Investment & Financial Services Association Ltd
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19 April 2004

Secretary
Insurance Contracts Act Review
C/- Department of the Treasury
Langton Crescent
PARKES ACT 2600

Attention: Ms Fiona Spry
Email: icareview@treasury.gov.au

Dear Mike

REVIEW OF THE INSURANCE CONTRACTS ACT 1984 (ICA) – SECTION 54

IFSA welcomes the opportunity to comment on the report into the operation of section 54 by Alan Cameron and Nancy Milne published in October 2003.

As outline in the attached submission, IFSA believes that because of the fundamental differences between life insurance and general insurance that section 54 does need to be changed to account for these changes.

Should you require any further information, please do not hesitate to contact Philip French, David Micó or myself on (02) 9299 3022.

Yours sincerely

Richard Gilbert
Chief Executive Officer

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REVIEW OF THE INSURANCE CONTRACTS ACT 1984

Issue Papers Second Stage – Report into the operation of section 54
IFSA's Comments

It is IFSA's view that issues arising in the life insurance arena are different to those occurring in general insurance. We would submit that these differences ought to be recognised and considered as part of the recommended changes to section 54.

In the report into the operation of section 54, the Review found that:

- There may be problems with late notification on group life insurance policies. Some policies of this nature are occasionally written on a "claims made" basis. The panel had not seen any policies of this type and was concerned to ensure that any such policies would not be impacted by any proposed amendment.

- No submissions had been able to provide any solid evidence of problems caused by late notification of claims.

1. Determination of Prejudice under section 54(1)

In *Moltoni Corporation* v QBE *Insurance* [2001] HCA 73 the High Court found that in considering prejudice under section 54(1), the court will look at actual financial damage that has been or will be sustained as a result of the relevant act or omission.

Putting the test at this level creates enormous difficulties for life insurers. Section 54(1) speaks of the "insurer's interests" being prejudiced. In IFSA's view the insurer's interests may be prejudiced by various factors, which are discussed below. It is often not possible to put a quantified figure on that prejudice.

2. Determination of the Value to be Attributed to Prejudice

a) Late Notification of Claims in Group Insurance

Late notification of claims causes significant problems for life insurers.

i) Percentage examples by year reported

One of our members has provided the following information on Total Permanent Disablement ("TPD") claims.

For TPD claims notified in any given year the table below sets out the distribution of years in which group insurance claims were actually incurred and notified during the last 4 years.

The pattern of claims being notified on any individual fund may be slower or faster than that set out below. Delays in the reporting of claims from industry funds are generally longer than those exhibited by single employer corporate superannuation arrangements.

Year zero means the claim was incurred in the same calendar year it was reported, 1 means the year prior to that.

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Year Incurred = x years before the calendar year notified where x is	Distribution of claims reported by Year Incurred
0	17%
1	40%
2	20%
3	9%
4	6%
5-9	7.5%
10+	0.5%

The above is based on claims experience of 1200-1300 TPD claims being reported each year. As an example the above indicates that 40% of TPD claims reported in 2002 were for claims incurred in 2001 but more importantly around a quarter (23%) of TPD claims notified in 2002 were incurred in in 1999 or earlier. Indeed the above indicates that 8% or 1 in 12 TPD claims notified in 2002 are from 1997 or before, ie. the claim has been notified 5 or more years after the insured is actually claiming to have become TPD.

The effects of late notification are significant in a number of respects. A primary concern is the policy reserves that were set aside to meet a claim no longer being available to meet late notified claims. As group insurance policies move from one life insurer to another every three to five years, how long must a life insurer or a reinsurer need to maintain reserves when the cover has ceased under a group insurance policy or indeed a personal policy? Collation of medical evidence from 5 or more years ago, while often possible, is very difficult to find. Even if it is found there is little if any ability to get a second opinion on the extent of the disability at that time. The claimant may be TPD now but may not have been, for example, 7 years ago when the employee ceased work.

It is usually impossible for the insurer to say exactly what it would have done at the time the insured claims to have been TPD. It will often be extremely difficult to show how specific processes would have led to a quantifiable reduction in liability (following the Moltoni decision). For example, if the insured would have participated in a rehabilitation program, the insurer will have to seek expert evidence to show that this would have reduced the insurer's liability. Further, there may be evidence that could have been sought at the time of TPD but cannot at the time of claim (for example, witnesses cannot be located). The Moltoni decision has resulted in the insurer often being in an impossible position of being denied the opportunity to gather evidence and therefore being unable to show prejudice in the Moltoni sense.

ii) Specific case examples

(1) The member claimed to be TPD. Although medical evidence received from a doctor in September 2002 confirmed that the member suffered from the claimed sickness, this diagnosis was not made until 1995, some three years after the member ceased work with her contributing employer. As such, the doctor was not in a position to comment on the majority of the questions on the medical statement, nor substantiate the permanence of the member's condition at the time of ceasing work.

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This claim was lodged in October 2000, 8 years after the date for which the member claimed to have become TPD. The insurer's interests were prejudiced as a result of this late notification. The information obtained by the insurer during its assessment could not be used to determine total and permanent disablement in October 1992.

In order for the insurer to make a complete assessment at the time of claim, it would require a full factual assessment with the member / previous employer to determine details of the member's performance at the time, ability to carry out her assigned work duties etc. This can be extremely difficult to achieve.

In this example, it was not medically established that the insured was TPD at the time she ceased working. Whilst the insurer would have been entitled to deny liability, it was clearly prejudice by the delay and the lack of clarity in the evidence. The insurer therefore compromised the claim.

(2) The member lodged a claim about 8 years after allegedly becoming TPD. The treating doctor's surgery had burned to the ground and all notes destroyed. The insurer was not therefore given the opportunity to fairly assess whether or not the member was TPD.

(3) The member last worked in November 1993 and submitted a claim in April 2003. Originally the member had a hand injury but some time later developed a psychiatric condition. He had a motor car accident in early 2003. In these circumstances it is very difficult to apportion the causes of the disability. The member had also not kept Group Certificates for 1991 to 1997 so it was not possible to assess whether he had been working. Given the time elapsed there are often difficulties getting information from former employers. Many employers go out of business in a 10 year period.

(4) In a further example from one of our members, acceptance of an employee as an insured under the employer's group income continuance policy was automatic if the employee was nominated as being an insured. Under the policy terms the nomination had to be made after the prospective insured had been an employee for six continuous months but before the seventh month commenced – a 30 day window in which to nominate applied. Under the policy, outside of this period the employee had to be individually underwritten.

The purpose of the restriction in the nomination time was to protect the insurer from a prospective insured nominating when a claim was imminent. It is arguable that s54 forgives the prospective insured's (or the employer policyholder's) omission to nominate the person within the one month window.

Potentially, any employee employed for 6 months or more can argue that they ought be insured even if they never nominated or their employer never nominated. If that is the effect of section 54 in such policies then it is an example of where section 54 may operate to stifle the utility of consumer friendly automatic acceptance terms. If that is so, insurers may have to reconsider whether automatic acceptance terms are commercially feasible or premiums must be increased to allow for cases where the law allows those to join when a claim is imminent as is arguably allowed by section 54 where automatic acceptance terms are offered. Both would be unfortunate outcomes for consumers.

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b) Interaction with section 29

A claim notified late may cause a life insurer to lose the opportunity to make enquiries and avoid the policy within the prescribed period (3 years from the time the contract was entered into) under section 29(3). There will necessarily be occasions where it is evident that apart from the late notification, the insurer would have been able to avoid the policy and the insured would not have been able to make the claim under that policy. Alternatively, the insurer may be able to exercise its rights under section 29(4). Section 54 undermines the remedies available to the insurer under section 29 if the claim is notified late.

c) Limitation periods

A couple of recent cases (*Cigna Insurance Asia Pacific Limited* v *Packer* [2000] WASCA 415 and *Tonkin* v *Western Mining Corporation Limited* (1998) 10 ANZ Insurance Cases at 61) have considered the issue as to when a cause of action arises in a TPD claim. Where a TPD definition requires the formation of an opinion by the insurer or Trustee as to whether the insured is TPD, the cause of action arises at the time the opinion is formed. Where there is no requirement for an opinion, the cause of action arises once the insured satisfies the TPD definition. This creates significant problems for the insurer, as there is no limitation period to deter claims being brought to the insurer's intention years after an injury or disability occurs.

3. Proposed changes to Section 54

a) Section 54A

The Review recommends the introduction of a new section 54A. In IFSA's submission it would be appropriate to extend the recommended amendment to include group life insurance. There does not seem to IFSA to be any sensible reason why the recommended notification requirement on an insured under a "claims made" policy should not apply to insureds under group life insurance policies. If the insured is aware of circumstances that might give rise to a claim, he/she ought to be required to notify the insurer prior to expiration of the policy.

Group life insurance policies generally last 3 – 5 years. Requiring the insured to notify within the term of the policy would negate any problems in determining which insurer may be responsible for a claim. It would also mean that an insurer is able to provide for future claims, with an associated impact on premiums.

b) Section 54 and prejudice

In IFSA's submission the requirement for an insurer following the Moltoni decision, to show quantifiable prejudice, often leaves insurers with no remedy under section 54. We would encourage the Review to consider amending section 54 to ensure that prejudice need not be precisely quantifiable.

4. "Claims made" policies

Life insurers have written "claims made" group policies in the past but it is IFSA's understanding that these policies are no longer used.

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