

# **Consultation Draft – Life Insurance Code of Practice**

Submission to the Financial Services Council

**10 January 2019**

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## Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.<sup>1</sup>

The ALA office is located on the land of the Gadigal of the Eora Nation.

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<sup>1</sup> [www.lawyersalliance.com.au](http://www.lawyersalliance.com.au).

## Introduction

1. The ALA welcomes the opportunity to have input into the issues raised by the FSC Consultation Draft on the Life Insurance Code of Practice (FSC Code). This submission makes comments on the proposed FSC Code in relation to but not limited to the specific feedback questions. We are available to discuss any of the below in further detail if that would be of assistance.
2. We see the proposed version 2.0 of the FSC Code as representing good progress on the key objectives of the FSC members and believe that, with refinements, it will result in improvements in consumers' insurance and investment outcomes. It will also assist the industry to rebuild public trust and confidence in the value of automatic death and disability insurance provided through superannuation. That will in turn help to ensure that super fund members and their families continue to benefit from low-cost, high-quality insurance in the event of death or disability.
3. We do however see a number of gaps and some problems in the FSC Code as currently proposed. The submission below should be read in conjunction with our previous submissions to the FSC concerning the development of the FSC Code version 1.0, our various submissions made to the Insurance In Superannuation Working Group,<sup>2</sup> and our submission in response to policy questions arising from Module 6 of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, 22 October 2018.<sup>3</sup>
4. As a general preliminary matter, we note that the ALA has long advocated for all insurers to be required, as a licensing condition, to commit and adhere to a binding and enforceable Code of Practice that has been ratified by ASIC (including through compliance with ASIC's 'RG 183 Approval of financial services sector codes of conduct'<sup>4</sup>). ASIC should have an active role in monitoring an independent code administrator with the power to impose sanctions for breaches of the code.
5. The ALA otherwise supports recommendations of the ASIC Enforcement Review Taskforce Report of December 2017 concerning industry codes in the financial sector, noting that the

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<sup>2</sup> Available here: <https://www.lawyersalliance.com.au/resources/2017>.

<sup>3</sup> Available here: <https://www.lawyersalliance.com.au/documents/item/1360>.

<sup>4</sup> <https://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf>.

proposed version 2.0 of the FSC Code continues to fail to satisfy the following recommendations:

Number	Description
18	ASIC approval should be required for the content of and governance arrangements for relevant codes
20	Approved codes should be binding on and enforceable against subscribers by contractual arrangements with a code monitoring body
21	An individual customer should be able to seek appropriate redress through the subscriber's internal and external dispute resolution arrangements for non-compliance with an applicable approved code

6. Similarly, version 2.0 of the FSC Code fails to adhere to several important recommendations of the Parliamentary Joint Committee on Corporations and Financial Services (PJC).<sup>5</sup> The ALA does acknowledge however that not all industry participants are FSC members and given PJC Recommendation 4.63, the FSC has made a reasonable first attempt to combine the two codes of practice into a single code.

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

### Clause 2.15

7. The FSC Code should confirm under the heading 'Legal Status of Chapter 1' that it prevails over the terms of any relevant insurance contract to the extent of any inconsistency. The ALA submits that there is little value in a Code of Practice which contains terms that an FSC member can simply contract out of.

### Clause 2.18

8. The FSC has not explained its reasoning for clause 2.18 regarding the cessation of the FSC Code once 'proceedings' have been commenced. Further, the clause is likely to mislead or confuse lay readers as it does not refer to what such 'proceedings' may relate or against whom they are commenced. For example, if a member sues an insurer but not the trustee, does the FSC Code cease to apply vis-à-vis the FSC member trustee? This is not clear. What if a claimant sues regarding a TPD claim but also has an ongoing income protection claim? Will the FSC Code

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<sup>5</sup> [https://www.apf.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/LifeInsurance/Report/b02](https://www.apf.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report/b02).

cease to apply in relation to all claims? If so, what is the policy rationale for this? Furthermore, the FSC Code should at the very least make it clear that any breaches of the FSC Code occurring prior to the commencement of 'proceedings' will not in any way be extinguished or derogated by the commencement of 'proceedings' and such breaches will remain reportable to the LCCC for investigation.

#### Clause 3.1(d)

9. The ALA's experience is that particularly in the group insurance sector, consumers are often unable to understand the differences in coverage available. The consequences of not having adequate coverage can mean families are placed in extreme financial hardship in the event of unexpected injury or illness. They then become reliant on government welfare and the public health system if they do not have adequate insurance coverage. This leads to significantly reduced quality of life, with hardship becoming ongoing and self-perpetuating.
10. Over recent years, the quality of TPD definitions in group policies being written have reduced some superannuation funds' offerings to 'junk insurance'. That is, collecting premiums from policy holders while providing little to no genuine prospect of insurance coverage in the event of serious injury or illness.<sup>6</sup> This was demonstrated recently in the REST case study featured in the Financial Services Royal Commission wherein a fund member had premiums deducted from her account for years after her entitlement to claim ceased due to a cessation of coverage triggered by a low account balance and the cessation of work. That was despite the fact that her membership statements noted her extant death and TPD cover (albeit with a small print disclaimer).<sup>7</sup>
11. This problem is exacerbated by the fact that s37 of the *Insurance Contracts Act 1984* (Cth) currently only requires disclosure of the 'unusual terms' to the named insured and not the consumer with group cover.

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<sup>6</sup> See for example: <http://www.abc.net.au/news/2018-06-03/sunsuper-insurance-members-sue-qld/9825324>; <https://www.afr.com/personal-finance/superannuation-and-smsfs/rest-industry-super-withheld-paraplegic-womans-disability-insurance-20160520-goztiy>; <https://www.smh.com.au/business/banking-and-finance/cba-fought-employee-with-ms-20160401-gnvwo9.html>; <http://www.abc.net.au/news/2017-07-11/amp-accused-of-dragging-out-disability-insurance-claims/8698278>; <https://www.afr.com/business/insurance/prepare-for-life-insurance-horror-show-20180909-h15414>.

<sup>7</sup> Other examples are detailed at paragraphs 13-28 of the ALA's submission in response to policy questions arising from Module 6 of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, 22 October 2018: <https://www.lawyersalliance.com.au/documents/item/1360>.

12. It is submitted that this issue can and should be mitigated against by FSC members codifying their commitment to disclose the following matters concerning price and product offerings to all insureds covered under group superannuation insurance, in the Key Facts Sheet (KFS):

- a. Price: The premium cost should be compared to equivalent cover available in an independent benchmarked retail product for insureds of the same demographic as the member;
- b. Product: A rating of definitions should be developed with tiering total and permanent disablement (TPD) definition classes to ensure a like-for-like comparison. For example, definitions:
  - i. that are consistent with the early release provisions in the *Superannuation Industry (Supervision) Act 1993* (Cth) (SIS Act) could be a Tier 1 definition;
  - ii. that use the 'unable' test (as opposed to 'unlikely') could be Tier 2;
  - iii. that include a retraining clause or otherwise have regard to education, training or experience obtained by a consumer after the date of assessment could be Tier 3;
  - iv. that include a pre-existing exclusion clause could be Tier 4;
  - v. that include an Activities of Daily Living (ADL) test could be Tier 5

A member could then clearly see where their TPD cover sits within that comparison.

13. This would mitigate against the risk of insureds not realising and doing something about their sub-standard insurance terms. This should be done consistently across all FSC members.

#### Clause 3.1(e)

14. Life insurance policies are commonly held for many decades. Over such time, a policy may become obsolete, with less favourable terms compared to on-sale products, even as its premiums are increased to keep pace with on-sale policy rates. For example, some TPD and income protection policies sold in the 2000s contained blanket exclusion clauses against mental health related claims before, thankfully, most life insurers moved away from such

conditions. There is presently no legal obligation on life insurers to provide policy upgrades or 'riders' to off-market policies.

15. Such upgrades will only occur where the insurer makes a commercial decision to do so, typically due to bad publicity as with the CommInsure heart attack scenario, but also in response to pressure from financial advisers (receiving trailing commissions from the prior sale of the insurer's outdated policy) who would be compelled to advise insured clients of their inferior product if such upgrades did not occur.
16. Of course it is possible for insureds to switch to an on-sale product to obtain the benefits of market improvement; however, the evidence is that many will not do so due to apathy as lay consumers will rarely know about the specific product upgrades which they could take advantage of by shopping around. This is where financial advisers theoretically assist; however, insureds are wary — with good reason — of financial advice, given the risk that such advice will be against their best interests.<sup>8</sup> This risk is exacerbated by financial advisers' history of policy rewriting behaviour (insurance churning) driven by their desire to secure commissions in perpetuity. Insurance rewriting infamously subjects insureds to a fresh underwriting process and thereby heightens the risk of a claim under a new policy being declined due to pre-existing conditions or non-disclosure.
17. Consistent with Recommendation 10.60 of the PJC, the ALA also calls for the FSC Code to require FSC members to:
  - a. regularly update all definitions in policies to align with current medical knowledge and research;
  - b. standardise definitions across all types of policies;
  - c. use clear and simple language in definitions; and
  - d. clearly explain which associated conditions that may arise from the initial condition, including mental ill-health, are covered by the insurance policy.

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<sup>8</sup> See ASIC report 562 'Financial advice: Vertically integrated institutions and conflicts of interest' dated January 2018 which found that in 75% of the advice files reviewed the advisers did not demonstrate compliance with the duty to act in the best interests of their clients. Further, 10% of the advice reviewed was likely to leave the consumer in a significantly worse financial position.

18. To enable this to occur, the FSC Code should oblige FSC members to consult with all relevant stakeholders to develop, publish and maintain an agreed set of minimum terms for FSC members to adhere to, including in relation to upgrades to legacy policies. If the insurer chooses to design and offer a low price/inferior product, it must disclose this prior to entry into the policy, in clear prominent terms (in the KFS or otherwise), that the consumer's policy terms are not in accordance with recognised minimum industry standards and that upgrades may not be passed on to keep up with such standards (Substandard Terms Disclosure).

#### Clause 3.2

19. This clause addresses Recommendation 10.60 of the PJC report only insofar as it relates to medical definitions. It does not comply with the PJC's recommendation to 'standardise definitions across all types of policies'. This should be done as described above.

#### Clause 3.3

20. Many disputes arise when consumers end up with less favourable insurance coverage terms after a group policy-owner renegotiates terms with an existing insurer or changes insurer. These disputes can result in years of litigation for claimants who clearly met the relevant disability definition(s) but whose liability is disputed by both outgoing and incoming insurer under a group superannuation scheme. The FSC Code should provide that:

- a. where a renegotiation of terms occurs, clear and prominent Substandard Terms Disclosure will be given to affected consumers;
- b. where a change of insurer occurs:
  - i. clear and prominent Substandard Terms Disclosure will be given to affected consumers; and
  - ii. the transition will be subject to FSC Guidance Note No. 11 *Group Insurance Takeover Terms*.

#### Clause 3.4

21. The submissions above regarding price and product disclosure in the KFS, and Substandard Terms Disclosure, are repeated.

### Clause 3.5

22. The submissions above regarding price and product disclosure in the KFS, and Substandard Terms Disclosure, are repeated. The submissions below regarding the *Disability Discrimination Act 1992* are repeated.

### Clause 3.5A(a)

23. This clause is not a consumer protection but purports to give the FSC members rights against consumers that will be inconsistent with the law in some circumstances. For example, even where a consumer agrees to an exclusion clause imposed by an insurer, the clause may itself be unlawful if, for example, it is in breach of the *Disability Discrimination Act 1992*, the ICA (e.g. the duty of utmost good faith) or the common law. The ALA sees no reasonable basis for this clause given that the FSC Code's stated purpose is to set out the life insurance industry's key commitments and obligations to consumers.

### Clause 3.5A(e)

24. The ALA submits that the FSC Code should expressly ban FSC members from knowingly promoting the policy to any person who is considering purchasing funeral insurance for or on behalf of any person under age 40. The reasons for this are self-evident noting the Financial Services Royal Commission has demonstrated that insurance sales have often been targeted towards representatives or elders of the would-be life insured.

### Clause 3.5A(i)

25. Given the elevated risk of funeral insurance mis-selling/exploitation, particularly to low socio-economic communities, as demonstrated by the Freedom Insurance case study in the Financial Services Royal Commission,<sup>9</sup> and the fact that pursuant to s15 of the ICA, an insurance contract is not subject to the unfair contract legislation contained within the Australian Consumer Law (ACL), it is submitted that the FSC Code should provide that wherever funeral insurance is sold in an unsolicited manner (cold-calling and door-to-door) the contract will not commence unless the consumer "opts in" to the contract, subsequent to the initial contact by the trader. That is consistent with the detailed and sensible policy position of the Consumer Action Law Centre.<sup>10</sup>

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<sup>9</sup> See for example <https://www.afr.com/brand/chanticleer/banking-royal-commission-shows-how-freedom-trapped-customers-in-unwanted-insurance-20180912-h159ma>.

<sup>10</sup> See for example <https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=22&ved=2ahUKEWiah66vmbzfAhVadXAKHfGkDfwQFjAVegQIEh>

#### Clause 3.6A(b)

26. The ALA submits that the FSC Code should expressly ban FSC members from knowingly promoting the policy to any person who is considering purchasing funeral insurance for or on behalf of any person not in the target market. The reasons for this are self-evident noting that the Financial Services Royal Commission has demonstrated that insurance sales have often been targeted towards representatives or elders of the would-be life insured.

#### Clause 3.6A(c)

27. Given the elevated risk of accident-only insurance mis-selling, the fact that pursuant to s15 of the ICA an insurance contract is not subject to the unfair contract legislation contained within the ACL, it is submitted that the FSC Code should provide that wherever accident-only insurance is sold in an unsolicited manner (cold-calling and door-to-door) the contract will not commence unless the consumer “opts in” to the contract, subsequent to the initial contact by the trader.

#### Clause 3.6B(c)

28. The ALA submits that the FSC Code should expressly ban FSC members from including clauses in income protection policies that enable FSC members to reduce/offset insured benefits against Centrelink benefits. Centrelink imposes its own offset against such payments pursuant to the *Social Security Act 1991*<sup>11</sup> and therefore such policy offset clauses have the practical effect of reducing a consumer’s total income replacement benefits to below their insurable income, which is inconsistent with the purpose of the insurance purchased – namely, to indemnify the consumer for their lost income.

#### Clause 4.1(i)

29. The ALA supports Recommendation 6.45 of the PJC. Specifically, that the life insurance industry should have, as a matter of urgency, a balance of affiliated and non-affiliated products on its Approved Product Lists (APL), and if affiliated products are recommended, the affiliation should be disclosed, and the consumer should be given a comparison with non-affiliated products.

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[AC&url=https%3A%2F%2Fcdn.tspace.gov.au%2Fuploads%2Fsites%2F60%2F2016%2F07%2FConsumer\\_Action\\_Law\\_Centre.pdf&usg=AOvVaw1vDzSHmcHePTqY5T7ki-6j](https://www.fscdn.tspace.gov.au/fuploads/sites/2016/07/Consumer_Action_Law_Centre.pdf&usg=AOvVaw1vDzSHmcHePTqY5T7ki-6j) at page 62.

<sup>11</sup> Section 17 and Part 3.14.

30. The ALA calls upon the above standard to be enshrined in the FSC Code.
31. The ALA also supports Recommendation 10.3 from the Productivity Commission’s report on ‘Competition in the Australian Financial System’ for greater transparency of products on APLs. In addition to the recommended reporting requirement that a proportion of products recommended are off-APL, it is submitted that regulations for minimum quotas for the recommendation of non-affiliated products should be enshrined in the FSC Code; it is important that advisers don’t passively hold non-affiliated products on their APLs without actually considering and recommending them.
32. In that regard, the ALA does not consider the FSC Standard No 24: Life Insurance Approved Product List Policy to be an adequate response to the problems associated with the practice of vertical integration that has led to such poor consumer outcomes for so many years,<sup>12</sup> noting:
- a. it is non-binding;
  - b. it centres around ‘best practice principles’ rather than hard requirements; and
  - c. it imposes no real consequences to non-adherent members.

#### Clause 4.11

33. Given the elevated risk of Consumer Credit Insurance (CCI) mis-selling and the fact that pursuant to s15 of the ICA, an insurance contract is not subject to the unfair contract legislation contained within the ACL, it is submitted that the FSC Code should provide that wherever CCI insurance is sold in an unsolicited manner (cold-calling and door-to-door) the contract will not commence unless the consumer “opts in” to the contract, subsequent to the initial contact by the trader.

#### Clause 5.2A

34. The ALA submits that an additional sub-clause should be included to expressly ban FSC members from seeking family history information relating to events that occurred more than five years prior to the policy inception. It is submitted that information outside that period is not likely to be of sufficient relevance to warrant the burden of the request to the consumer.

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<sup>12</sup> For data on the vertical integration practices see paragraphs 35-56 of the ALA’s submission in response to policy questions arising from Module 6 of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, 22 October 2018: <https://www.lawyersalliance.com.au/documents/item/1360>.

## Clause 5.6

35. The ALA submits that this clause should provide that FSC members will, where possible, provide a list of three independent service providers, from which the consumer may nominate one.

## Clause 5.17

36. On the issue of compliance with anti-discrimination law, the ALA points out that this clause does no more than restate the law. This is inconsistent with ASIC's RG183.30 which states that 'a code must do more than restate the law (and indeed should offer consumers benefits that exist beyond the protection afforded by law)'.<sup>13</sup>
37. The ALA, along with various other consumer groups,<sup>14</sup> has been concerned about the demonstrated systemic problems and discriminatory practices in the way insurers design, price and offer policies and assess claims for people with past or current conditions, particularly mental health conditions. In particular, there are discriminatory practices within the insurance sector in terms of determining terms during underwriting, the avoidance of policies and the writing of exclusion clauses.
38. Under the *Disability Discrimination Act 1992* ('DD Act') insurers may discriminate where the discrimination is based on actuarial or statistical data on which it is reasonable for the insurer to rely.<sup>15</sup> In 2006, a Memorandum of Understanding (MoU) was entered into between stakeholders from the mental health sector and insurance sector. This MoU helped develop the detailed guide 'Mental Illness and Life Insurance — What You Need to Know'.
39. Despite these efforts, a 2011 report from the Mental Health Council of Australia (MHCA) and BeyondBlue demonstrates that many individuals who have suffered mental illness continue to experience discrimination from the insurance industry.<sup>16</sup> Significantly:
- 45 per cent of respondents said that their application for income protection insurance was declined due to mental illness;
  - 67 per cent said it was difficult to obtain life and income protection insurance; and

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<sup>13</sup> <https://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf>.

<sup>14</sup> See for example the Financial Services Royal Commission submissions of the Public Interest Advocacy Centre (PIAC) dated 26 April 2018: <https://www.piac.asn.au/wp-content/uploads/2018/04/18.04.26-RC-submission-FINAL-.pdf>.

<sup>15</sup> *Disability Discrimination Act 1992* s46(1)(f).

<sup>16</sup> Mental Health Council of Australia and BeyondBlue, *Mental Health, Discrimination & Insurance: A Survey of Consumer Experiences 2011*.

- 50 per cent had insurance cover but paid more or had exclusions for mental illness/health claims.<sup>17</sup>

40. Despite the provision in the *DD Act* that allows insurers to discriminate where the discrimination is based on actuarial or statistical data on which it is reasonable for the insurer to rely, there is no positive obligation for insurers to provide copies of the actuarial and statistical data upon which they relied when making decisions on insurance applications and claims. It may be that such information can be compelled from an insurer through disclosure in a legal action but it is submitted that a disabled consumer ought not to have to take on the stress, inconvenience, cost and risk associated with such an action in order to understand the basis for an insurer's underwriting decision.

41. In the case of *Ingram v QBE Insurance (Australia) Ltd*<sup>18</sup> the insurer did not produce evidence to prove that its acts of discrimination were based on actuarial or statistical data within the statutory exceptions or that it would have suffered unjustifiable hardship if it had not included the mental illness exclusion in the policy issued. No doubt the insurer would have produced such information had it existed. This exemplifies the industry's misuse of exclusion clauses without any proper documented basis.

42. The ALA submits that the FSC Code should set standards that elaborate on, exceed or clarify this controversial area of law by compelling FSC members to produce actuarial or statistical data within the statutory exceptions wherever an underwriting decision is made, both at the front-end application process and in the event of an avoidance/variation of the contract pursuant to s29 of the ICA. Only then can consumers have confidence in the actual compliance of their insurer with the discrimination laws.

#### Clause 5.20

43. The ALA accepts that it is reasonable for an insurer to seek medical information to determine whether there has been a non-disclosure/misrepresentation that prejudiced it in the underwriting process. That is because in order to determine the extent of prejudice suffered by an insurer, if any, due to a non-disclosure or misrepresentation, it must know what information it should have had at the time of underwriting.

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<sup>17</sup> Mental Health Council of Australia and BeyondBlue, *Mental Health, Discrimination & Insurance: A Survey of Consumer Experiences 2011*.

<sup>18</sup> *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 1936.

44. However, only precise and targeted authorities should be used, and insurers should only be entitled to obtain records dating back a reasonable period of time, which the ALA submits should be no more than five years prior to policy inception.
45. It is submitted that the language “we will try” is vague, unclear and cannot be objectively tested by consumers (outside of court proceedings where disclosure of documents occurs). Too often we see policies avoided on the basis of alleged non-disclosure/misrepresentation following trawling by insurers of a claimant’s medical history, and often on the basis of a reference to depression or anxiety that resolved before the policy commenced. Under s29(3) of the ICA, in order to avoid a policy (that was entered after 28 June 2014) *ab initio*, and thereby deny any claim, a life insurer need only prove that it would not have entered into the policy on the same terms, even where:
- a. the non-disclosure/misrepresentation was innocent (non-fraudulent);
  - b. but for the non-disclosure/misrepresentation the life insurer would have accepted the risk and provided a policy (albeit on different terms such as a premium loading or exclusion) that would respond to the claim actually made.
46. Even for policies that started after 28 June 2014, we very seldom see FSC members enliven s29(6) of the ICA to vary the contract so as to place it in the position it would have been in but for the alleged non-disclosure/misrepresentation, even where there is no allegation of fraud. That results in a disproportionately harsh outcome for the consumer where the outcome should be relative to the prejudice suffered by the insurer.
47. It is therefore submitted that the FSC Code should include a clause expressly *requiring* all FSC members to utilise s29(6) and not avoid the policy from inception unless an insurer can prove that:
- (1) it would not have accepted the risk on terms that would have responded to the claim actually made; and
  - (2) the non-disclosure/misrepresentation was fraudulent.
48. The FSC Code should provide that in circumstances where FSC members invoke s29, including s29(6), its underwriting material relied upon to do so must be produced by the insurer prior to

any avoidance or change of terms. The FSC Code should provide for the provision of the following specific documents to the consumer, consistent with the FOS Circular edition 3:<sup>19</sup>

- *A copy of the applicable underwriting guidelines that were in operation at the time the insurance contract was entered into.*
- *A statutory declaration from a person with the appropriate authority in the insurer's underwriting department identifying:*
  - *the underwriting guidelines that were in operation at the time the applicant breached their duty of disclosure, and*
  - *how the insurer would have applied the underwriting guidelines to the applicant's contract of insurance had the correct disclosure been made.*
- *Where there are no clear underwriting guidelines covering the situation, examples of similar declines of insurance which are:*
  - *reasonably contemporaneous to when the non-disclosure occurred, and*
  - *similar in circumstances to the dispute. For example, if the non-disclosure is related to traffic history, the example should be that a policy was refused due to non-disclosure of traffic offences. An example of non-disclosure for modifications would not meet this requirement.*
- *Where the underwriting guidelines require the exercise of an underwriter's discretionary statutory declaration from the person who has (or would have had) the appropriate authority to exercise the relevant discretion explaining how that person would have exercised their discretion to the applicant's proposal together with any available examples to demonstrate the process by which the discretion is exercised.*

49. Such disclosure would also be in keeping with Recommendation 10.6 of the PJC's inquiry.

50. The ALA also refers to and repeats submissions under clause 5.17 above regarding the production of material in compliance with discrimination laws vis-à-vis policy avoidance or variation under s29 of the ICA.

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<sup>19</sup> <https://www.fos.org.au/circular3/Nondisclosure.html>.

51. Section 29(3) does not state the act that constitutes the avoidance of the contract; however, it is submitted that an avoidance cannot take place until the insurer has communicated the avoidance to the consumer and the consumer has received it. It is submitted that the FSC Code should contain a consistent industry position on the issue of notice in accordance with the above, and that it should further clarify that a notice will be taken to have been communicated to the consumer from the date three days after written notice was sent to the consumer's last known mailing address.

#### Clause 6.8

52. The ALA has been involved in many claims/disputes where, in the time period between the insured event and the payment of the claimed benefit, the policy lapses due to cancellation or non-payment of premium. Such lapses are generally caused by the consumer's impecuniosity due to the non-payment of their claim. Unfortunately, some insurers have disputed a consumer's right to claim benefits under the cancelled policy (e.g. ongoing income protection benefits from after the cancellation) even where the policy contains a premium waiver. That outcome harshly and disproportionately prejudices consumers who would have been able to maintain their policies but for the insurer's decision to dispute or delay acceptance of their claim.

53. To address this unfairness, it is submitted that the FSC Code should include a clause to the effect that where, after an insured event occurs, the consumer's policy lapses due to cancellation or non-payment of a premium, the FSC member will reinstate the policy upon the acceptance of any claim by the consumer:

- a. if the policy contains a premium waiver clause for claimants in receipt of income protection payments, at no charge to the consumer;
- b. if the policy does not contain a premium waiver clause for claimants in receipt of income protection payments, upon the consumer making payment of backdated premiums from the date of cancellation to the acceptance of the claim, within 28 days from the receipt of payment of the benefit from the FSC member.

#### Clause 8.5A

54. The comments concerning clause 5.20 above are repeated.

#### Clause 8.8A

55. The comments concerning clause 5.20 above are repeated.

#### Clause 8.10(b)

56. The ALA submits that this clause should provide that the FSC member will, where possible, provide a list of three independent service providers from which the consumer may nominate one.

#### Clause 8.10(c)

57. This clause purports to allow FSC members to send a claimant to multiple health practitioners of the same discipline as long as the consultations are six months apart. That is inappropriate and effectively enables 'doctor-shopping' by insurers over the course of a claim. If a further consultation is genuinely needed after six months due to some development in the claimant's condition, the insurer should only be entitled to send the claimant back to the original Independent Medical Examiner (IME) for supplementary opinion, not to a new IME. That accords with the principle that courts are generally loathe to permit a multiplicity of experts on a specific issue.<sup>20</sup>

58. In support of this submission, the ALA notes the unfortunate prevalence of 'doctor-shopping' by FSC members in respect to income protection claims which run over a number of years where the insurer wants to 'have a go' at the claimant on an intermittent basis despite having medical evidence supporting the claim. See for example the case study examined by the ABC's 2016 story wherein the claimant, Mr Fernando, who suffered from major depression and adjustment disorder, was compelled by his income protection insurer Westpac Life Insurance Limited to submit to examination by numerous different psychiatrists over three years until a third psychiatrist's opinion deviated from the preponderance of supportive evidence and was used by the insurer to cease payments.<sup>21</sup>

59. Furthermore, the word "avoid" is non-committal and should be replaced with definitive language.

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<sup>20</sup> *Tvedsborg v Vega* (2009) NSWCA 57; *Hinset Pty Ltd v Lane Cove Council* (2011) NSWLEC 120.

<sup>21</sup> Radio National's Background Briefing: "Insurance industry stuck in 'dark ages', say mental health advocates", 27 November 2016 (<http://www.abc.net.au/radionational/programs/backgroundbriefing/2016-11-27/8054972>).

Clause 8.11(p)

60. The ALA is aware of many instances where interviews have been used to seek information from claimants which are used to deny claims based on fraud (s56 of the ICA), an exclusion clause or an allegation of non-disclosure/misrepresentation. It can often be seen from the transcript of an interview that the interviewer held some suspicion which it sought to confirm, without forthrightly informing the claimant of the suspicion being tested. It is submitted that this is inconsistent with an insurer's duty to act in the utmost good faith.

61. The ALA submits that the FSC Code should include the following provisions concerning the conduct of interviews:

- a. That an interview will only be requested where the life insurer has a reasonable basis to believe that there are inconsistencies in the information it has about the claim based on documented evidence which is not based on an unconfirmed suspicion which the insurer hopes to later confirm through an interview and where that inconsistency cannot be reconciled without an interview;
- b. That where the insurer holds a suspicion concerning the claimant's conduct that, if true could lead to a denial of the claim or avoidance/variation of the contract, it will notify the claimant of the evidence in support of that suspicion, and provide a summary of specific issues to be discussed in the interview, at least 24 hours prior to the interview;
- c. That it will allow the claimant to have a legal representative present at the interview;
- d. That it will not compel the claimant to sign any statement or record of the interview;
- e. That it will not make any audio recording of the interview without the claimant's consent and will inform the claimant of her/his right to decline to have the interview recorded.

Clause 8.13

62. The ALA submits that the FSC Code should specifically state that surveillance will only be requested where the life insurer has a reasonable basis to believe that there are inconsistencies in the information it has about the claim based on documented evidence which is not based on an unconfirmed suspicion which the insurer hopes to later confirm through

surveillance and interview, and where that inconsistency cannot be reconciled without surveillance.

63. It is submitted that special provisions should be included concerning the deployment of surveillance of a claimant who has a diagnosed mental health condition or who is making a claim based on a mental health condition due to the specific and complex range of difficulties encountered by claimants suffering from psychological illness.
64. The ALA notes the limited utility of surveillance in such claims as well as the elevated risk of claimants' conditions being aggravated by surveillance activities.<sup>22</sup> That was demonstrated by the TAL Life Limited case study in the Financial Services Royal Commission which demonstrated the insurer's obvious lack of good faith by not only seeking evidence from a surveillance operative, but insisting on its delivery, which counterproductively led to the exacerbation of the claimant's illness.
65. The ALA endorses the pertinent remarks of Robb J concerning surveillance of psychological claimants in *Wheeler v FSS Trustee Corporation as trustee for the First State Superannuation Scheme*:<sup>23</sup>

'I will not attempt to be exhaustive, but the medical evidence suggests that both PTSD and major depressive disorder are insidious mental injuries, which can be extremely detrimental to the sufferer's ability to hold down regular employment, whether full-time or part-time; but the symptoms of the disorders are not permanently and consistently manifested. The psychological injuries may have the effect that the sufferer becomes too unreliable, too disorganised, too unsociable, and too lethargic, to be realistically employable, among other disabilities. However, when a person is suffering from these psychological disorders, what you see is not necessarily what you get. The sufferer may, at various times and periods, appear reasonably normal, and capable of engaging in many forms of employment. The presence of the psychological disorders is not necessarily inconsistent with periods of happiness and sociability. Indeed, treating psychiatrists and psychologists are most likely to advise sufferers to do their best to get out into the real world and try to live a normal life, as a remedial

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<sup>22</sup> See for example <https://www.smh.com.au/national/nsw/life-insurance-claims-often-more-stressful-than-original-injury-20151112-gkwzib.html>; <https://www.smh.com.au/business/banking-and-finance/doorknock-insurers-must-be-stopped-20160311-gngy5x.html>; <http://www.abc.net.au/news/2016-03-17/insurance-investigators-accused-of-bullying-and-intimidation/7255262>; <http://www.abc.net.au/radionational/programs/backgroundbriefing/2016-11-27/8054972>.

<sup>23</sup> *Wheeler v FSS Trustee Corporation as trustee for the First State Superannuation Scheme* [2016] NSWSC 534 at [273].

exercise. In short, the ordinary person cannot safely look at evidence of the occasional day to day activities of a person suffering from PTSD and major depressive disorder, and conclude that the person is not suffering from disabilities that may make the person practically unemployable, because the person is able from time to time to engage in the sort of activities of which healthy people are capable of doing.’

66. It is submitted that the FSC Code include the following provisions:

- a. FSC members proposing to conduct surveillance on a claimant with any non-physical medical condition be required to submit an ex parte application for approval to an independent body such as AFCA or the LCCC which would be mandated to consider and determine any such applications before surveillance is commenced;
- b. The test for approving the application be that the independent body is satisfied based on evidence proffered by the insurer that:
  - i. there is a reasonable basis for believing that the claimant has given inconsistent information to it in respect to the claim in issue which is not based on an unconfirmed suspicion which the insurer hopes to later confirm through the surveillance activity; and
  - ii. there is medical opinion from an appropriately qualified expert witness or otherwise that there is no danger that the proposed surveillance activity, conducted lawfully, will cause harm to the claimant.

#### Clause 8.19

67. We are aware of circumstances where insurers have withheld documents from their internal medical officers advising of their support for an admission of liability, but where the claims officer has decided not to follow that advice and declines the claim without providing the claimant with the document in issue.<sup>24</sup> This industry problem featured prominently in the Financial Services Royal Commission, where it was revealed how CBA routinely ignored the medical advice of its own employed doctors (including its chief medical officer Dr Benjamin Koh who blew the whistle on the company’s misconduct in 2016, to update its definition of

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<sup>24</sup> The ALA is prepared to provide you with the details of a specific ongoing litigation matter on these facts subject to the consent of SunSuper Pty Ltd and AIA Australia Limited.

heart attack), and routinely rejected related claims because it would cost the company more money.<sup>25</sup>

68. The ALA calls for a clause in the FSC Code compelling FSC members to admit liability where their internal medical officers have advised of their support for an admission of liability.

#### Clause 8.20

69. The ALA submits that this clause should be revised as follows:

‘Our claims assessors will be appropriately skilled and trained to make objective decisions. They will not make claims decisions on our behalf until they have demonstrated technical competency and an understanding of all relevant law, the Code and relevant FSC Standards and Guidance. We will ensure that the remuneration of our claims assessors, including their entitlements to any bonuses, is consistent with the principles set out in section 1.7 of the Code, and is not based, directly or indirectly, on financial or other targets for declined claims or deferrals of decisions.’

#### Clause 8.26

70. The ALA notes the findings of the PJC which firmly rejected the FSC’s proposal that life insurers have an expanded role in the rehabilitation of insured persons.<sup>26</sup> Specifically, the PJC stated:

*3.104 The committee has particular concerns about the FSC's answer regarding the provision of discretionary rehabilitation medical treatment. In the committee's view, a system that operates at the discretion of life insurers would appear to provide even less equity of access than a risk-rated system. A risk-rated insurance system at least has identifiable processes that can be held to account by dispute resolution systems, regulators and the courts. The FSC's discretionary proposal, however, has no equity of access and no accountability.*

*3.105 The committee also has concerns about AIA's suggestion that the current prohibition on life insurance in the health sector is a legislative anomaly. Rather, the evidence from the Department of Health indicates that the difference between risk-rated and community-rated*

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<sup>25</sup> <https://www.theaustralian.com.au/business/banking-royal-commission/banking-royal-commission-cba-rejected-heart-attack-claims-misled-ombudsman/news-story/3fcab50aa16c65d99fb48402f981b705>.

<sup>26</sup> [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/Rehabilitation/Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Rehabilitation/Report).

*insurance stems from the fact that Medicare was designed as a system of universal access for Australians.*

71. The ALA has concerns regarding instances where insurers have sought to use independent medical examiners to contact claimants' treating doctor(s), ostensibly to discuss treatment issues. The FSC considers such conduct clearly inappropriate for an independent medical examiner appointed by an insurer (and generally briefed with a copy of the Expert Witness Code of Conduct in anticipation of legal proceedings) to seek to involve himself or herself in discussions between the claimant client and their treating physicians concerning their treatment.<sup>27</sup> That would amount to a breach of the provisions of the *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).
72. The ALA submits that the FSC Code should set standards that elaborate on, exceed or clarify this controversial area of law by clearly stating that FSC members are not permitted to and will not provide funding for or otherwise facilitate rehabilitation medical treatment whether as a claim requirement or otherwise.
73. The ALA also has significant concerns about the increasing use of life insurance policies such as the SunSuper Pty Ltd/AIA Australia Limited TPD Assist policy which purports to allow AIA to decline a TPD claim where it decides the claimant has not fully participated in 'an Occupational Rehabilitation Program' to AIA's satisfaction. An ordinary member of the public could not be expected to know the difference between 'an Occupational Rehabilitation Program', which is not prohibited by statute, and 'discretionary rehabilitation medical treatment' which is prohibited. It is submitted that the FSC Code should set standards that elaborate on, exceed or clarify this important distinction.
74. It is the ALA's firm belief that the standards for lawful rehabilitation programs (i.e. programs that do not involve medical treatment) should be no less favourable to consumers than the discretionary rehabilitation medical treatment would be if the FSC's law reform proposal had been recommended by the PJC. Therefore, consistent with the representations of Mr Allan

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<sup>27</sup> The ALA is prepared to provide you with the details of a specific ongoing litigation matter on these facts subject to the consent of AIA Australia Limited.

Hansall of the FSC to the PJC,<sup>28</sup> the FSC Code should state that such rehabilitation programs should be subject to the following minimum standards:

- a. It will only be proposed 'when the [rehabilitation] is cost effective for both the customer and the insurer';
- b. Any rehabilitation proposal 'would always be arranged through the customer's treating physician, and would be dependent on the customer's agreement and participation';
- c. 'No consumer will be forced to receive [rehabilitation] they don't want'; and
- d. Any patient who does not wish to receive [rehabilitation] 'will not have their income protection and TPD insurance payments stopped'.

#### Clause 9.9

75. The ALA has long called for the FSC Code to require FSC members to advise insured persons of their right to independent legal advice at the point where a claim had been declined or delayed beyond the time provided for in the FSC Code claim determinations.
76. A claimant's access to independent legal representation is a fundamental right and one which ought to be respected by FSC members in all circumstances. Where a claim has been declined there is immediately a divergence of interests between the insurer and the claimant. Neither insurers nor fund trustees can independently advise claimants at this point and it ought to be incumbent on FSC members, as part of the duty of utmost good faith, to ensure that consumers know they have the right to access independent advice.
77. We would urge you to adopt our previous suggested changes in this regard.
78. Insurers who have complied with the FSC Code should have nothing to fear from the involvement of independent legal representatives. Claims that have been properly denied are unlikely to be disputed with legal representation. The provision of legal advice at this point will assure the claimant that the insurer has made the correct decision if that is the case. This can

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<sup>28</sup> [https://parlinfo.aph.gov.au/parlInfo/download/committees/commint/49094fee-6d97-4fb3-b5b2-18e6f649e791/toc\\_pdf/Parliamentary%20Joint%20Committee%20on%20Corporations%20and%20Financial%20Services\\_2018\\_06\\_19\\_6247\\_Official.pdf;fileType=application%2Fpdf#search=%22committees/commint/49094fee-6d97-4fb3-b5b2-18e6f649e791/0000%22](https://parlinfo.aph.gov.au/parlInfo/download/committees/commint/49094fee-6d97-4fb3-b5b2-18e6f649e791/toc_pdf/Parliamentary%20Joint%20Committee%20on%20Corporations%20and%20Financial%20Services_2018_06_19_6247_Official.pdf;fileType=application%2Fpdf#search=%22committees/commint/49094fee-6d97-4fb3-b5b2-18e6f649e791/0000%22) at page 25.

only benefit the relationship between the insurer and the claimant and avoid acrimony or misunderstandings as to the insurer's decision.

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

### Clause 12.9

79. The FSC Code should confirm under the heading 'Legal Status of Chapter 2' that it prevails over the terms of any relevant insurance contract or fund rules to the extent of any inconsistency. In relation to fund rules, as part of the FSC obtaining ASIC approval for the FSC Code, it should, if considered necessary by ASIC, seek a direction in respect to s58(2)(b) of the *Superannuation Industry (Supervision) Act 1993* (Cth) that trustees covered by the FSC Code be subject to the FSC Code, in the exercise of any of the trustee's powers. The ALA submits that there is little value in a Code of Practice which contains terms that an FSC member can simply contract out of.

### Clause 13.9

80. The ALA prefers option 2. While the proposal to impose a 'hard' cap on premiums as a percentage of salary is appropriate in principle, any cap needs to allow sufficient flexibility for different demographic cohorts within each fund's membership. Such arrangements should also have flexibility to accommodate different workplace practices, such as government organisations that contribute more than the Superannuation Guarantee (SG) rate of 9.5 per cent.

### Clause 13.13

81. The ALA repeats the comments made in relation to Clause 3.1(d) above.

### Clause 13.15

82. Consistent with Recommendation 10.60 of the PJC, the ALA also calls for the FSC Code to require FSC members to:

- a. regularly update all definitions in policies to align with current medical knowledge and research;
- b. standardise definitions across all types of policies;

- c. use clear and simple language in definitions; and
- d. clearly explain which associated conditions that may arise from the initial condition, including mental ill-health, are covered by the insurance policy.

83. The submissions at paragraph 18 above concerning FSC Code clause 3.1(e) are referred to and repeated.

#### Clause 13.22

84. Unless and until specific legal requirements for the automatic cancellation of insurance within superannuation have been passed, such examples should not be included as these may mislead or confuse consumers as to whether such examples are in fact applicable.

#### Clause 13.24

85. The ALA submits that the FSC Code should provide that those consumers who apply to have default cover reinstated after losing it due to a lapse in contributions ought not to be subjected to any underwriting requirements over and above those used for other members with default cover, providing their reinstatement request is received within a reasonable period of time, which the ALA submits should be 90 days from cancellation. The ALA is not aware of any grounds to assume that a lapse in contributions was related to injury or illness when it could be due to any number of factors that would not give rise to an anti-selection risk (e.g. pregnancy, change in employment, non-payment of employer contributions). In any case, the members applying will be subject to the usual blanket underwriting conditions such as 'active employment' tests.

86. Further, the term 'health assessment' at footnote 37 of the FSC Code, and clauses 13.9 and 13.22, are not defined. The lack of clarity as to that term is likely to mislead or confuse consumers. For example, does it mean that the life insurer will not ask for details of the consumer's health, or just that it won't require them to attend a doctor for a health assessment?

#### Clause 13.25

87. The measures proposed at clause 13.25 only involve the relevant FSC members identifying insurance in other funds. It is silent on what action, if any, is taken by the FSC member once that has occurred. The Code should clearly state the role and limits FSC members have in facilitating any consolidation, and caution against FSC members providing any information to

consumers that could be construed as an opinion or recommendation in the nature of personal advice. On that point, we refer to the recent decision of *ASIC v Westpac Securities Administration Limited & Anor*<sup>29</sup> where ASIC alleged that in its telephone campaigns Westpac's BT Funds Management Limited (BT) breached the law by telephoning banking customers and encouraging them to transfer their superannuation savings into BT-administered accounts. As a result of these efforts, Westpac successfully increased its funds under management by almost \$650 million and had no regard to whether or not such a transfer was more appropriate for any of the customers including whether any insurance held in the fund being exited would be lost. Gleeson J found that BT failed to ensure that its conduct was 'provided efficiently, honestly and fairly in contravention of s912A(1)(a) of the *Corporations Act 2001* (Cth)' as the customers would not have known that Westpac was acting purely out of self-interest in promoting the switch.

88. The fact is that cessation, whether automatic or through consolidation, may result in a member losing superior cover, paying higher fees and otherwise being placed in a position that is less suitable to the consumer's personal circumstances. Due to the low public engagement in super, this fact may not be appreciated by the majority of affected members who are being unwittingly disadvantaged by a consolidation.
89. The ALA does not oppose automatic cessation of insurance in an inactive fund in principle; however, we call for accompanying counter-measures to ensure that a member's insurance held in the prevailing fund is not inferior in its terms or less adequate in its quantum to the cover being lost. That is why it is inadequate for the trustee to simply identify, and inform a member of an inactive fund without a broader account rationalisation approach in place which consistently ensures that a member does not end up worse off as the result of a consolidation. The ALA further calls for the FSC Code to ban the types of activities demonstrated by BT in the above case, being activities which BT itself described as a "plainly self-interested" sales or marketing exercise.
90. On a related note, the risk that multiple insurances may result in one or more policies not being claimable is not limited to income protection offsets. This risk extends to total and permanent disablement (TPD) exclusion clauses found in some super policies that will not pay where a

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<sup>29</sup> *Australian Securities and Investments Commission v Westpac Securities Administration Limited & Anor.* [2018] FCA 2078.

member is eligible to claim or has received a benefit on disability grounds. See for example the following definition from the previous NGS Super/CommInsure policy:<sup>30</sup>

**'Excluded Member** Means a *Member* to whom any of the following applies:

- a) a terminal illness, TPD, trauma or similar benefit has been paid or is payable or can be claimed in respect of the *Member* under any insurance policy, whether that policy be owned by the *Member* or another person (including the *Fund* or another superannuation scheme);
- b) the *Member* has received, or is eligible to receive, a benefit, or has had a claim for a benefit admitted, from:
  - (i) the *Fund*; or
  - (ii) another superannuation scheme;on the basis the fund or scheme has found the *Member* to suffer from 'permanent incapacity' or a 'terminal medical condition' under the Superannuation Industry (Supervision) legislation or any legislation which replaces it; or
- c) the *Member* had or was eligible to have cover under any group life policy issued to the *Fund* and the *Member*:
  - (i) opted out of being covered; or
  - (ii) cancelled the cover; or
  - (iii) ceased being a member of the *Fund*.'

91. The ATO has stated that as at 30 June 2018 approximately 39 per cent of workers held more than one super account.<sup>31</sup> As such, this CommInsure policy effectively excludes TPD claims by almost half of its members despite taking non-refundable premiums from them.

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<sup>30</sup> A further example is found at paragraph 23 here: <https://www.lawyersalliance.com.au/documents/item/1360>.

<sup>31</sup> <https://www.ato.gov.au/About-ATO/Research-and-statistics/In-detail/Super-statistics/Super-accounts-data/Super-accounts-data-overview/>.

92. The ALA submits that such clauses are manifestly inconsistent with the objective of reducing underinsurance and the taking of premiums for such cover is unconscionable. We call for the FSC Code to provide for a ban against TPD clauses that offset or nullify one another.

#### Clause 14.5

93. The Key Facts Sheet (KFS) should clearly explain the role of the trustee, including having fiduciary obligations to the member base as a whole, in the event of claim, and not being an advocate for an individual in the ordinary sense. For example, trustees should clarify how they interpret 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'.<sup>32</sup> For example:

- a. whether its actions to pursue an insurance claim might extend to commencing court proceedings on behalf of the member in the event that it disagreed with an insurer's decision, or whether its involvement in making a claim would end at denial stage; and
- b. whether it will warn or protect the member if a court limitation is approaching.

94. The ALA points out that it is clear that with extremely rare exceptions, fund trustees do not take action to commence court proceedings on behalf of members with reasonable prospects of success, as confirmed by the cases won by claimants against insurers (and trustees) over the years without any support from the trustee. Rather, trustees leave pursuing such an action to consumers themselves if the consumer happens to retain a lawyer and have the wherewithal to prosecute such a claim despite the risks and stressors involved. The inevitable consequence is that a proportion of consumers with reasonable prospects of success who have claims declined do not seek legal help due to their vulnerability and/or circumspection; meaning that they never receive their benefit or any settlement reflecting those prospects. Clarity is needed on this issue, starting with confirmation in the FSC Code and the KFS that members have the option of retaining independent legal representation in the event of a claim, and that important limitation dates apply (if trustees are not going to assume that role, which in our submission they are not equipped or suitably insured to do).

95. Trustees should also confirm that information provided to them by the consumer is not subject to legal professional privilege and may be obtained by the insurer.

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<sup>32</sup> Section 52(7)(d) of the SIS Act.

96. The ALA otherwise repeats the submissions regarding KFS disclosure set out above in response to proposed clause 3.1.

#### Clause 14.6

97. The proposed iteration of the KFS does define 'active employment' or 'at work', and does not demonstrate to consumers, in any practical manner, how claim eligibility may be limited by the need to meet such tests. It is submitted that the KFS should do more than provide 'high level' information about the fund – it should actually tell consumers whether they currently meet such a test, thereby giving them certainty as to whether they have a limited or otherwise inferior form of cover.

98. Too often, consumers do not find out about the application of some form of limited/inferior cover such as a pre-existing exclusion clause or Activities of Daily Living definition until their claim is declined, despite paying the same premium as optimally insured members. That is because neither trustees nor insurers know which group members will be deemed to have inferior conditions until after a claim is lodged.

99. The REST case study in the Royal Commission hearings highlighted the effects of this problem for a disabled and vulnerable consumer. In that case the trustee (REST), the FSC member insurer (AIA) and the participating employer (McDonalds) failed to have proper systems in place to determine vulnerable consumers' employment status and other circumstances directly material to each fund member's eligibility for cover.

100. That case is emblematic of a widespread industry problem. The ALA submits that the KFS should confirm what the member's current work status is. That is, whether they have met the underwriting test for 'active employment' or 'at work' by meeting the minimum hours worked per week based on available data, so the consumer knows what cover they actually have instead of having to be retrospectively underwritten at the time of claim.

101. Furthermore, it is submitted that the FSC Code should provide that full cover is granted where either of the following has occurred:

- a. a certain qualifying period of unrestricted employment has passed; or
- b. a member's compulsory super guarantee contributions made to the fund by the employer is above a threshold set by the fund/insurer.

102. Neither of the above should be burdensome administratively, as funds obviously have the data on their members' contribution periods and amounts ready to hand. Using that data, funds and their insurers could determine the scope of cover for each consumer, and clearly disclose same to them in their KFS and periodical membership statements. It is submitted that the above approach is workable and reasonable: if after a qualifying period of employment a pre-existing condition has not caused a member to cease work, or within that qualifying period they are working sufficient hours to attract a certain level of super guarantee contributions, then any such pre-existing condition's effect on risk is much diminished and the insurer ought to recognise that.

#### Clause 14.14

103. The ALA submits that the categories for TPD at clause 14.14 of the FSC Code are inadequate and are likely to mislead or confuse lay readers. For example, they do not once mention rehabilitation or retraining clauses, which can have a huge impact on the operation of a definition to the facts. They also conflate 'unlikely' and 'unable' definitions into one class when these are legally distinguishable in very important ways that are well known to the FSC. They also fail to deal with benefit design regarding the payment of lump sum versus incremental payments and that should be done here or elsewhere in the FSC Code with clarity. We again call for a tiering system for TPD policies, as discussed in the submissions responding to FSC Code clause 3.1(d) above.

#### Clause 15.12

104. The Code should make it clear that the FSC member trustees' obligations under the FSC Code will not cease upon cessation of a consumer's membership but will persist as long as the claimant was a member at the time of the insured event.

#### Clause 16.12

105. The ALA submits that the FSC Code should commit FSC member trustees not to tell an enquirer that they are ineligible to claim if they do not have cover at the time they make their enquiry and will investigate whether they had cover at the time they ceased work.

#### Clauses 16.15 and 16.16

106. Clauses 16.15 and 16.16 of the FSC Code should provide for the provision of information to claimants that important limitation dates apply, about which they can seek independent legal advice.

#### Clause 16.21

107. It is submitted that the FSC Code should affirm FSC members' commitment to have due regard to a TPD claimant's real world prospects of obtaining employment in the competitive labour market in accordance with the legal authorities<sup>33</sup> so that the public can have confidence that the test is not being applied abstractly (i.e. without regard to the practical realities faced by disabled job applicants).

108. That should include a commitment that FSC members will not assess the availability of employment in an alternative geographic location to where the claimant lives 'without also taking into account the costs of the claimant relocating or travelling to acquire such employment'.<sup>34</sup> That would accord with the leading common law authorities and provide clarity for consumers on this area of law. On that issue, the ALA is aware of instances where FSC members have assessed a claimant's employability across the entire State of Queensland in circumstances where they live in remote or indigenous communities and where a relocation or commute to an area that may have employment available is financially impossible.<sup>35</sup>

#### Clause 17.5

109. The ALA cautions against premium adjustment arrangements including because:

- a. particularly where the trustee and insurer are related corporate entities as is generally the case for retail funds, there is a moral hazard as the trustee is incentivised to 'rubber stamp' the insurer's decision. Indeed, there have been dozens of court cases in which the insurer's decision was overturned, even though the trustee had approved that decision. In other words, it raises real or perceived questions of conflict of interest on the part of the trustee and insurer, which operate against a claimant member's interests and which may not accord with community standards and expectations;

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<sup>33</sup> See, for example, *Diosdado SAYSENG v Kellogg Superannuation Pty Ltd and Anor* [2007] NSWSC 583 at [64], [73] and the recent decision in *Jones v United Super Pty Ltd* [2016] NSWSC 1551 at [66], upheld on appeal, which stated that 'An ability to engage in work should not be governed solely by capacity, but also by opportunity'.

<sup>34</sup> *Carroll v United Super* [2018] NSWSC at [197] – [207]; *MX v FSS Trustee Corporation as Trustee of the First State Superannuation Scheme & Anor* [2018] NSWSC 923 at [90] – [100].

<sup>35</sup> The ALA is prepared to provide you with the details of a specific ongoing litigation matter on these facts subject to the consent of SunSuper Pty Ltd and AIA Australia Limited.

- b. they inherently cause inequity, disadvantaging members who cease their membership and favouring new members.

110. If FSC members are going to continue to engage in premium adjustment arrangements or 'profit sharing' despite the above and other issues, the FSC Code should undertake that trustees will not have regard to such arrangements in the administration of members' claims and will also make publicly available data on the actual amount received from the insurer in the past financial years.

111. The ALA notes that Commissioner Hayne is actively considering whether fund trustees should be prohibited from engaging an associated entity as the fund's group life insurer.<sup>36</sup> It is submitted that the FSC members should 'get ahead' of this issue by including such a ban in the FSC Code. That is the proper approach to take given the inherent risks associated with large volume vertical integration as seen in the numerous cases studies in the Financial Services Royal Commission involving retail superannuation trustees who almost without exception insure their members with their affiliated companies at rates that represent poor value compared with equivalent cover offered by, for example, industry funds. Such cover often contains draconian exclusion clauses. Indeed, there are few if any examples of a fund trustee owned by a major bank or AMP engaging a non-affiliated insurer.

### Clause 20.3

112. The ALA submits that offset clauses (other than under income protection policies) should be banned by the FSC Code in light of the fact that TPD, death and other contingency-based insurance products are not indemnity policies and therefore do not attract public policy grounds for such an offset. Furthermore, we note the public position of FSC members that there is a substantial underinsurance problem in Australia and the fact that such an offset clause exacerbates the very problem FSC members have raised publicly to encourage greater insurance sales.<sup>37</sup>

113. Further to the submissions above in response to FSC Code clause 3.6B, a clear standard for any purported offsetting of Centrelink should be reached and enshrined in the Code to ensure

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<sup>36</sup> See Question 26 of the Policy questions arising from Module 6:

<https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwik1eekws7fAhWPF4gKHXa2A6MQFIAAegQIABAC&url=https%3A%2F%2Ffinancialservices.royalcommission.gov.au%2Fpublic-hearings%2Fdocuments%2FRound-6-closing-submissions%2Fpolicy-questions-arising-from-module-6.pdf&usg=AOvVaw3Gduc8Gn4-F1DH1U-RCbU>

<sup>37</sup> See for example quote of former AMP Chairman Peter Mason: *AMP to fight Gillard's backlash against insurance commissions*, Sydney Morning Herald, Eric Johnston, 13 May 2011 <https://www.smh.com.au/business/amp-to-fight-gillards-backlash-against-insurance-commissions-20110512-1ekls.html>.

that income protection payments are consistent with industry practice and public policy as publicly stated by FSC members.<sup>38</sup>

114. It is submitted that a clause should be included to state a consistent industry position regarding the refund of premiums in the event that an avoidance occurs. In that respect, it is submitted that the position should be for the full refund of all premiums on the avoided policy regardless of the basis for avoidance.

115. Given that TPD and death cover are usually coupled, it is not clear whether the refund referred to in the FSC Code will refund the full coupled premium including the death component on acceptance of a TPD claim. This should be made clear.

#### Clause 22.5(c)

116. The ALA continues to strenuously oppose this clause which is obviously inappropriate. It is not a consumer protection but purports to give the FSC members rights against consumers that will be inconsistent with the law in some circumstances. Specifically, it is inconsistent with insurers' long-established 'procedural fairness' obligations<sup>39</sup> and their duty of utmost good faith. We are aware, for example, of circumstances where insurers have withheld documents from their internal medical officers advising of their support for an admission of liability, but where the claims officer has decided not to follow that advice and declines the claim without providing the claimant with the document in issue.<sup>40</sup> Clearly, information that may be prejudicial to the FSC member is precisely the information that the law requires *must* be disclosed to the consumer and a clause should be included to that effect.

117. Regarding clause 22.5 as a whole, it is not a consumer protection but purports to give the FSC members rights against consumers that will be inconsistent with the law in some circumstances and therefore has no proper place in a code of practice.

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<sup>38</sup> See for example TAL's position that "[Income protection Insurance](https://www.tal.com.au/slice-of-life-blog/life-insurance-and-income-protection-for-the-self-employed) will generally cover up to 75% of your monthly income": <https://www.tal.com.au/slice-of-life-blog/life-insurance-and-income-protection-for-the-self-employed>.

<sup>39</sup> *Sayseng v Kellogg Superannuation Pty Ltd & Anor* [2003] NSWSC 945 per Bryson J at [82].

<sup>40</sup> The ALA is prepared to provide you with the details of a specific ongoing litigation matter on these facts subject to the consent of SunSuper Pty Ltd and AIA Australia Limited.

## Chapter 3 – Code Governance, Sanctions and Definitions

### Clause 25.15

118. Further to the submissions made in the Introduction above, it is noted that clause 25.12 is currently not compliant with ASIC's Regulatory Guide (RG) 183 *Approval of financial services sector codes of conduct*<sup>41</sup> regarding remedies and sanctions. No reasoning has been given for the lack of compliance and it is submitted that consistency with the RG is expected and important given the contextual history leading to the formulation of the Code.

### Clause 27 – 'Exceptional circumstances'

119. The term 'so late' in sub-paragraph (a) is undefined and open to misuse. The test of lateness should be measured by actual prejudice suffered by the FSC member consistently with the principle enshrined in s54 of the ICA.

### Clause 27 – 'Unexpected circumstances'

120. It is submitted that the definition of 'unexpected circumstances' is excessively broad in that it is not limited to factors outside FSC members' control. The broad codicil is prone to misuse and the ALA is aware of FSC members invoking it as the basis for requesting documents and information that are routine (or expected) but which the FSC member has not sought in a timely manner, noting the tendency of insurers to make requests on a piecemeal basis which contributes to the historically high delays<sup>42</sup> in the assessment of life insurance TPD and income protection claims.

121. The ALA submits that the definition should include a non-exhaustive list of information requirements that are expected in claims (and are therefore not to be relied upon to invoke this clause). The list should include requests for documents/information from or relating to:

- a. Medicare;
- b. PBS;

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<sup>41</sup> <https://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf>.

<sup>42</sup> Noting for example ASIC Report 498, *Life insurance claims: An industry review*, October 2016 found that one life insurer took an average of 21 months to determine TPD claims:

[https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKewiawaH5883fAhUDbrwKHdW\\_oDOAQFiABegQIBBAB&url=https%3A%2F%2Fasic.gov.au%2Fregulatory-resources%2Ffind-a-document%2Freports%2Frep-498-life-insurance-claims-an-industry-review%2F&usg=AOvVaw1-GerHOMt8bpeR9FzrGduG](https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKewiawaH5883fAhUDbrwKHdW_oDOAQFiABegQIBBAB&url=https%3A%2F%2Fasic.gov.au%2Fregulatory-resources%2Ffind-a-document%2Freports%2Frep-498-life-insurance-claims-an-industry-review%2F&usg=AOvVaw1-GerHOMt8bpeR9FzrGduG)

- c. Tax or other financial material;
- d. Centrelink;
- e. Employment information;
- f. Treating doctor's statements;
- g. Medical information including IME reports;
- h. Interview/investigation material;
- i. Surveillance material;

where the FSC member's request for the documents/information was not made by the FSC member within the earlier of:

- a. 28 days of receiving the claim being received; or
- b. 7 days of the FSC member receiving a targeted authority from the claimant enabling the FSC member to access the information sought.

122. The ALA submits that 28 days is a reasonable period of time to expect an FSC member to consider the initial claim material and determine what requests should be made and to make such requests.



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