

Unfair terms in insurance contracts: Options Paper
Corporations and Financial Services Division
Treasury
Langton Crescent
PARKES ACT 2600

Attention: Mr Andrew Sellars
Via email: ICAReview@treasury.gov.au

5 May 2010

Dear Mr Sellars

UNFAIR TERMS IN INSURANCE CONTRACTS

The Insurance Council of Australia¹ (Insurance Council) appreciates the opportunity to respond to the Treasury paper seeking comments on options to deal with the potential for unfair terms in insurance contracts (Options Paper)². The Insurance Council's responses to each of the questions in the Options Paper and its specific comments on each of the options are contained in Attachment A.

We note the review stems from a recommendation from the Senate Economics Legislation Committee (Senate Committee) that the "Government address insurance contract legislation to ensure that the **Insurance Contracts Act 1984 (Cth)** (the Insurance Contracts Act or the Act) provides an equivalent level of protection for consumers to that provided by the Trade Practices Amendment (Australian Consumer Law) Act 2010" (ACL).³

Adequate protection is already provided for consumers

As argued in our submissions to the Senate Committee (included as Attachment B for ease of reference), the Insurance Council submits that the Insurance Contracts Act in fact provides better protection to consumers of insurance than would the ACL which was not specifically drafted to address the particular issues raised by insurance contracts.

¹ The Insurance Council of Australia is the representative body of the general insurance industry in Australia. Our members represent more than 90 percent of total premium income written by private sector general insurers. Insurance Council members, both insurers and reinsurers, are a significant part of the financial services system. December 2009 Australian Prudential Regulation Authority statistics show that the private sector insurance industry generates gross premium revenue of \$32.9 billion per annum and has total assets of \$94.2 billion.

The industry employs approx 60,000 people and on average pays out about \$95 million in claims each working day. Insurance Council members provide insurance products ranging from those usually purchased by individuals (such as home and contents insurance, travel insurance, motor vehicle insurance) to those purchased by small businesses and larger organisations (such as product and public liability insurance, professional indemnity insurance, commercial property, and directors and officers insurance).

² Released by the Hon Chris Bowen, Minister for Financial Services, Superannuation and Corporate Law on 17 March 2010.

³ Australia, Parliament, Senate Economics Legislation Committee, *Report on the Trade Practices Amendment (Australian Consumer Law) Bill 2009*, p 68 (Recommendation 2). See also chapter 2 for a discussion on the IC Act exemption. The Committee recommended that the "government address insurance contract legislation to ensure that the Insurance Contracts Act provides an equivalent level of protection for consumers to that provided by the Trade Practices Amendment (Australian Consumer Law) Bill 2009". The Committee further recommended that "Consideration by the government of the 2004 review of the Insurance Contracts Act should determine whether this will be achieved by amending the ICA to achieve a harmonisation with the amendments proposed in the Australian Consumer Law bills, or by amending the Trade Practices Amendment (Australian Consumer Law) Bill 2009 to apply to insurance contracts."

The Insurance Contracts Act's preamble describes it as:

*"An Act to reform and modernise the law relating to certain contracts of insurance so that a **fair** balance is struck between the interests of insurers, insureds and other members of the public and so that the provisions included in such contracts, and practices of insurers in relation to such contracts, operate **fairly**, and for related purposes."*⁴ (our emphasis)

The effectiveness of the Act in promoting fairness will be strengthened by the amendments that were tabled in the Commonwealth Parliament⁵ on 17 March 2010; for example, the proposed ability of ASIC to intervene as a party in any proceeding relating to a matter arising under the Act.

As can be seen from the detail set out in the submissions in Attachment B, the provisions providing protection for consumers under the current Act are many and include:

- section 13 which places on both parties an obligation that they act towards each other with utmost good faith and section 14 that prevents a party relying on a contract provision if to do so would be contrary to this requirement.

The High Court recently stated that "... an insurer's statutory obligation to act with utmost good faith may require an insurer to act, consistently with commercial standards of decency and fairness, with due regard to the interests of the insured."⁶

The importance for consumers of sections 13 and 14 will be strengthened by the proposed amendment that gives ASIC the same powers in relation to an insurer's breach of the duty of utmost good faith as it has in relation to a breach by the insurer of a financial services law. Also, it is proposed that the duty of utmost good faith extend to third party beneficiaries under the contract.

- Other restrictions on insurers' contractual rights and remedies to meet specific situations where it would be unfair for the insurer to rely on the right or remedy. For example, section 54 restricts the ability of the insurer to rely on a specific act or omission of an insured which brings into play an exclusion in the policy if that act or omission did not cause or contribute to the loss or where the insurer cannot show actual prejudice. Consequently, if the insured were unlicensed or under the influence of alcohol but this did not cause or contribute to the loss the insurer could not generally rely on such exclusions in a motor vehicle policy to refuse a claim.

The protections that consumers enjoy in relation to general insurance contracts are further bolstered by provisions of the Corporations Act, the free (to consumers) external dispute resolution avenue provided by the Financial Ombudsman Service (FOS) and the General Insurance Code of Practice (the Code). It is also relevant to note the recent changes to the Code which now emphasise the duty of utmost good faith. (See response below to Options Paper Question 2 for details)

The data on claims paid and disputes cited in the Options Paper⁷ and records of cases dealt with by FOS show that the current regime of protection serves general insurance policyholders well. Importantly, due to its broad terms of reference, FOS can look beyond the terms of the contract when making a decision.

⁴ The Insurance Contract Act applies to most insurance contracts apart from reinsurance, health insurance, and marine insurance, see section 9 of the Act for a complete list.

⁵ Insurance Contracts Amendment Bill 2010 (the Bill)

⁶ *CGU v AMP* (2007) HCA 36

⁷ Options Paper page 3

A decision will include not only consideration of legal principles, but applicable industry codes, good industry practice and what is fair in all the circumstances.

No demonstrated need for unfair terms legislation in relation to insurance contracts

The Insurance Council considers that the examples of alleged unfairness raised in the consumer submissions to the recent Senate Inquiry do not demonstrate the need for the ACL to apply to insurance contracts. In the large majority of cases, the result in the examples did not stem from any innate unfairness in the term itself but how the contract term was applied in a specific case. (See Attachment C).

Attachment D provides examples of cases decided by FOS in favour of consumers on the basis of the utmost good faith provisions of the Insurance Contracts Act. This illustrates the effectiveness of existing remedies, such as sections 13 and 14, within the Insurance Contracts Act.

The unsuitability of the ACL and remedies for insurance contracts

The Insurance Council submits that the ACL and its remedies for unfair terms are not well suited to insurance contracts. The Insurance Contract Act is more effective because it provides appropriate remedies to address specific problems experienced with insurance contracts. This is a more positive and useful outcome than the simple voiding of the term in question as provided for under the ACL. See the response to Options Paper Question 2 in Attachment A for details.

Conclusion

Given that existing remedies are already effective; the lack of compelling evidence of the need to apply the ACL to insurance contracts; and the absence of insurance specific remedies within the ACL's unfair contracts term provisions, the Insurance Council strongly recommends that the Government adopt the option of maintaining the status quo.

Ordinarily, the Insurance Council would advocate that the appropriateness of self regulatory solutions be considered first of all to address consumer concerns. The outcome of the recent independent review of the General Insurance Code of Practice testifies to the value of this approach. However, in light of recent changes to the Code to emphasise the duty of utmost good faith, the Insurance Council considers that the status quo also encompasses Option D, self regulation.

Although Option C is more attractive than Options A and B because it works within the existing regulatory regime for insurance contracts, consistent with the views already put, the Insurance Council holds that the Insurance Contracts Act (including its proposed amendments) along with provisions of the Corporations Act, the FOS regime and the Code already provide strong and effective protections for consumers.

However, if, during the course of this review, examples of consumer detriment caused by unfair contract terms are found to exist that are not addressed by the current regulatory regime, the Insurance Council and its members would be willing to work co-operatively on developing specific remedies within the Insurance Contracts Act. It may be that stakeholders would draw comfort from clarifying within the Act that, as stated by the Courts, the duty to act with utmost good faith encompasses an obligation on an insurer to act, "consistently with commercial standards of decency and fairness" (refer footnote 6). It is important to note that the duty flows both ways and the insured has utmost good faith obligations to the insurer.

Regardless of the possible question of specific targeted amendments, the Insurance Council rejects the suggestion under Option C that insurers be required to demonstrate that reliance on a term is not a breach of section 14. Reversal of the onus of proof would impose a heavy and unnecessary burden on insurers and it would also make little sense given the customer would be best placed to lead evidence as to why in the circumstances reliance on the term would be a breach of the duty of utmost good faith. Further, the FOS outcomes examined in Attachment D show that consumer redress for unfairness does not depend on legal process being made easier.

Option A, the amendment of the Act's section 15 which excludes insurance contracts from the application of judicial review for unfair contracts terms, would result in the unnecessary layering of the ACL upon existing remedies. It would lead to consumer confusion as to the most appropriate avenue for redress and, as the ACL only applies to consumer contracts, the development of divergent consumer and business regimes for insurance.

The Insurance Council cannot see that anything would be gained under Option B by trying to fit the ACL's unfair contract term provisions into the Insurance Contracts Act. The Act's remedies are already satisfactory. For example, almost all of the situations dealt with in the ACL's list of potentially unfair terms (the 'grey list') are covered explicitly by provisions in the Act (see Attachment A, response to Option B). Adoption of Option B would also result in either insurance contracts for business being subject to review for unfair contract terms when they would not under the ACL or the development of inconsistent interpretation and application of common terms between the two types of customers (wholesale and retail customers) .

Furthermore, it is open to debate whether the terms of an insurance contract can be easily separated, as is suggested in the Options Paper, into those that relate to the main subject matter of the contract and those that do not. Of particular importance, this would potentially leave open to challenge clauses which are necessary to defining the risk that the insurer is willing to accept.

If you have any questions or comments in relation to our submission please contact John Anning, Insurance Council's General Manager Policy, Regulation Directorate on tel: (02) 9253 5121 or email: janning@insurancecouncil.com.au .

Yours sincerely



Robert Whelan
Executive Director & CEO

Attachment A

SECTION 15 OF THE INSURANCE CONTRACTS ACT AND UNFAIR CONTRACT TERMS

The Problem

Consultation question 1

Please provide any data/information, not referred to above, that would assist in determining the extent to which unfair contract terms in insurance contracts are causing consumers actual or potential loss or damage.

The Insurance Council is not aware of any data that would support the contention that there are unfair terms in general insurance contracts which are causing consumers actual or potential loss or damage.

General insurance policies are purchased by millions of consumers every year. Home and motor insurance contracts are the most common types of personal (retail) insurance sold. As at 30 June 2009, these represented 73% of all personal insurance new business and renewals.¹

In respect of retail general insurance products it should also be remembered that they are:

- short term – usually for a 12 month periods or less
- in general can be cancelled at any time with a refund of the balance of premium (in addition to the statutory cooling off period)
- can be changed at renewal if not before
- are of low risk to the consumer – indeed it is riskier to not have insurance

We submit that there has been no evidence presented to suggest that there is systemic unfairness in these forms of contracts. If systemic unfairness existed, the level of complaints would be much higher than it is.

There are approximately 30 million retail policies in force in Australia in a given year. In 2008-2009 there were 30,972,178 retail policies in force.² As stated in the Options Paper, out of this number there were 3,020,382 claims and of these claims 98% were paid. This claims paid percentage has been consistent for a number of years.³

Of the 2% of claims which were not paid, a small proportion have resulted in disputes (20,258), with the majority of these handled by insurers' own Internal Dispute Resolution (IDR) processes. Very few disputes have proceeded (and typically proceed) to External Dispute Resolution (EDR) at the Financial Ombudsman Service (FOS) – with only 2400 disputes resolved by FOS in 2008-2009. The number of disputes as a proportion of the number of claims is a very small 0.7%. When the number of disputes is compared to policies in force it is an even smaller figure of 0.06%

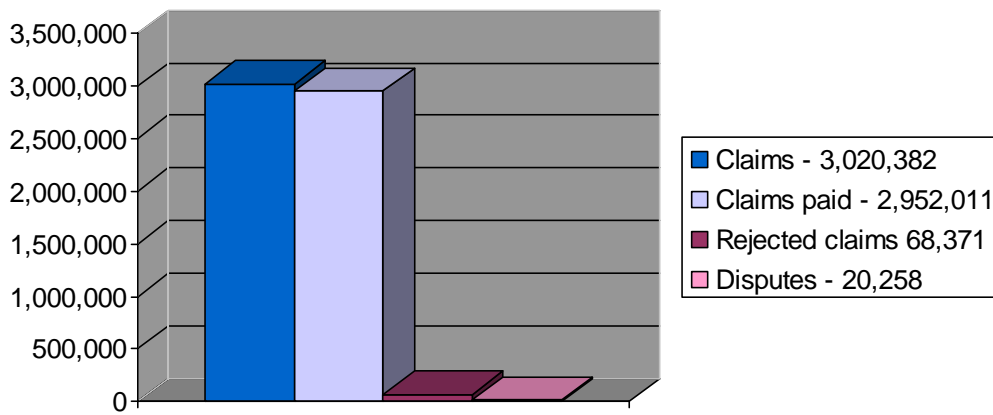
The number of disputes resolved at EDR compared to claims is only a small 0.08%.

The following graphs help put this data in perspective:

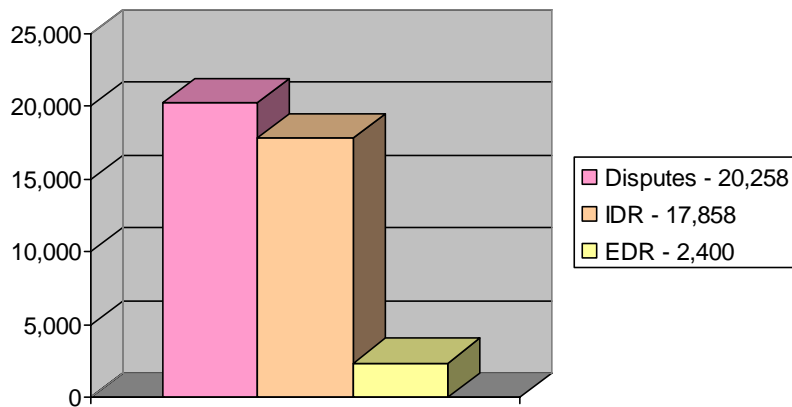
¹ FOS, *General Insurance Code of Practice Overview of the 2008-2009 Financial Year*, p 8.

² *Ibid*, p 6.

³ See: IOS, *General Insurance Code of Practice Overview of the 2007-2008 Financial Year*, p 1; IOS, *Annual Review 2006*, pp 10 & 41.



Dispute data expanded



Of those matters that ended up in dispute, it should be noted that it is unknown how many related to alleged unfair terms. Table 3 of the *IOS Annual Review 2007-2008* shows that 68% of reasons for denial of liability in the 2007-2008 period related to “exclusions or conditions⁴”. The statistics do not reveal whether any of these cases involved an alleged or actual unfair term. The disputes for example could have related to:

- the evidence available to rely on the exclusion or condition;
- whether the elements of the exclusion or condition had been satisfied; or
- whether particular provisions of the Insurance Contracts Act prevented the insurer relying on the exclusion or condition.

If one factored in the other possible reasons for a dispute around a condition or exclusion apart from an allegation of a term being unfair the figure is likely to be much lower than the already negligible figure of 0.047%. It also needs to be considered that an allegation that the term was unfair does not mean it was actually found to be. In this regard, it should be noted

⁴ IOS, *IOS Annual Review 2007-2008*, p 14.

that in the 2007-2008 year 58% of general insurance disputes were decided in favour of the insurer.⁵

Overall, the majority of disputes arising out of rejected claims are handled internally through IDR and out of this an even smaller number proceed to EDR. Very few cases are litigated. This is important to note as the small number of cases considered by the courts in relation to retail insurance policies is not evidence that consumers have no recourse with reference to the Insurance Contracts Act nor that the provisions of utmost good faith are not applied. This can be demonstrated by reference to cases dealt with by FOS.⁶

Cases

In the last financial year, the vast majority of complaints were dealt with by IDR and of those slightly over one-third of disputes were found in favour of consumers⁷. This is similar to the previous 2007-2008 financial year. This demonstrates that IDR provides a valuable mechanism for reviewing complaints before they escalate to EDR.

When complaints do escalate to EDR, FOS (and previously its predecessor the Insurance Ombudsman Service - IOS) has the capacity to review such complaints against a broad range of criteria noted (see below). This includes reference to the Insurance Contracts Act.

An advanced search under the General Insurance section of Determinations on the FOS website on the phrases "section 13 of the Insurance Contracts Act 1984" and "section 14 of the Insurance Contracts Act 1984" brings up many cases. Attachment D provides examples of cases dealt with by FOS which have found in favour of consumers on the basis of the utmost good faith provisions of the Insurance Contracts Act. The following case summaries illustrate the power of this obligation:

- **Determination 41384** – Travel – cancellation – sections 13, 14 & 54(5)
 The issue in dispute was whether the exclusion relied upon by the member applied in the circumstances of the claim and if so whether the member was entitled to decline liability in response to the claim on this basis.

The IOS stated in its determination that "it would be grossly unfair in all of the circumstances for the member to rely on this policy exclusion, and I would invoke the provisions of Section 14 of the Act to prevent it from doing so".
- **Determination 37979** – Home building and contents – water damage – scope of cover – section 13
 IOS determined that the insurer's delays in processing and dealing with the claim were unreasonable and constituted a breach of the duty of good faith. The insurer was required to contribute towards the cost of repairs.
- **Determination 603 11 18347** – Home buildings – fire – quantum – section 14
 IOS found that it was not fair and reasonable and consistent with the concept of utmost good faith for the insurer to rely on the strict words of the limitation. The IOS Panel in this case determined that the insurer was required to pay the claimant in respect of repairs, for loss of rent and for a building consultant's report.

⁵ IOS, *General Insurance Code of Practice Overview of the 2007-2008 Financial Year*, p 15. 26% were in favour of the applicant and 13% were settled.

⁶ It should be noted, however, that notwithstanding the low level of litigated cases in relation to retail policies there are cases on section 13 and 14 – see for example: Sharpe, Tulloch, Masel and Gill, *Australian Insurance Law Annotated*, Butterworths, 2005.

⁷ Op cit n 2, pp 16 & 20.

- **Determination 200 12 11655** – Motor vehicle – security requirements – section 14, 37 and 54

The key issue in dispute was whether an insurer had given notice to the claimant of the exclusion and whether the insurer was entitled to rely on the exclusion to deny the claim. IOS found that it would be unfair for the insurer to rely on a policy term in the absence of its ability to prove that a policy booklet was provided to the claimant and the insurer was liable to indemnify the claimant to the extent of the market value of the vehicle less excess.

Exclusion clauses

In many cases, the examples purported by consumer advocates to demonstrate the existence of unfair contract terms that the Act cannot address (some of which are outlined in the Options Paper⁸) relate to the use of exclusion clauses. The first example in the Options Paper, in relation to unattended luggage, is a type which is often cited (see Attachment C for responses to other examples raised in consumer submissions).

We submit the strength of Insurance Contracts Act remedies is that they allow for each case to be assessed on their own facts. In the case of unattended luggage, whether a consumer has taken care to protect their luggage is a matter of degree. No one would dispute a failure to take care if a consumer left their luggage unattended on the side of a busy road while they went shopping. If, on the other hand, they had their luggage right beside them when it was stolen at gun point, they have taken care.

There would be many cases between these two extremes where views may differ as to whether a consumer has taken care. However, the fact that views may differ does not make a term in a policy, which excludes cover if the insured has failed to take reasonable care to protect their luggage, unfair. Terms requiring an insured to take reasonable care to protect their property are designed to discourage careless behaviour and fraud.

In addition, the nature of an insurance contract is such that limitations and exclusions are necessary to define the cover which the insurer is willing to provide. These enable the risk that the insurer is willing to provide to be matched with what the insured is willing to pay. Exclusions need to be transparent and disclosed to the insured. It appears that what is being advocated in some of these examples is not the removal of 'unfair terms' but the removal of exclusions, or in effect creation of a comprehensive all risks cover without limitation. We are unaware of any insurer who provides such cover and would query whether it would be available and, if so, affordable.

Using the unattended luggage example, it would be an open invitation to fraud if the insurer were not able to exclude instances where reasonable care had not been taken by the insured to safeguard their luggage. The policy would be expected to react if the insured had left their luggage in the middle of an airport. It would be extremely unlikely that an insurer would provide cover on such a basis.

Consultation question 2

Please provide details of any existing regulation, not referred to above, that affects unfair terms in insurance contracts.

Consumer protection under the Insurance Contracts Act

The Options Paper provided a good overview of the Insurance Contracts Act provisions that provide protection against unfair contract terms. The Insurance Contracts Act statutorily

⁸ pp 2-3.

codified and consolidated the operation of laws with respect to insurance and when read in conjunction with the common law now provides a comprehensive body of law in relation to the administration of insurance contracts in Australia⁹. The Act's purpose was "to provide a uniform and **fair** set of rules to govern the relationship between the insurer and insured."¹⁰

In particular, sections 13 and 14 respectively require an insurer to act with utmost good faith and prevent an insurer relying on a term if, in specific circumstances, to do so would be a breach of that duty. These sections, unlike the unfair contracts legislation, would not make a term void for the length of the contract. Thus terms which would be fair in most circumstances but unjust to rely on in another can be dealt with appropriately. If the facts are such that it would be a breach of the duty of utmost good faith to rely on the term then the term is not void for the length of the contract – it simply cannot be relied on in that circumstance.

As noted by Kirby J in *CGU v AMP* (2007) the principle of utmost good faith is fairly unique to insurance contracts and "unlike most other contracts known to the law".¹¹

"The principle is that the parties to insurance contracts in Australia, unlike most other contracts known to the law [our emphasis], owe each other, in equal reciprocity, an affirmative duty of utmost good faith. This is so now by s13 of the Act. In the context of that section, emphasis must be placed on the word "utmost". The exhibition of good faith alone is not sufficient. It must be good faith in its utmost quality.

The resulting duty is one that pervades the dealings of the parties to an insurance contract with each other. In consequence of the Act, and of the reform that it introduced in s13, the duty of good faith as between insurer and insured now takes on a true quality of mutuality. It governs the conduct of insurers whereas, previously, as a practical matter, the duty of good faith was confined to a duty cast upon insureds because the remedies for proof of the absence of good faith were usually of no real use to the insured.

The duty is more important than a term implied in the insurance contract, giving rise to remedies for breach, although, by the express provision of s13, it is certainly that. The duty imposes obligations of a stringent kind in respect of the conduct of insurer and insured with each other, wherever that conduct has legal consequences."

In addition, sections 53 and 54 offer significant protection to insureds. Section 53 makes void a term of an insurance contract that seeks to authorise or permit the insurer to vary, to the prejudice of the insured, the contract (unless the contract is exempt from the section by the Regulations to the Act).

Section 54 limits the ability of the insurer to rely on terms of the policy in relation to acts or omissions of the insured. If the act or omission could not be reasonably regarded as being capable of causing or contributing to the loss (or even if it could but the insured proves none of the loss was actually caused by act or omission), the insurer cannot rely on a clause in the policy to refuse the claim on the basis of that act or omission unless it can prove actual prejudice.

⁹ As noted by the ALRC historically "The Australian law of insurance contracts...[was]...a mixture of common law principles, many of them inherited from earlier times, and a number of Imperial, Federal and State statutes...". *ibid*, p xix.

¹⁰ See Senate Hansard, 1 December 1983, pp3134-3138.

¹¹ Kirby J in *CGU v AMP* (2007) HCA 36 at 176-178.

Thus for example, if the insurer was seeking to rely on an alcohol exclusion to refuse a motor vehicle damage claim, it could only generally do so if it were shown that the act of driving under the influence of alcohol could be reasonably regarded as being capable of causing or contributing to the loss. Further, even if the insurer can prove this, if the insured can demonstrate that none of the loss was actually caused by the act of driving under the influence then the insurer must generally pay the claim.

The Option Paper details other relevant provisions within the Act and there is no need to reiterate here the wide range of protections they provide. We have made reference to such protections in Attachment B.

Other existing regulation that affects unfair terms in insurance contracts

As noted in our earlier submissions, Australian retail consumers of general insurance already benefit from a strong, predominantly national, regulatory regime - specifically through the Insurance Contracts Act, and also through the *Corporations Act 2001* (Corporations Act), and the ASIC Act 1999 (ASIC Act).

In relation to the Corporations Act, there is an overarching obligation on insurers as the holder of an Australian Financial Services License to do all things necessary to ensure that financial services covered by their licence are provided efficiently, honestly and fairly (see section 912A of the Corporations Act). Further, section 991A of the Corporations Act states "A financial services licensee must not, in or in relation to the provision of a financial service, engage in conduct that is, in all the circumstances, unconscionable". This section provides if a loss or damage because a financial services licensee contravenes this provision, they may recover the amount of the loss or damage against the licensee.

ASIC powers and penalties

As noted in the Options Paper, the proposed section 14A in an updated Act would make it clear that an insurer's breach of the duty of utmost good faith is a failure to comply with a financial services law. This will enable ASIC to apply against the offending insurer penalties such as suspension or cancellation of their Australian Financial Services Licence (AFSL). ASIC could also require an enforceable undertaking from an insurer to refrain from the use of terms found to be contrary to the duty of utmost good faith. These powers are commensurate with those available to ASIC under the ACL.

Appropriate action by ASIC is facilitated by the obligation that insurers have under section 912D of the Corporations Act to self report any significant breaches of a financial services law. Also, under the FOS terms of reference, and ASIC Regulatory Guide 139, FOS must report any systemic issues and serious misconduct to ASIC.¹²

Internal and External Dispute Resolution

Under the Corporations Act, a condition of holding an AFSL is for insurers to both provide access to an IDR service and also to be a member of an EDR scheme which retail consumers can access for free.¹³

FOS is the EDR scheme to which insurers currently subscribe.¹⁴ The criteria for determination of disputes by FOS include not only consideration of legal principles, but applicable industry codes, good industry practice and what is fair in all the circumstances.¹⁵

¹² See Section D, clauses 11.1 to 11.3 of the FOS TOR available at <http://www.fos.org.au>

¹³ s 912A(1)(g) and s 912A(2) of the *Corporations Act*.

¹⁴ For further information on FOS see their website: www.fos.org.au

¹⁵ Clause 11.5 of the current *General Insurance Terms of Reference* of the Financial Ombudsman Service. The proposed Terms of Reference to come into effect on 1 January 2010 also have a similar criteria (see clause 8.2 of the Proposed Terms of Reference submitted to ASIC available on the FOS website at: http://www.fos.org.au/centric/home_page/about_us/terms_of_reference_june_09.jsp)

That is, FOS has a broader charter and can look beyond the terms of the contract to what also is fair and reasonable in all the circumstances when making a decision. It is important to note that FOS is also not bound by precedent (although can have regard to it) and so can look at the individual circumstance of each case when making a decision.

All decisions of FOS are binding on members but not consumers. If a consumer is dissatisfied with the outcome they can pursue legal action.

As noted above, FOS must report any systemic issues and serious misconduct to ASIC.¹⁶

General Insurance Code of Practice

The General Insurance Code of Practice (Code) is the general insurance industry's promise to be open, fair and honest in the way it deals with customers. The Code was first developed and introduced by the Insurance Council of Australia in 1994.

In 2005, a revised Code, building on the previous Code's framework, was developed by the Insurance Council and its members. The focus was on the Code being a voluntary set of standards to be upheld by insurers. It commenced operation in July 2006 and is monitored and enforced by FOS. It is designed specifically to complement the "black letter" regulatory framework within Australia that applies to the general insurance industry.

The Code commits insurers to high standards which they uphold in the services they provide to their customers. These standards apply when selling insurance, dealing with insurance claims, responding to catastrophes and disasters, and handling complaints.

The Code applies to all general insurance products which are covered by the Insurance Contracts Act. For example, it applies to: home building; home contents; comprehensive motor vehicle insurance; travel insurance; consumer credit; and sickness and accident.

In 2009, the Code was underwent a review which was conducted by an Independent Reviewer Mr Robert Cornall AO. The Independent Reviewer made 10 recommendations in his final report¹⁷ all of which have been accepted by the Insurance Council Board and the revised Code (containing changes based on the recommendations) is due to come into effect on 1 May 2010.

One of the changes made to the Code is to highlight the duty of utmost good faith. The new clauses will read as follows:

- 1.19 *The objectives of this Code will also be pursued and its provisions applied having regard to the fact that a contract of insurance is a contract involving the utmost good faith which requires each party to the contract to act towards the other party with the utmost good faith in respect of any matter arising under the contract.*
- 1.20 *This Code requires us to be open, fair, and honest in our dealings with customers and commits us to high standards of service when selling insurance, dealing with claims, responding to catastrophes and disasters and handling complaints.*

FOS, as monitor of the Code, investigates and reports on compliance. Part of the process of monitoring compliance involves the conduct of on-site reviews of each participating company's compliance and investigating reports of alleged non-compliance with the Code.

¹⁶ See Section D, clauses 11.1 to 11.3 of the FOS TOR available at <http://www.fos.org.au>

¹⁷ The report can be accessed at www.codeofpracticereview.com.au

FOS releases annually an overview of the Code's operation. See for example the recently released *General Insurance Code of Practice Overview of the 2008-2009 Financial Year (Overview)*.

The Overview outlines examples of non-compliance and the steps that are taken by FOS when a company has failed to comply with the Code. These include determining whether there were any consumers disadvantaged as a result of the failure and also whether the breaches were isolated or occurring more widely. It can then monitor a participating company's progress to ensure any corrective measures are implemented.

The addition of the above new clauses further strengthens the standards monitored by FOS.

OPTION – STATUS QUO**Consultation question 4**

- A. Please provide details of any additional costs and benefits of the status quo.
- B. If possible, please state the magnitude (either in dollar terms or qualitatively) of the costs and benefits referred to above and any additional costs and benefits.

	<i>Benefits</i>	<i>Costs</i>
<i>Consumers</i>	<ul style="list-style-type: none"> • Certainty • Affordability • Continued availability of products and product features 	
<i>Industry</i>	<ul style="list-style-type: none"> • Certainty • No unnecessary increase in compliance burden 	
<i>Government</i>		

For the reasons explained above in responding to consultation questions one and two, the Insurance Council strongly recommends that the Government adopt the option of maintaining the status quo.

OPTION A – PERMIT THE UNFAIR CONTRACT TERMS PROVISIONS OF THE ASIC ACT TO APPLY TO INSURANCE CONTRACTS

Consultation question 5

- A. Please provide details of any additional costs and benefits of Option A.
- B. If possible, please state the magnitude (either in dollar terms or qualitatively relative to the status quo) of the costs and benefits referred to above and any additional costs and benefits.
- C. Are there any other factors that impact on the feasibility of this option?

	<i>Benefits</i>	<i>Costs</i>
<i>Consumers</i>		<ul style="list-style-type: none"> • Possible increase in the cost of insurance • Risk of disadvantage from 'blanket' banning of terms under a Court order • Confusion as to most appropriate remedy • Development of separate consumer and business regulatory regimes • Possible withdrawal of cover in risky market segments. • Adverse implications for availability of re-insurance
<i>Industry</i>		<ul style="list-style-type: none"> • Uncertainty • Increased compliance burden • Possible withdrawal of cover in risky market segments.
<i>Government</i>		<ul style="list-style-type: none"> • Need to monitor appropriateness of separate consumer and business regulatory regimes

The ACL is not suited to insurance contracts

There are many factors that impact the feasibility of this option. As noted above, the ACL is not specifically drafted with insurance contracts in mind. Insurance contracts involve the application of individual terms to specific facts. Rather than voiding the term, it may well be a better outcome for the policyholder to apply a remedy as provided for in the Insurance Contracts Act (See the discussion under Option B on how the Act deals with terms on the

ACL list of potentially unfair contract terms.) Accordingly, we submit, the level of consumer protection is better and more appropriate under the Insurance Contracts Act.

We also note that while the ACL gives ASIC a wide power to apply to the Court to make a variety of orders for the benefit of classes of persons, this may not necessarily be of practical benefit to insureds. Such a class of persons could include members of the public who are insureds under the same type of insurance contract but are not insureds under the particular contract in dispute. Determining whether a term is unfair can depend heavily on the circumstances of the particular case. We would query whether the application of declaratory powers under the ACL across a broad class of consumers would involve appropriate consideration of individual circumstances. We submit that relief available under the Insurance Contracts Act does not pose such problems as any question of 'unfairness' is addressed on a case by case basis.

Potential implications of the removal of s 15

The removal of s 15 would potentially:

- reduce uniformity and consistency of insurance laws with respect to consumer contracts;
- the resulting uncertainty as to whether a term necessary to limit the insurer's risk could be found void may lead to increases in the cost of insurance and the possible withdrawal of cover in risky market segments; and
- affect the availability of reinsurance.

Reducing uniformity

The removal of section 15 would result in the ACL and Insurance Contracts Act applying concurrently to insurance contracts. This would reduce uniformity and consistency of insurance laws with respect to consumer contracts and potentially create a dual system of regulation for insurance contracts.

It still remains to be seen how this would be interpreted and applied in practice, although having two sets of laws will mean that both could be used by lawyers with resultant parallel bodies of insurance law. The unfair contracts terms regime would be yet another layer of regulation on top of existing remedies. It will only lead to confusion as to the operation of existing remedies and result in increased disputation. Consumers and insurers would not only have to consider the impact of the raft of remedies available under the Insurance Contracts Act but also how the unfair contracts regime may impact. This, we submit, would defeat the intention behind the ACL.

We note the second reading speech on the ACL by the Minister for Competition Policy and Consumer Affairs:

"This tangle of consumer laws must be rationalised. We must reduce confusion and complexity for consumers and provide consistency of consumer protection. We must reduce compliance burdens for business".¹⁸

We submit that should section 15 be removed, and the ACL apply as well as the Insurance Contracts Act, none of these stated objectives will be achieved – it will not reduce confusion and complexity nor provide consistent consumer protection. It will also not reduce compliance burdens for business but increase them.

Another concern would be that, as the ACL will only apply to consumer contracts, the removal of section 15 could create a dual system of regulation for insurance contracts applying to retail customers and wholesale customers respectively – with the former being subject to the ACL and the Insurance Contracts Act and the latter regulated solely by the

¹⁸ Dr Craig Emerson MP, *CPD (House)*, 24 June 2009, p (need page number)

Insurance Contracts Act. This could lead to inconsistent interpretation and application of common terms between the two types of customers. We stress that, as the ACL was not intended to extend to business customers, its application to insurance contracts as a whole would have serious unwarranted consequences for non retail buyers of insurance.

Uncertainty

In simple terms, insurance policies are priced according to the scope of cover provided and the likelihood and cost of possible claims. Products are currently priced based on a level of certainty as to the application to the Insurance Contracts Act. The layering of the ACL's unfair contract term provisions upon existing remedies brings with it the potential for:

- voiding of terms, including possibly terms that define the scope of cover;
- uncertainty as to the outcome of individual claims by consumers for redress as the relief provided will depend on the relief mechanism chosen; and
- differences in the application of terms between retail and wholesale consumers.

This situation could cause an insurer to increase its prices and/or possibly withdraw product benefits or from market segments until more certainty is obtained as to the impact of the new remedies available to consumers.

We note that similar uncertainties in relation to the impact of section 54 of the Insurance Contracts Act on claims made policies affected the availability of professional indemnity and directors and officers insurance policies for some time. It took the resolution of a number of cases before insurers had confidence that they could calculate the consequences of section 54.

Impact on reinsurance

It should be noted that terms within insurance contracts are also dictated by reinsurance arrangements. A reinsurer will specify what they will and will not cover. The extent of cover in any specific case will be determined by a reinsurance contract (treaty). Should a term commonly used within an insurance contract be found to be unfair under the ACL, this could have significant consequences on an insurer's reinsurance arrangements. A breach of the reinsurance treaty may leave the insurer exposed to the full extent of the claims.

OPTION B – EXTEND IC ACT REMEDIES TO INCLUDE UNFAIR TERMS PROVISIONS

Consultation question 6

- A. Please provide details of any additional costs and benefits, not referred to above, of Option B.
- B. Where possible, please state the magnitude (either in dollar terms or qualitatively, relative to the status quo) of the costs and benefits referred to above and any additional costs and benefits.
- C. Are there any other factors that impact on the feasibility of this option?

	<i>Benefits</i>	<i>Costs</i>
<i>Consumers</i>	•	<ul style="list-style-type: none"> • Possible increase in the cost of insurance • Development of separate consumer and business regulatory regimes • Possible withdrawal of available cover in risky market segments.
<i>Industry</i>	•	<ul style="list-style-type: none"> • Uncertainty • Increased compliance burden • Possible withdrawal of cover in risky market segments.
<i>Government</i>		<ul style="list-style-type: none"> • Possible need to monitor appropriateness of separate consumer and business regulatory regimes

The Insurance Council cannot see that anything would be gained under Option B by trying to fit the ACL's unfair contract term provisions into the Insurance Contracts Act. The Act's remedies are already satisfactory.

As can be seen from the following table, almost all of the situations dealt with in the ACL's list of potentially unfair terms (the 'grey list') are covered explicitly by provisions in the Act. The Insurance Contract Act provides solutions appropriate to insurance in response to potentially unfair situations.

	Example of unfair contract term	Application to general insurance policies
a)	a term that permits, or has the effect of permitting, one party (but not another party) to <u>avoid</u> or <u>limit</u> performance of the contract	<p><u>Avoidance</u>: The question of avoidance in an insurance context generally relates to pre-contract disclosures and not the terms of the contract itself.</p> <p>An insurer is permitted by sections 28 of the IC Act to avoid a contract in limited circumstances that do not</p>

	Example of unfair contract term	Application to general insurance policies
		<p>relate to terms of the policy but rather generally pre-contract disclosures. That avoidance is subject to section 31 which gives the court overriding power to disregard avoidance in certain circumstances.</p> <p>Even in respect of a fraudulent claim an insurer cannot avoid the policy but only cancel the policy- see section 56 of the IC Act</p> <p><u>Limit performance:</u> Policies generally contain limits on cover, but not provisions allowing the insurer to limit its performance beyond that which is set out in the policy terms and conditions. To the extent exclusions restrict cover, they are subject to provisions of the IC Act such as section 13, 14 and 54 of the IC Act.</p>
b)	<p>a term that permits, or has the effect of permitting, one party (but not another party) to terminate the contract</p>	<p>Sections 63 of the IC Act prevents an insurer cancelling a contract of insurance, except as provided by the Act. Sections 59, 60, 61 and 62 permit cancellation in certain circumstances.</p> <p>The reasons are limited and are designed to prevent insurers from cancelling policies when it would be inappropriate to do so (e.g. when they become aware that a cyclone may hit an area in the next week). Except as provided by section 62, an insurer can only cancel a policy by giving written notice and the cancellation can only take effect at a time and date into the future (section 59). An insurer if they receive a written request from the insured must give reasons for cancellation (section 75)</p> <p>Section 58 allows an insurer not to renew a policy that would usually be renewed or re-negotiated. However, there are strict requirements in section 58 as to how this must be done. Also Part 2 of the General Insurance Code of Practice puts requirements on the insurer if they are not offering renewal (see clause 2.1 5).</p> <p>Some policies allow the insured, but not the insurer, to terminate the contract.</p>
c)	<p>a term that penalises, or has the effect of penalising, one party (but not another party) for a breach or termination of the contract</p>	<p><u>Breach of contract:</u> Various provisions of the IC Act such as sections 13, 14 and 54 provides important protection for insureds who breach a term of a contract of insurance where it would not be appropriate for the insurer to rely on the breach.</p> <p><u>Penalties for termination of contract:</u> Insurance policies that are consumer contracts would not usually contain penalties for one party (but not the other party) for termination of the contract. If an insured wishes to cancel a policy, they will often be entitled to a pro rata refund of premium less maybe a small</p>

	Example of unfair contract term	Application to general insurance policies
		cancellation fee.
d)	a term that permits, or has the effect of permitting, one party (but not another party) to vary the terms of the contract	<p>Section 53 of the IC Act renders void a provision in a contract of insurance permitting the insurer to vary unilaterally the contract to the prejudice of the insured except in relation to contracts exempted by section 53 in the Regulations to the Act.</p> <p>It is possible for an insurer to vary the terms of a contract of insurance in a way that advantages or benefits the insured.</p> <p>Section 52 of the IC Act prevents an insurer excluding, restricting or modifying the operation of the IC Act to the prejudice of a person other than the insurer itself.</p>
e)	a term that permits, or has the effect of permitting, one party (but not another party) to renew or not renew the contract	<p>Section 58 of the IC Act provides important protection for insureds in relation to the renewal of a contract of insurance. Generally, it requires a written notice to be provided to the insured in respect of renewable insurance covers and provides for the cover to continue where that requirement is not met. The notice must be given at least 14 days prior to expiration of the policy</p> <p>Also Part 2 of the General Insurance Code of Practice puts requirements on the insurer if they are not offering renewal (see clause 2.1 5). The insurer must</p> <ul style="list-style-type: none"> a) give reasons; b) refer the insured to another insurer, FOS or NIBA for information about alternative insurance options (unless the insured already have someone acting on their behalf); and c) if the insured is unhappy with the decision, make available information about our complaints handling procedures.
f)	a term that permits, or has the effect of permitting, one party to vary the upfront price payable under the contract without the right of another party to terminate the contract	<p>Such a term would likely be caught by section 53 of the IC Act and therefore be void.</p> <p>An insured may seek to increase cover during the term of the policy (e.g. if they renovate their home or buy new content items) and this may result in the insurer requesting additional premium. However, this would reflect the new risk the insurer is taking on.</p> <p>An insured would usually have a right to terminate an insurance policy at any time</p>

g)	a term that permits, or has the effect of permitting, one party unilaterally to vary financial services to be supplied under the contract	<p>Section 53 of the ICA renders ineffective a provision in a contract of insurance permitting the insurer to vary unilaterally the contract to the prejudice of the insured-see above.</p> <p>A contract of insurance could contain a term that allows a unilateral variation to the prejudice of the insurer.</p>
h)	a term that permits, or has the effect of permitting, one party unilaterally to determine whether the contract has been breached or to interpret its meaning	Insurance policies that are consumer contracts would not usually contain terms of this nature. In addition, no decision of an insurer is final – the insured may seek a determination from FOS or other judicial relief.
i)	a term that limits, or has the effect of limiting, one party's vicarious liability for its agents	Insurance policies that are consumer contracts would not usually contain terms of this nature. In addition, section 917 of the Corporations Act 2001 provides for the holder of an AFSL to be responsible for the conduct of its representatives.
j)	a term that permits, or has the effect of permitting, one party to assign the contract to the detriment of another party without that other party's consent	Insurance policies that are consumer contracts would not usually contain terms that allow the insurer to assign the contract. However, insureds may be entitled to assign their rights to another unless the contract prohibits this.
k)	a term that limits, or has the effect of limiting, one party's right to sue another party	<p>If this is referring to the right of one party to a contract to sue another party to the contract for non performance of the contract then a term that sought to limit this right, if included in an insurance contract, would almost certainly be in breach of section 13 and 14 of the IC Act. Also, section 53 of the Act may be relevant.</p> <p>As noted above, FOS has the power to do what in its opinion is fair in all the circumstances, having regard to each of the following:</p> <ul style="list-style-type: none"> a) legal principles; b) applicable industry codes or guidance as to practice; c) good industry practice; and d) previous relevant decisions of FOS or a Predecessor Scheme (although FOS will not be bound by these). <p>FOS would most likely regard such a term as unfair.</p>
l)	a term that limits, or has the effect of limiting, the evidence one party can adduce in proceedings relating to the contract	Insurance policies for consumers would not usually contain terms of this nature. In any case, section 13 and 14 of the IC Act would likely operate to prevent such terms being relied on. Courts may also consider issues of procedural fairness in relation to such terms. Redress from FOS would also be possible.

m)	a term that imposes, or has the effect of imposing, the evidential burden on one party in proceedings relating to the contract	Insurance policies may contain terms that require insureds to produce evidence of or relating loss or damage but such terms are not unreasonable if applied appropriately. For example, if the insured is alleging they owned an item that was lost or stolen and for which a claim has been lodged, it is not unreasonable to request evidence of ownership. If such terms were not applied appropriately, then there are protections under the IC Act. For example, sections 13, 14 and 54. If there are court proceedings then the law, not the terms of the contract, places the onus on the party bringing the proceedings to prove their case.
n)	a term of a kind, or a term that has an effect of a kind, prescribed by the regulations	(Not applicable - no terms are currently prescribed regulations.)

Adoption of Option B would also result in either insurance contracts for business being subject to review for unfair contract terms when they would not be if the ACL applied directly in insurance contracts or the development of divergent business and consumer regulatory regimes (similar to the risk under Option A) if unfair contract term provisions were introduced into the Act solely to apply to consumer contracts.

Furthermore, in light of how the courts have analysed the scope of cover¹⁹, it is open to debate whether the terms of an insurance contract can be easily separated, as is suggested in the Options Paper, into those that relate to the main subject matter of the contract and those that do not. Some policies use a broadly drafted insuring clause which provides a wide indemnity and then define the scope of cover by using a large number of exclusions. Other policies have more tightly worded insuring clauses and relatively fewer exclusions.

Of particular importance, this difficulty in neatly identifying the terms defining the scope of the insurance contract would potentially leave open to challenge clauses on the basis of unfairness which are necessary to defining the risk that the insurer is willing to accept. This would make insurance unworkable in its present form and lead very likely either to significantly increased premiums to cover total risk cover or withdrawal from especially risky market segments.

¹⁹ See for example *Wallaby Grip Ltd v QBE Insurance* [2010] HCA 9 at 28 and 29.

OPTION C – ENHANCE EXISTING IC ACT REMEDIES

Consultation question 7

- A. Please provide details of any additional costs and benefits, not referred to above, of Option C.
- B. If possible, please state the magnitude (either in dollar terms or qualitatively, relative to the status quo) of the costs and benefits referred to above and any additional costs and benefits.
- C. Are there any other factors that impact on the feasibility of this option?

	<i>Benefits</i>	<i>Costs</i>
<i>Consumers</i>	If additional consumer protections are proven to be necessary: <ul style="list-style-type: none"> • Certainty • Affordability 	
<i>Industry</i>	If additional consumer protections are proven to be necessary: <ul style="list-style-type: none"> • Certainty • No unnecessary increase in compliance burden 	
<i>Government</i>		

Although Option C is more attractive because it works within the existing regulatory regime for insurance contracts, consistent with the views already put, the Insurance Council holds that the Act provides effective protections for consumers. Consequently, the Insurance Council cannot see what improvements (beyond those currently before Parliament) could be made.

The Insurance Council rejects the suggestion under Option C that insurers be required to demonstrate that reliance on a term is not a breach of section 14. Reversal of the onus of proof would impose a heavy and unnecessary burden on insurers. It would allow an insured, through a bare allegation that the insurer had breached the duty of utmost good faith, to require the insurer to present evidence relating to all aspects of its claims process. That would require insurers to engage in considerable additional work and thereby incur significant extra costs, to address what could be entirely unfounded allegations. The Insurance Council submits that the onus of proving a breach of the duty of utmost good faith should remain with the party alleging the breach (which will normally be the insured) as the customer would be best placed to lead evidence as to why in the circumstances reliance on the term would be a breach of the duty of utmost good faith. The FOS outcomes examined in Attachment D show that consumer redress for unfairness does not depend on legal process being made easier.

However, if, during the course of this review, examples of unfair terms in insurance contracts are demonstrated to exist, the Insurance Council and its members would be willing to work co-operatively on developing specific remedies that could be inserted in the Insurance Contracts Act.

OPTION D – ENCOURAGE INDUSTRY SELF-REGULATION TO BETTER PREVENT USE OF UNFAIR TERMS BY INSURERS

Consultation question 8

- A. Please provide details of any additional costs and benefits, not referred to above, of Option D.
- B. Where possible, please state the magnitude (either in dollar terms or qualitatively, relative to the status quo) of the costs and benefits referred to above and any additional costs and benefits.
- C. Are there any other factors that impact on the feasibility of this option?

	<i>Benefits</i>	<i>Costs</i>
<i>Consumers</i>	<ul style="list-style-type: none"> • Certainty • Affordability 	
<i>Industry</i>	<ul style="list-style-type: none"> • Certainty • No unnecessary increase in compliance burden • Enhanced reputation 	
<i>Government</i>	<ul style="list-style-type: none"> • At no cost to Government, additional constraints on unfairness to complement black letter law and ASIC enforcement 	

In light of recent changes to the Code to emphasise the duty of utmost good faith (as explained above in response to Consultation Question Two), the Insurance Council considers its members have already adopted self regulation in line with Option D. Please see answer above to consultation question 2.

Attachment B

Mr John Hawkins
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4 August 2009

Dear Mr Hawkins

TRADE PRACTICES AMENDMENT (AUSTRALIAN CONSUMER LAW) BILL 2009

The Insurance Council of Australia Limited¹ (Insurance Council) refers to your letter of 7 July 2009, and appreciates the opportunity to comment on the Trade Practices Amendment (Australian Consumer Law) Bill 2009 (the Bill) which was referred to the Senate Economics Legislation Committee (the Committee) on 25 June 2009.

The Insurance Council strongly supports the establishment of a national regime of consumer protection. By eliminating inconsistencies between jurisdictions, a national regulatory regime will create greater certainty as to what is the law, thereby increasing the likelihood of better compliance. Compliance costs should also be lower as businesses with national reach (the majority of Insurance Council members) will not have to take account of variations in the law in different jurisdictions.

This submission addresses several aspects of the Bill of particular interest to general insurers.

Unfair Contract Terms

As explained in Insurance Council's submissions to Treasury of 27 March and 26 May 2009 responding respectively to the consultation paper on an Australian Consumer Law and draft provisions on unfair contract terms (copies enclosed), Australian retail consumers of general insurance already benefit from a strong, predominantly national, regulatory regime specifically through the Insurance Contracts Act 1984 (Insurance Contracts Act), and also through the Corporations Act 2001 (Corporations Act), and the ASIC Act 1999 (ASIC Act). The Insurance Contracts Act and the Corporations Act provide protection against unfair contract terms. Additionally, there are provisions in all three laws that guard against unfair or unconscionable conduct.

Section 15 of the Insurance Contracts Act excludes insurance contracts from the operation of a Commonwealth, State or Territory Act that provides relief in the form of judicial review of unfair contracts or the making of a misrepresentation except for relief in

¹ The Insurance Council of Australia is the representative body of the general insurance industry in Australia. Our members represent more than 90 percent of total premium income written by private sector general insurers. Insurance Council members, both insurers and reinsurers, are a significant part of the financial services system. March 2009 Australian Prudential Regulation Authority statistics show that the private sector insurance industry generates gross premium revenue of \$31.7 billion per annum and has total assets of \$93.8 billion. The industry employs approx 60,000 people and on average pays out about \$99.2 million in claims each working day.

Insurance Council members provide insurance products ranging from those usually purchased by individuals (such as home and contents insurance, travel insurance, motor vehicle insurance) to those purchased by small businesses and larger organisations (such as product and public liability insurance, professional indemnity insurance, commercial property, and directors and officers insurance).

the form of compensatory damages. This provision originated in the Australian Law Reform Commission's conclusion that in light of the utmost good faith obligation, it was unnecessary for insurance contracts to be subject to a facility for judicial review of unfair contractual terms.² The Panel which reviewed the Insurance Contracts Act several years ago concluded that the exclusion provided by section 15 was still valid.³

Consequently, in view of the strong protection already provided to insureds, the Insurance Council endorses as entirely appropriate that the Bill does not alter the exemption provided under section 15 of the Insurance Contracts Act. This is the basis upon which unfair contract term provisions have operated in Victoria⁴ without any consumer detriment being reported.

In addition to the exclusion for insurance contracts provided by section 15 of the Insurance Contract Act, operation of the unfair contract terms provisions will not apply to terms required or expressly permitted by a law of the Commonwealth or a State or Territory.⁵ This is important because several of the examples of potentially unfair contract terms contained in the Bill are specifically permitted by the Insurance Contracts Act.⁶

Prohibition of Indemnification of Monetary Penalties

The Bill introduces civil penalties into the Trade Practices and ASIC Acts for contraventions in relation to:

- unconscionable conduct;
- unfair practices;
- pyramid selling;
- product safety and information;
- use of prohibited terms; and
- failing to respond to a substantiation notice or providing false or misleading information in response to a substantiation notice.

The ASIC Act will be amended to include provisions (Section 12GBD) mirroring existing sections 77A, 77B and 77C of the Trade Practices Act (see Attachment A) prohibiting the indemnification of officers of bodies corporate in relation to the payment of pecuniary penalties. The Trade Practices Act provisions closely follow section 199A of the Corporations Act. (See Attachment B for relevant Corporations Act provisions.)

Division 1 of Part 2D.2 of the *Corporations Act* restricts the scope of company indemnities and company-funded Directors and Officers (D&O) insurance policies.⁷ As you will appreciate, the public policy goal behind these restrictions is to prevent companies from shielding directors and officers from liability, whether by way of indemnification or through the payment of D&O insurance premiums. Otherwise, companies could undermine the law by removing the force and effectiveness of provisions in the *Corporations Act* which impose responsibilities, and concomitant liabilities, on directors and officers.

² Australian Law Reform Commission 1982, Insurance Contracts ALRC 20, para 51.

³ Review of the Insurance Contract Act 1984, Final Report on second stage, page 53.

⁴ Information provided to Insurance Council by Commonwealth Treasury at a meeting on 13 May 2009.

⁵ The Australian Consumer Law: Consultation on draft provisions on unfair contract terms, page 17.

⁶ For example, "A term that permits or has the effect of permitting one party but not the other to avoid or limit the performance of the contract" and A term that permits or has the effect of permitting one party but not the other to terminate a contract.

⁷ D&O policies cover directors and officers against the risk of liabilities incurred in their capacity as directors and officers. It may also provide cover to the company taking the policy by way of reimbursement for amounts lawfully paid by the company to its directors and officers for such liabilities.

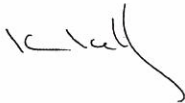
However, neither the Trade Practices Act nor the Bill has an equivalent to section 199B of the Corporations Act which sets out the liabilities for which a company cannot pay an insurance premium. The approach taken in the Corporations Act leaves it clear that a company can pay an insurance premium for the liabilities not set out in section 199B.

With attention focused by the new civil penalties, general insurers that offer D&O and their legal advisers are questioning whether, because of the absence of an equivalent to section 199B, the Bill precludes payment of premiums for D&O insurance which covers such liabilities. There is no apparent policy distinction which explains the different approach between the Corporations Act and the Trade Practices Act and the Australian Consumer Law.

The Insurance Council would appreciate the Committee seeking clarification of the intention behind the legislative approach adopted in the Bill to the prohibition of indemnification of officers. As the Committee will recognise, depending on the outcome Insurance Council members may need to amend existing as well as future D&O policy wordings. This would have significant legal and cost implications for both insureds and insurers and should only be required if there is a strong policy justification.

If you require any further information on these matters, please contact John Anning, Insurance Council's General Manager, Policy – Regulation Directorate on (02) 9253 5121, or at janning@insurancecouncil.com.au

Yours sincerely



Kerrie Kelly
Executive Director & CEO

TRADE PRACTICES ACT 1974

77A Indemnification of officers

- (1) A body corporate (the **first body**), or a body corporate related to the first body, must not indemnify a person (whether by agreement or by making a payment and whether directly or through an interposed entity) against any of the following liabilities incurred as an officer of the first body:
- (a) a civil liability;
 - (b) legal costs incurred in defending or resisting proceedings in which the person is found to have such a liability.

Penalty: 25 penalty units.

- (2) For the purposes of subsection (1), the outcome of proceedings is the outcome of the proceedings and any appeal in relation to the proceedings.

Definitions

- (3) In this section:

civil liability means a liability to pay a pecuniary penalty under section 76 for a contravention of a provision of Part IV.

officer has the same meaning as in the *Corporations Act 2001*.

77B Certain indemnities not authorised and certain documents void

- (1) Section 77A does not authorise anything that would otherwise be unlawful.
- (2) Anything that purports to indemnify a person against a liability is void to the extent that it contravenes section 77A.

77C Application of section 77A to a person other than a body corporate

If, as a result of the operation of Part 2.4 of the *Criminal Code*, a person other than a body corporate is:

- (a) convicted of an offence (the **relevant offence**) against subsection 77A(1) of this Act; or
- (b) convicted of an offence (the **relevant offence**) against section 11.4 of the *Criminal Code* in relation to an offence referred to in subsection 77A(1) of this Act;

the relevant offence is taken to be punishable on conviction by a fine not exceeding 5 penalty units.

CORPORATIONS ACT 2001

Part 2D.2—Restrictions on indemnities, insurance and termination payments

Division 1—Indemnities and insurance for officers and auditors

199A Indemnification and exemption of officer or auditor

Exemptions not allowed

- (1) A company or a related body corporate must not exempt a person (whether directly or through an interposed entity) from a liability to the company incurred as an officer or auditor of the company.

When indemnity for liability (other than for legal costs) not allowed

- (2) A company or a related body corporate must not indemnify a person (whether by agreement or by making a payment and whether directly or through an interposed entity) against any of the following liabilities incurred as an officer or auditor of the company:
- (a) a liability owed to the company or a related body corporate;
 - (b) a liability for a pecuniary penalty order under section 1317G or a compensation order under section 1317H or 1317HA;
 - (c) a liability that is owed to someone other than the company or a related body corporate and did not arise out of conduct in good faith.

This subsection does not apply to a liability for legal costs.

When indemnity for legal costs not allowed

- (3) A company or related body corporate must not indemnify a person (whether by agreement or by making a payment and whether directly or through an interposed entity) against legal costs incurred in defending an action for a liability incurred as an officer or auditor of the company if the costs are incurred:
- (a) in defending or resisting proceedings in which the person is found to have a liability for which they could not be indemnified under subsection (2); or
 - (b) in defending or resisting criminal proceedings in which the person is found guilty; or
 - (c) in defending or resisting proceedings brought by ASIC or a liquidator for a court order if the grounds for making the order are found by the court to have been established; or
 - (d) in connection with proceedings for relief to the person under this Act in which the Court denies the relief.

Paragraph (c) does not apply to costs incurred in responding to actions taken by ASIC or a liquidator as part of an investigation before commencing proceedings for the court order.

Note 1: Paragraph (c)—This includes proceedings by ASIC for an order under section 206C, 206D, 206E or 206EAA (disqualification), section 232 (oppression), section 1317E, 1317G, 1317H or 1317HA (civil penalties) or section 1324 (injunction).

Note 2: The company may be able to give the person a loan or advance in respect of the legal costs (see section 212).

- (4) For the purposes of subsection (3), the outcome of proceedings is the outcome of the proceedings and any appeal in relation to the proceedings.

199B Insurance premiums for certain liabilities of director, secretary, other officer or auditor

- (1) A company or a related body corporate must not pay, or agree to pay, a premium for a contract insuring a person who is or has been an officer or auditor of the company against a liability (other than one for legal costs) arising out of:
- (a) conduct involving a wilful breach of duty in relation to the company; or
 - (b) a contravention of section 182 or 183.

This section applies to a premium whether it is paid directly or through an interposed entity.

- (2) An offence based on subsection (1) is an offence of strict liability.

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

199C Certain indemnities, exemptions, payments and agreements not authorised and certain documents void

- (1) Sections 199A and 199B do not authorise anything that would otherwise be unlawful.
- (2) Anything that purports to indemnify or insure a person against a liability, or exempt them from a liability, is void to the extent that it contravenes section 199A or 199B.

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28 August 2009

Dear Mr Hawkins

TRADE PRACTICES AMENDMENT (AUSTRALIAN CONSUMER LAW) BILL 2009

The Insurance Council of Australia Limited¹ (Insurance Council) refers to its previous submission on this issue dated 4 August 2009, and appreciates the opportunity both to lodge a supplementary submission, and to appear before the Committee on Wednesday, 26 August, to discuss the unfair contract term provisions of the Trade Practices Amendment (Australian Consumer Law) Bill 2009 (the Bill).

In this supplementary submission the Insurance Council wishes to reiterate and expand upon the points we have previously made, that:

1. The Insurance Council acknowledges that, in regards to many sectors of the economy, there may be benefits for consumers as a result of a national consumer protection regime covering unfair contract terms. However, in relation to general insurance, nationally consumers have been well protected for some time by the Insurance Contracts Act 1984, supplemented by other laws such as those in the Corporations Act 2001 and ASIC Act 2001;
2. The evidence does not support the need for the application of the proposed unfair contracts terms legislation to general insurance. To do so would result in unwarranted layering of regulatory requirements on insurers and would lead to operating inefficiencies, the cost of which ultimately is passed on to the consumer;
3. The proposed unfair contract terms legislation rather than assisting insureds will create uncertainty in the application of insurance terms to claims, which will likely lead to further disputes resulting in inconvenience and delay for consumers in settlement, increasing costs and possibly premiums; and,

¹ The Insurance Council of Australia is the representative body of the general insurance industry in Australia. Our members represent more than 90 percent of total premium income written by private sector general insurers. Insurance Council members, both insurers and reinsurers, are a significant part of the financial services system. March 2009 Australian Prudential Regulation Authority statistics show that the private sector insurance industry generates gross premium revenue of \$31.7 billion per annum and has total assets of \$93.8 billion. The industry employs approx 60,000 people and on average pays out about \$99.2 million in claims each working day.

Insurance Council members provide insurance products ranging from those usually purchased by individuals (such as home and contents insurance, travel insurance, motor vehicle insurance) to those purchased by small businesses and larger organisations (such as product and public liability insurance, professional indemnity insurance, commercial property, and directors and officers insurance).

4. The existing exemption under section 15 of the Insurance Contracts Act for insurance contracts from the operation of unfair contracts terms legislation should be retained.

Protection provided by the Insurance Contracts Act 1984

Australian retail consumers of general insurance already benefit from robust protection provided by the detailed provisions of the Insurance Contracts Act 1984 (the Act). When it was introduced into Parliament in December 1983, the Act's purpose was described as:

- to improve the flow of information between the insurer and 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 insured.² (our emphasis)

The preamble to the Act describes it as:

*"An Act to reform and modernise the law relating to certain contracts of insurance so that a **fair** balance is struck between the interests of insurers, insureds and other members of the public and so that the provisions included in such contracts, and practices of insurers in relation to such contracts, operate **fairly**, and for related purposes."*³ (our emphasis)

The Act has been in operation since 1 January 1986. It is incorrect, as has been argued in some submissions and the media, to assert that insurance is no different to other industries such as telecommunications and energy. Insurance is a rare but important example where, decades ago, Parliament had the forethought to establish a comprehensive set of rights and obligations specifically around the insurance contract.

Statistical data points to the effectiveness of the consumer protection currently provided to general insurance policyholders. In the Financial Ombudsman Service's (FOS) Annual Report for 2008, Table 11 Summary of Insurer's Annual Returns for personal lines shows that of 3,167,439 claims lodged with insurers, over 98% were paid. Only 17,973 (0.57%) involved a dispute, and of those, only 2,046 (0.065%) were referred to FOS. Similar percentages apply for 2007 and 2006. Considering the Ombudsman scheme is free for consumers to access and use (see below), these numbers show how effectively general insurers meet their responsibilities under the Act.

Amongst the many consumer protection provisions in the Act that protect against unfair terms are the following:

j) Sections 13 and 14

Two very important obligations are contained in sections 13 and 14 of the Act.

² See Senate Hansard, 1 December 1983, pp3134-3138.

³ The Insurance Contract Act applies to most insurance contracts apart from reinsurance, health insurance, and marine insurance, see section 9 of the Act for a complete list.

Section 13 provides:

"A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with utmost good faith."

Although there is no statutory definition of the requirement to act in utmost good faith, it has been held by the Courts that it means to act with scrupulous fairness and honesty and the courts have broadly interpreted this concept. The High Court in *CGU v AMP (2007) HCA 36* recently discussed utmost good faith in detail.⁴

Gleeson CJ and Crennan J noted at paragraph 15 of the judgment that the concept of good faith is not limited to dishonesty. Further their Honours stated

"In particular we accept that utmost good faith may require an insurer to act with due regard to the legitimate interests of an insured, as well as to its own interests. The classic example of an insured's obligation of utmost good faith is a requirement of full disclosure to an insurer, that is to say, a requirement to pay regard to the legitimate interests of the insurer. Conversely, an insurer's statutory obligation to act with utmost good faith may require an insurer to act, consistently with commercial standards of decency and fairness, with due regard to the interests of the insured. Such an obligation may well affect the conduct of an insurer in making a timely response to a claim for indemnity."

Kirby J noted at paragraph 127:

"The language of s13 [of the Insurance Contracts Act 1984] including the statement of the general principle as a legal obligation separate from the implication of a provision into the contract, supports AMP's submission that s13 of the Act had the effect of introducing a larger and reciprocal obligation between the insurer and the insured in place of what had, for all practical purposes, previously been a one-way street. Such a view of s13 would fit comfortably with other protections for consumers, introduced into the Act, based on the report of the Australian Law Reform Commission"

His Honour further states at paragraph 176 to 178:

"The principle is that the parties to insurance contracts in Australia, unlike most other contracts known to the law [our emphasis], owe each other, in equal reciprocity, an affirmative duty of utmost good faith. This is so now by s13 of the Act. In the context of that section, emphasis must be placed on the word "utmost". The exhibition of good faith alone is not sufficient. It must be good faith in its utmost quality.

The resulting duty is one that pervades the dealings of the parties to an insurance contract with each other. In consequence of the Act, and of the reform that it introduced in s13, the duty of good faith as between insurer and insured now takes on a true quality of mutuality. It governs the conduct of insurers whereas, previously, as a practical matter, the duty of good faith was

⁴ See also:

- Australian Associated Motor Insurers Ltd –v- Ellis (1990);
- Sheldon v Sun Alliance Ltd (1989);
- Barbaro v NZI Insurance Australia Ltd (1994); and
- Maksimovic v Royal & Sun Alliance Life Assurance Australia Ltd (2003).

confined to a duty cast upon insureds because the remedies for proof of the absence of good faith were usually of no real use to the insured.

The duty is more important than a term implied in the insurance contract, giving rise to remedies for breach, although, by the express provision of s13, it is certainly that. The duty imposes obligations of a stringent kind in respect of the conduct of insurer and insured with each other, wherever that conduct has legal consequences.”

Callinan and Heydon JJ note at paragraph 257:

“At the outset we should say that we agree with the Chief Justice and Crennan J that a lack of utmost good faith is not to be equated with dishonesty only. The analogy may not be taken too far, but the sort of conduct that might constitute an absence of utmost good faith may have elements in common with an absence of clean hands according to equitable doctrine which requires that a plaintiff seeking relief not himself be guilty of tainted relevant conduct.”

Section 14(1) provides:

"If reliance by a party to a contract of insurance on a provision of the contract of insurance would be to fail to act with the utmost good faith, the party may not rely on the provision."

Section 14 renders any unfair clause void. The effect is the same as under the unfair contracts legislation. See the following cases:

- Barwon Region Water Authority v CIC Insurance Ltd (1997);
- Banks v NRMA Insurance Ltd (1988); and
- ACN 007 838 584 v Zurich Australia Ltd (1997).

ii) Section 21, 21A, 22 and 28- non disclosure.

These sections place significant limits on when an insurer can rely on non disclosure by an insured to reduce or refuse a claim. For example, for eligible policies of insurance (being motor, home, sickness & accident, consumer credit and travel) an insurer when cover is first offered is required by law to ask specific questions rather than just relying on a general duty of disclosure.

iii) Sections 23, 24 26, 27 and 28- misrepresentation

These sections of the Act place significant limits on when an insurer can rely on misrepresentation to refuse to pay a claim. For example, section 26 provides that where a statement that was made by a person in connection with a proposed contract of insurance was in fact untrue but was made on the basis of a belief that the person held, being a belief that a reasonable person in the circumstances would have held, the statement shall not be taken to be a misrepresentation.

Section 27 provides that a person shall not be taken to have made a misrepresentation by reason only that the person failed to answer a question included in a proposal form or gave an obviously incomplete or irrelevant answer to such a question.

iv) Sections 35 and 37

Section 35 requires insurers in relation to prescribed contracts⁵ to clearly inform customers up front as to how their contract terms differ from standard contract terms which are outlined in the Regulations to the Act.

Section 37 requires insurers in relation to non prescribed contracts to clearly inform the insured up front as to unusual terms in their policies.

If section 35 or section 37 are not complied with then the insurer will not be able to rely on those terms (except in the case of section 35 where the insured or a reasonable person in the circumstances could have been expected to have known of the term).

v) Section 39 and 62

Section 39 says an insurer cannot refuse to pay a claim in whole or part by reason of non payment of an instalment of the premium unless the instalment has remained unpaid for a period of at least 14 days and before the contract was entered into the insurer informed the insured in writing of the effect of the provision.

Section 62 says an insurer cannot cancel a instalment contract of insurance unless at least one instalment of the premium has remained unpaid at the time the contract is sought to be cancelled for a period of at least one month and before the contract was entered into the insurer clearly informed the insured of the effect of the provision.

vi) Section 46

Section 46, in relation to prescribed contracts, restricts the ability of insurers to rely on certain terms in their policy where there was a defect or imperfection in property and the insured was not aware of the defect or imperfection and a reasonable person in the circumstances could not have expected to have been aware of it.

vii) Section 52

Section 52 prevents an insurer from contracting out of the Act.

viii) Section 53

Section 53 makes void a term of an insurance contract that seeks to authorise or permit the insurer to vary, to the prejudice of the insured, the contract (unless the contract is exempt from the section by the Regulations to the Act).

ix) Section 54

Section 54 limits the ability of the insurer to rely on terms of the policy in relation to acts or omissions of the insured. There are two arms to the section. If the act or omission could not be reasonably regarded as being capable of causing or contributing to the loss (or even if it could but the insured proves none of the loss was actually caused by act or omission), the insurer cannot rely on a clause in the policy to refuse the claim on the basis of that act or omission unless it can prove actual prejudice.

Thus for example, if the insurer was seeking to rely on an alcohol exclusion to refuse a motor vehicle damage claim, it could only generally do so if it could be shown the act of driving under the influence of alcohol could be reasonably regarded as being capable of causing or contributing to the loss. Further even if the insurer can prove this, if the insured can prove none of the loss was actually caused by the act of driving under the influence then the insurer must generally pay the claim.

⁵ Contracts prescribed in the regulations to the Act are for the following classes of insurance: motor vehicle, homebuilding, home contents, sickness and accident, consumer credit and travel

Section 15 of the Insurance Contracts Act

Section 15 of the Insurance Contracts Act excludes insurance contracts from the operation of a Commonwealth, State or Territory Act that provides relief in the form of judicial review of unfair contracts or the making of a misrepresentation except for relief in the form of compensatory damages. As explained below, this exemption leaves untouched a number of avenues of consumer redress.

In its report which laid the foundation for the Act, the Australian Law Reform Commission concluded that in light of the utmost good faith obligation, it was unnecessary for insurance contracts to be subject to a facility for judicial review of unfair contractual terms.⁶ The Panel which reviewed the Act in 2004 concluded that the exclusion provided by section 15 was still valid.⁷

The Review Panel did go on to comment that:

“If a nationally consistent model for review of consumer unfair contracts is developed, the balance of consideration may shift and the issue should be revisited.”⁸

However, it also concluded that:

“The Review Panel believes that sections 13 and 14 of the IC Act relating to the duty of utmost good faith, have potential to be utilised by insureds in connection with insurer conduct that might otherwise be dealt with under statutes dealing with unfair contract terms or unconscionable conduct. This capacity will be enhanced further if the Review Panel’s proposal for treating a breach of the duty of utmost good faith in Chapter 1 is adopted.”⁹

It should be noted that the recommendations which the Review Panel made in May 2004 remain to be translated into legislation. A draft Bill to update the Act was released for comment on 12 February 2007. After a very significant amount of work by all stakeholders, agreement was reached in late 2007 on the broad matters to be addressed in the amending legislation. The Insurance Council is currently hopeful that a Bill will be introduced into the current session of Parliament. Any consideration of section 15 should therefore take account of the proposed amendments to make the operation of the Act more effective, including the introduction of powers to enable ASIC to intervene in any proceeding under the Act.

Other protections available to consumers

Apart from the Act, there is also a variety of additional generic protections available to insurance policyholders. (See Appendix A for details.) In particular, under the Corporations Act 2001 there is an over arching obligation on general insurers as the holders of Australian Financial Services Licences to do all things necessary to ensure that financial services covered by their licence are provided efficiently, honestly and fairly¹⁰.

Further, section 991A of the Corporations Act 2001 states “A financial services licensee must not, in or in relation to the provision of a financial service, engage in conduct that is, in all the circumstances, unconscionable.” This section provides if a person suffers loss or damage because a financial services licensee contravenes this

⁶ Australian Law Reform Commission 1982, Insurance Contracts ALRC 20, para 51.

⁷ Review of the Insurance Contract Act 1984, Final Report on second stage, page 53.

⁸ Ibid.

⁹ Review of the Insurance Contract Act 1984, Final Report on second stage, page 54.

¹⁰ Section 912A(1).

provision they may recover the amount of the loss or damage against the licensee. This provision is not to be impacted by the section 15 exemption.

It is also very important to note the ability of general insurance policyholders to access the Financial Ombudsman Service. This independent umpire provides free, fair and accessible dispute resolution for those unable to resolve a dispute directly with their general insurer. External dispute resolution processes can help to resolve disputes through negotiation or conciliation as an alternative to court proceedings and can make decisions which are binding on participating general insurers.

Impact of contravening the Act

Under the unfair contracts provisions in the Australian Consumer Law Bill, if a term in a consumer contract is unfair, the supplier (or party that is not the consumer) will not be able to rely on that term as it will be void. The remainder of the contract will still be valid to the extent it is capable of operating without the unfair term.

As has been shown above, the same remedy is already provided by the Act, with parties being unable to rely on unfair contracts terms. The Insurance Council submits that if a general insurer were to seek to rely on a clause in a policy and it was found to be void (for example under section 14) and the contract could not effectively operate without it, an insurer would clearly be prevented from seeking to rely on the rest of the contract. To the extent an insurer sought to do so, the consumer would potentially be entitled to a claim for damages for breach of the insurer's duty of utmost good faith under section 13. The insurer would also be in breach of its Corporations Act obligations (as explained above).

There have been statements in a recent media article¹¹ that the unfair contracts provisions of the Bill go beyond the Act in that it would force insurers to strike out clauses in all similar contracts not only the contract the subject of a dispute. This is incorrect and misleading as there is no such consequence unless very specific steps are taken such as the Minister prescribing by regulation the term as prohibited or ASIC obtaining a declaration from the Court that a term is unfair or prohibited.

Currently, under the Act, ASIC has no right to bring an action on behalf of the consumer as it does under the Bill, although it can seek to appear as an interested party. However, as explained above, this right is amongst the amendments proposed to be made to the Act in light of the Review Panel's recommendations.

In summary, **taking action under the unfair contract terms provisions of the Bill would in many cases see consumers worse off than if they had taken action under the Insurance Contracts Act.** For example, specific remedies unavailable in the Bill apply under the Act to the termination of a contract. Some terms cited in the Bill as being potentially unfair actually operate under the Act to curtail the rights and remedies insurers would otherwise have under the contract.¹² These include:

- avoiding a contract for fraud (section 31);
- minimum claim amounts in relation to certain types of insurance (section 35);
- the requirement that pre-contractual written notice be provided of unusual terms (section 37);
- rendering void provisions in interim contracts of insurance that make the application to, or the acceptance of replacement cover by the insurer a condition precedent to the interim cover (section 38);

¹¹ Sydney Morning Herald, Money Supplement, 12 August 2009, page 11.

¹² The Insurance Council recognises that operation of the unfair contract terms provisions will not apply to terms required or expressly permitted by a law of the Commonwealth or a State or Territory.

- excluding or limiting liability due to another insurance contract (section 45);
- relying on exclusions regarding pre-existing defects, imperfections and pre-existing sickness or disability (sections 46 and 47); and
- termination of some renewable insurance contracts (section 58).

Whether terms are unfair or not

Some submissions lodged with the Senate Economics Committee point to individual cases where it is alleged unfair terms prevented claims from being paid. However caution needs to be exercised in taking into account individual cases as a justification for generally applying change for the following reasons:

- a) The full facts and circumstances of such claims need to be properly examined before a conclusion can be drawn that the term relied on was unfair.
- b) There is a clear difference between terms that may be unfair as distinct from terms that may be otherwise fair but allegedly applied unfairly

For example, in its submission of 30 July 2009, the Consumer Action Law Centre cites two examples of disputes arising over travel insurance claims where claims had been denied because of a policy condition that required the insured to take all reasonable precautions to safeguard their luggage and personal effects. The cover would not operate if the luggage and personal effects were left unsupervised in a public place.

The Insurance Council submits that such a condition is not unfair or unreasonable. The terms of an insurance contract represent a fine balance between the risks that an insurer is willing to assume and the price that a consumer is willing to pay. It is impossible to imagine that an insurer would provide cover through a policy undertaking to indemnify those not taking reasonable precautions or leaving their luggage or personal effects unsupervised in a public place.

The Insurance Council does not make comment on the specific conclusions reached by the FOS Panel in these cases but submits that the crucial elements for adjudication would be “reasonable precautions” and “unsupervised”.

Similarly, in the Insurance Law Service’s example involving the uninsured motorist extension, it is not unfair that the insurer requires that they accept that the insured would be legally entitled to recover more than 50% of the cost of repairs to their car from the uninsured driver. It is not open to the insurer, as stated in the Insurance Law Service submission, simply to refuse to accept for no good reason that the insured has the required legal entitlement.¹³ Such a refusal would be contrary to section 14 of the Act that a party to an insurance contract cannot rely on provisions except in the utmost good faith.

Section 15 of the Insurance Contracts Act does not need to be amended

In light of the matters raised in this submission the Insurance Council submits that there is no need to alter the limited exemption in section 15 of the Act to allow the unfair contract term provisions of the Bill to apply to insurance contracts.

Apart from being unnecessary, adding another layer of requirements will lead to confusion for the insured and the insurer because it will be unclear how the two tests - the duty of utmost good faith and fairness - apply in relation to each other.

¹³ The insurer involved has already explained to the Committee the circumstances behind this claim, which were not fully disclosed in the Insurance Law Service’s submission.

The Committee will appreciate that evaluating the application of the unfairness test will be especially problematic given the subjective nature of judgements about the balance of rights and obligations. Any exclusion could be seen as impacting significantly on the consumer's rights. The issue is then whether the term is reasonably necessary to protect the legitimate interests of the party who would be advantaged by the term. This is another subjective judgement where an insurer may emphasise prudent risk management while a consumer may focus on their own economic well-being.

The use of two tests may lead to increased costs as all contracts will have to be reviewed. It is likely that these costs will be passed onto the consumer via premiums, without adding any value to the consumer. General insurers will also need to address the complication that, while the Australian Consumer Law will apply to consumer contracts, the Act applies to insurance contracts for business as well.

It is a major tenet of good regulatory practice that, before regulation is adopted, a problem is identified and consideration is given to whether new government action is needed to correct the problem.¹⁴ The Insurance Council strongly submits that a problem of unfairness has not been demonstrated to exist with general insurance contract terms.

If the Committee comes to the conclusion that the Bill's provisions do offer better protection to insurance policyholders, the Insurance Council urges the Committee to recommend that a separate and thorough review be undertaken on the interaction between the Australian Consumer Law and the Act. It is likely that further significant amendments, apart from alterations to section 15, would also be necessary to remove all duplication and inconsistency.

Without such detailed analysis, it would risk serious confusion to simply add the repeal or amendment of section 15 to the reform package to update the Act which is expected to be considered shortly by the Commonwealth Parliament.

Please do not hesitate to contact Mr John Anning, Insurance Council's General Manager, Policy-Regulation Directorate on (02) 9253 5121 or janning@insurancecouncil.com.au if you require any further information.

Yours sincerely



Kerrie Kelly
Executive Director and CEO

¹⁴ Australian Government, Best Practice Regulation Handbook, August 2007, page 52.

ADDITIONAL PROTECTION FOR INSURANCE POLICYHOLDERS

The Corporations Act 2001

The Corporations Act also contains provisions that protect directly or indirectly against unfair contract terms.

i) Cooling off

There is a 14 day cooling-off period for risk insurance products acquired by retail clients.¹⁵ This means the customer can always cancel in this period and receive a fair refund of premium.

ii) Product Disclosure requirements

The Act prescribes minimum content requirements for Product Disclosure Statements (PDS). For general insurance, PDSs usually comprise part of the contract of insurance between the insurer and insured. They must be provided to the customer either at the time of sale or, in some circumstances, within 5 business days of the sale and be written in a clear, concise and effective manner.¹⁶ For general insurance, the PDS must include:

- contain information about significant characteristics or feature of the product or of the rights' terms and conditions and obligations attaching to the product;
- dollar disclosure of significant benefits, and the costs of the product;
- the terms and conditions of the policy itself (with the meaning of the Insurance Contracts Act and in particular section 35 and 37 Insurance Contracts Act notice information);
- information about the dispute resolution process available to the customer; and
- information about the cooling off regime.

There is also a general obligation to include other information in a PDS that might influence a decision of a consumer whether or not to acquire the product.¹⁷

A customer may recover the amount of any loss or damage suffered because a PDS was defective¹⁸. ASIC also has specific powers in relation to issuing a stop order on a defective PDS¹⁹.

In addition there is an over arching obligation on insurers as the holder of a Australian Financial Services Licence to do all things necessary to ensure that financial services covered by their licence are provided efficiently, honestly and fairly²⁰ and to maintain compensation arrangements for retail clients²¹.

Further, section 991A of the Corporations Act 2001 states "A financial services licensee must not, in or in relation to the provision of a financial service, engage in conduct that is, in all the circumstances, unconscionable." This section provides if a person suffers loss or damage because a financial services licensee contravenes this provision they may recover the amount of the loss or damage against the licensee.

¹⁵ Corporations Act section 1019A(1)(a)(i)

¹⁶ Corporations Act sections 715A and 1013C.

¹⁷ Sections 1013D and 1013E, Regulation 7.9.15D, 7.9.15E and 7.9.15F.

¹⁸ Sections 1022A and 1022B.

¹⁹ Section 1020E.

²⁰ Section 912A(1).

²¹ Section 912B.

The unconscionable conduct remedies under the Corporations Act and ASIC Act (see below) are presumed to be unaffected by section 15 of the Insurance Contracts Act 1984 which does not impact actions for compensatory damages.

ASIC Act 2001

In terms of wrongful conduct as distinct from unfair terms, there are also the following provisions in the ASIC Act:

- unconscionability (ss 12CA, 12CB);
- misleading or deceptive conduct or representations (ss 12DA and 12DB); and
- remedies (Part 2 Div 2G).

Financial Services Ombudsman (FOS)

There is a requirement under the Corporations Act 2001 for a general insurer to be a member of an external dispute resolution scheme. General insurers that are members of the FOS are bound by its terms of reference. That body deals with disputes between insurers and their insureds and the body is entitled to have regard to what is fair and reasonable in all the circumstances when determining disputes.²²

General Insurance Code of Practice (the Code)²³

The Code which has been adopted by members of the Insurance Council has the objectives:

- a) to promote better, more informed relations between insurers and their customers;
- b) to improve customer confidence in the general insurance industry;
- c) to provide better mechanisms for the resolution of complaints and disputes between insurers and their customers; and
- d) to commit insurers and the professionals they rely upon to higher standards of customer service.

Amongst the obligations that Insurance Council members assume by adopting the Code, it is worth noting Section 2.4 that applies to the selling of an insurer's products by its Employees and Authorised Representatives:

"Its Employees and Authorised Representatives will conduct their services in an honest, efficient, fair and transparent manner."

²² General Insurance Terms of Reference, Clause 11.15. A similar provision is likely to be contained in the uniform FOS terms of reference currently being developed.

²³ <http://www.codeofpractice.com.au>

Attachment C

UNFAIRNESS AND THE INSURANCE CONTRACTS ACT: EXAMPLES USED IN CONSUMER ADVOCATE SUBMISSIONS

Quote from submission	Source of Quote	Our Comments
<p>“There has been considerable public reporting over the last two decades on what might be described, in one form or another, as examples of systemic unfairness in the drafting of terms in insurance policies. These concerns have been identified in different contexts by a range of bodies, including in the Trade Practices Commission Life Insurance and Superannuation report, Annual Reviews of the Insurance Ombudsman Service (now Financial Ombudsman Service), information brochures by the Insurance Ombudsman Service, information produced by the Insurance Law Service and legal Aid NSW, consumer submissions into the 2004 Review of the <i>Insurance Contracts Act</i> and consumer submissions into the 2009 <i>General Insurance Code of Practice...</i>” (p 5)</p>	<p>National Legal Aid¹</p>	<p>The Trade Practices Life Insurance and Superannuation report does not relate to general insurance.</p> <p>In addition, this statement is a broad generalisation. We are unaware of any evidence presented in these other references cited which relates to systemic unfairness in the drafting of terms in insurance policies.</p> <p>We submit that the overall data in relation to payment of claims should be examined before concluding there is a need for change. As noted in the covering submission, 98% of claims and a very small proportion of rejected claims go on to become disputes.</p>
<p>Appendix A to the National Legal Aid submission states: “‘This appendix sets out examples of unfair terms in insurance contracts drawn from the Annual Reviews of the Insurance Ombudsman Service (formerly known as Insurance Enquiries and Complaints Ltd)’”²</p>		<p>We make the following comments:</p> <ol style="list-style-type: none"> 1. When looking at specific examples in FOS (IOS) Annual Reports, it is necessary to focus not only on the examples but also the overall conclusions as to how the insurance industry is dealing with claims. The statistics quoted in the reports are also of relevance- see Attachment A. 2. Many of the examples provided by National Legal Aid are not examples of unfair terms and/or demonstrate that existing remedies are adequate. In particular: <ol style="list-style-type: none"> i) The second example on page 12 relates to insurers incorrectly applying provisions of the Insurance Contracts Act something for which remedies already exist but the unfair contracts legislation would not address.

¹ National Legal Aid, *Submission to the Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill*, dated 14 August 2009.

² Ibid, p 12.

		<p>ii) The first part of the example on page 13 relates to an alleged incorrect communication of a policy term, not an unfair term. The second part of the example relates to the policy being difficult to follow, not that the terms themselves were unfair. Also what is significant is that the FOS felt they had the power to find in favour of the Applicant.</p> <p>iii) The example on page 14 was considered by the FOS to be a drafting error rather than an example of an unfair term.³ Note particularly the comment on page 19 of the IOS Annual Report <i>“The illustration following will demonstrate how drafting errors can occur”</i> and the comment on page 20 <i>“It will be observed from a careful perusal of the two policy terms the insertion of the words “any wilful or reckless act” appears to have been put in the wrong place”</i>. No suggestion appears to be made that the term was unfair. Also if anything the drafting error operated to the insurer’s detriment in relation to the second case referred to in the Annual Report.</p> <p>iv) The example on page 15 was a case of a brochure saying something different to the policy. What is important about this decision is that the IOS was able to rely on section 35 of the Insurance Contracts Act to find in favour of the applicant. That is there was a remedy the IOS felt it could rely on.</p> <p>v) Again the example on page 16 shows the IOS had sufficient power to find in favour of the applicant finding the insurer had not established the policy exclusion.⁴ Also, it is important to note that there is an example in the IOS Annual Review 2005-06 immediately following this example where the IOS referred to the principle of utmost good faith to find in favour of the applicant. The Panel stated:</p> <p><i>“In this case, the applicant is 74 years of age, and in the Panel’s opinion, it would be inequitable and contrary to the principles of utmost good faith to interpret the policy exclusion as including any</i></p>
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³ See IOS Annual Report 2005-06, pages 19 and 20

⁴ See IOS Annual Report 2005-6, pages 21 to 22

⁵ See IOS Annual Report 2005-6, pages 22

⁶ See FOS Determination 20276

		<p><i>condition of which the applicant had been aware during the 74 years of her life, albeit of a minor or major nature.</i>(our emphasis) <i>In the Panel's opinion, to interpret this broad clause within the context of the commercial purpose of the policy, the member would need to prove that, at the time the applicant took out the policy, she could be expected to be aware of a medical condition, which might impact on the circumstances of her journey and/or might translate into relevant terms in the context of an insurance policy to cover travel contingencies.</i></p> <p><i>In the Panel's opinion, for the member to simply assert that 18 years prior to policy inception, the applicant had experienced significant coronary artery disease and therefore, this was a pre-existing medical condition, is nowhere near sufficient to establish the burden of proving the complex elements of the policy exclusion, ..."</i>⁵</p> <p>vi) The example on page 17 and 18 is an issue of whether the insurer had clearly informed the insured of the relevant term, not whether the term was unfair. In any event the decision was in favour of the applicant; the IOS significantly relying on the remedies of section 14 and 35 of the Insurance Contracts Act.⁶</p>
Consumer Credit		
<p>"Consumer credit insurance has the highest claims rejection rate as a proportion of total claims made. 10.65% of a total 18,945 claims lodged in 2006/07 were rejected. This figure represents the difficulties consumers face in claiming on these policies, suggesting the existence of unfair terms." (p 4)</p>	<p>ILS⁷</p>	<p>The "rejection" rate does not suggest the existence of unfair terms. One would need to look at the reasons for the "rejections" before one could conclude they relate to unfair terms</p>

⁷ Insurance Law Service, *Submission to the Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill*.

Travel claims		
<p>“Travel Insurance has a well earned reputation of being difficult to claim on – as a proportion of claims made, it has the second highest rate of claims rejection at 8.6%. Out of a total 169,329 claims made during 2006/07, this means over 14,000 claims rejected.</p> <p>A common problem with travel insurance is claims being denied because the consumer did not fully supervise their luggage in a “public place”. Of course, if the luggage is always fully supervised it is much less likely to be stolen. The use of the term effectively means that consumers are often left with no cover simply because they averted their eyes for a few minutes. An example being travellers rushing between terminals found a bag had gone missing on a train.</p> <p>The Financial Ombudsman Service (FOS) decided that the term operated to exclude cover.” (p 4)</p>	<p>ILS</p>	<p>We note that only 24% of disputes received by the IOS in this period were found in favour of the applicant.</p> <p>The “rejection” rate does not suggest the existence of unfair terms. One would need to look at the reasons for the “rejections” before one could conclude they relate to unfair terms</p> <p>The case cited by ILS is, determination Number 38421 of the FOS. The FOS stated the following:</p> <p><i>“Considering the circumstances of this dispute, I note that for the loss to have occurred in the manner initially described by the applicant their bag must necessarily have been in a position where it could be taken without their knowledge. This is reinforced by the applicant’s assertion that they only noticed the loss when they gathered their bags up to leave the train. I also note that this bag contained a large proportion of the applicants’ valuables and was evidently small enough to carry (or steal) with ease.</i></p> <p><i>Although it is likely that this situation came about in part due to the crowding of the train, which is of course a matter beyond the applicants’ control, it is nevertheless a situation that could have been better guarded against as indicated by the member. I am therefore of the opinion that the bag that is the subject of this dispute was left unsupervised in a public place as defined by the policy terms and conditions.”</i>⁸</p> <p>The insurer had suggested the stolen carry-on bag should have been afforded more care and could have been held directly by one of the applicants or placed between their legs.⁹</p> <p>As noted in the response to Options Paper question, whether a consumer has taken care to protect their luggage is a matter of degree. No one would dispute a failure to take care if they left their luggage unattended on the side of a busy public road while they went shopping. If on the other hand they had their luggage right beside them when it was stolen at gun point they have taken care. There may be a difference of opinion in such cases as to what constitutes reasonable care, but it does not make the term itself unfair.</p>

⁸ FOS Determination 38421, page 4

⁹ FOS Determination 38421, page 4

<p>“In fact, insurance is arguably one of the areas in which consumers most need UCT regulation. Insurance contracts can be complex with fine print exclusions and claim requirements significantly impacting on or altering the overall insurance cover purchased under the contract.</p> <p>For example, consumers commonly have their claims for lost, damaged or stolen items or baggage denied under their travel insurance policies because insurers commonly include a term in travel insurance contracts excluding cover for loss, theft or damage of property left “unattended” or “unsupervised” in a “public place”.</p> <p>However, this essentially ensures that the insurance cover consumers believe they have bought for lost or stolen property is generally not useful, as it is precisely when consumers take their eyes off their property, even if only for a very short period, that their property is likely to be lost or stolen, and consumers assume that their insurance would cover this situation but it does not tend to.</p> <p>Numerous determinations in the favour of insurers in such cases, based on the terms of the travel insurance policy, have been made by the General Insurance division of the Financial Ombudsman Service (formerly the Insurance Ombudsman Service) over the years.</p> <p>In just one recent case, a consumer whose luggage was stolen after he boarded a city transfer bus at Hong Kong airport and placed his luggage in the luggage rack on the lower level of the bus but sat on the top deck had his claim denied because he did not keep the luggage under observation.¹⁰ In another recent case, a consumer’s claim for one stolen bag was denied after he hailed a taxi on a road in Thailand to go to the airport and left his bags 3 to 6 metres away while he was haggling with the taxi driver over the fare, as the driver had pulled into the kerb slightly away from where he had been standing with his bags.”¹¹ (p 11)</p>	<p>CALC¹²</p>	<p>In relation to the first part of this quote see other parts of our submission and in particular Attachment A</p> <p>In relation to the two travel cases cited as examples:</p> <p>Both of the cases cited went to FOS who found in favour of the insurer – One needs to carefully examine these cases.</p> <p>The first case was a determination of the FOS- determination 37465.¹³ which is available on the FOS website.</p> <p>The claim had been denied by the insurer on “...<i>the basis that the luggage was left unsupervised in a public place, a circumstance which forms an exclusion under the policy terms and conditions.</i>”¹⁴</p> <p>The FOS said the following:</p> <p><i>“The Panel is persuaded that the facts of the case clearly demonstrate that the applicant did not keep the luggage under observation, he was not in a position to observe anyone interfering with it as he did not see it being taken and accordingly he was not placed to attempt to prevent the theft. As such the Panel notes the applicant has failed to satisfy the relevant tests to prove the stolen luggage was supervised.</i></p> <p><i>Accordingly, based on the information supplied, the Panel is satisfied the member has established that the luggage would be considered to have been left unsupervised in a public place and therefore falls within the policy exclusion 5c which explains it will not pay for claims arising because of property left unsupervised in a public place.</i></p> <p><i>The Panel also notes that whilst it may have been reasonable or required for the applicant to have placed the luggage in the luggage racks, it is reasonable to expect that the applicant, in compliance with his policy terms and conditions, would have sat down stairs in close proximity to his luggage which the applicant has advised was possible.”</i></p> <p>In our view it is open to serious question whether as to whether the determination was based on an unfair term. The relevant facts are:</p>
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¹⁰ FOS, *Determination Case No: 37465*, 25 March 2009.

¹¹ FOS, *Determination Case No: 36202*, 25 February 2009.

	<ul style="list-style-type: none"> • the applicant was in a foreign country, • the applicant made a conscious decision to leave his luggage on a rack downstairs and then sit up stairs on the bus, • by sitting upstairs and leaving his luggage down stairs he could not keep it under observation, and • the applicant conceded he could have sat down stairs¹⁵ <p>The Insurance Council considers that it was reasonable for the insurer to rely on terms which required the luggage to be supervised in a public place or required the insured to take reasonable precautions to protect it.</p> <p>In certain situations insurers need to place limits in policies by imposing on the insured reasonable standards of behaviour. If, for example, insurers did not place obligations on insureds to take reasonable precautions to safeguard their luggage then insureds could leave their luggage anywhere safe in the knowledge the insurer will pay if it is stolen. This would encourage careless behaviour, fraud and result in increased premiums.</p> <p>Also, our members advise that that each claim in these types of circumstances is assessed on the individual facts. Reasonable care would be determined in each case as would the concept of luggage being left “unattended”/“unsupervised”.</p> <p>In relation to the second case (determination 36202)¹⁶ the applicant was in Khao San Road, Bangkok, Thailand. The bag was stolen while the applicant was speaking to a taxi driver. The member denied the claim on the basis that the applicant:</p> <ul style="list-style-type: none"> • <i>“Left his bag unsupervised in a public place; and</i> • <i>Did not act in a responsible way to protect his property and avoid making a claim.”¹⁷</i>
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¹² Consumer Action Law Centre, *Submission to the Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill*.

¹³ The determination can be found by going to the FOS website clicking on Cases, then Determinations and Adjudications, then General Insurance and then entering the number 37465 under Case Number.

¹⁴ FOS Determination 37465, page 1

¹⁵ FOS Determination 37465, page 2

¹⁶ The determination can be found by going to the FOS website clicking on Cases, then Determinations and Adjudications, then General Insurance and then entering the number 36202 under Case Number.

¹⁷ FOS Determination 36202, page 1

¹⁸ FOS Determination 36202, pages 4 and 5

	<p>The determination notes:</p> <p><i>“The principal issue for the Panel’s consideration is whether the applicant left his luggage and personal effects unsupervised in a public place. The term “unsupervised” is defined in the policy. The applicant has given two slightly differing versions of events. In the claim form he stated that he moved five to six metres away to flag down a taxi, whilst in his Referral Notice he maintains that he was three to four metres away. In his Referral Notice he states that he had his eyes on his bags all the time whilst his earlier correspondence he states that he was not focused on what was going on around him and had turned away from where the bags were left for a minute to speak to the tax driver.</i></p> <p><i>The Panel accepts the member’s submission that the earlier version of events is more likely an accurate summary of what occurred. The Panel is of the view that the applicant did leave his bags unsupervised. The Panel accepts that notwithstanding he only moved away from the bags briefly, nevertheless he left his bags three to six metres away on the pavement whilst he spoke to the taxi driver. There is no doubt that Khao San Road constitutes a public place, as one of the most popular tourist thoroughfares in Bangkok. The fact that the applicant did not see anyone take the bags also suggests that they were not always directly in his line of vision.</i></p> <p><i>The Panel is also of the view that the applicant has not taken reasonable precaution to protect his property and avoid making a claim. The fact that the stolen bag contained valuable electrical items increases the degree of care that the applicant should have exercised. In the Panel’s opinion, to leave those items and walk several metres away in a popular tourist area outside an internet café frequented by backpackers, was not reasonable in the circumstances. He could have at least carried the bag (that was ultimately stolen) with him.</i></p> <p><i>The Panel notes the applicant’s comments that the bags were heavy and he was travelling alone. However, in the Panel’s opinion the smaller bag was not too heavy to prevent a thief snatching it and making away with it in a short space of time without being observed. The applicant also stated that the location of the road works made it difficult for him to flag down a taxi without leaving his bags. The Panel accepts the member’s submissions that a more reasonable course of action would have been to flag down a taxi at a different point, or alternatively to have taken at least</i></p>
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		<p><i>one of the bags with him.</i>"¹⁸</p> <p>The Insurance Council submits that the decision was fair. The applicant failed to take reasonable care to protect their luggage. The applicant was in a foreign country. They chose to leave their luggage on the side on the road while they spoke to a taxi driver. The luggage was left outside an internet café frequented by backpackers. The road is described as "<i>one of the most popular tourist thoroughfares in Bangkok.</i>" The bag that was stolen contained valuable electrical items. The Applicant could have at least have kept that bag in his possession. Additionally the applicant provided inconsistent versions of the event.</p>
<p>"• <i>The travel insurance policy that only covers injury sustained at the departure terminal subject to his establishing he travelled to the point of departure by public conveyance.</i></p> <p>The insurance cover is clearly illusory due to the use of unfair terms." (p 3)</p>	<p>ILS</p>	<p>One would need to know the full circumstances of the case in order to comment on the fairness or otherwise of the term. [This may be Determination 18506. Free cover under credit card was limited in scope, but not in terms described in the ILS quote.]</p>

Motor Vehicle		
<p>“Legal Aid Queensland’s top 10 unfair terms No 1 - in an insurance contract</p> <p>An assumption that the insured will receive cover when buying insurance is often not the case. Not only does the insured not necessarily get what they paid for, many consumers are simply unaware what it is that they have paid for.</p> <p>By way of example, in a Comprehensive Motor Vehicle policy, a Certificate of Insurance read “Not insured when [client] drives the vehicle”. Insurer knew client was the main driver of the vehicle.</p> <p>Client, who was a young driver with a poor driving record, wasn’t advised on the phone of the written exclusion when he paid almost \$3 000 for comprehensive motor vehicle insurance.</p> <p>Driver assumed that because he was buying a comprehensive motor vehicle policy and paying a lot of money for it (based on his poor driving record) he was covered. Insurer rejected the policy after an accident advising him that he was “insured as an insured but not as a driver of the vehicle”.(p 1)</p>	<p>Legal Aid QLD¹⁹</p>	<p>Again, one would need to know the full facts before coming to a conclusion. It is arguable that the “utmost good faith” provisions of the Insurance Contracts Act could be applied in such a case.</p> <p>However, a likely issue in this case is whether the customer was clearly advised, when the policy was taken out, they would not get cover when he was driving the vehicle and whether the policy otherwise provided cover (e.g. for fire, theft, malicious damage or when someone else was driving the vehicle). If they were clearly informed then it would be difficult to argue unfairness. It may be that given the customer’s poor driving record no one would insure him and this was the best cover he could get for his vehicle.</p>
Uninsured Motorist Extension		
<p>“This is a cover included in third party property damage insurance policies. It covers when an uninsured motorist collides with the insured and that other motorist is at fault in the accident.</p> <p>In a...policy it states:</p> <p><i>The amount covered for the uninsured motorist extension is the current market value of your car up to \$3000. We will pay up to the amount covered for accidental loss or damage to your car caused by an uninsured third party motorist provided:</i></p> <p><i>We accept you would be legally entitled to recover more than 50% of the cost of repairs to your car from the owner or driver of the other</i></p>	<p>ILS</p>	<p>In relation to condition 1, we submit that an insurer needs to have the right to accept that the other party is at fault. Depending on the policy, the scale of fault can vary. The relevant member in this case advises that there was a judgement given, however it was a default judgement which did not establish liability. In this particular claim, there were two independent witness accounts that showed the insured was in fact at fault. It is open to the client to take the issue to FOS if they wish to pursue it further and the insurer in this case has informed the client of this right.</p> <p>In relation to condition 2, in this instance, the insurer was unable to confirm the status of the at fault uninsured driver without the permission</p>

¹⁹ Legal Aid Queensland, *Submission to the Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill*.

<p><i>vehicle, and</i> <i>You have satisfied us that the owner or driver of the other vehicle is not insured against that cost, and</i> <i>You can give us the registration number of the other vehicle and the name and address of its driver.</i> This is a very unfairly drafted term. (p 5)</p>		<p>of that driver – due to Privacy Act requirements. However, the consumer could obtain a police report showing this. The insurer would accept this as sufficient evidence that the uninsured was uninsured and would move to process the claim.</p>
<p>“Mr L, a refugee, purchased a third party property car policy for his vehicle. The policy included Uninsured Motorists Extension which covered him for damage to his car caused by an uninsured driver. However, the insurer interpreted the policy to require Mr L to obtain a police report, and a letter from the other driver admitting liability, and being uninsured. The other driver was charged with numerous charges over the accident including being in possession of a weapon. These policy requirements were unfair but not necessarily in breach of the Insurance Contracts Act. The insurer only backed down when the legal service pointed out that the police report stated that the other driver was on the wrong side of the road, was unlicensed and had threatened our client with violence.” (p 3)</p>	<p>West Heidelberg Community Legal Centre</p>	<p>It is necessary to know the full facts and circumstances and review the actual policy terms before commenting on this example.</p>

Disclosure		
<p>“• <i>An applicant who lost a \$50,000 car damage claim because he did not disclose one speeding offence prior to policy renewal. How many consumers would miss this at renewal! (p3)</i>”</p>	<p>ILS</p>	<p>This is not an example of an unfair term. The insurer would not have been relying on a term in the policy but rather a non disclosure pursuant to section 21 of the Insurance Contracts Act. To the extent the insured may have been unaware of the requirement to disclose the information the issue is being addressed by the proposed amendment to the Insurance Contracts Act concerning non disclosure and eligible contracts of insurance.²⁰</p>

²⁰ See section 21B of the Insurance Contracts Amendment Bill 2010

Exclusions/ Coverage		
<p>“• A landlord was not covered by his policy when the tenant burned down the home. This is because of an exclusion for damage caused by an invitee.</p> <p>This is a potential public interest problem for policy holders who are landlords.</p> <p>Landlords can be faced with very irresponsible tenants who cause considerable property damage. Landlords expect to be covered and yet may not be. It also means this exclusion can affect lenders with a mortgage over the property in question.” (p 3)</p>	ILS	<p>We note that this example comes from the Insurance Enquiries and Complaints Limited (now FOS) 2004 Annual Review. An analysis of the Annual Review shows the policy was a home building policy. If the insured had a landlord policy it is likely the policy would have covered the insured for damage caused by the tenant.</p>
<p><i>The injured worker who could not claim disablement benefits as the policy provided cover only if disablement occurred within 12 months of the incident giving rise to the claim.</i></p> <p>Very unfair term given public hospital waiting lists! (p 3)</p>	ILS	<p>The fairness of the term would depend on the full facts of the case. If for example, the term was clearly explained to the consumer when the policy was taken out and the premium reflected this term then it may not be regarded as unfair.</p> <p>It would be a factual issue as to whether the disablement occurred within 12 months of the incident giving rise to the claim.</p>
<p>“Section 35 was intended to provide standard terms which would protect against unfair contract terms. The effect of <i>Ham’s case</i> was that, so long as the insurer provided the relevant notices in English at the time of purchase the consumer has no basis for complaint. This has meant that sometimes complex notices in English are given to people from CALD backgrounds who do not comprehend them. This lends itself to being unfair.</p> <p>Case Study <i>Case Study 2- Mrs B</i> Mrs B purchased a policy with the help of a friend who called the insurer from a public phone. The friend answered all questions about disclosure and did not ask Mrs B for any clarifications. All documentation, the policy and the section 22 disclosure warning notice was sent to Mrs B in English – a language she could not read in relation to disclosure that she had not personally provided. The</p>	West Heidelberg Community Legal Centre ²¹	<p>In relation to the case studies quoted, unfair terms legislation would not be relevant to any consumer detriment here because the problem does not lie with the contract terms.</p> <p>We also note that some of our member insurers provide interpreter services.</p>

²¹ West Heidelberg Community Legal Centre, *Submission to the Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill*.

<p>protections provided by the Insurance Contracts Act cannot assist CALD consumers unless the insurance industry uses interpreters and provides notices in other languages. Mrs B purchased a policy, made a claim, made a complaint to Financial Ombudsman Service without any use of interpreters or ever receiving any correspondence or notices in her own language.” (p4)</p>		
<p>“Motor vehicle claim In a no-fault comprehensive motor vehicle insurance policy, an insurer sought to rely upon the following exclusion clause to refuse the claim: “[You] have not taken all precautions to avoid the incident” (p 7)</p>	<p>National Legal Aid²²</p>	<p>It is very difficult to comment on this case without knowing more about the circumstances. However, it would be a breach of the duty of utmost good faith for an insurer to accept premium for such an insurance policy and then deny a claim on the basis that the very fact of an accident indicated that the insured had not taken all theoretical precautions, no matter how unreasonable. Such provisions are read down or struck out by FOS which has the power to deal with issues of this nature and the reasonableness of relying on this clause would depend on the facts. If for example the insured was driving along while having an argument on a mobile phone it could be argued they have not taken all reasonable precautions.</p>
<p>Hire Car insurance</p>		
<p>“Our clients have faced seemingly random deductions from their credit cards months after hiring a car. Clauses in many contracts allow these deductions on the basis of damage not apparent when you returned the car after hire. The damage is often quantified by in-house repairers linked to the hire company. Consumers pay to protect themselves from a claim if they have an accident. By contrast, the exclusion terms in many car rental contracts leave the consumer without any insurance at all for common accidents (such as undercarriage damage, damage caused by an animal, damage caused by rain or hail). From our perspective, the insurance is often illusory which makes the choice to rent a car a very risky proposition with most risk being passed onto the hirer and consumers oblivious of this until after an accident has occurred.” (p 2)</p>	<p>Legal Aid QLD</p>	<p>We understand that this “insurance” is usually not provided by a licensed insurer.</p>

²² National Legal Aid, *Submission to the Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill*.

Attachment D

DETERMINATION

CASE NO: 41384

*Travel – cancellation – Insurance Contracts Act 1984, Ss 13, 14 & 54(5)
commercial purpose of the policy – revocation of previously approved leave due to
security reasons act necessary to protect the safety of a person*

SUMMARY OF FACTS

The male applicant is a member of the Australian Defence Force. On 23 September 2008, he took out a travel insurance policy with the member to cover him and his family for a 12 day trip to Bali between 30 May 2009 and 10 June 2009. He also applied for, and was granted, leave for that period in September 2008. However, his entitlement to travel to Bali (as distinct from his leave) was revoked by order of the Chief of the Defence Force on 9 December 2008 due to security concerns because of the increased risk to Defence personnel safety in Bali. As the applicants were no longer able to travel to Bali, they incurred a loss of \$4,603.88 which they claimed from the member who declined liability, contending that their inability to travel was due to the prohibition directed at the male applicant from travelling to Bali due to him being a member of the Defence Force and the perceived increase of risk as to safety.

ISSUES IN DISPUTE

Whether the exclusion relied upon by the member applies in the circumstances of the claim, and if so, whether the member is entitled to decline liability in response to the claim on this basis; and

Whether the provision of Sections 13, 14 and 54 of the Insurance Contracts Act impact on this dispute.

RELEVANT POLICY PROVISIONS

“SECTION 1 – CANCELLATION FEE, LOSS OF DEPOSITS

...

In addition to the General Policy Exclusions applying to all Sections of the Policy, We will not pay for:

...

- 1.7 Cancellation or disruption to travel which relates to Your or Your Travelling Companion’s business or employment, including but not limited to, not being able to take leave from that employment...”

LAW INVOLVED

Section 13 of the Insurance Contracts Act 1984 provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

Section 14 of the Insurance Contracts Act 1984 provides that if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. In deciding this issue the court shall have regard to any notification of the provision that was given to the insured, whether a notification is required by section 37 or otherwise.

Section 54(1) of the Insurance Contracts Act 1984 (the Act) provides that where but for this section an insurer may refuse to pay a claim, either in whole or in part by reason of some act of the insured or another 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 that claim by reason only of that act, but its 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. Subsection (2) states that subject to the succeeding provisions of this section, where an 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. Subsection (5) however prohibits the insurer from denying the claim where the act in question was necessary to protect the safety of a person or to preserve property, or where it was not reasonably possible for the insured or that other person not to do the act.

OUTCOME AND REASONS

There has been an exchange of material upon which the disputing parties rely. I am accordingly satisfied that each party has had full access to the material on which the other party bases its case, and also an opportunity to reply to matters raised by such party. In these circumstances, it is unnecessary to restate the material presented in any unnecessary detail.

It is not in dispute that the applicants' claim would be covered if not for exclusion 1.7 relied on by the member. It is also clear that their inability to travel was because the male applicant's previously approved entitlement to travel to Bali was revoked by an order (described as a "signal") issued by the Chief of the Defence Force, due to the increased security risk in relation to Defence personnel travelling to Bali.

The "signal" or prohibition against travel issued by the Chief of Defence indicates that the order was motivated by heightened concern of an attack on Australian interests in Bali following execution of the Bali Bombers. As the male applicant is a member of the Australian Defence Force, it may have been that he was considered to be a higher value target of such an attack over ordinary Australians. In the circumstances, it is plain that the revocation of his entitlement to travel to Bali was essentially done to preserve his safety as well as the safety of his family members. Therefore, insofar as the act of the Chief of Defence revoking his entitlement to travel is concerned, I am satisfied that it was necessarily done to protect the safety of military personnel and their family.

Insofar as the applicant's compliance with the Chief of Defence's order is concerned, it is plainly obvious that he had no choice but to comply with the order or risk a court martial. In the circumstances, I am satisfied that it was not reasonably possible for him to ignore the order.

In my opinion, the member has not established the provisions of the policy exclusion. In order to do so, the member has the onus to establish that the proximate cause for the loss was that the male applicant was unable to travel as a result of some matter that "relates to [his] employment including not being able to take leave." After considering the material provided, I am satisfied that whilst his connection with the Defence Services was relevant to him not being able to undertake the holiday, the reason why the applicant's right to travel to Indonesia (as distinct from his leave entitlement) was revoked was because of the increased security risk of travelling to Bali (and other parts of Indonesia) due to circumstances which existed in Bali at the relevant time such as the aftermath of the execution of the Bali bombers. In

considering the policy terms, I am obliged to do so in the context of the commercial purpose of the policy and the legitimate expectation of the insured. In my opinion, this policy exclusion was designed to operate in entirely different circumstances to those relevant to this dispute, for example leave being cancelled due to staff shortages or the internal workings of an employer or where an employee was required to place his employment or business interests ahead of his travel interests.

In any event, even if I am wrong in this analysis, I believe it would be grossly unfair in all of the circumstances for the member to rely on this policy exclusion, and I would invoke the provisions of Section 14 of the Act to prevent it from doing so.

I note that the parties have made submissions in relation to whether Section 54 of the Act is relevant to the circumstances of this dispute. In my opinion, the act giving rise to the claim was the prohibition issued by the Department of Defence for its personnel to travel to Bali due to heightened security risks. This made it impossible in terms of common practicalities for the applicants to travel to Bali. This directive was issued for safety purposes, which would in my opinion provide relief pursuant to section 54(5) of the Act.

On the basis of the above analysis, I determine the member is to indemnify the applicants for the loss. I note that the applicants seek payment of \$4,603.88, I have no information in the material exchanged which verifies that sum as their loss. I will accordingly leave this matter to the parties to resolve by way of direct negotiation. However, either party is at liberty to seek a further determination on the matter should a dispute in that respect subsequently arise.

I therefore determine that the member meets its liability under the policy, and that it pays interest at the statutory rate on the amount assessed as due and payable to the applicants from 6 May 2009, the date it first denied the claim, until it fully and finally settles the claim in accordance with the terms of this Determination.

DETERMINATION

CASE NO: 36731

*Travel Insurance – loss of personal property – proof of loss
– Insurance Contracts Act 1984 Ss 13, 14 & 54*

SUMMARY OF FACTS

The applicant took out a travel insurance policy to cover an overseas trip with his wife and son to visit his and his wife's family in Ireland. The policy was incepted on 17 June 2008 and the applicant left Australia on 25 June 2008, with the return date being 15 July 2008. Unfortunately, the applicant's wife's mother died on 14 July 2008 and they extended their stay in Ireland. The applicant rescheduled their travel plans and returned to Australia on 6 August 2008.

While the family was packing on 3 August 2008 for their return to Australia, the applicant's son discovered his Sony PSP, value \$399, and a mobile phone, value \$199, were missing. The applicant contacted other family members and friends trying to locate the missing items but they have not been found.

On his return to Australia, the applicant submitted a claim on the member on 12 August 2008 for the amount of \$598.

The member has rejected the claim on the grounds that the applicant has been unable to establish that the loss occurred during the period of insurance and that the claim was not submitted within 72 hours of the loss being discovered, as required by the terms and conditions of the policy of insurance.

ISSUES IN DISPUTE

Whether the member is entitled to rely on the policy conditions to reject the applicant's claim.

RELEVANT POLICY PROVISIONS

"Claims procedure

Making a claim

If **you** wish to make a claim, **you** must:

▼ ...

Lost or damaged property

...

If **your** property is lost or damaged in other circumstances, **you** must register the loss with **us** within 72 hours of the loss or damage becoming known to you, by either:

▼ Calling our First Response Claims Team on ...

▼ You can e-mail us at ...

▼ You can fax us on ...

...

Section 6 – Personal baggage and travel documents

What you are covered for:

...

6.1 **We** will repair, replace or pay **you** for the loss, or theft of, or damage to **your personal baggage**, clothing or **personal effects** if they are lost, damaged or stolen during **your journey**.

...

What you are not covered for:

...

We will not pay a claim under Section 6.1 if:

- a) ...
- d) **you** do not comply with the requirement to report the loss to **us** as set out on page 8."

LAW INVOLVED

Section 13 of the Insurance Contracts Act 1984 provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

Section 14 of the Insurance Contracts Act 1984 provides that if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. In deciding this issue the court shall have regard to any notification of the provision that was given to the insured, whether a notification is required by section 37 or otherwise.

Section 54 of the Insurance Contracts Act 1984 (insofar as it is relevant to this claim) provides that where but for this section an insurer may refuse to pay a claim, either in whole or in part by reason of some act of the insured or another person, being an act that occurred after the contract was entered into, the insurer may not refuse to pay that claim by reason only of that act, but its liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced by that act, and where the act could reasonably be regarded as being capable of causing or contributing to a loss in respect of which cover is provided by the contract, the insurer may refuse to pay the claim.

OUTCOME AND REASONS

The Member's Position

On 12 August 2008, the applicant telephoned to lodge a claim for the loss of a PSP and mobile phone, which belonged to his son. The applicant advised that his son had been staying with friends during their trip but had discovered the items missing when packing to return to Australia.

The applicant advised that despite enquiries with friends overseas, the items had not been located. A completed claim form for the loss was received on 22 August 2008.

It assessed the claim and wrote to the applicant on 3 September 2008 advising that the claim had been declined. The reason for this decision was that the loss had not been reported to it within 72 hours, as required by the terms and conditions of the policy, and/or that the loss did not occur during the period of cover provided by the policy.

The applicant advised that the loss of the items was discovered on 3 August 2008. They travelled back to Australia the following day, arriving home on 5 August 2008. The applicant states that he initially expected the items to be found at a friend's house. However, that did not prove to be the case.

There is no dispute between the parties that the loss was not reported to it as required under the terms and conditions of the policy. However, nine days had passed from when the loss was stated to have been discovered to when the applicant contacted it to lodge a claim.

The travel insurance policy is clear and unambiguous in the requirements to report the theft, loss or damage of personal belongings. A total of 72 hours is allowed for

the reporting of a loss, which it considers to be a fair and reasonable timeframe for making contact with it to do so. In this case, there is no evidence that the applicant was prevented from complying with those conditions.

Although the applicant stated that he expected the items to be located, it remains that there is no evidence to support his claim that the items were lost during the journey that he was insured for. The travel insurance policy expired on 6 August 2008, however it was a further six days before the applicant contacted it.

Therefore, it contends that the applicant failed to meet the policy terms and conditions in failing to report the loss within 72 hours. Accordingly, it considers that the applicant is not entitled to indemnity for the loss.

The Applicant's Position

He took out travel insurance with the member for his family's trip to Ireland. The trip was to last for three weeks and they were due back in Australia on 15 July 2008. Unfortunately, his wife's mother died unexpectedly on 14 July 2008 and all their travel arrangements had to be rescheduled.

He arranged for his family to return to Australia on or about 4 August 2008 and extended their travel insurance with the member until their return. Unfortunately, during all the confusion his son mislaid his PSP and his mobile phone which was not noticed until late on the evening prior to their departure, that is 3 August 2008. Despite a big search, neither the PSP nor the phone were found. The applicant believed both of the items must have been at a friend's house as his son had been to many houses during their stay and believed they would eventually be located. His overseas family promised to continue looking for the items and to forward them if found.

He and his family returned home at about 6.00pm on 5 August 2008 and they were committed to looking after their own family responsibilities. He was absolutely certain both items would be found and did not report the loss for that simple reason. When neither of the items turned up, he reported the loss to the member which was then well over the 72 hours since the loss was discovered.

The member has also rejected his claim because he did not have evidence that the loss occurred while he and his family were on holidays. He did not realise that he had to have evidence of every item they took on holidays in the event of loss or theft.

The applicant and his family had suffered a sudden bereavement and when they returned home after a long and extended journey the applicant considered he was doing the correct thing in not informing the member of the lost items until it was established the items were lost. He also takes issue with the member in questioning his integrity and honesty because he could not provide evidence of the items being lost on the journey because he did not have photographs of the items.

Determination

The member has rejected the applicant's claim for the loss of his son's Sony PSP and mobile phone on the grounds the applicant:

- was unable to establish that the loss occurred during the period of insurance; and
- the loss was not reported to it within 72 hours of the loss being discovered.

The applicant has stated that his son had the two items with him during his trip to Ireland and only discovered they were missing when they began packing their luggage on 3 August 2008.

Section 13 of the Act provides:

“A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.”

The member states that the applicant has been unable to establish that the loss occurred during the period of insurance. However, it has not presented any explanation as to how it arrived at this decision. It seems to have confused the date of loss and the date of reporting the claim. The applicant has stated that the loss was only discovered when the family began packing for the return to Australia. His son, eleven years old at the time of the loss, had been visiting a number of friends and relatives during the stay in Ireland and the items could have been left at any one of these places or lost, or left, elsewhere.

In refusing to accept that the loss occurred during the period of insurance without any substantive evidence, the member is not acting towards the applicant with the utmost good faith. There is an element of fairness that must be exercised in cases of loss where there is no physical evidence of loss such as, for example, loss by burglary or fire. In any event, in my opinion it was reasonable and responsible for the applicant to report the loss after all enquiries as to the whereabouts of the missing goods had been exhausted.

Accordingly, I am satisfied that the applicant's claim that the loss occurred while the family was in Ireland has been satisfied, and was therefore during the period of insurance, and the applicant has, *prima facie*, a claim that falls within the terms and conditions of the policy.

However, the member has rejected the claim because the loss was not reported to it within 72 hours of the loss being discovered, and because it is not satisfied the loss occurred during the currency of the policy.

The applicant has stated that the loss was discovered on 3 August 2008, the day before leaving Ireland for Australia, and that he arrived back in Australia on 5 August 2008. At that time he was still hopeful his son's items would be found and returned to him. However, this did not occur and he submitted a claim on the member on 12 August 2008, nine days after the loss was discovered, as he wanted to be certain the goods were lost before making the claim.

Section 54 of the Act provides that where the member may refuse to pay a claim by reason of some act of the applicant, being an act that occurred after the contract was entered into, the member may not refuse to pay that claim by reason only of that act, but its liability in respect of the claim is reduced by the amount that fairly represents the extent to which the member's interests were prejudiced by that act, and where the act could reasonably be regarded as being capable of causing or contributing to a loss in respect of which cover is provided by the contract, the member may refuse to pay the claim.

The subject matter of the claim is a Sony PSP and a mobile phone. Although the applicant did not report the loss within 72 hours strictly as required by the policy, it is difficult to accept that the member was prejudiced by this act. In my opinion, the act,

that is, not reporting the loss within 72 hours, did not contribute to the loss or increase the quantum of the loss, and in any event, the applicant had a responsibility to make certain the goods were lost before reporting the claim.

Therefore, I determine that Section 54 of the Act precludes the member from relying on the policy condition requiring the loss to be reported to it within 72 hours to reject the claim, because the member has not demonstrated that it has been prejudiced by the miniscule delay in reporting what is a very minor claim.

Accordingly, I determine that the member is to meet the applicant's claim for the loss of the Sony PSP and mobile phone. However, although the applicant has submitted his claim for the amount of \$598, this amount must be adjusted to that which reflects the applicant's monetary loss.

The applicant's son's mobile phone was not purchased but was provided to him by the service provider in return for accepting a \$29 monthly service plan. There was no charge for the phone itself. The plan commenced on 12 October 2007 and was for a two year period. However, when he replaced the lost phone the service provider charged him a fee of \$10 per month for the use of the phone. This cost would not have been incurred if he had kept his original phone.

Therefore, in my opinion, the cost for the applicant's son's replacement phone would appear to be \$10 per month for the period 14 September 2008, the date when the new phone was purchased, to 12 October 2009, the date the original agreement would have expired. The daily charge is .33 cents therefore the total charge will be:

- 14 September 2008 to 12 October 2008 .33 x 28 days = \$9.33
- 12 October 2008 to 12 October 2009 12 months = \$120.00
- Total \$129.33

I determine the member is to pay this amount to the applicant.

The applicant submitted a claim for the amount of \$399 for the Sony PSP. However, he has since submitted a quotation for a similar PSP for \$339.99. This quotation may, or may not, still be available and I determine the applicant is to submit the purchase invoice for a new Sony PSP to the member for the reimbursement of the cost.

The policy excess of \$100 is to be deducted from the total amount to be paid by the member.

DETERMINATION

CASE NO: 37979

Home Building and Contents – water damage – scope of cover – policy exclusions – delay in addressing claim – escalation of damage – Insurance Contracts Act 1984, S13 – Terms of Reference, 10.2, 10.3, 11.15

SUMMARY OF FACTS

The applicants' home was insured with the member under a home building and contents policy from 28 September 2007 to 28 September 2008. Incepted on 28 September 1990, the building is currently insured for up to \$615,000 subject to an excess of \$300. On 2 June 2008, the applicants lodged a claim for water damage to their home; purportedly arising from a leak in the bathroom. Following its investigations into the claim, the member declined liability on the basis that the leak came from the shower recess and shower screen which it contends are excluded under the policy.

ISSUES IN DISPUTE

1. Whether damage to the home was caused by an event for which the policy provides cover, and if so, is the member entitled to deny liability on the basis of the exclusion it relies on and;
2. Whether the member had unreasonably delayed processing the claim, and if so, whether the home sustained more damage as a result of the delay such that it is fair and reasonable that the member should indemnify the applicants for the loss.

RELEVANT POLICY PROVISIONS

"Home Cover

When we insure your Home, we will cover it for loss of or damage which:

- is caused by an Insured Event and
- happens in the period of insurance.

...

Insured Events 1 to 11...

Insured Events

- 7. Bursting, leaking, discharging or overflowing of water or liquids at the insured address from:**
- ✓ pipes and taps
 - ✓ roof gutters and rainwater downpipes
 - ✓ tanks
 - ✓ swimming pools or spas
 - ✓ water beds
 - ✓ dishwashers or washing machines
 - ✓ bath, sinks, toilets or basins
 - ✓ water collection trays in freezers, refrigerators or airconditioners.

NOT Insured

Repair or replacement of the tank, pipe or container that water or liquid escaped from.

Repair or refurbishment of a leaking shower floor base, or leaking shower cubicle walls.

Loss or damage:

...

X caused by leaking shower floors or bases or shower cubicle walls"

Bursting or leaking

- ✓ of a water main, fire hydrant or water supply pipe at or near the insured address....

LAW INVOLVED

Section 13 of the Insurance Contracts Act 1984 provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

TERMS OF REFERENCE

- ...
- 10.2 A Panel... may determine a dispute by finding in one or more of the following ways:
- (a) In the case of a claim dispute:
 - ...
 - (ii) A member is liable or not liable to meet a claim and, if so, the extent of that liability; and
 - (b) In the case of any dispute:
 - (i) A member is liable to pay or not to pay an amount of money to or for and on behalf of the applicant; and
 - ...
 - (vii) Any other remedy that may be appropriate in the circumstances.
- 10.3 A Panel... may not determine that a member is liable to pay any punitive, exemplary, aggravated or unspecified general damages.
- ...
- 11.15 In arriving at a determination a Panel... shall have regard to what is fair and reasonable in all the circumstances; regard must also be had to good insurance practice, the terms of the policy, and established legal principle."

OUTCOME AND REASONS

There has been an exchange of the material upon which the disputing parties rely. The Panel is accordingly satisfied that each party has had full access to the material on which the other party bases its case, and also an opportunity to reply to matters raised by such party. In view of the aforesaid, it is unnecessary to restate the material in any detail unless required.

The member's case is that the relevant leaks had come from the bathroom's shower recess and shower screen. In this regard, it relies primarily on two reports issued by one JS from its authorised builder, US and a further report issued by one LH, a leak detection specialist from P&C.

In his undated report, JS advised –

"Circumstances: We attended [the applicants' home] at a time agreed with [the applicants], to inspect water damage to the downstairs powder room ceiling and upstairs floor tiles. Our inspection found the flooring under the bathroom tiles sagging due to a long term leak. Extent Of Damage: The damaged bathroom floor tiles require removal, the damaged flooring replace and the floor retiled on new substrate. The damaged powder room ceiling bulkhead requires repainting. Cause: The damage is consistent with water escaping from a pipe in the wall or the shower recess. Conclusion: As approved by your office, we have appointed a leak detection contractor to inspect and report on the source of the leak and will update you upon receipt of their report as whether a defined event has occurred..."

LH inspected the home, and in his 25 June 2008 report, advised –

"As requested I attended the above sit (sic) to investigate and report on cause of water damage to ceiling in ground floor powder room.

Directly above claims area is the family bathroom.

Damage to ceiling is intermittent which coincides with shower usage.

Acoustic and pressure tests were carried out on both domestic hot and cold water line along with tap hardware. No leakages were recorded from these service lines at time of inspection.

Dye and flow test to shower recess revealed damage in claims areas has originated from discharged water through screen area.

Further tests showed water discharge to originate from right hand side of shower screen door where wall tiles, shower base and frame intersect.

This area was highlighted and marked to insured at time of inspection.

Conclusion: No mains water or plumbing lines are contributing to claims area.

Damage originating from defective shower recess."

Following LH's 25 June 2008 report, JS, in a further 16 July 2008 report, advised the member that the leak had come from the bathroom's shower recess and that the damage caused was excluded under the policy.

Having reviewed the relevant policy wordings, the Panel notes that damage caused as a result of leaking "*shower floors or bases or shower cubicle walls*" is not covered under the policy.

The applicants' case is founded on the basis the leak came from either, the hot or cold water supply pipes in the bathroom. In this regard, they have produced a report from a plumber, one MM from MP. In his 24 October 2008 report, MM advised –

"On inspection we found that there is a water leak on either the hot or cold supply pipes to the shower taps. This problem could be either a faulty connection or a nail or screw protruding the pipe.

The leak has caused the flooring timber to rot and tiles have dropped in the corner adjacent to the shower base. There is also slight carpet damage on the rear side of the shower wall.

There is also plaster and electric light damage to the powder room below caused by water dripping from above. We believe these matters need to be addressed as a matter of urgency as further damage to shower base and screen will occur if the problem is not resolved."

The contents of MM's report were put to JS who then contacted MM for further clarification. In his 11 November 2008 report, JS advised –

"...[The applicants'] plumber, MM, advised by phone that he had capped off the shower rose, opened the tap set and listened for a period of 5 minutes or so, noting that no leakage occurred in the downstairs room. A pressure gauge was not used during the test. He also advised that [the applicants] first stated to him that the leak occurs constantly and later advised that the leak only occurs when the shower is used. The plumber conceded that the shower recess could be the source of the leak."

In a further response to MM's report, the member procured another report from one PT of JPF (whom it refers to as an external assessor) as well as another leak detection report issued by one, DM.

In his undated report, PT advised that he inspected the home on 6 November 2008, and further reported as follows –

“CAUSE OF DAMAGE:

Upon inspection of the claimed area, and upon receipt of a leak detection report, we were able to attribute the damage to the degenerated sealant between the polymarble shower base and the tiled walls of the shower recess located directly above the damage.

...

CONCLUSION:

As the damage as inspected, is not the result of an event covered under the policy, we can recommend DENIAL of the claim.”

The leak detection report relied on by PT was the one issued by DM who had reported as follows –

“... I attended the [applicants’] property Wednesday 12th November 2008 to determine the cause of water damage to the area surrounding the shower in the family bathroom.

Pressure and acoustic test equipment was used on the hot and cold water system and tap ware in the area of the claim and no leak was noted.

I now flow and dye tested the shower recess and noted that due to degenerated sealant between the poly base and tiled walls, water is seeping into the wall cavity from where this is then causing the damage to the timber floor of the bathroom and ceiling below.

This was indicated to the insured at time of testing.

CONCLUSION:

Cause of water damage is due degenerated sealant between poly base and tiled walls.”

The Panel has perused the photographs supplied and found them to be of limited assistance. Nonetheless, having carefully considered the matter, the Panel is more inclined to accept the member’s expert evidence as to the source of the leak.

LH and DM confirm that they had conducted acoustic and pressure tests on both the pipes (the ones which MM claims one of them was leaking) and found no leak. In contrast, there is nothing to indicate that MM had carried out any test to confirm that one of them was indeed leaking. There is also nothing to indicate that he had indeed found a faulty connection, or for that matter, a nail or screw protruding into any of these pipes. In the Panel’s view, MM is more likely speculating on possible causes of, and this is especially evident from the manner in which he phrases the possibilities. In short, whilst MM lists a number of possibilities, he was not conclusive on the matter.

In light of the above, the Panel is, on balance, more inclined to the view that the leak which caused the damage to the applicants’ home had come from a leaking shower recess, screen and tiles. As the policy clearly excludes losses or damage which arises from “*shower floors or bases or shower cubicle walls*”, the Panel is accordingly satisfied that the applicants would have no claim under the policy.

The Panel will now consider the other matter in dispute, namely, the time taken by the member to bring this matter to a conclusion.

The Panel notes that an inordinate amount of time has elapsed between the initial report of this claim and the communication of the final review decision. The applicants submit that the time taken not only to investigate and decide on the claim but also to communicate its decision to them was unreasonable, by which time the cost to repair the damage in their home had escalated from \$1,850.20 (according to initial estimate) to some \$8,300 (according to PT's estimate which was done some 5 months after the claim was lodged).

The claim was lodged on 2 June 2008, and the material indicates that by 16th July (or shortly thereafter) the member had in its possession, two reports from JS (undated and 16 July 2008 reports) as well as LH's 25 June 2008 reports which appear conclusive in their findings, such that the member would have been in a position to make a final decision as to indemnity. However, it was not until 15 September 2008 (some 2 months later) when it finally decided to formally deny the claim. Even then, the applicants contend that they were unaware of the decision as at 20 October 2008 on which date they had called the member to complain that they had yet to receive the letter. According to the applicants, they finally received the letter in November 2008.

The member had purported to suggest that it had verbally declined the claim on 5 August 2008 but having perused the member's file notes in this regard, the Panel is not persuaded that a final decision was clearly communicated to the applicants at that time. The Panel notes that whilst the relevant file note begins with a statement – "*declined claim*" – and an indication that the applicants were advised of the contents JS's report, the message given to the applicants suggests that the member's decision was conditional on further enquiries with US. Indeed, the relevant portion of the file note reads –

"Have [phoned insured] and [advised (presumably, of the contents of JS's report)] – [insured advised] the waste pipe was not checked and this is what he believes is causing the damage.

Have [advised] i would decline the claim however would check with [UBS] on the waste pipe – have also [advised insured] of idr process if unhappy" [Emphasis added]

Be that as it may, even if the claim was verbally declined on 5 August 2008 the decision was still delayed almost three weeks following the reports. As the member was already in possession of the relevant material to decide the claim by 16 July 2008, to decline the claim on 5 August 2008 (which is some 20 days later), the member had already gone beyond prescribed time limit of 10 business days (which translates to 2 weeks or 14 days) as provided under the Code. The fact that the member did not formalise its decision in writing to the applicant until 15th September (which letter the applicants maintain they did not receive) has compounded the effect of the delays to date.

In the Panel's opinion, the member had taken an inordinate amount of time to investigate, decide and communicate its decision to the applicants. The Panel is of the view that the time taken was unreasonable in the circumstances, and this has contributed to the delay in the applicants rectifying the damage at a lower cost - on the contrary, had unfairly exposed them to much higher cost.

Section 13 of the Act provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

Utmost good faith has been described as a term with a range of meanings in the legal context encompassing notions of fairness, reasonableness and community standards of decency and fair dealing: Mann, *Annotated Insurance Contracts Act* (4th ed, Lawbook Co, 2003), p 38. It is said to impose a market standard of fairness: Sutton, *Insurance Law in Australia* (3rd Ed, LBC Information Services, 1999), pp 157 - 158.

A lack of good faith is not necessarily equated with dishonesty, but may require decisive conduct by insurers, making timely decisions and prompt processing of claims.

In the Panel's view, the member's unreasonable delays in processing and communicating its decisions in this matter, constitutes a breach of its duty of utmost good faith.

Insofar as the water damage has continued to worsen throughout this period, the Panel is somewhat surprised that despite the obvious deterioration of the shower room floor, the adjacent areas and the electrical risk, no action appears to have been taken by the applicants to minimise or rectify the leak, irrespective of its origins. Failure to rectify the problem has contributed to the escalating damage and cost of repair.

Accordingly, having carefully considered the respective submissions of the parties, the material, relevant policy wordings and the law, the Panel is inclined to make a determination that has regard to what is fair and reasonable in all the circumstances. The Panel determines that the parties should each bear a share of the cost attributable to the deterioration.

The difference between JS's estimate of \$1,850.20 and PT's estimate of \$8,300 namely, \$6,449.80 fairly represents the degree of deterioration. The Panel accepts JS's and PT's estimations as accurate reflections of the likely costs to repair the home in the absence of any alternative quotes from the applicants.

In the Panel's view, the member has breached its duty of utmost good faith. Conversely the applicants, whilst perhaps inexperienced in such matters should nevertheless have taken some steps to avoid the continuing deterioration.

The Panel determines that the member shall contribute \$4,000 towards the cost of repairs.

Insofar as complaints of the member's handling of the claim are concerned, the Panel has also referred them to the Code compliance manager for investigation.

DETERMINATION

REFERRAL NO: 603 11 18347

*Home Buildings – fire – quantum – Insurance Contracts Act (1984) S14
utmost good faith*

SUMMARY OF FACTS

The claimant had a home buildings insurance policy which provided cover against loss and damage caused by the insured events. She had bought the house in about March 2000 and after the claimant attended to renovations, it was let to a tenant. In about April 2001, the tenant moved out and for a short time, the claimant lived in the property in order to prepare the premises to let again. She also requested a real estate agent secure a suitable tenant.

On 1 July 2001, while the home continued to be without a tenant and after the claimant had returned to her own home approximately 300 kilometres away, someone entered the building and lit a fire. The fire, smoke and water caused damage throughout the home.

The insurer appointed a loss adjuster who, in turn, appointed a repairer to carry out various repairs to the home at a cost of approximately \$22,000. The repairer was not a registered builder.

The claimant was dissatisfied with the standard and extent of the repairs and following protracted exchanges between the claimant and the loss adjuster, appointed a building consultant in October 2002 to review the file and examine the home. Following receipt of the building consultant's report, the insurer acknowledged certain aspects of the repairs were inadequate and offered the claimant \$8,000 in settlement of the claim. The claimant had pursued an amount in excess of \$40,000, which included an amount for a loss of capital value, loss of rent, the cost of obtaining a builder's report, legal costs, travel expenses and other miscellaneous costs. Thereafter both the claimant and the insurer had further examinations carried out by other building consultants, with the insurer's building consultant reporting its findings in May 2003.

After protracted discussions between the parties, the insurer acknowledged repairs in addition to those identified by the building consultant appointed by the loss adjuster, had been inadequate and offered to rectify the damage or pay a cash settlement of \$21,553.50. Subsequently it changed its offer to paying the sum of \$20,000 in relation to the repairs and offered to pay \$3,000 on an *ex gratia* basis in relation to the various other expenses, but it refused to pay any amount in relation to the loss of rent.

ISSUES IN DISPUTE

Whether the insurer's settlement offer adequately indemnifies the claimant in relation to the loss and in consequence of the inadequate repairs.

RELEVANT POLICY PROVISIONS

"Unliveable means:

Damaged to such an extent by an insured event that normal domestic activities including cooking, sanitation and personal hygiene cannot take place and local authorities will not provide permission for the home to be inhabited.

.....

What we will pay when you claim

...

Repairing or Replacing

When we agree to pay *your* claim for loss or damage:

- we may choose to pay:
 - the reasonable costs of repair or
 - the reasonable costs of replacement to new condition with property the same size and specifications or with items as near to original as is currently possible or
 - ...

...

Variations to *your* insurance if

(a) *you* are a landlord

...

6. Loss of Rent

if the *home* is leased at the time of the *event* and the loss or damage makes the *home* *unlivable* and rent payments cease then we will pay for the lost rent, provided the amount we pay does not exceed:

- 10% of the *buildings* sum insured or
- the amount of lost rent for up to 12 months from the date of the *event* whichever is the smaller.

This expense will only be paid during repair or replacement and only while the *home* remains unlivable.”

LAW INVOLVED

Section 14 of the Insurance Contracts Act 1984 provides that if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. In deciding this issue the court shall have regard to any notification of the provision that was given to the insured, whether a notification is required by section 37 or otherwise.

OUTCOME AND REASONS

In this matter the insurer accepted the claim for damage caused to the home by fire and proceeded to settle the loss by arranging and paying for the repairs. It is not in dispute those repairs were inadequate and of a poor standard and did not fulfil the insurer's obligations under the terms and conditions of the policy. It is clear from the material provided the process was not appropriately managed by the insurer and its agents, despite its being obvious from an early stage there were problems with the repairs. The Panel is nevertheless surprised the insurer did not take the opportunity to exercise more control of the process at an early stage and ensure its obligations were met.

Essentially there are four elements to the dispute. Each has been considered separately as follows:

Cost of completing/rectifying the repairs

This aspect in particular has been the subject of much correspondence between the parties over a lengthy period of time. Although the claimant initially pursued a slightly higher amount than that offered, she has indicated she is willing to accept the insurer's building consultant's estimate as being "near enough".

The Panel notes the estimate was originally for an amount of \$20,553 based on costings developed on 15 May 2003, but the offer was later stated to be \$21,553 in a letter dated 30 July 2003 from the insurer's building consultant to the claimant's solicitor. No explanation was offered in relation to the revised amount but it is noted

the amount was increased following a review by the building consultant of additional material received from the claimant. While it is noted the additional material was not specifically costed by the insurer's building consultant, it would appear that, based on that material, it was conceded some further items would be appropriately included in the scope of works.

Against this background, the Panel considers it highly unusual for the insurer's building consultant to firstly offer \$21,553.50 as a cash settlement in lieu of carrying out repairs but for the insurer to then reduce the offer to \$20,000. Given its building consultant's revised offer was \$21,553.50 the Panel considers this represents a fair and reasonable settlement of the claim insofar as it relates to completing and rectifying the repairs required after the fire.

Loss of rent

The claimant is pursuing loss of rent for 69 weeks at \$120 per week, being a total of \$8,280. The insurer has refused to pay anything in this regard on the basis the home was not leased at the time of the fire as required by the policy. However, this decision appears to ignore the fact the delays in the claimant being able to let the property were in the main due to the poor standard of repairs and the time taken to resolve the dispute with the insurer. It is not in dispute there were substantial problems with the repairs and the Panel considers it obvious these problems have caused the claimant delays in being able to rent the home and that, at all relevant times, the claimant was desirous of renting the home.

Section 14 of the Insurance Contracts Act 1984 ("the Act") would prevent the insurer from relying on an exclusion under the policy, where such reliance would be contrary to the duty of utmost good faith. The Panel accepts the original intention in framing the exclusion would be to limit liability under the policy for loss of rent to circumstances where the property was let and was then subject to an insured event rendering the property unliveable. However, the Panel considers it would not be fair and reasonable and consistent with the concept of utmost good faith for the insurer to rely on the strict words of this limitation in the circumstances of this dispute for the following reasons. Firstly the Panel believes the insurer contributed to the extended period during which the property would not have been acceptable to tenants. Secondly, the Panel would expect that, were it the case a tenant occupied the property after the loss, the claimant would be liable as landlord to compensate a tenant for the reduction in the enjoyment of the property due to the loss of amenity and thirdly, the claimant intended to let the property during this period. Taking into account these matters, the Panel is not satisfied the insurer is entitled to benefit from the claimant not having formally let the property as at the date of the loss in relying on the exclusion clause.

It is noted the delays in resolving the claim were lengthy but it would be impossible to identify a specific amount of time that delay was attributable solely to the insurer or its agents' conduct after the loss. In this regard, it is noted there were also delays in the claimant and/or her legal representatives pursuing the claim and responding to correspondence. In any event, such a payment would also be dependant on the claimant actually suffering a loss, which would include considering the likelihood of the claimant securing a suitable tenant. In that regard whilst the claimant had placed the property with an agent prior to the fire, it had remained untenanted for a period of almost two months prior to the fire. In addition, under the analysis formulated by the Panel, it is not considered fair or reasonable for the insurer to be held liable for loss of rent during the period it ought to have been possible to attend to the repairs.

After considering all the factors analysed above, and insofar as it is possible to attribute delay to the insurer's conduct of the claim over the two years in which the dispute has endured, the Panel is of the opinion a fair and reasonable settlement would be nine months loss of rent at \$120 per week, being \$4,680. .

Cost of the claimant's building report

The claimant submits she should be entitled to be reimbursed the cost of obtaining a report from a building consultant. The cost of the report was \$1,760.

The Panel notes the insurer has submitted it

"...does not accept that it was necessary for the Insured to incur any additional costs including costs associated with obtaining additional building reports and legal advice".

Nevertheless, the insurer has also submitted it will pay "reasonable costs incurred". The Panel is of the opinion, it is clear from the material provided it was entirely reasonable and in particular, necessary for the claimant to have obtained a report from a building consultant. The Panel notes the policy provides cover for an engineer's fees "that might be necessary to repair or replace the home following an event" which may include the steps necessary to resolve a dispute in the claims process. On that basis the Panel finds the insurer is required to pay the cost of the report, being \$1,760.

Other costs including legal costs, travel expenses etc

In relation to this aspect the claimant is pursuing the sum of \$6,000. She submits her legal costs are approaching \$5,000. She incurred significant travelling costs that are set out in a schedule and exceed \$7,000 and she also incurred medical expenses due to stress.

In relation to this aspect of the claim, the Panel notes that, notwithstanding the insurer's statement it did not believe it had been necessary for the claimant to incur such expenses, it has offered to pay \$3,000 in relation thereto. It is noted this sum was offered on the basis it included the cost of the claimant obtaining a building consultant's report.

After considering all the circumstances of this dispute, the Panel is satisfied it was reasonable and necessary for the claimant to have sought legal advice in order to resolve the claim. However, other issues then arise as to the amount of work carried out and at what rate. It is also noted that even if this matter had proceeded to court and the claimant had been successful, it is likely she would have been required to meet a proportion of her own legal costs.

In relation to the travel expenses, they mainly relate to the distance to the home from where the claimant was living at the time. In general the claimant would be expected to bear the cost of having to travel the distance between her home and her rental property as part of the normal claims process. Nevertheless, the Panel considers the insurer's conduct of the claim resulted in the claimant needing to travel to the property in excess of the ordinary number of visits that would be expected in the event of a loss of this type. The Panel therefore accepts some of the claimant's travel has been established to be reasonable cost incurred due to the poor conduct of the claim.

In relation to medical expenses claimed, the Panel is of the view that, in order to succeed in any forum for this alleged loss, the claimant would need to provide much more extensive evidence to support her claim which may not be economical for her

to do so given the amount involved. In view of the level of proof submitted, the Panel does not consider this loss to be established.

After considering all the material provided, the Panel is satisfied the claimant incurred various expenses in relation to her claim which would not have been incurred had it been handled more competently. As indicated above, the insurer has offered to pay reasonable costs incurred by the claimant in the prosecution of her claim. In that regard the Panel is of the opinion the amount of \$4,000 would be a fair and reasonable sum to reimburse the claimant for those costs of which the great majority consists of travelling expenses from her home to the site of the insured premises, which was a substantial distance.

In summary the Panel determines the insurer is required to pay the claimant \$21,553 in relation to the cost of repairs, \$4,680 in relation to loss of rent, \$1,760 for the building consultant's report and \$4,000 as reasonable costs for the balance of the various expenses claimed.

DETERMINATION

REFERRAL NO: 200 12 11655

*Motor Vehicle — security requirements –
Insurance Contracts Act 1984 S14, 37, 54*

SUMMARY OF FACTS

The claimant operates a business selling used cars. The business held a motor trades package insurance policy covering among other matters motor vehicles for market value up to \$20,000 per insured event, with a \$650 excess. On or about 23 February 2000, the vehicle, a Ford Falcon utility, was stolen from the car yard. The insurer denied liability on the basis that the vehicle was stolen using a key which the claimant had left in the ignition while the motor was running.

CLAIMANT'S POSITION

The insurer is relying upon an exclusion that was not adequately notified to it. It was never given a copy of the policy booklet, either when the policy was taken out or when it was renewed. The insurer should not therefore be allowed to rely upon the exclusion.

INSURER'S POSITION

The policy booklet was mailed to the claimant together with the schedule when he originally arranged the policy in December 1998. Since he received the schedule, he must also have received the policy. A replacement policy booklet (containing the current terms) was mailed to the claimant with his new schedule on 2 February 2000 after he renewed the policy in December 1999. The claimant was also mailed newsletters while he was a policy holder, and articles in these would also have drawn his attention to the fact that car theft was not covered if the keys were in the vehicle. The claimant was therefore informed in writing of the terms of the policy and the insurer is entitled to rely on the exclusion to deny the claim.

The claimant's statement that he never received either policy booklet is not credible. He clearly received the policy schedule which was enclosed with the policy booklet. Further, the claimant stated to one of its claims officers that had he known the claim would be denied for this reason, he would have lied about the keys being in the car. This shows he is willing to lie to support his claim. Further, while the claimant alleges that the insurer delayed renewing the policy at the end of 1999, discussions relating to the renewal began as early as 7 December and a renewal was arranged at a meeting with the claimant on 21 December 1999.

ISSUES IN DISPUTE

Whether the insurer had given the claimant notice of the exclusion;

Whether the insurer is entitled to rely on the exclusion to deny the claim.

RELEVANT POLICY PROVISIONS

From the policy booklet in use when the policy was taken out:

"Exclusions

The following are excluded -

...

(e) destruction or damage, or the incurring of a liability ... at the time when

...

(iv) the Motor Vehicle ... is in possession of a person as part of the person's stock in trade;

...

(h) destruction or damage occurring as a result of the Insured failing to take steps that are, in the circumstances, reasonable for the security of the Motor Vehicle after accidental damage has occurred to it"

From the revised policy booklet:

"EXTENT OF COVER

...

This insurance does not cover:

...

theft of the Vehicle if the theft involved the use of its own key and the key was left in or on the Vehicle".

LAW INVOLVED

Section 14 of the Insurance Contracts Act 1984 provides that if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. In deciding this issue the court shall have regard to any notification of the provision that was given to the insured, whether a notification is required by section 37 or otherwise.

Section 37 provides that an insurer may not rely on a provision included in a contract of insurance, not being a prescribed contract of a kind that is not usually included in contracts of insurance that provides similar insurance cover unless, before the contract was entered into, the insurer clearly informed the insured in writing of the effect of the relevant provision.

OUTCOME AND REASONS

Pursuant to regulations 5 and 6 of the Insurance Contracts regulations, a motor vehicle policy is a prescribed contract and the theft of a motor vehicle is a prescribed event. However, the regulations provide that in terms of a motor vehicle policy, for the contract to be a prescribed contract, the insured must be a natural person. In this case the insured is a business name, the proprietor of which is a registered company. In these circumstances the contract of insurance was not a prescribed contract, and therefore Section 35 of the Act does not apply and thus Section 37 of the Act is relevant. This section requires the insurer to give notice in writing of a term of the contract which falls within the category as being an unusual term, namely a provision in a contract of insurance of a kind that is not usually included in contracts of insurance that provide similar insurance cover. Neither party has addressed this issue, however, in the Panel's experience such a term as the term on which the insurer relies is one not normally found in motor vehicle policies, whether they be policies sold to an individual or a corporation. In these circumstances the Panel has reached the conclusion that the insurer was obliged to notify the insured of the critical policy term in writing.

In this matter the claimant states he never received a copy of the policy booklet and therefore his representatives were unaware of the critical policy term on which the insurer relies to deny the claim. The claimant is a business name, and the registered proprietor of the business name is a company.

The claimant has consistently denied ever receiving the policy booklet or any other material setting out the exclusion. Section 29 of the Acts Interpretation Act 1901 provides that where a document has been properly addressed and mailed to the last known address of a person, they are deemed to have been given it unless they prove the contrary. However, to have the benefit of this presumption, the insurer needs to prove on balance that the policy was mailed to the claimant.

Despite being invited to do so, the insurer failed to provide any evidence to support its claim that the policy booklet and other material setting out the policy term were ever mailed to the claimant. In these circumstances, the Panel concludes it has not established that the claimant was clearly informed in writing of the exclusion on which it relies to deny the claim.

The Panel also refers to Section 14 of the Act, which provides that if it would not be consistent with the duty to act with the utmost good faith for a party to rely upon a particular policy term, the party may not do so. One of the facts to be taken into account in considering this provision is the degree of "notification of the provision". In this case there was no notification of the provision and the Panel has reached the conclusion based on this section also, that it would be unfair for the insurer to rely upon a policy term in the absence of its ability to prove that the policy booklet was provided to the claimant.

The Panel accordingly determines that the insurer is liable to indemnify the claimant to the extent of the market value, less the \$650.00 excess.

DETERMINATION

CASE NO: 27041

*Home Building – water damage – utmost good faith
Insurance Contracts Act 1984 S13*

SUMMARY OF FACTS

The applicant insured his home building against loss or damage caused by listed events. On 13 June 2006 the applicant lodged a claim on the policy for internal damage to his home due to water entering the ceiling cavity over the lounge and bathrooms. The member accepted the claim and recommended that the applicant arrange to have re-pointing attended and the roof tiles cleaned. The applicant followed this advice but then asked the member compensate him for damage to the roof guttering that he considered resulted from this work. The member refused on the basis such a loss was excluded from cover under the contract. The applicant does not agree the member is entitled to reject the claim after advising him to have this work carried out. The amount in dispute is \$1,350.

The applicant submits that he lodged a small claim for water damage to the bathroom ceiling but as a consequence he was required to pay \$1,100 for roof cleaning and \$1,350 for guttering replacement. The member's assessor arranged that a building inspector report on the cause of the damage and the report received incorrectly identified a broken tile over the eaves near the bathroom as the cause. Later it was found by a roof repairman that there was a broken tile over the bathroom ceiling. The assessor instructed him to have roof cleaning work carried out as was detailed in a report provided by a building management service.

He considered this work was unnecessary as he had always attempted to keep his property in good condition. However, he had no choice as the assessor told him that otherwise he would have been unable to make any other claims in the following six months, a risk he did not want to take. As a result of the pressure cleaning and de-mossing of the roof tiles on 31 August 2006, the roof guttering was damaged. He immediately contacted the assessor and was told to lodge a further claim for this damage. She came to the home and inspected it on 4 September 2006. The assessor told him the gutters had rust and corrosion and whilst the pressure cleaning had caused the openings, the damage was not covered under the policy.

The guttering was in solid condition before the roof was cleaned. While the member alleges the damage was due to rust and corrosion, these holes could not have just appeared overnight as they did. The tiles were cleaned by a pressure spray that is strong enough to cut a finger and it is reasonable to accept that the process damaged the spouting. The assessor agreed the guttering may well have remained functional for another couple of years and said this would be reported to her manager, but he does not know whether this happened. The member has not responded to his complaint that he had this work carried out only due the assessor's instructions, not a recommendation, and threat to restrict cover on the property for 6 months. In addition, the chemicals used in the cleaning process are strong enough to cause corrosion.

The initial spray of chemicals that are strong enough to cause corrosion onto the roof loosened the moss which was then washed off into the guttering. This blocked the guttering and downpipes that were then pressure cleaned, damaging the guttering.

The member has insisted this work be done to his house resulting in damage to the guttering that it says is not covered. He does not consider it is reasonable that the member is able to walk away from any responsibility for this damage. While the member has referred to the policy not covering rust and corrosion, it has ignored the substance of his complaint that the damage flowed from it insisting he arrange cleaning of the roof tiles at a time when there were no previous leaks from the roof guttering.

The applicant had obtained 9 quotations for the roof work, the member's building management service providing the 5th most expensive quote. Most of the tradesman that attended advised him it was not necessary to remove the moss from the tiles, other than for cosmetic purposes, as it was not harmful. Nevertheless he acted on the member's assessor's advice as he was concerned about not being insured. After the guttering was replaced he was then contacted by someone who was acting on behalf of the member to have the guttering inspected. The only guttering left was some that was reusable that he intended to use on the garage at his home. The rest of the guttering was removed by the guttering contractor. He does not accept that the member is entitled to refuse his additional claim.

The member has responded, advising that the water damage claim was accepted and that its assessor recommended that the roof needed cleaning and re-pointing. The applicant arranged this after which it was noted the gutters were leaking. When the guttering damage was reported it appointed building consultants to report on this damage. The report received indicated that there was no evidence of high pressure cleaning damage to the guttering inspected and that there was surface rust present. This is a maintenance issue and the damage has not been caused by an insured event. As well the policy excludes claims resulting from rust and corrosion and there is no cover for replacement guttering under the policy.

ISSUES IN DISPUTE

The extent of the member's liability under the policy.

RELEVANT POLICY PROVISIONS

"Section One

– Your Home: The Cover

What IS covered

...

We will cover You for loss or damage to Your Home caused by an Insured Event during the Period of Insurance.

The reasonable cost of rebuilding, replacing or repairing to Your Home so that it is, if possible, in the same condition as when new, or when last renovated, will be paid by us.

What is NOT covered

1. ...
2. The exclusions on pages 38 and 39.

...

"Exclusions Applicable to Your Policy

In respect of Sections 1, 2, 4 and 5, We will not pay for loss

or damage caused by or arising from or occurring to any item by way of :

1. ...
- ...
6. Wear and tear, lack of maintenance or inherent defect;

7. Rust corrosion, mildew, wet or dry rot, rising damp or seepage and other signs of failure to keep Your Home in good order and repair;"

LAW APPLICABLE

Section 13 of the Insurance Contracts Act 1984 provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

OUTCOME AND REASONS

The policy was issued on a defined events basis and I note there is no defined event that covers damage to the guttering due to the cleaning process followed here. However, as has been continually presented since the claim was first refused, the applicant considers the loss flowed from the actions and instructions of the member's assessor who came to his home regarding the initial claim for water damage to a ceiling. I note that the member's decision to refuse the guttering claim was reviewed under its Internal Dispute Review process (IDR). Following this review, in a letter dated 1 November 2006, the decision to refuse the claim was maintained on the basis the damage claimed was not caused by an insured event. This letter makes no reference to relying on any exclusion under the policy but I note the member has raised an exclusion as an additional basis for refusing the claim when submitting its response to this service.

The applicant has provided a number of detailed letters, to both this service and before that to the member, setting out the reasons for his dissatisfaction with the member's decision to refuse the further claim. Central to the applicant's claim, and complaint, is his submission that the assessor did far more than recommend the roof of the home be cleaned. He has maintained that the member's assessor advised him that unless this was arranged there would be no cover under the contract in the ensuing 6 months. This is effectively an allegation of intimidation and it is of concern that the member has not referred to this aspect of the dispute in its submission before me.

The member has provided 2 reports from outside contractors in its submission before me. The first, dated 20 June 2006, is from a building and management service. This report appears to have been directed to the member's assessor. It records that the roof was inspected, no storm created openings were found and there was a build up of leaves at one point on the roof. It identified the possible source of water entry was a broken tile over the eaves at the bathroom. There is no copy of any report from the assessor in the member's material to indicate what, if any, commentary was provided to the member by the assessor in respect to the assessment or this report.

The second report, dated 24 October 2006, relates to an inspection of the property by a building consultant. This records that at the time of the inspection new colourbond guttering had been installed and that 2 sections of the replaced guttering were available to him. The reports states that these exhibited some surface rusting on the inside and that there was no damage due to high pressure cleaning. This report, as it applies to the guttering, concludes as follows:

"If by extrapolation the condition of the other gutters and rainwater downpipes of the previous (old) existing rainwater system removed from the site and now not able to be

viewed were as per the two gutters presently still on the site then there would not have been any damage to the metal gutters and rainwater downpipes.

If the gutters that were previously removed from the site exhibited a lot more rusting to the metal surfaces than that of the two gutters left behind it could have been damaged by a high pressure water cleaning system."

There is no report from the assessor to be read in conjunction with the building consultant's report quoted above. The applicant has submitted that the assessor has inspected his property twice, the last time being before the guttering was replaced. There is nothing in the member's material concerning the outcome of these inspections by the assessor, other than confirmation that the assessor did attend at the property twice on its instruction.

The applicant has alleged that the assessor did more than suggest or recommend that the roof be cleaned; it is central to the applicant's submission that he had no choice in this matter as the assessor advised there would be no further cover for claims during the next six months if this was not done. Despite this significant allegation of pressure from the assessor, the member has not responded to this aspect of the dispute in any significant way. There is no indication this allegation was referred back to the assessor for comment and a written response. There is ample consumer information available to alert homeowners to there being little or no need to clean moss from tiled roofing on the basis the moss does not affect the efficiency of the roof. Despite the applicant advising that some of the contractors that provided quotations to him also gave him this advice, the member has also not responded to this aspect of the applicant's complaint.

As this case is disclosed in the material before me I comment as follows:

- It is agreed the applicant lodged a legitimate claim for water damage to a ceiling.
- The member has not refuted the applicant's advice that its assessor put him into a situation in which he believed there was no option other than to accept the assessor's direction to repair and clean the roof.
- The member has not provided a copy of an assessors report or a statement from the assessor to explain the action taken and the advice provided to the applicant.
- The member has not refuted the applicant's advice that some of the contractors that provided quotations for the roof work advised him it was not necessary that the moss be cleaned from the roof tiles. I accept the applicant's belief this cleaning was unnecessary is reasonably held.
- There is no copy of any report in respect to the assessor's inspection of the damaged guttering. The applicant has advised this took place after he advised the assessor that the guttering was damaged by the roof cleaning process. The member has not commented on this, or provided any statement from the assessor concerning the applicant's allegation that the assessor agreed the cleaning process had contributed to the damage to the guttering.
- All of the above is contrary to good insurance practice and to the member's duty to act in good faith towards the applicant; these failures have resulted in the applicant suffering financial loss that I consider entitles him to a further payment under the claim.

It is agreed by the applicant that the 2 lengths of guttering inspected by the building consulted represented guttering that was in better condition than the remaining guttering. These remaining available lengths were not damaged by cleaning

according to the consultant and the images provided do not contradict that position. It was not unreasonable that the applicant allow the guttering contractor to dispose of the remaining guttering as his submission shows the member's assessor did inspect this. I do not agree that it is reasonable the member meet the full cost of replacing the guttering as there is sufficient material available to indicate that replacement of this would have been necessary eventually, and that the assessor's insistence on the roof work had the effect of bringing this replacement forward in time. The remaining guttering appears to be relatively sound with surface rust visible; the applicant agrees the guttering in other locations was more deteriorated but was still serviceable. That the guttering was damaged by the force of the cleaning process supports there was deterioration but it is not established that guttering was not functioning correctly before that time. Overall I consider it reasonable the member be required to pay 25% of the cost of the new guttering to the applicant.

In relation the cleaning of the tiles I find the member is to reimburse the applicant for the cost of the cleaning process, but not for the cost of the re-pointing or other roof repairs that were included in the total paid to the roofing contractor. It will be necessary that the applicant provide details of the break up of this cost in order that the member is in a position to make the payment.

Accordingly, I determine that the member is required to indemnify the applicant as detailed above. In the event the parties are unable to agree on the payment to be made in respect to roof cleaning, either party may request that I issue a supplementary determination concerning this aspect of the dispute.

DETERMINATION

CASE NO 28581

*Landlords home building policy – loss of rent – extent of cover
– Insurance Contracts Act 1984 S13*

SUMMARY OF FACTS

The applicant has a defined events home building insurance policy covering a rental property. The building sum insured was \$350,000 with a policy excess of \$300. A claim was lodged on the policy for rent default on the part of tenants in the house. The member rejected the claim on the basis there was no tenancy agreement covering the period under claim. The applicant does not agree that this is correct, the amount in dispute being \$4,103.

The applicant's submission

The tenant signed a 6 month tenancy agreement for the period commencing from 10 February 2006. The agreement did not terminate at the end of the 6 month period but instead stayed in place on a monthly rental basis. It is extremely common that landlords rent properties on this basis, once the initial period of the lease has expired. He does not agree the member's rejection of the claim is correct as there was a rental agreement in place at the time of the defaults.

The member's submission

Documents submitted in support of the claim show that the tenant paid the rent up until 24 September 2006 and that the tenancy agreement had been signed for the period ending 10 August 2006. As there was no current rental agreement in place as at the time of rent default the claim is not covered by the policy. The applicant would have been aware that the lease expired on 10 August 2006 and that the rental term had gone beyond the term of the original agreement. Cover for rent default ceased on the expiry of the agreement on 10 August 2006.

ISSUES IN DISPUTE

Whether the loss is covered by the policy.

RELEVANT POLICY PROVISIONS

“Important terms explained

The following table defines and explains the meaning of some terms used in this PDS. ...

term	meaning
rental agreement	A current written contract between you and your tenant which sets out the term of the rental period and the rent, bond and conditions for occupying the house

...

Additional features

...

Insured

2(c) default or non-payment of rent when under rental agreement

If you have a rental agreement for a fixed period and the tenant does not pay any rent for at least **4** consecutive weeks, we will pay you the unpaid rent caused by the tenant:

- not paying or refusing to pay
- vacating the home or unit without giving the notice required by the rental agreement or

- being evicted before the rental agreement term finishes

...

The most we will pay for all claims resulting from the same tenant is:

- 14 weeks rent starting from the beginning of the 5th consecutive week of unpaid rent or
- \$4,000

whichever is less."

LAW APPLICABLE

Section 13 of the Insurance Contracts Act 1984 provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

OUTCOME AND REASONS

The onus of proof is on the applicant to establish, on the balance of probabilities, that he has suffered a loss caused by a risk insured against. Once the claimant has established that the loss was prima facie caused by a risk insured against, the onus shifts to the member to show, on the balance of probabilities, that the damage was not caused by an event covered by the policy or that the claim falls within an exclusion in the contract of insurance if that is the member's belief. In support of his submission the applicant provided a copy of the lease signed by his tenant. I note that this residential tenancy agreement included the following:

"Term

The term of this agreement is 6 months beginning on 11/02/2006 and ending on 10/08/2006.

At the end of the term the tenant can stay in the residential premises at the same rent or an increased rent if the rent is increased in accordance with the Residential Tenancies Act 1987) but otherwise under the same terms unless or until the agreement is ended in accordance with the Residential Tenancies Act 1987."

The applicant also provided a copy of a facsimile from the estate agent managing the property that advised as follows:

"We advise that the tenant signed the original lease for a period of 6 months to commence on 11/02/06 and ended on 10/08/06. Under the residential tenancies Act 1987, the tenant can remain in the property on a continuation basis (still bound by the terms and conditions of the fixed term agreement) until the agreement is ended by either party or the tribunal in accordance with the act.

The tenant in this case did just that. The fixed term lease ended on 10/08/06 but the tenant remained in the property on a continuation basis until the tribunal ended the agreement on 18/12/06 for non payment of rent."

I have carefully read the material provided by the parties, including a copy of the tenancy agreement signed by the applicant's tenant. I do not agree there was no current rental agreement in place after 10 August 2006 and until the tenant was ordered to vacate the property. Up until the date the tenant was ordered to vacate there was a current lease in force that provided the tenant with the right to maintain his tenancy in the home. The lease agreement did not terminate at the end of the initial 6 month period as it provided for the rental of the property to continue on monthly basis in accordance with the Residential Tenancies Act 1987. In effect, after the expiry of the initial 6 month period, the rental agreement became an ongoing agreement for one month consecutive periods. I have no hesitation in finding the lease agreement continued to constitute a rental agreement as defined in the policy

after 10 August 2006. In my view, the clear commercial purpose of the policy is to cover a loss such as that claimed and the member's attitude to the claim represents a failure to act in good faith towards the applicant, contrary to the requirements of Section 13 of the Insurance Contracts Act 1984.

Accordingly, I determine that the member's is required to indemnify the applicant for the loss as provided under the policy. Further, the member is required to pay interest on the settlement, at the statutory rate of 8.89%, from 31 January 2007 until the date of payment.

DETERMINATION

CASE NO 31771

*Home Building – storm –exclusion –Insurance Contracts Act (1984) S's13 & 14
- utmost good faith*

SUMMARY OF FACTS

The applicant's property was insured under a building policy with the member. The policy incepted on 7 March 2000 and was renewed annually thereafter. The period of insurance relevant to this determination was from 7 March 2007 to 7 March 2008. The building was insured for the sum of \$169,361. An excess of \$300 applied to each claim. The applicant's tenant is her brother. On 8 June 2007 a storm caused damage to the property. The applicant states damage was caused to the home, a garage and fence at the property. On 13 June 2007, the applicant reported the damage to the member.

The member assessed the damage to the garage/shed and found it had collapsed due to wear and tear, rust and corrosion. The member denied indemnity to the applicant for damage to the garage/shed on the basis the policy excludes loss and damage caused through wear and tear, rust and corrosion. The member has not yet assessed the damage to the home and fence.

The applicant submits a storm caused the collapse of the garage/shed. She submits that while the shed was old, it was useable, structurally sound and maintained sufficiently. The applicant is critical of the assessment of the claim by the member. She states the roof of the garage became loose during the storm on 8 June 2007 and when she reported the damage to the member, she was informed to make the garage safe but to leave it *in situ* to enable the damage to be assessed. Due to delays by the member in assessing the damage, a second storm caused a wall to the garage/shed to detach and as a result, it had to be pulled down to make the area safe. The applicant also states the member has failed to address damage caused to the home and fence in the storm on 8 June 2007 which was reported to the first assessor who attended the property.

ISSUES IN DISPUTE

Whether the damage to the garage/shed is covered.

Whether the damage to the home and fence is covered.

RELEVANT POLICY PROVISIONS

"WHAT YOU ARE COVERED FOR

Storm

If your home or contents suffer loss or damage caused by

- a violent wind, cyclone or tornado
- thunderstorm or hail which may be accompanied by rain or snow, or
- a sudden, excessive run-off of water as a direct result of a storm in your local area

...

we will under buildings insurance

- ▶ rebuild or repair that part of your home that was damaged
- ▶ rebuild or repair that part of any gate, fence or free-standing wall that was damaged by wind, *unless*

- they were not kept in good order and repair, that is, they were not structurally sound or well maintained

...
What you are not covered for – general exclusions we will NOT cover

- ▶ loss, damage, injury or death that occurs as a result of

-
- wear, tear, rust, corrosion, deterioration or erosion

-
- faulty design or workmanship

...
Things that may put your claim or cover at risk

You may put your insurance claim or cover at risk if you do not meet your obligations to us. We may refuse a claim, cancel your Policy, or do both if you

-
- ▶ do not maintain your home in good repair and condition. This means your home must be watertight, structurally sound, secure and well maintained

...
Glossary

Use this glossary to find the meaning of words and phrases in this booklet.

.....
home

is any fully enclosed building with walls and a roof used primarily for domestic purposes at the site, that can be locked up

- for buildings insurance, this also includes any fixtures or home improvements at the site

...
storm

is a violent wind, cyclone, tornado, thunderstorm or hail which may be accompanied by rain or snow, or a sudden, excessive run-off of water as a direct result of a storm in your local area. It does not include persistent rain by itself."

LAW INVOLVED

Section 13 of the Insurance Contracts Act 1984 ("the Act") provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

Section 14 of the Act provides that if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. In deciding this issue the court shall have regard to any notification of the provision that was given to the insured, whether a notification is required by section 37 or otherwise.

OUTCOME AND REASONS

The onus of proof rests with the applicant to establish she has suffered a loss in circumstances that entitles her to cover under the policy. If the applicant can *prima facie* establish a loss covered under the policy then the onus shifts to the member to establish it is not liable to meet the claim.

The member does not dispute the weather conditions on 8 June 2007 were extreme. It does not dispute that a storm as defined by the policy occurred on that day. It also does not dispute that damage to the garage occurred as a result of the storm. The

member has provided a copy of the incident description given by the applicant to the member's claims operator on 13 June 2007 which states:

"During the storm strong winds have caused the tin roof of the garage to lift and the walls of the garage have collapsed and fallen in."

It appears the storm on 8 June 2007 caused widespread loss and damage in the area. The applicant has provided a copy of a news report dated 9 June 2007 from ABC News Online reporting on the storm. Part of the news report states that:

"A significant part of New South Wales has been declared a natural disaster area after a savage storm which has been compared to a mini-cyclone swept through Newcastle, caused havoc on the Central Coast, and went on to lash Sydney."

The news report states that State Emergency Services had received over 5,000 calls for assistance due to the storm but that it had been impossible to reach everyone because of the wind and flooding.

The property is located in Stockton which is on a peninsula immediately to the east of Newcastle. The peninsula separates the northern suburbs of Newcastle from the Pacific Ocean. The property is situated on a street which runs next to the beach on the eastern side of the peninsula. The property is therefore right next to the Pacific Ocean and exposed to the elements.

The chronology of events in this matter is difficult to follow. The applicant has provided an undated statement from the tenant of the property in support of her Referral Notice to the Service. The tenant states an assessor for the member first inspected the property "many weeks" after the storm. The tenant states the assessor:

- Took photographs and measurements of the garage, advised at least a new roof would be required and perhaps the whole garage would need to be replaced, and mentioned a "make safe may be necessary".
- Examined, took photos and measurements of the fence, and advised the whole fence and rear gate would have to be replaced.
- Examined the house interior and took notes and measurements where water had come in and caused damage to the walls. The assessor advised the tenant he would arrange for an electrician to attend the property to make it safe as shocks were being felt through several power points due to rain/moisture from the storm.

The member has provided a copy of an invoice dated 11 September 2007 from a builder appointed by the member who attended the site on 26 July 2007. The description in the invoice states:

"Emergency call out on 26/07/08 at the above address

1. Electrical

Attended site to check electrical

Disconnected circuits from switchboard and carried out test all tested OK."

The tenant states the second inspection of the property was by a builder again several weeks later. The builder advised him the garage would have to be demolished and rebuilt. The builder indicated to the tenant that he was concerned about more damage and safety issues regarding the condition of the garage as more damage was occurring through each new storm and wind. The builder indicated that he would come back to the property in a few days to dismantle the garage and remove it from the property.

The member has provided a copy of the report from its builder which is undated but states the builder inspected the property on 15 August 2007. The member has

tendered a facsimile from the builder dated 22 January 2008 which states this report was submitted to the member on 11 September 2007. The builder's report states:

"Upon inspection we found the timber/corrugated shed to the backyard in very poor condition. The front wall had been blown down and the roof has collapsed. The remainder of the walls are in very poor condition and do not comply with current building codes as it is almost impossible to determine what damage was caused by the recent storms in June, due to the existing condition we can only provide a quote to demolish and rebuild to code."

And:

"We have tried on several occasions to contact insured to arrange for a time to book in our estimator, but we have had no success. We have left message on land line, we have also tried the mobile but it is switched of. On the 24/08/07 a gentleman named Ron answered the phone and he informed me that he will leave message on the table for the insured to call back but we have had no response."

The builder provides a quote to demolish the garage and rebuild a new garage to comply with the Building Code of Australia in the sum of \$17,521.

The tenant states:

"3rd assessor (**first from [the member]**) came over 5 months after the original damage had been caused by the storm. By this time the garage had been open and exposed to the elements and salt air and was basically disintegrating the structure and the tin cladding, a state it is still in today. The fence was leaning and rear gate and fence section had fallen down.

- He took, I believe 3 photos of the garage and left without much comment, or even looking at the fence or interior of the house damage
- This was my last contact with an assessor or builder" **[emphasis added]**

The member submits an assessor employed by the member first attended the property on 27 September 2007, conducted an inspection of the garage and took photographs of the garage. The member submits it cannot locate records of an earlier attendance by an assessor appointed by the member as alleged by the tenant. However, the Panel is satisfied on the balance of probabilities that an assessor appointed by the member did in fact attend the property to conduct an assessment of storm damage to the garage/shed, fence and the home prior to 26 July 2007, when an electrical make safe inspection was conducted at the property by a representative of the builder appointed by the member. The Panel relies on the following to make that finding:

- The tenant states there was such an attendance by the assessor.
- The tenant states the assessor indicated to him that the assessor would arrange for an electrician to attend the property to make it safe and that in fact occurred on 26 July 2007.
- The undated report from the builder submitted to the member on 11 September 2007 names the same assessor who attended the property on 27 September 2007 as the assessor appointed in the matter.
- The tenant states the assessor who attended the property on 27 September 2007 was the same assessor who attended the property prior to 26 July 2007.

The member submits it became aware of further damage to the property (that is, to the fence and the home) on receipt of the applicant's submission. However, clearly the assessor employed by the member was made aware of that damage prior to 26 July 2007. The member was therefore aware of that damage prior to receipt of the

applicant's submission and for reasons which are not readily apparent failed to address issues of damage to the home and fence at the property.

Section 13 of the Act provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

Utmost good faith has been described as term with a range of meanings in the legal context encompassing notions of fairness, reasonableness and community standards of decency and fair dealing: Mann, *Annotated Insurance Contracts Act* (4th ed, Lawbook Co, 2003), p 38. It is said to impose a market standard of fairness: Sutton, *Insurance Law in Australia* (3rd Ed, LBC Information Services, 1999), pp 157-158.

More recently the duty of utmost good faith was considered by the High Court in *CGU Insurance Ltd v. AMP Financial Planning Pty Ltd* (2007) HCA 36. The High Court accepted the view that a lack of good faith is not to be equated with dishonesty and that other conduct short of dishonesty may suffice (Gleeson CJ and Crennan J at [15]; Kirby J at [136]-[137]; Callinan and Heydon JJ at [257]). Good faith may also require:

- Clear, candid and decisive conduct by insurers and insureds (Kirby J at [72]);
- An insurer to make timely decisions (Gleeson CJ and Crennan J at [15]; Kirby J at [134]; Callinan and Heydon JJ at [259]);
- An insurer to make up its mind to either accept or deny indemnity (Kirby J at [180]; Callinan and Heydon JJ at [259]); and
- Prompt and business like processing of claims for indemnity (Kirby J at [139]).

In the Panel's opinion the member has not acted with the utmost good faith in this matter. Significantly it has not provided any material from the assessor who first inspected the property prior to 26 July 2007 and who took photographs of damage to the home, the fence and garage at the property during that first inspection. It has not provided copies of the photographs taken by the assessor during the first inspection. By the time this assessor returned to the property on 27 September 2007, the assessor only addressed issues relating to damage to the garage/shed and did not address issues relating to damage to the fence and the home.

It took the member many weeks to inspect the property. The evidence suggests the inspection occurred in around mid-July 2007 or two weeks prior to the make safe electrical inspection on 26 July 2007. The applicant states her husband took photos of the damage to the shed on 13 June 2007 and the applicant has produced copies of these photos in her material. These photos show the roof of the garage has come away and one of the rafters has fractured. The walls of the garage are still in place. The applicant states the walls of the garage were leaning in following the storm on 8 June 2007 but did not collapse. She states they leaned in because the roof beams had snapped and this is supported by the photographs taken by her husband on 13 June 2007.

The applicant states subsequent storms caused further damage to the garage which was in a pre-existing weakened state due to the storm on 8 June 2007. She states that as a consequence she had to remove one of the walls to make the area safe. She states the photos taken by the builder appointed by the member on 15 August

2007 show the garage with the wall removed and the roof buckled far more significantly than in the photos taken by the applicant's husband on 13 June 2007.

The member relied on the builder's report submitted to the member on 11 September 2007 to assert the garage/shed did not comply with the Building Code of Australia and yet the builder does not indicate in its report exactly how the garage did not comply with the Code. In any case, by the time the member's assessor inspected the garage on 27 September 2007, and then drafted and forwarded the initial letter denying indemnity to the applicant dated 3 October 2007, a period of around four months had elapsed since the initial storm. The tenant at the property states that during this period the condition of the garage/shed deteriorated significantly.

Section 14 of the Act provides that if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. The member cannot now assert the garage was not well maintained or kept in good order or repair, or that it exhibited signs of wear, tear, rust, corrosion, deterioration and it was this condition that caused the garage to collapse.

The Panel therefore determines the member is required to indemnify the applicant for the damage to the garage/shed.

The contact person for the member has advised that issues relating to damage to the fence and the home are currently being addressed in consultation with the applicant. Clearly the same issues regarding sections 13 and 14 of the Act apply to damage to the home and fence, as they applied to the damage to the garage. The Panel cannot make a determination in regard because the damage to the home and the fence are yet to be assessed.

However, should a dispute arise regarding cover under the policy for damage caused to the fence or home during the storm on 8 June 2007, then either party may approach the Service for a supplementary determination.

DETERMINATION

CASE NO: 31581

*Motor Vehicle– prejudice – Insurance Contracts Act (1984) S's14 & 54
– uninsured driver*

SUMMARY OF FACTS

The applicant's vehicle was insured for an agreed valued of \$26,000 with the member under what was described as a "fully comprehensive" motor vehicle insurance policy between 28 September 2006 and 28 September 2007. The policy was subject to a basic excess of \$250. On 6 September 2007, the applicant lent his vehicle to a friend, DZ. While driving the vehicle, DZ claims to have hit an oil patch while exiting a roundabout causing him to lose control of the vehicle and collide into some wood bollards. A claim for the cost of repairs (approximating \$8,340.07) was lodged with the member who, in turn, denied it on the basis, it was not being driven by the applicant as the only nominated driver at the time of the accident.

ISSUES IN DISPUTE

Whether the member was entitled to deny the claim on the basis it was not being driven by the insured or another nominated driver at the time of the accident.

RELEVANT POLICY PROVISIONS

"DEFINITIONS

The following definitions apply when reading the PDS and the attached Policy.

...
'Nominated Driver' Means:
1. Only the Persons Nominated on the proposal form; or
2. Any other person agreed to by Us in writing as a Nominated Driver

POLICY RISKS AND BENEFITS

SIGNIFICANT RISKS	SUMMARY OF RISK
Failure to Nominate Drivers	Any driver not nominated on the Proposal Form or shown on the Schedule is not covered by this Policy
Nominated Driver	Additional drivers can be added with [member's] agreement.
Accidental/malicious damage (including windscreen & window glass)	[Member] will pay up to the agreed or market value that applies, repair Your vehicle, or pay the cost of repair.

SECTION 1 – LOSS AND DAMAGE

Damage to the Vehicle

Provided that the insured vehicle was being driven by You or a Nominated Driver at the time of accident and any loss or damage is incurred, We will provide indemnity against loss of or damage to the Insured Vehicle by, at Our option:

- paying for the amount of loss or damage providing it does not exceed the Value of the Vehicle as shown on your Schedule, less any applicable excess or;
- repairing, reinstating or replacing the Insured Vehicle or any part of it with parts that are new or consistent with age and condition of the Insured Vehicle, less any applicable excess or;
- Cash settlement, less any applicable excess.

GENERAL EXCLUSIONS

This Policy Does Not Cover:

1. loss, damage or liability whilst the Insured Vehicle is being driven by or last driven by a person who is neither You nor a Nominated Driver. Provided that this exclusion (1) does not apply to persons driving the Insured vehicle for the purpose of servicing, repair or testing;

...

GENERAL CONDITIONS

...

3. You must give notice as soon as possible of:

...

- (b) any change in or addition to the person/s (Nominated Drivers) who will be driving the Insured Vehicle;"

LAW INVOLVED

Section 54(1) of the Insurance Contracts Act 1984 (the Act) provides that where but for this section an insurer may refuse to pay a claim, either in whole or in part by reason of some act of the insured or another 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 that claim by reason only of that act, but its 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. Subsection 2 states: 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.

Section 14 of the Act provides that if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. In deciding this issue the court shall have regard to any notification of the provision that was given to the insured, whether a notification is required by section 37 or otherwise.

OUTCOME AND REASONS

There has been an exchange of the material upon which the disputing parties rely. Accordingly, the Panel is satisfied that each party has had full access to the material on which the other party bases its case, and also an opportunity to reply to matters raised by such party. In view of the aforesaid, it is also unnecessary to rehearse the material unless required.

On the face of it, the member is entitled to apply the policy exclusion clause and refuse to indemnify the applicant for this claim. However, before doing so, the member must address section 54 of the Act. The member, to the extent it has dealt with this issue, relies upon the following submission:

"It is clear the driver of the vehicle Mr DZ was a non-nominated driver and whilst under his control, damage was sustained to the vehicle. This act was causative of the loss and therefore the exclusion applies and the company may refuse to pay the claim".

By implication, the member is inferring 'this act' was the 'non-nomination' of Mr DZ. However there were in fact two separate acts at work here. The first act was the non-nomination of Mr DZ as a driver.

The second act was Mr DZ's causing damage to the vehicle whilst it was under his control. Section 54(1) of the Act provides that an insurer may not refuse to pay a claim by reason of 'some act' of the insured after the contract was entered into.

However this must be read down to the extent that subsection (2) applies whereby to the extent 'the act'

"...has caused or contributed to the loss for which insurance cover is provided by the contract.....the insurer may refuse the claim".

It appears to the Panel that, on the facts before it, there is no objective evidence as to what might be the elements comprising 'the act' which has caused the loss for which insurance cover is provided. The member has merely submitted:

"whilst under Mr DZ's control, damage was sustained to the vehicle".

The applicant has stated that 'Mr DZ skidded on an oil patch which caused him to hit some roadside bollards'. It is not in dispute between the parties Mr DZ was a mature aged driver, with a good driving record and no police charges ensued from the accident. It therefore seems reasonable for the Panel to conclude this was a driving incident which might have adversely affected any driver, even the applicant. Accordingly the Panel finds, on the balance of probabilities that sub-section (2) of the Act does not arise, in that there was no 'act' which Mr DZ committed which caused the loss for which insurance cover is provided.

Turning now to the failure to nominate Mr DZ as a driver, the Panel believes this omission is in fact 'some act' which arose after the contract was entered into and that its attention must now focus on the operation of sub-section (1) of the Act. Accordingly the member must demonstrate the extent to which its rights were prejudiced by this omission and to what extent that prejudice allows it to either partially or totally deny the claim. As section 54 of the Act has been the subject of considerable judicial interpretation, the Panel, pursuant to its 'fair and reasonable' mandate, is prepared to consider the issue of section 54(1) despite the member's failure to adequately address this aspect.

Current judicial interpretation of the section broadly supports the contention section 54(1) prevents an insurer from relying upon the breach of a policy term per se if in fact there is no relationship or connection between the act constituting the breach of the policy term and the loss. As previously indicated, the Panel is of the view the facts of this case permit it to reach the view, there is no causal link between the policy breach, being the failure to nominate Mr DZ as a driver, and the loss. To what extent then has the member suffered any other financial penalty arising from this policy breach?

Does the 'lost opportunity test' apply? Whereby the insurer may allege the prejudice equates to the whole loss as it was denied the opportunity to decline cover, pursuant to its underwriting guidelines, arising from the policy breach. In this case the Panel is not persuaded of the applicability of this doctrine. Insofar as "*Nominated Drivers*" are concerned, the Panel notes "*[additional] drivers can be added with [the member's] agreement*" according to the table entitled "*Policy Risks And Benefits*" in the policy. This suggests the applicant may nominate DZ as a "*Nominated Driver*" subject only to the member's agreement. That the member's agreement appears necessary is also supported by the fact the policy defines "*Nominated Driver*" to include a person "*agreed to*" by the member.

In contrast however, it is also noted General Conditions 3 merely requires the applicant to give the member "*notice*" of "*any change in or addition to the person/s (Nominated Drivers) who will be driving the Insured Vehicle*" which suggests the applicant may unilaterally nominate his "*Nominated Drivers*". In short, contrary to what was suggested in the "*Policy Risks And Benefits*" table as well as the definition

of "*Nominated Driver*", General Conditions 3 appears to suggest the member's agreement is unnecessary. In the circumstances, the Panel will consider the process of proposing "*Nominated Drivers*" as merely procedural in nature namely, a process done as a matter of course. A driver would be considered a "*Nominated Driver*" so long as the applicant gives notice to the member. It is arguable that it is unnecessary for the member to agree with the nomination.

However, even if this were not the case and there are hypothetical circumstances which might cause the member to decline the nomination of a particular driver as proposed by the applicant, on account of that person's poor driving history, then the Panel is not persuaded that scenario can be entertained in respect of Mr DZ's nomination.

The Panel's view in this regard is reinforced by the fact the member had completely failed to rebut the applicant's and his broker's claim that the member would have covered DZ as a "*Nominated Driver*", if only the applicant had informed it. Furthermore, the policy provides no allowance for premium changes purely on the fact the applicant nominates a "*Nominated Driver*". Insofar as drivers are concerned, the only factor that determines premium changes is the age of the drivers. As the member had failed to rebut the applicant's and his broker's assertions as well as demonstrate how the premium would change if the applicant had formally nominated DZ as his "*Nominated Driver*", the Panel is left with little else but be drawn to the conclusion it had not suffered any prejudice at all from the applicant's policy breach. Certainly in respect of Mr DZ, the 'lost opportunity' test does not apply.

In the particular factual circumstances of this case, for the member to refuse to indemnify the applicant for the accident, solely on the grounds of the failure to nominate Mr DZ when an objective view of Mr DZ's driving history reveals the member would have automatically agreed, is to put the member at risk of breaching the 'utmost good faith' provision of section 14 of the Act.

In light of the aforesaid reasons, the Panel therefore determines the member indemnifies the applicant for the damage to his vehicle, subject of course, to any applicable policy excess.

DETERMINATION

CASE NO: 33326

Home Building – legal costs – extent of cover – Insurance Contracts Act 1984, S's 13 & 14 – utmost good faith – delay in making a decision re claim – clause 10.2(vii) Terms of Reference

SUMMARY OF FACTS

The applicants held a home contents insurance policy with the member for the period 25 July 2006 to 25 July 2007, subject to a \$100 policy excess.

On 29 November 2006 the applicants lodged a claim with the member for burglary of a number of contents in their home amounting to approximately \$30,000. During the claims process the member was not satisfied that the applicant had proven ownership of a majority of the items and appointed an investigator in December 2007 who subsequently conducted multiple interviews of the applicants.

However, In May 2007 the applicants were not satisfied the member had progressed the claim within a reasonable period and engaged a solicitor to act on their behalf following which a resolution to the claim was achieved shortly thereafter. The applicants paid the solicitor \$2,000 for his services and have sought reimbursement from the member for this cost. The member has denied the reimbursement of the solicitor's costs the applicants incurred, as it states such costs are specifically excluded under the terms of the policy.

ISSUES IN DISPUTE

Whether the member was entitled deny liability for the applicants' claim for the solicitor's costs he incurred.

RELEVANT POLICY PROVISIONS

"What is not part under any part of your policy (cont)

...

extra costs following an insured event

- * consequential losses or extra costs following an Insured Event including:

...

- professional, expert, legal, consulting or valuation costs unless you obtained our prior written authority to incur these costs...

Making a claim

What you must do if there is an incident that could lead to a claim

If you suffer loss or damage, or there is an accident you must:

...

- ✓ give us evidence of value and ownership of lost, stolen or damaged goods or property, especially for articles such as jewellery, artworks, hand-woven rugs and collections, and the price of recently purchased items such as stereo's, TVs, cameras, computers, listed contents items or specified effects, if we ask for this"

LAW INVOLVED

Section 13 of the Insurance Contracts Act 1984 provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

Section 14 of the Insurance Contracts Act 1984 provides that if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. In deciding this issue the court shall have regard to any notification of the provision that was given to the insured, whether a notification is required by section 37 or otherwise.

OUTCOME AND REASONS

There has been an exchange of the material upon which the parties rely. Each party has thus had full access to the material on which the other party bases its case. As a consequence, it is not necessary to discuss all this material in any great detail. I also note that most of the member's claim file has not been included in its response.

It is not disputed that the applicants have suffered loss which is covered by the policy. The dispute involves the member's decision not to pay legal costs the applicants incurred by engaging a solicitor without the prior knowledge or approval of the member. In any event the member states, such costs are otherwise expressly excluded by the policy.

The male applicant submits that upon submission of the claim, he was met with a loss adjustor appointed by the member and produced the following documents in support of his claim:

Item No	Item	Proof provided
1	Musical keyboard	Photo
2	Engagement ring	Photo & valuation certificate
3	Antique silver vase	Photo
4	Plasma TV	Manual & sales docket provided
5	2 Gold bangles	Photo & sales docket
6	Laptop computer	Operating manual provided
7	Home stereo	Operating manual & sales docket
8	2 Nokia mobile phones	Operating manuals
9	Video camera	Operating manual & sales docket
10	Digital camera	Operating manual, box & sales docket
11	Personal Computer (PC)	Operating manual & sales docket

The applicants categorically refute the member's allegations in its submission that insufficient documentation was provided in support of the claim and refer to the above list as evidence of their co-operation. They state the member appointed an investigator who demanded an excessive amount of documentation and information which in their view, was not related to the claim. The applicants describe that such information included, but was not limited to telephone records (home & mobile) of both he and his wife, a copy of the male applicant's passport, visa to overseas and flight tickets, bank & credit card statements and even phone numbers and addresses of their parents, relatives and friends.

They submit that they co-operated with the member as much as practicable and provided everything it had asked for, however the claim was not resolved. They state that attempts at contacting the member to either progress the matter or even

ascertain the status of the claim were met with calls being passed from one operative to another without success. In the end, they felt that it was necessary to engage a solicitor to act on their behalf in order to reach a resolution to the matter. They are now simply seeking reimbursement of these costs in order to finalise the matter.

The member maintains that it has correctly declined the applicants claim for reimbursement of legal expenses in accordance with the terms and conditions of the policy. It acknowledges that there were some delays in the settlement of the claim but contends that many of these delays were as a result of the applicants' actions. However, the member has not detailed what "actions" by the applicants it seeks to rely on in apportioning blame for delays. The Panel notes that the member alleges the applicant did not have sufficient proof of ownership for some items and there were concerns with the claim. Again, the member has not detailed any of these concerns for consideration by me as to whether such requests were reasonable, nor has it provided the Service with the majority of its files, including assessors and investigator's reports.

It should be noted that a second interview was scheduled by the member however this was cancelled by the applicant on 28 March 2007. The applicants submit that the reason for the delay was that the female applicant, who was some seven months pregnant, was not well which, I consider reasonable in the circumstances. Following this, the applicant refused to be interviewed at the member's premises and instead requested that any interview be conducted at the family home. The member submits that an interview was finally conducted at the applicants' home and it requested the applicants provide certain documents so that the claim could be finalized. It submits that attempts to contact the applicants were made several times without success and a letter was sent to the applicants on 21 May 2007. However, the member has not provided the Service with a copy of the letter and its contents are unknown to me. The member has provided me with minimal information to enable me to objectively assess its claim performance.

The applicants engaged a solicitor in late May 2007 and contact was made by the solicitor on 22 May 2007 with the member, enquiring as to the status of the claim. On 1 June 2007 the member submits that it partially accepted the claim for the items for which the applicants had been able to prove ownership but maintained its declination for the items for which the applicant could not provide proof of ownership. I find this statement puzzling as the member has not provided any explanation on why it withheld payment on certain items when it readily admits that proof had in fact been provided.

As they were not satisfied with the members settlement offer, the applicants referred the matter to the Service and on 30 October 2007 the member requested that the applicants provide evidence in the form of a statutory declaration for the remaining items. They did so and the claim was settled in full in February 2008, namely 15 months after the claim was made.

In its submission, the member acknowledges that it is not always possible to have receipts, valuations or other proof of ownership and value for some items and in these circumstances, will reasonably forego some proof of ownership in order to progress a claim. However, this is subject to only a small portion of a total claim being outstanding. In this matter, it contends that the proof of ownership provided was for only half the claimed amount, being approximately \$15,000 and is of the belief that it would not represent good claims practice to forgo the proof of ownership

requirements in these circumstances. Hence, it submits that the applicants failed to comply with repeated requests to provide relevant documents or be available for interview. They state the investigations could have been completed in a timely manner had it not been for a lack of co-operation by the applicant by not providing relevant documentation and cancelling the second interview with the investigator. Hence, the decision made by the applicants to engage a solicitor was in its opinion unnecessary and of their own volition and in any event, is specifically excluded under the terms of the policy.

I have analysed the limited documentation provided to me critical to this dispute against the legislation that must be applied, namely sections 13 and 14 of the Insurance Contracts Act. The provisions of the Act override the policy terms in certain situations.

The member's policy documentation states:

"Making a claim

What you must do if there is an incident that could lead to a claim

If you suffer loss or damage, or there is an accident you must:

- ✓ give us evidence of value and ownership of lost, stolen or damaged goods or property, especially for articles such as jewellery, artworks, hand-woven rugs and collections, and the price of recently purchased items such as stereo's, TVs, cameras, computers, listed contents items or specified effects, if we ask for this."

The member must therefore prove, on the balance of probabilities, that the applicants have failed to provide all reasonable assistance in relation to the claim. The member submits that, the onus is on the applicants to prove their loss under the terms of the policy and by virtue of their alleged failure to do so, they have delayed settlement of the claim. However, as I have stated, the applicants have submitted a list of the items and detailed what proof was provided and this information has not been rebutted by the member, other than to state in the closing stages of its submission that the applicants had in fact provided proof of half of the claimed items. In reviewing the list, I am inclined to agree with the applicants that they have satisfied their obligations under the policy, and particularly the relevant policy provision and should have been entitled to indemnity at a much earlier time.

I have reviewed the member's material and I note very surprisingly, neither the assessors or investigators reports have been provided for my review. The member has however provided a copy of its file notes. I have reviewed these in detail and the file notes do not correlate with the chain of events expressed in the members' submission, namely the information contained under the heading "Member's Position".

Nonetheless, even by providing the member with the benefit of the doubt, I am still concerned that almost six months after the date of the claim the member had yet to make a decision as to whether it would accept or deny the claim. I am of the view that this is a grossly excessive period of time and an authorised officer of the insurer should have made a decision earlier in response to the claim. If it was of the opinion the applicants had been uncooperative it should have simply denied the claim. In my opinion not to make a timely decision in response to a claim's is contrary to the requirements of section 13 of the Act and the General Insurance Code of Practice. The High Court has stated that excessive delay by an insurance company in making a decision in response to a claim, constitutes a failure to comply its obligation to act with utmost good faith.

In this regard, I have considered the material presented by the parties in consideration of the dispute. The member submits the crux of the dispute is not whether the applicants' claim could have been handled better but whether they have the right at law to claim for legal expenses incurred without the approval of the member.

The applicants' policy covers them for the reasonable cost of employing professional, expert, legal, consulting or valuations costs but only when the member has agreed to pay for the costs in writing beforehand. Nonetheless the applicants' policy covers costs if the member has agreed to those costs beforehand. However it is unclear as to what the member's position would have been if the applicants had asked the member to provide cover the solicitor's costs prior to his appointment.

In my opinion, the facts of the matter support the applicant's decision to appoint a solicitor in the circumstances. This decision achieved settlement for the applicants on a number of items, and ultimately the member accepted the remaining items subject to a statutory declaration. I find there is no plausible reason why such a decision could not be reached earlier.

In reaching this decision I have taken into account that the applicants submitted to what they state was a three hour interview with the investigator. Unfortunately I have not been provided with a copy of that report or the assessor's report, or even the report following the second interview. Be that as it may, in my opinion the member should have been in a position to make a final decision about this claim within a maximum of four months after the claim was made. Even if I was of the opinion the applicants had been uncooperative, the member should have denied the claim, or part of the claim. My criticism is that they failed to make any decision at all. In these circumstances I am of the opinion the applicants were entitled to obtain legal advice, irrespective of the policy terms.

In arriving at this conclusion, I accept that the policy does not cover such costs that are insured without the member's consent. I have not been told what the member's attitude would have been if they had been asked to consent. However, in my opinion, the member's failure to comply with section 13 of the Act in the circumstances, brings into operation section 14 of the Act, which precludes the member from relying on a provision in the contract where there would be a failure to act with utmost good faith. Furthermore, I have the power to determine that legal costs be met pursuant to the provisions of clause 10.2(vii) of the Terms of Reference as well as considering clause 11.15 of the Terms of Reference, and I propose to do so in the circumstances of this dispute.

Accordingly, for the reasons outlined above I determine that the member indemnify the applicants for their solicitor's fees in the amount of \$2,000, subject to obtaining reasonable proof, that the fees are fair and reasonable in the circumstances.