National Legal Aid Secretariat
GPO Box 9898
Hobart TAS 7001

Executive Officer: Louise Smith

t: 03 6236 3813
f: 03 6236 3811
m: 0419 350 065

e: louise.smith@legalaid.tas.gov.au

National Legal Aid

14 August 2009

The Secretary
Senate Economics Legislation Committee
PO Box 6100
Parliament House
Canberra
ACT 2600

Dear Secretary

Submissions to Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill

Introduction

National Legal Aid (NLA) represents the Directors of the eight State and Territory legal aid commissions (commissions) in Australia. The commissions are independent statutory authorities established under respective State or Territory enabling legislation. They are funded by State or Territory and Commonwealth governments to provide legal assistance to disadvantaged people.

NLA aims to ensure that the protection or assertion of the legal rights and interests of people are not prejudiced by reason of their inability to:

- obtain access to independent legal advice;
- afford the appropriate cost of legal representation;
- obtain access to the Federal and State and Territory legal systems; or
- obtain adequate information about access to the law and the legal system.

Support for legislation

A number of legal aid commissions have been long-standing advocates for the need to introduce legislation addressing unfair terms in contracts. Commissions have responded to the Standing Committee of Officials of Consumer Affairs Working Party on Unfair Contract Terms in early 2004; the Productivity Commission's Draft Report of the Inquiry into Australia's Consumer Protection Framework in 2008; and to an issues paper on Australian Consumer Law - Fair Markets – Confident Consumer from the Standing Committee of Officials of Consumer Affairs in 2009.

Unfair terms in standard form consumer contracts have been rife for some time. As identified in the reports and inquiries[1] leading up to the development of the current bill, unfair terms in standard form contracts have found their way into most types of consumer contracts, from insurance contracts to loan agreements and from mobile phone contracts to hire care agreements.

To date, the common law has struggled to reconcile consumer rights with classic contract law.[2]. Legislative attempts to date[3] to reform the common law have been equally ineffective in ensuring the removal of unfair terms from standard form contracts. This is partly because most remedial legislation requires proof of procedural unfairness as well as substantive unfairness before intervention will occur. It is also because remedial legislation has relied on individual consumers taking proactive steps to have a trader brought before a court to review unfair terms in an agreement. Very few consumers have the will, the patience or the money to take such steps, and government funding for legal aid in these types of matters is limited.

The confidence that unfair terms legislation will bring to consumer markets is that, for the first time, the regulator will have the power to take *proactive* steps to ensure traders across all industries draft contracts on fair terms—except, of in relation to insurance contracts, if the Bill is passed in its current form.

Insurance contract exclusion

The proposed exclusion of insurance contracts from unfair terms legislation[4] is in spite of the recommendations of the Productivity Commission[5], and the decisions of the Ministerial Council on Consumer Affairs (MCCA) and the Council of Australian Governments (COAG)[6] to develop national generic unfair terms legislation to apply to all standard form consumer contracts.[7]

The economic and social impact of the proposed exclusion of insurance contracts has not been recently assessed in any way by any level of government.[8] The recent and unexpected justification maintained for the

---

[1] Productivity Commission Final Report into Australia's Consumer Policy Framework (2008), the Standing Committee of Officials of Consumer Affairs Working Party on Unfair Contract Terms (2004), the Standing Committee on Law & Justice, Legislative Council NSW (2006)

[2] The principle of laissez-faire economics that moulded the laws of common law contract were based on underling assumptions that is that two parties of equal power were able to bargain around terms suitable to both those parties and hence that once negotiated on terms, parties should be bound to them. Further detail, see Legal Aid NSW submission to NSW Legislative Council Inquiry into Unfair Terms (2006) at pp 9-11

[3] This includes *Contracts Review Act* (NSW) 1980 and *Consumer Credit Code* and *Insurance Contracts Act* (Cth) 1984

[4] The limitation of the operation of the unfair terms legislation is in light of provision in s 15 *Insurance Contracts Act*: Explanatory Memorandum, 2.100 at p.31-32

[5] Productivity Commission Recommendations – See in particular Recommendation 4.1 and 4.2 (30 April 2009)

[6] Ministerial Council on Consumer Affairs Communiqué (23 May 2008)

[7] Subject to constitutional limitations outlined in Productivity Commission Recommendation 4.1

[8] The 2004 Review into the Insurance Contracts Act did not involve a review s 15 in light of any proposed implementation of national unfair terms in contracts legislation, as the Productivity

insurance contract exclusion appears based solely on the existence of a section[9] in the *Insurance Contracts Act* which was devised and considered some 30 years ago by the Australian Law Reform Commission (ALRC)[10] when hopes were high that a new regulatory framework in insurance might encourage insurers to contract on a fairer basis with consumers. The ALRC was also supportive of the inclusion of a provision in the terms of s 15[11] as it was believed that enacting consistent Federal legislation was more desirable than existing piecemeal State legislation.[12]

At that time, the ALRC had particular aspirations that by enshrining into legislation the principle of utmost good faith and the development of standard form contracts in general insurance would signal a new culture in insurance based on the common law principle of *uberrima fides* [13].

Unfortunately, the impact of these changes anticipated by ALRC has not been realised. These issues are discussed in more detail below.

1. Duty of utmost good faith

The ALRC outlined its expectations about the impact of utmost good faith[14] and a prohibition on an insurer from relying on any term in breach of the duty of utmost good faith[15] as follows:

> Both parties to an insurance contract are subject to the requirement of *uberrima fides*. This should be restated as a contractual duty between the parties. Neither party should be entitled to rely on a contractual provision when to do so would involve a breach of the duty of utmost good faith. **That should provide sufficient inducement to insurers and their advisers to be careful in drafting their policies and to act fairly in relying on their strict terms.**[16] [Emphasis added]

Yet, within a decade of enacting the new legislation, parliamentarians were was already voicing the concerns of consumer groups that the reliance on the consumer to take proactive steps to hold insurers to account was undermining the impact of these provisions.

Commission recommendations were made some four years later. The reference in that report to s 15 contains equivocal comments about the benefit or otherwise of retaining s 15 and referred back to assessments made in 1980 when s 15 was originally considered by ALRC: ss Cameron Review Insurance Contracts Act at pp 23-24

[9] s 15 Insurance Contracts Act (Cth) 1984

[10] Australian Law Reform Commission Report 20 (1980)

[11] Noting though that s 15 was amended in 1994 to include the reference to 'judicial review'.

[12] ALRC 20 (1980) at para 51. The Commission had in mind legislation such as Contracts Review Act (NSW) 1980 – which applied in NSW but not elsewhere.

[13] This discussion is developed under Chapter 3 (para 48 – 81). See particularly para 51 in regard to s 15.

[14] s13 *Insurance Contracts Act* (Cth) 1984

[15] s 14 *Insurance Contracts Act* (Cth) 1984

[16] ALRC 50 at para 51

> **The Act has been criticised by consumers, largely because it is costly and cumbersome for individuals to take legal action where a breach of the act has occurred.**[17] [Emphasis added]

Given this problem, the body of case law on s 13 and s 14 of the *Insurance Contracts Act* is quite modest.[18] Over the last three decades, very few consumers have taken the significant step of suing their insurer to enforce their legal rights under s 14.[19] This is not surprising given very few consumers have the finances or the motivation to risk the consequences of an adverse costs order in court proceedings.

We are equally unaware of the regulator ever commencing litigation against an insurer for breach of utmost good faith provisions. It is our casework experience that, for whatever reason, the regulator has not shown a willingness to actively engage with insurers on the drafting of terms which breach utmost good faith provisions.

2. Standard cover

The ALRC considered standard cover[20] as the other new and significant concept it hoped would ensure that the reasonable expectations of insured parties were met. [21] The protection that s 35 hoped to provide consumers was a prescribed contract with minimum standards on key clauses – essentially setting a minimum prescribed standard of fairness in terms to specified general insurance contracts.

However, the very significant limitation on the usefulness of s 35 to in protecting consumers is that an insurer is able to comply by informing a consumer in writing at the time of policy inception of a derogation from standard cover.[22]

Unfortunately for consumers, the interpretation given to the words 'clearly informed in writing' in s 35, through the decision in Hams v CGU Insurance Ltd has been that an insurer who serves a copy of an insurance policy at the time of inception[23] on an insured which contains

---

[17] *Hansard*, Parliament of Australia (Cth) Insurance Laws Amendment Bill (No 2) 1994

[18] For commentary on s 13 and s 14 see Annotated Insurnace Contracts Act (4th Ed), Mann 2003; Australian Insurance Law (1st Ed), Pynt

[19] The leading High Court case at present on good faith is the case of *CGU insurance Ltd v AMP Financial Planning Pty Ltd* [2007] HC 36. However, whilst this decision contains some of the most current pre-sentiment of the Court on the importance of the duty of utmost good faith, the reality is that such comment was dicta. The Court found that despite the undesirable behaviour of CGU, AMP was not able to rely on a breach of utmost good faith as a means of succeeding in the claim.

[20] s 35 *Insurance Contracts Act*

[21] This discussion is developed under Chapter 3 (para 48 – 81). See in particular paras 48-50 and 81

[22] s 35 (2) *Insurance Contracts Act*

[23] s 69 *Insurance Contracts Act provides* that provision of a copy of the policy within 14 days of the date of the contract (usually completed over the phone) is sufficient compliance with this requirement.

such exclusion clauses (derogations from standard cover) will in most circumstances have complied with s 35.[24]

In practical terms, the impact of the *Hams* decision has been to allow insurers to continue on a 'business as usual' basis. Contracts are not necessarily drafted according to the reasonable expectation of insured parties; they are drafted on terms suitable to insurers, with exclusions contained and served on insured parties as part of their written policy. Equally, because insurers are not required to provide notice of derogation at the time of renewal, consumers may never see the document containing the derogation more than once.[25] As very few consumers read their policies[26] and even fewer can understand the interplay of related sections, standard cover has not effected significant change for consumers.

On both counts, the *Insurance Contracts Act* has failed to deliver for consumers a legal basis upon which they can be guaranteed their insurer will contract on terms that are not unfair to consumers.

Systemic breaches of *Insurance Contracts Act*

There has been considerable public reporting over the last two decades on what might be described, in one form or another, as examples of systemic unfairness in the drafting of terms in insurance policies. These concerns have been identified in different contexts by a range of bodies, including in the Trade Practices Commission Life Insurance and Superannuation report[27], Annual Reviews of the Insurance Ombudsman Service (now Financial Ombudsman Service)[28], information brochures produced by the Insurance Ombudsman Service[29], information produced by the Insurance Law Service[30] and Legal Aid NSW[31], consumer submissions into the 2004 Review of the

---

[24] *Hams v CGU Insurance Ltd* [2002] NSWSC 273 per Einstein J

[25] S 21 A *Insurance Contracts Act*

[26] There is now a considerable body of work in Australia and UK documenting and accounting for consumer behaviour in this regard: see for instance L Griggs 'The [ir]rational consumer and why we need national legislation governing unfair contracts terms' (2005) 13 CCLJ 51.

The Insurance Ombudsman Service made the same observation on consumers when it stated:

> **"The fundamental principle relevant to all insurance disputation on which all parties agree is that no-one ever reads the policy before a claim is made."** (2005) IOS Annual review, Addendum, p.4

[27] Trade Practices Commission Life Insurance and Superannuation Report, December 1992

[28] See IOS (IEC) Annual Reports from 1992 – 2008. For instance, Panel Chair's Report, 2004 Annual Report IOS

[29] For instance, see "A Guide to Travel Insurance", IOS (2006)

[30] See for instance Insurance Law Facts Sheets – 'What Can I Do if my Home/Contents Claim is Refused?'

[31] See 'Turning the Tide: Storms, Flood - Insurance & You' , Legal Aid NSW

Insurance Contracts Act[32] and consumer submissions into the 2009 *General Insurance Code of Practice*[33].

To further assist the Inquiry in understanding the extent of the systemic breaches of the *Insurance Contracts Act* over an extended period, we have annexed to this submission relevant excerpts from various Annual Reviews of the Insurance Ombudsman Service.[34]

The Insurance Council of Australia as recently as this year has acknowledged the existence of unfair terms in insurance contracts, referring to two particular examples of unfair terms that are specifically permitted by the *Insurance Contracts Act*:

- a term that permits or has the effect of permitting one party but not the other to avoid or limit the performance of the contract; and
- a term that permits or has the effect of permitting one party but not the other party to terminate a contract.[35]

Refused claims in insurance

The significant size of the insurance market, including the significant number of insurance policies issued and claims denied, further demonstrates the need for this area of trade to be included in unfair terms legislation.

The net premium revenue for general insurers as at June 2008 was $6,080,000,000.[36] In 2007-2008[37], there were 31,259,018[38] general insurance policies issued and 3,172,539[39] claims made, of which 69,433[40] were refused. The reason for refusal of many of these claims would have been unfair[41] exclusion clauses in policies.

Case studies as breaches of *Insurance Contracts Act*

The following case studies provide, in our view, further support for the proposition that the *Insurance Contracts Act* does not and cannot remedy unfairness in insurance contracts. The case studies illustrate in practical terms for our clients the limitations of the principle of utmost good faith and standard cover in the Act.

---

[32] Response to Review of Insurance Contracts Act on sections other than s 54, Legal Aid Commission of NSW (2004)
[33] Insurance Law Service submission to General Insurance Code of Practice, 2009
[34] Annexure A – IOS Annual Reviews (excerpts)
[35] ICA Submission to Treasury dated 16 May 2009 at p. 2 – see footnote 6
[36] ICA website, APRA Key General Insurance Statistics – Trend Series
[37] IOS Annual Report, 2007-2008
[38] Op cit , p.17
[39] FOS General Insurance Code of Practice, Overview of 2007-2008 Financial Year, p. 6
[40] Calculated by deducting 3,103,106 (claims paid) from 3,172,539 (claims made): FOS General Insurance Code of Practice, Overview of 2007-2008 Financial Year, p. 6
[41] That is, 'unfairness' as outlined in the test in the Australian Consumer Law Bill (2009): s 3.

Case studies - unfair terms in insurance contracts

Motor vehicle claim
In a Comprehensive Motor Vehicle policy, a Certificate of Insurance read ""Not insured when [client] drives the vehicle". The insurer knew that the client was the main driver of the vehicle. The client, who was a young driver with a poor driving record, was not advised on the phone of the written exclusion when he paid almost $3,000 for comprehensive motor vehicle insurance. The driver assumed that because he was buying a comprehensive motor vehicle policy and paying a lot of money for it (based on his poor driving record) he was covered. The insurer rejected the policy after an accident, advising him that he was "insured as an insured but not as a driver of the vehicle".

Motor vehicle claim
In a no-fault comprehensive motor vehicle insurance policy, an insurer sought to rely upon the following exclusion clause to refuse the claim:

> "[You] have not taken all precautions to avoid the incident."

Travel insurance claim
In a travel insurance policy, a client was denied his claim on the basis that he left his baggage "unattended".

The client left his baggage on top of his other bags at his side (within arms reach) but was distracted at the time of the theft, asking for directions.

Third party property motor vehicle claim
In a third party motor vehicle property claim, an insurer sought to rely on the limited nature of its Uninsured Motorist Extension clause which said:

> "If the car is involved in a non fault accident with an uninsured vehicle, we will cover your damage up to $3000...but only if you report the accident to the police and provide evidence that the other vehicle in uninsured."

The client was not able to report the matter to the police as they routinely refuse to take details from drivers where there has been no personal injury damage, involves minor vehicle damage and where there is no prospect the laying of charges. The client was also equally unable to provide proof that the other driver was uninsured.

Application of *Insurance Contracts Act* to case studies

On our analysis, most if not all of the abovementioned provisions would breach the duty of utmost good faith and thus fall foul of s 14.

Equally, most of the abovementioned case studies would breach the standard cover provisions of the *Insurance Contracts Act*. But as the

exclusions were all provided in writing, s 35 has no application to each and every case outlined above.

The issue is, of course, that if s 13 and s 14 worked as the ALRC had initially hoped, Legal Aid offices would never see such case studies because insurers would not draft contracts which breached minimum standards of (objective) fairness. The case studies demonstrate the divide between the hopes for utmost good faith and the considerable practical limitations of reliance by consumers on utmost good faith in the market place.

No economic assessment of insurance exclusion

The Productivity Commission's comprehensive assessment of the consumer protection framework in Australia put forward a compelling case for generic consumer law implementation, stating:

> There is little reason for *any* variation in the content of the generic consumer law.
>
> The generic law reflects broad notions of efficiency, fairness and equity, which the vast majority of consumers and businesses would regard as appropriate and reasonable irrespective of where they live or trade.
>
> The broad, principles-based, nature of the generic law allows for its application to a wide variety of particular circumstances. This largely removes any case for variations in the law itself to account for specific local requirements."[42] *[Productivity Commission's emphasis]*

The Productivity Commission specifically considered and warned against the economic and social cost of divergence in the regulatory environment:

> Differences in enforcement intensity and/or priorities at the jurisdictional level can similarly lead to divergent requirements for businesses (and variable outcomes for consumers).
>
> The costs of divergences in the requirements or application of the generic law should not, of course, be overstated. Even the more significant differences may not necessarily require businesses that adhere to ethical standards to employ tailored compliance strategies.
>
> Nonetheless, as indicated above, the cumulative costs of even individually small differences can be material. And because many of them are seemingly needless, they can also be a source of significant frustration for businesses. More importantly, a continuation of the

[42] Productivity Commission Final Report into Australia's Consumer Policy Framework, Vol 1, p.19

> recent regulatory 'break-outs' will see the compliance burden increase in the future. It will also (inimically) increase as unnecessary specific consumer regulation is repealed (see below) and the generic law becomes the sole means of protecting consumers in a wider range of areas. "[43]

The notion that there should be a special exclusion for insurance contracts was not considered or assessed by the Productivity Commission in its report. It appears that the economic and social impact of an exclusion of insurance contracts from the operation of unfair terms legislation has not been assessed by any level of government.

As outlined above, the special exclusion for insurance does not have sound foundation in legal principle. To the extent that any legislation, State or Commonwealth, was inconsistent with unfair terms legislation, it was clearly contemplated by the Productivity Commission that such laws would be repealed or amended. [44]

The justification for the insurance exclusion, as identified in Explanatory Memorandum to the Australian Consumer Law Bill, is based on a simple reference to s 15 of the *Insurance Contracts Act*.[45] However, for the reasons outlined above, reliance on section 15 as the justification for the exclusion is flawed, based as it is on outdated notions on the effectiveness of the duty of utmost good faith and standard cover.

The concession made to industry that s 15 of the *Insurance Contracts Act* will not be repealed[46] is a troubling development. It threatens to undermine the foundation upon which the Productivity Commission believed consumer framework should be based - national, consistent and transparent unfair terms legislation. It will also present real challenges for government if other industries over time seek to state their case for a special exclusion.

The ramifications for consumers of general insurance policies and life insurance policies[47] of not receiving the benefit of unfair terms legislation will be considerable.

Equally, the lack of any power for the regulator to seek redress to the courts in relation to unfair insurance contracts[48] will make it more difficult for the regulator to negotiate with the insurance industry concerning the fairness of terms in standard form contracts.

---

[43] Productivity Commission Final Report into Australia's Consumer Policy Framework, Vol 1, p.19
[44] Productivity Commission Final Report into Australia's Consumer Policy Framework, Vol 1, p.19 -20
[45] Australian Consumer Law Bill (2009), Explanatory Memorandum, pp 31 - 32
[46] To the extent of the inconsistency with Australian Consumer Law Bill (2009)
[47] Life insurance policies will be caught by s 15 *Insurance Contracts Act* to the extent that the policies are annualised life policies (which includes many group life policies in superannuation).
[48] 'Judicial review' exclusion as set out in s 15 (2).

The obvious and simple solution to the concerns outlined is to repeal s 15 *Insurance Contracts Act* to the extent necessary to allow for the proposed unfair contracts legislation to apply.

Recommendation

That a consequential amendment be made to delete the word "unfair" from s 15(2)(a) *Insurance Contracts Act.*

Transparency test

The inclusion of the concept of transparency as a matter of primacy in determining unfairness is a new and unnecessary element that reconceptualises the test in a detrimental way to consumers. Rather than focusing on substantive unfairness per se, the concept of transparency imports the false notion that consumers can somehow make an informed choice in relation to unfair terms, as long as those terms are disclosed.

It is our casework experience that it is false to assume consumers can make an informed choice about contract terms, even where they are purportedly transparent, because:

- most consumers do not read contracts – most rely on a notion that traders will act in a fair and reasonable way when it comes to enforcing their rights; [49]
- even when they read contracts, consumers do not often understand how a particular clause will operate in practice; [50] and
- even where a contract is read and understood, standard clause contracts are non-negotiable – it is a falsity to think that consumers can somehow bargain their way through amending or deleting a clause in a contract that is unfair but transparent. [51]

A more appropriate way to deal with the transparency principle is to remove it from the second limb of the test and place it in the grey list of examples of unfair terms.

---

[49] The history of unfair terms in contracts legislation in this country and the UK (particularly the new Bill which sets this aspect into the test) is that this is the legal (and moral) foundation for the proposed legislation.

[50] This means that at no time prior to contract formation will a consumer (especially someone who has difficulty with English as a first language) be able to make an informed choice as to whether the term will affect them.

[51] Standard form contracts are contracted on a 'take it or leave it' basis, hence the need for this remedial legislation.

In relation to the definition of 'transparent', National Legal Aid further recommends that the fourth criterion of "readily available to any party affected by the term" be amended to "readily available to any person likely to be affected by the contract term". This amendment would be consistent with the proposed criterion in s14 of the draft *Unfair Contract Terms Bill 2004* in the United Kingdom, which we submit is a more appropriate definition.

Recommendation

i) Remove the transparency aspect from the second limb of the test of unfairness and place it in they grey list as an example of unfair term (suggested wording: "a term that is not transparent").

ii) Define the term 'transparent' (with its four limbs) in the definition section; and

iii) amend the fourth limb of transparency definition to read "readily available to any person likely to be affected by the contract term"

Conclusion

The regulatory impact of excluding insurance contracts from the application of unfair terms legislation has not been adequately considered. To the extent that any existing legislation is inconsistent with unfair terms legislation, it was within the contemplation of the Productivity Commission that such laws (State or Commonwealth) would be repealed or amended.

The legal justification for excluding insurance contracts is not sound. Reliance on principles of good faith and standard cover is both misguided and inconsistent with evidence of current practice in the insurance industry.

The reality for consumers of insurance products is that they depend upon insurance to protect their basic economic interests, and contract with insurers from a situation of significant disadvantage. Insurance consumers need the support of unfair terms legislation as much as consumers of other products. They also need a regulator who is legally empowered to take enforcement action against insurers who seek to rely upon terms that are fundamentally unfair.

Yours faithfully



N S Reaburn
Chairperson
National Legal Aid

Appendix A –
Annual Reviews, Insurance Ombudsman Service

This appendix sets out examples of unfair terms in insurance contracts, drawn from the Annual Reviews of the Insurance Ombudsman Service (formerly known as Insurance Enquiries and Complaints Ltd).

2006-2007 IOS Annual Review

Panel Report

'Rubbery' policy terms
The Panel has also considered a number of policies which include terms best described as "rubbery". They contain "open-ended" or vague exclusions or clauses which make the commencement or operation of the policy dependent upon external factors. One example of a rubbery policy is the type of travel policy which has an open-ended class of persons whose illnesses are excluded from policy cover if they cause cancellation of the journey. An example of a rubbery clause is a policy exclusion entitling an insurer to deny a claim if the illnesses causing cancellation of the journey is due to (after listing specific classes of persons) "any other person on whom your trip depends". The Panel has found that such a clause gives an insurance company a huge discretion to apply the exclusion. Does it mean the tour operator, the financier, the guide for a trekking or cycling holiday, the skiing or diving instructor, or some distant relative whose sudden death results in the command to return immediately for the dignity and honour of the family?"[52]

2006 IOS Annual Review
Panel Report

Panel Report – 15 years on... How far have we Progressed?
Non-Disclosure
It was in our Annual Review of 1999 that the Panel Chair raised the issue of insurance companies cancelling insurance policies retrospectively after an allegation of innocent non-disclosure or misrepresentation was made. The Panel Chair report stated as follows:

> "It is noted with some concern that in an unacceptable number of cases insurers are still making very basic mistakes such as 'avoiding' policies in cases where innocent misrepresentation or non-disclosure is alleged, failing to properly consider the effect of various provisions of the Insurance Contracts Act, **particularly Sections 13 and 14 (utmost good faith),** Sections 46 and 47 (unknown defects and medical conditions), and Section 54 (breach of policy term) and purporting to cancel policies retrospectively contrary to Sections 59 and 60 of the Act." **[Emphasis added]**

Since then, the Code of Practice Secretariat has written to every member company explaining to their staff that they cannot retrospectively cancel policies except in

[52] 2006-2007 Insurance Ombudsman Annual Review, p.19

cases of fraud. We have continued to comment, sometimes stridently, in numerous determinations that this procedure is illegal and yet it still happens occasionally."[53]

Panel Report – 15 years on... How Far Have we Progressed?

Insurance and the Telephone

Frequently policyholders allege the telephone operator did not understand their employer's or their principal's product or gave false or misleading information. The problem of clear communication is compounded by the impact of the Financial Services Reform Act (FSRA) and the constraints on giving advice imposed on insurance companies and their agents. The class of agents who sell policies include banks, building societies, credit unions, travel agents, brokers who operate with the underwriting authority of companies (not necessarily binders) car dealers and estate agents.

Determination No. 24702 illustrates the problem. In this case, the applicant stated the bank's telephone operator (the bank was the member's agent) informed her that jewellery was covered except any items of over $5,000 value which was contrary to the policy terms. The applicant alleged the member's representative admitted there were problems with this agent. As the Panel said:

> "These are serious allegations to make and the Panel would expect them to be dealt with specifically by the member's representative. Whilst the member's representative did state in part of the member's submission 'no evidence of a staff error could be found', the Panel would have expected him to admit or deny the statement attributed to him by the applicant to have set out the enquiries that were made; and to have dealt specifically with the allegation made by the applicant that the agent informed her, full cover applied to jewellery valued at $5,000 or less."

In any event, the Panel noted the policy itself was difficult to follow. The Panel then went on to state:

> "The Panel thus observes the policy includes concepts such as 'Valuable items", "Special contents" and "Special valuable items" and of more concern is the reference to "Special valuable items" which does not appear until one reads the section "Paying claims". In the Panel's opinion what the member should have done to have complied with section 35 of the Act was the following:
>
> 1. It should have included significant reference in the product disclosure statement to the fact that valuable items were not in fact covered except to a sum of $2,000 or $1,250 for any one item.
>
> 2. It is important to place all these limitations in the one part of the policy and the Panel cannot understand why reference was not made to all the limitations in cover at say pages 23 and/or 24 of the policy. As stated above, it is only when the reader refers to the section of "Paying claims", the reader has ascertained there is the option of obtaining "Special valuables" cover. It would have been a very simple matter for the section of the policy contained at page 36, to which the Panel has made reference, to be placed immediately alongside the limitation of cover for valuable items contained at page 23 of the policy.

[53] IOS Annual Review, 2006 at p. 17

3. The Panel believes it is unnecessary to have a multiplicity of terms to cover valuable items and the use of the term "Valuables", "Special valuables" and "Special Contents", particularly when they are spread over different parts of the policy, makes reading of the policy more difficult."

In the circumstances, the Panel determined the dispute in favour of the applicant. The communication problem we have identified makes it necessary for insurance companies to ensure agents are trained to keep policy concepts simple, especially where policy limitations apply. They should either record telephone conversations or ensure the operators keep records of conversations. **They should make sure that policies are drafted clearly because jewellery limitations are not contained in the statutory cover.**[54] [Emphasis added]

Panel Report – 15 years on... How Far have we progressed?

Policy documentation

This result is to be contrasted with Determination No. 24004 when the applicant's son lost control of the vehicle he was driving and hit a power pole and two parked vehicles. The member denied liability to meet this claim on the grounds the collision was caused:

> "whilst the vehicle was being driven in a manner which resulted in a deliberate exposure to any wilful or reckless act, or exceptional danger."

In the police proceedings arising from the accident, the son admitted he had driven recklessly and dangerously. However, the Panel found extreme difficulty in understanding the nature and scope of the policy exclusion and in the course of the determination made the following comment:

> "It appears the exclusion requires proof of a deliberate act on the part of the driver as distinct from an error of judgement, even a significant error of judgement. It also appears this deliberate act must involve exposure to "exceptional danger". The Panel has great difficulty in understanding the phrase "deliberate exposure to any wilful or reckless act".
> The Panel cannot understand why, if the member wanted to refuse cover in circumstances where the driver of the vehicle drove recklessly, it did not, similar to other insurers, simply set out an exclusion in those terms. In the Panel's opinion the use of the language referred to above, is convoluted and almost meaningless. The terms "deliberate exposure", "exceptional danger" or "wilful or reckless act", are not defined in the policy. In the Panel's opinion, it is impossible to give meaning to the term, and in any event, it falls well short of the standard to clearly inform a policyholder of relevant terms not contained in standard cover as set out in section 35 of the Act."

It will be observed from a careful perusal of the two policy terms the insertion of the words "any wilful or reckless act" appears to have been put in the wrong place. In the latter dispute, this drafting process made a significant impact on the result of the determination.[55]

---

[54] IOS Annual Review, 2006 at p. 18-19

[55] IOS Annual Review, 2006 at p. 19-20

Panel Report – 15 years on... How Far Have we Progressed?
Policy documentation

"A related subject deals with the dichotomy between the aspirations of the marketing department and the more sober, turgid function of the policy draftsperson. This issue was raised in our Annual Review of 2000 and was revisited in Determination No. 23969. This dispute arose following a claim for a lump sum payment under a personal accident policy. The policy provided limited benefits as it only made provision for lump sum benefits payable for very serious injuries such as a 100% loss of use of a limb, paraplegia etc. The applicant claimed relief under section 35 of the Insurance Contracts Act and the Trade Practices Act on the basis the policy was misrepresented to her. Shortly before policy inception, the applicant received a brochure outlining the policy benefits and the brochure referred to the following outline of cover:

> "…. The good news is that from as little as 23 cents a day you can have complete peace of mind. Knowing that if the unexpected should occur, you'll receive a cash payment of up to $100,000 to help ease the pain of your injury. And this can be doubled to $200,000, for less than double the premium."

The applicant also received documentation which stated:

> "This Plan will pay you up to $200,000 if you are injured in an accident".

Approximately a week after the policy had been taken out, the applicant received a copy of the policy. The letter accompanying the brochure made the following statement:

> "….. With the [company] accident protection Plan you can relax, knowing that if you are ever unlucky enough to have a specified accident, you can receive a financial payment."

In considering the applicant's submission that she had been misled as to the policy benefits, the Panel took into account the member's submission that a distinction has to be made between marketing material and policy documentation and in terms of marketing, an insurance company should be given more scope in the presentation of material to a prospective policyholder. Dealing with these responses, the Panel made the following statement:

> "The Panel accepts the member's arguments that in the case of marketing materials, there will be some "puffery" in order to attract customers, such is the nature of marketing. This is particularly so in the case of advertising material which is of an introductory or preliminary nature. However, in this instance, the member was marketing a policy which did not include standard cover and the brochure was intended not to whet the appetite of the individual but rather to explain the policy benefits. In other words, it was a direct offer to purchase insurance rather than a preliminary advertisement. A distinction can be drawn between inflating the benefits of a policy and misleading a customer about what the actual terms of that policy are...
>
> The Panel found the documents presented to the applicant did not satisfy the provisions of section 35 of the Act and therefore the policy provided to the

applicant was replaced by the statutory policy which provided cover in the circumstances within the applicant's claim."[56]

Panel Report – 15 years on... How Far Have we Progressed?
Travel Insurance

We first raised issues in relation to this segment of the industry many years ago. Travel insurance has been the subject of comment in our Annual Reviews in 2002 and 2003. The number of travel-related disputes is disproportionate to the percentage of policies issued.

In our view there are a number of reasons for this phenomenon.

1. Travel insurance is sold without any consistent underwriting processes. It appears to us the only underwriting that occurs is that individuals may be asked if they have any pre-existing medical condition, the definitions of which vary considerably from policy to policy.

2. The insurance policies are sold in the circumstances where the policyholders' preoccupations are in other directions as they have just collected their hotel vouchers and airline tickets and the concept of insurance, is more of an irritation to be endured,
rather than a significant contract of enormous potential.

3. Many travel policies are not well designed or user friendly and may contain surprising or devastating exclusions in unlikely places e.g. unattended luggage exclusions which, in many instances, exclude cover unless the luggage is strapped to your arms or legs or both.

4. The drafting of many travel insurance policies in our view is mediocre. The definitions of pre-existing medical conditions are a catalyst for a rich amount of debate and analysis by IOS decision-makers which the following example reveals.

In Determination No. 23662, the dispute contained a claim for benefits under a travel policy brought by an 83-year-old man when his overseas trip was cancelled after he was informed in May 2005, he required coronary by-pass surgery. The member denied the claim on the basis that it arose out of a pre-existing medical condition. The Panel noted particularly the policy was specifically designed for persons aged between 70
and 84. The applicant's medical history revealed that 19 years previously i.e. in 1986, he saw a cardiologist and subsequently an angioplasty was performed on 3 June 1986. Regular tests were conducted until January 1989 when the applicant again underwent
angioplasty. For the next 16 years, the applicant had no heart symptoms despite regular medical checking although he had been taking preventative medication to decrease the potential for blood clotting and to keep his blood pressure low. He had apparently led an active and healthy life over this period. The member relied on a policy exclusion for a pre-existing medical condition which was relevantly defined as "any chronic or ongoing
medical condition". In the circumstances, the Panel concluded the member had not established the policy exclusion.

[56] IOS Annual Review, 2006 at p. 20-21

The Panel stated:
"In the Panel's opinion, it would be well known to the member's underwriters, as it is to the majority of members of the public, that the great majority of persons aged between 70 and 84 years, and certainly aged 83 years and eight months, would be in less than perfect health. When an insurer chooses to provide travel insurance to the "mature agedtraveller", it must inevitably follow, that the
member's underwriters are dealing with a section of the population, that are less likely to be in excellent health than persons 40 or 50 years younger.

This view is reinforced by the definition of "existing medical condition" contained in the policy which makes specific reference to the fact "hypertension
alone, controlled by medication is not considered an existing health disorder" (see page 8 of the policy.)."[57]

2005 IOS Annual Review
Panel Report
The Policy Terms
Now we come to the substantive terms of the policy, many of which are not in the policy document. For example, they may be found in the policy schedule or the policy certificate or in a separate letter providing special policy terms, or in a brochure or a PDS, which may or may not be part of the actual policy, or in a derogation notice (which, sadly, we do not see many of these days).

In some instances, part of the policy term might be in the policy, and another part may be in the schedule or the certificate. In these circumstances, it is important the documents speak to one another.

This problem arose in Determination No. 20276 when the Panel had to consider whether the insurer had met its obligations to clearly convey a crucial limitation of cover – namely that it only covered drivers 30 years and over. The applicant brought a claim for damage to her motor vehicle when it was involved in an accident while being driven by her 20-year-old daughter. At the
time when she took out the policy, there were no persons likely to drive the vehicle who were under the age of 30. However, subsequent to that time, her daughter obtained her licence and the applicant allowed her to drive the vehicle on the day of the accident. The policy schedule provided by the insurer at the time of policy inception included the following:

"Comprehensive cover – provides cover for:
• Certain optional covers (where agreed) such as rental or loan car
following an accident, removal of basic excess for windscreen claims, protected no claim bonus and restricted driver cover.

Note that the restricted driver option provides a discounted premium, but limits the drivers who are covered under the policy."

It then set out a number of policy excesses including:
"Inexperienced Driver Excess $600

[57] IOS Annual Review, 2006 at p. 20-21

Undeclared Young Driver Excess $900"

The inexperienced driver excess was said to apply to drivers over the age of 25 who had held their Australian driver licence for less than two years and the undeclared young driver's excess applied to drivers under the age of 25 years not listed on the policy schedule.

The applicant, not surprisingly, on reading this document thought her daughter was covered although she expected to pay an additional excess.

However, the policy document provided something else which the applicant said she did not expect. On page 11 of the policy, under the heading "Restricted Drivers", the following appeared:

> "When the current schedule shows that the restricted driver option applies, we will not cover any accidental loss, damage or liability, which results in a claim, when the driver of your vehicle was a person under 30 years of age."

The product disclosure statement contained in the introduction to the policy document provided no such exclusion, although it did state:

> "Note that the restricted driver option provides a discounted premium, but limits the drivers who are covered under the policy."

The policy contained an index which includes "Words with Special Meanings" on page 4, and while there were two types of driver descriptions in this section of the policy and a special meaning was given to them, there was no definition therein of the word "restricted driver". In the course of its determination, the Panel made the following comments:

> "... an insurer must take great care to make sure its procedures for selling the policy and the documentation it produces thereafter is expressed in the clearest possible terms.
>
> After all, the obligation is to act with the utmost good faith, not simply good faith, which is a heavy onus in this context on an insurer;" [Emphasis added]

The fundamental principle relevant to all insurance disputation on which all parties agree is that no-one ever reads the policy before a claim is made. This is always how it has been and probably will be. Most people read mortgage documents, loan agreements, leases, contracts for the purchase of motor vehicles, even rate notices, but they will not, or maybe cannot, read an insurance policy."[58]

2004 IOS Annual Review

Panel Report

[Referring to 4 determinations before the Panel Chair in travel insurance, motor vehicle insurance, landlord insurance and total and permanent disability, which are outlined in Insurance Law Service submission[59] to the Senate Inquiry]

---

[58] 2005 Insurance Ombudsman Service Review, Addendum at pp 3 - 4

[59] Insurance Law Service Submission to Senate Inquiry into Australian Consumer Law Bill (2009),p 3-4

In his report, the Panel Chair, Peter Hardham, illustrated a number of instances where the Panel has made decisions which, whilst legally correct, may be viewed as unfair or harsh. This raises the question as to whether there is more law than justice in some areas of insurance law and practice. In other words, does the law produce results which the community might regard as providing an unjust result?[60]

2003 IOS Annual Review
Claims Review Panel Report – The Illusory Nature of Cover
[The Panel referred to Determination 15669 in respect of a home and contents policy, an insurer rejected a claim for damage caused by leaking pipes on the basis of an exclusion clause which broadly defined damage to include "no matter how caused". The issue was that earth movement will in such circumstances occur and that movement may be caught by such a broad exclusion.]

The point we want to make in dealing with this dispute 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 the the circumstances covered by a policy exclusion, particularly where the policy exclusion is in a separate part of the policy.[61]

1999 IEC Annual Review
Claims Panel Review Report
Of course there are many different definitions of flood, some narrow and some wide. In one instance the Panel was dealing with a policy where flood was defined as including water that escaped not only from a natural or artifical watercourse, it also included water discharged from sewerage systems by the general pressure induced by floodwater, and to our surprise, it also included "general run-off that comes from any area outside the building. [62]

1998 IEC Annual Review
Claims Panel Review Report
'Unusual Provisions'
[The Claims Review Panel considered various examples in insurance contracts of unusual provisions and noted that insurers had failed to comply with their obligations to advise insureds of unusual terms in their policies under s 35 and s 37.]

In Determination D, the Panel had to consider a claim under a policy that provided 'we will not pay for any loss by theft unless there is forcible entry to your building'. This was not an unusual clause, but what caused the problem was the expression 'forcible entry' was specially defined in the policy to mean 'Forcible entry means the unauthorised forced entry of your building which causes **physical damage to your building at the point of entry**. This definition imposed a much wider meaning to the term 'forcible entry' as imposed by the Courts and constituted a much wider exclusion than that contained in Standard Cover.[63] **[Panel's emphasis]**

1993 IEC Annual Review
Travel Insurance – case study

---

[60] 2004 Insurance Ombudsman Service Annual Review, p.25
[61] 2003 Insurance Ombudsman Annual Review, p.28-29
[62] 1999 Insurance and Enquiries and Complaints Ltd p.9
[63] 1998 Insurance and Enquiries and Complaints Ltd, p. 9

Ms F returned home from overseas to be at her mother's sick-bed. She thought that she was covered for the cost to resume her trip but found that because more than 50% of the trip had elapsed, she was not. The policy wording made this clear but the promotional part of the brochure – where the benefits are highlighted – described the benefits to include 'Free flight return overseas to continue your journey if disrupted. The qualification was made, but not in an equally prominent fashion.[64]

[64] 1993 Insurance and Enquiries and Complaints Ltd, p. 10