuters, 2016)

Part 1 – Insurance contracts

2 An overview of the *Insurance Contracts Act* 1984 (Cth)

Since 1 January 1986, most classes of insurance contracts in Australia have been regulated under the *ICA*. The exceptions to the application of the *ICA* include contracts of marine insurance,[4] insurance that is required under state or territory legislation (including workers compensation and compulsory third party insurance for motor vehicles), private health insurance[5] and reinsurance.

The *ICA* was introduced following the recommendations of a wide-ranging review by the Australian Law Reform Commission (ALRC) between 1976 and 1982. In its Report No. 20 'Insurance Contracts' (ALRC 20), the ALRC noted with concern the imbalance between insurers and insureds, as well as the tendency of insurers to rely upon minor and technical breaches of policy wordings to refuse claims. The federal government adopted the recommendations in the ALRC 20 report to introduce legislation to remedy these concerns. The Explanatory Memorandum to the *Insurance Contracts Bill* 1984 (Cth) which introduced the *ICA* reflected notions of transparency (which are italicised below) when explaining that the main purposes of the Bill were to: '… improve the *flow of information* from the insurer to the insured so that the insured can make an *informed choice* as to the contract of insurance he enters into and is *fully aware* of the terms and limitations of the policy; and to provide *a uniform and fair* set of rules to govern the relationship between the insurer and the insured'.[6] As discussed below, the *ICA* regulates the relationship between insurers and insureds throughout the life cycle of a contract of insurance, with its provisions governing pre-contractual disclosure, the ability of insurers to refuse (or limit their liability) when determining claims, and the circumstances under which insurers may cancel contracts.

One of the most significant provisions of the *ICA* is s 13, which imposes duties of utmost good faith on each party to an insurance contract governed by the *ICA*. Furthermore, s 14 of the *ICA* prevents parties to a contract of insurance from relying on a provision of the contract except in the utmost good faith. Due to its generality the meaning of utmost good faith is challenging to define conclusively, and as the considerable

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[4] The *Marine Insurance Act* 1909 (Cth) (MIA) governs contracts of marine insurance in Australia. Due to the small size of the Australian marine insurance market there have been far fewer cases on the MIA in comparison to those on the ICA. For an overview of the law of marine insurance in Australia, see Ian Enright and Rob Merkin *Sutton on Insurance Law* 4th Edition (Thomson Reuters, 2015), 705 - 842

[5] The *Private Health Insurance Act* 2007 (Cth) governs private health insurance

[6] Explanatory Memorandum, *Insurance Contracts Bill* 1984 (Cth), 1

number of academic commentaries have acknowledged, [7] the application of the duty will depend on the circumstances of each case. As the authors of the leading text *Sutton on Insurance Law* have noted, the wide concept of utmost good faith has been held to encompass notions of fairness, reasonableness and community standards of decency and fair dealing; and also to require both parties to an insurance contract to have due regard to the interests of the other party.[8]

As noted in the introduction, whilst the term 'transparency' is not directly used in the *ICA* (or in Chapter 7 of the *Corporations Act* 2001 (Cth) (the *Corporations Act*), which as Part 2 of this Chapter explains regulates financial services including insurance), the term appears in other Australian legislation dealing with unfair contract terms. The *Australian Securities and Investments Commission Act* 2001 (the ASIC Act) (which is examined in Part 2 of this chapter) incorporates consumer protection provisions in relation to financial services. Subdivision BA of the *ASIC Act* deals with unfair contract terms in consumer and small business contracts. Section 12BG of the *ASIC Act* explains that when determining if a term in a consumer or small business contract is unfair, one of the factors the court must take into account is whether the term is 'transparent'. Whilst the term is not defined, s 12BG(3) of the *ASIC Act* explains that a term is 'transparent' if it is expressed in reasonably plain language, legible, presented clearly and is readily available to the party affected by the unfair term. If a term in a consumer or small business contract is found to be unfair, the term will be void.[9] However as s 15 of the *ICA* provides that relief under other legislation does not apply to contracts of insurance governed by the *ICA*, the unfair contract term provisions do not apply to contracts of insurance. Whilst a 2013 reform bill proposed the incorporation of unfair contract terms provisions into the ICA,[10] leading to mixed reactions form commentators,[11] these proposals were not incorporated into the *Insurance Contracts Amendment Act* 2013 (the *ICAA*) which was passed by the Senate on 20 June 2013 and given royal assent on 28 June 2013.

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[7] See for example Fred Hawke 'Utmost Good Faith - What does it really mean?' (1994) 6 *Insurance Law Journal* 91; Kelly Godfrey 'The duty of utmost good faith: The great unknown of modern insurance law' (2002) 14 *Insurance Law Journal* 1; Ryan Nattrass 'Extending the unfair contract terms laws to insurance contracts: Is the duty of good faith fair enough?' (2012) 23 *Insurance Law Journal* 299; and Brenda McGivern 'Coming to the party: The evolution of post-contractual duties of utmost good faith under the ICA' (2013) 24 *Insurance Law Journal* 159

[8] Ian Enright and Rob Merkin *Sutton on Insurance Law* 4th Edition (Thomson Reuters, 2015), 471 - 476

[9] *Australian Securities and Investments Commission Act* 2001 (Cth) s 12BF(1)

[10] The *Insurance Contracts Amendment (Unfair Terms) Bill* 2013 (Cth) proposed to incorporate a mirror provision to s 12BG of the ASIC Act into a new s 15B of the ICA, however this proposal was not adopted. For commentary see Peter Mann and Stanley Drummond 'Utmost good faith, unconscionable conduct and other notions of fairness - Where are we now?' (2017) 29 *Insurance Law Journal* 10

[11] See for example Rob Merkin 'Unfair terms in insurance contracts: A solution in search of a problem' (2012) Insurance Law Journal 272 and Ryan Nattrass 'Extending the unfair contract terms laws to insurance contracts: Is the duty of utmost good faith fair enough?'(2012) 23 *Insurance Law Journal* 299

3 The pre-contractual phase: Obligations of the insured and the insurer

Part IV of the *ICA* regulates pre-contractual disclosure. Before an insurance contract is entered into, the *ICA* requires the insured to disclose (and not to misrepresent) information which they know or ought reasonably to know to be relevant to the risk to be transferred – and provides the insurer with remedies if these obligations are not fulfilled. Specific disclosure requirements apply to consumer forms of insurance. As well as imposing pre-contractual disclosure obligations on the insured, the *ICA* also imposes several obligations on the insurer. These include clearly informing the insured of the duty of disclosure, notifying the insured of unusual terms, and of derogation from the "standard cover" regime (which applies to consumer forms of insurance).

Between 2003 and 2004 a wide-ranging review of the adequacy of the ICA was undertaken by leading insurance lawyer Nancy Milne and former ASIC Chairman Alan Cameron (the Milne-Cameron Review). As the sections below explain, the Milne-Cameron Review made a number of recommendations for improving the operation of the *ICA* to ensure that it reflected contemporary market developments and achieved an appropriate balance between the interests of insurers and insureds. However the recommendations of the Milne-Cameron Review were not enacted until the passing of the *ICAA* in 2013, which introduced several changes to the *ICA* applying to contracts of insurance entered into after 28 December 2015 (30 months after the date of royal assent to the *ICAA*),[12] examples of which are discussed below.

The Explanatory Memorandum to the *Insurance Contracts Amendment Bill* 2013 (Cth) reflected notions of transparency when explaining the objective of these reforms was to: '… ensure that the duty of disclosure requirements in the *ICA* strike an appropriate balance between, on one hand, ensuring insurers have *reliable information to assess and price risk* and, on the other hand, the need to avoid placing unfair burdens on insureds in respect of the remedies available against them for non-disclosure'.[13] (Emphasis added) As discussed below, the need for insurers to have reliable information to assess and price risk has been a consistent theme in the cases that have applied the provisions of Part IV of the *ICA* dealing with pre-contractual disclosure.

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[12] For an overview of the reforms introduced through the ICAA 2013, see Rehanna Box and Tove Webster 'Evolution not revolution: Insurance Contracts Amendment Act finally passed' (2013) 28(8) *Australian Insurance Law Bulletin* 114; and Julie-Anne Tarr 'Accountability 30 years on: Insurance Contracts Act Reform' (2015) 43 *Australian Business Law Review* 68

[13] *Insurance Contracts Amendment Bill* 2013 (Cth), [2.52]; See also Julie-Anne Tarr 'Insurance contract disclosure - an uncertain balance' (2015) 26 *Insurance Law Journal*, 110

3.1 The first quadrant of utmost good faith: The insured's pre-contractual duty of disclosure

Section 21 of the *ICA* sets out the disclosure obligations of an insured before entering a contract of insurance. It provides:

'(1) Subject to this Act, an insured has a duty to disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known to the insured, being a matter that:

(a) the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms; or

(b) a reasonable person in the circumstances could be expected to know to be a matter so relevant, having regard to factors including, but not limited to:

(i) the nature and extent of the insurance cover to be provided under the relevant contract of insurance; and

(ii) the class of persons who would ordinarily be expected to apply for insurance cover of that kind'.

The two numbered provisions in s 21(1)(b) were added by the *ICAA* in response to the recommendations of the Milne-Cameron Review to provide greater clarity to the operation of the objective knowledge limb. Section 21(2) of the *ICA* lists four exceptions to the duty of disclosure, which include a matters that diminish the risk; that is of common knowledge; that the insurer knows ought to know in the ordinary course of its business; and matters in respect of which the insurer has waived compliance with the duty of disclosure.

The High Court of Australia (HCA) has held that each policy and renewal is a separate contract attracting a fresh duty of disclosure.[14] Along similar lines, s 26 of the *ICA* provides that the insured must not misrepresent information which they know, or which a reasonable person in their circumstances could be expected to know, to be relevant to the risk to be transferred. In cases where the insured fails to disclose, or misrepresents, information that is relevant to the risk to be transferred, as discussed below the *ICA* provides the insurer with remedies, which differ for contracts of general and life insurance.[15] It has also been held that the duty of utmost good faith under s 13 of the *ICA* does not place a higher duty on the insured than the pre-contractual disclosure obligations under Part IV of the *ICA*.[16]

3.1.1 General insurance

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[14] *CE Heath Underwriting and Insurance (Aust) Pty Ltd v Edwards Dunlop & Co Ltd* (1993) 176 CLR 535; (1993) 7 ANZ Ins Cas 61-165; [1993] HCA 21

[15] For the definition of a 'contract of life insurance', see s 9 of the *Life Insurance Act* 1995 (Cth)

[16] *CIC Insurance Ltd v Barwon Region Water Authority* (1998) ANZ Ins Cas 61-425; [1998] VSCA 77 at [40]. For commentary see Peter Mann *Mann's Annotated Insurance Contracts Act* 7th Edition (Thomson Reuters, 2016), 83

For contracts of general insurance, in cases where the insured's failure to disclose, or misrepresentation of relevant information is made fraudulently, under s 28(2) the insurer may avoid the contract. If the insured's failure to disclose, or misrepresentation of relevant information is not made fraudulently, under s 28(3) the insurer may not avoid the contract – but may reduce its liability to the amount that would place the insurer in a position it would have been in had the non-disclosure or misrepresentation not occurred. Additionally s 60 of the *ICA* sets out the circumstances in which an insurer may cancel a contract of general insurance. These circumstances include the failure of the insured to comply with the duty of utmost good faith or the duty of disclosure; where the insured fails to pay policy premiums; and where an insured makes a fraudulent claim.[17] The following cases illustrate the application of these remedies.

In the leading HCA decision of *Permanent Trustee Australia Ltd v FAI General Insurance* (2003) 214 CLR 514; 12 ANZ Ins Cas 61-565 [2003] HCA 25, the majority of the court held that an insured's "shopping around" for alternative professional indemnity (PI) cover did not constitute 'relevant' information that would require disclosure under s 21(1)(a). In consultation with its broker, Permanent Trustee Australia had decided not to approach one of its existing insurers (FAI) to participate in the renewal of its PI insurance if satisfactory quotes were obtained from other insurers. Permanent subsequently accepted a 30 day discounted extension from FAI to its insurance policy. During the period of this 30 day extension, Permanent notified its insurers (including FAI) of circumstances likely to give rise to a claim. FAI refused to indemnify Permanent based on its failure to disclose its intention not to renew its insurance with FAI. In finding for Permanent, the majority emphasised that s 21 focused on matters that were *relevant* to the insurer's decision to accept *the risk* being transferred, rather than on commercial or emotive considerations. As McHugh, Kirby and Callinan JJ put it:

> 'Insurers do business in a commercially competitive world. They must know that any rational insured would look for three particular qualities in its insurer: capacity to meet a claim; diligence and expedition in its dealings with it; and, the amount and competitiveness of the premium … Insurers have no right to, and cannot credibly be believed to have any right to the perpetual or unchanging goodwill, and therefore custom, of each and all of its insureds'.[18]

[17] Section 56 of the *ICA* deals with fraudulent claims and is discussed in 4.1 below
[18] *Permanent Trustee Australia Ltd v FAI General Insurance* (2003) 214 CLR 514; 12 ANZ Ins Cas 61-565; [2003] HCA 25 at [35]

Fourteen years earlier, in *Advance (NSW) Insurance v Matthews* (1989) 166 CLR 606; 5 ANZ Ins Cas 60-910; [1989] HCA 22, the HCA had upheld an insurer's refusal of a fire damage claim under a home insurance policy based on the insured's breach of s 21(1)(b). When completing an application for a home and contents insurance policy, Mr and Mrs Matthews had answered "no" to the questions 'Have you ever had any claim rejected?' and 'Are there any other facts relating to the risks to be insured or the persons making this application which should be disclosed to enable a true assessment of the application to be made before acceptance?'. However, Mr Matthews had previously had a claim for fire damage at one of his business properties rejected several years earlier. After examining the definition of 'the insured' in the policy, the HCA concluded that Mr Matthews' fraudulent non-disclosure also extended to Mrs Matthews, and upheld the insurer's avoidance of the contract under s 28(2).

The objective knowledge limb of s 21(1)(b) was also held to have been breached in *GIO General Ltd v Wallace* (2001) 11 ANZ Ins Cas 61-506; [2001] NSWCA 299. In that case a home-owner failed to disclose both the increased use of his property for purposes connected with his tree surgeon business, and threats and property damage he experienced due to disputes with neighbours and employees of his business. The New South Wales Court of Appeal (NSWCA) found his failure to disclose such information enabled the insurer to reduce its liability under s 28(3) when his home was damaged by a deliberately lit fire. Along similar lines, in *Lindsay v CIC Insurance* (1989) 16 NSWLR 673; 5 ANZ Ins Cas 60-913 Rogers CJ Comm D had previously held that the undisclosed use of a suburban office complex as a brothel constituted information which a reasonable person could expect to know was relevant under s 21(1)(b) of the *ICA* – and which justified the insurer's reduction of its liability to nil under s 28(3) when the office complex was damaged by fire.

More recently in *Prepaid Insurance v Atradius (No 2)* [2014] NSWSC 21, McDougall J considered the effect of incorrect statements made by the commercial manager of a telecommunications provider in an application for a trade credit insurance policy. The commercial manager had provided incorrect responses to questions relating to the repayment practices of a major customer (which subsequently became insolvent), which constituted non-disclosures under s 21 and misrepresentation under s 26 respectively. In an earlier 2012 decision McDougall J had held that the commercial manager's 'reckless indifference' to the truth of his responses amounted to fraudulent misrepresentation and non-disclosure, thereby entitling the insurer to avoid the policy under s 28(2).[19] However the NSWCA over-turned this reasoning, holding that

[19] *Prepaid Services Pty Ltd & Ors v Atradius Trade Credit Insurance NV* (2012) 17 ANZ Ins Cas 61-937; [2012] NSWSC 608

a fraudulent misrepresentation required the absence of an honest belief in the truth of the representation,[20] and remitted the matter back for re-determination. In the 2014 decision McDougall J nevertheless found that s 28(3) was engaged on account of the commercial manager's incorrect statements. In concluding that 'if truthful and complete answers had been given in respect of the payment plans, Atradius would not have issued the policy', His Honour held that the insurer could reduce its liability to nil.[21]

3.1.2 Life insurance

For cases of non-disclosure or misrepresentations of relevant information in contracts of life insurance, s 29 of the *ICA* provides insurers with similar remedies to those applicable to general insurance, with some key differences. For fraudulent non-disclosure and misrepresentation, s 29(2) enables the insurer to avoid the contract. For non-disclosure and misrepresentations which are not fraudulent, s 29(3) enables the insurer to avoid the contract within three years of entering it. Lastly, the *ICAA* introduced an additional new remedy for insurers under s 29(4) to vary the sum insured under the policy to more accurately reflect the premiums that would have been payable had an insured complied with the duty of disclosure or not made a misrepresentation for contracts of life insurance entered into after 28 December 2015. The cases reviewed below illustrate how these provisions provide fair and workable mechanisms for achieving a properly-informed transfer of risk in the life insurance context.

In *Schaffer v Royal & Sun Alliance Life Assurance Aust Ltd* (2003) 12 ANZ Ins Cas 90-116; [2003] QCA 182, the insured had misrepresented the results of previous medical tests for breathlessness when applying for a life insurance policy. The insurer therefore proceeded to cancel the contract under s 29(3) of the *ICA*. However evidence from the insurer's underwriters did not conclusively establish that the insurer would not have entered into *any* contract of life insurance with her – instead the underwriters' evidence indicated they would have required further testing before deciding whether to issue the policy, and if so on what terms. However in the later decision of *Davis v Westpac Life Insurance* (2008) 15 ANZ Ins Cas 80-132; [2007] NSWCA 175, it was held that s 29(3) was satisfied where the life insured had failed to disclose a sleep apnoea condition. Evidence from the underwriters conclusively established that the insurer would not have issued the policy on any terms had it been made aware of the insured's condition.

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[20] *Prepaid Services Pty Ltd & Ors v Atradius Trade Credit Insurance NV* (2013) 17 ANZ Ins Cas 61-981; [2013] NSWCA 252

[21] *Prepaid Insurance v Atradius (No 2)* [2014] NSWSC 21 at [133]

The WASCA clarified the test for fraudulent non-disclosure under s 29(2) in *NRG Victory Australia v Hudson* (2003) 13 ANZ Ins Cas 90-121; [2003] WASCA 291. In that case the life insured Mr Hudson had experienced severe dermatitis from exposure to epoxy-based products in his previous occupation as a spray painter. This caused him to cease this work and seek alternative employment, eventually gaining a role as a forklift driver. In an application for an insurance policy three years after leaving his spray-painting job, he answered a question about current medical conditions in the negative. When he subsequently developed a serious rash, the insurer declined his claim on the basis of fraudulent non-disclosure. However the Western Australian Court of Appeal rejected the insurer's declinature of Mr Hudson's claim. After accepting Mr Hudson's evidence that he believed he had recovered from the skin condition, the court held that the relevant standard of knowledge standard was that of an ordinary worker in Mr Hudson's position, rather than the standard of knowledge to be expected from a doctor with an expert knowledge of skin diseases.

More recently in *Hitchens v Zurich Australia Ltd* (2015) 18 ANZ Ins Cas 62-076 [2015] NSWSC 825, the insured, a Mr Hitchens, had fraudulently misrepresented his recent medical history when applying for an income protection policy. He had provided false answers to questions about his attendance at numerous medical centres to obtain prescription medication, and to questions about the extent of his medical conditions. He had also failed to answer several questions on the policy application form. In upholding Zurich's avoidance of the policy, White J dismissed Mr Hitchens' contention that by not following up on these incomplete responses the insurer had waived the duty of disclosure, reasoning that that 'on any view, an underwriter is not expected to be a detective'.[22]

3.1.3 Consumer forms of insurance – Standard cover and disclosure requirements

An innovative recommendation from the ALRC 20 report which lead to the adoption of the *ICA* was the introduction of 'standard cover' for consumer forms of insurance. The standard cover regime applies to motor vehicle, home building, home contents, sickness and accident, consumer credit and travel insurance, which are prescribed as 'eligible contracts of insurance' in the *Insurance Contracts Regulations* 2017 (the *IC Regulations*). One leading commentator has explained that 'Standard cover was designed to address the difficulties encountered by insureds which existed due to the expertise of insurers in drafting policies and carefully defining risks and the inexperience and inability of the vast majority of insureds to understand the policy and its precise legal effect. In broad terms, standard cover achieves this by matching the community's

[22] *Hitchens v Zurich Australia Ltd* (2015) 18 ANZ Ins Cas 62-076; [2015] NSWSC 825 at [178]

understanding of fundamental risks with the minimum cover required by the policy'.[23] The *IC Regulations* set out 'prescribed events' which will be covered; exclusions that will not be covered; and minimum amounts that such 'eligible contracts of insurance' will cover. As 3.2 below explains, s 35(2) of the *ICA* requires the insurer to 'clearly inform the insured in writing' of any derogation from standard cover in 'eligible contracts of insurance'.

For 'eligible contracts of insurance', the insured's pre-contractual disclosure obligations are covered in s 21A – which in contrast to s 21, requires the insurer to ask more specific questions in applications for insurance. For example, in *Michail v Australian Alliance Insurance Co Ltd* [2013] QDC 284, Dorney DCJ held that the insurer was justified in reducing its liability to nil under s 28(3) in respect of damage to the insured's Aston Martin convertible. His Honour held that the insured had failed to disclose the previous suspension of his driver's licence and his accumulation of traffic infringements, which he held were 'known' by the insured within the meaning of s 21A(6). The insured's appeal to the Queensland Court of Appeal was dismissed.[24] The *ICAA* introduced amendments to s 21A to prevent insurers from asking "catch-all" questions in applications for eligible contracts of insurance, and also introduced a new s 21B to govern an insured's disclosure requirements when renewing an eligible contract of insurance.

Whilst ss 28(2) and 29(2) of the *ICA* enable insurers to avoid the contract where the insured has either fraudulently misrepresented, or fraudulently failed to disclose relevant information, s 31(1) of the *ICA* provides the court with a discretionary power to disregard such avoidance of by the insurer. However under s 31(2) the court may only exercise this power if it considers the insurer has not been prejudiced by the insured's non-disclosure or misrepresentation, or where it considers any such prejudice to be minimal or insignificant. In exercising the s 31(1) discretion, s 31(3) requires the court to be mindful of the need to deter fraudulent conduct.

Two cases illustrate the application of s 31. Firstly, in *Von Braun v Australian Associated Motor Insurers* (1998) 10 ANZ Ins Cas 61-419; [1998] ACTSC 122, the insured had misrepresented the agreed value of his motor vehicle with his previous insurer as $65,000 – whereas it had actually been $60,000. When the vehicle was stolen the insurer avoided the contract under s 28(2) of the *ICA* based on this fraudulent

[23] Samantha Traves 'Utmost good faith, reliance upon and notification of terms: The obligations of insurers and the rights of insureds' (2012) 23 *Insurance Law Journal*, 4
[24] *Michail v Australian Alliance Insurance Co Ltd* [2014] QCA 138. For commentary, see Julie-Anne Tarr 'Insurance contract disclosure - an uncertain balance' (2015) 26 *Insurance Law Journal* 109, 114

misrepresentation. However in the Supreme Court of the Australian Capital Territory Higgins J in the ACT Supreme Court exercised the s 31 power to adjust the agreed value of the motor vehicle down to $56,000. By contrast, in the earlier decision of *Burns v MMI-CMI Insurance Ltd* (1994) 8 ANZ Ins Cas 61-287, the insured had only disclosed one previous burglary in an insurance application – whereas there had actually been around 30-40 previous burglaries. In the Supreme Court of Victoria Beach J refused to exercise the s 31 power, reasoning that no amount of premium could have induced the insurer to enter into a contract of insurance if full disclosure had been made.

3.2 The second quadrant of utmost good faith: The insurer's pre-contractual obligations

As Traves has comprehensively discussed,[25] the *ICA* includes a number of provisions requiring the insurer to notify the insured of both their obligations and of the scope of cover under policies before accepting an application for insurance.[26]

Firstly, before entering into a contract of insurance s 22 requires the insurer must clearly inform the insured in writing of the general nature and effect of the duty of disclosure, which as 3.1 above noted is contained in s 21, and for eligible contracts of insurance, in s 21A. The *IC Regulations* prescribe the forms of writing that must be used to inform the insured of the duty of disclosure for general, life and eligible contracts of insurance. If the insurer fails to comply with s 22, it may not exercise any remedies for non-disclosure unless the insured's failure to disclose was fraudulent. In *Suncorp General Insurance Ltd v Cheihk* (1999) 10 ANZ Ins Cas 61-442; [1999] NSWCA 238 the insurer had declined the insured's claim for the agreed value of his Porsche when it was stolen, based on his failure to disclose previous convictions for driving whilst disqualified and the cancellation of his drivers' licence in the renewal of his policy. However the NSWCA dismissed the insurer's appeal against an earlier NSW District Court finding that was favourable to Mr Cheihk. Whilst noting that Suncorp's renewal notice included one mention of the duty of disclosure, the NSWCA held that s 22 had not been complied with, as the notification was included on the reverse side of the Certificate of Insurance without drawing the insured's attention to it. As Stein JA summarised: 'Hidden away, and un-highlighted in any fashion, is a sentence which make reference to the duty of

[25] Samantha Traves 'Utmost good faith, reliance upon and notification of terms: The obligations of insurers and the rights of insureds' (2012) 23 *Insurance Law Journal* 1

[26] However s 71 of the *ICA* provides that provisions of the *ICA* which require notices, statements, documents or other information to be provided before the contract is entered into will not apply in cases where the insurance is arranged by a broker

disclosure'.[27] On account of its failure to comply with s 22, Suncorp was unable to avoid its liability to indemnify Mr Cheihk for his loss under s 28.

Secondly, for contracts of insurance which are not prescribed as 'eligible contracts of insurance', s 37 requires insurers to clearly notify insureds of 'unusual terms'. Insurers are prevented from relying on 'unusual terms' unless they have clearly informed the insured in writing before the insurance contract was entered into. Whilst the *ICA* does not define 'unusual terms', examples of policy terms that have been held to have been 'unusual' include an insurer's interpretation of 'delivered' within a trade credit insurance policy (although in that unusual case the insurer had become insolvent by the time the insured brought legal proceedings),[28] and a 'burning cost adjustment' clause within a transport fleet policy.[29]

Thirdly, for 'eligible contracts of insurance' s 35 requires insurers to clearly inform the insured in writing of any derogation to the standard cover set out in the *IC Regulations*. An example of where this requirement was not satisfied was seen in *Lockwood & Lockwood v Insurance Australia Ltd* (2010) 16 ANZ Ins Cas 61-843; [2010] SASC 140. After the insured couple's motor vehicle was seriously damaged when it was driven by their unlicensed 14 year old son without their permission, the in insurer declined their claim based on a widely drafted exclusion clause in their motor vehicle policy. Kourakis J held that the wide ambit of the exclusion clause would have the effect of rendering the cover for theft under the policy largely nugatory, and that the insurer's wide discretion to refuse claims to be a substantial derogation from the purpose of the policy as it would have been understood by laypersons.[30]

By contrast in the earlier case of *Hams v CGU Insurance Ltd* (2002) 12 ANZ Ins Cas 61-525 [2002] NSWSC 273 Einstein J had held that CGU's provision of two booklets containing the policy wording satisfied the requirements of s 35(2) of the *ICA* to 'clearly inform … in writing' the owners of a large sheep station in North West NSW about a flood exclusion in their "rural pack" insurance policy. After considering competing expert hydrological evidence and the principles of proximate cause, His Honour held that the flood exclusion in the policy applied to discharge CGU from liability to indemnify Mr and Mrs Hams for

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[27] *Suncorp General Insurance Ltd v Cheihk* (1999) 10 ANZ Ins Cas 61-442; [1999] NSWCA 238 at [13]
[28] *Messagemate v (Aust) Pty Ltd v National Credit Insurance (Brokers) Pty Ltd* (2002) 85 SASR 303; (2003) 12 ANZ Ins Cas 61-546; [2002] SASC 327. Williams J held that whilst the specialist broker had arranged this policy, the broker could not be held liable for what His Honour characterised as FAI's "absurd" construction of the term 'delivered' within the policy
[29] *Suncorp Metway Insurance Limited v Mason Place Pty Ltd* [2011] QDC 209 at [11]
[30] Samantha Traves 'Utmost good faith, reliance upon and notification of terms: The obligations of insurers and the rights of insureds' (2012) 23 *Insurance Law Journal*, 7 - 8

significant damage to their sheep station following a flood which occurred in February 2000. Einstein J clarified the insurer's obligations under s 35(2) in the following terms:

> 'I certainly do not accept that as a general rule it would be incumbent upon an insurer to provide along with a document containing the provisions [of the policy], either a text on insurance law or an annotated Policy identifying and explaining either the general principles of insurance law or the principles dealing with the proper approach to the construction of Policy provisions. The fact is that the principles which underpin the law of insurance are often complex in the extreme and it could not be the case, as it seems to me, that a condition precedent to an insurer establishing that it had clearly informed the insured in writing of the relevant limitation, required the insurer to annotate the Policy by reference to principles of insurance law'.[31]

Justice Einstein's reasoning was followed in the similar flood damage case of *Marsh v CGU Insurance Ltd t/as Commercial Union Insurance* (2004) 13 ANZ Ins Cas 61-594; [2004] NTCA 1, where Mildren J remarked that 'Even though s 35 is plainly beneficial legislation, a fair reading of s 35(2) does not warrant the conclusion that the result need go further than provide for the relevant exclusion in the policy wording in clear and unambiguous language and in a manner which a person of average intelligence and education is likely to have little difficulty in finding and understanding if that person reads the policy in question'.[32]

However in more recent years there have been changes to the insurer's obligations to inform consumers about the coverage of their policies before insurance contracts are entered into. Following the devastating Queensland floods of 2011, the wide-ranging Natural Disaster Insurance Review (NDIR) undertook a comprehensive inquiry into Australia's legal and institutional arrangements for dealing with flood risk. The NDIR found there was widespread misunderstanding amongst many Australian consumers about coverage for flood damage within home and contents policies,[33] and also that a wide range of flood definitions were used in the Australian insurance market.[34] A particular problem noted by the NDIR was the manner in which many consumers were informed about the coverage in their policies for flood damage as required by s 35(2) of the *ICA*.[35] After noting that the flood exclusion in *Hams v CGU* (discussed above) was to be

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[31] *Hams v CGU Insurance Ltd* (2002) 12 ANZ Ins Cas 61-525; [2002] NSWSC 273 at [244]
[32] *Marsh v CGU Insurance Ltd t/as Commercial Union Insurance* (2004) 13 ANZ Ins Cas 61-594; [2004] NTCA 1 at [11]
[33] Commonwealth of Australia, *Inquiry into flood insurance and related matters: Final Report*, September 2011, Natural Disaster Insurance Review, 98
[34] Commonwealth of Australia, *Inquiry into flood insurance and related matters: Final Report*, September 2011, Natural Disaster Insurance Review, 109
[35] See also Julie-Anne Tarr 'Disclosure under the Prescribed Insurance Contracts Regime: Section 35 of the Insurance Contracts Act 1984 and Consumer Protection Revisited' (2001) 29 *Australian Business Law Review* 198 at

found on one page of the policy document that had exceeded 40 pages in length,[36] the NDIR Report identified the pressing need for clearer notification to consumers about the inclusions and exclusions in respect of flood cover in home and contents policies.

Following a consultation process by the Australian Treasury to improve the availability and transparency of flood insurance cover for Australian consumers,[37] two key reforms were introduced into the *ICA* in 2012. The first of these reforms was the introduction of a standard definition of flood for eligible contracts of insurance.[38] The second reform was the introduction of Key Facts Sheets for prescribed eligible contracts of insurance – these being home buildings insurance contracts and home contents insurance contracts.[39] Key Facts Sheets are required to provide a summary on two A4 sized pages of the cover and exclusions under the policy, as well as information about policy limits, excesses, legal liability, maximum level of cover and the contact details of the insurer.[40] This information is required to be set out in the format prescribed in the *IC Regulations*.[41]

4 The post-contractual phase: Obligations of the insured and the insurer

4.1 The third quadrant of utmost good faith – The insured's post-contractual obligations

The third quadrant of utmost good faith concerns the obligations of an insured once a policy comes into operation. Certain acts or omissions by insureds, for example the failure to notify changes to the risks covered by a policy, can mean a contract may not be operating on a fully-informed basis. The most litigated of all the *ICA* provisions is s 54, which places certain restrictions on the ability of insurers to refuse to pay claims once a contract of insurance comes into operation.[42] In its review of the common law which applied to insurance contracts, the ALRC 20 report observed that many insurance policies allowed insurers to refuse

199; and Samantha Traves 'Utmost good faith, reliance upon and notification of terms: The obligations of insurers and the rights of insureds' (2012) 23 *Insurance Law Journal* 1

[36] Commonwealth of Australia, *Inquiry into flood insurance and related matters: Final Report*, September 2011, 99

[37] Commonwealth of Australia *Reforming flood insurance: A proposal to improve availability and transparency* (November 2011), see https://archive.treasury.gov.au/documents/2221/PDF/transparency_november2011.pdf

[38] *Insurance Contracts Act* 1984 (Cth) s 37B. The prescribed definition is set out in Reg 34 of the *Insurance Contracts Regulations* 2017 (Cth). See also Justine Bell 'When will a flood be classified as a "flood"? A review of the Insurance Contracts Act reform' (2012) 23 *Insurance Law Journal* 312

[39] *Insurance Contracts Regulations* 2017 (Cth) Reg 12

[40] *Insurance Contracts Act* 1984 (Cth) ss 33A – 33D

[41] *Insurance Contracts Regulations* 2017 (Cth) Regs 12 – 13; Schedule 5

[42] In *Entwells Pty Ltd v National & General Insurance Co Ltd* (1991) 6 ANZ Ins Cas 61-059 at 77,136, Ipp J held that '… s 54(1) does not limit or restrict the effect of s 13. It merely provides the extent of the remedy for the duty imposed by s 13'. For commentary, see Peter Mann *Mann's Annotated Insurance Contracts Act* 7th Edition (Thomson Reuters, 2016), 63 – 64.

to pay claims, and in several cases to cancel policies, on account of minor or technical breaches of policy requirements by insureds. The ALRC noted with concern that in many cases breaches of policy requirements did not cause or contribute to losses claimed by insureds.[43] The commission therefore recommended the adoption of a causal connection test between an insured's breach of a policy requirement and the loss claimed, which if satisfied would allow insurers to refuse to pay claims. In cases where the causal connection test could not be satisfied, the ALRC 20 report recommended the adoption of a proportionality test enabling insurers to reduce their liability for a loss by reference to the extent to the prejudice resulting from an insured's breach of a policy requirement.[44] These recommendations were incorporated into s 54 in the following terms:

'Insurer may not refuse to pay claims in certain circumstances

(1) Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.

(2) Subject to the succeeding provisions of this section, where the act could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract, the insurer may refuse to pay the claim.

(3) Where the insured proves that no part of the loss that gave rise to the claim was caused by the act, the insurer may not refuse to pay the claim by reason only of the act.

(4) Where the insured proves that some part of the loss that gave rise to the claim was not caused by the act, the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act.

(5) Where:

(a) the act was necessary to protect the safety of a person or to preserve property; or

(b) it was not reasonably possible for the insured or other person not to do the act;

the insurer may not refuse to pay the claim by reason only of the act.

(6) A reference in this section to an act includes a reference to:

(a) an omission; and

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[43] Australian Law Reform Commission, *Insurance Contracts*, Report No 20 (1982) [218] – [220]

[44] Australian Law Reform Commission, *Insurance Contracts*, Report No 20 (1982), [228] – [229]. For commentary, see Peter Mann *Mann's Annotated Insurance Contracts Act* 7th Edition (Thomson Reuters, 2016), 409 - 410

(b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.'

The causal connection test recommended in the ALRC 20 report appears in s 54(2) and allows insurers to refuse to pay claims in cases where an insured's act or omission causes or contributes to a loss in respect of which insurance cover is provided by the policy. For example, in *Austcan Investments Pty Ltd v Sun Alliance Insurance Ltd* (1992) 7 ANZ Ins Cas 61-116 the insured changed of the use of its premises from selling waterbeds to manufacturing waterbeds (which involved storing large quantities of flammable lacquer at the premises). A clause in the policy required alterations to the activities carried on at the premises to be notified to the insurer, which the insured failed to do. After a fire (the cause of which was attributed to the flammable lacquers) damaged the premises, the insurer succeeded in avoiding liability under s 54(2) on account of the insured's actions in allowing the change to the use of the premises.

By contrast, s 54(2) was not engaged in *Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd* (1993) 176 CLR 332; 7 ANZ Ins Cas 61-156; [1993] HCA 5. In that case the insured held an unregistered mobile machinery policy which covered for damage to the insured's mobile crane. The policy required material changes to the 'facts or circumstances existing at the commencement of the policy' to be promptly notified to the insurer. After the commencement of the policy the insured registered the mobile crane so that it could be driven on public roads; however the insured's broker failed to notify this change to the insurer. The mobile crane was subsequently damaged when it overturned whilst lifting some steel structures from a rail truck. The HCA held that the insurer was entitled to reduce its liability in respect of the claim to nil under s 54(1) on account of the 'prejudice' it had suffered through its loss of the opportunity to cancel the policy and go off-risk had it known of the change to the use of the crane. Similar reasoning was applied by the Queensland Court of Appeal in *Gibbs Holdings Pty Ltd v Mercantile Mutual Insurance (Aust) Ltd* (2002) 11 ANZ Ins Cas 61-484; [2000] QCA 524, where the insured had failed to comply with a policy requirement to notify the insurer of changes in the use of its warehouse. The majority of the Queensland Court of Appeal accepted that the insured's actions in allowing a plastics manufacturer to occupy part of its warehouse did not cause or contribute to a fire (which had actually been deliberately lit in another section of the warehouse) under s 54(2). Nevertheless, the majority followed *Ferrcom* to conclude that the insurer's 'prejudice' under s 54(1) was its loss of opportunity to go off-risk by cancelling the policy. As [6.1] in Part 2 of this chapter discusses, the insureds in both *Ferrcom* and *Gibbs* also pursued legal actions against their brokers for failing to notify these changed circumstances to the respective insurers.

However in two other cases the insurers were unable to establish 'prejudice' under s 54(1) resulting from breaches of policy conditions by insureds. Firstly in *Antico v Heath Fielding Australia Pty Ltd* (1997) 188 CLR 652; 9 ANZ Ins Cas 61-371; [1997] HCA 3, the insured company director failed to obtain the insurer's consent before incurring significant legal costs in defending a claim for an alleged breach of his directors' duties. The Directors and Officers insurance policy required a Queen's Counsel (QC) to provide an opinion about the prospects of defending such claims before the insurer would be liable to cover legal fees. However the HCA held that the insurer would only suffer prejudice if the insurer could establish that a QC would have opined that there were no prospects of defending the claim. As the evidence did not establish this, the HCA held that the insurer had not been 'prejudiced' by the insured's omission. This meant the insurer was unable to reduce its liability in respect of the director's claim under s 54(1).[45] Secondly in *Moltoni Corp Pty Ltd v QBE Insurance Ltd* (2001) 205 CLR 14; 11 ANZ Ins Cas 61-512; [2002] HCA 73 the insured demolition company failed to promptly notify its insurer about an injury sustained by one of its employees. The insurer argued that the 17 month delay in notifying the injury caused it prejudice through losing the opportunity to require the injured employee to undergo alternative medical examinations and treatments. However the HCA held that as the insurer had only raised these alternative courses of action as possibilities, it was not entitled to reduce its liability under s 54(1), explaining that 'the relevant prejudice suffered [under s 54(1)] is to be measured by reference to what *would* have happened (as distinct from what *could* or *might* have happened) if the act or omission had not occurred'.[46]

It is also worth noting for completeness that in the early years of the previous decade, a number of s 54 cases before the courts considered the effect of the failure to promptly notify professional indemnity insurers about circumstances likely to give rise to claims against insureds. A contentious issue in several of these cases concerned the effect of 'deeming provisions' in policies – which extended cover to include claims made after expiry of the insurance period if during the period of insurance the insured became aware of facts or circumstances giving rise to the claim, and notified the insurer of those facts and circumstances before the policy expired.[47] However as Australian insurers ceased including such 'deeming provisions' in their policies, the scope for disputes about insureds' failures to promptly notify potential claims has now been greatly diminished.[48]

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[45] *Antico v Heath Fielding Australia Pty Ltd* (1991) 188 CLR 652 at 674 – 675; [1997] HCA 35
[46] *Moltoni Corp v QBE Insurance Ltd* (2001) 205 CLR 14; [2001] HCA 73
[47] For a comprehensive overview of the decisions on this topic, see Patrick Mead 'Notifications under claims made and notified professional indemnity insurance policies and the effect of ss 54 and 40 of the Insurance Contracts Act 1984 (Cth)' (2009) 20 *Insurance Law Journal* 1
[48] Michael Kirby 'Australian insurance contract law: Out of the chaos – A modern, just and proportionate reforming statute' (2011) 22 *Insurance Law Journal*, 11

The other key provision of the *ICA* dealing with insurance claims is s 56, which enables the insurer to refuse to pay a claim that is made fraudulently. For example, in *Tiep Thi To v Australian Associated Motor Insurers Ltd* (2001) 11 ANZ Ins Cas 61-490; [2001] VSCA 48 the Victorian Court of Appeal upheld the insurer's refusal of a claim for damage to the insured's Toyota Landcruiser after it was driven and crashed by her unlicensed 15 year old son. Being unaware that her policy covered damage when the vehicle was being driven by an unlicensed person without her consent, the insured falsely stated in her claim that her 15 year old son had been set upon by a gang of youths roaming her neighbourhood who had stolen and damaged the vehicle. Buchannan JA held that '… the existence of an underlying valid claim does not render fraud irrelevant; the dishonest intention required for fraud is at least one to induce a false belief in the insurer for the purpose of obtaining payment or some other benefit under the policy, with or without belief or knowledge of a lack of entitlement; and fraud which relates to the claim made with the requisite intent will disentitle the claimant even if made subsequent to the first presentation of the claim'.[49]

4.2 The fourth quadrant of utmost good faith – The insurer's post-contractual obligations

The fourth quadrant of utmost good faith concerns the insurer's post-contractual conduct. In recent years there have been an increasing number of cases in which aggrieved clients have challenged the decision-making processes used by insurers to decline claims. As discussed below, in many of these cases the insurers' adherence to the duty of utmost good faith under s 13 of the *ICA* has been questioned – particularly in cases where the insurers were not open and frank in their dealings with the insureds. The decisions that have been handed down by the courts on such challenges have led to the growth of jurisprudence on the standards expected of insurers when determining claims. Additionally as Part 2 of this chapter will explain, the two regulators of the Australian insurance industry, ASIC and APRA, have become increasingly active in their monitoring of the processes through which insurers determine claims relating to comparatively vulnerable consumers.

The leading HCA decision on s 13 of the *ICA* is *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1; 14 ANZ Ins Cas 61-739; [2007] HCA 36. During 1999 two representatives of the Australian financial services company AMP had acted outside the terms of their respective authorities, resulting in many of AMP's clients incurring significant losses. AMP then faced pressure from ASIC to devise a protocol for settling claims by the affected clients in a timely manner. However AMP's professional indemnity policy with CGU prevented it from admitting liability or settling claims without

[49] *Tiep Thi To v Australian Associated Motor Insurers Ltd* (2001) 11 ANZ Ins Cas 61-490; [2001] VSCA 48 at [23]

obtaining the CGU's written consent, and also required AMP's liabilities to clients (and hence its right to indemnity under the policy) to be conclusively established by advice from a Senior Counsel. Whilst CGU indicated through its lawyers that it 'agreed in principle' to the protocol that had been devised to compensate the affected clients, it also advised that it reserved its decision on its liability to indemnify AMP, and advised AMP to act as a 'prudent uninsured'. After almost two years of delays and changes of lawyers, CGU refused AMP's claim. The majority of the HCA upheld CGU's refusal of AMP's claim due to its failure to comply with the policy's requirement to obtain CGU's consent before settling the clients' claims. However in his dissenting judgement Kirby J (who had chaired the ALRC 20 inquiry which lead to the *ICA*) was highly critical of CGU's failure 'to act with clarity, candour and decisiveness',[50] as well as what he characterised as the 'dilatory, prevaricating, confused, uncertain, inattentive and misleading way in which, over two years, CGU, with its four successive firms of solicitors, delayed and postponed its decision to deny indemnity'.[51] Whilst the HCA's decision found by a 4:1 majority that CGU had not breached its duty of utmost good faith in its refusal of AMP's claim, many other courts have found insurers to have breached this duty in the determination of claims.

The field of Total and Permanent Disability (TPD) insurance has given rise to several cases where courts have found breaches of the duty of utmost good faith by insurers in determining such claims.[52] TPD insurance policies are typically arranged by trustees of superannuation funds to provide lump sum benefits for incapacitated superannuation fund members. Whilst such claimants are not usually parties to the insurance contract arranged between superannuation trustees and insurers, the *ICAA* recognised the status of claimants in such positions as 'third party beneficiaries'.[53] The *ICAA* also extended insurers' duties of utmost good faith towards third party beneficiaries,[54] thereby reflecting the practice by many previous courts.[55]

Whilst TPD definitions vary between insurers, one typical example of the criteria that must be satisfied for TPD benefits to be payable is that 'the Insured Person is unable to follow their usual occupation by reason

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[50] *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1; 14 ANZ Ins Cas 61-739; [2007] HCA 36 at [72]
[51] *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1; 14 ANZ Ins Cas 61-739; [2007] HCA 36 at [139]
[52] For an overview of these cases see Robin Bowley 'The progressive evolution of Australian insurers' duty of utmost good faith to third party claimants' (2016) 27 *Insurance Law Journal* 194
[53] *Insurance Contracts Act* 1984 (Cth) s 11
[54] See now *Insurance Contracts Act* 1984 (Cth) s 13(4)
[55] For commentary on these amendments, see Rehanna Box and Tove Webster 'Evolution not revolution - Insurance Contracts Amendment Act finally passed' (2013) 28(8*) Australian Insurance Law Bulletin* 114; and Julie-Anne Tarr 'Accountability 30 years on: Insurance Contracts Act Reform' (2015) 43 *Australian Business Law Review* 68

of an accident or illness for six consecutive months and in our opinion, after consideration of medical evidence satisfactory to us, is unlikely ever to be able to engage in any Regular Remuneration Work for which the Insured Person is reasonably fitted by Education, Training or Experience'.[56] The determination of TPD claims can be a complex process, requiring insurers to evaluate frequently conflicting evidence from medical specialists, allied health professionals, investigative surveillance and labour market analyses in order to determine whether a claimant has satisfied the TPD definition in the applicable policy. The courts have held that in cases where an insurer's decision-making process is found to be unreasonable, TPD claims may be determined by the court on the available evidence.[57] The following cases highlight examples of decision-making processes of insurers which have been held to be in breach of the duty of utmost good faith and fair dealing through their lack of openness and transparency.

In *Wyllie v National Mutual Life Association of Aust Ltd* (1997) 217 ALR 324; [1997] NSWSC 146 an accountant who had suffered a stroke applied for a TPD benefit under his superannuation policy. When the insurer requested his treating doctor to provide a report on the extent of his incapacity it failed to provide the relevant TPD definition that needed to be satisfied in order for benefits to be payable to Mr Wyllie. The insurer relied upon the treating doctor's (misconceived) conclusion that Mr Wyllie was capable of performing closely-supervised accounting work in declining his claim, and also refused to provide him with access to the documentation it had relied upon in declining his claim. In finding for Mr Wyllie, Hunter J concluded that the insurer had failed to act reasonably, fairly or in good faith in its assessment of Mr Wyllie's claim. His Honour characterised the insurer's conduct as 'manifestly unfair' in failing to provide Mr Wyllie with an opportunity to address the matters upon which the treating doctor had formed the opinion that he did not satisfy the TPD definition in the policy for benefits to be payable.[58]

Along similar lines in *Sayseng v Kellogg Superannuation Pty Ltd and Anor* [2003] NSWSC 945, the insurer formed the view that a manual worker who had lodged a claim for TPD benefits had exaggerated the extent of his back injury, after considering reports form medical specialists and private surveillance agents. However the insurer did not provide Mr Sayseng with an opportunity to comment on this adverse information before declining his claim. In setting aside the insurer's declinature of Mr Sayseng's claim, Bryson J was highly critical of the insurer's failure to provide Mr Sayseng with the opportunity to comment upon the adverse information before making its final determination.[59]

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[56] *Hannover Life Re of Australasia Ltd v Dargan* [2013] NSWCA 57 at [16]
[57] *Lazarevic v United Super Pty Ltd* [2014] NSWSC 96 at [147]
[58] *Wyllie v National Mutual Life Association of Aust Ltd* (1997) 217 ALR 324 at 342; [1997] NSWSC 146
[59] *Sayseng v Kellogg Superannuation Pty Ltd and Anor* [2003] NSWSC 945 at [93] – [97]; upheld on appeal: *Hannover Life Re of Australasia Ltd v Sayseng* (2005) 13 ANZ Ins Cas 90-123; [2005] NSWCA 214

The insurer's decision-making process in rejecting a TPD claim was sharply criticised in *Dumitrov v SC Johnson and Son Superannuation Pty Ltd and Anor* [2006] NSWSC 1372. Gzell J concluded that the insurer had failed to inform the claimant (a manual worker with limited English) about the information he needed to present to substantiate his claim; did not inform the assessing doctor of the relevant TPD definition in the policy; failed to make further inquiries in relation to a specialist medial report that was favourable to the claimant; and also did not provide the claimant with an opportunity to comment on the reports it relied upon to decline his claim. Having determined the insurer had breached its duty of utmost good faith in determining the claim, in a subsequent decision Gzell J awarded the claimant interest under s 57 of the *ICA* to compensate for the insurer's unreasonable withholding of insurance monies.[60]

In the more recent decision of *Wheeler v FSS Trustee Corp Atf First State Superannuation Scheme* [2016] NSWSC 534, Robb J held that the insurer had breached its duty of good faith and fair dealing through its "constructive denial" of a TPD claim by a former police officer for a psychological injury. After not responding to three requests by the claimant's solicitors and the trustee of her superannuation fund to release medical reports relating to the claim, the insurer gave the claimant only 14 days to respond to a "procedural fairness" letter which enclosed the full volume of information the insurer had collected in the three years after the TPD claim had been lodged. Having found the insurer in breach of its duty of utmost good faith,[61] His Honour then proceeded to find that the claimant satisfied the requirements for TPD benefits on the evidence before the court.[62]

The foregoing sections have shown how the provisions of the *ICA* promote both fairness and transparency in the contractual relationship between insurers and insureds throughout the policy life cycle. The second part of this chapter examining the regulation of insurers and intermediaries shows how the regulation of Australian insurers and intermediaries by ASIC and APRA also ensures transparency in the conduct of insurance business.

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[60] *Dumitrov v SC Johnson and Son Superannuation Pty Ltd (No 2)* (2007) 14 ANZ Ins Cas 61-722; [2007] NSWSC 42

[61] *Wheeler v FSS Trustee Corp Atf First State Superannuation Scheme* [2016] NSWSC 534 at [300]

[62] *Wheeler v FSS Trustee Corp Atf First State Superannuation Scheme* [2016] NSWSC 534 at [366] – [368]