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APRA imposes new 'fit and proper' standards

On 3 March 2004 APRA released a 21 point checklist to be used by financial services companies to assess the quality of their boards, executives, auditors and actuaries.

Those companies will be obliged to report regularly to APRA, confirming each institution has a "fit and proper" policy. The "fit and proper" standards will apply to banks, building societies, credit unions, general insurers and life insurers.

The proposed criteria cover whether a person has:

- appropriate knowledge, skills, experience, competence, judgment, character, honesty and integrity;
- been subject to criticism, discipline, disqualification or removal by a professional or regulatory body or Court;
- been subject to adverse findings and relevant criminal or civil proceedings;
- been refused a commercial or professional licence;
- failed to manage personal debts satisfactorily;
- been a responsible officer in an entity at the time it failed;
- been obstructive, misleading or untruthful with regulatory bodies or a Court;
- demonstrated a lack of willingness to comply with regulatory or professional requirements;
- breached a fiduciary obligation;
- been involved in business practices that appear negligent, deceitful or otherwise improper;
- failed to deal with conflicts of interest appropriately; or
- been or is considered of bad repute.

If the "fit and proper" standards are adopted in these terms, the risk is that APRA regulated entities will be obliged to comply

with an additional layer of complexity and costs in an environment where there is already an overlapping range of duties and responsibilities. It seems to us that industry submissions directed to a single, rational and comprehensive set of corporate governance guidelines are warranted.

Andrew Goldstein Technical Analyst
e: agoldstein@ebsworth.com.au

Life insurers must read: application of section 47 demystified

■ *Asteron Life Ltd v Zeiderman*, New South Wales Court of Appeal, 5 March 2004

In this recent decision, the NSW Court of Appeal analysed the meaning of “by reference to” in the wording of section 47(2) of the Insurance Contracts Act.

The respondent took out a trauma policy with the appellant. The policy was issued on 9 February 2000. The policy relevantly provided that: “We will not pay for cancer **if first diagnosed**... within three months after the issue date in the schedule...” (emphasis added).

The respondent was diagnosed with cancer on 8 May 2000, his treating doctor informed him of the diagnosis on 9 May 2000.

The appellant relied on the exclusionary clause to deny the claim for trauma benefit. The respondent sued the insurer in the District Court and was successful. By a majority decision (Meagher JA and Bergin J, Spigelman CJ dissenting), the Court of Appeal found for the insurer and upheld the appeal.

Section 47(2) precludes an insurer from relying on an exclusion if it meets these criteria:

- it has the effect of limiting or excluding the insurer’s liability; and
- that limitation or exclusion operates “by reference to” a sickness or disability to which the insured was subject at a time before the contract was entered into.

The Court of Appeal was asked to consider whether the exclusionary provision in this policy meets the second criterion (it was agreed that the first criterion was satisfied). Meagher JA held that the proper construction of the exclusionary clause in this case is that it “only

excludes claims arising out of a diagnosis within the [waiting period], and the date of the onset of the underlying pathology is completely irrelevant”.

Accordingly, Meagher JA (and Bergin J) held that the exclusionary clause in this policy has the effect of limiting the relevant liability not by reference to pre-contractual pathology, but by reference to post-contractual diagnosis, irrespective of whether the insured was subject to a particular sickness or disability before the parties entered into the contract. Therefore section 47(2) does not apply to override the exclusion in the policy.

Alisa Kwan Lawyer
e: akwan@ebsworth.com.au

Court of Appeal considers the test for fraudulent non-disclosure or misrepresentation

■ *NRG Victory Australia Ltd v Hudson*, Supreme Court of Western Australia – Court of Appeal, 28 November 2003

In this case, the respondent (life insured) applied for membership of the Superannuation Trust of Australia in mid-1993. The application form also served as an application for excess cover above the automatic level under the fund’s group life policy.

At the time of completing the application form, the respondent represented that the following statements were true:

- that he had not received medical advice that he had a medical condition which was going to affect his ability to carry out the normal duties of his occupation; and
- that he had never had a neck, back or shoulder injury or disease which had required more than two weeks off work, or had recurred more than twice, or which was still causing him trouble.

These statements were untrue because the respondent had earlier been diagnosed with post-occupational dermatitis when he was working as a spray painter and he had ceased work between November 1990 and late 1992 because of this condition. At the time of application he was employed as a packer, loader/forklift driver.

The application for insurance was accepted in 1993. The respondent developed a rash in late 1993 and ceased work from January 1994. He made a claim on his policy in mid-1998. The appellant denied his claim on the basis that he fraudulently misrepresented his skin conditions on his application form, purporting to avoid the cover under section 29(2) of the Insurance Contracts Act.

Trial judge's findings

The trial judge found that the respondent did not consider that he had post-occupational dermatitis at the time he completed his application in 1993 because his skin problems had settled. Further, the trial judge accepted that the respondent had never received medical advice that he had a medical condition which was going to affect his ability to carry out the normal duties of his then occupation. As a result, while untrue, the statements did not constitute actionable misrepresentations by virtue of section 26(1) of the Insurance Contracts Act.

Section 26(1) provides that a statement made on the basis of a belief that a person held (being a belief that a reasonable person in the circumstances would hold) is not a misrepresentation even if the statement was untrue.

As a result, the trial judge did not need to consider whether the relevant answers given by the respondent were fraudulent within the meaning of section 29(2), although he also found that the statements were not fraudulent. The case was appealed to the WA Supreme Court.

Appeal findings

The Full Court of the WA Supreme Court upheld the trial judge's findings and dismissed the appeal. Parker J commented that, given the operation of section 26(1), there is no need to decide whether section 29(2) operates, but His Honour considered the question in any event.

After examining various case authorities, Parker J held that the following statement of law found in Professor Sutton's text of *Insurance Law in Australia* reflects the correct test for fraud for the purposes of section 28 and section 29 of the Insurance Contracts Act:

A fraudulent misrepresentation is one made with an absence of an actual and honest belief in its truth: it is a deliberate decision by the insured to mislead or conceal something from the insurer, or recklessness amounting to indifference about whether this occurs.

The Full Court accepted the trial judge's findings that, at the time of application, the respondent believed that he was fully recovered from the dermatitis, that he did not have post-occupational dermatitis and that his condition

was not a disease. He believed any limitations on his capacity to work related only to his previous job as a spray painter and not as a loader/forklift driver. The respondent therefore did not deliberately mislead or conceal his conditions to the insurer, nor was he recklessly indifferent as to whether the misleading or concealment occurred or not.

Interestingly, according to the judgment of Steytler J, the trial judge also found that the respondent "knew or could reasonably be expected to know" that the existence of his skin condition was relevant to the insurer's decision whether to accept his application for increased cover. Neither the trial judge nor the Full Court appeared to have examined whether, having regard to section 26(2), the untrue statements were not excluded from being taken to be misrepresentations under the Act. Nevertheless, given the Court's finding that the misrepresentations were not fraudulent, the outcome would not have changed even if such analysis was conducted.

Points of interest

1. The trial judge held that, in answering both questions in the insurance application, the respondent was subject to a duty of disclosure under section 21(1) of the Insurance Contracts Act, whereas this duty falls on the insured (the trustee of the fund), not the life insured.
2. In this case, the respondent was covered by a superannuation fund group life policy. Section 32 of the Insurance Contracts Act would therefore apply so that the cover provided by the group life policy in respect of the respondent (the member) would be treated as though it was provided by an individual contract of insurance between the insurer and the trustee of the fund as the insured. This is relevant to the insurer relying on section 29 of the Insurance Contracts Act, but was not considered by the Court.
3. If the respondent was found to have made a fraudulent misrepresentation and the insurer was entitled to avoid the contract under section 29(2), it is unclear whether the insurer must only avoid the cover over the automatic acceptance level, or all the cover. In the latter case the insurer would arguably need to reinstate the automatic cover pursuant to its duty to act with utmost good faith.

If you have any queries in relation to this case, please contact us to discuss further.

Alisa Kwan Lawyer
e: akwan@ebsworth.com.au

Peter MacKenzie Partner
e: pmackenzie@ebsworth.com.au

News in brief

Version 5 of the ASIC Licensing Kit

ASIC has released version 5 of the licensing system and the AFS Licensing Kit for entities applying for an AFS licence. Version 5 does not contain information on the streamlining or composite assessment processes, as these are no longer available.

Statement of Advice extension to some overseas listed products

ASIC has issued class order CO 04/10, which extends the exemption that allows retail advice about some financial products traded on approved foreign markets to be provided without a statement of advice (SOA).

Citing your licence number on PDS documents

ASIC is extending transitional relief from the requirement for licensees to cite their licence number on PDS documentation. The extension is granted under class order CO 04/103 and will apply until 1 October 2004.

Relief for wholesale foreign financial services providers

ASIC Information Release 04-04 contains practical guidance on applying for licensing relief available under class orders CO 03/1099, 03/1103 and 04/0100.

ASIC relief to allow mixed money to be paid into insurance brokers' trust accounts under section 981B

Class order 04/189 allows monies (other than only client monies) to be paid in a single sum into a trust account established and maintained by an insurance broker under section 981B of the Act. Ordinarily, section 981B permits only client monies to be paid into an account established under that section. The relief requires the licensee to pay out any non-client monies within five business days.

SCT complaint resolution procedure amendments

The Senate has recently passed amendments to the *Superannuation (Resolution of Complaints) Act 1993*. The amendments give the Superannuation Complaints Tribunal (SCT) the power to direct a conciliation conference if it believes that it will assist in the resolution of the complaint or to reduce the number of complaints heard by the SCT. Parties will be notified by telephone or in writing and are able to dispute the conference with the SCT. The amendments also extend the time for an appeal for a total and permanent disablement (TPD) claim to two years from the original decision to reject the claim and the lodgement time for an employment-related claim for TPD to two years after employment ceases.

Andrew Goldstein Technical Analyst & Alisa Kwan Lawyer

For more information, contact our Financial Services Team

Peter MacKenzie Partner	e: pmackenzie@ebsworth.com.au	t: 61 2 9234 2591
Ann Newbrun Partner	e: anewbrun@ebsworth.com.au	t: 61 2 9234 2533
Brian Thomas Partner	e: bthomas@ebsworth.com.au	t: 61 2 9234 2592
Michael Neylan Partner	e: mneylan@ebsworth.com.au	t: 61 2 9234 2312
Ian Enright Partner	e: ienright@ebsworth.com.au	t: 61 2 9234 2302
John Goulios Partner	e: jgoulios@ebsworth.com.au	t: 61 3 8624 2006
Peter Daley Partner	e: pdaley@ebsworth.com.au	t: 61 7 3303 8812

sydney melbourne brisbane

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