FEDERAL COURT OF AUSTRALIA

Australian Securities and Investments Commission v Zurich Australia Limited (No 2) [2023] FCA 1641

File number(s):	NSD 1052 of 2022
Judgment of:	**JACKMAN J**
Date of judgment:	21 December 2023
Catchwords:	**INSURANCE** – whether insurer breached the duty of utmost good faith under s 13 of the *Insurance Contracts Act 1984* (Cth) – where the insured's income protection policy was avoided for fraudulent non-disclosure of health issues – where the insured was provided with an opportunity to address the insurer's concerns – whether the insurer was required to make further enquiries – whether the insurer was required to notify the insured of its concerns of fraud – whether the insurer was required to inform the insured of avenues of dispute or appeal – no contraventions established
Legislation:	*Corporations Act 2001* (Cth) ss 1101AC, 1101AF, 1101B *Insurance Contracts Act 1984* (Cth) ss 13, 29, 75A, 75B *Life Insurance Act 1995* (Cth) s 195 *Federal Court Rules 2011* (Cth) r 30.01
Cases cited:	*Allianz Australia Insurance Ltd v Delor Vue Apartments CTS 39788* [2022] HCA 38; (2022) 97 ALJR 1 *Australian Securities and Investments Commission v TAL Life Limited (No 2)* [2021] FCA 193; (2021) 389 ALR 128 *Australian Securities and Investments Commission v Zurich Australia Limited* [2023] FCA 712 *Beverley v Tyndall Life Insurance* [1999] WASCA 198; (1999) 21 WAR 327 *Briginshaw v Briginshaw* (1938) 60 CLR 336 *Carroll v United Super Pty Ltd* [2018] NSWSC 403 *CGU Insurance Limited v AMP Financial Planning Pty Ltd* [2007] HCA 36; (2007) 235 CLR 1 *Finch v Telstra Super Pty Ltd* [2010] HCA 36; (2010) 242 CLR 254 *Folmer v VicSuper Pty Ltd* [2018] NSWSC 1503 *Halloran v Harwood Nominees Pty Ltd* [2007] NSWSC 913

	International Harvester Company of Australia Pty Ltd v Carrigan's Hazeldene Pastoral Company (1958) 100 CLR 644 *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* [1992] HCA 66; (1992) 67 ALJR 170 *Pape v Federal Commissioner of Taxation* [2009] HCA 23; (2009) 238 CLR 1 *Re OnePath Life Limited (No 2)* [2022] FCA 811 *Rejfek v McElroy* [1965] HCA 46; (1965) 112 CLR 517 *Secured Income Real Estate (Australia) Ltd v St Martins Investments Pty Ltd* (1979) 144 CLR 596 *Shepherd v Felt & Textiles of Australia Ltd* (1931) 45 CLR 359 *Sibbles v Highfern Pty Ltd* (1987) 164 CLR 214
Division:	General Division
Registry:	New South Wales
National Practice Area:	Commercial and Corporations
Sub-area:	Commercial Contracts, Banking, Finance and Insurance
Number of paragraphs:	75
Date of hearing:	11–12 December 2023
Counsel for the Plaintiff:	Mr D Luxton
Solicitor for the Plaintiff:	Maddocks Lawyers
Counsel for the Defendant:	Mr J Williams SC, Mr H Atkin and Ms H Donaldson
Solicitor for the Defendant:	King & Wood Mallesons

ORDERS

NSD 1052 of 2022

BETWEEN:	**AUSTRALIAN SECURITIES AND INVESTMENTS COMMISSION** Plaintiff
AND:	**ZURICH AUSTRALIA LIMITED (ABN 92 000 010 195)** Defendant

ORDER MADE BY: **JACKMAN J**

DATE OF ORDER: **21 DECEMBER 2023**

THE COURT ORDERS THAT:

1. The originating process be dismissed.
2. The plaintiff pay the defendant's costs.
3. In the event that the defendant seeks a lump-sum costs order:
   (a) the defendant file and serve written submissions together with any affidavit(s) in support by 2 February 2024;
   (b) the plaintiff file and serve any written submissions and any affidavit(s) in support by 16 February 2024; and
   (c) the defendant file and serve any written submissions and affidavit(s) in reply by 1 March 2024.

Note: Entry of orders is dealt with in Rule 39.32 of the *Federal Court Rules 2011*.

REASONS FOR JUDGMENT

JACKMAN J

1 These proceedings concern a policy for income protection and life insurance (the **Policy**) issued by the company known at the time as OnePath Life Ltd (**OnePath**). In these reasons, I have not referred to the Insured by name in order to protect the Insured's privacy and to avoid unnecessary personal distress. I have also referred to relevant personnel of OnePath by way of anonymised references as Persons A, B, C, D and E, adopting the practice agreed between the parties at the time when they prepared the Statement of Agreed Facts (**SOAF**) in these proceedings on 22 June 2023. Despite the apparently dehumanising aspect of those references, I am conscious that the questions raised in the proceedings as to the duty of utmost good faith concern human problems, not purely intellectual ones: see *Australian Securities and Investments Commission v TAL Life Limited (No 2)* [2021] FCA 193; (2021) 389 ALR 128 at [64] and [198] (Allsop CJ).

2 The Policy was issued in June 2016, and events relating to the handling of the claim and the eventual avoidance of the Policy for fraudulent non-disclosure occurred between 2018 and 2020. From 30 November 2009 to 30 May 2019, OnePath was a wholly owned subsidiary of the ANZ Banking Group Ltd (**ANZ**). On 31 May 2019, OnePath became a wholly owned subsidiary of Zurich Financial Services Australia Ltd. On 1 August 2022, OnePath's life insurance business was transferred to Zurich Australia Ltd (**Zurich**) by operation of s 195 of the *Life Insurance Act 1995* (Cth) following the confirmation by this Court of a scheme for that transfer in *Re OnePath Life Limited (No 2)* [2022] FCA 811 (Jagot J). In *Australian Securities and Investments Commission v Zurich Australia Limited* [2023] FCA 712 at [18], I held that, from the Effective Date of 22 August 2022, the effect of the scheme was to transfer any liability in relation to the claims of Australian Securities and Investments Commission (**ASIC**) in these proceedings from OnePath to Zurich. Accordingly, I ordered that Zurich be substituted for OnePath in the proceedings.

3 In these proceedings, ASIC seeks:

(a) declarations under s 75A of the *Insurance Contracts Act 1984* (Cth) (**ICA**) that OnePath breached the duty of utmost good faith implied by s 13(1) of the ICA and thereby contravened s 13(2A), being a civil penalty provision, in three ways;

(b) the imposition of a civil pecuniary penalty under s 75B of the ICA; and

(c) an order under s 1101B(1) of the *Corporations Act 2001* (Cth) that OnePath take all reasonable steps to cause to be published a notice stating that it has been ordered to pay a pecuniary penalty because it has contravened s 13(2A) of the ICA.

4 On 27 June 2023, I ordered that, pursuant to r 30.01 of the *Federal Court Rules 2011* (Cth), ASIC's application for the declarations of contravention be heard and determined separately from, and in advance of, the balance of the relief sought in the originating process. These reasons deal with the separate hearing of ASIC's application for the declarations of contravention.

The Salient Facts and Documents

5 On 15 March 2016, the Insured met with the Financial Adviser, an employee of ANZ, at the ANZ branch in Grafton. At that meeting, the Financial Adviser provided the Insured with a Financial Services Guide (**FSG**) for ANZ Financial Planning dated 23 February 2015. The FSG included statements that ANZ offered services through ANZ Financial Planning, and that "ANZ Financial Planning acts on behalf of other product issuers (including other ANZ Group Members) when it sells" products including life insurance products (CB tab 114, p 1546). It appears that ANZ Financial Planning is a business unit of ANZ, rather than a separate legal entity.

6 On 18 May 2016, the Insured met with the Financial Adviser again at the ANZ branch in Grafton. At that meeting, the Financial Adviser presented the Insured with a Statement of Advice dated 28 April 2016, which included a recommendation to purchase income protection insurance and life insurance offered by OnePath, and to cancel her existing insurance. The Financial Adviser also provided the Insured with the OnePath OneCare insurance product disclosure statement (**PDS**) dated 1 July 2014, the Supplementary PDS dated 5 December 2015, and the OnePath OneAnswer Frontier Personal Super & Pension PDS dated 2 May 2016. The Financial Adviser discussed the recommendations with the Insured, and took her through the Statement of Advice. The Statement of Advice instructed the Insured to read the OneCare PDS and Supplementary PDS. The Financial Adviser and the Insured finalised an application form for OnePath OneCare Income Protection and Life Insurance cover on a computer within the branch (**Application Form**) (CB tab 22, p 409). The Financial Adviser reminded the Insured that further details may be required through the underwriting process and to be patient and to understand it is "to ensure everything is disclosed" and that the Insured will know the impact of her medical history on cover (CB tab 22, p 410).

7 The Application Form signed by the Insured on 18 May 2016 begins with a detailed description of the policy owner's duty of disclosure and of the possible consequences of not complying with that duty. That description is substantially repeated on the first page of the Personal Statement which forms part of the Application Form (CB tab 21, p 394). A surprising submission was made by ASIC that the document called the Personal Statement was not in evidence (T18.5), but it obviously was, as it forms a fundamentally important part of the Application Form. The first page of the Personal Statement concludes with an acknowledgement by the Insured that she understood her duty of disclosure and her duty to ensure that all of the information provided in the Personal Statement was true and complete.

8 Some of the questions in the Personal Statement were framed by reference to specified periods of time. For example, the question concerning smoking history (CB tab 21, p 396) asked whether the Insured had smoked tobacco, cigars or a pipe "During the past five years", and if so whether the Insured had smoked tobacco, cigars or a pipe "Within the last 12 months, or used a nicotine replacement treatment within the last 3 months". By contrast, the section of the form under the heading "Medical history" (CB tab 21, p 397) was not framed by reference to a specific time period, but instead used the word "ever" in posing the question "Have you ever been diagnosed with, had any symptoms of, or had or been advised to have any consultation or treatment for any of the following (if you are unsure, select 'Yes' to see a list of conditions)". There then appeared a lengthy list of conditions.

9 The Insured ticked the box for "Yes" in answer to the sub-question "Any other accident, injury, pain or disorder affecting a joint, muscle, ligament, tendon, cartilage or limb (including any of the shoulder, hip, hand, wrist, knee, ankle, foot, head, jaw, ribs, arm or leg)?" (CB tab 21, p 397). That answer then called for further information (CB tab 21, p 399), in which the Insured ticked the box for "Hip" but not the box for "Shoulder or collarbone", and indicated that the condition was a cartilage injury on the right side, and in answer to the question "Select when you last had symptoms, pain or restriction due to this condition in your right hip", the Insured answered "More than 5 years ago".

10 The Insured also ticked the box marked "Yes" in answer to the sub-question "Any form of mental health condition, or fatigue related illness?" (CB tab 21, p 398), and then ticked the "Yes" box for the further sub-question "Depression (including major depression, dysthymia)" (CB tab 21, p 398). That answer then called for further information about the Insured's mental health condition (CB tab 21, p 401). In answer to the question, "Have you ever received any

treatment (including medication, counselling, etc.) within the past two years, or had any symptoms within the past two years, for any nervous or mental disorder?", the Insured ticked the box marked "Yes". The next question was not limited to a specific timeframe but used the word "ever" as follows: "Have you ever had any time off work for any nervous or mental disorder?", to which the Insured ticked the box marked "No". Similarly, the next question used the word "ever" as follows: "Have you ever been referred for specialist psychological or psychiatric counselling, or been admitted as an in-patient to any hospital or clinic, for any nervous or mental disorder?", to which the Insured ticked the box marked "No". In answer to the request to provide the diagnosis of the Insured's condition or conditions as described by the treating medical attendant, the Insured said: "Approx 1999/2000 depression relating to overall unhappiness and sadness in work situation and personal life. Proactively sought medication recognising depression symptoms." In answer to the request to specify for each condition the date diagnosed and date the condition ceased (if applicable), the Insured stated: "1999/2000 lasted a few weeks. Had 5 weeks off work on sick leave until well to return to work – post medication and break from work." In answer to the request to specify the symptoms for each condition, the Insured stated: "Verge of tears, general unhappiness in workplace. Medicated and full recovery (no symptoms) and remained with employer for another 3 years." In answer to the question whether the Insured had ever had any recurrence of the symptoms, the Insured ticked the box marked "Yes", and in answer to the request to provide the dates of the last symptoms stated: "Stayed on medication for over 6 years to start with as happy with impact. Stopped medication approx for 6 years, however resumed approx 2 years. Happy to be on medication when recognise feeling flat or stress". In answer to the question: "Have you ever attempted suicide or self harm?", the Insured ticked the box marked "No". In answer to the question whether the Insured was aware of the cause or reasons for her mental health condition, the Insured ticked the box marked "Yes", and then in answer to the request to provide details stated: "General stress from stress, duties and busy at work. Dealing with other staffing issues (eg less staff at work and unhapiness [sic] of employees). Medication to take edge off and function to best of ability. Have been with this employer for 12 years and never had anytime off for depression. Proactively happy to take medications". In answer to the request to provide details of the treatment including any medication taken for the condition, the Insured stated: "Efexor 2 a day". In answer to the question: "Have you ever been admitted to hospital or any other care facility?", the Insured ticked the box marked "No". In answer to the request for details of the doctor who holds the records relating to this condition, the Insured gave the details for Dr John Bradshaw, a general practitioner, at the Queen Street Clinic in Grafton.

11 In answer to the question whether the Insured had "ever" made a claim for, among other things, workers' compensation, the Insured ticked the box marked "No" (CB tab 21, p 403). However, that answer was corrected in a Personal Statement Adjustment Form signed by the Insured on 7 July 2016 (CB tab 35, p 533-535), in which the Insured said that that answer was incorrect and referred to having made a claim for workers' compensation for depression in 2001 and an injury on her right side in 2001 and 2003, noting that there is an indecipherable word used by the Insured in describing the right side injury (CB tab 24, p 421).

12 The Personal Statement then set out the authority provided by the Insured for her medical practitioner to release details of her personal medical history to OnePath for the purpose of further assessing the application (CB tab 21, p 404). On the same page, the Insured acknowledged and agreed to having read and understood the duty of disclosure and declared that the statement and answers provided in the Personal Statement were true and complete. The "Declarations" section of the Application Form again set out the details of the duty of disclosure (CB tab 21, p 406). The Declarations given by the Insured (CB tab 21, pp 406-7) included the following:

> - I have read and understood my duty of disclosure, and declare that the statements made in this application including any Personal Statement are true and complete.
> - I have received and read the relevant OneCare Product Disclosure Statement (PDS) prior to completing and submitting this application.
> - …
> - I authorise my adviser, named in this application, to receive and access my personal information including financial, medical, and other matters, whether disclosed in this application or obtained from third parties (e.g. doctors, accountants), for the purposes of management and administration of my application, policy and any claims. Where there is any change to this authority, or to my adviser, I will notify OnePath Life of the change.
> - I understand my financial adviser is acting as my agent in completing and submitting this application whether electronically or by any other method acceptable to OnePath Life.
> - I understand the insurance applied for in this application is subject to further assessment by OnePath Life and will not become effective until my application is accepted and a Policy Schedule is issued by OnePath Life.

13 Those declarations made it clear that the Financial Adviser was acting as the agent of the Insured in making the application. It was also clear from the last declaration in the extract above that it was a matter for OnePath whether to accept the application for insurance, rather than that being a decision made by the Financial Adviser in a way which would bind the insurer. I

note at this point that a submission was made that the Financial Adviser was acting as the agent of OnePath in selling life insurance to the Insured, based on the statement in the FSG that ANZ Financial Planning acts "on behalf of" other product issuers (including other ANZ Group Members) when selling life insurance products (CB tab 114, p 1,546). I reject that submission. The expression "on behalf of" as used in that statement in the FSG is ambiguous, in that it may refer either to acting in the interests of an entity, or as representative of the entity. It is only the latter sense which may give rise to a relationship of agency, and even then there are many kinds of commercial representatives (such as distributors) who do not satisfy the legal meaning of the word "agency", namely an authority or capacity in one person to create legal relations between a person occupying the position of principal and third parties: *International Harvester Company of Australia Pty Ltd v Carrigan's Hazeldene Pastoral Company* (1958) 100 CLR 644 at 652 (Dixon CJ, McTiernan, Williams, Fullagar and Taylor JJ).

14 On 18 May 2016, OnePath sent a letter to the Insured enclosing the Insured's Personal Statement Adjustment Form and an Interim Cover Certificate. The covering letter included a reminder as to the Insured's duty of disclosure (CB tab 23, p 411). On 23 May 2016, OnePath submitted a request for a report from Dr Bradshaw, the Insured's general practitioner, in relation to the Insured's mental health, blood pressure and general health. The request was directed to United Healthcare Group (**UHG**). On 25 May 2016, OnePath received an email from UHG stating that Dr Bradshaw would not release anything whatsoever to UHG (CB tab 30, pp 519-20). That led to UHG cancelling the request for information from Dr Bradshaw. On 14 June 2016, an underwriting note was prepared in relation to the Insured's application for insurance, noting that the only real concern with the Insured was in respect of mental health, and given that the insurer had "quite good disclosure" from the Insured in relation to mental health, that was always going to be an exclusion, and due to the doctor's refusal to complete the requested report, mental health would be excluded (CB tab 24, p 414). On 15 June 2016, OnePath sent a letter to the Insured which included an offer for income protection and life insurance cover, with the income protection cover being offered expressly subject to an exclusion in relation to mental illness, and the life insurance cover being offered at standard rates (CB tab 31, p 521-523). The letter again included a reminder as to the Insured's duty of disclosure. Also on 15 June 2016, the Financial Adviser telephoned the insured, and discussed the impact of the mental health exclusion, and how the Financial Adviser had indicated that that was to be expected (CB tab 32, p 524).

15 On 28 June 2016, the Insured met with the Financial Adviser, again at the ANZ branch in Grafton. They discussed the mental health exclusion and the Insured accepted the offer which OnePath had made on 15 June 2016 (SOAF at [23]). The Insured signed the declaration, which included the declaration that the Insured understood and acknowledged that her duty of disclosure outlined in the PDS continued up until the date that OnePath accepted her application and issued a policy. The Financial Adviser emailed the signed letter to OnePath. On 28 June 2016, OnePath sent a letter to the Insured which enclosed the Insured's Policy Schedule, the OneCare Policy Terms and a Welcome to OnePath brochure.

16 On 7 July 2016, the Insured completed and signed the Personal Statement Adjustment Form to which I have referred above (CB tab 35), informing OnePath that she had made workers' compensation claims in 2001 for depression and an injury on her right side in 2001 and 2003. On 14 July 2016, OnePath made a telephone call to the Insured in relation to the information provided in that form. As is agreed in the SOAF at [26], during the telephone conversation OnePath reminded the Insured of her duty of disclosure and, in relation to the right side injury disclosed in the Personal Statement Adjustment Form, the Insured:

(a) confirmed that the disclosure related to an injury to her back, which probably occurred in approximately 2001;

(b) confirmed that the injury caused strong pain in the sacroiliac area;

(c) confirmed that symptoms continued on and off until about 2004;

(d) confirmed that she had approximately two weeks off work in relation to the injury; and

(e) confirmed that she had made a claim for workers' compensation in relation to the injury and time off work, which was finalised in December 2003.

The discussion did not address the Insured's mental health history. On 22 July 2016, the Insured was advised by OnePath that, following OnePath's review of the Personal Statement Adjustment Form, there would be no changes to the Policy.

17 On 14 February 2017, the Insured injured her right shoulder in a workplace incident. Despite undergoing surgery in relation to the injury, the Insured's right shoulder tendon later ruptured during physiotherapy. The Insured underwent further surgery on 6 December 2018 in relation to the injury.

18 On 25 October 2018, the Insured completed and signed an Initial Claim Form for income protection, which she submitted on 14 November 2018, together with an Initial Treating

Doctors Statement by Dr Bradshaw and supporting documentation. The Initial Treating Doctors Statement included disclosure of a previous right shoulder injury (CB tab 46, p 705). On or about 27 November 2018, after some further enquiries, OnePath accepted the Insured's claim for specified benefit periods, subject to ongoing assessment of the claim, and started to pay the Insured benefits, accruing from 27 June 2018.

19 In November and December 2018, and again in early 2019, OnePath sought further information from the Insured regarding her prior shoulder injury and medical records from Dr Bradshaw. By email of 18 January 2019, Dr Bradshaw declined to provide OnePath with the medical records requested by OnePath. On 25 November 2019, OnePath sought a Statement of Claims from the Insured's previous health fund, HCF, and a report from the Insured's orthopaedic surgeon. On the same day, OnePath sent a letter to the Insured which enclosed a supplementary personal statement for completion. On 2 December 2019, the Insured sent an email to OnePath in response to its letter of 25 November 2019, in which she (wrongly) stated that the previous right shoulder injury was "mentioned when policy was first filled out" (CB tab 61, p 810).

20 On or about 2 December 2019, HCF provided a Statement of Claims, which contained details of claims made by the Insured under her HCF policy for the period 19 January 1996 to 27 November 2019, including various dates of admission to the Grafton Base Hospital, but did not include information as to the reasons for those hospital admissions.

21 On 3 December 2019, OnePath requested the Insured's medical records from the Grafton Base Hospital. On the same day, OnePath notified the Insured of the records obtained from HCF, its knowledge of her admissions to the Grafton Base Hospital, and that it had made a request for a copy of her records from that hospital. On the same day, the Insured responded to OnePath saying, among other things, that the admissions to Grafton Base Hospital were for mental health issues during the early 2000s, and more recently for two shoulder surgeries (CB tab 63, p 814). On 7 January 2020, OnePath sent a letter to the Insured requesting that she complete a supplementary personal statement in relation to her pre-existing right shoulder injury. On 17 January 2020, the Insured provided a supplementary personal statement which included confirmation by Dr Bradshaw that he had no record of shoulder injuries between 2005 and 2017 (CB tab 66, p 928).

22 On or about 27 April 2020, OnePath received the requested hospital records from the Grafton Base Hospital, which disclosed that in the period from 2001 to 2005, the Insured was admitted

to the Grafton Base Hospital on six occasions in relation to her mental health, including suicidal ideation and suicide attempts. The Grafton Base Hospital records (CB tab 68) revealed that:

(a) on 7 May 2001, the Insured had been admitted to the emergency department (p 1,268), having taken 7 Serapax and 13 Aropax tablets the previous evening (p 1,271). The records indicate that the Insured "stated she hoped she could kill herself" (p 1,271). The Insured was discharged on 8 May 2001 (p 1,285);

(b) on 24 May 2001, the Insured was admitted to Grafton Base Hospital (p 1,239). The records indicate the reason for admission being "Depression, suicidal ideations, change of medication" (p 1,258). During that admission, on 26 May 2001, the Insured presented to the nurses' station having cut her arm with a Stanley knife hidden in her bag (pp 1,243-1,244). The records of the admission contain several references to the Insured making statements that she wanted to die (pp 1,245-1,246). The Insured was discharged on 4 June 2001 (p 1,260);

(c) on 12 May 2002, the Insured was again admitted to hospital (p 1,226). The records indicate that she had engaged in superficial slashing of both of her arms (pp 1,227-1,228). The records stated that the Insured had plans and means of self-harm (p 1,229). The Insured was discharged on 15 May 2002 (p 1,226);

(d) on 24 November 2002, the Insured was again admitted to hospital (p 1,214). The records again contain references to the Insured's suicidal ideation and planning (p 1,217). The Insured was discharged on 26 November 2002 (p 1,214);

(e) on 3 March 2003, the Insured was again admitted to hospital (p 1,199). During that admission, the Insured consumed 60 mg of Diazepam which she had secreted in her bag (p 1,204). This was referred to as an "acute overdose" (p 1,199). The Insured was discharged on 5 March 2003 (pp 1,214-1,216); and

(f) on 24 November 2005, the Insured was again admitted to hospital as part of a safe "time out" in circumstances where she had suicidal thoughts with some non-fixed plans (p 947). The Insured was discharged on 26 November 2005 (p 950).

23 The Claim Assessment Notes from OnePath's initial assessment of the Grafton Base Hospital records on 6 May 2020 record that the Insured did not advise OnePath of her six admissions to hospital for suicidal ideations, overdose and self-harm in the period 2001 to 2005 (CB tab 50, p 758). OnePath made a further request for medical records from Dr Bradshaw, and on 27 May

2020, OnePath received confirmation from Dr Bradshaw's clinic that the Insured had revoked OnePath's authority to request the medical records (CB tab 73).

24 On 11 June 2020, a OnePath Retail Claims Consultant (referred to in the SOAF as Person A) requested permission to refer the claim for technical review (CB tab 75, p 1,335). It was recognised in that email that, given the Insured had been on policy for over three years, OnePath would only have a remedy if there had been fraud. On 17 June 2020, a OnePath Principal Claims Consultant (referred to in the SOAF as Person B) instructed Person A to proceed with a retrospective underwriting review to determine whether cover would have been offered to the Insured had the information then held by OnePath in relation to the Insured's mental health history been known prior to accepting the Policy (CB tab 75, p 1,334). On 19 June 2020, Person A prepared a Retrospective Underwriting Request, which was signed on 22 June 2020 by a OnePath Retail Senior Claims Consultant (referred to in the SOAF as Person C) (CB tab 76, pp 1,338-1,344). In an Underwriting File Note dated 29 June 2020, a OnePath underwriter (referred to in the SOAF as Person D) concluded that, based on the knowledge of the Grafton Base Hospital admissions, OnePath would have declined the Insured's request for income protection cover, while life insurance cover would have been accepted at standard rates (the same rates as were initially offered to and accepted by the Insured) (CB tab 77), referring to "mental health issues between 2001 and 2005 with multiple episodes of suicidal ideation and a least one attempted suicide". Person D had not been involved in the initial underwriting of the Insured's income protection or life insurance cover.

25 On 29 June 2020, Person A sent the Retrospective Underwriting to Persons B and C (CB tab 75, p 1,333), and received a reply that day from Person B instructing Person A to proceed with a procedural fairness letter and adding "if our fraud argument is reasonable (once we receive her pro-fair response), then I would support declining this claim" (CB tab 75, p 1,333). Further emails were sent internally within OnePath on 30 June and 1 July 2020, which also involved a OnePath Manager (referred to in the SOAF as Person E). On or about 7 July 2020, the draft letter discussed in those emails was finalised, and was sent to the Insured on 9 July 2020 (the **Procedural Fairness Letter**) (CB tab 85).

26 The Procedural Fairness Letter referred to the Insured's income protection claim, and stated that the purpose of the letter was to make the Insured aware of the information that OnePath would take into consideration when making a decision about whether the Insured meets the criteria for payment of income protection benefits under the Policy and to draw specific issues

to her attention which may be adverse to her claim, and to give her an opportunity to respond to the matters raised in the letter. The letter stated: "In particular, it appears that the responses provided in your Application Form were incorrect or incomplete."

27 Under the heading "Background", the letter referred to the questions which the Insured was asked in the Application Form regarding her medical circumstances, and expressed concerns that some of her responses in the Application Form were not supported by information that OnePath had subsequently obtained. The letter stated that it provided the Insured with the information obtained during OnePath's investigations, so that the Insured had the opportunity to respond or provide additional information before OnePath made its decision on her claim.

28 The letter then set out the duty of disclosure contained in the Application Form, which the Insured had declared she had read and understood (CB tab 85, p 1,434). The quoted extract contained express reference to the remedies available to the insurer for breach of the duty of disclosure within three years of entering into the contract (which I note had obviously elapsed by 7 July 2020), and then referred to the circumstance where the failure to tell OnePath something was fraudulent, in which case OnePath may refuse to pay a claim and treat the contract as if it never existed.

29 Under the heading "Information relevant to our review", the letter referred to the Application Form and the Grafton Base Hospital records. Copies of those documents were enclosed with the letter, together with a request to let OnePath know if there are any documents not listed above in the letter which the Insured considered should be considered in OnePath's assessment of the claim (CB tab 85, p 1,434-1,435). The letter then set out the specific responses in the Application Form concerning the Insured's mental health condition, including the Insured's negative answers to questions as to whether she had ever been admitted as an in-patient to any hospital or clinic for any nervous or mental disorder, whether she had ever had longstanding (ie longer than 12 months) recurrent or multiple episodes of any type of nervous or mental disorder, whether she had ever attempted suicide or self-harm and whether she had ever been admitted to hospital or any other care facility. The letter then set out the substance of the Grafton Base Hospital records (CB tab 85, p 1,436).

30 Under the heading "Potential barriers to the claim continuing", the Procedural Fairness Letter stated as follows:

> Insurance Contracts Act (Section 29) provides that in certain circumstances an insurer may avoid a contract of insurance where there has been non-compliance with the duty

> or [sic] disclosure, or where an insured has made a material misrepresentation, prior to the parties entering into the contract.
>
> Avoiding a contract of insurance means the cover is treated as though it had never existed. We are considering our rights under Section 29 in light of the evidence we have outlined above.

31 Under the heading "What to do next", the Procedural Fairness Letter stated as follows (CB tab 85, p 1,437):

> Before we proceed to make a decision on your claim, you have the opportunity to provide an explanation as to why you failed to disclose and/or misrepresented your mental health medical history in your Application Form and before we accepted your Application.
>
> If you wish to provide a response or submit further information for us to consider, you will need to do this in writing within 21 days from the date of this letter.

32 On the same day, 9 July 2020, Person A and the Insured spoke over the telephone. During the telephone call (SOAF at [61]):

(a) the Insured confirmed that she had revoked OnePath's authority to request clinical notes;

(b) Person A told the Insured that OnePath had received the Grafton Base Hospital records;

(c) Person A told the Insured that OnePath had noted concerns in relation to what was disclosed in the Application Form as compared to the Grafton Base Hospital records;

(d) Person A told the Insured that he needed to send the Insured a copy of the Grafton Base Hospital records and a letter stating OnePath's concerns by post;

(e) Person A requested that the Insured read what OnePath's concerns were and that the Insured respond in writing;

(f) Person A told the Insured that she would be given 30 days to respond to OnePath's letter, being a longer time than the 21 days normally allowed for a response. Person A told the Insured that if she required longer than 30 days to respond, she should let Person A know; and

(g) Person A told the Insured to call him back if she was not sure about something in the material to be posted.

33 The Procedural Fairness Letter reached the Insured on 17 July 2020 (CB tab 89). On 22 July 2020, the Insured sought a three week extension for provision of a response to the Procedural Fairness Letter, and on 27 July 2020, Person A confirmed by email to the Insured that a principal claims consultant had approved an extension of time to respond to 30 August 2020

(CB tab 90, p 1,452). By 5 August 2020, the Insured had engaged the Financial Rights Legal Centre (**FRLC**), an independent community legal centre, to act on her behalf in relation to her claim (CB tab 94). On 7 August 2020, the FRLC sent a letter to OnePath on behalf of the Insured, requesting certain documents including a copy of the agency or broker or other agreement between OnePath and ANZ relating to the distribution of insurance products and/or provision of insurance advice (CB tab 94, p 1,462). Following further discussions between OnePath and the FRLC, on 20 August 2020, a further extension was provided giving the Insured until 30 September 2020 to provide a response, that extension having been approved by Person E. In response to the FRLC's letter of 7 August 2020, on 28 August 2020, OnePath sent a copy of telephone recordings between OnePath and the Insured to the FRLC (CB tab 93), and on 31 August 2020, OnePath sent a copy of the Insured's income protection claim file to the FRLC (CB tab 94, p 1,460). One Path did not provide any agency, broker or other agreement between OnePath and ANZ relating to the distribution of insurance products and/or provision of insurance advice.

34 On 29 September 2020, the FRLC on behalf of the Insured sent a letter to OnePath responding to the Procedural Fairness Letter (**Response Letter**) (CB tab 97). The opening paragraph of the Response Letter stated that the FRLC acted for the Insured and understood that OnePath had asked the Insured to explain the reason she did not fully disclose her history of mental illness on her insurance application, and stated that they were instructed to respond in the manner which followed. Under the heading "Disclosure on the insurance application", the Response Letter stated as follows:

> In 2016, [the Insured] attended an ANZ branch and was referred to an adviser, [the Financial Adviser]. Details of the adviser are listed on the insurance application.
>
> [The Financial Adviser] helped [the Insured] answer the mental health questions on the application form. [The Financial Adviser] asked [the Insured] whether she ever had any mental health issues and [the Insured] answered yes. The questions that followed were more specific and [the Insured] asked for clarification about how far back in time she needed to go when responding to the questions. [The Financial Adviser] stated that she would need to go back 5 years.
>
> During a conversation with [the Financial Adviser], [the Insured] discussed her mental health issues and [the Financial Adviser] asked whether [the Insured] was taking medication and if so, whether it was working well. [The Insured] confirmed she was taking medication and was stable. [The Financial Adviser] then confirmed that she did not have to go back beyond 5 years.
>
> The medical records mentioned in your letter dated 7 July 2020 related to events outside the 5 year period and so [the Insured] understood that she was not required to disclose them on her application. As you can see, [the Insured] relied on the information provided by the adviser in branch and disclosed information accordingly.

The Response Letter then referred to the request for documents previously made and noted that there remained outstanding a copy of the applicable underwriting guidelines, and a copy of the agency or broker or other agreement between OnePath and ANZ relating to the distribution of insurance products and/or provision of insurance advice. The Response Letter asked OnePath to confirm when those documents would be provided (CB tab 97, p 1,468).

35 On 30 September 2020, Person A sent an email to the FRLC attaching the applicable underwriting guidelines, but did not respond to the other request for production of the agency, broker or other agreements.

36 On 30 September 2020, there was a series of emails between Persons A, B and E concerning the Response Letter. In the course of those emails, Person A said that he assumed that they would need a copy of the Financial Adviser's notes and Statement of Advice, but acknowledged that he was not familiar with the process. Person E, being a more senior employee, responded that there was no need to request the Statement of Advice or Financial Adviser's file. There is also a reference to forwarding the Response Letter to those responsible for complaints at ANZ Financial Planning, although that appears to be directed to the FRLC's request for the agency or broker or other agreement. At the end of that series of emails, Person A asked Person E whether the income protection claim should continue to be managed as usual awaiting a further response from the solicitor, or whether OnePath would proceed to deny the claim due to non-disclosure, to which Person E answered ambiguously "Proceed as normal" (CB tab 99, p 1,471). Shortly afterwards on 30 September 2020, Person A sent to the FRLC the retrospective underwriting referral for the Insured (CB tab 103).

37 On 1 October 2020, Person A made a note which summarised aspects of the Response Letter and other interactions with the FRLC and stated under the heading "Action" the following: "Based off what we received to date and what we are aware of determination made to decline the IP [income protection] claim." (CB tab 50, p 742).

38 On 7 October 2020, OnePath sent a letter to the Insured stating that, after reviewing all the material provided by the Insured and obtained by OnePath in connection with the claim, OnePath had decided to avoid the Insured's income protection cover from inception, and would not be continuing payment of income protection benefits (the **Avoidance Letter**). In the second paragraph, the Avoidance Letter stated that it set out:

- the reason for our decision;

- how your policy is affected;
- how you can find out more information about our decision; and
- what you can do if you are not satisfied with our decision.

That fourth aspect of the letter was in fact not addressed by the contents of the Avoidance Letter.

39 The Avoidance Letter referred to the Insured's duty of disclosure, the underwriting review, the Response Letter, and the information known from the Grafton Base Hospital records. The Avoidance Letter then said as follows under the heading "Breach of the duty of disclosure" (CB tab 107, p 1,493):

> It is evident that you did not inform Onepath of your correct medical history and other important matters when you applied for income protection insurance.
>
> In failing to inform Onepath of the matters now known, we are of the view that you have breached your duty of disclosure, and that this breach is fraudulent.
>
> In making this determination we have considered the following:
>
> - While you advise that you completed the application under the guidance of [the Financial Planner], this information was not available for the underwriter of OnePath Life Limited to consider at the time of application.
> - It is the obligation of the Life Insured and Policy Owner to ensure they comply with the Duty of Disclosure by ensuring that all information provided to The Insurer is accurate including reviewing the accuracy of the responses in the Application Form.
> - The application included wide-ranging questions which made it clear that Onepath was concerned to know the entirety of your medical history and not just conditions that occurred within the prior 5-year period. The medical questions on the application specifically asks [sic] "Have you **ever** attempted suicide …. Have you **ever** been admitted to hospital …" and do not limit this to 5 years.
> - We consider that you knew, or a reasonable person in the circumstances would have been aware of the requirement to disclose the full history of your mental health issues.
> - It seems you were selective in your disclosure to Onepath Life. For example, when asked about your medical history, you disclosed part of your mental health issues, however you did not provide the full details that is [sic] now known:
>
> To the question *have you ever attempted suicide or self-harm?* You answered NO
>
> To the question *have you ever been admitted to hospital or any other care facility?* You answered NO
>
> In our opinion, you completed the application and other documents recklessly and with a total disregard to your obligation to provide true and complete information to

Onepath.

40 The Avoidance Letter then referred to s 29(2) of the ICA, as stating that if the failure to comply with the duty of disclosure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract. It was then stated that in terms of the requirement to establish fraud for the purposes of that provision, the courts have identified that that can be satisfied by either a deliberate decision to conceal the true facts or to mislead the insurer, or by reckless indifference as to whether the duty of disclosure is complied with or the facts disclosed are true and correct. The letter then conveyed OnePath's decision to exercise its rights under s 29(2) of the ICA to avoid the Insured's income secure standard cover from inception, thereby treating that cover as though it never existed and stated that no claims would be met under it. The Avoidance Letter confirmed that the Insured's life cover would remain and continue to be honoured as long as the Insured continued to pay the premiums required to keep that cover in force. The letter then stated that the amount which OnePath had paid the Insured in total disability benefit payments exceeded the amount that the Insured had paid in premiums for income protection standard cover, and thus no refund of premiums was due.

41 Although the Avoidance Letter did not include the foreshadowed information as to what the Insured could do if she was not satisfied with OnePath's decision, the FRLC on behalf of the Insured lodged a complaint on 13 April 2021 to OnePath seeking a reinstatement of the income protection cover on the basis that the insured's non-disclosure was innocent (CB tab 109). On 22 June 2021, OnePath rejected that complaint, and indicated that the Insured could have her complaint reviewed free of charge by the Australian Financial Complaints Authority (**AFCA**), an external dispute resolution scheme (CB tab 111, p 1,510). On 28 September 2021, the FRLC took up that opportunity with AFCA on behalf of the Insured (CB tab 112).

Section 13 and the Duty of Utmost Good Faith

42 Section 13 of the ICA, as in force since 13 March 2019, provides relevantly as follows:

> (1) A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.
>
> (2) A failure by a party to a contract of insurance to comply with the provision implied in the contract by subsection (1) is a breach of the requirements of this Act.
>
> (2A) An insurer under a contract of insurance contravenes this subsection if the insurer fails to comply with the provision implied in the contract by subsection (1).

Civil penalty: 5,000 penalty units

43 In *CGU Insurance Limited v AMP Financial Planning Pty Ltd* [2007] HCA 36; (2007) 235 CLR 1, the High Court accepted that the duty of utmost good faith is not limited to dishonesty: at [15] (Gleeson CJ and Crennan J); [257] (Callinan and Heydon JJ). Gleeson CJ and Crennan J at [15] said that utmost good faith "may require an insurer to act with due regard to the legitimate interests of an insured, as well as to its own interests" and "may require an insurer to act, consistently with commercial standards of decency and fairness, with due regard to the interests of the insured". I note that their Honours used the word "may" and avoided language conveying an absolute or inflexible requirement. Similarly, in *Allianz Australia Insurance Ltd v Delor Vue Apartments CTS 39788* [2022] HCA 38; (2022) 97 ALJR 1 at [95], Kiefel CJ, Edelman, Steward and Gleeson JJ said that the implied condition of utmost good faith is not limited to honest performance. At [96], their Honours said that rights and powers must be exercised, and duties must be performed, consistently with "*commercial* standards of decency and fairness", as distinct from standards of decency and fairness more generally. At [97], their Honours said that there is no free-standing general obligation upon an insurer, independent of its contractual rights, powers, and obligations, to act in a manner which is decent and fair; rather, the obligation to act decently and with fairness is a condition on how existing rights, powers and duties are to be exercised or performed in the commercial world. At [103]-[104], their Honours said that the duty of utmost good faith must be applied in a manner which is coherent with the operation of existing legal doctrines, whose existence was well established at the time of the ICA, and with the ICA itself.

44 In the present case, both parties accepted that the content of the duty of utmost good faith depends on the factual circumstances of the case. Both parties accepted the correctness of the statement by Allsop CJ in *Australian Securities and Investments Commission v TAL Life Limited (No 2)* at [173]:

> It is inappropriate to draw conclusions of principle or of rules from other articulated fact situations about a duty of this character. Fact situations should not be converted into rules by a process of extrapolation and abstraction.

That statement is of particular importance in the present case, as much of ASIC's argument relies on isolated judicial statements, made in relation to fundamentally different factual circumstances, as though they were of application to the present case, and often ignoring statements in the same judicial reasoning which qualify the statements upon which ASIC relies. That approach to the use of judicial authority recalls the technique deprecated by Heydon J,

with his Honour's characteristic felicity of expression, in the following terms in *Pape v Federal Commissioner of Taxation* [2009] HCA 23; (2009) 238 CLR 1 at [424]:

> Striking aesthetic effects can be achieved by selecting semi-precious stones, splitting them into fragments, jettisoning some fragments, fine-chiselling the remainder, and placing them into a fore-ordained pattern in the manner of a Byzantine mosaic, or a Florentine table of pietra dura, or that type of Mughal craftsmanship involving the inlaying of marble known as parchin kari. The employment of analogous processes in relation to legal propositions, however, rarely leads to convincing conclusions.

45 In particular, ASIC's argument relies heavily on decisions concerning policies of insurance (and superannuation trust deeds) where the definition of disablement depended upon the formation of a subjective state of belief or satisfaction by the insurer (or trustee). In those cases, the insurer's state of satisfaction is determinative of the insured's rights under such policies. By contrast, a purported but invalid avoidance of a policy under s 29(2) of the ICA, by an insurer who wrongly asserts that an insured was fraudulent, is simply ineffective.

46 For example, in its written submissions at [108], ASIC makes a submission of apparently general application that in a contract of insurance, there is an implied term requiring the insurer in the context of the consideration of a claim under a policy to give the insured an opportunity to respond to any adverse materials. That proposition is said to be supported by the reasons of Malcolm CJ and Ipp J in *Beverley v Tyndall Life Insurance* [1999] WASCA 198; (1999) 21 WAR 327. However, *Beverley* was concerned with a disablement policy of the kind referred to above, whereby the insured's entitlement depended upon proving to the satisfaction of the insurer that the relevant definition of incapacity had been met. That was central to the Court's reasoning, as is evident from the reasons of Ipp J at [86] in emphasising that the insurer's omission to disclose the medical reports of the doctors whose advice it had sought had to be seen in the context of the insurer being a "judge in its own cause". Both Malcolm CJ and Ipp J relied on principles concerning the interpretation of contractual provisions conferring quasi-judicial decision-making functions on a person, where such provisions may implicitly require that a decision be reached honestly, in good faith and reasonably: see [14] and [91] respectively. Ipp J said at [36] that the judgment of an insurer under a policy of this kind is in the nature of a discretionary judgment, in the sense that it cannot be successfully impugned on the grounds that it is incorrect, given that reasonable minds may differ. However, as Zurich submits, a decision by an insurer or an insured to assert and exercise a contractual right that is not dependent upon any subjective state of satisfaction is qualitatively and fundamentally different. Such an exercise can be challenged on the ground that it is objectively incorrect; that is, on the basis that the asserted right does not exist or cannot validly be exercised. In such a case, the

party purporting to exercise the right is not acting as a judge in its own cause. On the contrary, the exercise of the right is either effective or not, and any dispute as to the matter can be determined by a court or other tribunal.

47 It is not necessary in this case to deal separately with all the cases relied upon by ASIC which involved policies (or trust deeds) where cover (or the payment of trust benefits) depended upon the subjective state of mind of the insurer (or trustee). However, I will deal with four of those cases, as they are said to support two propositions which are fundamental to ASIC's case, namely that the duty of utmost good faith requires that the insurer (a) make an obvious enquiry, and (b) seek further information in order to resolve conflicting accounts.

48 The first of those propositions, namely that the condition of utmost good faith may require that the insurer make an obvious enquiry, is said to be supported by two cases. The first is *Carroll v United Super Pty Ltd* [2018] NSWSC 403 at [92]-[94] (Slattery J). That case concerned a decision of a superannuation trustee and a life insurer (Hannover) to reject a claim, where the obligation of indemnity depended upon Hannover's state of satisfaction as to the insured meeting the specified requirements of disability. The successful challenge to Hannover's decision did not depend upon a failure by Hannover to make enquiries as such, but on the absence of evidence in support of Hannover's conclusion that Mr Carroll could have continued managing his own business by undertaking lighter non-manual aspects of management, and the failure to put that proposition to Mr Carroll for comment: [152]-[153]. Similarly, Hannover's reasoning concerning Mr Carroll's golf activity was unreasonable in circumstances where it was unsupported by any evidence: [162]-[163].

49 The second case relied upon for this proposition is *Halloran v Harwood Nominees Pty Ltd* [2007] NSWSC 913 at [38] (Brereton J). That case also concerned a superannuation trust deed which relevantly provided that the question of disablement shall be decided by the insurer and the trustee in their absolute discretion: see [20]. At [38], being the passage on which ASIC relies, Brereton J said as follows:

> Mr Cavanagh submitted that the insurer was entitled to take into account information that had been submitted by the employee/claimant in the claim without seeking out more information, the onus being on the employee to make out his claim. At least as a general statement, I entirely agree; I add the qualification "as a general statement" because, conceivably, there may be circumstances in which an insurer would not act fairly or reasonably by rejecting a claim when there had been some obvious oversight by the claimant in its preparation which could easily be remedied by a request for further information.

The statement as to the general principle in that passage is contrary to ASIC's submission as to OnePath being duty-bound to make further enquiries, and ASIC expressly disclaimed any submission that there was an obvious oversight by the Insured in the present case: T52.39-42. ASIC did place reliance on the statement by Brereton J immediately following that extract, namely that it is to be borne in mind that the process is not an adversarial one, but Brereton J was dealing there expressly with the process of forming the requisite opinion which was required by the relevant clause. As Zurich submits, where an insurer is exercising a right of avoidance, that does involve an adversarial role and does not involve any adjudicatory function at all: T117.3-11. In that passage, Brereton J was considering a hypothetical possibility that the duty might, in conceivable cases, require the insurer to make further enquiries of an insured who had made an obvious oversight in preparing their claim. As Zurich submits, the actual decision in *Halloran* turned upon the fact that the trustee had directed itself to the wrong question (see [51]-[54]), rather than any failure by the insurer to make an obvious enquiry.

50 ASIC's proposition that the duty of utmost good faith may require that the insurer seek further information in order to resolve conflicting accounts is also said to be supported by two cases. The first is *Finch v Telstra Super Pty Ltd* [2010] HCA 36; (2010) 242 CLR 254 at [66] (French CJ, Gummow, Heydon, Crennan and Bell JJ). That case also concerned a superannuation trustee's duty to a member when forming an opinion as to the member's disablement, in circumstances where the trust deed specifically required the trustee to take into account certain classes of evidence before forming its opinion. The trustee's rejection of Mr Finch's claim was made in the face of uncontroverted medical evidence from three doctors that Mr Finch was suffering from a severe psychological condition which rendered him unlikely ever to obtain employment. As Zurich submits, the High Court's reasoning depended upon the fact that the superannuation trust was a strict, rather than a discretionary, trust and that the trustee was under a duty to take into account "information, evidence and advice the Trustee may consider relevant" which implicitly required it to make enquiries for such materials: [66]. The High Court's reasoning placed emphasis on the fact that the trustee's formation of an opinion was determinative of the form and quantum of Mr Finch's beneficial interest in the trust: [30] and [66]. The decision says nothing about an insurer's duty of utmost good faith, and nothing about the application of that duty in circumstances where the insurer is not performing any quasi-adjudicative functions. In contrast to the duties imposed on the trustee in that case, the High Court in *Delor Vue* at [95] expressly stated that the duty of utmost good faith is not fiduciary in character.

51 The second case relied upon by ASIC for this proposition is *Folmer v VicSuper Pty Ltd* [2018] NSWSC 1503 at [237] (Hallen J). That case also concerned a policy where benefits were payable only if the occurrence of an insured event had been established to the satisfaction of the insurer: [106]. Hallen J considered that the opinion formed by the insurer was not one that was reasonably open to it, and that the insurer had failed to have proper regard to the information available to it: [356] and [363]. The passage relied upon by ASIC, namely [237] of Hallen J's reasons, is in the following terms, which tend to undermine, rather than support ASIC's case:

> Yet, in forming its opinion, the obligation of the insurer cannot be equated with the duty of a judge, or a tribunal member, in a judicial, or quasi-judicial, determination of legal rights and liabilities. Nor does it require the insurer to inquire to a point of factual perfection: *Alcoa of Australia Retirement Plan Pty Ltd v Frost* (2018) 36 VR 618; [2012] VSCA 238, at [60].

Similarly, at [249] Hallen J said that what is involved in relation to forming an opinion is not the same as what is involved in decision-making by a Court, and the insurer's written reasons cannot be expected to be comparable to that of a Court.

52 The reasons of Hallen J bear on a further submission by ASIC, to the effect that given the seriousness of an allegation of fraud, it was necessary for OnePath to have an actual persuasion of the mind as to the existence of fraud, on the basis of clear and cogent proof. That submission was said to be supported by the decisions of the High Court in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* [1992] HCA 66; (1992) 67 ALJR 170 at 171 (Mason CJ, Brennan, Deane and Gaudron JJ), and *Rejfek v McElroy* [1965] HCA 46; (1965) 112 CLR 517 at 521 (Barwick CJ, Kitto, Taylor, Menzies and Windeyer JJ). Those two cases involve the principles stated by Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The majority in *Neat Holdings* at 171 expressly noted that that principle reflects "a judicial approach that a court should not lightly make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct". The relevant principle is one which applies to judicial decision-makers making final and binding determinations of serious factual allegations at the conclusion of adversarial litigation. Neither authority nor principle supports the proposition that an insurer, when deciding whether to avoid a policy for fraud, may only do so consistently with the duty of utmost good faith when positively satisfied of the insured's fraud on the basis of clear and cogent proof. That is all the more true where the insurer is not performing any decision-making obligation under the terms of the policy, but is simply determining whether it has grounds to, and should, exercise a contractual and statutory right. As I have said above, whether a policy

may be avoided by an insurer under s 29(2) of the ICA does not depend upon the insurer having any particular subjective state of mind, but depends simply on whether the insured's misrepresentation or failure to comply with the duty of disclosure was fraudulent. That is a question of objective fact which, in the event of a dispute, is able to be resolved by a court exercising judicial power. If the purported avoidance by an insurer under s 29(2) is found to be invalid, then, in the words requested by John Keats for his epitaph, it is merely "writ in water".

53 There was some debate at the hearing before me as to whether it is necessary or sufficient for an insurer to have reasonable grounds, or a reasonably arguable case, for raising an allegation of fraud in exercising contractual rights, and also whether it is necessary for the insurer actually to form a reasonable conclusion on the matter before exercising those rights. However, ASIC expressly and repeatedly conceded that Zurich had formed a reasonable conclusion that the Insured in the present case had fraudulently not disclosed the facts in her Application Form, and limited its case to one concerning the manner or process adopted in reaching that decision: T51.17-32, 54.25, 54.44-55.1, 56.19-22, 132.29-36. Accordingly, it is not necessary to consider those issues in the present case.

54 That concession by ASIC also renders it unnecessary to deal with the submission made by Zurich to the effect that the content of the duty of utmost good faith in the context of an insurer avoiding a policy for fraudulent misrepresentation or non-disclosure must be limited so as to be consistent with the fundamental principle of contract law that a contracting party may, at the point of judicial determination, justify the termination, rescission or avoidance of a contract on a ground not asserted, and not even known, at the time of termination, rescission or avoidance as the case may be: *Shepherd v Felt & Textiles of Australia Ltd* (1931) 45 CLR 359; *Secured Income Real Estate (Australia) Ltd v St Martins Investments Pty Ltd* (1979) 144 CLR 596 at 611 (Mason J); *Sibbles v Highfern Pty Ltd* (1987) 164 CLR 214 at 231 (Brennan J). As the High Court said in *Delor Vue* at [103]-[104], the duty of utmost good faith must be coherent with the operation of legal doctrines which were well established at the time of the ICA and with the ICA itself. The question as to how the content of the duty of utmost good faith can be reconciled with that principle of contract law does not arise in the present case, in that Zurich relies on the material and reasons which it had at the time it decided to avoid the Policy, and ASIC accepts that that material provided a reasonable basis for the conclusion that the Insured had engaged in fraudulent misrepresentation and non-disclosure.

55 I turn then to a consideration of the three ways in which ASIC contends that OnePath breached the duty of utmost good faith.

The First Alleged Contravention: Making Reasonable Inquiries and Giving Appropriate Consideration

56 ASIC submits that the Response Letter and any consideration of the circumstances ought to have put OnePath on notice of the need to make further inquiries, particularly of the Financial Adviser who had been involved with the gathering of the Insured's information, as well as the completion, finalisation and submission of the Application Form. ASIC submits, somewhat surprisingly, that there is no evidence that OnePath rejected the explanation given in the Response Letter as to the Financial Adviser having told the Insured that there was no need to go back beyond five years in disclosing matters in the Application Form, and says that OnePath gave the information sufficient credence to refer it to ANZ Financial Planning complaints. Again somewhat surprisingly, ASIC submits that rather than reaching a conclusion that there had been fraud within the meaning of s 29(2) of the ICA, OnePath was considering the wrong question as to fraud. ASIC criticises Zurich for basing its contentions as to fraud on "a literal reading of the questions". ASIC submits that OnePath could and should have raised with the Insured its consideration that the Response Letter explanation was inconsistent with the Application Form.

57 ASIC also submits that whether the Financial Adviser was the Insured's agent says nothing one way or the other as to whether the Insured held the necessary intent or recklessness to constitute fraud, as the Response Letter was said to be consistent with the Insured and the Financial Adviser having been mistaken about the need to disclose mental health information extending beyond five years. Further, ASIC submits that an agency relationship between the Insured and the Financial Adviser does not preclude the possibility of the Financial Adviser also having been OnePath's agent for the purposes of receiving the Insured's mental health information. ASIC submits that OnePath made no attempt to confirm, or refute, the Insured's explanation with the Financial Adviser, but appears to have rejected the explanation out of hand. ASIC submits that OnePath could readily have sought the Financial Adviser's file and the Statement of Advice, and OnePath might then have contacted the Financial Adviser directly. ASIC submits that the duty of utmost good faith required OnePath to seek to resolve the conflicting bodies of information, by obtaining information from the Financial Adviser and reverting to the Insured to clarify as necessary, and there was no pressing need to determine the claim. ASIC submits that OnePath failed to ask the Financial Adviser the following matters:

the circumstances in which the Application Form came to be completed, including on what dates, whether in person and the process followed; whether the Financial Adviser stated or otherwise indicated that in providing information as to her mental health history, the Insured did not need to give information going back further than five years; why answers given as to mental health history appear to have been affected by the format of the questions, and why there were inconsistencies within the mental health history information within the Application Form; whether the Financial Adviser had been satisfied that the Insured had fully and properly provided all information in response to the Application Form questions as to her mental health history, and if not, why; and whether the Financial Adviser directly asked each of the questions about which OnePath held concerns, including whether the Insured had ever attempted suicide or self-harm. Further, ASIC submits that OnePath failed to ask itself the correct questions, namely: did it reasonably conclude that the relevant failure was fraudulent?; did it reasonably conclude that the Insured did not have a positive belief that precluded an intention to mislead or deceive or recklessness as to the same?; and had its processes allowed it to reasonably reach its conclusions? ASIC submits that given the serious repercussions for the Insured, the omissions were unfair and unreasonable, and by those omissions OnePath failed to exercise and perform its rights, powers and obligations consistently with the duty of utmost good faith.

58 As I have indicated above, ASIC expressly and repeatedly conceded at the hearing before me that OnePath had drawn a reasonable conclusion as to the Insured having been fraudulent in failing to comply with her duty of disclosure and making misrepresentations to OnePath, and limited its case to criticisms of the manner and process with which OnePath reached that reasonable conclusion.

59 In my view, it is obvious from the terms of the Avoidance Letter of 7 October 2020 that OnePath rejected the Insured's explanation provided in the Response Letter to the effect that the Financial Adviser had told the Insured that she need not go back beyond five years in providing information concerning her mental health condition, and that the Insured purportedly relied on that advice. The Avoidance Letter set out in five bullet points the matters which OnePath had considered in determining that the Insured had breached the duty of disclosure fraudulently. The first bullet point was a reference to the Insured advising that she had completed the Application Form under the guidance of the Financial Adviser but "this information" was not available for the underwriter of OnePath to consider at the time of application. That statement does not constitute acceptance of the purported explanation provided in the Response Letter, and the reference to "this information" goes no further than

the fact claimed by the Insured that she had completed the Application Form under the guidance of the Financial Adviser. In any event, the third bullet point constitutes a clear rejection of the purported explanation as to the Financial Adviser having advised the Insured that there was no need to go back more than five years in her answers and disclosures. The third bullet point refers to the clarity with which medical questions on the Application Form were expressed, using the word "ever" repeatedly. The fourth bullet point draws the obvious conclusion that the Insured knew of the requirement to disclose the full history of her mental health issues. It is thus fanciful to read the Avoidance Letter as anything other than a clear rejection by OnePath of the purported explanation given in the Response Letter.

60 In my view, that was an obvious conclusion for OnePath to draw in the circumstances. The questions in the Application Form pertaining to mental health are clear in their terms. They could not conceivably have been read by the Insured as not requiring information going back more than five years, and it is equally implausible that the Financial Adviser would have given advice to that effect. Even if, for the purposes of analysis, one supposes that the Financial Adviser might have given such grossly improper advice, it is clear from the answers actually given by the Insured that the Insured did not rely upon it. The Insured did provide answers in her Personal Statement to various questions concerning her mental health which dated back much more than five years. The Insured disclosed that she suffered from depression in "1999/2000", and claimed that the depression lasted "a few weeks", following which she made a "full recovery". The Insured also stated that she "Stayed on medication for over 6 years… Stopped medication approx for 6 years however resumed approx 2 years", an answer evidently extending back more than five years.

61 ASIC sought to distinguish the "box tick" answers from the narrative answers, on the basis that the "box tick" answers only go back five years, whereas the narrative answers go back beyond five years. That is inconsistent with the Insured's "box tick" answers disclosing her prior hip injury, in respect of which she last had symptoms "More than five years ago" (CB tab 21, pp 397, 399). Moreover, it is not the explanation that was proffered by the Insured in the Response Letter, and the duty of utmost good faith cannot possibly require an insurer to formulate, and then to consider, explanations for misrepresentations other than those given by the insured. The Personal Statement Adjustment Form itself demonstrates that the Insured had reviewed her Personal Statement with care, and made an additional disclosure concerning a workers' compensation claim made in 2001 (well over five years previously) in connection with her depression. That is itself cogent evidence that the Insured's misrepresentation of her mental

health history was the product of dishonest selectivity, rather than any lack of understanding of the questions asked.

62 ASIC's criticism of the promptness with which OnePath determined to avoid the Insured's policy in the week following receipt of the Response Letter is without merit. An insurer should act timeously and this is itself an aspect of the duty of utmost good faith. Expeditious decision-making is not to be criticised. OnePath had in fact given the Insured some two and a half months to respond to the Procedural Fairness Letter, including two extensions. Given the implausibility of the explanation proffered in the Response Letter, there was nothing improper in OnePath considering and promptly disbelieving that explanation. The submission by ASIC that OnePath did not genuinely consider the Response Letter at all is fanciful given the terms of the Avoidance Letter, which I have referred to above, in engaging with and dismissing the explanation proffered by the Insured. In the circumstances of this case, there was no need for OnePath to obtain the Financial Adviser's file or to speak to her in relation to the matter. The explanation proffered in the Response Letter was so inherently implausible that this could not conceivably be the kind of exceptional case where an inquiry of a third party might be called for. The possibility of seeking production of the Financial Adviser's file was raised by a relatively junior OnePath employee, namely Person A, who acknowledged his lack of familiarity with the process, and was dismissed by a more senior employee, namely Person E.

63 Accordingly, ASIC's claim that OnePath breached its duty of good faith by avoiding the Insured's cover without embarking on further inquiries or consideration must be rejected.

The Second Alleged Contravention: Identifying and Seeking a Response Regarding Specific Concerns as to Fraud

64 ASIC submits that OnePath failed to act with the utmost good faith by avoiding the Policy without, in the Procedural Fairness Letter or otherwise:

(a) notifying the Insured that OnePath held concerns that non-disclosures or misrepresentations within the Application Form were fraudulent, identifying the basis for such concerns;

(b) notifying the Insured that OnePath was considering whether there was a basis to avoid the Insured's income protection cover by reason of fraudulent non-disclosures or misrepresentations within the Application Form, identifying the basis for such consideration; and

(c) inviting the Insured to address the concerns and considerations referred to in (a) and (b) in view of the bases for such concerns and considerations.

ASIC relies in support of those contentions on a number of cases concerned with policies where the payment of benefits depended upon the insurer (or trustee) being satisfied of certain matters, which, as I have said above, are qualitatively and fundamentally different from the present case. ASIC also relies on statements in *Australian Securities and Investments Commission v TAL Life Limited (No 2)* at [192]-[199], but that was a case in which there was no equivalent of, or counterpart to, the Procedural Fairness Letter sent by the insurer to the insured at all.

65 ASIC submits, surprisingly, that the Procedural Fairness Letter did not explain that information within the Grafton Base Hospital records was inconsistent with responses set out in the Application Form. ASIC submits that the Procedural Fairness Letter did not identify that OnePath's specific concerns related to the Insured's recorded history of suicidal ideation and attempted suicide. ASIC even went so far as to submit that the issues outlined in the Procedural Fairness Letter did not include any reference to any of the concerns actually held by OnePath as to why the Application Form disclosures were incomplete or false. ASIC submits that the Procedural Fairness Letter did not express a concern that the Insured might have been at least reckless as to the truth of her disclosures, but referred to s 29 of the ICA in general terms. ASIC submits that the failure to identify specifically OnePath's concerns as to fraud in the Procedural Fairness Letter appeared to have been intentional. ASIC then submits that by omitting the specifics as to OnePath's concerns, the Procedural Fairness Letter has the potential to deprive the Insured of a proper opportunity to put relevant material to OnePath, specifically as to why the inaccurate information had not been fraudulent. ASIC submits that it is immaterial that the Insured had the advantage of legal representation from the FRLC. ASIC also relies on OnePath's guidelines for "Procedural Fairness – Claims" (CB tab 70), as to the purpose of procedural letters including clearly setting out the potential barriers to the claim having regard to the available evidence so as to comply with the duty of utmost good faith, and that the letter should include the evidence (and a summary of the evidence) relied on by OnePath (CB tab 70, p 1,294). Further, the guidelines say that a supplementary procedural fairness letter must be issued if new information is received from a third party (CB tab 70, p 1,298). ASIC also relies on OnePath's guidelines for "Investigating Non-Disclosure and Misrepresentation – Claims" (CB tab 72, pp 1,320 and 1,325-6).

66 In my view, OnePath did provide the Insured with ample opportunity to explain the circumstances in which the misrepresentations and non-disclosures in the Application Form occurred and whether they should be regarded as fraudulent. I have referred above to the contents of the Procedural Fairness Letter, which set out each of the answers which OnePath regarded as false, and provided a detailed summary of information from the Grafton Base Hospital records, including the dates of admission, page references and relevant quotations from documents. The Procedural Fairness Letter referred specifically both to "attempted suicide" and "self-harm gesture, suicidal ideation and attempt, intentional overdose 2001" (CB tab 85, p 1,436).

67 Further, the duty of utmost good faith did not require that OnePath expressly state that it was concerned that the Insured may have been dishonest. In my view, it was sufficient for OnePath to have expressly provided the Insured with "the opportunity to provide an explanation as to why you failed to disclose and/or misrepresented your mental health medical history in your Application Form and before we accepted your Application" (CB tab 85, p 1,437). Zurich submits, and I accept, that there are obvious and sound reasons why an insurer may wish not to raise express accusations of fraud before an insured has had an opportunity to state credible and honest explanations for any misrepresentations or non-disclosures, and to do so may be unduly and unnecessarily upsetting to an individual insured, in cases where there is a convincing explanation to be proffered. I note that in *Australian Securities and Investments Commission v TAL Life Limited (No 2)* at [201], Allsop CJ was critical of an insurer for making "hurtful" statements to an insured. In the present case, the position taking by Person E was that the consideration of whether OnePath could rely on s 29(2) should come after the Insured had been given an opportunity to explain what had occurred (CB tab 84, p 1,431).

68 In any event, it was obvious to any reasonable reader of the Procedural Fairness Letter that OnePath was likely to consider whether to avoid the policy for fraud. The Procedural Fairness Letter made express reference to the possibility of the contract of insurance being avoided where the failure to tell OnePath something was fraudulent. Further, the Procedural Fairness Letter referred to the three-year limitation on avoidance for non-fraudulent non-disclosure, and it was obvious that more than three years had passed since the contract was entered into, and therefore the contract could only be avoided under s 29(2); that is, if the non-disclosure or misrepresentation was fraudulent. That point is fortified by the fact that the explanation proffered in the Response Letter was clearly directed to allaying a concern that the Insured had been dishonest by claiming that the Insured had been misled by advice from the Financial

Adviser as to not having to go back beyond five years in disclosing her mental health condition. In that regard, ASIC expressly and repeatedly conceded at the hearing before me that the explanation put forward in the Response Letter was relevant to the question of fraudulent intention and nothing else: T33.39-34.32, 35.17-20, 64.25-28. ASIC submitted that that concession still permitted the submission by ASIC that it was possible that something else could have been said if the question about fraudulent intent had been asked directly (T35.24-26), however no suggestion was put forward as to what that might have been and, in any event, nothing further was put forward when the Insured made the complaints, both internally to OnePath and externally to AFCA on 13 April 2021 and 28 September 2021 respectively, in the full knowledge that OnePath had avoided the income protection cover in the Policy for fraudulent misrepresentation and non-disclosure (CB tabs 109 and 112).

69 Accordingly, I reject ASIC's submissions as to the second alleged contravention.

The Third Alleged Contravention: Informing the Insured of her Dispute Rights and Appeal Processes

70 ASIC submits that OnePath failed to act with the utmost good faith by failing within the Avoidance Letter to inform the Insured of her rights and the availability of processes, both internally to OnePath and externally, to dispute or appeal OnePath's decision to avoid the income protection cover within the Policy. ASIC submits that such a duty is consistent with the Life Insurance Code of Practice (2019) (**LICOP**). The LICOP provided relevantly at [8.19] that an insurer which declines a claim will let the insured know in writing that the insured has the right to request a review if he or she disagrees with the decision and the insurer will give details of its complaints process. ASIC submits that the Avoidance Letter did not inform the Insured of the right to request a review of the avoidance decision, nor did it give details of OnePath's complaints process. ASIC acknowledges that the Avoidance Letter was sent to the insured via the FRLC, but submits that OnePath could not assume that the Insured would remain represented, and could not reasonably assume that the FRLC would give the necessary advice as to rights of appeal. ASIC submits that it was not sufficient that rights of appeal had been referred to in the PDS, which was provided to the Insured in May 2016, over four years earlier. ASIC also refers to OnePath's guidelines for "Procedural Fairness – Claims" (CB tab 70, p 1,303), which requires remedies for redress (by way of internal and external dispute resolution) to be provided in the letter of declinature of claims.

71 It appears that the information concerning rights of review and appeal was intended to be included in the Avoidance Letter, as that is one of the four matters referred to at the beginning of the Avoidance Letter (CB tab 107, p 1,491). Accordingly, it appears that the information was omitted by oversight or administrative error. Whether a failure is deliberate or innocent must be relevant to the question of whether there has been a breach of the duty of utmost good faith: see *Australian Securities and Investments Commission v TAL Life Limited (No 2)* at [174].

72 Further, at the time that OnePath sent the Avoidance Letter the Insured was represented by lawyers from the FRLC. Those lawyers had written the Response Letter about a week earlier, and there is no reason to think that they would have ceased to act for the Insured in circumstances where they were simply waiting for OnePath's response to the Response Letter. It is a reasonable assumption that the lawyers at the FRLC were competent, professional and well familiar with avenues of review and appeal from decisions concerning financial rights, and that they did not require OnePath to tell them how to do their job. In fact, the lawyers at the FRLC were familiar with internal and external avenues of review and appeal, as is shown by the fact that they acted on the Insured's behalf in pursuing those internal and external avenues of review.

73 As to the LICOP, Zurich submits, and I accept, that the LICOP is not an "approved code of conduct" or a "mandatory code of conduct" for the purposes of ss 1101AC or 1101AF of the *Corporations Act 2001* (Cth). Further, the provision of the LICOP on which ASIC relies deals with the communication of decisions to decline claims rather than decisions to avoid contracts of insurance. Further, as [2.16] of the LICOP makes clear, it is not intended to create any legal or other rights between the insurers which subscribe to the LICOP and any person or entity other than the Financial Services Council. It therefore does not give rise to any legal rights between an insurer and an insured, and therefore there are no rights capable of being conditioned by the duty of utmost good faith, in the sense discussed in *Delor Vue* at [97].

74 Accordingly, I reject ASIC's submissions as to the third alleged contravention.

Conclusion

75 It follows that ASIC's originating process should be dismissed with costs. Zurich wishes to have the opportunity, if it so decides, to make an application for costs on a lump-sum basis. Accordingly, in the orders which I have made today, I have set a timetable for written submissions and affidavits relating to that matter, in the event that Zurich decides to pursue it. I anticipate that I will decide any question of costs being awarded in a lump-sum on the papers.

I certify that the preceding seventy-five (75) numbered paragraphs are a true copy of the Reasons for Judgment of the Honourable Justice Jackman.

Associate: 

Dated: 21 December 2023