THOMSON GEER
LAWYERS

Superannuation Case Law Update

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Contents

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Thomson Geer thanks Scott Charaneka (Head of Superannuation and Wealth Management), Stanley Drummond (Adjunct Head of Superannuation and Wealth Management), Ben Grant (Senior Associate), Tina McDill (Lawyer), Emma Brooker (Lawyer) and Sammia Rebecca Jensen (Graduate Lawyer) who all provided invaluable assistance in preparing this paper.

1. Pension payments from foreign fund – no exemption from taxation – *Macoun v Commissioner of Taxation* [2015] HCA 44

The High Court (French CJ, Bell, Gageler, Nettle and Gordon JJ) has unanimously held that a former officer of the International Bank for Reconstruction and Development (the IBRD) was not entitled to an exemption from taxation in respect of monthly pension payments he had received. The case is *Macoun v Commissioner of Taxation* [2015] HCA 44.

Legislative framework

Section 6(1)(d)(i) of the *International Organisations (Privileges and Immunities) Act 1963* (Cth) (the IOPI Act) and regulation 8(1) of the *Specialized Agencies (Privileges and Immunities) Regulations* (Cth) (the SAPI Regulations) confer upon a person who holds an office in an international organisation to which the IOPI Act applies an exemption from taxation on salaries and emoluments received from the organisation. The exemption is set out in Item 2 of Part 1 of the Fourth Schedule to the IOPI Act.

The IBRD is an international organisation to which the IOPI Act applies.

Background

Mr Macoun, a former sanitary engineer with the IBRD, received monthly pension payments from a Retirement Fund established under the IBRD's Staff Retirement Plan in the 2009 and 2010 income years, when he no longer held an office in the IBRD. The Commissioner of Taxation included the monthly pension payments in Mr Macoun's assessable income for the 2009 and 2010 income years.

Mr Macoun sought review of the Commissioner's decision in the Administrative Appeals Tribunal (the AAT).

The AAT's decision

The AAT set aside the decision and substituted the decision that the monthly pension payments did not form part of Mr Macoun's assessable income and were exempt from Australian income tax. The Commissioner appealed to the Full Federal Court.

The Full Federal Court's decision

The Full Court allowed the Commissioner's appeal, holding that regulation 8(1) of the SAPI Regulations confined the privileges specified in Part 1 of the Fourth Schedule to the IOPI Act to persons currently holding an office in an international organisation to which the IOPI Act applied. As Mr Macoun did not hold such an office in the IBRD in the 2009 and 2010 income years, the exemption from taxation was not available to him.

By grant of special leave, Mr Macoun appealed to the High Court.

The High Court's decision

The High Court unanimously dismissed Mr Macoun's appeal.

The High Court held that Mr Macoun was not entitled to an exemption from taxation for the relevant part of his monthly pension payments because he had ceased to hold an office in the IBRD when he received them, and because he received them from the Retirement Fund established under the Staff Retirement Plan rather than from the IBRD. The High Court also held that Mr Macoun's monthly pension payments did not fall within the phrase "salaries and emoluments" in Item 2 of Part 1 of the Fourth Schedule to the IOPI Act, and that Australia's international obligations did not require Australia to exempt the monthly pension payments from taxation.

2. No duty to investigate TPD claim, but must give reasons for denial – *Ziogos v FSS Trustee Corporation* [2015] NSWSC 1385

In allowing a claim by a member of a superannuation scheme for a total and permanent disablement (TPD) benefit, the Supreme Court of NSW (Ball J) said that the insurer's duty of utmost good faith did not require it to undertake its own investigations of the claim. However, that duty did require the insurer to give reasons for its denial of the claim. The case is *Ziogos v FSS Trustee Corporation* [2015] NSWSC 1385.

Background

The trustee of a superannuation scheme held 2 insurance policies that provided TPD cover in respect of members of the scheme. The definitions of TPD in the policies included the following wording (emphasis added) (at [63]):

> … the Insured Member having been absent from their Occupation with the Employer through injury or illness for six consecutive months and having provided *proof to our satisfaction* that the Insured Member has become incapacitated to such an extent as to render the Insured Member *unlikely ever* to engage in any gainful profession, trade or occupation for which the Insured Member is reasonably qualified by reason of the education, training or experience.

A member of the scheme was employed by the NSW Police Force. While a police officer, she was exposed to a number of very stressful situations. These included a case where a baby had died, a case where an 18 year old male had been found hanging in a shower, a case where an intoxicated male with a sword had chased her, many other cases in which a person had died, sometimes as a result of a serious accident, and cases where she had been required to inform a family of the death of a family member.

From about 2006 the member began to feel

nauseous prior to going to work, and had difficulties sleeping the night before. These symptoms persisted for the next 4 years.

In 2010 the member saw Dr Smith, a psychiatrist, who gave her a workers' compensation certificate and placed her on restricted duties. The member returned to work the following day. However, she suffered further anxiety attacks and was given a workers' compensation certificate for one week off work. She was also referred to a clinical psychologist. She never returned to work.

Dr Smith diagnosed the member as suffering from a chronic adjustment disorder with depressed and anxious mood and also significant symptoms of post-traumatic stress disorder. He continued to see the member about once every 6 weeks.

In 2011 the member lodged a TPD claim with the trustee. She claimed to be suffering from post-traumatic stress disorder, anxiety and depression as a result of her work in the police force. Her claim was supported by standard forms completed by Dr Smith and another doctor. One section of the form was headed "Report on permanent incapacity" and had a number of subheadings. Under the subheading "Any current incapacity for which you have treated this member", Dr Smith wrote "Chronic PTSD [ie post-traumatic stress disorder]". Under the heading "Present Diagnosis" Dr Smith wrote "Chronic PTSD anxiety/depression". Under the heading "Any other comments" he wrote "Not able to work"(at [4] and [16]).

The trustee lodged the claim with the insurer, who investigated the claim. The insurer arranged for the member to see Dr De Saxe, a psychiatrist, and Mr Anderson, a psychologist. The insurer also arranged surveillance of the member.

In 2013 the insurer wrote to the trustee denying the claim. In this letter the insurer summarised the medical reports it had obtained and then expressed its conclusions. The letter read in part (at 56):

> We are of the opinion that the Dr De Saxe and Mr Anderson reports and surveillance supports [the member] to have a work capacity and note that they both were of the opinion that [the member] had the capacity to work 20 hours per week. It was also noted in the medical reports that [the member] informed that she rarely left the home and when she did she needed company. The surveillance showed [the member] was capable of attending shops and driving while on her own.
>
> …
>
> When considering TPD, the question of "unlikely ever" allows [the insurer] to take into consideration the likelihood of [the member] returning to any occupation for which she is suited. In [the member's] case her current age of 37 is a factor relevant to the circumstances of the claim and where [the member] has an effective 28 years before a normal retirement age of 65, we consider that it is more likely than not that she will return to gainful employment.
>
> …
>
> The medical evidence points to the Complainant having transferable skills and experience, and a number of the medical reports before the Tribunal suggest that as the Complainant's condition is slowly improving, it is likely that she will eventually return to work, albeit not in the Police Service".
>
> [Thomson Geer note: This paragraph suggests that prior to commencing proceedings, the member had made a complaint to the Superannuation Complaints Tribunal. However, this is not clear from the judgment.]
>
> **Conclusion**
>
> Our view is that there is sufficient evidence to show that [the member] has a capacity to work in either a full time or part time capacity, in a gainful occupation for which she is suited by education, training or experience.

The insurer's decision was communicated to the member. At the member's request, the insurer's decision was reviewed by a claims review committee that had been established in accordance with the 2 insurance policies. The committee decided that the insurer's decision to deny the claim was correct. The member was notified of the committee's decision.

The proceedings

In 2014 the member commenced proceedings in the Supreme Court of NSW against the trustee and the insurer. She later filed an amended statement of claim abandoning her substantive claims against the trustee, and the trustee filed a submitting appearance.

The court's decision

The court noted that in denying the claim, the insurer had relied on the conclusion that the member had "a capacity to work in either a full time or part time capacity". The insurer also relied on the video surveillance and on the member's age (at [97]).

The court held, however, that the insurer could not reasonably have reached the conclusion that the member had a capacity to work in either a full time or part time capacity on the evidence available to it. The court said (at [99]):

> In my opinion, it could not reasonably be inferred from the evidence available to it that [the member] had the capacity to work in either a full-time or part-time capacity. The only person who arguably expressed that opinion was Dr De Saxe. However, … [Dr] De Saxe's position remained equivocal despite the fact that he was given an opportunity to clarify it and it was contradicted by the opinions given by Dr Smith and Mr Anderson ... In my opinion, in the face of the opinions expressed by Dr Smith and Mr Anderson, and the equivocal nature of the opinion expressed by Dr De Saxe, it was unreasonable for [the insurer] to conclude that [the member] had the capacity to work in either a full-time or part-time capacity. That is particularly

> so where that conclusion was inconsistent with the conclusion reached by [the member's] treating psychiatrist and no reason was advanced for rejecting that conclusion.

Nor was it reasonable for the insurer to conclude on the material before it that the member had the capacity to return to work at some time in the future. That conclusion had been based on the opinions of Dr De Saxe and Mr Anderson, the member's age and the video surveillance. As for the member's age, Mr Anderson's opinions did not appear to relate to any specific attributes of the member and her symptoms. Rather, they were "expressions of general hope and expectation" that could be stated in relation to anyone suffering from post-traumatic stress disorder. Similarly, although the member's age may have been a relevant factor when taken together with other factors, to the extent that the insurer formed the view that at some time the member would be able to return to work because she had so many working years left of her life, it was confusing what was possible with what was likely and unlikely (at [101]-[102]).

It was also unreasonable for the insurer to place weight on the video surveillance. That surveillance indicated that the member was capable of undertaking the activities she was filmed undertaking. However, those activities bore no relationship to the activities that she would be required to undertake in employment.

The court held that the insurer had not acted reasonably or with the utmost good faith in reaching the conclusion that it did. In denying the member's claims, the insurer had breached the policies. Consistently with the authorities, it was a question for the court whether the member was TPD

The court was satisfied that the member had discharged the onus of establishing that she was unlikely ever to engage in any gainful profession, trade or occupation for which she was reasonably qualified by reason of her education, training or experience. She was TPD within the meaning of the policies.

The duty of utmost good faith

In the course of its judgment, the court made a number of important observations about the insurer's duty of utmost good faith, that would appear to have broader application.

First, the insurer's duty of utmost good faith does not require it to actively investigate claims. Rather, the member has an evidentiary burden of putting material before the insurer so that the insurer can be satisfied that the member is TPD. The court explained the matter in this way (emphasis added) (at [77]):

> In written submissions, [the insurer] contended that the effect of the requirement that the insured person provide proof was to place the onus of proof on the insured person. [The member] took issue with that proposition. However, the dispute in relation to this issue is more apparent than real. [The insurer's] submission, at least as finally put, was that [the member] bore the onus of bringing forward sufficient material that satisfied [the insurer] that the required state of affairs existed. As Stevenson J pointed out in *Shuetrim v FSS Trustee Corporation* [2015] NSWSC 464 at [43]ff (a case relied on by [the insurer]), the effect of that requirement might be described as placing an evidential burden on the insured person. However, at the time an insured person makes a claim under a policy, there are no proceedings on foot between the parties; and there can be no question of one party or the other bearing the onus of proof. Rather*, [the insurer] had to be satisfied of a certain state of affairs; and it was up to [the member] to put material before it that brought about that state of satisfaction. Having regard to the terms of the policy, [the insurer] was not required by the duty of utmost good faith to undertake its own investigations*.

In our view, the statement in this passage that the duty of utmost good faith does not require the insurer to investigate claims is consistent with the following passage of Young AJ in the earlier case of *Chapman v United Super Pty Ltd* [2013] NSWSC 592 at [52]:

> … I am not the person who decides whether the [member] is totally and permanently disabled. The Trust Deed gives that decision to the Trustee and the Insurer. When considering that decision it is important to remember that the plaintiff clearly bears the onus of proving the loss is covered by the terms of the policy: Petersen v Union des *Assurances de Paris IARD* (1995) 8 ANZ Ins Cas 61-244 and that the Insurer is entitled to put the claimant to strict proof: *Regina Fur Co Ltd v Bossom* [1958] 2 Lloyd's Rep 425. Although these propositions may have to be stated with less certainty after the High Court's decision in *Finch v Telstra Super Pty Ltd* [2010] HCA 36; (2010) 242 CLR 254; (2010) 271 ALR 236, they remain basically true for the instant case.

Second, the duty of utmost good faith requires the insurer to give the member a reasonable opportunity to bring forward material in support of their claim. In some circumstances, the duty may even require the insurer to go further and point out areas of deficiency in the member's claim. The court said (emphasis added)(at [78]):

> If the onus was on [the member] to bring forward adequate material, then an obligation on [the insurer] arising from the duty of utmost good faith was to give her a reasonable opportunity to do so. *Moreover, in some circumstances, the duty may go beyond that. If, for example, an unrepresented claimant failed to put forward sufficient material to enable [the insurer] to address the substantive issues that it was required to address (that is, whether the claimant suffered from TPD) then, in my opinion, the duty of utmost good faith would require it to say so and to give the claimant an opportunity to put forward additional material.*

Third, the court restated the well-known principle,

endorsed by the NSW Court of Appeal in *Hannover Life Re of Australasia Ltd v Sayseng* [2005] NSWCA 214 at [85], that the duty of utmost good faith requires the insurer to give the insured person a reasonable opportunity to comment on material that the insurer has obtained that is adverse to the insured person's claim. (This principle is commonly referred to in the insurance industry as "procedural fairness".)

Fourth, where a member's claim depends on the insurer forming an opinion or reaching a state of satisfaction about a matter, the duty of utmost good faith requires the insurer to give reasons for its decision, to that the member can be satisfied that the decision was reached in the utmost good faith. The court said (at [75]):

> In my opinion … [the insurer] was also required by its duty of utmost good faith to give reasons for its decision. It is only by examining those reasons that it is possible to determine whether it acted with the utmost good faith in forming the opinion it was required to form. To put the point another way, where an insured person's rights depend not on the objective fact (whether or not the insured suffered from TPD) but on the insurer's opinion concerning that question, the requirement of utmost good faith requires the insurer to explain how it reached the decision it did so that the insured person can be satisfied that the decision itself was reached in the utmost good faith.

Other points

The court also made several other points about TPD claims.

First, the date for assessment of the member's condition is the date when the insurer actually makes its decision, although in this case the choice of date was not material. (This view contrasts with the more widely supported view that the date for assessment of a member's TPD claim is the time when the member first suffers from TPD in accordance with the trust deed and the policy. On this more supported view, where there is a qualifying period (usually 6 months) the date for assessment is at the end of that period.)

Second, following *White v Board of Trustees* [1997] 2 Qd R 659 at 673 per White J, the word "unlikely" in the definition of TPD means "improbable" in the sense of there being less than a 50% chance. However, the test is not a purely statistical one. The court said (at [83]):

> Although one helpful way of giving meaning to the word "unlikely" is to say that it requires a less than 50 per cent chance, it should not be inferred from that that the test is a statistical one. The test is not concerned with what is likely in the population as a whole, but rather whether having regard to what was known about [the member], it was unlikely that she would ever be able to engage in any gainful profession, trade or occupation for which she is reasonably qualified by reason of her education, training or experience.

Third, following *Halloran v Harwood Nominees Pty Ltd* [2007] NSWSC 913 at [76] and other cases, the issue for the insurer is whether it is unlikely that the member will actually obtain paid employment for which they qualified by education, training or experience. The question is not whether *in theory* they might obtain employment of that type.

The result

In the result, the court held that the member was TPD within the meaning of the policies. The parties were directed to bring in short minutes of order to give effect to the judgment.

Take away points

Three key take away points concerning an insurer's duty of utmost good faith emerge from this judgment.

First, an insurer's duty of utmost good faith does not require it to actively investigate claims. Rather, the member has an evidentiary burden of putting material before the insurer so that the insurer can be satisfied that the member is TPD.

Second, the duty of utmost good faith requires the insurer to give the member a reasonable opportunity to bring forward material in support of their claim. In some circumstances, the duty may even require the insurer to go further and point out areas of deficiency in the member's claim.

Finally, where a member's claim depends on the insurer forming an opinion or reaching a state of satisfaction about a matter, the duty of utmost good faith requires the insurer to give reasons for its decision, to that the member can be satisfied that the decision was reached in the utmost good faith.

3. TPD claim – date for assessment – *Harrison v Retail Employees Superannuation Pty Limited* [2015] NSWSC 1665

In allowing a claim by a member of a superannuation fund for a total and permanent disablement (TPD) benefit, the Supreme Court of NSW (Lindsay J) has taken as the date for assessment of disablement the date "that, medically, [the member became] disabled, because of sickness or injury, from being likely ever to engage in any reasonably suitable occupation". In this case, that date was some months before the member actually went off work – that is, he "soldiered on" for a while. The case is *Harrison v Retail Employees Superannuation Pty Limited* [2015] NSWSC 1665.

Background

The trustee of a superannuation fund held a group insurance policy that provided TPD cover in respect of members of the fund. The definition of TPD in the policy read in part:

> disablement where we [ie, the insurer] are satisfied on medical or other evidence that an *insured member*:
>
> (a) (i) has been absent from employment for 6 consecutive months because of sickness or injury; and
>
> (ii) is so disabled at the start of those 6 months and continuously since that time that the *insured member* is unlikely to ever engage in any reasonably suitable occupation …

"Insured member" was defined as including "deemed members". Briefly stated, a "deemed member" was defined as a person for whom the trustee had not received an application for membership of the fund, and whom the trustee had set up on its systems as a deemed member. "Application" was in turn defined as an application for membership of the fund on a form issued by the trustee "offering an insurance election".

The policy provided that, in the case of a deemed member, cover under the policy ended 12 months after the trustee received the first mandatory employer contribution in respect of that member, if the trustee had not within that 12 months received an application for membership by the member.

In 2000 the claimant joined the fund as a deemed member. The first mandatory employer contribution in respect of the claimant was received on 5 June 2000.

The claimant was not made aware that for his cover to continue, he had to complete an application for membership of the fund. The claimant did not complete an application, and (as the court held) his cover ceased on 5 June 2001, being 12 months after receipt of the first mandatory employer contribution.

The court noted that medical evidence identified 1 April 2001 as the date upon which the claimant became permanently incapable of gainful employment for which he was reasonably qualified by education, training or experience. (The nature of the claimant's disablement was not specified in the judgment.) There was no medical evidence to the contrary. The claimant "soldiered on", attending work until, having given due notice to his employer, his employment was terminated on 6 November 2001.

In 2010 (some 9 years later) the member lodged a TPD claim. The insurer denied the claim.

The proceedings

The member commenced proceedings in the Supreme Court of New South Wales against the trustee and the insurer. The trustee initially filed a defence, but later filed a submitting appearance.

The court's decision

The date for assessment

The court said that there were 4 potential dates on which "disablement" could be said to have occurred for the purpose of the policy:

- *date 1* – "at the time that, medically, an insured member becomes disabled, because of sickness or injury, from being likely ever to engage in any reasonably suitable occupation". Here, on the uncontested medical evidence, this date was 1 April 2001 (which was before the claimant's cover ceased). The claimant contended for this date;
- *date 2* – "at the time that the insured member's disablement manifested itself in an absence from employment that could, ultimately, be seen as the commencement of a continuous period of six months absence from employment". Here, this date was agreed to be 6 November 2001 or thereabouts (which was after the claimant's cover had ceased);
- *date 3* – "at the end of the six month period of absence from employment". Here, this date was agreed to be 6 May 2002 or thereabouts. The insurer contended for this date; and
- *date 4* – "at the time that [the insurer] was 'satisfied', or ought to have been 'satisfied', that the insured member has been absent from employment for six consecutive months (because of sickness or injury) and is so disabled throughout that time that he or she is unlikely ever to engage in any reasonably suitable occupation".

As mentioned above, the claimant contended for date 1, ie he became TPD in the sense that he was unlikely ever to return to any form of work for which he was suited on 1 April 2001 and that, having attained that level, the only impediment to his entitlement to a TPD benefit was that he could not apply for a TPD benefit until he had been off work for 6 consecutive months. That possibility, read with the purpose of the definition, would, in some if not all cases, render the definition "self-defeating".

The insurer contended for date 3, ie the end of the six month qualifying period. The court considered this interpretation to be problematic in that the end of a six months absence from employment would "be likely, in some if not all cases, to have occurred outside an insured member's period of employment and therefore, quite possibly, outside the period of any available insurance cover".

The court said that the choice of date for assessment came down to a choice between dates 1 and 2, in the following terms:

> When one has regard to the purpose of the policy (provision of insurance), and the purpose of the definition (identification of an insured event), the choice to be made, in construction of the definition of "total and permanent disablement", is between the first two time perspectives.

The court opted for date 1, saying:

> In my opinion, the first time perspective (that which favours the date 1 April 2001) is to be preferred. The requirement for a six months absence from employment is essentially an adjectival (administrative or evidentiary) requirement, not one that controls the meaning of the substantive concept of "disablement". The grant of insurance cover by reference to "disablement" cannot be derogated from by machinery provisions directed towards an assessment whether or not there has been "disablement".

The choice of date 1 as the date for assessment meant that the claimant was entitled to the TPD benefit.

Section 54 of the Insurance Contracts Act

In the alternative to his primary argument that 1 April 2001 was the correct date for assessment, the claimant also relied on sections 14 and 54 of the *Insurance Contracts Act 1984* (Cth).

The court's approach to section 54 is of particular interest. (The court said that the claimant's invocation of s 14 involved no more than a reformulation of his section 54 argument.)

Briefly stated, section 54 may affect an insurer's right to refuse to pay a claim where the contract of insurance permits the insurer to refuse to pay a claim, either in whole or in part, because the insured or some other person has done some act, or omitted to do some act, after the contract was entered into.

Here, the member contended that:

- the policy issued by the insurer was a group policy that was current at all material times;
- the "act (or omission) of the insured or some other person" that occurred, after the issue of the policy, that engaged the operation of s 54 was the trustee's failure to procure from him an application for ongoing cover for submission to the insurer; and
- as the policy was an ongoing group policy, the insurer could not be said to have suffered any prejudice as a result of that omission.

The insurer contended that as the policy was an occurrence based policy, an inherent restriction of which is that a claimant must identify an insured event occurring within the policy period, neither section 14 nor section 54 provided any assistance to this claimant. Rather, this claim depended entirely upon whether he could establish that he became TPD during the period he was covered as a deemed member of the fund.

The court decided, *obiter*, that section 54 assisted the claimant. The court said:

> In my opinion, if (contrary to my finding) the [claimant] became TPD on or about 6 November 2001 (in circumstances in which, for want of an "application", the [claimant's] cover ceased on 5 June 2001) s 54 would operate to preclude the [insurer] from refusing to pay the [claimant's] claim by reason only of the want of an "application".

Among its reasons for reaching this conclusion, the court said:

> (e) this case is distinguishable from another form of occurrence based policy in respect of which:
>
> (i) a claim is made in relation to an event which occurred outside *a period of cover fixed at the time the policy was issued*, involving no act or omission which, occurring after issue of the policy, affected the period of cover; and
>
> (ii) the policy had expired *by effluxion of time, according to its terms*, without any act or omission post-dating entry into the policy.

The result

In the result, the court held that the claimant had become TPD on 1 April 2001 (ie on date 1, which was before his cover ceased) and that he was entitled to recover the TPD benefit.

Comments

The date for assessment

The correct date for assessment of disablement always depends in the first instance on the particular policy wording.

Subject to this, prior to *Harrison* the weight of judicial opinion supported date 3 (ie the end of the qualifying period) – which is the date the insurer contended for in *Harrison*.

There has also been a lesser level of judicial support for date 4 (ie, the date when the insurer or trustee actually makes their assessment).

Given the level of interest in the question of the correct date for assessment of disablement, it is perhaps curious that in *Harrison* Lindsay J opted for date 1 without any reference to, or discussion of, previous authority on the question.

The law in this area is unsettled, and is clearly unsatisfactory. A particular risk for superannuation trustees and fund members is that where there are successive insurance policies providing TPD cover, the two insurers may assert competing dates for assessment, and both deny liability on that basis.

Section 54 of the Insurance Contracts Act

Section 54 *of the Insurance Contracts Act* is the subject of a large body of case law.

The conventional view among insurance lawyers is that s 54 cannot assist a person whose "omission" is a failure to take out an insurance policy, or a failure to vary the terms of an insurance policy.

This view draws considerable support from the judgments of Walsh J (at first instance) and the Full Court of the Supreme Court of Western Australia (Kennedy, Owen and Steytler JJ) in *Kelly v New Zealand Insurance Co Ltd:* (1993) 7 ANZ Ins Cas 61-197; on appeal (1996) 130 FLR 97; (1996) 9 ANZ Ins Cas 61-317.

In *Harrison*, the approach taken to the concept of an "omission" for the purposes of section 54 seems both novel and inconsistent with *Kelly*. Taken to its extreme, on the *Harrison* approach section 54 may assist a member of a superannuation fund whose "omission" is a failure to apply for additional units of death and TPD cover, or a failure (in the case of a member who is not a MySuper member) to apply for any units of cover at all.

Take away points

This decision in *Harrison* has created uncertainty in two areas. First, contrary to the weight of judicial opinion, the court did not choose the end of the qualifying period as the date for assessment of disablement, but rather a date that was some months before the claimant actually went off work. Second, the court applied section 54 of the *Insurance Contracts Act* in a way that seems novel, by treating the want of an application that would have extended the insurance cover as an "omission" for the purposes of that section.

4. TPD claim – takeover terms – *Mehmet v IOOF Investment Management Ltd* [2015] NSWSC 1914

In remitting a claim by a member of a superannuation fund for a total and permanent disablement (TPD) claim to the insurer and the trustee for reconsideration, the New South Wales Supreme Court (Stevenson J) has considered the takeover terms in the insurance policy. The case is *Mehmet v IOOF Investment Management Ltd* [2015] NSWSC 1914.

Background

In 2001 the member suffered an injury.

In 2002 he joined the fund. At that time the fund's insurer was Hannover Life Re of Australasia Ltd (Hannover).

On 1 July 2003 Hannover was replaced by Lumley Life Ltd (Lumley) as the fund's insurer.

In 2007 Lumley was replace by TAL Life Limited (TAL) (apparently by way of a Part 9 transfer under the *Life Insurance Act 1995* (Cth)).

Both the Lumley and TAL policies provided for a continuation of the cover provided to fund members pursuant to "Takeover Terms". The Takeover Terms were set out in clauses 3.23 and 3.24 of the TAL policy as follows:

> 3.23 We agree to provide cover under this policy without requiring evidence of good health for groups of five (5) or more members with existing group life cover on the following conditions:
>
> (a) The cover under this policy wholly replaces the previous insurance policy cover; and
>
> (b) The takeover is limited to the level of cover and type of benefit provided under the previous policy; and

(c) Transfer cover is limited to the Standard Total and Permanent Disablement definition; and

(d) We receive written confirmation from the previous insurer of the acceptance terms applicable to the transferring Insured Persons; and

(e) The cover is current and in force at the date of transfer to [TAL].

3.24 The terms for the transfer of such cover shall be in accordance with the industry guidance note current at the time of takeover (currently IFSA [ie the Investment and Financial Services Association] Guidance Note No. 11) or such other terms as agreed by [TAL] in writing at the time, but in any event [TAL] will ensure that no member loses the cover that had been applicable at the time of that transfer as a result of the transfer.

On 11 February 2010 the New South Wales Workers Compensation Commission awarded the member workers' compensation for the entire period from 8 May 2001 to 9 February 2010.

In 2011 the member lodged a TPD claim in respect of the injury he had suffered in 2001.

In 2013 and 2014, on a total of 4 occasions, TAL denied the claim.

In 2013 the member commenced proceedings in the Supreme Court of New South Wales against the trustee and TAL.

TAL's contentions

TAL contended that:

- the terms of the transfer of the member's TPD cover from Hannover to Lumley, and thus to TAL, were to be determined by reference to IFSA Guidance Note 11;
- the Guidance Note provided that:
    - the incoming insurer would provide TPD cover to insured members who were "at work" on the relevant date (agreed to be the business day before Lumley took over cover; 30 June 2003, as Lumley took over cover on 1 July 2003);
    - insured members who were not "at work" on the relevant date due to sickness or injury would only be provided "new events cover";
    - a member is not "at work" if, relevantly, the member was "entitled to claim … workers' compensation benefits" on that date; and
    - "new events cover" excludes cover for any medical condition which caused the member to be "not at work" on the relevant date, and thus for the medical condition which gave rise to the entitlement to workers compensation;
- on 11 February 2010 the New South Wales Workers Compensation Commission awarded the member workers' compensation for the entire period from 8 May 2001 to 9 February 2010;
- the member must therefore have been "entitled to" workers compensation benefits on 30 June 2003;
- the member was therefore "not at work" for the purposes of the IFSA Guidance Note; and
- the member was thus only entitled to "new events cover" and not to cover for the medical condition which caused him to be "not at work"; and therefore not to a TPD benefit arising from his 12 March 2001 injury.

The court's decision

In rejecting TAL's argument, the court referred to clause 3.24 of the policy (set out above), which effectively overrode the IFSA Guidance Note. The court said:

22. … in my opinion the answer to the question of whether Mr Mehmet is entitled to a TPD benefit lies in the wording of cl 3.24 of the TAL policy, and in particular the proviso to that clause which, to repeat it, reads:

… but in any event [TAL] will ensure that no member loses the cover that had been applicable at the time of that transfer as a result of the transfer.

23. I read the words "but in any event" as meaning "no matter what appears in the IFSA Guidance Note". In my opinion, by the proviso, TAL agreed that nothing in the Guidance Note would have the effect of rendering a member disentitled to cover to which, but for the change of insurers, that member would have otherwise been entitled.

24. The obvious purpose of the provision was to ensure that a Fund member, such as Mr Mehmet, who had TPD cover when he became a member of the Fund, would not lose that cover merely because of a change in the identity of the insurer engaged by the Trustee pursuant to its powers under the Trust Deed.

25. As I have said, when Mr Mehmet joined the Fund, Hannover was the insurer. Under that policy, Mr Mehmet had TPD cover which was not subject to any "at work" requirements. In my opinion, the effect of cl 3.24 of the TAL Policy is to "ensure" that Mr Mehmet retained that level of cover notwithstanding the fact that Lumley, and then TAL, became the insurer.

The court also said that it was "unreasonable" for the trustee and TAL "simply to ignore" the member's Evidentiary Statement explaining why he had left his employment (at [50]), and that TAL's analysis of the available medical evidence was "flawed" (at [80]). The court said:

I see considerable force in [the member's counsel's] submission that TAL made reference

only to evidence that supported its earlier announced decision to decline indemnity, and made reference to little, if any, evidence that was inconsistent with that denial.

The result

In the result, as the parties had agreed that the court was not to determine whether the member was TPD, the court remitted the member's claim to the insurer and the trustee for reconsideration.

Take away points

There are 3 take away points that emerge from this decision. First, an insurer's liability always depends on the particular words used in the policy. Here, the reference to the IFSA takeover terms was overridden by the wording of the policy. Second, explanations given by a member making a claim must be given due consideration. Third, the available medical evidence must be assessed in a balanced way.

5. Trust deed amendments – meaning of "accrued benefits" – declarations and orders – *Beck v Colonial Staff Super Pty Ltd (No 2)* [2015] NSWSC 1360

As reported in item 1 of the September 2015 issue of the Superannuation Case Law Update, on 6 July 2015 the New South Wales Supreme Court (Slattery J) held (among other things) that purported amendments to the trust deed of a superannuation fund in December 1996 that removed discretionary "Leaving Service Benefits" contravened regulation 13.16 of the *Superannuation Industry (Supervision) Regulations 1994* (Cth) (SIS Regulations) and were ultra vires and void.

In a supplementary judgment, the court has now made declarations and orders. The judgment is *Beck v Colonial Staff Super Pty Ltd (No 2)* [2015] NSWSC 1360.

Background

The background to the dispute was set out in the September 2015 issue of the Superannuation Case Law Update. What follows is a short summary.

In 1987 Mr Beck (the member) became a member of the fund.

In July 1996 the trust deed of the fund was amended. Following these amendments, clause A11.3 of the trust deed provided a discretionary "Leaving Service Benefit".

The amendment power was also varied so that any amendments were subject to "the Relevant Requirements", which included the *Superannuation Industry (Supervision) Act 1993* (Cth) and the SIS Regulations.

In December 1996 the trust deed of the fund was again amended. These amendments restructured and redefined members' benefits. Among other amendments, clause A11.3 was deleted.

In February 2005 the member claimed a Leaving Service Benefit under clause A11.3. The member's claim was rejected. It was pointed out to him that the clause providing the Leaving Service Benefit had been deleted from the trust deed.

In July 2005 the member's employment was terminated.

The proceedings

In 2011 the member commenced proceedings in the Supreme Court of New South Wales.

The principal judgment

As mentioned above, on 6 July 2015 the court held (among other things) that the amendments that purported to delete the Leaving Service Benefits contravened regulation 13.16 of the SIS Regulations and were ultra vires and void. The matter was adjourned for any argument as to the form of orders.

On 14 September 2015 the court heard supplementary arguments as to the form of orders.

Declarations and orders

On 28 September 2015 the court made declarations and orders to the following effect (among other declarations and orders):

- a declaration that the deletion of clause A11.3 was void and of no effect;
- an order that the trustee give due consideration to the exercise of the power in clause A11.3 in favour of the member as at the

date of termination of the member's employment; and

- an order that the employer pay the member's costs of the proceedings.

Appeal

The supplementary judgment indicates that the trustee and the employer intend to appeal to the New South Wales Court of Appeal.

6. TPD claim dismissed – *Edington v Board of Trustees of the State Public Sector Superannuation Scheme* [2015] QSC 312

As reported in item 2 of the September 2015 issue of the Superannuation Case Law Update, on 21 August 2015 the Queensland Supreme Court (Bond J) held that a member of a superannuation scheme had not established that the trustee of the scheme, in rejecting the member's claim for a total and permanent disablement (TPD) benefit, had breached its duty as alleged by the member. Nor in the circumstances of the case was there a contract of insurance between the trustee and the member.

In a supplementary judgment on 3 November 2015, the court has dismissed the member's claim. The decision is *Edington v Board of Trustees of the State Public Sector Superannuation Scheme* [2015] QSC 312.

Background

The background to the dispute was set out in the September 2015 issue of the Superannuation Case Law Update.

Questions for separate determination

At the request of the parties, the court had set down 5 questions for separate determination.

The court noted that the member's claim involved two broad alternatives: a claim for review of a decision of the Board of Trustees of the State Public Sector Superannuation Scheme as a trustee under section 8 of the *Trusts Act 1973* (Qld), and a claim that there was a contract of insurance between the Board and the member which the Board had breached. The questions according fell into two categories: questions about the Board's decision as trustee, and questions about the claim based on a contract of insurance.

The questions were answered in favour of the Board: *Edington v Board of Trustees of the State Public Sector Superannuation Scheme* [2015] QSC 245 (21 August 2015).

Notice of appeal

On 18 September 2015 the member filed a notice of appeal to the Queensland Court of Appeal.

Further submissions

Following the judgment on 21 August 2015, the member contended that the answers to the separate questions did not dispense entirely with his claim. The Board disagreed and filed an application that the member's claim be dismissed.

Further submissions were heard on 1 October 2015. The member applied for an adjournment and the matter was adjourned until 6 November 2015.

Through his solicitors the member subsequently indicated that he was agreeable to the matter being determined on the basis of the material that had already been placed before the court, and the further hearing date of 6 November 2015 being vacated.

Orders disposing of the proceedings

On 3 November 2015 the court delivered a supplementary judgment in which the matter was resolved in the Board's favour. The answers to the separate questions dispensed entirely with the member's claim.

The court:

- vacated the further hearing date of 6 November 2015;
- ordered that the claim be dismissed; and
- ordered the member to pay the Board's costs.

Appeal

As mentioned above, the member has appealed to the Queensland Court of Appeal.

7. Allocation of death benefit – *Stock v NM Superannuation Pty Ltd* [2015] FCA 612

The Federal Court (Tracey J) has affirmed a superannuation trustee's decision to pay the death benefit to the member's 3 non-financially dependent adult children in equal shares, and not to the executors of the member's estate. The case is *Stock v NM Superannuation Pty Ltd* [2015] FCA 612.

Background

The member died in 2011, aged 93 years. He was survived by 2 adult sons aged 63 and 54, and by an adult daughter aged 60. He was also survived by a number of grandchildren. His spouse had died before him.

The total death benefit (as at July 2014) was about $3.916 million.

The member had nominated his spouse as a beneficiary on one of his insurance policies in the fund, but she had died before him. He had not made any other nominations.

In 1995, following a dispute which had lasted for some time, the member, the spouse and the 2 sons had entered into a settlement deed.

Also in 1995, the member and the spouse had made a signed statement of wishes in relation to the administration of their respective estates and assets held through trusts and companies. This read in part:

> … it is our wish that our sons and their families be excluded from any interest in our estates or in the companies and other entities controlled by us …
>
> Our Trustees are to take such steps as they consider necessary to protect our estates and companies and entities controlled by us from any claim which may be made by [the sons] or their respective families.

In 2004 the member had made a will appointing his daughter and 2 other people as his executors and trustees, and bequeathing a fixed amount to each of his grandchildren (including the children of his sons) and the remainder of his estate to his daughter. He bequeathed nothing to the sons.

In 2012 probate was granted.

The sons commenced proceedings against the executors under the *Administration and Probate Act 1958* (Vic), claiming that the member had made inadequate provision for their proper maintenance and support.

The trustee's allocation

The trustee proposed the following allocation:

- to each of the adult sons and the adult daughter – one third (to the exclusion of the executors).

The executors (including the daughter) objected. The trustee indicated that it would consider a request by them to pay the benefit to them on receipt of a deed of release signed by all 3 of the member's children. In response to this, the executors (through their lawyer) said that the daughter did not expect that her brothers would sign a deed of release because of the 1995 settlement deed.

The daughter also claimed to have been in an interdependency relationship with the member during the latter years of his life. The trustee was not satisfied that an interdependency relationship had been established.

The trustee confirmed its original allocation. In so doing, the trustee noted the unresolved court proceedings and the absence of any release in favour of the trustee:

> Given the fact that the Trustee was made aware of the litigation underway in relation to the Deceased Member's estate, and given that it was

> unknown what result the court proceedings would be it was inappropriate to pay the benefit to the LPR, particularly where the Trustee has not been indemnified and released from any further liability by the three children of the Deceased Member.

The executors complained to the SCT. They argued that the trustee should have paid the benefit to them on the basis that the member's wishes were clear and stated in the 1995 settlement deed, the 1995 statement of wishes of the member and the member's spouse, and the member's will made in 2004.

The SCT determination

The SCT affirmed the trustee's decision: D14-15\073 (26 September 2014).

In so doing, the SCT observed that a superannuation trustee is not bound to follow a direction in a will.

The SCT noted this trustee's general practice of not paying the benefit to the LPR where the member is survived by dependants, and concluded that it was "not unreasonable" for the trustee to follow this practice in this instance.

The daughter had not established an interdependency relationship. There was no

The SCT concluded that since there was no evidence to support a greater claim on the benefit by any of the adult children, it was fair for the trustee to decide to pay the benefit to the adult children of the member as non-financial dependants, in equal shares.

The executors appealed to the Federal Court. They alleged that the SCT had "erred in holding that a superannuation trustee is in general not to pay to the legal personal representative of a deceased member unless there are no dependants or a binding death benefit nomination in favour of the legal personal representative" (ground 1). They also complained that the SCT had failed to give adequate reasons for its decision (ground 2).

The Federal Court decision

The Federal Court (Tracey J) affirmed the trustee's decision and dismissed the appeal.

In relation to ground 1, the court said (at [39]) that:

> At no point did the Tribunal rule, as a matter of law, that, in general, a trustee should not make payments out of a superannuation fund to the legal personal representative of a deceased member unless there are no dependants or the deceased has made a binding nomination requiring payment to the legal personal representative.

The court went on (at [40]):

> The legality of the Trustee's general practice was not contentious. The [executors'] submissions to the Tribunal did not seek to suggest that the practice was unlawful.

In any event, even if the SCT had made such a ruling and it was contrary to law, it did not follow that such an error had any material impact on the SCT's decision.

The executors accordingly failed on ground 1.

In relation to ground 2 (the alleged failure to give adequate reasons), the court rejected the 3 particular deficiencies alleged by the executors.

The appeal was accordingly dismissed.

The result

In the result, the trustee's decision to pay the death benefit to the member's 3 non-financially dependent adult children in equal shares, and not to the LPR, was affirmed by the SCT and the Federal Court.

Take away point

This case highlights that in exercising its discretion as to the manner of allocation of a death benefit, a superannuation trustee is not bound to follow the member's wishes, whether expressed in a will or otherwise.

8. Misleading statements – "Free SMSF set up" services – *Australian Securities and Investments Commission v Superannuation Warehouse Australia Pty Ltd* [2015] FCA 1167

The Federal Court of Australia (Beach J) has held that Superannuation Warehouse Pty Ltd (the company) made false, misleading, and deceptive statements on its websites by offering "Free SMSF Setup", when in fact, it was not free. The case is *Australian Securities and Investments Commission v Superannuation Warehouse Australia Pty Ltd* [2015] FCA 1167.

Legislative framework

Briefly stated, section 12DA of the *Australian Securities and Investments Commission Act 2001* (Cth) prohibits a person, in trade or commerce, from engaging in conduct in relation to financial services that is misleading or deceptive, or likely to mislead or deceive. Section 12DB prohibits a person, in trade or commerce, in connection with the supply or possible supply of financial services, or in connection with the promotion by any means of the supply or use of financial services, from making certain kinds of false or misleading representations.

Background

The company provided online accounting and administration services for SMSFs.

There were two relevant periods here. In the pre-disclaimer period, the company offered "Free SMSF Setup" (and cognate phrases), without disclaimers. In the post-disclaimer period, the company added some disclaimers to those "Free SMSF Setup" phrases.

Pre-disclaimer period

From January 2014 to August 2014, on two of the company's websites, it offered "Free SMSF Setup" (among other variant phrases, representing free SMSF setup).

Collectively, the statements represented that the company would set up an SMSF:

- at no cost;
- without the need for the applicant to agree to, or be bound by, any conditions; and
- without the need for the applicant to agree to a fixed monthly fee.

The statements did not represent the reality, which was in fact that in the setup of an SMSF, the company:

- charged a fee of $950 for setup with a corporate trustee;
- required the applicant to authorise the company to be the fund administrator (for which there was a fixed monthly administration fee);
- required the applicant to put in place a payment plan for monthly payments for administrative services; and
- charged a fixed monthly fee (in arrears) for administration services performed.

ASIC action

In April 2014, ASIC issued an infringement notice to the company alleging that it had engaged in misleading or deceptive conduct in relation to financial services and had made false or misleading representations where it promoted "free setup" of SMSFs without clearly disclosing that conditions and charges were associated with the "free setup".

The company did not pay the infringement notice penalty of $10,200.

Post-disclaimer period

From August 2014 to May 2015, the two company websites were updated with disclaimers, added inconsistently in places where "Free SMSF Setup" (among other variant phrases, representing free SMSF setup) was offered.. The asterisks corresponded to a statement in the footer of the website that read “Free SMSF Setup was only available to individual trustees”.

Collectively, the statements, together with the inconsistent disclaimers, represented that when set up with an individual trustee the company would set up an SMSF:

- at no cost;
- without the need for the applicant to agree to, or be bound by, any conditions; and
- without the need for the applicant to agree to a fixed monthly fee.

The statements, together with the inconsistent disclaimers, did not represent the reality, which was that in fact that in the setup of an SMSF with an individual trustee, the company:

- required the applicant to authorise the company to be the fund administrator (for which there was a fixed monthly administration fee);
- required the applicant to put in place a payment plan for monthly payments for administrative services; and

- charged a fixed monthly fee (in arrears) for administration services performed.

ASIC action

In May 2015 ASIC announced that it had commenced legal action in the Federal Court, seeking financial penalties and orders to prevent the company from advertising "free" SMSF setup.

First hearing

Later in May 2015 ASIC and the company had their first hearing of the matter.

The company agreed to interim orders preventing it from advertising "Free SMSF Setup" on its websites if the setup was not free.

The matter was set down for trial on liability only.

Second hearing

In October 2015, ASIC and the company had their second and final hearing of the matter, which dealt with liability only.

The Federal Court found that the company had breached section 12DA(1) of the *Australian Securities and Investments Commission Act 2001* (Cth) by advertising "free" SMSF setup on its websites. The Federal Court found that that statements made by the company were misleading or deceptive, as the setup was not free, and that the true cost of the SMSF setup was not clearly or prominently disclosed on the websites.

Pre-disclaimer period

The Federal Court found that in the pre-disclaimer period, the "Free SMSF Setup" statement (and variant statements) on the websites were false, misleading, and deceptive because it represented that the company would set up an SMSF at no cost when in fact, it was not free, as mentioned above.

Post-disclaimer period

Although the company's websites were later updated to include disclaimers (albeit inconsistent ones), the Federal Court said this was still a contravention, though “less egregious”.

Additionally, the Federal Court found that for applications for SMSF set up with a corporate trustee, it was not clear and prominent on the websites where “Free SMSF Setup” was advertised, that a payment of $950 was involved.

The result

The company admitted that the representations on the two websites were false and misleading.

The Federal Court ordered the company to (which the company consented to):

- pay a penalty of $25,000 to the Commonwealth;
- post notices on its websites disclosing the misleading or deceptive conduct for a period of a month;
- notify affected clients of the misleading or deceptive conduct;
- establish an extensive “Compliance, Education and Training Program" (which the Federal Court provided as an Annexure) at its own cost. This program was to include, among other things, at least annual practical training for all directors, officers, employees, and representatives of the company; and
- refrain from posting or publishing any representations for services which refer to "Free SMSF Setup", where the setup is not free, until either 31 May 2016, or until it has completed the requirements of its Compliance, Education and Training Program.

Take away point

In November 2015, in a Media Release *15-322MR Court orders penalty for false and misleading 'Free SMSF Setup' advertising*, ASIC welcomed the decision. Deputy Chair Peter Kell said “deciding to establish a self-managed superannuation fund is a significant financial decision. Consumers should not be misled by advertising, including online. ASIC considers that terms such as ‘free’ convey a strong impression to consumers and should not be used where there is any charge or cost associated with the product or service advertised.”

9. SMSF – breaches of SIS Act – *Deputy Commissioner of Taxation (Superannuation) v Ryan* [2015] FCA 1037

The Federal Court of Australia (Edelman J) has held that the trustees of a self-managed superannuation fund (SMSF) committed serious contraventions of the *Superannuation Industry (Supervision) Act 1993* (Cth) (SIS Act) and imposed a monetary penalty of $20,000 against each trustee. The case is *Deputy Commissioner of Taxation (Superannuation) v Ryan* [2015] FCA 1037.

Background

From January 1999 to January 2014 Mr and Mrs Ryan (the Trustees) were the trustees and only members of a SMSF (the Fund) (at [1]).

Between June 2009 and June 2012 the Trustees, after an unsuccessful business venture, experienced financial difficulties and made a series of withdrawals from the Fund to enable them to meet their personal expenses (at [5-7]).

Some of the withdrawals were made as loans to the Trustees and repaid. Some of the loans were unsecured, had no interest rate and no repayment term. Some of the withdrawals were not repaid (at [8]).

In November 2012, as a result of reports from the auditor of the Fund and income tax returns lodged by the Fund, the Deputy Commissioner of Taxation (Superannuation) (the Commissioner) commenced an audit of the Fund (at [10]).

In October 2013, the Commissioner wrote to the Trustees asking each of them to show cause why they should not be disqualified from being trustees of superannuation entities (at [11]).

In November 2013, the Trustees wrote to the Commissioner acknowledging the contraventions, apologising for their actions, and offering to rectify the contraventions and then roll-over the superannuation benefits in the Fund and close the Fund. The Trustees did not rectify the contraventions (at [12 and 14]).

In January 2014, the Commissioner disqualified each of the Trustees from being a trustee of a superannuation entity, under section 126A of the SIS Act (at [13]).

In May 2015, the Commissioner wrote to the Trustees advising that proceedings would be commenced against the Trustees (at [15]).

The proceedings

In 2015, the Commissioner brought proceedings against the Trustees. The Commissioner alleged that the Trustees had contravened the following provisions of the SIS Act, in connection with the Fund between 2009 and 2012:

- section 62(1), being the sole purpose test;
- section 65(1), being the prohibition against a trustee of a regulated superannuation fund lending money of the fund to a member or relative of that fund;
- section 84(1), being the in-house asset rules; and
- section 109(1), being the requirement that all dealings by a trustee of a superannuation entity be at arm's length.

For the purposes of section 196 of the SIS Act, each of these provisions is a civil penalty provision.

The Trustees admitted they had contravened these sections (at [19] and [22]).

The judgment

The court held that the Trustees had contravened the provisions of the SIS Act. The reasons for the decision were as follows:

- contravention of section 62(1) – the court held that when the Trustees withdrew money from the Fund they had failed to ensure that the Fund was maintained solely for one or more of the purposes prescribed in section 62(1);
- contravention of section 65(1) - the court held that the withdrawals form the Fund gave financial assistance to the Trustees and therefore contravened the prohibitions on lending money of the fund to a member of the fund contained in section 65(1);
- contravention of section 84(1) – the court held that the withdrawals from the Fund by the Trustees breached the in-house asset rules by causing the market value ratio to exceed 5%; and
- contravention of section 109(1) – the court held the withdrawals by the Trustees of loans for their own purposes were not at arm's length and were on more favourable terms than was reasonable to expect if they were at arm's length, and so contravened section 109(1) (at [20-24]).

Consideration of pecuniary penalty

The court referred to the judgment of Mansfield J in *Olesen v Eddy* [2011] FCA 13 where his Honour said that one important consideration in the imposition of pecuniary penalties under section 196 of the SIS Act is general deterrence.

The court said (at [59]):

> In particular, those who take advantage of a self-managed superannuation fund have a responsibility to manage that fund in accordance with the terms of the Deed and the legislation and a civil penalty for contravention of that obligation needs to be sufficiently high to deter contravention by others, although not oppressive.

The court also quoted from the judgment of Gordon J in *Olesen v Parker* [2011] FCA 1096 where his Honour had identified the following relevant factors in determining an appropriate civil penalty under the SIS Act:

1. the nature and extent of the contravening conduct;
2. the amount of any loss or damage caused;
3. the size of the organisation;
4. the deliberateness or otherwise of the contravention(s);
5. the period over which the contravention(s) extended;
6. the degree of co-operation of the person concerned, either in the investigation or the subsequent hearing;
7. the past record of the person;
8. the person's financial position;
9. any amounts already paid by way of compensation or legal costs;
10. contrition; and
11. any applicable public policy position.

Applying these factors to the present case, the court said that the contravening conduct of the Trustees involved substantial sums of money and that the Fund was almost exhausted (at [62]). The contraventions were deliberate, as when they made the withdrawals the Trustees knew and understood that they were contravening the SIS Act (at [63]).

The court noted that there had been prior contraventions by the Trustees (which the Commissioner had not taken to court (at [2])) and that although the Trustees had the capacity to pay a pecuniary penalty, their financial position was not strong (at [68]).

The contraventions amounted to almost the entire value of the Fund, put the savings of the Trustees at risk and did so in circumstances in which their contraventions were deliberate, repeated over a period of 3 years and were not first contraventions (at [64]).

The court also noted that the Trustees had fully co-operated with the Commissioner in relation to the proceedings and the court accepted that the Trustees were contrite (at [74-75]).

The maximum penalty for contravention of a civil penalty provision under the SIS Act at the time of the contraventions was $220,000. The court noted that the contraventions in this case were of a very similar nature and were part of a continuing course of conduct involving the same facts and circumstances. The court therefore treated $220,000 as the maximum penalty (at [62]).

The result

In the result, the court held that the contraventions were serious and ordered that each of the Trustees pay a penalty of $20,000 for their contraventions of the SIS Act, to be paid in monthly instalments of over 3 years (at [76]).

The court also made declarations that the Trustees had contravened the pecuniary penalty provisions of the SIS Act (at [78]).

Finally, the Trustees were ordered to pay the costs of the Commissioner, once those costs were fixed (at [80]).

Take away point

This decision illustrates how a court may treat contraventions by a superannuation trustee under the civil penalty provisions of the SIS Act.

10. TPD claim – medical examinations – *Salmon v Kinetic Superannuation Ltd* [2015] QDC 287

The Queensland District Court (Everson DCJ) has held that, in proceedings by a member of a superannuation fund to recover a total and permanent disablement (TPD) benefit, it was not unreasonable for the trustee and the insurer (the defendants) to require the member to be independently medically examined by one expert of the defendants' choosing in each of the disciplines relevant to the claim. The case is *Salmon v Kinetic Superannuation Ltd* [2015] QDC 287.

Background

The member commenced proceedings in the Queensland District Court against the trustee and the insurer to recover a TPD benefit. The trustee and the insurer had denied the claim on the basis of medical evidence placed before them.

The defendants wanted to have the member independently examined by experts of their choosing, and made an application to this effect. They sought to have the member independently medically examined by an orthopaedic surgeon, a psychiatrist and a vocational assessor, and in their application nominated 3 experts in each of these fields.

Conversely, the member said that the defendants ought to merely obtain any further reports from experts who have already examined him, and made an application to this effect.

The court's decision

The court noted that the member had not been independently medically examined by an expert of the defendants' choosing, and said that it was not unreasonable to require him to be so examined by an expert in each of the proposed disciplines. The member's claims for a declaration as to his entitlement to a TPD benefit, and in the alternative damages, were matters which the court had to assess on the evidence placed before it. It was not unreasonable for a party facing a proceeding in the court to seek independent medical examinations of the plaintiff even when he has previously been examined in other circumstances by experts.

The court added that it was not reasonable to subject the member to the examination of more than one expert in a given field or examination by an expert in a field which is not relevant to the subject matter of the proceeding. These are obvious limitations on the court's discretion.

The result

In the result, the court made an order along the lines of the draft order provided by the defendants, and dismissed the member's application.

Take away point

Where a member of a superannuation fund claims a TPD benefit, it is not unreasonable for the trustee and the insurer to require the member to be independently medically examined by one expert of their choosing in each of the disciplines relevant to the claim.

11. TPD claim – waiver of legal professional privilege – *Allen v The Queensland Local Government Superannuation Board* [2015] QDC 237

The Queensland District Court (Smith DCJA) has held that the trustee of a superannuation scheme had waived legal professional privilege in respect of legal advice given by the trustee's lawyers which had been referred to in the trustee's board papers. The case is *Allen v The Queensland Local Government Superannuation Board* [2015] QDC 237.

Background

A member of a superannuation scheme claimed a total and permanent disablement (TPD) benefit.

The member's claim was considered at a meeting of the board of the trustee on 3 September 2014. The board papers for that meeting included a recommendation by the trustee's insurance manager that the board uphold an earlier decision to decline the claim (at [11] and [13]). An accompanying chronology of events read in part (at [12]):

> In a letter to the board received on 26 June 2013, Ms Allen's appointed lawyers, Maurices Blackburn, requested the board to again review its decision to deny her claim for payment of a total and permanent disablement benefit. To support the claim a report from Dr Bankole Sotard dated 20 May 2009, a report from Dr Morris Bersin dated 12 December 2012 and a letter dated 13 February 2013 and a medical certificate dated 26 November 2012 from Dr Robert Cargill was provided. On 30 July 2013, the matter was referred to King & Co [ie King & Company, Solicitors] for legal opinion to determine if the board is obligated to re-examine the claim given the passage of time since the claim was first lodged and the two previous assessments of the claimant being declined. And in their response to the board dated 16 October 2013 King & Co confirmed that the board is required to reconsider the claim based on that fact that new medical evidence was supplied.

The insurance manager had used the King & Co advice in preparing the recommendation to the board, but the advice was not provided to the board and it was not before the board when it made its decision (at [25]-[26]).

The board decided to decline the claim, as per the insurance manager's recommendation (at [13] and [26]).

The member commenced proceedings against the trustee in the Queensland District Court.

The member's lawyers requested a copy of the King & Co advice. The trustee objected to producing the advice on the bases that it was not relevant and was subject to legal professional privilege (at [16]-[18]).

The member applied to the court for disclosure of the advice.

The court's decision

Relevance

The court noted:

> [30] Ultimately in this case the Court will need to decide whether the decision was made in good faith with real and genuine consideration and in accordance with the purposes for which the discretion was conferred.

The court held that "reliance on the ultimate advice was relevant to the conclusion reached by the [trustee]", and so the advice was relevant to the issues in the proceedings (at [28]).

Waiver of legal professional privilege

The court also held that the trustee had waived legal professional privilege over the advice.

After referring to a number of authorities on waiver of privilege and noting that here, the board's "state of mind" was a very relevant issue (at [60]), the court said (emphasis added):

> [62] In my view, after having considered the authorities taking into account the principles of fairness and consistency, privilege has been waived for the following reasons.
>
> [63] Very relevant to the conclusion to be reached by the Court is the approach taken by the Board in reaching its decision. It seems to me that the submission was a crucial document in this regard. Integral in that submission was a reference to the conclusions expressed in the legal advice. As noted the defence specifically alleges the decision was made in good faith taking into account all relevant considerations and no irrelevant ones (para 22).
>
> [64] The submission is certainly a disclosable document in this action as it goes to the heart of the decision here. This was not a meeting held behind closed doors like eg in [Tarong Energy Corporation Ltd v South Burnett regional Council [2010] 1 Qd R 575]. Tarong is also distinguishable as no part of the advice was used or disclosed in that case.
>
> [65] The reasons and the approach taken by the Board should be open to scrutiny bearing in mind the issues to be considered in this action as outlined in *Finch* [*v Telstra Super Pty Ltd* (2010) 242 CLR 254].
>
> [66] The state of mind of the Board is a very relevant matter. The legal advice goes to the state of mind. The board here adopted in full the recommendation of its officer who considered the legal advice in making his recommendation.
>
> [67] I consider the advice has either directly or indirectly been put in issue in these proceedings.
>
> [68] In those circumstances the principles of fairness and inconsistency dictate that a conclusion should be reached that privilege was waived.

The court held that the whole of the advice (and not just part of it) had become disclosable (at [69]).

The result

In the result, the court held that the trustee had waived legal professional privilege over the King & Co advice, and ordered disclosure of the whole of it (at [70]).

Costs

In a subsequent judgment, the court ordered the trustee to pay the member's costs of and incidental to the application on the standard basis, as agreed or assessed: *Allen v The Queensland Local Government Superannuation Board (No 2)* [2015] QDC 251.

Take away point

This decision highlights that where a trustee's state of mind is in issue in proceedings, legal advice obtained by the trustee that is "integral" to the formation of that state of mind may be disclosable.

12. Insurance – disability discrimination – *Ingram v QBE Insurance (Australia) Ltd* [2015] VCAT 1936

The Victorian Civil and Administrative Tribunal (A Dea, Member) has held that an insurer engaged in discrimination in breach of section 44 of the *Equal Opportunity Act 2010* (Vic) first, when it issued a travel insurance policy which included a mental illness exclusion and second, when it refused indemnity relying on that exclusion. The case is *Ingram v QBE Insurance (Australia) Ltd* (Human Rights) [2015] VCAT 1936.

The Equal Opportunity Act

Briefly stated, section 44 of the *Equal Opportunity Act* makes it unlawful for a person to discriminate against another person in the provision of "goods or services" – which includes insurance and superannuation – on the ground of a number of specified attributes, including "disability".

Section 47 allows for discrimination in respect to insurance policies in certain circumstances. Section 47(1) relevantly provides:

> An insurer may discriminate against another person by refusing to provide an insurance policy to the other person, or in the terms on which an insurance policy is provided, if –
>
> (a) the discrimination is permitted under –
>
> …
>
> (ii) the Disability Discrimination Act 1992 of the Commonwealth; or
>
> (b) the discrimination –
>
> (i) is based on actuarial or statistical data on which it is reasonable for the insurer to rely; and
>
> (ii) is reasonable having regard to that data and any other relevant factors ...

In relation to section 47(1)(a)(ii), section 29A of the *Disability Discrimination Act 1992* (Cth) provides that it is not unlawful for a person (the discriminator) to discriminate against another person on the ground of a disability of the other person if avoiding the discrimination would impose an "unjustifiable hardship" on the discriminator.

Background

In late 2011, during the course of her year 11 studies, Ms Ella Ingram and her mother decided she could join a school tour to New York scheduled for 30 March to 11 April 2012. The required deposit and subsequent instalments were all paid. Some of the costs were applied to a travel insurance policy issued by QBE Insurance (Australia) Ltd (QBE) on 8 December 2011.

In about January 2012, for the first time in her life, Ms Ingram experienced symptoms of depression. Over the course of the following months she was diagnosed with that illness and received treatment. In consultation with her doctors and mother, Ms Ingram decided not to go on the planned school trip, in the interests of her health.

In about April 2012 Ms Ingram's mother made enquiries about claiming the cost of the trip on the QBE policy. The claim for $5,860 was lodged in May 2012 and was denied by QBE on 17 August 2012. The refusal was confirmed by a further letter sent on 4 December 2012.

In rejecting the claim, QBE relied upon a general exclusion that said, in summary, there was no cover where the claim arose directly or indirectly due to mental illness.

Ms Ingram applied to the Tribunal for a declaration that QBE had unlawfully discriminated against her, compensation for economic loss and the damage of hurt and humiliation suffered by her and costs.

QBE denied having discriminated against Ms Ingram.

The Tribunal's decision

The Tribunal found (at [10]):

- at the relevant points in time, Ms Ingram had a "disability" within the meaning of that term in the Act;
- QBE engaged in direct discrimination in breach of section 44 of the *Equal Opportunity Act* first, when it issued her with a policy which included the mental illness exclusion and second, when it refused her indemnity relying on the terms of that exclusion;
- QBE could not rely upon the statutory exceptions to excuse the discrimination. That is because QBE did not produce evidence to prove it is more probable than not that:
    - at the relevant points in time, the acts of discrimination by QBE were based on actuarial or statistical data. Accordingly, the exception contained in section 47(1)(b) of the Act and section 46(2)(f) of the *Disability Discrimination Act 1992* (Cth) which depend on such data did not apply;
    - it would have suffered unjustifiable hardship if it had not included the mental illness exclusion in the policy issued to Ms Ingram. Accordingly, the exception contained in section 29A of the *Disability Discrimination Act 1992* (Cth) did not apply;
- as a consequence, QBE engaged in unlawful discrimination when it included the mental

illness exclusion in the policy issued to Ms Ingram and when it denied her indemnity relying on that exclusion;
- Ms Ingram was entitled to economic loss in the sum of $4,292.48, being the value of her cancelled trip; and
- Ms Ingram was entitled to non-economic loss in the sum of $15,000 for hurt and humiliation.

However, the Tribunal declined to make a declaration that QBE had engaged in unlawful discrimination. The Tribunal said (at [11]):

> I have declined Ms Ingram's application to ensure that an impression is not given that my decision automatically applies beyond the dispute between these parties and, in particular, to avoid any impression that it applies to all insurers.

The result

In the result, the Tribunal held that QBE had engaged in unlawful discrimination on the ground of disability (ie mental illness) an awarded Ms Ingram $4,292.48 for economic loss and $15,000 for hurt and humiliation.

Comments

Discrimination against a person in the provision of insurance or superannuation on the ground of the person's disability or age is generally rendered unlawful by the *Disability Discrimination Act 1992* (Cth), the *Age Discrimination Act 2004* (Cth) as well as State and Territory legislation including the *Equal Opportunity Act 2010* (Vic). There are limited exceptions to these general prohibitions, but these exceptions need to be understood, and appropriate research needs to be completed, before reliance can be placed on any of these exceptions.

As this decision shows, supporting actuarial or statistical data cannot be gathered "after the event".

About Thomson Geer

Thomson Geer is one of the largest independent, truly national full-service law firms in Australia, with over 80 Partners and about 500 lawyers and staff – located evenly across our offices in Sydney, Melbourne, Brisbane and Adelaide.

As one of Australia's top ten independent commercial law firms by size, our expertise, enthusiasm, responsiveness and innovative approach has allowed us to build and retain strong relationships with Australia's leading businesses and government bodies.

Our Superannuation and Wealth Management team is led by Scott Charaneka and Stanley Drummond.

In 2015 Scott and Stanley were both named in Who's Who Legal as leading individuals within the practice area of Pensions & Benefits worldwide. In 2015 and 2014 Scott was named in Best Lawyers in Australia in the Superannuation Law and Regulatory Practice categories, while Stanley was named in the Insurance Law category.

They are frequent speakers at seminars and training courses convened by the Association of Superannuation Funds of Australia and other industry and professional bodies, and the authors of many texts and articles.

Scott and Stanley have comprehensive experience in establishment, licensing, governance, administration, distribution, restructuring, investments and tax matters associated with superannuation, life insurance and management investment products. They act for many of Australia's largest private and public sector financial institutions.

For further information contact:

Scott Charaneka

Head of Superannuation and Wealth Management
T +61 3 8080 3637
M 0477 700 380
E mailto:scharaneka@tglaw.com.au

Stanley Drummond

Adjunct Head of Superannuation and Wealth Management
T +61 2 8248 5854
M 0400 676 386
E mailto:sdrummond@tglaw.com.au