

# Consumers' Federation of Australia



## SUBMISSION TO THE REVIEW OF THE INSURANCE CONTRACTS ACT

The CFA was established in 1974 and is the main peak body for consumer advocacy organisations in Australia. Currently the CFA has 95 member groups around Australia across a variety of areas of interest to consumers. A copy of the CFA's Objectives are attached to this submission (Annexure 1).

This submission constitutes a distillation of the views of the CFA's member groups on key points arising out of the Issues Paper. Detail as to the rationales informing those views is for the most part to be found in the individual submissions of member agencies.

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## **SECTION 1 – MATTERS NOT COVERED IN THE ISSUES PAPER**

### **1.1 OVERALL COMMENTS ON THE IC ACT**

The consumer movement welcomed the advent of the Insurance Contracts Act in 1984, as a positive step for consumers. Our view has not altered.

We see this review as an opportunity to fine-tune and improve the Act, rather than make wholesale changes. The fundamental principles underlying the Act are, by and large, still relevant and correct.

The list below sets out the most important issues where we believe some change to the IC Act would be beneficial (or alternatively, where no change should be made). Each issue is covered in more detail in the body of our submission.

- the repeal of section 15, so that insurance contracts are subject to general unfair contract legislation (once introduced);
- refining the reasonable person test in section 21A, so that the specific circumstances of the insured are taken into account in its application;
- defining “eligible contracts of insurance” in a way that will ensure section 21A covers all domestic insurance products;
- changes to the standard cover regime so that it works as originally intended, particularly in relation to disclosure;
- the retention of section 29;
- the expansion of section 31 to encompass innocent non-disclosure or misrepresentation;
- addressing the problems of innocent co-insureds through the protections of section 31 and 56;
- extension of the IC Act to cover warranty products.

There are some other important issues that our submission does not cover as they are adequately covered by others. In this regard, we support the submission of the Financial Services Consumer Policy Centre, specifically in relation to:

- the need to address insurance products that are essentially worthless, such as GAP insurance; and
- consumer credit insurance; a product with limited coverage and unnecessarily narrow definitions.

## 1.2 MATTERS OUTSIDE THE TERMS OF REFERENCE

This section has comments on a number of matters not addressed in the Issues Paper. Although strictly outside the Terms of Reference for this review, we think it is important that these issues are brought to the attention of the reviewers and the Government.

The effectiveness of the Insurance Contracts Act (the “IC Act”) is obviously critical to the operation of the insurance marketplace. But there are other components of equal importance. These include the adequacy of the dispute resolution system and the access of Australians to fair and affordable insurance products.

Below we describe six specific issues. These issues are not the only ones of importance, but were raised by consumer advocates in discussions as we prepared this submission.

- 1) refusal of insurance to consumers where the consumer has a criminal record (but prima facie this would not affect the risk to the insurer), has become bankrupt or the consumer has a disability;
- 2) inability to access insurance due to refusal of insurance, including third party property insurance, where the consumer has a criminal record or a poor driving history but has legitimate right to drive a motor vehicle;
- 3) disputes between uninsured consumers and an insurance company about third party property damage to a vehicle;
- 4) the large number of people who do not have third party property insurance;
- 5) the interaction between car finance and contracts for insurance of vehicles – some consumers sign a contract for finance, after gaining telephone approval for insurance, but the insurance company later withdraws; and
- 6) the need for a “basic insurance product”.

### **1. Refusal of Insurance**

#### *Criminal Histories*

Some consumers are being denied access to insurance because of the existence of a past criminal history, in situations where this history is, prima facie, not relevant to the decision to underwrite the risk.

These cases were brought to our attention by Legal Aid Queensland.

Annexure 2 sets out the questions posed by some major insurers regarding criminal histories for the insurance of motor vehicle. Some of them are unnecessarily broad. For example, Suncorp asks consumers to answer:

“Have you in the last 10 years, knowingly committed a criminal offence?” and then proceeds to ask for details.

Aggrieved consumers have no real avenue of appeal in such matters. Although the Terms of Reference for the Insurance Enquiries and Complaints Ltd cover a failure to offer insurance or to only offer insurance on non-standard terms, they exclude non-claims disputes that are solely about a commercial judgment or policy, or assessment of risk.

Additionally there maybe no legal requirement to disclose those convictions as they are spent or they were committed when the person was a juvenile.

### *Bankruptcy*

Insurance is also often refused due to a consumer's bankruptcy – apparently a hangover from the days of debtors' prisons and the old adage that a bankrupt cannot be trusted. Financial counsellors report having seen a number of clients who have found themselves years in this position. They report that clients cannot even obtain third party property insurance for a car or home contents insurance.

### *Disabilities*

People with disabilities are also being refused access to insurance or find that narrow policy wording makes the insurance effectively unworkable. The Mental Health Council of Australia recently signed a Memorandum of Understanding with the Insurance and Financial Services Association, which commits both organisations to work toward a fairer approach in that particular industry.

A similar approach would be helpful in general insurance.

## **2. Access to Insurance**

Some consumers are caught in a bind. The consumer has the right to drive and access or ownership of a motor vehicle. However honest disclosure will lead to a refusal to insure.

This can lead to dire social consequences arising from the total exclusion of these consumers from the insurance market place. The insurance industry has described uninsured drivers as socially irresponsible yet intentionally excludes large numbers of consumers from access to vehicle insurance, including third party property insurance. The inability of legitimately licensed drivers to obtain insurance may well be justification for reconsidering the need for compulsory third party property insurance to provide limited cover for these drivers and protection for other road users.

## **3. Terms of Reference for the IEC - Disputes about Third Party Property Damage**

Uninsured consumers can bring complaints to the IEC where the insurer is claiming that the uninsured is liable for damage to the insured's property up to a limit of \$3,000. This limit is far too low. Damage to vehicles is frequently greater than this amount. A more realistic level would be \$10,000.

Consumers are also required to pay a fee of \$ 150. Although it may be waived, consumers are often not aware that they may request this. The fee is prohibitive for many low income consumers.

As well, this avenue of redress is only available if the insurance company has not commenced legal action. Often consumers and their advocates are not aware of the avenue of redress in any event.

#### **4. Third Party Property**

Accidents happen. Many consumers do not have third party property insurance for their vehicle. If at fault in an accident, the financial burden can be significant. Many low-income people are forced into bankruptcy. An uninsured vehicle owner may be left with a claim they are unable to recover.

This problem is not an easy one to solve, but some policy effort needs to be addressed to it. Consumer education may be part of the solution, but may not have a large impact.

The CFA is looking forward to discussing this further with the Insurance Council of Australia.

#### **5. Interaction between Car Finance and Comprehensive Car Insurance**

Consumers using finance to purchase a car are required by the lender to take out comprehensive car insurance. The complete transaction – sale of the car, finance and insurance – is often completed entirely at the premises of the motor dealer.

Some consumers, despite having been given an insurance cover note at the time of car purchase and the grant of the loan, later find that their insurance is withdrawn. This may be because the consumer was not told that they needed to disclose their driving history. It may also be because modifications have been made to the vehicle or other unusual features of the vehicle that are not disclosed when the cover note is obtained. This is often so, because the consumer is unaware of modifications or the unusual features of the vehicle. The knowledge is often in the possession of the motor dealer and or finance broker who may or may not pass on that information whether to the insurer or the insured as they are interested in processing the sale and obtaining finance.

When such matters are rectified when the policy documents actually arrive, the consumer finds themselves in an invidious position - no comprehensive car insurance and in breach of their loan conditions. This can lead to repossession of the vehicle and a substantial financial cost if the vehicle sells for less than the amount of the loan (as has occurred in some cases).

#### **6. Basic Insurance**

Many low income people simply cannot afford insurance, whether this is for home contents in a rented property, for a car or for their homes. This is a serious problem, as this group of consumers is just as likely as any other group, to need the protections that insurance provides. The problem is exacerbated if the consumer has a criminal record or a poor driving history.

The problem is largely one of affordability, although we believe that restrictive underwriting guidelines contribute to the exclusion of many consumers from the market.

One solution that could be explored is the provision by insurance companies of a “basic” insurance product that had a defined set of features – no more and no less. This product would, we assume, be cheaper than the products currently in the

marketplace. Companies could compete on price and service, but the complexity would be removed.

A similar arrangement was almost agreed with the banking industry recently. The Australian Bankers' Association sought authorisation from the ACCC for the industry to offer a basic banking product. For various reasons this was later withdrawn, but the concept remains a very good one.

## SECTION 2 – RESPONSE TO THE ISSUES PAPER

This section of our submission follows the topic order of the Issues Paper.

In most cases, we have provided a summary of the overall position of the CFA, followed by answers to selected questions in the Issues Paper. We have not responded to all questions or all issues.

### 1. SCOPE AND APPLICATION

#### **Marine Insurance**

In August, the High Court handed down *Gibbs -v- MMI* [2003] HCA 39. The outcome was not positive for consumers.

The case concerned a Mrs. Morrell, who was paraflaying off the back of a boat operated in the Swann River estuary by Mr. Gibbs, the operator. Instead of landing on the beach as promised by Mr. Gibbs, Mrs. Morrell landed in a tree. Mrs. Morrell sued Mr. Gibbs and won. Mr. Gibbs, claimed against his third party liability policy.

Mr. Gibbs had made some misrepresentations and non-disclosures that would have been overcome by section 28 and section 54 of the IC Act, but if the Marine Insurance Act (the "MI Act") applied there would be no such relief. In a three to two decision, the High Court said that the policy was marine insurance with a divided majority on whether that was because of the old "ebb and flow of the tide" argument from the Admiralty Acts or because the activity was a "marine adventure" within the section 9 of the Marine Insurance Act.

The effect of this case is that all public liability insurances for boats (and possibly private consumer boat comprehensive and third party insurances) - even those operating quite far inland - will be covered by the Marine Insurance Act. The operators and their consumers will not have the protections of the IC Act. This situation needs to be clarified. Clearly there is the potential for significant detriment.

The view of the CFA is that the IC Act should cover all consumer marine insurance and/or at least all inland waters insurance contracts (whether consumer or not). CFA believes the amendments to the IC Act in 1998 to include coverage of marine pleasure craft within the Act were intended to achieve coverage of consumer transactions leaving commercial transactions to be covered by the Marine Insurance Act.

In this respect, we disagree with the finding of the Australian Law Reform Commission. The ALRC recommends that the MI Act cover inland waters. The only concession made to consumer protection is to recommend some amendments to the MI Act that incorporate some of the ICA protections.

*1.6 Would bringing insurance of water transportation of goods for non-commercial purposes within the scope of the IC Act have any significant negative consequences?*

Not in our view.

*1.8 Are there any other insurance-like products which should be subject to the IC Act?*

Extended warranty products – for example in relation to cars or white goods – should be subject to the IC Act. These products are clearly a form of insurance. The insurer assesses the risk of the product failing and requiring repair and sets the premium, which is paid in advance, on this basis. If the extended warranty is activated the costs of repair are covered by the warranty provider. It is understood that the definition of financial products in the Corporations Act 2001 has defined some of these products as a financial product.

It would appear that extended warranty products were developed at least partly in an effort to avoid the regulation of the IC Act. However there is concern that warranty providers are not subject to provisions such as Section 54 which would prohibit common practices such as rejecting claims on the basis that the consumer had not strictly complied with time limits for such things as servicing the vehicle or posting proof of the car service. It is important that the IC Act be amended not merely to bring this identified insurance-like product within its ambit, but also to prevent similar attempts at avoidance in the future. In addition, where insurance-like products are developed in such a way as to avoid regulation, adequate protection of consumers requires that the legislative response be more timely than has previously been the case.

## **2. DEFINITIONS AND PROCEDURAL PROVISIONS**

*2.2 Are there any notices or documents required in writing under the IC Act that should always require traditional writing rather than being communicated electronically?*

No, provided there are appropriate safeguards.

*2.3 For those documents that could be communicated electronically, what safeguards or protection measures should be included for recipients? For example, should there be requirements such that:*

- the recipient must consent to electronic communication;*
- the communication is capable of being retained and printed;*
- the communication is clear and readily understood;*
- that place and time of origin is certain;*
- that any contractual information can be downloaded or printed; or*
- any other requirements?*

Yes to all.

It is important that electronic communication is at the behest of the consumer and they are not forced to accept this format, if it is not their choice.

Disclosure has to be specifically directed to the consumer – just putting information up on a public website, and telling people it is there would not be sufficient.

## **3. POWERS OF ASIC**

CFA accepts that this issue is being dealt with in another forum.

#### 4. DISCLOSURES AND MISREPRESENTATIONS

The CFA's focus is on the insurance products most commonly purchased by consumers, the majority of which are defined in the IC Act as "eligible contracts of insurance". Our comments therefore focus on sections 21 and 21A in relation to these products, rather than commercial insurance.

An overall summary of our views is:

- section 21A is an important consumer protection mechanism for consumers. Our strong view is that it should be retained, subject to some amendments to improve the way it operates;
- the disclosure requirements in 21A should apply equally to both new contracts of insurance (as at present) and also renewals. (This would mean that s21 would not apply to renewals.);
- section 21A should also apply to life insurance;
- the ideal position is that all domestic insurance products are defined as "eligible insurance products"; and
- the "reasonable person" test regarding disclosure of "exceptional circumstances" should be refined to take into account the specific backgrounds of individual insureds.

A cursory search of the IEC's determination database reveals the central importance of disclosure. Between January 1999 and April 2004<sup>1</sup>, there have been 642 determinations on claims that, at least in part, have considered disclosure<sup>2</sup>. Our estimate is that this category represents approximately 13% of the determinations made by the IEC Claims Review Panel each year<sup>3</sup>. Any efforts to improve the disclosure regime, and consumers' understanding of it, are critically important.

##### **Genetic Testing**

The study of genetics has developed rapidly over the last decade and continues at a pace. As a result, concerns have been raised about genetic testing including from an insurance and public policy perspective. In response, the life insurance industry has developed a Genetic Testing Policy (see IFSA Standard No. 11.00 January 2002) that sets voluntary standards and limits on the use of genetic test results.

We have significant concerns about disclosure obligations, under sections 21 and 21A of the IC Act, in relation to genetic information. Insurance companies may potentially impose obligations on consumers to disclose certain matters relevant to genetic testing, particularly with respect to information regarding third parties, such as relatives of an applicant for insurance. For example, it may be open to an insurer to ask an applicant for insurance if any relative has undertaken genetic testing and if so, what were the results.

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<sup>1</sup> The entire time period for which a search of the database may be made.

<sup>2</sup> Small business (21), Consumer credit (39), Home contents (170), Home building (71), Marine (7), Motor vehicle (200), Motor vehicle TPPD (1), Personal accident/sickness (102), Travel (27), Other (4).

<sup>3</sup> We were unable to obtain exact figures. Our estimate is as follows: 642 claims over a five year timeframe is about 128 per year. The IEC panel determined 936 claims in 02-03. 128/936 is 13.7%.

From a public policy and privacy perspective it would be inappropriate for insurance applicants to be required or invited to disclose the genetic testing results of others as such information could affect the insurability of such persons, would not necessarily give them any opportunity to correct any errors in information provided and could discourage persons from undergoing genetic testing, medical treatment or from participating in research.

Our view is that a specific exemption to the duty of disclosure under sections 21 and 21A of the Insurance Contracts Act should be inserted for the disclosure of any genetic tests or related information with respect to persons other than the applicant for insurance.

Answers to some of the questions posed in the Issues Paper provide more detail and are set out below.

## **Answers to Specific Questions**

### *4.1 Should there be a reconsideration of the mixed objective/subjective test of the insured's duty of disclosure?*

Yes.

#### Section 21

For consumers, section 21 applies at present in relation to renewals of “eligible contracts of insurance”. As discussed later, our view is that this section should not apply at all to eligible contracts of insurance.

#### Section 21A

Our view is that the “reasonable person” test, as it is currently worded, negates the benefit of section 21A. The whole point of section 21A is to stop consumers having to second-guess the underwriting guidelines of insurance companies. Consumers cannot be expected to know what will be relevant and what will not be relevant, to the decision of the insurer.

There is no question that insurance companies are in a superior position, compared with the consumer, to understand, comprehend, investigate and foresee the likely risks of a particular insurance contract. If this was already becoming clear to the ALRC in 1981, it is even more so now. Technology, in particular, data processing and the internet, place insurance companies in a better position now, to assess risk than ever before. Consumers do not have the same access to that technology or information. Actuarial risk analysis is based on the aggregation of data and it already accounts for individual variations in the calculation of premiums or the decision whether to accept a risk.

Placing a burden on consumers to know what else (besides what they have been asked) an insurance company needs to know is not likely to add to the process. It merely provides an opportunity – unfairly - for insurance companies to refuse claims. In no other consumer contract is such a burden placed upon the consumer. In consumer credit, for instance, no one suggests that a consumer has a duty to advise a prospective credit provider of “any other factors” which will affect their capacity to repay the amount owing under a loan contract. They must, of course, answer the credit provider's questions accurately and honestly but all stakeholders agree that it is the credit provider who is in the position to know what information is required to assess the loan application.

Of course, in credit, as in insurance, this is all subject to fraud. Disclosure obligations are already subject to the obligations in section 28 and 29 in relation to fraud but there is no objection to restating this exception in the new section 21. In addition, the requirement, under

section 21A, for consumers to advise insurers of any exceptional circumstances gives additional protection to insurers selling eligible contracts of insurance.

Our view is that the “reasonable person” test in section 21A should be refined, so that it takes into account the specific circumstances of the insured. This would change the character of the test from an objective one, to also incorporate a degree of subjectivity. This would be a fairer way of applying the test.

ALRC 20 noted that:

Fairness to the insured can only be achieved by taking account of those differences between individual insureds ... Literacy, knowledge, experience and cultural background are all vitally important factors affecting the behaviour which can reasonably be expected of insureds, both by insurers and by the legal system which regulates the insurance relationship. Insurers sell to a wide market. They often do so with a minimum of formality. Subject only to the principle of utmost good faith, they must take the individual members of the relevant market as they find them. The existing requirement of disclosure imposes obligations on those individuals which many of them, acting in the utmost good faith, are unable to discharge.<sup>4</sup>

IEC determination 16913 of 6/3/02, provides an example of how not considering the specific circumstances of consumers, but only the “reasonable person” test could be unfair (the claim also concerns other parts of the IC Act):

(T)he claimant asserts that when the application form was completed in June 1999, the insurer’s employee did not explain what she meant by deadlock and certainly no reference was made to “double keyed deadlocks”. At that time the claimant submits:

“... We ticked “yes” that we had deadlocks however at that time we werent (sic) aware what a “deadlock” was exactly. Due to the fact that we didn’t understand the language too well we got help, with filling in the form, by an employee of [insurer].”

The claimant’s narrative appears to be supported by a circle that captures the two “Yes” ticks on the application form in response to questions 6a) and b) in relation to deadlocks on doors and key operated window locks. Adjacent to the circle are initials which seem to be those of the insurer’s employee who initialled acceptance of the application form<sup>5</sup>.

#### Eligible Insurance Products

Ideally section 21A should apply to all domestic insurance products (including life insurance products as discussed later).

At present, section 21A applies only to “eligible insurance products”. These are defined explicitly in the regulations. This means that some domestic products may be excluded already and “new” domestic products are automatically excluded.

The exact solution to this issue is not readily apparent. It could usefully be the subject of consultation with industry. Topics to canvass include: clarifying the extent of other common domestic insurance products and whether the definition of “eligible insurance contract” could be cast more broadly, rather than relying on specific inclusions.

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<sup>4</sup> ALRC 20, Paragraph 183, page 111.

<sup>5</sup> The Panel in this case found in favour of the insured, on the basis of section 26 of the Act.

*4.2 Should there be a revised duty of disclosure applying to all policies whereby potential insureds are required to answer honestly all of a series of specific and relevant questions put to them by an insurer?*

We have not formed a view on this issue. We do not have specific experience of how insurance operates in the commercial marketplace.

*4.3 Should section 21A be repealed?*

No. Our experience is that 21A operates in the manner intended and fairly balances the rights of insurers and insureds. However, as noted above, we believe that section references to the “reasonable person” test should be removed.

*4.4 Should section 21A be extended to include life insurance?*

Yes. Section 21A should apply to insurance products commonly accessed by consumers. Life insurance is one of these.

We understand that many life insurers already ask a range of questions in their application forms - some broad, and some more specific. However, under s21, they are still able to rely on non-disclosure of a matter in circumstances where they did not make specific enquiries about that matter.

In contrast, expanding s21A to include life insurance will place greater emphasis on the need for insurers to specifically seek the information that they need for risk assessment, and will reduce the likelihood that claims will be denied because the consumer failed to appreciate all of the factors that might be relevant to assessing the risk.

*4.5 Should insurers be required to inform insureds what information is relevant to their decision to accept their risk or not?*

This is addressed by section 21A and the requirement to ask insureds specific questions. We have not formed a view on this in relation to commercial insurance.

*4.6 Should the duty of disclosure requirements be streamlined so that the duty that applies to new contracts of insurance also applies at the time of renewal or variation of contracts?*

Yes. It is confusing to have two different disclosure regimes for eligible contracts of insurance. At contract initiation, consumers answer a specific set of questions, but at renewal, the duty of disclosure becomes much broader. Of interest in relation to this point is the practice of the AAMI insurance company. As we understand their practice, AAMI do not attempt to give the general warning on disclosure for renewals thereby waiving their right to rely on section 21. AAMI are on record as saying that the current statutory requirement puts an unreasonable burden on consumers. Recently, the AAMI CEO Mr. Robert Belleville commented as follows:

“It is time that the industry did away with the general duty of disclosure and instead committed to asking those specific questions on which its decision to insure is based.”<sup>6</sup>

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<sup>6</sup> “Protecting and Promoting Consumer Interests”, Speech to the Consumer Congress, Melbourne, March 2004. Available on the website of Consumer Affairs Victoria.

The disclosure regime for both insurers and the insured should be consistent with the intent of the Act which is to make renewals effectively a new contract. This will place the onus on industry to reproduce the same questions year after year but, likewise, it gives industry an opportunity to make fresh inquiry about new circumstances as their significance to the risk changes. It will lead to less reliance on the memories and understanding of consumers as to what is relevant and reasonable and, we argue, fewer disputed claims.

One option for industry under such a regime could be that they spelt out the consumer's answers from the previous year, and then asked if anything has changed. Again, this will assist in directing the minds of consumers to the importance of disclosure.

*4.8 Should warnings be given by the insurer to the insured advising them that:*

- *an insurer does not verify facts made by an insured until a claim is made; and*
- *the duty of disclosure still applies between the completion of a form seeking insurance and the date the contract comes into effect?*

Yes. We support the approach set out by Legal Aid NSW in their answer to question 4.13 (this sets out improved criteria for a disclosure notice).

*4.9 Should section 25 of the IC Act be expanded to include a non-disclosure by a life insured?*

No empirical evidence has been produced to show that non disclosure by lives insured (as opposed to the policy owners) has created problems for insurers. To extend section 25 to lives insured would create a separate regime of disclosure including the requirement to complete application forms to undergo health screening etc for persons.

*4.10 Should the section 22 obligation that is imposed on insurers be extended to renewals and variations of contracts?*

Yes. Disclosure does not diminish in importance.

We support the approach set out by Legal Aid NSW in their answer to question 4.13 (this sets out improved criteria for a disclosure notice).

*4.11 Should section 22 be amended so that it emphasises the importance of giving honest answers and the effect of failing to do so or of making misrepresentations?*

Yes.

*4.13 What is the best way of ensuring insureds understand the importance of the duty of disclosure message that is given to them by insurers?*

Insurance is a unique transaction. The ramifications of non-disclosure are so foreign and unexpected for a consumer, that they are rarely comprehended. This will continue to be the case, until these ramifications are explicitly and clearly brought to the attention of consumers. Bland statements about the importance of disclosure do not meet this need.

The importance of disclosure needs to be brought more strongly to the attention of consumers. One suggestion is through more prominent and strongly worded statements about the

ramifications of non-disclosure. This approach is similar to the health warnings on the sides of cigarette packets. We need to make stronger efforts in this area.

In this regard, we support the approach taken by Legal Aid NSW in its answer to this question, viz:

- a) In the case of a written notice, the warning is clearly set out in legible font (no smaller than size 12) on the front page of the proposal form (or on the front page of a separate notice provided with the proposal form) and headed (in bold size 14 or above font) “Important Notice - please read before completion of the proposal”;
- b) A similar written notice screen be displayed on Internet applications before an electronic proposal form is able to be completed. The proposer should indicate that he or she has read the relevant notice by clicking a confirmation button;
- c) In the case of an oral notice (such as that provided in relation to telephone applications) the notice should be preceded by words to the following effect: “[Name of Insurer] requires that you listen to the following important notice before it will consider your application for insurance”.

More broadly however, we need to consider this issue in the context of human behaviour. Policy makers often assume that consumers are logical, rational beings that make considered judgments after weighing up the evidence. The reality of course is far different. Recent research from the new field of behavioural finance for example, shows that people consistently judge risk incorrectly.

Ideally, research into the psychology of behaviour in relation to disclosure would be helpful not only in this jurisdiction, but in all that rely on disclosure as a form of consumer protection. Such research could provide insights into what types of messages are most effective: for example, do the best messages take a “scare” approach, should they include actual examples of what could happen if a matter is not disclosed honestly?

Without this knowledge, any changes made to the disclosure regime that may look good on paper, but make absolutely no difference in the marketplace.

*4.15 Should section 69 provide that an oral duty of disclosure given to one insured or their agent be deemed to be given to all insureds who are parties to the proposed contract of insurance?*

No.

The most practical approach is that the insurer should be allowed to give the oral notice to one of the insureds, as long it is followed up with separate written notices to each of the co-insureds.

For example, if a couple contact an insurer seeking home and contents insurance, it cannot be assumed either that one co-insured will be aware of all facts required to be disclosed, or will pass on any warning about disclosure to the other co-insured. It might be the case that one co-insured has lived in the property for some time, and the other has only recently moved in with her. If the new arrival arranges the insurance he is not necessarily in a position to know whether there have been, for example, any claims, break-ins etc in the last five years. Unless the duty of disclosure is communicated directly to both insureds (together with a message

regarding the importance of that duty), there is a significant risk of non-disclosure of relevant information, which the insurer could rely on if the legislation allows for the proposed deeming provision.

Other examples come from the records of the IEC. An insured was a youngish male, and his mother contacted the insurer to organise car insurance. Assume she is his authorised agent - she was unaware of some minor offences, and having not disclosed them - a subsequent claim by him was rejected. The insurer should not be able to rely on such non-disclosure where the insured was not directly informed of his duty of disclosure and the importance of that duty.

The answer of "no" to this question really backs up the message we are trying to get across in the answer to 4.13. Where an insurer can give oral notice to one person only but is still required to give written notice directly to all insureds, it is even more important that this written notice really bring to the attention of each insured what is required, and the importance of that obligation.

*4.16 Should subsection 21(1) be amended so that where a number of contracts are sold at the same time (that is, there is a bundle of contracts) the insurer is obliged to inform the insured only once of its duty to disclose?*

Yes.

*4.17 Should the law be amended so that where an insured uses the services of an intermediary any non-disclosure or misrepresentation made by the intermediary to the insurer is said to be that of the insured?*

No.

*4.18 Should any limits be placed on this "sheeting home" of the non-disclosure or misrepresentation to the insured?*

*4.19 Is this a significant concern requiring legislative action, or of relevance only in unusual cases and therefore not a high priority?*

Responsibility is already sheeted home to the insured for misrepresentations. This is not an area in need of urgent reform. Further, complex issues arise in relation to when an intermediary should be seen as acting for an insured (rather than an insurer) and therefore any proposed reform in this area should not be rushed through with the rest of this review.

## 5. STANDARD COVER

### General Comments

The philosophy behind standard cover is to facilitate insured persons being made aware of restrictions or exclusions on benefits that they would otherwise reasonably expect to be provided under certain general insurance policies.

The Act acknowledges that insureds usually don't read and understand all of the terms of their insurance contracts and thereby requires insurers to bring such non-standard or unusual terms to the attention of insureds and thereby "clearly inform" insureds of the non-standard terms.

Whilst it is correct to state that insurance policies have generally become somewhat easier to understand, it nevertheless remains the reality that most Australians do not read or understand the fine print of their insurance policies. Insurers have done next to nothing to highlight non-standard cover terms and exclusions.

The Courts have interpreted the obligation to clearly inform the effect of the contract as not requiring a special disclosure document and that in most circumstances the provision of an insurance policy will suffice (see *Hams v. CGU Insurance Ltd* (2002) 12 ANZ INS CAS 61-525).

This interpretation does not sit well with the intention to make insureds aware of terms they would otherwise not presume to be in certain insurance contracts. In practice insured persons are still left to extract non-standard terms from policy documents which may run to 50 or 100 pages and are terms that are not highlighted, but simply form part of the normal fine print of an insurance contract.

### Our Position

Standard cover is an important consumer protection mechanism and should be retained. The regime however is not working as intended. The following should occur to address this:

1. a separate examination, including consumer input, of the current prescribed contracts and prescribed events, to ensure they reflect fair practice and are up-to-date;
2. the development of a process for approving additional products, including consumer input, under the standard cover regime;
3. vastly improved disclosure requirements for any derogations from standard cover, based on the Schumer Box approach (that is, a similar approach to that being taken to disclosure of key terms and conditions in the Uniform Consumer Credit Code); and
4. providing that non-standard terms will be voided if they are unfair.

Each point is discussed briefly below.

- 1. Examination of the current prescribed contract regime to ensure it is fair and up-to-date*
- 2. Development of a process for approving additional prescribed products*

Standard cover, as outlined above, is an important mechanism for ensuring a fair marketplace. The issue therefore, is in ensuring the standard cover provisions operate as originally intended.

Our suggestion is that the Federal Government convene a Reference Group, comprising industry and consumer representatives, to specifically review the products currently included as “prescribed contracts” and to assess what should be “prescribed events” in relation to those contracts.

To ensure that standard cover provisions, remain up-to-date and adequately adapt to a changing marketplace, such a group could have an ongoing role, meeting say once per year.

### *3. Vastly improved disclosure of derogations from standard cover*

The disclosure requirements of section 35, viz the insurer’s obligations to “clearly inform” the insured, have not worked as intended. The current situation is what would colloquially be known as a “Clayton’s disclosure” – the disclosure you’re having, when you’re not having disclosure. As is well documented, adequate disclosure of non-standard terms occurs simply by including the terms in the insurance policy. Clearly this must change.

Our suggestion is that the review take the approach that will shortly be introduced into the Uniform Consumer Credit Code. Amendments to the Code, will provide for what is known as “Schumer Box<sup>7</sup>” disclosure. This means that the key terms and conditions of a loan have to be disclosed in a certain way, at the front of a credit contract.

The same approach could be provided for in insurance contracts, with all non-standard terms separately collected and disclosed at the front of the contract (using plain language, with a reasonable font size, with an explanation of the purpose of the disclosure and so on).

When contracts are formed over the phone, insurance companies should be required to separately explain standard cover and disclose derogations in a clear manner. These messages must be separated from any marketing material.

Appropriate amendments will need to be made to section 35(2) to put our suggestions into effect.

### *4. Providing that non-standard terms will be voided if they are unfair.*

Disclosure is an inherently weak form of consumer protection. People often do not understand what they are signing, despite improved disclosure. There is always an imbalance in the bargaining positions of a consumer and an insurer. And frequently unfair contractual terms are so rife across an industry anyway, there is little an extremely well-informed consumer could do by attempting to “shop around”.

It is one thing to disclose non-standard terms in a fairer way (as set out above); it is quite another if those standard terms are in themselves intrinsically unfair. In our view, a derogation from standard cover should have to meet a test of fairness.

Our suggestion is that Part V, Division 1 of the IC Act, also provide that unfair terms can be voided.

Section 32W of the Victorian Fair Trading Act 1999 sets out an adequate form of wording:

A term is unfair if contrary to the requirements of good faith and in all the circumstances, it causes a significant imbalance in the parties’ rights and obligations arising under the contract to the detriment of the consumer.

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<sup>7</sup> From the surname of the US Senator who suggested it a number of years ago.

## Answers to Specific Questions

*5.1 Does the PDS regime effectively duplicate the requirements of the standard cover provisions in terms of purpose and outcomes? If so, how are the standard cover provisions duplicated and why is that problematic?*

No.

The intention of the PDS and standard cover regimes are fundamentally different. A PDS relies entirely on disclosure as its primary consumer protection mechanism. It assumes that consumers have the ability to adequately compare products and shop around, based on disclosure. Product Disclosure Statements for insurance products describe what a policy includes.

On the other hand, standard cover protects consumers by providing for a set of minimum standards. The intention of section 35 was that consumers would be advised as to what a policy excludes or where the policy differs from the minimum that could be expected. This is quite a different approach.

A PDS will not solve the issue of disclosure.

*5.2 If there is problematic duplication between the PDS regime and the standard cover regime (either in whole or in part), how best could duplication be addressed (for example, through amendment of the IC Act, the creation of new regulations under the FSRA or a combination of both)?*

This so-called “problem” is likely to have been exaggerated for the reasons set out above. We do not believe that any legislative change is required.

As well, the PDS regime is still new and untested. It may be too early to draw conclusions about whether it will achieve its intended purpose.

*5.3 Are there any reasons why the notification of “unusual terms” should not occur in relation to all, or some, insurance policies or clients?*

There is no reason to narrow the operation of section 35 by limiting the types of insurance which are standard cover policies for the reasons set out above. To the contrary, perhaps life insurance policies could be considered for inclusion as standard cover policies with carefully considered and drafted regulations determined by the Reference Group as suggested above.

*5.4 Under the IC Act, if an insurer cannot prove that disclosure of unusual terms occurred before the contract was entered into, then the insured will receive standard cover. Under the PDS regime, the onus is with the insured to pursue compensation for loss or damage resultant from an insurer’s breach of the regime. Is the additional consumer protection element provided by the standard cover provisions still necessary?*

Yes – absolutely.

As we noted above, the PDS and standard cover regimes operate in fundamentally different ways. As such, different remedies are appropriate.

Changing the onus under the IC Act, as the question above infers, would undermine the intent of section 35.

*5.5 Alternatively, do the remedies available under the standard cover provisions mitigate the need for remedies under the FSRA, in relation to prescribed contracts? If so, should further remedies be provided under the IC Act?*

No. As we argued above, the regimes have separate purposes.

*5.6 Are there any other issues that should be considered in relation to the operation of the PDS regime and the standard cover provisions?*

In our commentary above, we argued for the introduction of Schumer Box disclosure of derogations from standard terms.

*5.7 Should the standard cover regulations be retained? If so, is it feasible to modernise the regulations? If not, how could the policy intention of the standard cover regulations be otherwise achieved?*

Yes, definitely. See our commentary regarding the establishment of a Reference Group to consider this issue.

*5.8 Does the interpretation in Hams case give effect to the policy intention of section 35 of the IC Act? If not, what would amount to "clearly informing" the insured as to how an insurance contract differs from the standard contract?*

See our commentary at the beginning of this part of our submission. Schumer Box disclosure in written contracts would be a positive step.

*5.9 Could the requirements under section 35 of the IC Act be better dealt with by expanding the operation of section 37? If so, how could section 37 be expanded to maintain or improve the current standard cover regime?*

No.

A general disclosure requirement is too broad. It would cause uncertainty and lead to the undermining of standard cover. If there is a suggestion that the prescribed standard cover terms need updating, that is not a basis for repealing or reducing the protections of Section 35 and the Regulations.

To the contrary, it is submitted that Section 35 is a very important consumer protection measure to ensure that consumers are sold insurance products consistent with their expectations.

## 6. REMEDIES OF INSURED

### Unfair Contractual Terms (Sections 14 and 15)

Section 15 should be repealed. As explained below, section 15 has failed in the past and it is likely to become increasingly anachronistic in the future.

Section 15 is based on two unsustainable premises: firstly, that insurance contracts are so different from all other transactions that they should be immune from the impact of the general law and, secondly, that the Insurance Contracts Act can somehow be the “*summa theologica*” of every issue or circumstance which can arise from insurance contracts. Stated plainly, these premises are self-evidently erroneous.

Looking to the future, our strong view is that broad unfair contracts legislation should apply across the marketplace – including the insurance marketplace. The reviewers will be aware that the introduction of legislation of this nature is the subject of a discussion paper recently released by the Standing Committee of Officials of Consumers Affairs. There is no reason why the insurance industry should be a special case and be exempted from such laws, because of the existence of sections 14 and 15.

As to the past, contrary to the original aspirations of the ALRC, section 14 has not been sufficient to “encourage insurers to carefully draft policies and to act fairly in strictly enforcing policy terms”<sup>8</sup>. As a consequence, section 15 has demonstrably failed. This has led to consumer detriment – but detriment that is not easily remedied. Three examples from different sources are provided below.

- 1) Extracts from recent annual reports of the Insurance Enquiries and Complaints Ltd (IEC) are attached as Annexure 3. These extracts document a number of unfair terms in insurance contracts that have come to the attention of the Claims Review Panel within the IEC.

The views of the IEC are based on the large number of complaints with which the organisation deals; they are not formed by anecdote or isolated incidences. The IEC may be able to assist an individual consumer in dispute with an insurance company, but it **cannot address systemic issues inherent in unfair insurance contracts**. In our view, these examples indicate an underlying problem.

- 2) The statistics included in the SCOCA discussion paper indicate that unfair insurance contracts are rife in Europe. The insurance sector is the fourth highest category by number of cases of unfair terms (page 93). Unfair terms occur mainly in relation to life insurance, dwelling, health and motor vehicles (page 97). Unfair terms most commonly place unfair obligations or liabilities on the consumers (page 96). The Australian experience is unlikely to be much different – other than that at present - there is no mechanism for consumers to challenge unfair terms.
- 3) The ASIC submission in response to the SCOCA discussion paper noted that “ASIC staff are aware of some very broad exclusions in certain total and permanent disability policies. For instance, one policy excluded cover for "any

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<sup>8</sup> Page 23 of the Issues Paper

injury, disease or disorder of the spine, its muscles, ligaments, discs or nerve roots whether arising alone or in conjunction with any other illness"<sup>9</sup>.

For the CFA, the introduction of uniform unfair contracts legislation would be one of the most important advances in consumer protection in recent years. As the SCOCA paper notes, the current legislative regime does not provide adequate remedies for substantive unfairness in contracts. Section 15 has not done so in the specific circumstances in which it operates.

Similarly, unconscionable conduct regimes, such as those found in the ASIC Act, do not adequately address substantive unfairness in contracts. On this comparison at least, there is very little overlap between the duty of utmost good faith and unconscionable conduct. We have not considered whether, if section 15 was to be repealed, what impact this would have on section 14.

### **Section 57 - Interest on Delayed Payments**

Pursuant to Section 57 of the Insurance Contracts Act, prescribed interest is payable on the amount payable under a contract of insurance from the date it was unreasonable for an insurer not to have paid the monies until the date of payment.

The prescribed rate was originally 11% but was amended to 13% in 1990. The rate was again amended in 1997 to be the equivalent of the 10 year Treasury Bond Yield plus 3%. Since 1997, the amended interest rate has varied between approximately 8.8% and 9%.

In contrast, some state civil courts have the power to award interest at substantially higher rates with respect to insurance claims that are litigated and where judgment is entered for an insured. For example, under the Victorian Supreme Court Act 1986, a court can award interest on insurance contracts the subject of legal proceedings and judgments at the rate set out under the Penalty Interest Rate Act 1983 (Vic) which is currently 11.25%. The rate has consistently been in excess of the amended rate under the Insurance Contracts Act.

Section 57(4) of the Insurance Contracts Act specifies that the section applies to the exclusion of any other applicable law including state laws and the common law. It is arguable that there is an inconsistency between Section 57 of the Insurance Contracts Act and relevant state legislation prescribing interest at a higher (or lower) rate (see *NRMA Insurance Ltd v. Tatts* (1989) 5 ANZ Ins Cas 60-902).

At common law, a court may award damages by way of interest (simple or compound), and it is legally questionable whether such an award would be in contravention of Section 57 of the Insurance Contracts Act (see *Elders Ltd v. Swinbank* (2000) 96 FCR 303 c/f *Hungerfords v. Walker* (1989) 171 CLR 125).

The principle underlying Section 57 of the Insurance Contracts Act is to encourage insurers to settle claims expeditiously and to compensate successful insured claimants for losses arising from being denied payment by insurers (see generally *Blackley v. National Mutual Life Association of Australasia Ltd* (No. 2) (1973) 1 NZLR 68 and *Legal and General Insurance Australia Ltd v. Eather* (1986) 4 ANZ Ins Cas 60-749).

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<sup>9</sup> This policy was recently considered by the General Insurance Enquiries and Complaints Scheme. In the IEC Panel's opinion, a policy exclusion of this wide-ranging nature was unusual, except where the insured had an identified history of back problems. The Panel relied on sections 14 and 35 of the *Insurance Contracts Act* to find the insurer liable: see IEC Determination 7-15806

Accordingly, it is submitted that:

1. The prescribed rate under the IC Act should be amended to increase the prescribed interest rate to provide incentive to insurers to finalise the claims expeditiously.
2. The suggested prescribed rate should be the 10 year Treasury Bond Yield plus 5%.
3. Section 57 of the Insurance Contracts Act should be amended to specify that the prescribed interest should compound on an annual basis from when the benefit should reasonably have been paid, until the date of payment.
4. Sections 57(4) and (5) of the IC Act should be amended to accommodate state legislation and the common law to the extent to which they provide interest at a higher rate than Section 57 of the Insurance Contracts Act.

#### Answers to Specific Questions

*6.1 Is the restriction in section 15 of the IC Act on remedies available to the insured for unfair contractual terms still appropriate? If so, are there any remedies under other laws that should be similarly restricted in the context of insurance contracts?*

No – the restriction imposed by section 15 is not appropriate. Section 15 has minimal impact in preventing unfair contractual terms in insurance contracts.

We are perplexed at the second part of this question as to whether “there are any remedies under other laws that should be similarly restricted...?” This pre-supposes an answer of “yes” to the first question. We take a strong contrary view.

The Issues Paper does not canvass what these “other laws” may be.

The debate in Australia is as to how we address substantive unfairness in contracts in the marketplace as a whole. The review needs to engage in this debate. The insurance industry should not be exempted should unfair contracts legislation be introduced.

*6.2 Should the prescribed interest rate be increased so as to provide an incentive to insurers to finalise claims?*

Yes, as detailed in the above submission.

*6.3 Should it be made clear in the IC Act whether compound interest is available in addition to the prescribed interest under section 57? If so, how?*

Yes, as detailed in the above submission.

*6.4 Are contractual remedies sufficient for insureds, or should there be an opportunity to obtain damages for consequential loss, punitive or exemplary damages in tort for unreasonable delay in payment of claims?*

If Section 15 is repealed, as is our submission, then the opportunity for consequential loss and punitive or exemplary damages will arise for those consumers who can prove that there was unreasonable delay in the payment of claims.

If section 15 is not repealed, then our submission is that section 15(2) must be expanded beyond mere “compensatory damages” to include these other heads of damage. There is no

good reason why the existence of the insurance contract should extinguish what duty of care arises (in the normal course of the law) on the part of the insurer to the insured. As we observed above in relation to section 15 generally, section 14 has not been a sufficient inducement to the insurance industry to draft fair contracts and to administer them fairly. Fear of the Courts, administering the general law, might do better.

In any case, there are many situations where contractual and tortious duties exist side by side, for instance for those professional relationships between solicitors and clients, doctors and patients and financial advisers and their clients.

Sometimes, interest alone cannot be adequate compensation for the damage, inconvenience, pain and suffering and lost opportunities which consumers endure as a consequence of an unfairly delayed payment of a valid claim.

In particular, consequential losses, which flow from delays in paying claims such as forced sales of houses and loan or mortgage defaults, deserve compensation. However, at common law, it is questionable whether a civil court has power to award consequential damages unless an insurer has repudiated a contract by refusing to pay a claim or if the relevant insurance contract allows for the payment of damages (which is most unlikely). (See *Johnson v. Australian Casualty Co Ltd* (1992) 7 ANZ Ins Cas 61-109)

The Insurance Code of Practice obliges insurers to assess claims “promptly” and within “a reasonable time”<sup>10</sup> and it is appropriate that IC Act give effect to this obligation by not excluding relief for consumers who suffer from its breach.

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<sup>10</sup> Insurance Code of Practice section 5.1

## **7. REMEDIES OF INSURER**

### **Section 29 - Fraud versus Innocent Non-Disclosure/Misrepresentation**

Section 29 provides remedies to life insurers for non-disclosure and misrepresentation. The section distinguishes between fraudulent and non-fraudulent (innocent) non-disclosure or misrepresentation.

With respect to the former, an insurer may avoid a contract at any time or vary the contract within three years of the commencement of the policy whilst with respect to the latter, an insurer may only avoid or vary the contract under certain underwriting conditions and within three years of the commencement of the policy.

The principle underlying the distinction between the remedies available for fraudulent and innocent non-disclosure or misrepresentation, is the need to deter fraud on the one hand and ensure that there is proportionality between the (innocent) conduct and the remedy on the other hand.

Remedies for innocent non-disclosure or misrepresentation involve the insurer retrospectively re-underwriting the risk. The right to vary or avoid a contract is expressed in broad subjective terms (i.e. what that insurer would have done with the information) and is not fettered by any objective analysis as to whether the variation or avoidance was reasonable.

The three year time limit is designed to strike a reasonable cut-off point at which the variation or avoidance of a policy would produce unjust outcomes for insureds whose conduct was innocent, as opposed to deliberate or reckless.

If an insurer did not become aware of the non-disclosure or misrepresentation within three years of the commencement of the policy (usually by means of a claim), any innocent non-disclosure or misrepresentation of a pre-existing condition is unlikely to have been of underwriting significance. Whilst not all pre-existing conditions result in death or disablement within three years of the commencement of the policy, the vast majority do and would therefore entitle an insurer to apply remedies of variation or avoidance.

No empirical evidence has been produced by any life insurers or in any of the submissions to the Review Panel, that a significant number of claims have been accepted despite undisclosed or misrepresented pre-existing conditions which would otherwise have resulted in policy variations or avoidance. Similarly, no evidence has been produced of the inability of insurers to respond to innocent non-disclosure or misrepresentation in relation to income, occupation or other details.

Accordingly, it is submitted that the remedies for non-disclosure and misrepresentation under Section 29 of the Act strike a fair balance between the interests of insurers and insureds and in particular the three year time limit has been an effective consumer protection measure to moderate the broad remedies of subjective retrospective underwriting available to life insurers pursuant to Section 29 of the Act.

### **Section 29(3) Wording**

It is asserted in some of the submissions to the Review Panel that the wording in Section 29(3) of the Act is flawed insofar as it requires a life insurer to establish that it would not have been prepared to enter into a contract of life insurance on any terms.

It is argued that the use of the phrase “a contract” in Section 29(3) as opposed to “the contract” which is used elsewhere in sub-section (3) and in Sections 29(1), (2) and (4) means that an insurer would have to establish that it would not have been prepared to enter into any contract of life insurance whatsoever to invoke the remedies under Section 29(3) of the Act. The consequences of such an interpretation, it is asserted, is that a life insurer would have to establish that it would not have been prepared to offer an insured even an investment-only life insurance policy to avoid the contract under Section 29(3) of the Act, which in the case of medical non-disclosure or misrepresentation would be highly unlikely.

However, it is submitted that such a narrow interpretation of Section 29(3) of the Act is not sustainable as it may make redundant the subsequent phrase in Section 29(3) – “on any terms”. To give meaning and effect to the said phrase, it is submitted that an insurer may only have to establish that it would not have been prepared to enter into the contract of life insurance for all the types of cover that were in fact agreed between the parties. With respect to a bundled life insurance policy, this would mean that an insurer would have to be satisfied that it would not have accepted the risk for all the types of cover attached to the policy to invoke the avoidance remedy under Section 29(3) of the Act. The insurer would not have to be satisfied it would not have entered into a contract for any life insurance product at large.

It is submitted that such an interpretation would be a reasonable outcome and consistent with the principle underlying the section of the Act by linking any remedy open to an insurer under Section 29(3) of the Act to the contract in fact entered into between the parties.

On the other hand, if Section 29(3) of the Act was amended to allow insurers to detach one or more types of insurance cover from a bundled policy, this may leave a life insured with insurance he or she did not really want. In this regard, many consumers are convinced by life insurance agents to include other types of insurance when approached for one type of cover, eg to add death or trauma cover to the core need for income protection insurance. To allow an insurer to avoid some types of insurance cover under a policy and to continue with others could fundamentally change the nature of the contract, contrary to the needs of the insured.

It has been suggested that Section 29 of the Act should be repealed and the remedies open to life insurers for non-disclosure and misrepresentation should be collapsed into Section 28 of the Act. We do not support such a proposal. There is a clear distinction between general insurance policies which are pure risk policies and life insurance policies which may be bundled policies or include investment components. The remedies under Section 28 of the Act would allow a life insurer to detach parts of contracts which, it is submitted, is inappropriate for many life insurance policies for the reasons detailed above.

Accordingly, we submit that Section 29(3) of the Act operates effectively to give insurers avoidance remedies for innocent non-disclosure or misrepresentation but within the confines of the entirety of the contract entered into between the parties.

### **Section 32 – Group Life Schemes**

Section 32 specifies that the remedies under the Act for non-disclosure and misrepresentation apply to group life insurance policies under superannuation schemes.

Whilst it is appropriate that the prescribed remedial limitations should apply to life insurance contracts within the superannuation regime, it is submitted that the same should apply to other group insurance products which have developed over the years such as group insurance policies offered under employment, industry and other schemes.

### **Section 59 – Cancellation Procedure**

Some of the submissions to the Review argue that there is a gap in the Act in relation to the power of the life insurer to cancel a policy because of fraud.

It is argued that Section 56 of the Act, whilst allowing for the refusal to pay a claim because of fraud, does not allow for the cancellation of the policy for fraud under Section 59. This, it is said, is in contrast to the rights of a general insurer to cancel a policy for a fraudulent claim (see Section 60(1)(e)).

With respect, this analysis of the Act is incorrect. Section 56 of the Act prevents an insurer from avoiding a contract (ie cancelling from the date of inception). It does not prevent an insurer from exercising a right to cancel a policy (ie cancelling prospectively).

Indeed, life insurers who identify fraud on a claim routinely notify the insured of the cancellation of the claim pursuant to Section 56 of the Act and at the same time, give notice of the proposed cancellation for fraud under Section 59 of the Act.

Accordingly, it is submitted that there is no gap in the legislation requiring any remedial measures such as merging Sections 59 and 60 of the Act.

From a statutory construction perspective, it could be said that the cancellation/ forfeiture procedure for life insurance policies with an investment component set out under Section 210(5) of the Life Insurance Act 1995 should be incorporated into Section 59 of the Act.

### **Answers to Specific Questions**

#### *7.1 Should there be a statutory definition of "fraud"?*

Yes.

Although the civil courts have grappled with what constitutes fraudulent non-disclosure and fraudulent misrepresentation with varying degrees of certainty (see generally the discussion in the Annotated Insurance Contracts Act 4th Edition Peter Mann at pp 98-101 and 109-110), in our view, a properly worded statutory definition of fraud would provide greater certainty as to what is a very important and controversial legal notion that has major implications for the insurance entitlements of consumers.

#### *7.2 Should an insurer be entitled to avoid a policy for immaterial non-disclosure or misrepresentation?*

No. The whole purpose of the disclosure regime is to expose factors which may affect a person's insurability.

Accordingly, Section 29(1)(c) of the Act should be retained or strengthened consistent with the principle of proportionality.

#### *7.3 Should section 29 of the IC Act be repealed? Alternatively, should it be partially repealed so its application is limited to whole of life and endowment policies?*

No. The distinction between remedies of non-disclosure of life insurance products and general insurance products under the Act, was not based upon the distinction between investment products and risk products respectively. The distinction between the remedies was in part based upon an acknowledgement that the Life Insurance Act 1945 already regulated the conduct of life insurers.

Although whole of life and endowment life insurance policies are now less common than at the time of the commencement of the Insurance Contracts Act, they did and still do, include risk components. Further, bundled life insurance policies which include various risk products and perhaps also investment-linked benefits are very common, as opposed to general insurance policies which are pure risk and not usually bundled contracts.

As detailed above, the retrospective re-underwriting remedies available to a general insurer under Section 28 of the Act are not an appropriate fit for bundled life insurance contracts. As such, it is submitted that there were and remain significant differences in the nature of life insurance and general insurance policies justifying discrete remedies for non-disclosure and misrepresentation.

*7.4 If section 29 should be repealed or partially repealed, should life insurers be able to use the remedies that are available under section 28 or is there another approach that would be preferable?*

It is our strong view that Section 29 of the Act should not be repealed either wholly or in part.

*7.5 Should the different categories of insurance, for example life insurance and general insurance, be dealt with in separate parts of the IC Act?*

Yes, to the extent they are now, such as with respect to remedies available under Sections 28 and 29 respectively. General insurance policies are pure risk policies and do not necessarily involve complex medical disclosure issues and as such, the more simplified non-disclosure remedies under Section 28 of retrospective re-underwriting are more appropriate.

Beyond this, it is submitted that the sections of the Act that apply generally to different categories of insurance have worked reasonably well and we see no compelling reason to completely segregate the different types of insurance.

*7.6 Should the three year time periods mentioned in section 29 be repealed?*

Three year time periods have operated effectively to provide reasonable remedies for insurers for non-disclosure and misrepresentation. To simply repeal the 3 year time limit would upset the balance between the interests of insurers and insureds.

*7.11 Should Division 3 of Part IV of the IC Act apply to non-superannuation group life schemes?*

Yes. There has been a significant proliferation in the number and type of life insurance policies sold as part of group schemes under employment enterprise agreements or awards, unions or other organisations. Such non-superannuation group life schemes were not contemplated when the Insurance Contracts Act was introduced and it would leave a substantial gap in consumer protection in life insurance if they were not covered by the Insurance Contracts Act.

## **8. RESTRICTIONS ON INSURERS' CONTRACTUAL RIGHTS AND REMEDIES**

### **Section 31**

Section 31 of the Act allows a Court to disregard an insurer's avoidance of an insurance contract because of fraudulent non-disclosure or misrepresentation and to award an insured some or all of the insurance benefit in limited circumstances.

The section does not extend to innocent non-disclosure or misrepresentation, presumably on the basis that an insured may be eligible for payment of some or all of the insurance benefit pursuant to Sections 28 and 29 of the Act.

However, the Courts have interpreted the retrospective underwriting provisions of sections 28 and 29 of the Act for innocent non-disclosure or misrepresentation as allowing an insurer to reduce liability for benefits to nil (see *Ferrcom Pty Ltd v. Commercial Union Assurance Co of Aust Ltd* (1989) 5 ANZ INS CAS 60-907 and *Alexander Stenhouse Ltd v. Austcam Investments Pty Ltd* (1993) 7 ANZ INS CAS 61-166).

A reduction of payments to nil can, and does, produce unfair outcomes not consistent with the doctrine of proportionality which was generally adopted by the Australian Law Reform Commission in its Report 20 on insurance law which was the catalyst for the IC Act.

In our view, section 31 should be extended to give the Courts a discretion to intervene in some circumstances to award payment of some or all of the insurance benefit, in cases of innocent non-disclosure or misrepresentation.

### **Section 45**

Section 45 of the Act voids a provision of a general insurance contract that has the effect of limiting or excluding liability because of other insurance held by the insured.

An example of such a policy is a sickness and accident insurance policy that includes an offset clause for benefits paid under other insurance policies or statutory compensation schemes.

Section 45 voids the "other insurance" provision to the extent to which there is an overlap between the benefits provided. However, there is an exception for compulsory statutory insurance (such as workers' compensation) with respect to which any offset clause is unaffected.

However, section 45 does not extend to life insurance policies and, it is submitted, there is no justification for such a limitation.

Sickness and accident insurance policies may be either guaranteed renewable (life insurance) policies or non-guaranteed renewable (general insurance) policies. As section 45 now reads, some but not all sickness and accident insurance policies must not include an "other insurance" provision - surely an illogical situation, placing general insurance policies at a competitive disadvantage.

### **Section 47**

Some submissions to the Review criticise the application of section 47 of the Act to trauma or critical illness insurance policies.

It is argued that trauma policies typically include waiting periods for eligibility for benefits as an underwriting device to deter anti-selection and fraudulent claims but that section 47 undermines this by disentitling an insurer from relying on the waiting period to exclude a

claim with regard to a disability or sickness the insured had but was not reasonably aware of prior to the commencement of the policy.

It is submitted that this argument is flawed because there can be no suggestion that an insured who had a disability or sickness prior to the commencement of the policy but was not reasonably aware of same, could be said to have acted fraudulently or anti-selected the policy. If an insured did act fraudulently or anti-select a trauma policy, section 47 would have no application because the person would necessarily have been aware of the pre-existing sickness or disability.

## **Answers to Specific Questions**

### *8.1 Should section 31 be repealed? If so, why?*

No. Section 31 provides a valuable mechanism for “just and equitable” remedies for insured consumers, despite some fraudulent non-disclosure or misrepresentations, but only where it is “harsh and unfair” not to do so. This is still a high standard and the onus of proving the absence of significant prejudice to the insurance company lies with the consumer. The relief is already more restrictive in the IC Act than it was in the draft legislation attached to the original ALRC Report 20.

### *8.2 Should section 31 be expanded so it also applies where it is alleged there has been innocent non-disclosure or misrepresentation?*

Yes. There are many cases where sections 28 and 29 allowed insurers to reduce liability to nil for only innocent non-disclosure or misrepresentation. Theoretically, the insured consumer would do better under section 31 if their non-disclosure or misrepresentation was fraudulent than innocent. This anomaly should be repaired by expanding section 31.

### *8.5 Should section 45 be amended so as not to advantage offshore insurers as against Australian insurers? If so, should any amendment be limited to any classes of insurance policy?*

Yes and, if so, the amendment should apply to all classes of insurance.

### *8.6 Should the meaning of “specified” in subsection 45(2) be clarified?*

Yes. Interpretation of “specified” has been very strict so that the “other” policy must be identified. If this is to remain the law (and we think it is unduly restrictive) then this must be clarified by, for instance, substituting “identified” for “specified.” Also, see our remarks above about further amendment to section 45.

### *8.7 Should the legislative intent of section 46 of the IC Act be clarified? If so, how?*

No, effectively for the same reasons set out in the text above in relation to s47.

### *8.8 Should the legislative intent of section 47 of the IC Act be clarified? If so, how?*

No, for the reasons set out in the text above in relation to section 47.

*8.9 Should section 47 directly address waiting periods that are imposed before cover is provided for some trauma conditions?*

Section 47 only applies to trauma & crisis care policies to the extent to which an insured suffered from a pre-existing sickness or disability on which he/she was not reasonably aware at the commencement of the policy. The section has no bearing on sicknesses or disabilities the insured was aware of at the commencement of the policy & conditions which occur after the commencement of the policy.

Accordingly section 47 has a limited impact on the waiting periods imposed on some trauma conditions.

In our view, the impact of section 47 is perfectly appropriate to trauma and crisis care policies given that the underwriting principle of waiting periods is to prevent exposure to claims for certain conditions which may have been clinically diagnosed after the commencement of a policy but with respect to which an insured may have experienced symptoms or suspected he/she suffered from prior to the commencement of the policy. Section 47 would have no application in such scenarios.

## 9. INNOCENT CO-INSUREDS

This issue is covered in the second IEC submission (dated 13 February 2004). The CFA strongly supports the recommendations made in that submission.

Where an insurance policy is purchased by multiple persons, each insured should be entitled to the protection of that policy. In practice, however, this does not always occur.

The example given in the IEC's submission – in which the innocent co-insured is a wife whose family home is deliberately burnt down by her husband – is illustrative of the problem, and indicative of the extent of the injustice that can and does result. The actions of the husband in this example are as beyond the control of the wife as would be the actions of any other third party, yet because the insurance that protects against such risk is in his name as well as in hers, she is denied its protection.

There are many reasons why insurance may be purchased jointly, particularly where the policy protects property which is jointly owned. If insurers are to provide single policies to multiple insureds, the Act must ensure that innocent co-insureds continue to receive appropriate cover, notwithstanding the independent actions of other parties to the insurance contract.

The mechanisms proposed in the IEC submission – which would allow the court (and the IEC Panel) similar powers to those provided by sections 31 and 56 of the Act – would be appropriate, and would allow the flexibility required to provide fair outcomes on a case by case basis.

### Answers to Specific Questions

*9.1 Is there a need for amendments to the IC Act provisions to deal expressly with co-insureds?*

Absolutely. As we noted above, co-insureds face a number of specific issues that can lead to demonstrably prejudicial outcomes, in respect of which they need equally specific and targeted protections.

The mechanisms proposed in the IEC submission - which would allow the court (and the IEC Panel), similar powers to those provided by sections 31 and 56 of the Act - would effectively and appropriately protect co-insureds from some of the harshest prejudices, allowing the flexibility required to provide fair outcomes on a case by case basis.

- *Should there be any additional notification requirements warning prospective insureds of the risks of entering into a contract with other co-insureds?*

Yes. To the extent that a co-insured will receive a level of protection different to that obtained by a single insured, or to the extent that the protection obtained may be affected by other co-insureds, it is crucial that prospective insureds are warned of these risks prior to entering into contracts of insurance.

Relevant parallels can be drawn between co-insureds and third party guarantors to credit contracts. The risks inherent in such transactions are

sufficient to dictate that additional protections are afforded prospective guarantors, with specific notice requirements a feature of both legislative (eg. the Uniform Consumer Credit Code) and non-legislative (eg. the revised Code of Banking Practice) regulatory regimes.

- *Would it be desirable to introduce the distinction between joint and composite policies into the IC Act?*
- *Should insured contracts in favour of co-insureds be required to state whether it is intended to be treated as a joint or composite policy?*

Yes, to the extent that this may assist in clarifying the protection available to or obtained by co-insureds. If the distinction is introduced it is imperative that the nature of the policy - joint or composite - is stated.

*9.2 Are there any other measures that would be desirable to address the difficulties faced by co-insureds?*

Other than those already discussed, none that we are aware of.

## 10. THIRD PARTY BENEFICIARIES

### General Comments

We also support the comments and recommendations made in the second IEC submission (February) in relation to persons who are not parties to the insurance contract.

Problems experienced by third party beneficiaries to an insurance contract can be exacerbated where the policy has been purchased by an employer. For example, the Consumer Law Centre of the ACT recently received an enquiry from a consumer who had moved to the ACT for work, and whose new employer had arranged and paid for that move. The consumer believed that her goods had been damaged by the removalist, but the insurance policy covering such damage had been purchased by her employer, and she was receiving no cooperation from either the removalist or her employer.

Not being a party to the contract, the consumer had not seen the contract nor had she been able to obtain a copy in order to ascertain the nature and extent of the protection offered. She was very reluctant to press her case too hard as she believed this might negatively impact on her employment, despite the fact that the nature of the transaction was such that her employer should not have had any continuing role in the matter.

The application of the Act to third party beneficiaries is necessary to ensure that the rights and protections offered to insureds are available to all insureds regardless of who may have taken control of the contractual process. It is important too that third party beneficiaries are not denied access to the IEC Ltd.

### Answers to Specific Questions

#### *10.1 Should the legislative intent of subsection 48(3) be clarified?*

We acknowledge that there is a divergence of opinion regarding the operation of section 48(3), and agree the issue should be clarified. For obvious reasons of fairness and certainty, where an insurer provides cover to third party beneficiaries the defences available to that insurer should only be those that arise out of the conduct of the third party claimant, and not merely conduct of the insured.

#### *10.3 Should the 'persons' referred to in section 48 be limited to existing beneficiaries at the time the contract of insurance was entered into?*

No. In group insurance contracts the beneficiaries change over time as employees/superannuation members etc come and go.

#### *10.4 Should section 13 also apply to third parties?*

Section 48 of the IC Act imposes on third party beneficiaries to an insurance contract the same obligations as if they were insured. We would assume that this would include the obligation to act towards the insurer with the utmost good faith. Section 48 does not, however, impose a similar obligation on the insurer. In order to ensure proper protection of all beneficiaries, and to promote both consistency and the integrity of the duty of utmost good faith, we believe section 13 should apply equally to third party beneficiaries as to insureds and insurers.

The proposed amendment involves ensuring that a third party beneficiary has the same obligations and protections as insureds. In our view additional amendments will be required to achieve that outcome, as the IC Act otherwise limits certain rights and protections to "insureds". For example, section 74 of the IC Act provides that an insured must be given a copy of the policy document on request. This provision does not currently apply to third party beneficiaries, however as noted in the general discussion above, it is fundamentally important that third party beneficiaries not be denied basic rights and protections of this nature.

*10.5 Should life insureds have a statutory right to bring an action against the insurer to enforce payment of the policy proceeds if payable under the contract?*

The common law principle of privity of contract was to the effect that only the parties to an insurance contract had a right to claim.

The High Court in *Trident v. McNiece* (1988) 165 CLR 107 extended the common law privity of contract principle but there is some doubt whether the dictum extends to beneficiaries under insurance policies (see for example *Visic v. State Government Insurance Commission* (WA) (1990) 3 WAR 122).

Section 48 of the Act extends the common law privity of contract principle by allowing persons specified in an insurance contract as covered by the contract to recover losses against the insurer even though they are not a party to the contract.

However, only contracts of general insurance and life insurance policies under Retirement Savings Accounts are covered by the extension to non-insureds (see Sections 48 and 48AA respectively).

Group life insurance policies under superannuation schemes and employment agreements are not included despite the fact that millions of Australians are covered by such contracts.

Section 48A covers life insurance policies effected on the life of a person but for the benefit of a third party. As such, the section does not extend to group superannuation or employment contracts.

Pursuant to compulsory workplace superannuation, most superannuation fund members are covered for death and disability benefits under group policies taken out by fund trustees. Likewise, under many enterprise agreements, employers take out group insurance policies on behalf of participating employees. All such group policies under superannuation schemes and many under employment agreements are life insurance policies. However, only those employees covered under general insurance group employment contracts or Retirement Savings Accounts can claim under Section 48 and 48AA respectively.

It is submitted that there is no good reason why the millions of Australians covered under such life insurance policies should not also have a right of recovery from the insurer. Indeed, it may be that it was assumed by the legislature that such a right already existed in relation to superannuation fund members when Section 48AA was inserted to give the right of recovery to Retirement Savings Account holders only.

*10.7 Should section 51 be expanded to make its remedy available to claimants in other situation? If so, what are the situations?*

We believe that the section should be expanded so as to give full effect to the insurance cover in respect of which the claim is brought. Section 51(1)(c) provides adequate limitation - any greater limitation operates merely to provide a windfall to insurers, and denies both insureds and claimants the protection to which they are otherwise entitled (and which the insured has specifically sought to obtain).

*10.8 Should subsection 51(1) be limited in respect of the insured's 'liability in damages' for tort and contract?*

No, for the reasons discussed on 10.7 above.

*10.10 Should the words 'reasonable enquiry' be legislatively defined with a list of actions prescribed?*

No. Given the range of circumstances which might give rise to a claim being brought pursuant to section 51, reliance on the flexibility of the "reasonable enquiry" test is appropriate.

## 11. MISCELLANEOUS ISSUES

### Section 75 – Reasons for Cancellation etc

Pursuant to Section 75(1) of the Insurance Contracts Act, where an insurer refuses to insure or renew insurance, cancels a contract of insurance or offers insurance on modified terms, the insurer must provide written reasons for its decision if requested to do so by the insured.

A similar requirement is imposed on life insurers with respect to providing reasons related to the state of health of the life insured (section 75(5) of the Act).

The Act does not prescribe the type of information written reasons must include nor does it specify that relevant documents such as medical reports, underwriting manual extracts, etc that must be provided.

In practice, the reasons provided by insurers are often unclear, uninformative and raise more questions than they answer. Accordingly, the principle underlying the section of the Act, namely to inform an insured of the reasons behind the underwriting decision of the insurer, is not being effectively implemented by Section 75 of the Act.

It is submitted by the Consumers Federation of Australia that to be effective, there needs to be a greater level of prescription in Sections 75(1) and (5) of the Act. Specifically, the sub-sections should be amended to require:

- A clear and precise statement of reasons for refusing cover or offering cover on special terms.
- When the decision is related to the state of health of an insured, the insurer must provide the insured with full copies of all medical reports, records and notes provided to or obtained by the insurer with respect to the decision.
- Where the decision is based on other reports, studies or manuals, the insurer must provide the insured with copies of all the said documents or at least extracts of the documents sufficient to fully identify and inform the insured of the basis for the reasons for the decision.
- Full details of any other relevant factors must be provided that the insurer relied upon in making its decision.

## **ANNEXURE 1 – CFA OBJECTIVES**

The objects for which the association is established are to promote the interests of consumers, in particular low income and disadvantaged consumers, through identifying areas in which the interests of consumers are being adversely affected;

- advocating policy and law reform changes to benefit consumers;
- conducting consumer awareness and information programs;
- liaising with other consumer and community groups to advance the interest of consumers;
- facilitating consumer responses to government, industry and regulators where specific funding or resources are available;
- and doing other things to further the interests of consumers.

## ANNEXURE 2 – DISCLOSURE AND CRIMINAL HISTORIES

The information in this annexure was provided by Legal Aid Queensland.

A research of various major insurance company websites revealed a startling variation in questions posed to any potential insured which canvassed past criminal involvement.

In August /September 2003, by going through the motions of completing an on-line application forms for insurance (with a focus on motor vehicle insurance, which seems reasonably to be the most likely form of insurance sought by young people), there was no discernable formula or set criteria across the board for such questions investigating a person's past dealings in the criminal law system.

RACQ Insurance posed this question:

“Have you or any intended insured, during the last 10 years been charged with any criminal offence or have you or they been convicted of a criminal offence whether a conviction was recorded or not?”

Suncorp asked for on their application form:

“Have you in the last 10 years, knowingly committed a criminal offence?” and then proceeds to ask for details.

NRMA asked a more specific question that might clearly be relevant to the issue of insuring property. This was:

“In the last 5 years has any owner named in this Insurance application been convicted of a criminal offence in relation to fraud, theft or burglary, arson criminal or willful damage?”

The explanation of Duty of Disclosure that RACQ provides, clearly states:-

**“What you must tell us:** When answering our questions, you must be honest and you have a duty under law to tell us anything known to you, and which a reasonable person in the circumstances, would include in answer to the question. We will use the answers in deciding whether to insure you and anyone else to be insured under the policy, and on what terms.

**Who needs to tell us:** It is important that you understand you are answering our questions in this way for yourself and anyone else whom you want to be covered by the policy.

**If you do not tell us:** If you do not answer our questions in this way, we may reduce or refuse to pay a claim, or cancel the policy. If you answer our questions fraudulently, we may refuse to pay a claim and treat the policy as never having worked.”

## **ANNEXURE 3 – EXAMPLES OF UNFAIR CONTRACT TERMS IN INSURANCE CONTRACTS**

The extracts below are from the Annual Reports of Insurance Enquiries and Complaints Ltd (IEC). IEC handles disputes between consumers and insurance companies.

### **From the 2003 Annual Report**

“Most home building policies provide cover for damage caused by leaking pipes. However, usually in a separate part of the policy, the cover provided is substantially negated by exclusions ... The point we want to make ... is that we believe cover contained in an insurance policy is indeed illusory, if the very event giving rise to the claim, for which cover is provided, is likely by virtue of a process of cause and effect to give rise to the circumstances covered by a policy exclusion ...” (p28 -29)

“The panel has also dealt with a variety of other situations where policyholders had realistically expected they would be covered for particular events, but their expectations were not realised when their claims were made. Some instances where this has occurred were as follows:

- (a) A claimant who discovered he was not covered pursuant to a consumer credit policy because he refinanced his loan with a different financier, and was not aware that the policy purported to terminate cover as soon as the financier was changed despite the fact that the terms of the two loans were not significantly different.
- (b) Policyholders who claim for stolen luggage who discover the claims were not covered because of a policy exclusion for unattended luggage, defined as “leaving it in a position from which it may be stolen”, so that the actual act of stealing it virtually establishes that it must have been unattended. In these circumstances cover is only effectively provided where in effect, the goods are stolen by means of an armed robbery.
- (c) Policyholders whose claims were denied because of an onerous definition of unoccupancy, which provided that occupancy is constituted by the necessity of someone living in the home, as distinct from “occupying it”, that is attending upon it and visiting it in such a way as to satisfy the common law interpretation of that term.

... In the Panel's opinion policies which artificially define terms need to have a means of clearly bringing those provisions to the notice of policyholders, particularly in an environment where insurance policies are becoming more complex and substantially longer and where the sheer size and complexity of the document makes it for the insurer to resort to the increasingly archaic practice of providing a derogation notice.” (page 32)

### **From the 2002 Annual Report**

“The subject of ‘flood’ has been commented on in previous Annual Reviews but it has again caused controversy ...In one instance, the definition of ‘flood’ was very narrow and required the Panel to decide whether a concrete drain was a creek, the word ‘watercourse’ having been omitted from the definition. The Panel encourages insurers, as it has been doing for the last seven years to define the term ‘flood’ in clear and comprehensive terms.” (page 35)