Superannuation determination

Case numbers: 613562 & 619820 11 July 2019

1 Overview

1.1 Complaint

The complainant is the daughter of the deceased, who was a member of the fund. She is the nominated beneficiary of the deceased's death benefit from the fund under a binding nomination dated 17 March 2015.

The death benefit had an insured component of $78,750 under a policy between the trustee and the insurer. The insurer seeks to avoid cover for the insured death benefit because the deceased did not disclose two medical conditions when she applied for cover on 29 November 2009 under a policy held by the trustee with the previous insurer. Alternatively, the insurer seeks to avoid cover on the basis of fraudulent misrepresentation.

The trustee accepted the insurer's avoidance of cover and has refunded the insurance premiums to the deceased's account. The insurer's decision to avoid cover and the trustee's decision to accept the avoidance of cover are the decisions under review.

1.2 Issues and key findings

Did the deceased fail to comply with the duty of disclosure?

The deceased did not have a duty of disclosure at the relevant time.

Did the deceased make a fraudulent misrepresentation?

The deceased answered two questions incorrectly on her application form. I am satisfied, having regard to her medical history, that the deceased was at least reckless in answering one of the questions on the application form.

Was the insurer entitled to avoid cover?

The deceased's misrepresentation was made to the previous insurer. No misrepresentation was made by the deceased to the insurer. The insurer is not entitled to avoid the deceased's cover.

Were the trustee's and the insurer's decisions fair and reasonable?

The trustee's and the insurer's decisions were not fair and reasonable because the insurer does not have the right to avoid the deceased's cover.

1.3 Determination

The determination sets aside the trustee's and the insurer's decisions. AFCA's substituted decision is that the deceased's cover remains in place. The insurer must pay the insured benefit to the trustee, with interest under section 57 of the *Insurance Contracts Act 1984*. The trustee must pay the insurance proceeds to the complainant, less the premiums payable for the cover.

2 Reasons for determination

2.1 AFCA's review power and procedural fairness

In determining superannuation complaints, AFCA must:

- comply with its rules and the Corporations Act
- consider whether the trustee's and the insurer's decisions were fair and reasonable in their operation in relation to the complainant in all the circumstances
- not make a determination that is contrary to law or to the trust deed or the insurance policy.

The issue is whether the decisions under review were fair and reasonable, based on all of the information obtained by AFCA.

In reaching my determination, I have reviewed the AFCA file and considered all the material provided by the parties. Additionally, I am satisfied the material I have relied on has been provided to all parties and they have had an opportunity to respond.

2.2 Did the deceased fail to comply with the duty of disclosure?

The insurer relies on section 21 of the Insurance Contracts Act

The insurer says the deceased had a duty of disclosure under section 21 of the *Insurance Contract Act 1984* (ICA), which is set out in part 3.3 of this determination. The insurer says the deceased failed to disclose two relevant medical conditions – depression and myelofibrosis (a form of blood cancer) when she applied for cover in November 2009.

Case law establishes that section 21 did not apply to a life insured under a group insurance contract in 2009

Recent case law establishes that section 21 of the ICA did not apply to a person seeking cover under a group insurance contract in 2009 (see *Sharma v LGSS Pty Ltd* [2018] FCA 167, discussed in part 3.4 of this determination). This is because section 21 applies to the 'insured' as a contracting party. The trustee was the 'insured' under its group insurance contract with the previous insurer, not the deceased.

At the time she applied for cover under the group life contract, the deceased was a proposed 'life insured' and therefore did not have any duty of disclosure as an 'insured' under section 21 of the ICA.

The deceased did not have a duty of disclosure at the time she applied for cover

Section 32 of the ICA at the time of the deceased's application for cover extended the duty of disclosure, but not to a proposed life insured. It only extended the duty to a proposed member of a superannuation scheme (see part 3.3 of this determination).

The deceased was already a fund member, having joined the fund in 2003. Therefore, the deceased did not have a duty of disclosure under the ICA when she applied for cover. (Section 32 was amended from 28 June 2014.)

2.3 Did the deceased make a fraudulent misrepresentation?

A representation is fraudulent if it is false and made knowingly or recklessly

Case law establishes that a representation is fraudulent if it is false and made:

- knowingly without belief in its truth; or
- recklessly not caring if it was true or false

(See *Tyndall Life Insurance Co Ltd v Chisholm* (2000) 11 ANZ Cas 90-104; *Graham v Colonial Mutual Life Assurance Society Ltd (No 2)* [2014] FCA 717).

The deceased answered two questions incorrectly

On her application form, the deceased answered 'No" to each of these questions:

- Can you confirm that you are actively working as at the cover application date; that you are able to perform all your usual duties on a permanent full time basis and that you are not currently receiving any form of medical treatment?
- To the best of your knowledge, have you ever had any type of cancer, chest pain, high blood pressure, heart/vascular complaint, back or joint disorder, paralysis, stroke or mental/nervous disorder including stress, anxiety or depression?

These answers are incorrect because the deceased's medical records show that she was seeing her doctor to monitor her medication for blood cancer as recently as September 2009 and that she had been diagnosed with depression in March 2007 and placed on anti-depressant medication.

The deceased may have been confused about the first question

It is possible the deceased was confused in answering the first question extracted above. This is because the question about medical treatment was 'bundled' together with two other questions about her work capacity. The deceased could therefore have interpreted it as a question about whether she was receiving medical treatment that prevented her working. It is also possible that the deceased may not have interpreted the medication she was taking for her blood cancer as 'medical treatment'.

The deceased answered the second question recklessly and therefore fraudulently

The deceased's medical records show she had been diagnosed with blood cancer. She was having regular blood tests and regularly consulting her doctor from 4 October 2007 – 30 September 2009 to check whether her platelet count and white

cell count were responding to medication. She applied for cover on 29 November 2009.

In these circumstances it is difficult to conceive that the deceased could honestly believe that she did not have a type of cancer. I also note that the two medical conditions suffered by the complainant – cancer and depression – were the first and last conditions listed in the second question extracted above. It would therefore be difficult to miss them. A reasonable person would know that these medical conditions were relevant to the previous insurer's decision to accept the risk, because:

- in the case of her blood cancer, cancer is a serious medical condition;
- in the case of depression, she had been prescribed anti-depressant medication; and
- for both conditions, they were specifically listed in the question.

I am satisfied that the deceased was at least recklessly indifferent to the truth of her answer when she responded 'No' to this question. The deceased therefore made a fraudulent misrepresentation when she completed her application form.

2.4 Was the insurer entitled to avoid cover?

Section 29 of the Insurance Contracts Act allows cover to be avoided for fraudulent misrepresentation

Section 29 of the ICA allows an insurer to avoid a contract of insurance if a person who became the insured made a misrepresentation to the insurer before the contract was entered into. (Section 29 is set out in part 3.3 of this determination.) If the misrepresentation was fraudulent, the insurer is not limited to exercising its right to avoid the contract within 3 years. It may do so at any time (subject to meeting the other requirements of the section).

Section 25 of the ICA treats a life insured as the insured if a pre-contractual misrepresentation was made.

Section 27A(3) of the ICA allows cover for each life insured under a policy to be treated as a separate contract (see part 3.3 of this determination). An insurer can therefore avoid the cover of a particular life insured under a group insurance policy for fraudulent misrepresentation.

The insurer has provided a retrospective underwriting opinion from the previous insurer

To exercise its right under section 29(2), an insurer must show that it would not have provided cover if the person had not made the fraudulent misrepresentation.

The insurer has provided a retrospective underwriting opinion from the previous insurer, based on the previous insurer's underwriting guidelines, to show the previous

insurer would have declined all cover if it had known about the deceased's blood cancer. Based on this evidence, I am satisfied the previous insurer would have had the right to avoid the deceased's cover under its policy with the trustee.

The deceased's misrepresentations were not made to the insurer

In this case the insurer decided to avoid the deceased's cover under its policy with the trustee, after making investigations following her death. However, the deceased's misrepresentations were made to the previous insurer.

The insurer says the deceased's cover under its policy was provided under industry takeover terms (see part 3.6 of this determination). There is no evidence that the deceased made any representations to the insurer before the insurer agreed to provide cover for the deceased under its policy.

The insurer cannot avoid the deceased's cover

No misrepresentations were made to the insurer as required by section 29(1)(b) of the ICA. The insurer cannot avoid the deceased's cover under section 29.

The insurer's arguments do not change the legal position

The insurer has made several submissions about why AFCA should find that it has the right to avoid cover under section 29:

- 'Insurer' in section 29 should be interpreted to mean 'the insurer on risk'. The insurer says, and I accept that, when it entered into its policy with the trustee, it did so without 're-rating' the risk. It also says it adopted the same terms as the previous insurer's policy. This statement is not quite right. The insurer's policy was on similar, but not identical, terms to the previous policy and it was nevertheless a new policy. It was not a 'transfer' of the previous insurer's policy.

  This argument does not assist the insurer because:

  - It does not overcome the fact that the deceased did not make any misrepresentation to the insurer before the insurer entered into its contract of insurance with the deceased, so as to 'enliven' section 29.
  - It would require section 29 to be read as if a pre-contractual misrepresentation made to one 'insurer on risk' can be relied on by a subsequent 'insurer on risk' to avoid cover. There is nothing in the wording of section 29 to treat a misrepresentation made to one insurer as a misrepresentation made to another insurer.

- A term of the insurer's agreement with the trustee was that the 'individual conditions, exclusions, restrictions or loadings which applied to [the deceased] on the day before the Policy start date will continue to apply'. This term is set out in part 3.2 of this determination. However, it does not assist the insurer because the

right to avoid cover does not arise from a term in the previous insurer's policy. It is a statutory right that applies in certain circumstances that must be proven to exist.

- 'Insured' has been interpreted to include the legal personal representative of an 'insured' so 'insurer' should be interpreted to include its successor in title. This argument does not assist the insurer, because the insurer is not a successor in title to the previous insurer.

- Section 29 should be interpreted so that insurers do not lose rights when a trustee changes insurers. This argument does not assist the insurer because AFCA cannot make a superannuation determination contrary to law. The clear wording of section 29 requires the insured to have made a misrepresentation to the insurer that is seeking to avoid the contract. It is for Parliament to change the law, not AFCA.

- A change of insurers is common in the superannuation industry and the Financial Services Council (FSC) Guidance Note 'Group Insurance Takeover Terms' supports seamless cover for fund members in these circumstances. A narrow interpretation of 'insurer' is therefore not consistent with good industry practice. This argument does not assist the insurer because there is nothing in the FSC guidance note dealing with the assignment of one insurer's 'rights' to another insurer. Insurers may negotiate such arrangements, however (see part 3.6 of this determination).

  It is commercially open to an incoming insurer to take an assignment of rights (including any statutory rights that might apply) from the outgoing insurer. The insurer acknowledges that no such assignment of rights was given in this case. Further, the guidance note makes it clear that responsibility for payment of a death benefit is with the incoming insurer if the death occurs after the 'takeover date'.

- AFCA should apply a 'fair in all the circumstances' test to support an interpretation that accords with industry practice and help to contain claim costs. This submission does not assist the insurer because the test that AFCA must apply for superannuation complaints is whether the trustee's and the insurer's decisions were fair and reasonable in their operation in relation to the complainant in the circumstances. AFCA does not have power, for a superannuation complaint, to make a determination contrary to law. AFCA cannot strain the natural meaning of the words in section 29 to accommodate commercial arrangements within the industry.

The trustee supports the insurer's arguments

The trustee has supported the insurer's arguments, alleging a breach by the deceased of a 'general duty of disclosure' and noting the effect on policy premiums if

'deficient' claims are not declined. For the reasons set out above, I am not persuaded by these arguments.

For completeness, the Federal Court in *Sharma* was not satisfied there remains a general duty of disclosure, given the ICA was intended to clarify and ameliorate the common law: see part 3.5 of this determination for an extract from the explanatory memorandum for the Insurance Contracts Bill.

The insurer was not entitled to avoid the deceased's cover

Despite the arguments raised by the trustee and the insurer, I find that the insurer is not entitled to avoid the deceased's cover under section 29 of the ICA, because it is not the insurer to whom the deceased's misrepresentations were made.

2.5 Were the trustee's and the insurer's decisions fair and reasonable?

The insurer's decision was not fair and reasonable

The insurer's decision to avoid the deceased's cover was not fair and reasonable in its operation to the complainant in the circumstances because the insurer did not have a statutory right to avoid the deceased's cover.

The trustee's decision was not fair and reasonable

The trustee's decision to accept the insurer's avoidance of the deceased cover was not fair and reasonable in its operation in relation to the complainant in the circumstances because the trustee must ensure the insurer pays claims in accordance with the insurance policy. Since the insurer did not have a statutory right to avoid the deceased's cover, the trustee's decision to accept the insurer's avoidance was not fair and reasonable to the complainant as the beneficiary of the death benefit, including the insured component.

2.6 Determination

The determination sets aside the trustee's and the insurer's decisions. AFCA's substituted decision is that the deceased's cover remains in place.

The insurer must pay the insured benefit to the trustee, with interest under section 57 of the *Insurance Contracts Act 1984* from the date that is 10 business days after the insurer received evidence of the deceased's death. This is consistent with the timeframes in the Financial Services Council Life Insurance Code.

The trustee must pay the insurance proceeds to the complainant, less the premiums payable for the cover.

3 Supporting information

3.1 Key facts

Record	Key points
29 September 1955	• Deceased's date of birth
1 November 2000	• The previous insurer commenced providing cover for fund members under its policy with the trustee.
11 December 2003	• Deceased joined the fund • Deceased cancelled her 'default' insurance cover
29 March 2007	• Deceased diagnosed with depression and placed on anti-depressant medication
10 May 2007	• Deceased diagnosed with myelofibrosis (blood cancer) and placed on medication
21 May 2007	• Deceased attended medical appointment to discuss myelofibrosis diagnosis
30 May 2007	• Deceased reviewed by medical practitioner to check response to medication
4 October 2007 – 30 September 2009	• Deceased regularly reviewed by medical practitioner for blood tests and response to medication
29 November 2009	• Deceased applied for death and Total and Permanent Disablement cover
1 December 2011	• The insurer commenced providing cover for fund members, including the deceased, under its policy with the trustee
1 December 2016	• Deceased's date of death (Cause of death Septis 4 days Relapsed acute myeloid leukaemia 12 months)

3.2 Governing documents

Trust deed

Clause 13.7 says:

> Subject to these Rules, the Applicable Requirements and the Pension Regulations, if a member dies, the Trustee shall hold the Benefit of that Member UPON TRUST:
>
> (a) if a Binding Death Benefit Nomination had been given to and accepted by the Trustee, to pay or apply that Benefit in accordance with the Binding Death Benefit Nomination …

A Binding Death Benefit Nomination is defined in clause 1.1. There is no dispute that the deceased gave and the trustee accepted a Binding Death Benefit Nomination within the meaning of the Trust Deed.

Clause 39.1 says:

> Subject to the Deed, the amount of Benefit payable:
>
> (a) on the death of a Member shall be the sum of:
> (i) the Member's Retirement Credit; and
> (ii) any amount of Group Life Insurance (if any) payable in relation to the Member by the Insurance Company pursuant to the applicable Policy and credited to the Plan in respect of that Member …

Policy

On 1 December 2011, the insurer agreed with the trustee to issue group life cover to the trustee for the benefit of fund members. Recital C of the agreement records an intention for the insurer's policy to replace the previous insurer's policy. The insurer's policy was initially issued on the same terms and conditions as the previous insurer's policy, with some amendments. One of the amendments was to replace clause 2.7.1 of the previous insurer's policy as follows:

> The death and Total and Permanent Disablement cover of an Insured Member which was in force under the [previous insurer's policy] on the day before the Policy start date will continue under this Policy from the Policy start date subject to the following conditions:
>
> (a) Any individual conditions, exclusions, restrictions or loadings which applied to a particular Insured Member on the day before the Policy start date will continue to apply until such time as they expire according to their terms;
> (b) […]

3.3 Insurance Contract Act

Duty of disclosure

Section 21 at the date of deceased's application said:

> (1) Subject to this Act, an insured has a duty to disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known to the insured, being a matter that:
> (a) the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms; or
> (b) a reasonable person in the circumstances could be expected to know to be a matter so relevant.
> (2) The duty of disclosure does not require the disclosure of a matter:
> (a) that diminishes the risk
> (b) that is of common knowledge

(c) that the insurer knows or in the ordinary course of the insurer's business as an insured ought to know; or
(d) as to which compliance with the duty of disclosure is waived by the insurer.

(3) Where a person:
(a) failed to answer; or
(b) gave an obviously incomplete or irrelevant answer to:

a question included in a proposal form about a matter, the insurer shall be deemed to have waived compliance with the duty of disclosure in relation to the matter.

Before 28 June 2014, section 32 said:

> This Division extends to the case where there was a failure to comply with the duty of disclosure or a misrepresentation was made, to the insurer under a blanket superannuation contract in respect of a proposed member of the relevant superannuation or retirement scheme as though:
>
> (a) the insurance cover provided by that contract in respect of that member were provided by an individual superannuation contract between the insurer as insurer and the trustee for the purposes of the scheme as the insured; and
> (b) that contract had been entered into at the time when the proposed member became a member of the scheme.

Section 32 was amended with effect from 28 June 2014 to say:

> (1) This Division extends to the case where there was a failure to comply with the duty of disclosure, or a misrepresentation was made to the insurer, in respect of a proposed life insured under a group life contract, as if:
> (a) the insurance cover provided by the group life contract in respect of the life insured were provided by an individual contract of life insurance between the insurer and the insured; and
> (b) the group life contract had been entered into at the time when the proposed life insured became a life insured under the group life contract.
>
> For the purposes of this Division, if the failure to comply with the duty of disclosure, or the misrepresentation, occurred after the proposed life insured became a member of the relevant superannuation, retirement or other group life scheme but before the insured cover was provided by the group life contract in respect of the life insured, then the failure or misrepresentation is taken to have occurred before the life insured became a life insured under the group life contract.

Misrepresentation

Section 25 says:

> Where, during the negotiations for a contract of life insurance but before it was entered into, a misrepresentation was made to the insurer by a person who, under the contract, became the life insured or one of the life insureds, this Act was effect as though the misrepresentation had been so made by the insured.

Section 26 says:

> (1) 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 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.
> (2) A statement that was made by a person in connection with a proposed contract of insurance shall not be taken to be a misrepresentation unless the person who made the statement knew, or a reasonable person in the circumstances could be expected to have known, that the statement would have been relevant to the decision of the insurer whether to accept the risk, and if so, on what terms.
> (3) This section extends to the provision of insurance cover in respect of:
> (a) a person who is seeking to become a member of a superannuation, retirement other group life scheme; or
> (b) a person who is a holder, or who is applying to become a holder, of an RSA.

Right to avoid contract

Section 29 says:

> (1) This section applies where the person who became the insured under a contract of life insurance upon the contract being entered into:
> (a) failed to comply with the duty of disclosure; or
> (b) made a misrepresentation to the insurer before the contract was entered into;
>
> but does not apply where:
>
> (c) the insurer would have entered into the contract even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into; or
> (d) the failure or misrepresentation was in respect of the date of birth of one or more of the life insureds.
>
> […]
>
> (2) If the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.
>
> (3) If the failure was not fraudulent or the misrepresentation was not made fraudulently, the insurer may, within 3 years after the contract was entered into, avoid the contract.
>
> […]

Before 28 June 2014, section 29(3) required an insurer to show that it would not have been prepared to enter into the contract on any terms.

Section 27A(3) says:

> If a contract of life insurance provides insurance cover in relation to 2 or more life insureds, this Division applies as if the insurance cover provided in relation to each life insured were provided by a separate contract of life insurance.

3.4 Case law

Sharma v LGSS Pty Ltd [2018] FCA 167

This case was an appeal to the Federal Court from a determination of the Superannuation Complaints Tribunal (Tribunal). Since AFCA's powers to determine superannuation complaints are based on the Tribunal's powers, the case is very relevant.

Mr Sharma was a member of the Local Government Superannuation Scheme and had applied for cover under that fund's group insurance arrangements. The Federal Court decided the Tribunal made an error of law in finding that Mr Sharma owed a duty of disclosure to the insurer under section 21 of the ICA. The Court noted that the ICA uses the term "insured" to refer to the contracting parties, citing two case law authorities. Mr Sharma was not an insured: paragraph [54]. Therefore, the Tribunal should not have found that Mr Sharma had a duty of disclosure under section 21 of the ICA: paragraph [48]. Further, the Court was not satisfied that any general duty of disclosure applied, especially to the current insurer: paragraph [49].

The Court also made several observations about the fact that any non-disclosures or misrepresentations had not been made by Mr Sharma to the insurer, because, like in this complaint, the current insurer was seeking to avoid cover but the representations were made to a previous insurer: paragraphs [46, 48-49]. The Court did not make a conclusive finding. However, in sending the complaint back to the Tribunal for reconsideration, the Court strongly suggested that any misrepresentations must have been made to 'that insurer' (being the insurer to whom the 'communications' had been made): paragraph [61].

3.5 Explanatory Memorandum to the Insurance Contracts Bill

Clause 21 – the insured's duty of disclosure

> 59. Present Law – An insured is required to disclose to the insurer all material facts relating to the insurance he proposes to effect and which are material to the insurer's assessment of the risk he is incurring or as to the premium he should charge. At common law, some lines of authority support the proposition that the insured's obligation is to disclose every material fact known to him and which a reasonable man would realise to be material. Other authorities, and particularly more recent Australian cases have rejected this approach in favour of a "prudent insurer" test …
>
> […]

61. Proposed Law – An insured will have, before the contract is entered into, a duty to disclose to the insurer all material facts of which he is aware. His duty will be to disclose those facts which he knows or which a reasonable person in the circumstance could be expected to know would be relevant to the insurer in his decision to accept the risk and, if so, on what terms …

62. Rationale – Clause 21 clarifies the existing law by specifying the test of materiality. It also ameliorates the existing law, particularly in so far as the "prudent insurer" test has been applied, for this test takes no account of the insured's circumstances or the circumstances in which the contract of insurance is negotiated. Clause 21 mitigates the application of the duty by providing that the insured's duty is only to disclose those facts which he knew or a reasonable person in the circumstances would have known to be relevant to the insurer's assessment of the risk …

3.6 FSC Guidance Note 11

The purpose of the guidance note is to allocate responsibility for claims as between an outgoing and incoming insurer in situations where group insurance policies are 'transferred' between them. Although the guidance note refers to a 'transfer', the so-called 'transfer' involves the outgoing insurer's policy ceasing to apply and the incoming insurer's policy commencing to apply: see definition of 'transferring member'. The guidance note seeks to ensure that cover for an insured member does not 'fall through the cracks' in these circumstances.

Clause 6 – Definitions

6.1.14 "transferring member" means a person who was covered under the outgoing insurer's group insurance policy on the day before the takeover date and in respect of whom replacement cover commences under the incoming insurer's policy on and from the takeover date.

Clause 10 – Death

10.3 The incoming insurer provides death cover to a transferring member if that member's death occurs on and from the takeover date, regardless of:

(a) any pre-existing conditions the transferring member may have had; and

(b) the transferring member's at work status on the day before the takeover date.

The incoming insurer is, therefore, liable for a claim in respect of the death of a transferring member if that member's death occurs on or after the takeover date.

Clause 14 – Special cases

14.1 Where this Guidance Note does not adequately deal with the circumstances of a transferring member, the incoming insurer may be willing to negotiate special terms in respect of the member.