FEDERAL COURT OF AUSTRALIA

Australian Securities and Investments Commission v TAL Life Limited (No 2) [2021] FCA 193

File number: VID 1360 of 2019

Judgment of: **ALLSOP CJ**

Date of judgment: 9 March 2021

Catchwords: **CORPORATIONS** – misleading or deceptive conduct – financial products – insurance – allegation that insurer had misled insured by making representations about insurer's right to delay the processing of the insured's claim and to withhold benefits under the policy until the insured provided an executed authority enabling the insurer to obtain and access the insured's medical records and Medicare and Pharmaceutical Benefits Scheme claims information – whether representation was made – whether representation was false or misleading – whether representation contravened s 1041H(1) of the *Corporations Act 2001* (Cth) – whether representation contravened ss 12DA(1) and 12BD(1) of the *Australian Securities and Investments Commission Act 2001* (Cth) – whether conduct was in connection with the supply of financial services – whether conduct was in relation to financial services – meaning of "financial services" – whether representation was made in connection with the issue of the policy – whether the process of claims handling is a service otherwise supplied in relation to the policy

INSURANCE – whether insurer breached the duty of utmost good faith under s 13 of the *Insurance Contracts Act 1984* (Cth) – where insured made an innocent non-disclosure and insurer avoided the policy – where insurer did not give the insured any notice of the investigation into the validity of her policy and did not give her an opportunity to address the insurer's concerns – where insurer alleged in policy avoidance letter that insured had breached her duty of good faith – where insurer threatened in policy avoidance letter to seek recovery of amounts paid under the policy

HIGH COURT AND FEDERAL COURT – jurisdiction of the Federal Court – power to award declaratory relief – whether Australian Securities and Investments Commission lacks standing to seek declaratory relief for breach of s

	13(2) of the *Insurance Contracts Act 1984* (Cth)
	CONSTITUTIONAL LAW – judicial power of the Commonwealth – requirement for a "matter" – whether there is a "matter" before the Court – where parties to insurance contract agreed in settlement deed that contract was avoided *ab initio* – whether ASIC lacks standing to seek declaratory relief for breach of s 13(2) of the *Insurance Contracts Act 1984* (Cth)
Legislation:	*Australian Securities and Investments Commission Act 2001* (Cth) ss 8(1), 12BA(1), 12BAA(7), 12BAB, 12DA(1), 12DB(1)
	Corporations Act 2001 (Cth) s 1041H(1)
	Federal Court of Australia Act 1976 (Cth) ss 5, 21, 23
	Insurance Contracts Act 1984 (Cth) ss 13, 11A, 11B, 75A(1)
	Judiciary Act 1903 (Cth) s 78B
Cases cited:	*ABN AMRO Bank NV v Bathurst Regional Council* [2014] FCAFC 65; 224 FCR 1
	Ainsworth v Criminal Justice Commission [1992] HCA 10; 175 CLR 564
	Australian Competition and Consumer Commission v Danoz Direct Pty Ltd [2003] FCA 881; 60 IPR 296
	Australian Competition and Consumer Commission v Dataline.Net.Au Pty Ltd [2006] FCA 1427; 236 ALR 665
	Australian Competition and Consumer Commission v Goldy Motors Pty Ltd [2000] FCA 1885; [2001] 23 ATPR 41-801
	Australian Competition and Consumer Commission v Kaye [2004] FCA 1363
	Australian Competition and Consumer Commission v MSY Technology Pty Ltd [2012] FCAFC 56; 201 FCR 378
	Australian Competition and Consumer Commission v Telstra Corporation Limited [2018] FCA 571
	Australian Securities and Investments Commission v Accounts Control Management Services Pty Ltd [2012] FCA 1164
	Australian Securities and Investments Commission v Australian Lending Centre Pty Ltd (No 3) [2012] FCA 43; 213 FCR 380
	Australian Securities and Investments Commission v Dover Financial Advisers Pty Ltd (No 2) [2019] FCA 2151; 140

ACSR 635

Australian Securities and Investments Commission v Superannuation Warehouse Australia Pty Ltd [2015] FCA 1167; 109 ACSR 199

Australian Securities and Investments Commission v Westpac Banking Corporation (No 3) [2018] FCA 1701; 131 ACSR 585

Australian Securities and Investments Commission v Youi Pty Ltd [2020] FCA 1701

Campomar Sociedad, Limitada v Nike International Limited [2000] HCA 12; 202 CLR 45

Delor Vue Apartments CTS 39788 v Allianz Australia Insurance Ltd (No 2) [2020] FCA 588; 379 ALR 117

Given v Pryor (1979) 39 FLR 437

Glynn v Margetson & Co [1893] AC 351

Helvering v Gregory 69 F2d 809 (2nd Cir 1934)

Homburg Houtimport BV v Agrosin Private Ltd (The 'Starsin') [2004] 1 AC 715

Joffe v The Queen; Stromer v The Queen [2012] NSWCCA 277; 82 NSWLR 510

Johnco Nominees Pty Ltd v Albury-Wodonga (NSW) Corporation [1977] 1 NSWLR 43

Motor Trade Finances Prestige Leasing Pty Ltd v Elderslie Finance Group Corporation Ltd [2006] NSWSC 1348

Pape v Federal Commissioner of Taxation [2009] HCA 23; 238 CLR 1

Plaintiff S10/2011 v Minister for Immigration and Citizenship [2012] HCA 31; 246 CLR 636

Quikfund (Australia) Pty Ltd v Airmark Consolidators Pty Ltd [2014] FCAFC 70; 312 ALR 254

Re Macks; Ex parte Saint [2000] HCA 62; 204 CLR 158

Sankey v Whitlam [1978] HCA 43; 142 CLR 1

Stealth Enterprises Australia Pty Ltd v Calliden Insurance Limited [2013] NSWSC 825; 17 ANZ Insurance Cases 61-979

Taco Company of Australia Inc v Taco Bell Pty Ltd [1982] FCA 170; 42 ALR 177

Todd v Alterra at Lloyd's Ltd [2016] FCAFC 15; 239 FCR 12

Warramunda Village Inc v Pryde [2001] FCA 61; 105 FCR 437

Division:	General Division
Registry:	New South Wales
National Practice Area:	Commercial and Corporations
Sub-area:	Commercial Contracts, Banking, Finance and Insurance – Insurance List
Number of paragraphs:	230
Date of hearing:	13–14 October 2020
Counsel for the Plaintiff:	Mr S Donaldson SC with Mr D Luxton and Mr A Ounapuu
Solicitor for the Plaintiff:	Johnson Winter & Slattery
Counsel for the Defendant:	Mr R G McHugh SC with Mr J Arnott
Solicitor for the Defendant:	Gilbert + Tobin

ORDERS

VID 1360 of 2019

BETWEEN:	**AUSTRALIAN SECURITIES AND INVESTMENTS COMMISSION** Plaintiff
AND:	**TAL LIFE LIMITED** Defendant

ORDER MADE BY: **ALLSOP CJ**

DATE OF ORDER: **9 MARCH 2021**

THE COURT ORDERS THAT:

1. Within 14 days the plaintiff file and serve proposed declarations and orders otherwise, including dealing with costs, whereby such declarations and orders dispose of the Amended Originating Process by the making of declarations as to the breach of s 13 of the *Insurance Contracts Act 1984* (Cth) by the defendant, and by otherwise dismissing the proceeding.
2. If within a further 14 days there is no agreement as to the appropriate form of declaration and orders for costs, the proceeding be relisted by arrangement with the Associate to the Chief Justice for argument as to the form of declaration and orders.
3. Volume 4 of the Court Book be admitted and marked as Confidential Exhibit D.

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

REASONS FOR JUDGMENT

ALLSOP CJ:

1 In this proceeding the Australian Securities and Investments Commission (**ASIC**) complains about the conduct of the respondent (**TAL** Life Limited) in the way in 2013 and 2014 it treated a person who had become an insured under an income protection policy. The proceeding was commenced following the **Royal Commission** into Misconduct in the Banking, Superannuation and Financial Services Industry. In order to protect the privacy of the woman in question, the Royal Commission referred to her as the "Second Insured". I will, for consistency, refer to her likewise. It is, however, perhaps important to recognise that the assessment of the propriety of how TAL conducted itself is to be undertaken recognising that the Second Insured was not just a contracting party (viewed in a disembodied way) with rights and obligations in law, but a person to whom, and to whose financial security, the policy was important. Such considerations do not, of themselves, create separate legal rights, but they inform the context and circumstances by reference to which standards of behaviour, set by Parliament, expected of participants in commerce, in particular here, insurance, are to be judged.

2 The conduct of which complaint is made in the proceeding and to which the Royal Commission directed its attention concerned the way TAL avoided the policy taken out by the Second Insured. At the Royal Commission, TAL, through executives and senior counsel, made certain clear and unqualified statements accepting that its conduct was worthy of criticism. It will be necessary to examine those statements in the examination and weighing of evidence.

The claims made in this proceeding

3 The claims for relief and the basis therefor were set out in an Amended Originating Process and an Amended Concise Statement both dated 10 July 2020, and ultimately refined in an annexure to ASIC's final submissions. The declarations sought in the Amended Originating Process read like a pleading seeking multiple individual declarations about aspects of TAL's conduct which were said to be misleading or deceptive or likely to mislead or deceive in contravention of provisions of the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**) and of the *Corporations Act 2001* (Cth), and to have breached s 13(2) of the *Insurance Contracts Act 1984* (Cth) by failing to act towards the Second Insured with the utmost good faith in accordance with the contractual term implied by s 13(1) of the *Insurance*

Contracts Act. This form of the declarations sought was inappropriate for reasons that the Court has previously given: *Warramunda Village Inc v Pryde* [2001] FCA 61; 105 FCR 437 at 440 [8]; and *Australian Competition and Consumer Commission v MSY Technology Pty Ltd* [2012] FCAFC 56; 201 FCR 378 at 388 [35]. The detailed nature of the individual declarations sought in the Amended Originating Process (somewhat reduced in length in the annexure to the final submissions) make it convenient not to attempt to summarise the impugned conduct save to say that the misleading and deceptive conduct was concerned with the claims handling process and the lack of good faith with the avoidance of the policy. It is preferable if I go immediately to the factual history of the relationship between TAL and the Second Insured. I will seek to explain the relief claimed and the nature of the dispute as I explain what happened.

4 As I was completing these reasons and dealing with the parties' submissions on relief I realised that the parties' legal advisors and I had overlooked the requirements of s 78B of the *Judiciary Act 1903* (Cth) in connection with one argument propounded by TAL: that the Court lacked jurisdiction to make certain declaratory orders against TAL because of the absence of a "matter" in Constitutional terms. The argument only manifested in that form with clarity at the very end of oral address. Nevertheless, the requirements of s 78B could not be ignored. Notices under s 78B of the *Judiciary Act* were served on the Attorneys-General of the Commonwealth, States and Territories by way of a letter from the solicitors for TAL, Gilbert + Tobin, dated 22 January 2021. On that same day, each Attorney-General, apart from the Attorney-General of Tasmania, acknowledged receipt of the letter, either by an automatic reply email or by an email from an employee of their Office. The form of the letter was approved by the Court. The letter stated that the Court was of the opinion that a reasonable period of time under s 78B(1) would lapse after 35 days. Substantive responses were received from the Attorneys-General of Tasmania (dated 28 January 2021), South Australia (dated 9 February 2021), Western Australia (dated 15 February 2021) and Queensland (dated 15 February 2021). Each of these Attorneys-General advised that they did not wish to intervene in the proceeding. As at the date of publication of these reasons, the Court is of the understanding that the parties have not received substantive responses from the Attorneys-General of the Commonwealth, New South Wales, Victoria, Australian Capital Territory or Northern Territory. I am of the view that the Attorneys have had a reasonable time to consider the question of intervention.

The evidence

5 The parties prepared a statement of facts and issues that were agreed and not agreed (**SOF&I**). The parties read affidavits: ASIC read the affidavit of Ms Lewis which set out ASIC's investigation process. Expert reports of a psychiatrist, Dr Phillips, concerning the adequacy of the material relied upon by TAL to avoid the policy were tendered. TAL read the affidavit of an underwriter, Mr Bird, that sought to justify the avoidance. Mr Bird was cross-examined. Documents were tendered by both sides. At the hearing one volume of the Court Book which contained audio recordings of certain telephone conversations was not put into evidence. The transcripts of the conversations were in evidence. During the preparation of these reasons I listened to these recordings thinking they were in evidence. I raised this with the parties and I will make an order that the volume of the Court Book be admitted as Confidential Exhibit D.

The facts

6 In September 2013, the Second Insured applied to TAL for an income protection policy of $5,000 per month. A company called iSelect, on behalf of TAL, provided the Second Insured with a Product Disclosure Statement (**PDS**), Official Quotes, a Financial Services Guide, and a Glossary and Reference Guide. This followed an initial telephone call with an iSelect representative. In the PDS (which was not said to be a contractual document) there was a section entitled "Making a claim", which contained the following (References to Court Book Part 2 being Confidential Exhibits C1 and C2 will be referred to as CB2 by tab number and the final four numbers of the document number: CB2 tab 10 p…0175):

> When it comes to making a claim you need to follow the requirements set out in your Policy Document. After you become aware of any claim or potential claim under Accelerated Protection, you must notify us at your earliest opportunity.
>
> **Claims will only be paid if the requirements in the Policy Document have been met.** We will tell you what information we need at each stage of your claim. We usually require you to complete a claim form and certain claim information. You must prove your claim in such a manner as we may reasonably request. Furthermore, we may require proof of any continuing entitlement from time to time, medical examinations at our expense and assistance (for Income Protection claims) in the ongoing management of the claim, including participation in recovery and rehabilitation support programs.
>
> …
>
> (Emphasis added.)

7 The PDS also had a full description of the duty of disclosure which included a clear statement of the consequences of non-disclosure, as follows (CB2 tab 10 p…0174):

> Before you enter into an insurance contract with us, you are required under the Insurance Contracts Act 1984 to provide us with the information we need to decide whether we'll accept your application for insurance, what terms will apply and what your premium will be.
>
> You, and the person whose life is to be insured under Accelerated Protection, must comply with the Duty of Disclosure as described below.
>
> Your Duty of Disclosure applies when applying for Accelerated Protection and when varying or replacing an existing Accelerated Protection Policy. It applies from the moment you start completing the Accelerated Protection application questions and until we advise that we have accepted your application for insurance, variation or replacement and issued a Policy Schedule.
>
> You must answer all of our questions honestly and completely. You must tell us everything you know and everything that a reasonable person in the circumstances could be expected to know is relevant to our decision whether to insure you and whether any special conditions need to apply to your Accelerated Protection Policy.
>
> You do not need to tell us about any matter that diminishes our risk, is of common knowledge, that we know or should know as an insurer or that we tell you we do not need to know.
>
> **If you have not disclosed all relevant matters to us and we would not have entered into the contract of insurance on any terms had we known about those matters, we may avoid the Accelerated Protection Policy from commencement. This means that we can treat your Accelerated Protection Policy as if it never existed and we would not be liable to pay any claims. Alternatively, we may decide to reduce the Benefit Amount for your cover to an amount we would have been prepared to cover for the premium amount paid, had you disclosed all the relevant facts to us.**
>
> If you have applied for your Accelerated Protection Policy via a financial adviser it is also your responsibility to ensure that the information provided to your adviser is accurate and complete.
>
> (Emphasis added.)

8 These extracts contained the clear statements that claims would only be met if the requirements of the policy had been met; and that if all relevant matters were not disclosed the policy may be avoided and the claim not met.

9 iSelect had a contractual relationship with TAL to assist prospective insureds to use a telephone facility to apply for TAL life insurance policies. In carrying out those obligations, iSelect placed advertisements of TAL products on its website. It was TAL's agent for collection of information. Disclosure to iSelect was disclosure to TAL.

10 The following day, 26 September 2013, another iSelect representative rang the Second Insured, to progress the application. The Second Insured was asked a number of questions. In the Amended Concise Statement they were described as "quick-fire questions". No complaint was, however, made in the hearing about the fairness of the questioning by iSelect.

11 At the beginning of the conversation the iSelect representative clearly informed the Second Insured of the need for honesty, and true and correct answers to the questions. He also informed her of her duty to disclose matters that a reasonable person could consider relevant to an insurer's decision to insure. He made clear that failure in these respects may lead to cancellation of the policy and the claim not being paid. The telephone call was thorough and detailed. It was conducted in a clear voice and efficiently. From the interview the following features of the Second Insured's position were made known. She was a 39 year old self-employed healthcare worker working "permanent full-time" four days a week for 47 weeks a year. She had two relevant Bachelor degrees. In answering the Second Insured was precise and apparently careful. The questioning traversed many aspects of her work and her business, including its financial aspects. The questioning was also directed to her health, beginning with her height, weight, and any tobacco and alcohol consumption. Questions were then directed to whether she or her family (mother, father, sister, brother) had suffered from various conditions including various heart conditions, cancer and mental disease to which the Second Insured gave some positive answers in respect of a close relation. She was then asked questions as to her personal medical history. The questioning was extensive, covering a very wide range of conditions. The questioning was at times not clear as to whether the Second Insured was being asked about present conditions or treatment or past *and* present conditions or treatment. This confusion might explain the answers she gave concerning depression and related conditions. ASIC accepted by the way it set out its case in the Amended Concise Statement that she was asked: "Have you ever had or received medical advice or treatment for [any of the following;]". That introduction to the relevant list of conditions was 100 lines and a number of minutes in conversation before the relevant subject (referred to below). Further, listening to the whole conversation, it is not at all clear that this was a continuing predicate or chapeau to the relevant subject of depression and mental health. For instance, not long before the relevant subject questions, she was asked whether she was currently able to perform her usual daily activities and all the duties of her occupation without restriction; to which she answered, "yes". The questioner continued (CB2 tab 14 p…0013):

> Alright, other than that though, any other back or neck pain including sciatica?

She was thus being asked about her present conditions. She answered, "no". There followed a list of associated conditions (including the relevant mental health conditions) to each and all of which the answer was "no" (CB2 tab 14 p…0013–0014):

> Any joint, for example, shoulder, ankle, knee, hip, bone or muscle pain or disorder

including RSI?

…

Rheumatoid arthritis, other forms of arthritis, osteoporosis or gout?

…

Any blood disorder or anemia?

…

Any thyroid disorder or lupus?

…

Depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, attempted suicide, chronic fatigue, post-natal depression or any other mental or nervous condition?

…

Any disorder of the cervix including abnormal Pap smear, ovary, uterus, breast or endometrium or are you currently pregnant?

…

Any complications of pregnancy or childbirth or a child with congenital abnormalities?

(Emphasis added to the relevant mental health questions.)

12 If the conversation had been the only communication concerning the Second Insured's disclosure there would be a powerful case that she answered the questions correctly as answers to questions about her present condition not to be linked to, or governed by, the predicate or chapeau to which I have referred.

13 The way ASIC stated its case was reflected in the SOF&I, which stated the following at para 14:

> The Application Summary included, among other things, a question which asked whether the Second Insured had ever had or received medical advice or treatment for depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, attempted suicide, chronic fatigue, post natal depression or any other mental or nervous condition. The Second Insured answered the question "no".

14 The Application Summary was the application document referred to below wherein the iSelect representative reduced the interview to writing. The document linked the chapeau or predicate to the question as to mental health and recorded the answer "no".

15 I must, of course, decide the case on the case framed by ASIC. It is to be noted that in the deed of release between TAL and the Second Insured dated 19 May 2015 settling her claim made

before the Financial Ombudsman Service, the Second Insured agreed that the policy remained void *ab initio*; but made no express concession as to non-disclosure or misrepresentation.

16 Later in the interview, the Second Insured referred to blood tests that she was to have in the next month requested by her GP because of mid-cycle bleeding, for checking hormone levels and thyroid levels.

17 On 26 September 2013, the iSelect representative who had conducted the interview emailed the Second Insured indicating that a TAL underwriter would need to review her application, but in the meantime she had interim cover. He enclosed her application. The document had been prepared by iSelect and included information derived from the interview, being the document referred to in the SOF&I as the "Application Summary". The document otherwise clearly and comprehensively recorded her answers including that blood tests were being obtained after mid-cycle bleeding, but that her GP was "not too concerned about it". The covering email contained the following recommendation (CB2 tab 15 p…4015):

> Please find attached a copy of your application. As previously mentioned, you are bound by your duty of disclosure to ensure that all information in your application is true and complete. As such, **please take some time to review the content of your application and notify iSelect if any amendments are required or additional information needs to be included.**
>
> (Emphasis added.)

18 The email also enclosed a medical authority form which she was asked to sign and return. It was said to be required "[s]hould TAL require additional medical information from your doctor". This was **not** executed or returned by the Second Insured.

19 No changes were made to the application (the Application Summary in the SOF&I) by the Second Insured and iSelect advised TAL on 26 September 2013 that a "verbal signature [had] been obtained from the client for this application." I assume this reflected the Second Insured informing the iSelect representative that the application was in order to pass on to TAL.

20 On 30 September 2013, a further conversation took place about the whiplash injury in 2010 and the blood test, to both of which reference had been made in the first interview. In this further conversation the Second Insured told the iSelect representative that the blood test had been done and that the results would be available shortly.

21 By letter dated 3 October 2013, TAL informed iSelect that it accepted the application. There was to be an exclusion as to the cervical spine, because of the prior whiplash injury in the 2010

car accident. No exclusion or qualification was to be required for anything that might be disclosed by the blood test, the results of which were not yet available.

22 On 8 October 2013, an iSelect representative telephoned the Second Insured to inform her of the acceptance of the application and to explain the cervical spine exclusion.

23 By letter dated 9 October 2013, TAL sent the Second Insured her policy schedule and the policy document. These two documents were expressed to set out the terms of the contract of insurance.

24 The policy document explained how so-called "accelerated protection" worked (CB2 tab 23 p…0961):

> **How Accelerated Protection works**
>
> Accelerated Protection is an insurance policy between us and you under which you can select a number of Plans comprising of Life insurance, Critical Illness insurance, Total and Permanent Disability (TPD) insurance, Income Protection and Business Expense insurance. Each of these Plans contains Included Benefits, and Optional Benefits that can be added at an additional cost. Each of these Plans and Included Benefits form a separate part of the Policy.

25 The Second Insured chose Income Protection only.

26 There was a guarantee of renewal (to 65 years of age), as follows (CB2 tab 23 p…0962):

> **Guaranteed renewal of cover**
>
> As long as you and the Life Insured have complied with the Duty of Disclosure set out in the Product Disclosure Statement and paid the premiums when due, cover continues until the Plan end date.
>
> This guarantee applies regardless of any change in the Life Insured's personal circumstances.

27 Part 6 of the policy dealt with Income Protection. It commenced as follows (CB2 tab 23 p…0977):

> Income Protection only applies under this Policy if 'Income Protection Plan' is indicated in your Policy Schedule.
>
> Income Protection is available as 'Standard', 'Premier' or 'Optimal'. The type applicable is shown in your Policy Schedule.
>
> Income Protection Standard and Premier conditions are set out in Part 6 of this Policy Document. Income Protection Optimal conditions are set out in Part 7 of this Policy Document.
>
> In all cases where we refer to a benefit payment, the statement is made on the basis that the benefit referred to is payable under the terms and conditions of the Policy. We will not pay a benefit if an exclusion applies. Exclusions are explained in Part 9 of this

Policy Document. **You must also satisfy our claim requirements explained in Part 10 of this Policy Document.**

(Emphasis added.)

28 The Second Insured chose the standard type.

29 Part 10 of the policy contained General Policy Conditions. Part 10.2 was headed "Claims". Thereunder it was stated that if there were a claim TAL would send a claim form "and explain in detail our requirements and what the next steps are." There followed a section entitled "Claim requirements" which contained a general introduction, certain administrative requirements, medical requirements, financial requirements, interview requirements and other information requirements. Relevantly, the policy provided as follows (CB2 tab 23 p…1006–1007):

Notifying us of a claim

If you wish to make a claim against the Policy, you must contact us at the earliest possible opportunity otherwise claim payments may be reduced to the extent the ability to assess the claim has been prejudiced by the delay in being able to adequately assess the claim.

Our contact details can be found in Part 1 of this Policy Document. **We will send you a claim form and explain in detail our requirements and what the next steps are.**

…

Claim requirements

Where we request an examination, assessment or financial audit by a person we nominate, we will meet the cost. Otherwise you must meet the cost of satisfying our claim requirements.

An event giving rise to a claim must occur at a time while the applicable cover is in force and claim payments can only be made, start to accrue or continue while appropriate cover is in place.

Administrative Requirements

You must provide us with, in a form satisfactory to us:

- a completed claim form;
- the Policy Schedule;
- proof of the event for which a claim is being made;
- proof of payment, when a claim for reimbursement is being made;
- proof of age (unless previously provided); and
- proof of probate and a death certificate for death claims.

You may also need to provide:

- proof of Policy ownership; and
- a signed discharge from an authorised person.

Medical Requirements

We must be satisfied of our liability to pay a benefit. Depending on the type of claim, you may be required to provide some or all of the following:

- an examination of the Life Insured by a Medical Practitioner of our choice. This may involve imaging studies and clinical, histological and laboratory evidence;
- an examination by an appropriate specialist Medical Practitioners [sic] registered in Australia or New Zealand (or other country approved by us), not being the Life Insured, you, the Life Insured's partner or spouse, or your partner or spouse;
- proof that a surgical procedure was medically necessary and was the usual treatment for the underlying condition.

For Terminal Illness Benefit claims two Medical Practitioners must certify the extent of the Sickness or Injury, one being the Medical Practitioner treating the condition and the other being the a Medical Practitioner nominated by us who must confirm the diagnosis and life expectancy.

For Income Protection and Business Expense insurance you will be required to provide an initial medical attendants report and monthly medical certificates in a form to be determined by the case manager.

…

Other Information Requirements

We may also request:

- **access to details of the Life Insured's previous medical consultations;**
- assessment of current functional and vocational capacity by an appropriately qualified person selected by us; or
- obtaining information from various parties, subject to appropriate consent, including you and the Life Insured (if applicable), in relation to your claim, by a member of our staff or someone appointed by us, as often as is required. This may include, but not be limited to, details of any previous Injury or Sickness claims in relation to the Life Insured and details of previous occupation duties.

(Emphasis added.)

30 Thereafter, until avoidance of the policy, TAL deducted premiums from the Second Insured's bank account.

31 On 16 December 2013, the Second Insured was diagnosed with cervical cancer. She notified TAL of this that day. On the following day, a representative of TAL (from the "claims team") rang the Second Insured. On that day, 17 December 2013, the TAL representative sent a letter by email to the Second Insured which enclosed the initial claim form. This information was

referred to in the Amended Concise Statement and SOF&I as the "Claims Pack". The letter stated (CB2 tab 25 p…1288–1289):

> At TAL, we're committed to supporting clients who have suffered an illness or injury. We assure you that your case will be handled professionally and as quickly as possible.
>
> Enclosed is the paperwork you need to make a claim on your policy. After we receive your claim form and requirements, you'll be assigned a dedicated case manager. They'll be your personal point of contact throughout the settlement of your claim and will keep you up to date with its progress.
>
> **What you need to do**
>
> To ensure your claim is assessed as quickly as possible, please provide the following items.

Checklist	Claims Requirement	What it means
	Initial Disability Claim Form	Please complete the enclosed form as accurately as possible, including the contact details of your medical consultants, to ensure a swift assessment.

…

Checklist	Claims Requirement	What it means
	Medicare and Pharmaceutical Benefits Scheme Authority form	Please complete and return the enclosed form. This gives us permission to access to [sic] your Medicare records.

…

> **What happens next?**
>
> Your dedicated case manager will start assessing your claim once they receive the requested items. We may need to ask for more information and you may need to assist us in the ongoing assessment of your claim, by:
>
> - undergoing medical examinations with the doctor of our choice
> - providing information about your income before you took out this insurance and/or before you made a claim
> - giving us the authority to gather further information about your claim, for example, from other companies, employers, government bodies and/or other relevant bodies
> - meeting with a TAL representative so they can gather further information about your claim.

32 The authority referred to above for Medicare records that was enclosed was the standard form issued by Medicare Australia. The authority was for Medicare claims history from 1 February 1984 to an unspecified time and for Pharmaceutical Benefits Scheme (**PBS**) claims history from 1 May 2002.

33 The claim form commenced with a box headed "IMPORTANT INFORMATION" which contained the following (CB2 tab 25 p…1296):

- Please answer all questions fully to ensure that your claim is assessed as quickly as possible. Answers left blank or not fully completed may delay the assessment of your entitlements to benefits.
- False or fraudulent statements or failure to advise TAL Life Limited (TAL) of any relevant information may lead to TAL refusing to pay your claim.
- If you have any questions regarding the completion of this form, please contact either your Financial Adviser or us via our Claims Toll Free Number on 1800 101 016.

34 The claim form contained the following authority for medical records (CB2 tab 25 p…1302):

> **MEDICAL AUTHORITY**
>
> I, _____ (full name) hereby authorise any doctor, hospital, therapist or other medical professional who has attended me, to release to TAL Life Limited, or its representatives, information relevant to my policy and/or claim, with respect to any sickness or injury, medical history, consultations, medications or treatment, received by me, together with copies of any and all medical records. I consent to TAL Life Limited collecting this sensitive information. A copy of this authority is to be regarded as if it were the original signed authority. This medical authority will only be used for the purpose of assessing initial and ongoing entitlements to a claim.
>
> Name
>
> Signature Date

35 Just above the medical authority was a privacy disclosure which stated the following (CB2 tab 25 p…1302):

> **PRIVACY DISCLOSURE**
>
> **Personal information is collected from or in respect of you to enable TAL Life Limited to provide or arrange for the provision of the product or service requested.** Further personal information may be requested from you at a later time, such as if you want to make alterations to the policy or at claim time. **If you do not supply the required information, we may not be able to provide the product or services requested or pay the claim.**
>
> In processing and administering your insurance (including at the time of a claim) we may disclose your personal information (excluding health information) to a number of parties such as organisations to whom we outsource our mailing and information technology, the Insurance Reference Service, Government regulatory bodies, and other companies within the TAL group and accountants (if applicable).
>
> We may also disclose your personal (including health) information to other bodies such as reinsurers, your adviser, health professionals, investigators, the administrator, lawyers, the trustee of any superannuation fund through which the policy is effected, external complaints resolution bodies and as required by law.
>
> By signing this form you agree to our collection, use and disclosure of your personal information.
>
> (Emphasis added.)

36 At the end of the initial claim form was the following declaration (CB2 tab 25 p…1302):

> **DECLARATION**
>
> I hereby declare that the information in this claim form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to advise TAL or [sic: of] any relevant information regarding my claim, TAL may refuse to pay, and cancel my claim.
>
> Name
>
> Signature Date

37 The initial claim form also had a question about what professionals the Second Insured had consulted. The question (numbered 11) was in the following terms (CB2 tab 25 p…1298–1299):

> Have you consulted a doctor, physiotherapist, psychologist, chiropractor or any other health care provider for this or any OTHER condition in the last 5 years?
>
> Yes □ No
>
> If yes, please give details
>
> Reason for consultation/condition(s) treated
>
> Date of treatment
>
> Name & address of treatment provider
>
> Name
>
> Address
>
> Suburb State Postcode

38 The Second Insured completed and signed the initial claim form including the medical authority on 23 December 2013. She executed the form from Medicare Australia authorising the release of Medicare and PBS information. She answered question 11 by referring only to the whiplash injury and the practitioners who treated her for that injury. The Second Insured also provided medical, hospital and pathology reports concerning her present condition of cervical cancer. All these documents were received by TAL on 3 January 2014.

39 Shortly thereafter a TAL case manager commenced assessment of the claim. In a document created at this time the TAL manager wrote the following under the heading "Strategy and decision" (CB2 tab 27 p…2152):

> At application the insured disclosed that she had mid cycle menstrual bleeding and was awaiting blood test results. It does not appear that u/w requested a copy of the insured's clinical notes, they have only obtained a spinal questionnaire which was directed to the insured and not the GP. The insured has also provided her investigation results which

> show that she had clear results and ultra sounds prior to policy application. We will need to investigate the full history to confirm that there were no earlier abnormalities which were not disclosed. Suggest we accept the claim at this stage

40 Three comments can be made about the attitude of TAL reflected here: First, the documents provided revealed no non-disclosure as to the cancer. Secondly, the Second Insured had disclosed the blood test which the underwriter did not follow up. Thirdly, the question of future investigation as to misrepresentation or non-disclosure and thus possible avoidance was to the mind of the officer; but, subject to that, the claim was accepted: "at this stage".

41 By letter of 8 January 2014, TAL sought from Medicare Australia all the Second Insured's Medicare and PBS records from 23 December 2008 to 23 December 2013. The terms of the letter are instructive. It stated (CB2 tab 30 p…0373):

> [Redacted] medical records
>
> We're currently investigating [Redacted] claim for DI (Accident) benefits.
>
> To ensure we make a fair and accurate assessment of their claim, please provide us with a copy of their Medicare and PBS history for the period 23/12/2008 to 23/12/2013.

42 The letter says that TAL was investigating the Second Insured's claim and the medical records (for five years) were needed to make a fair and accurate assessment of her claim. There was, however, no doubt that the Second Insured had cervical cancer. She was, to the knowledge of TAL, undergoing, or about to undergo, chemotherapy. What was being sought was five years' medical records in order that TAL could investigate whether there had been a non-disclosure or misrepresentation (implicitly about the cancer of the cervix) and so, implicitly, as to whether it could reject the claim or avoid the policy. The case is not about whether TAL misled Medicare Australia. It is, however, in part about whether TAL misled the Second Insured in the Claims Pack documents sent on 17 December 2013 about her obligation to sign a medical authority. The author of this letter (and it may well have been systemically authored as a standard form) recognised that the legitimate limits to seeking personal medical information were the "fair and accurate assessment of the claim". Such is related to, but different in kind and quality from, an assessment as to whether TAL has rights to reject an otherwise valid claim or avoid the policy by reason of misrepresentation or non-disclosure.

43 On the same day, 8 January 2014, TAL requested United Healthcare Group (**UHG**) to obtain on its behalf the Second Insured's clinical records from her GP, Dr D, and from her private health insurer. In the TAL file note concerning the request to UHG to obtain Dr D's clinical

notes there was an entry: "Do not contact applicant." This reflects the lack of notice to the Second Insured about the investigation as to the validity of her policy.

44 The following day, 9 January 2014, TAL wrote to the Second Insured informing her that her claim was accepted, explaining how benefits were calculated, waiving continuing premiums and asking to be kept up to date on progress. In this latter respect the letter stated (CB2 tab 31 p…0370–0371):

> **Keeping us up to date with your progress**
>
> During the period that you're receiving benefit payments, we need regular updates on your progress. To help us with the assessment for your next benefit payment, please:
>
> - complete the enclosed progress claim form,
> - ask your doctor to complete the enclosed Attending Doctor's Statement,
> - return both to us by in the enclosed reply paid 1 March 2014
>
> We may also ask you to:
>
> - undergo medical examinations with the doctor of our choice
> - provide information about your income before you took out this insurance and before you made a claim
> - give us the authority to gather further information about your claim, for example from other companies, employers, government bodies and/or other relevant bodies
> - provide your monthly profit and loss statement and tax returns
> - meet with a TAL representative so they can gather further information about your claim.

45 The letter was expressed in reassuring terms. The last two headings were "Support when you need it most" and "We're here to help". There was no information given that TAL was seeking prior medical information to assess whether there had been misrepresentation or non-disclosure. The author of the letter to whom I will refer as Ms KR was the case manager who had recommended investigation to ascertain whether there had been non-disclosure.

46 On about 17 January 2014, UHG provided TAL with copies of the Second Insured's Medibank Private health records.

47 On about 22 January 2014, UHG provided TAL with copies of the clinical records of the Second Insured's GP, Dr D. These documents included mental health assessments and plans and reviews at various dates in 2007 and 2009.

48 On 29 January 2014, Ms KR, the TAL case manager, wrote a file note about the record which contained the following (CB2 tab 4 p…1544):

> 5 January 2009 mental health assessment ended relationship depression [Redacted]
>
> used marijuana 18-22 unstable relationship
>
> 18 January 2008 referral to psychologist
>
> Assessment: Following receipt of Medicare hx the case will require referral to u/w. The insured did not disclose any mental health issues. This appears only to be as a result of a marriage break up it may have altered policy terms and conditions given the insured's other disclosures made at policy application

49 This entry was under the headings (CB2 tab 4 p…1544):

> Comments
>
> Medical Information
>
> …
>
> Policy validity investigation

50 On 6 March 2014, TAL received a progress claim form from the Second Insured. The form contained another competed medical authority. The interim claim was paid by TAL on 10 March 2014.

51 In late March, TAL received from Medicare Australia a copy of the Medicare and PBS records of the Second Insured from 1 March 2009 to 23 December 2013. Earlier records were not made available. Exceptional circumstances were said to be required for their production.

52 On 2 April 2014, TAL received a progress claim form from the Second Insured. The form contained another completed medical authority. The interim claim was paid by TAL on 3 April 2014.

53 Meanwhile, on 24 March 2014, Ms KR, the case manager, spoke with the Second Insured on the telephone and was told by her that she would like to return to part-time work in April, having decided not to sell the business. Discussion took place as to financial information that was necessary for a partial claim.

54 On 5 May 2014, TAL asked UHG to obtain on TAL's behalf copies of the clinical notes of another treating doctor, Dr M, at the same practice where Dr D practised.

55 On 7 May 2014, TAL informed the Second Insured by letter of payment of benefits from April to May 2014.

56 On 4 June 2014, UHG provided to TAL the medical records of Dr M. They contained further records concerned with the Second Insured's mental health.

57 The file notes of the case manager, Ms KR, reveal regular contact with the Second Insured and discussion as to her condition. The view of Dr D on or prior to 22 May 2014 was that she would return to work, though it was not clear when this would occur. In the file notes of Ms KR that reviewed Dr D's records it was noted that the insured had been referred to a psychiatrist. (This was incorrect. The Second Insured had been referred to a psychologist.)

58 On 11 June 2014, Ms KR made a file note that all clinical notes had now been received and "the case requires re-u/w referral." This is a reference to the need to "re-underwrite" the risk. This was a retrospective underwriting opinion to review the records. Ms KR prepared a referral on 11 June 2014. It annexed the Second Insured's Medibank Private records and those of Dr M, and probably those of Dr D. Parts of these records were redacted.

59 On 26 June 2014, Mr Bird provided his retrospective underwriting opinion. He stated in the report that the application would have been declined, referring, amongst other things, to "Depression – recurrent depressive disorder." Adjacent to the heading "Overall Decision" he wrote "Decline" and below it he wrote (CB2 tab 42 p…0241):

> Significant depression with specialist referral, suicidal ideation would be a decline minimum of 5 years since last episode and then RMO

60 The report contained extracts from Dr M's clinical notes which included references in 2007, 2008 and 2009 to depression, suicidality, "doing well with psychologist", reduced suicidality, a mental health assessment, "reaction to ending relationship", and "seeing a psychologist".

61 On 27 June 2014, the case manager, Ms KR, sent a referral to TAL's Claims Decision Committee recommending avoidance of the policy. The full terms of the recommendation were as follows (CB2 tab 44 p…2163):

> The insured applied for cover 29/09/2013 at application she disclosed bronchitis less than once a year and whip lash due to a high speed MVA last symptoms within 6 months an MRI in 2010 all clear of serious injuries and she required 2 weeks in hospital. A family history of [Redacted] was disclosed. Insured also disclosed drug use of marijuana last used more than 3 years ago.
>
> Cover was issued with a cervical spine exclusion.
>
> Policy validity investigation was undertaken and clinical notes were referred for re-underwriting.
>
> Clinical notes indicated that the insured had pre-existing depression in 2007, 2008, 2009. Based on the medical evidence obtained underwriting would have declined

> cover due to the insured's prior history of depression.
>
> Based on the cervical spine exclusion and depression decline the overall decision would have resulted in the application being declined.
>
> TAL would not have entered into a policy on any terms therefore the recommendation is to avoid the policy based on the remedy (29)3 of the insurance contracts act.

62 The Claims Decision Committee was set up under guidelines that were in evidence. The Committee was independent of the claims and case managers, although these persons attended to present the claim and contribute to the discussion.

63 On 30 June 2014, the Committee accepted the recommendation of Ms KR.

64 On that day, 30 June 2014, the case manager, Ms KR, telephoned the Second Insured with the bad news. The transcript and recording of this telephone call reveal the distress and concern caused to the Second Insured (albeit she expressed herself in polite terms) by the decision. I will return to the relevance of this in due course in discussing the content and operation of the implied term of the utmost good faith. But it is appropriate to say at this point in the chronology that policies of this kind providing income protection are very important to the economic and human wellbeing of people. The content of the term implied by s 13(1) of the *Insurance Contracts Act* and its application in individual cases are not subjects limited to the exercise or discharge of legal rights, abstractedly analysed, though that is, of course, relevant. It involves consideration of the human context of the people concerned. It is the acting towards each other (with commercial standards of decency and fairness) that is expected of both the insurer and insured by the terms of s 13. The policy was, obviously, of the utmost importance to the Second Insured: a 39 year old woman of modest means, self-reliantly self-employed experiencing cancer of the most serious kind. From the circumstances of the disclosures that were made and from the content of TAL's file there was not the slightest evidence of dishonesty or sharp practice in the conduct of the Second Insured. She was given this news over the phone (a letter was to follow) after not the slightest intimation of the undertaking of a "policy validity investigation" or the slightest opportunity to explain the circumstances of her treatment in 2007, 2008 and 2009 (four to six years before taking out the policy) or to explain why she had not disclosed those matters.

65 In the conversation with Ms KR, the Second Insured said, amongst other things: that she did not deliberately not disclose anything; and that she did not believe that (at the time of this conversation) TAL would not have given her any policy at all. When asked whether there was a reason that those matters had not been disclosed, she said "because I so don't feel that I had

an ongoing depressive issue … I disclosed everything that I remembered." She then referred to some of the highly personal and family matters that she had disclosed. When asked whether she recalled (that is at the time of this conversation) seeking treatment for depression the Second Insured said: "I remember going to my doctor and crying and being sad, sure. I would not call what I had as ongoing … I try not to remember bad bits of my life … I absolutely did not deliberately exclude something. So, I'm … stunned, shocked, incredibly sad and distressed." She was then effectively told that she might owe TAL about $15,000, which caused her audible distress. She was told that there was a process of internal review and that she would be sent a letter with all relevant information.

66 The conversation had begun with Ms KR saying the following (CB2 tab 45 p…0001):

> KR: Excuse me. Look I'm just calling you today, unfortunately in relation to some bad news. I'm not sure if I had advised you or not. But essentially, when you lodge a claim, we look into your past medical history to ensure that everything that was disclosed at application was correct.

There certainly had been no intimation in any of their communications (written or aural) that TAL would look into her past medical history to ensure everything that was disclosed at application was correct, in effect that there was a "policy validity investigation" being undertaken. Indeed, it can be inferred from the notes and the nature of the conversations that did occur from January to June that there was a deliberate decision or policy not to tell the Second Insured or someone in her position of such an investigation.

67 At the time of this conversation on 30 June 2014, TAL was aware of the Second Insured's difficult emotional and physical state. On 22 May, Ms KR read a medical report of Dr D describing pelvic pain, mood instability, and other chronic pain. The content was described in the report (transcribed in Ms KR's notes) (CB2 tab 4 p…1535):

> Prognosis: Cervical carcinoma serious and potentially lethal condition. Once she recovers from her tx she is likley [sic] to RTW [I infer: return to work]. Long term prognosis remains gaurded [sic] due to the relatibely [sic] short time that has passed from time of tx
>
> No additional factors prevent RTW

68 On the same day, 30 June 2014, the Second Insured requested an internal review. She renewed this on 1 July 2014, saying she had taken legal advice and was in "financial crisis".

69 By letter dated 3 July 2014, signed by Ms KR, TAL avoided the policy. The letter included the following (CB2 tab 50 p…0175–0176):

Information received throughout claim assessment

It has now come to our attention that your responses to the questions asked in the application were not accurate. In particular the following medical information was not disclosed:

- Clinical notes from Dr [M] which indicated the following relevant consults
- 16.1.07 referral re depression, declining anti-depressants
- 14.12.07 – Depression – suicidality, sleep disturbance. FH of mental illness
- 22.04.08 doing well with psychologist. Reduced suicidality
- 05.01.09 Mental Health Assessment reaction to ending relationship
- 11.11.09 Lethargic 4-5/12
- 10.02.10 fatigue

The details of your medical history set out above were relevant to our decision as to whether to accept your application and if so, on what terms. If we had been aware of the above stated information we would not have entered into an agreement to offer a policy on any terms.

…

Misrepresenting or failing to disclosure relevant information

In failing to correctly and completely provide your medical history in the application, you failed to disclose and/or misrepresented your medical history thereby breaching your duty of disclosure pursuant to s21 of the *Insurance Contracts Act 1984* (**the Act**). We are also of the opinion that **you also breached your duty of good faith** as set out under s13 of the Act.

As such, pursuant to s29(3) of the Act, TAL Life Limited (formerly TOWER Australia) hereby avoids the policy/policies from inception on the basis that had the non-disclosure and/or misrepresentation not occurred, TAL Life Limited would not have entered into a Policy.

Benefits paid under your claim

As we would have not offered a policy on any terms, you were not eligible for any benefit payment made under the Policy/Policies. As such, we are entitled to recover any benefit payments made to you. In this instance, we are prepared to refund of [sic] all premiums that you have paid (minus any premiums already refunded to you during the claim). We have listed these amounts below:

Total premiums paid:	$1,027.44
Total benefits paid:	$25,000.00
Premiums already refunded to you:	$677.35
Amount to be recovered:	$24,649.91

At this stage, we won't be requesting the payment of this amount; however we reserve any right to request recovery in the future.

If you have new relevant information

> We've made this decision based on the information currently available. If you have any new relevant information, you're welcome to submit it to us for review and consideration.
>
> If you're dissatisfied with how we've made our decision, you can submit your feedback in writing to:
>
> The Manager, Complaints Resolution
>
> TAL Life Limited
>
> GPO BOX 5380
>
> Sydney NSW 2001
>
> (Emphasis added, other than headings which were bold in the original.)

70 A number of things should be said about the above letter. First, as to the heading above the recited medical information, it was disingenuous. The information was not received "throughout [the] claim assessment". At least in respect of Dr M's records, it was sought and produced as part of a "policy validity investigation" that was separate from assessing her claim for cancer of the cervix. Secondly, TAL not only asserted non-disclosure and misrepresentation, but accused the Second Insured of a lack of utmost good faith. Thirdly, as must have been evident from any application of common sense and human experience, the contents of a doctor's clinical notes may not be an accurate reflection of what the patient knows, understands or is aware of, either contemporaneously or four to six years later. Fourthly, the letter threatened the Second Insured with further action to recover over $24,000, though "reserving its position" in this regard.

71 At no time prior to avoiding the policy did TAL:

(a) tell the Second Insured it was considering her medical history;

(b) tell her that it was examining her medical history to undertake a "policy validity investigation", that is ascertaining whether it had rights under the *Insurance Contracts Act*, including the right to avoid the policy *ab initio* with the consequent possible consequence not only of a refusal of the claim, but also of a possible liability to repay all moneys paid hitherto under interim claims;

(c) ask her to address any concerns as to non-disclosure or misrepresentation in her answers;

(d) make any additional enquiries of Dr D, Dr M or the psychologist to whom the Second Insured had been referred about the contents of the medical records and about her condition.

72 On 13 July 2014, the Second Insured again sought to take advantage of TAL's internal review. In the document seeking review she stated (CB2 tab 52 p…0290):

> I'm writing to request an internal review of the decision to void my insurance policy on these points:
>
> It was an accidental omission of medical history, certainly not a deliberate misrepresentation.
>
> I've been running a successful solo [Redacted] for seven years now. The only time away from work (aside from study breaks) was following my car accident, when I had two weeks off with a [Redacted] in 2010.
>
> As such, with no time required away from work, it didn't feature prominently in my mind.
>
> I wait to hear of your decision.

73 By letter dated 28 August 2014, TAL refused to change either its decision or its position on potential recovery of payments, saying (CB2 tab 55 p…0179):

> **Background**
>
> We understand that you have previously been informed of your Duty of Disclosure and the impact of breaches in TAL's letter to you dated 3 July 2014. Whilst we acknowledge that you have stated that this was unintentional, the medical information we received indicates that had full disclosure been made cover would not have been offered.
>
> **Benefits Paid**
>
> As you would therefore not have had insurance cover with TAL, we are entitled to recover all benefits paid to you prior to discovery of the undisclosed medical history.
>
> TAL will not at this point in time be requesting payment of the amount of $24,649.91. However we do reserve any right to request recovery in the future.

74 With the assistance of the Public Interest Advocacy Centre, on 5 September 2014, the Second Insured lodged a dispute with the Financial Ombudsman Service. The terms of the complaint were as follows (with aspects redacted to avoid any chance of identification of the Second Insured) (CB2 tab 57 p…0191–0192):

> **Summary of Dispute:**
>
> I have an ongoing claim on my income protection insurance policy as I had cervical cancer diagnosed in dec 2013, and received both radiotherapy and chemotherapy in jan and feb 2014. I was very ill and could not work, I'm still suffering side effects of treatment and haven't returned to work. TAL was paying me $5000/mth until I received a phone call on 30/06/2014 to inform me they have cancelled my policy as I didn't disclose depression from 2006/07.
>
> I was so shocked, this was an accidental omission! I told them about my mothers history of illness, my bronchitis, whiplash and pot smoking 20 yrs ago! I told them I had some blood tests outstanding at the time. I simply didn't recall depression the day

> I did the phone application! I'm an [Redacted] and have run a successful solo practice in Canberra for 8 years now, the only time off I've taken was for whiplash after my MVA in June 2010. Never have I been depressed enough to require medication or time off work, as such it didn't come to mind at the time of application. TAL is claiming that if I'd disclosed depression that they would not have offered me cover under any circumstance! I find this to be absurd and have spoken to legal aid who advised me that it would actually be discriminatory of them to not offer me some cover even if they included a rider or exclusion! I believe that with full disclosure they absolutely would have offered me cover, with some rider attached as they did for my whiplash injury.
>
> **Outcome Sought:**
>
> I believe they can now add a rider to my cover, as they did for my whiplash injury, to exclude me from claims until I haven't sought any help over a ??year period. I want my cover reinstated, and them to drop the threats of recovering $24649.91 from me, my benefits back paid for the months of June, July and August 2014, as well as my cervical cancer claim honoured and continued a legitimate illness with absolutely nothing to do with depression from 2006!!
>
> TAL continues to threaten me with 'the right to recover $24649.91 at any time in the future.' I want this to stop.
>
> TAL ceased to pay my monthly benefits and as such I want June, July and Augusts $5000 backpaid as $15000 to me.
>
> And I want me [sic] cover resumed so that I am still covered until I can resume my normal trading, reach the figure of $5000 income a month.

75 By deed of release dated 19 May 2015, TAL and the Second Insured settled the dispute. The settlement was without admission of liability of either party: that is, TAL maintained its rights to avoid; and the Second Insured maintained the position she set out in the terms of her complaint. The parties settled by a payment of another $25,000 by TAL, inclusive of interest and legal costs. The Second Insured kept the benefits hitherto paid. The parties agreed that the policy remained void *ab initio* and that the Second Insured was no longer an insured. Releases were given.

76 The evidence did not disclose the temporal extent of the disablement from working of the Second Insured caused by the cancer.

77 The Second Insured's experience became a case study at the Royal Commission. Statements of senior employees were filed pursuant to request by the Commissioner. I admitted these statements into evidence over the objection of TAL that they were irrelevant as opinions of persons who had no personal involvement in the matter. The evidence was of people who had authority to speak on behalf of TAL and who made themselves familiar with the affairs of TAL about which they gave evidence.

78 Ms van Eeden was the general manager of claims for the TAL group. She based her statement on her enquiries and experience. In relation to the approach taken Ms van Eeden said at paras 105 and 106 of her statement (CB2 tab 61 p…0257–0258):

> 105. On reflection, when viewed against TAL's current practices, [Redacted] claim assessment could have been and, were [Redacted] claim assessment to be undertaken today in accordance with TAL's current practices would have been, assisted by:
>
> a. seeking a report from the treating psychologist at TAL's cost to better understand her mental health status and treatment; and
>
> b. TAL notifying [Redacted] that we were undertaking enquiries in relation to the validity of her policy.
>
> 106. In my opinion, it would also have been appropriate to have written to [Redacted] setting out the relevant medical evidence obtained and the preliminary findings of TAL and providing her with an opportunity to respond before a decision was made. I would like to see this process implemented, at least in appropriate circumstances.

79 In relation to the notification to the Second Insured of the avoidance, Ms van Eeden said at paras 108, 110 and 111 of her statement (CB2 tab 61 p…0258):

> 108. Some of the communication with [Redacted] was not of the standard that TAL would consider appropriate. In particular, I do not believe there was sufficient empathy shown to [Redacted], given the lack of notice to her that the claim was being investigated, the manner in which the unwelcome news that her benefits would cease was conveyed, and leaving her with the impression that she may need to refund the benefits already paid to her by TAL.
>
> …
>
> 110. Decline and avoidance letters continue to be reviewed. It was not appropriate to inform [Redacted] that she had breached her duty of good faith in the declinature letter.
>
> 111. TAL's current practice is not to seek recovery of benefits paid to a customer in these circumstances. TAL's policy is to commence payment of an income protection claim, prior to finalising any investigation into the policy. TAL accepts that this should not result in a request for payment of benefits paid, except possibly in claims involving fraudulent conduct by the insured. TAL accepts there was no fraudulent conduct by [Redacted] in relation to her policy or claim.

80 As to the systemic nature of these matters, Ms van Eeden said the following at para 113 of her statement (CB2 tab 61 p…0259):

> 113. As to whether the conduct outlined above in response to this question is a representative example of, or is symptomatic of, a continuing or systemic issue that has occurred or continues to occur, as I have stated above, historically, in contrast to TAL's current practices, there were deficiencies:
>
> (a) in TAL's prior practice of referring in declinature letters to the breach of

the duty of good faith;

(b) in TAL's communications with the claimants, both in terms of insufficient empathy and keeping the customer informed;

(c) in TAL generally not providing the policyholder an opportunity to provide additional information prior to avoiding a policy when investigating a non-disclosure.

81 In her cross-examination by senior counsel assisting the Royal Commission, Ms van Eeden accepted the following propositions:

(a) TAL's failure to tell the Second Insured that it was investigating the validity of her policy was unacceptable and fell below community standards.

(b) At the time in June 2014 the failure to give the Second Insured an opportunity to provide information was a general practice and a systemic deficiency which had been rectified.

(c) The Second Insured was given no procedural fairness before the decision to avoid the policy.

(d) It was inappropriate to have told the Second Insured that she had breached her duty of good faith, because they could not have known (as was not the case) that she had done it intentionally.

82 Ms Phillips was the "General Manager, Health Services" for the TAL Group. She described her responsibilities as (CB2 tab 62 p…0133):

> My responsibilities in this role include leading a team to develop and support a customer health proposition in addition to providing various areas of the business with expert medical and forensic accounting support.

83 She based her statement on enquiries of relevant employees. Her evidence was as to the procedure for pre-existing conditions (CB2 tab 62 p…0138):

> In assessing an application which involves a pre-existing condition, the TAL underwriter considers the information disclosed by the applicant. If there is insufficient information to make an assessment to offer, decline or exclude insurance cover, the TAL underwriter will seek additional information in respect of the condition. The TAL underwriter will assess the applicant's information, and any relevant additional information, against the Reinsurance Guidelines and/or the TAL Guidelines (where appropriate) to determine whether to accept the application, apply an exclusion, or decline the application, or a particular benefit for which the applicant has applied.

84 In submissions to the Royal Commission senior and junior counsel on behalf of TAL made the following submissions and admissions, I infer on clear instructions:

(a) Counsel accepted, based on Ms van Eeden's evidence, that the accusation in the letter of 3 July 2014 that the Second Insured had breached her obligation of good faith was itself a breach of the implied term of good faith by TAL.

(b) Counsel accepted that the general practice up to mid-2017 that was exhibited in the case of the Second Insured of failing to afford a policyholder an opportunity to address TAL and any material it was relying on prior to deciding to avoid a policy was inappropriate and conduct which fell below community standards and expectations.

85 Further, counsel accepted, based on Ms van Eeden's evidence, that two other aspects of TAL's conduct fell below community standards and expectations:

(a) leaving her with the impression that she may be liable to repay the benefits that she had received in circumstances where her claim and any non-disclosure was not fraudulent;

(b) failing to afford her any procedural fairness.

86 I have referred above at [59] to the retrospective underwriting exercise undertaken by Mr Bird. It is necessary to deal with this procedure, and Dr Phillips' criticism of it, in some more detail. Mr Bird gave evidence.

The retrospective underwriting exercise and Dr Phillips' criticism

87 Mr Bird was an underwriter at TAL. He has been an underwriter for TAL since 2012. There was no suggestion that he was not qualified to undertake the task in 2014 of making an assessment of what would have been done in 2013.

88 The task of providing a retrospective underwriting opinion arises when a member of the claims team requests it. Mr Bird described this as follows in para 13 of his affidavit:

> … I was required to carry out a risk assessment to guide a decision about whether TAL would take on the risk of insuring the customer, and if so on what terms. In essence, what I did is assess the level of pre-existing risk (or likelihood) that a customer may experience the kind of loss or circumstances expected to be covered by the policy against TAL's appetite for that risk (I refer to this as 'underwriting risk'). Depending on my assessment of the underwriting risk presented by the customer, my conclusion may have been that TAL would accept the application on the standard terms for a policy, accept the application on non-standard terms (for example, with a premium or other loading or with an exclusion for certain types of risk), or not accept the application.

89 The underwriter or underwriters who had made the decision to insure the Second Insured were no longer at TAL.

90 Mr Bird performed the task with the assistance of underwriting guidelines, including those of the major reinsurer Munich Re. From his evidence it was clear that the guidelines were not rigid or inflexible, but, as the term suggested, guidelines for assistance.

91 Mr Bird said (see para 16 of his affidavit) that he formed a view about the risk of insuring the customer by applying the underwriting guidelines which he considered best applied to the medical and other information provided to him. This is important because Dr Phillips had some criticism of the applicability of one guideline over another based on his professional view as to the meaning of applicable terms in the guidelines. The choice made by Mr Bird, however, was one, within reason, for him to make. I will return to this point.

92 Mr Bird was given the medical records as well as the Second Insured's application documents. It was not Mr Bird's decision not to seek any further information from the Second Insured or her medical or health practitioners. He worked on an assumption that the medical records with which he was supplied by Ms KR would have been available to the underwriter in 2013 if the Second Insured had said yes to the relevant question. That assumption was reasonable, but in real life in 2013 the records could well have been supplemented by a more coherent and contextualised report or reports from the medical and health professionals, especially the psychologist. The way Mr Bird was briefed gave the Second Insured no opportunity to provide such coherent and contextualising reports.

93 In *Delor Vue Apartments CTS 39788 v Allianz Australia Insurance Ltd (No 2)* [2020] FCA 588; 379 ALR 117 at 179 [287], I said the following about a decision called for under s 28(3):

> An individual underwriter's decision in the counterfactual posited by s 28(3) on the hypothesis of innocent non-disclosure does not have to be entirely logical; nor must it accord with the court's view of what is more reasonable, nor must it accord with the views of others as to whether there were grounds for making another, and different, decision. Underwriting decisions can be made on a wide variety of considerations: some logical, some affected by the state of the market, some affected by the state of the business written by the insurer, and some based on experience, feel and intuition.

94 The only additional comment which I would add (as discussed later in these reasons) is that the task must also be carried out recognising the obligation of the utmost good faith.

95 Mr Bird concluded that the appropriate guideline was for "recurrent depressive disorder". Dr Phillips said there was no medical basis for that view. The importance of that guideline was that it revealed no real opportunity for the use of exclusions to protect TAL's position.

96 The evidence of Dr Phillips was not contested. His view was that there was no reasonable medical basis for the conclusion that there was a recurrent depressive disorder.

97 That can and should be accepted. But Mr Bird thought otherwise. He stated in paras 30 and 31 of his affidavit:

> 30 In particular, the medical records refer to matters including:
>
> (a) depressive symptoms from late 2007 including a mental health assessment which assessed her symptoms as scoring 37 on the K10 scale (which falls within the most serious tier based on the explanation attached to the assessment);
>
> (b) consultations with a psychologist over multiple years;
>
> (c) symptoms like lethargy and fatigue continuing into at least 2010;
>
> (d) developing depression in September 2013;
>
> (e) a history of self-harm; and
>
> (f) a reference to suicidality, which is by itself a significant underwriting risk.
>
> 31 In my view, these factors considered together mean that the best guideline for helping to assess the Second Insured's risk profile was the recurrent depressive disorder guideline, and that the risk profile that the Second Insured presented based on this information was outside TAL's appetite for risk as outlined in those guidelines. That is, in my view, applying those guidelines to the Second Insured's information would mean that a policy would not be offered to the Second Insured on any terms.

98 Mr Bird was not cross-examined as to a lack of truth in this. Looking at the clinical notes of Dr M (and Dr D), unless otherwise explained (as they could have been) there was a basis for an underwriter to think that there were significant mental health issues.

99 The guideline used by Mr Bird stated at the outset that a psychiatric report should be obtained. This was not done. In the light of the lack of affording the Second Insured a proper opportunity to say what she could put forward or what she would have put forward in 2013 if more information had been called for (as it would have been) had she answered "yes" to the relevant question, one might have thought that this recommendation in the guideline would be followed. Mr Bird did not consider it necessary; he viewed it as a suggestion only; he thought he had enough information to give an opinion.

100 I reject the submission of ASIC that the information in the clinical notes was so cryptic or disjointed that an underwriting decision could not be made without obtaining a medical opinion, if it had to be made on that basis. Some of the information was tolerably clear and concerning, in particular the scores on the psychological tests and the references to suicidality.

101 The difficulty is that this was not some theoretical underwriting decision. It was one, affected by the obligation of the utmost good faith, whereby the underwriter was seeking to identify what would have happened earlier if a question had been answered differently. That involved collecting and assessing, as nearly as possible, the information that would have been brought forth, or information as close to it as possible, at the earlier point of time.

102 I am not intending to set any inflexible required course of conduct in all cases. But here, if the Second Insured had answered "yes" to the relevant question in 2013, more information would have been sought from her. The doctors' and perhaps psychologist's notes and views would have become known. The Second Insured would have had the opportunity to obtain a complete, coherent and contextualised opinion or opinions. She would necessarily have been part of the process.

103 What occurred in the retrospective process for s 29(3) was to rely on notes, uncontextualised as a default to recreate reality, a reality without the participation of the Second Insured.

104 Whilst Mr Bird did not exhibit a lack of good faith, the inadequacies of his work (albeit not necessarily his conclusions) were brought about by the task he was set and the failure to give the Second Insured a proper opportunity to participate by putting to TAL such information as she was able to, which could have included reports from her doctors or psychologist.

105 I will deal with this further later in the section of these reasons on good faith, but the criticism of the retrospective underwriting cannot be divorced from the failure to give the Second Insured a proper opportunity to provide information.

106 TAL submitted it was a decision for TAL; but that does not excuse not involving the Second Insured. The decision is one for TAL, but it is one to recreate or to attempt to recreate a reality: What would have occurred on the earlier occasion? The Second Insured and what she would have done was and were part of that reality.

The first part of the case against TAL: the Claims Pack Representation

107 The first part of ASIC's case is that there were false and misleading representations in the communication from TAL to the Second Insured on 17 December 2013. On that day, TAL sent the letter by email referred to at [31] above, the Medicare Australia document being the authority to release Medicare and PBS claims information to a third party, a TAL claim payment form, the TAL Initial Disability Claim Form referred to at [33]–[37] above, and the Attending Doctor's Statement.

The case advanced

108 The case in relation to the misrepresentation changed in amendments to the concise statement made on 10 July 2020. The original case expressed in the Concise Statement dated 13 December 2019 involved two representations. The second representation, which was dropped in July 2020 and can thus be put to one side, was that TAL represented that it had a right to require the Second Insured to provide authorities enabling TAL to obtain and access any information required by TAL from any insurer, employer, or accountant or other relevant holder of information. The first representation was that by the information sent on 17 December 2013 (in the "Claims Pack") TAL represented (expressly or impliedly) to the Second Insured that it had a right to require her to provide authorities enabling TAL to obtain and access all of her medical records. This was said to be false because it had no such right under the policy, or otherwise The amended case from 10 July 2020 was that, by the information sent on 17 December 2013, TAL (expressly or impliedly) represented to the Second Insured that it had a right to delay processing of her claim and to withhold payment of benefits under the policy until she provided an executed authority enabling TAL to obtain and access the Second Insured's medical records "as incorporated in the Claims Pack", and an executed authority to release Medicare and PBS claims information "incorporated in the Claims Pack".

109 One can see immediately the relationship between the two matters with which the representations are concerned. A right to require the Second Insured to provide the executed authorities may well be the foundation of a right not to pay the benefit otherwise apparently due. The two rights are, however, distinct, as are the representations about them.

Whether the representation advanced was made

110 The documents sent on 17 December 2013 must be examined in their proper context to discern a representation, that is, that the Second Insured was expressly or impliedly told or that TAL made a statement: *Given v Pryor* (1979) 39 FLR 437 at 441 (Franki J), that TAL had the right

to delay processing of the claim, and to withhold payment of benefits, until the relevant executed authorities were provided. This is a question of fact to be addressed by considering what was said and done against the background of all the surrounding circumstances: *Taco Company of Australia Inc v Taco Bell Pty Ltd* [1982] FCA 170; 42 ALR 177 at 202 (Deane and Fitzgerald JJ), cited and approved by the Court in *Campomar Sociedad, Limitada v Nike International Limited* [2000] HCA 12; 202 CLR 45 at 84 [100]. The resolution of the question may be assisted by logical deduction or logical analysis, but it is not limited to, and may not in any particular case involve, such considerations. The question is whether, by the communication in its context, TAL stated to the Second Insured that it had the right to delay processing of the claim, or to withhold payment of benefits, until the executed authorities were provided.

111 The letter stated that the Second Insured "needed" to complete "the paperwork". The plain English meaning of her needing to do something was that she was required or expected to do it. She was asked to complete ("Please complete ...") the form accurately "to ensure a swift assessment". Under the heading "What happens next?", the Second Insured was told that her "dedicated case manager" (whom the letter elsewhere said would be assigned upon receipt of the claim form) will start assessing the claim once they (the dedicated case manager in gender neutral singular pronoun "they") received the requested items. To say, perfectly reasonably, we will start assessing your claim when we receive "the requested items" is not to say we will delay processing the claim and not pay benefits under the policy until all aspects of our requests are complete, nor is it to say that we have a right so to act. The statement is a straightforward one: that upon receipt of your claim and the requested items we will begin assessment.

112 The "Important Information" on the first page of the Initial Disability Claim Form (see [33] above) stated a reasonable and practical reality: Delay in the assessment process *may* be caused by incomplete or inadequate information. This is not a statement concerning any right to delay the process or to withhold payment.

113 The privacy disclosure (see [35] above) explained the purpose of the collection of information. It was somewhat abstractedly, almost abstrusely, expressed: "to provide or arrange for the provision of the product or service requested." The abstract or abstruse nature of the expression may, as will be seen, be derived from, or explained by, the language of relevant statutory provisions. Nevertheless, in the context of the claim form otherwise, it would be understood as a statement that the personal information was being collected to assess the claim. Thus, the

first paragraph of the privacy disclosure (see [35] above) is to be understood as saying: We collect this information to enable us to assess the claim. If you do not supply it we *may not be able* to assess the claim. Again, this is **not** a statement that TAL has a right to delay processing of the claim or to withhold payment of benefits until any or all of the requirements are completed.

114 The documents, including the covering letter, would be understood to be standard form business documents of an insurance company. The reader would naturally assume that TAL was entitled to require or at least to ask for these documents. Indeed, there is, in my view, an implied representation that TAL was entitled (on some lawful basis) to require (not just request) the information to be provided and the authorities to be executed. That is not, however, the representation of which complaint is made.

115 That said, taking the 17 December 2013 communication as a whole, to say that a failure to provide information *may* delay the assessment process is not a statement (express or implied) that there is some right to delay processing or to refuse to pay a benefit until some particular aspect of the required information is provided. If the insured thought about the subject he or she might logically deduce that this may be so; but I do not consider that, as a question of fact, and as a matter of language in its context, the 17 December 2013 communication made a statement that TAL had such a right or such rights.

116 ASIC submitted that the context of the communication on 17 December 2013 included the PDS that had been supplied in September 2013 (see [6] above). At one level such a submission might be seen as uncontroversial. Care is, however, required. The Claims Pack communication is said to be the source of a statement, of a representation (express or implied) that TAL had certain rights. The question is how the letter and its contents would be understood as a communication. The PDS may or may not have been read, or read fully or carefully. Nevertheless, a company in a position of TAL, required to provide a PDS to a prospective insured, is entitled, in the ordinary course, to conduct itself on the basis that the PDS has been read. The PDS, under the heading "Making a claim", made the clear statements set out at [6] above. Thus, in the clearest terms, TAL stated in the PDS that the claim would only be paid if the policy document requirements had been met. I will come to these shortly. That background does not, however, assist ASIC in extracting an implied representation in the Claims Pack documents as to the right to delay processing the claim or to refuse to pay a benefit until some or all aspects of the claim form have been executed or some information provided. The insured

has already been told that benefits will not be paid unless the requirements of the policy have been fulfilled. The Claims Pack required certain questions to be answered, information to be provided and authorities to be executed. The Claims Pack contained an implied representation that TAL had the right to require the information and authorities that it requested. That, in my view, as a matter of meaning of the communications in the Claims Pack in their context, is the limit and extent of the representations by TAL on 17 December 2013.

117 I consider that the representation of which complaint was first made, but which was abandoned, was in fact made.

118 It is unnecessary to speculate upon why the amendment was made to the Concise Statement to vary the character and terms of the representation advanced. It may have been to better the prospect of the case concerning the asserted representation falling within s 12DB(1)(i) of the ASIC Act, being the provision contravention of which would raise the liability of TAL to a civil penalty.

119 The first representation pleaded in the original Concise Statement would have been made out. It was a representation of importance. People in the position of the Second Insured here are being required to authorise the divulging of their most sensitive personal information. This is a matter of great importance. A requirement to grant such an authority carries with it an implicit assertion of the right to require such sensitive information. It is incumbent upon insurers to ensure that if they wish to be able to require such information, they must found their right to do so with clarity.

Whether the representation (if made) was false or misleading

120 If I be wrong in my view of the extent of the representation it is necessary to consider whether the policy and its terms permitted TAL to delay processing the claim and to refuse to pay a benefit unless the Second Insured executed the relevant authorities. This enquiry begins with the related question of whether TAL had the right to require the Second Insured to execute the authorities.

121 It is necessary to ascertain the meaning and extent of the policy. It is written in plain English. It is to be read and understood by the ordinary insured. It should be so construed. It is of course, in one sense, a commercial document; but it is also a contract entered into by ordinary people for their protection. In this respect I refer to what Justice Gleeson and I said in *Todd v Alterra at Lloyd's Ltd* [2016] FCAFC 15; 239 FCR 12 at 22–23 [42] and 23 [44] as to the

relevance of the social, as well as the commercial, purpose and object of the contract. The sense and meaning of a policy such as this will be that which insureds in their ordinary dealings would give the document: cf Lord Bingham of Cornhill's explication of Lord Halsbury LC's comments in *Glynn v Margetson & Co* [1893] AC 351 at 359 that "a business sense will be given to business documents", in *Homburg Houtimport BV v Agrosin Private Ltd (The 'Starsin')* [2004] 1 AC 715 at 737 [10]: "The business sense is that which businessmen, in the course of their ordinary dealings, would give the document." In a policy such as this, the business person is to be understood as the ordinary insured.

122 Thus one turns to the policy document.

123 The first part of Part 6 of the policy (see [27] above) made clear that the insured: "must also satisfy our claim requirements explained in Part 10 of the Policy Document". The language is apt to make that a contractual obligation. Thus Part 10 and relevantly Part 10.2 entitled "Claims" contained matters intended to be compulsory, that is contractually binding. Thus TAL had a right to require anything that is a "claim requirement" in Part 10. Further, the context of, and words preceding, the last sentence of the first part of Part 6 of the policy (see [27] above), is and are such that an ordinary reader would understand that TAL was not obliged to pay a benefit unless the claim requirements were satisfied. I have set out the relevant parts of Part 10.2 at [29] above.

124 There is an obligation to complete and provide a claim form in a form satisfactory to TAL.

125 There is a clear statement that TAL "must be satisfied of our liability to pay a benefit." That statement would be understood by the ordinary insured, in particular in its place under medical requirements, as a statement that TAL would not be liable to pay a benefit unless it was satisfied with the provision of information obtained from its claim requirements.

126 Under "Other Information Requirements" there is a reference to requesting (as opposed to requiring) information or documents, including: access to details of the Life Insured's previous medical consultations. ASIC submitted that the word "request" was significant and thus meant that such access was not a requirement. I reject that submission. The request that might be made was part of "Other Information Requirements", which was part of "Claim requirements", which *must be satisfied*. TAL was entitled to request and so to require access to details of previous medical consultations of the "Life Insured".

127 No case was made by ASIC that the Second Insured as a holder of Income Protection insurance was not a "Life Insured". The phrase was defined in Part 1 of the policy as meaning "the person whose life is insured under the Policy". Given the lack of argument by ASIC on the point I will construe the first dot point under "We may also request:" under the heading "Other Information Requirements" as referable to an insured under income protection cover.

128 I would not construe the statement in Part 10.2 under the heading "Notifying us of a claim" and above the heading "Claim Requirements" (see [29] above) that "We will send you a claim form and explain in detail our requirements …" as providing any broader reach of claim requirements that must as a matter of contract be satisfied than appears under the heading "Claim requirements".

129 The claim requirements include the requirement to provide a completed claim form "in a form satisfactory to us". The question arises whether that requirement permitted TAL to require either or both the Medicare Australia authority and the medical authority for clinical records. The claim form did not refer to Medicare or PBS records. That was a separate document provided by Medicare Australia that TAL included in the Claims Pack. No part of the "Claim requirements" required this. There was thus no contractual right to require this document to be executed. The medical authority to be executed was part of the claim form. To "complete" the claim form required the authority to be executed. If this were the only basis for requiring the medical authority to be executed, I have doubt as to whether this would be sufficiently clear or specific to amount to a requirement. The ordinary reader of the policy would understand the personal significance and importance of his or her medical records. He or she would, however, also understand the need for the insurer to appreciate his or her medical condition to assess the claim. It is unnecessary to draw any conclusion in this regard because the policy does entitle TAL to request (and so require) access to details of previous medical consultations. In that context, the claim form that is to be completed may legitimately contain the request for execution of the medical authority.

130 ASIC submitted that the policy document should be construed in a manner informed by the evident purpose of the requirements: that is to consider and respond to claims. This was said to be a restriction that was reasonable and in conformity with how a claims co-operation clause is to be construed. Reference was made to *Stealth Enterprises Australia Pty Ltd v Calliden Insurance Limited* [2013] NSWSC 825; 17 ANZ Insurance Cases 61-979 at [34]. There, in a summary disposal application, Campbell J construed a clause under a heading "Claims

Procedures" that the insured must "provide all reasonable information and assistance as we may require" as restricted to "providing reasonable information and assistance with regard to a claim under the policy." His Honour said that: "the condition does not extend to a contractual entitlement of the insurer to compel the insured to provide additional information about … the insured's entry into, or renewal of, the policy": see *Stealth* at [35] and [36].

131 TAL objected to this submission being relied upon as outside the Amended Concise Statement. I reject that submission. The proper reach of the policy was always in issue, as was the legitimacy of the requirement (at least in the Claims Pack) to execute the medical authority.

132 The limitation suggested conforms with the privacy disclosure in the claim form (see [35] above). This was a later document, and so not admissible to construe the policy, but it perhaps assists in an independent conclusion otherwise able to be reached, which I do reach, that the claims requirements were contractually intended to enable TAL to assess the claim.

133 It is necessary, however, to recognise that the assessment of any claim of life insurance or for income protection will or may involve the medical condition of the insured. The claim may be for a particular condition, but it will or may be legitimate for the insurer to consider potentially related conditions that bear upon the existence or nature of the claimed condition or disability. Thus, the obtaining of a widely expressed authority enabling access to details of previous medical consultations and previous conditions is both sensible and reasonable. How that right of access to medical records is thereafter used is, or may be, an entirely different question.

134 Thus, there was no contractual right in TAL either to require the Medicare Australia authority to be executed and provided, or to delay processing the claim or to refuse to pay a benefit unless and until it was provided. There was, however, a contractual right to require the medical authority in the initial claim form to be executed and provided and to delay processing the claim or to refuse to pay a benefit unless and until it was provided.

135 The above conclusions mean that if I am wrong about the content and extent of the representations in the Claims Pack of 17 December 2013 and if the asserted representations were made, only one (concerned with the Medicare and PBS records) was false.

136 Before turning to examining whether (on this hypothesis) the misrepresentation fell within he relevant statutory provisions, it is necessary, in the light of the later discussion as to the duty of the utmost good faith, to say something more about the medical authorities and information. First, from a legal point of view, and quite possibly from a claims manager's point of view,

claims assessment involves not only the ascertainment of the medical condition of the insured and how it conforms, or not, as the case may be, with the terms of the cover, but also whether the insurer is liable to pay an otherwise valid claim, in the light of the circumstances of the taking out or renewal of the policy. The two are, however, conceptually distinct. I broadly agree in this respect with the views of Campbell J in *Stealth* to which I have referred. If an insurer wishes to have a contractual right to require an insured to provide it with information or authorities to obtain information to investigate facts which may give it a right or remedy to avoid or vary the contract or refuse to pay an otherwise valid claim because of non-disclosure or misrepresentation, then, subject to the operation of the term implied by s 13(1) of the *Insurance Contracts Act*, it may well need a specific contractual provision.

137 Secondly, if an insurer, such as TAL here, legitimately includes in a claim form a wide authority to access medical records for the purposes of assessing the claim and after using the authority obtains information that puts it on notice of possible non-disclosure or misrepresentation, a question may arise as to what use can be made of that information, and what further information can be sought, not to assess the claim, but to investigate remedies depending upon non-disclosure or misrepresentation. For instance, here, whilst the concern of TAL, perhaps raised by the claim being made so soon after the policy was taken out, may have initially been as to non-disclosure as to the cancer, it became apparent from Dr D's records that there may have been an issue about the lack of disclosure about the mental health of the Second Insured. Thereafter, and after the claim itself had been accepted and relevantly fully assessed as to its nature, documents were sought from Dr M not to assess the claim, but to investigate the validity of the policy, principally, if not solely, by reference to issues of the mental health of the Second Insured. The relevance of these matters will be discussed below in the context of the good faith case.

Whether the representation (if made and if false) was made within the terms of the relevant provisions

138 If there was a representation that was false or misleading questions arise as to whether four statutory provisions were contravened:

(a) s 12DA(1) of the ASIC Act;

(b) s 12DB(1) of the ASIC Act;

(c) s 1041H(1) of the *Corporations Act*; and

(d) s 13(2) of the *Insurance Contracts Act*.

139 It was accepted by TAL that on this hypothesis, in the circumstances, s 1041H(1) was contravened. That subsection was in the following terms:

> A person must not, in this jurisdiction, engage in conduct, in relation to a financial product or a financial service, that is misleading or deceptive or is likely to mislead or deceive.

140 ASIC submitted that representations in the claims handling process, specifically in the Claims Pack sent to the Second Insured, also fell within both ss 12DB(1)(i) and 12DA(1) of the ASIC Act.

141 The arguments of TAL as to why ss 12DB(1) and 12DA(1) of the ASIC Act were not engaged, even if the hypothesis be correct, were similar, even though the wording of the provisions is different.

142 Section 12DB(1) relevantly provided:

> **A person must not, 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:
>
> …
>
> (i) **make a false or misleading representation concerning the existence**, exclusion or effect **of any** condition, warranty, guarantee, **right** or remedy (including an implied warranty under section 12ED);
>
> (Emphasis to show the relevant operative words as submitted by ASIC.)

143 Section 12DA(1) provided:

> A person must not, in trade or commerce, engage in conduct **in relation to financial services** that is misleading or deceptive or is likely to mislead or deceive.
>
> (Emphasis to show the relevantly different wording from s 12DB(1)(i). No party sought to draw any distinction between "false or misleading", and "misleading or deceptive or likely to mislead or deceive".)

144 I will focus first upon s 12DB(1)(i) and the meaning of "in connection with the supply ... of financial services".

145 An insurance contract is a "financial product": s 12BAA(7)(d); so the policy is a financial product.

146 The word "supply" was defined in s 12BA to include "provide, grant or confer", with a corresponding meaning as a noun.

147 The phrase "financial service" has the meaning given by s 12BAB: s 12BA(1). Section 12BAB(1) defines "financial service" for s 12BA(1) by setting out the circumstances in which a person "provides a financial service". Before looking to the two possible relevant circumstances in s 12BAB(1) (being paras (b) and (g)), the definition of the word "services" in s 12BA(1) should be noted. It *includes*:

> any rights (including rights in relation to, and interests in, real or personal property), benefits, privileges or facilities that are, or are to be, provided, granted or conferred in trade or commerce but does not include:
>
> (a) the supply of goods within the meaning of the *Competition and Consumer Act 2010*; or
>
> (b) the performance of work under a contract of service.

148 Thus, in s 12BAB(1)(b) or (g) one will be looking for the provision (which is the supply for s 12DB(1)) of a service which is financial which, relevantly, includes the provision, grant or conferral of a right or benefit or privilege or facility.

149 Section 12BAB(1)(b) provides:

> … [A] person provides a ***financial service*** if they:
>
> …
>
> (b) deal in a financial product (see subsection (7));

Subsection 12BAB(7) (relevantly) provides:

> For the purposes of this section the following conduct constitutes ***dealing*** in a financial product:
>
> …
>
> (b) issuing a financial product.

Thus, TAL would provide (that is, supply for s 12DB(1)) a financial service by issuing the policy. The question, for the purpose of determining whether ss 12DB(1) and 12BAB(1)(b) are engaged, is whether the false or misleading representation made in the Claims Pack (on this hypothesis) as to the right to delay claims handling or to withhold payment of a benefit until relevant authorities were executed and provided to TAL was "in connection with" the issue of the policy. In my view, it was not. The words "in connection with the issue of the policy" here describe a relationship or a circumstance that ceases before claims handling some months later. It is unwise, and likely to produce difficulty and over-refinement (which already exists in the complex definition-within-definition style of the drafting), to seek to provide a further explication of the meaning of the phrase "in connection with". It is, however, appropriate to

draw attention to the distinction between "in relation to financial services" in s 12DA(1) (addressed below) and "in connection with the supply or a possible supply of financial services" in s 12DB(1). The former appears to be a wider remit than the latter. As a matter of meaning, as it appears to me, making a misrepresentation about the right the insurer has in how it handles a claim, made in the context of the claim being made some months after the issue of the policy, cannot be said to be in connection with the issue of the policy so as to fall within the terms of ss 12DB(1) and 12BAB(1)(b).

150 A representation by A to B, made in the gathering of information relevant to the assessment of the liability of A to pay B its contractual entitlements, as to A's right to require information of B (the representation in the original Concise Statement) is a representation in connection with the process of assessment (and possibly in connection with, or in relation to, the policy itself and the operation of, and benefits under, the policy), but it is not in connection with the issue of the policy so as to fall within ss 12DB(1) and 12BAB(1)(b). (It would be otherwise if the (mis)representation were in a document (such as the PDS) which was distributed to the insured in connection with the issue of the policy (the dealing in the financial product for s 12BAB(1)(b)).

151 Likewise, a representation by A to B, made in the gathering of information relevant to the assessment of the liability of A to pay B its contractual entitlements, as to A's rights to delay assessment or to withhold payment of a benefit (the representation in the Amended Concise Statement) is a representation in connection with the process of assessment (and possibly in connection with, or in relation to, the policy itself and the operation of, and benefits under, the policy), but it is not in connection with the issue of the policy so as to fall within ss 12DB(1) and 12BAB(1)(b). (Likewise, it would be otherwise if the (mis)representation were, for instance, in the PDS.)

152 The fact that the falsity of the representation concerns a *right or benefit* under the policy (that is, under a financial product) does not necessarily mean that it was made in connection with the supply of a financial service or financial services, that is, in connection with the issue of the policy (s 12BAB(1)(b)) or with the provision, grant or conferring of a right, benefit, privilege or facility that is otherwise supplied in relation to the policy (s 12BAB(1)(g), addressed below).

153 Paragraph (g) of s 12BAB(1) provides:

> … [A] person provides a ***financial service*** if they:
>
> …
>
> (g) provide a service … that is otherwise supplied in relation to a financial product …

Picking up the definition of "service" in s 12BA(1), para (g) is to be read that TAL would provide (that is, supply for s 12DB(1)) a financial service by providing a service, including by providing, granting or conferring any right, benefit, privilege or facility, that is otherwise supplied (that is provided, granted or conferred) *in relation to* the policy.

154 TAL submitted that the process of claims handling, including the sending of the Claims Pack and prefatory to TAL determining whether to pay benefits under the policy in response to a claim, is not providing, granting or conferring any service or right, benefit, privilege or facility to the insured in relation to the policy. TAL accepted that it must conduct itself during the claims handling process with the utmost good faith; but, it submitted, it is not supplying a service in doing so. Part 6 of the policy required the insured to satisfy TAL's claim requirements in Part 10 of the policy. According to TAL, if a misrepresentation was made as claimed it was not in connection with providing a service of TAL, but in connection with requiring the insured to provide the information that he or she was obliged to provide.

155 ASIC emphasised the breadth and wide range of circumstances that have been considered to fall within "services" for the purposes of s 12BAB(1)(g). ASIC cited *ABN AMRO Bank NV v Bathurst Regional Council* [2014] FCAFC 65; 224 FCR 1 at 143–144 [758]–[759]. There, the question was whether in expressing an opinion in a rating as to the creditworthiness of the financial product (the notes in question) and by communicating the rating, the rating agency (Standard & Poor's) "provide[d] a service … that [was] otherwise supplied in relation to a financial product". The rating was a service and it was in relation to the notes. There was little discussion about "service" by the Court. The width of the phrase "in relation to" in para (g) of s 12BAB(1) was stated. There was little doubt that a rating provided was a benefit or facility (see the definition of "service" in s 12BA(1)) provided, or in ordinary parlance a help or benefit tending to the advantage of the prospective purchaser of the note.

156 ASIC also referred to *Motor Trade Finances Prestige Leasing Pty Ltd v Elderslie Finance Group Corporation Ltd* [2006] NSWSC 1348. There Elderslie provided facilities to MTFPL under a purchase and securitisation of receivables arrangement. MTFPL would receive applications to lease luxury cars and submit them to Elderslie. Elderslie would assess the applications and if approved supply finance and receive assignments of receivables and

guarantees. It was plain that Elderslie provided a service or commercial facility. Justice White said "service" had a wide meaning. That is correct and should be accepted, but does not take the matter very far. Notwithstanding their convoluted interlocking character, the definitions may reach the proposition that TAL is providing or conferring a claims handling "facility" (from the inclusive definition of "services" in s 12BA(1)) or a service, a claims handling service, being in ordinary parlance (the definition of "services" in s 12 BA(1) being inclusive) a help or benefit tending to the welfare or advantage of the insured: see *The Shorter Oxford English Dictionary on Historical Principles* (3rd ed, Oxford University Press, 1973) Vol 2 at 1950. The word "facility" also carries with it the notion of a means or something that makes possible the easier performance of an action: see *The Macquarie Dictionary* (rev ed, Macquarie Library, 1985) at 629.

157 Does A provide B with a service by sending requests for information in order to undertake such enquiries and consideration as is necessary for it to decide whether to pay what it is or may be otherwise contractually obliged to pay under the policy? A contract that says: A must pay B $X if fact Y has occurred, requires A to consider whether fact Y has occurred if B says that it has occurred. In considering that question and in undertaking an assessment process to decide that question, A seeks information from B. In doing so, A, on one view, is not giving a benefit or advantage or conferring a right or benefit or facility on B; it is requesting information in order to assess what it is contractually liable to do. That may, however, be a too abstracted and disembodied way of looking at the question. It may be looked at in a broader, more human, way. The legislation is, after all, about human and commercial conduct, relationships and activity. It is not a statute dealing with disembodied abstractions of jurisprudential rights and obligations. How an insurer conducts itself in its claims handling may be said to be part of the benefits for which an insured pays. A well-resourced, efficient, skilled and sympathetic approach to claims handling could be called in ordinary parlance a facility or service that is provided, one which no doubt would be reflected in the insurer's cost base and the insured's premium. That is how insurance can be marketed: that the approach to claims handling will be efficient and sympathetic. It would be an entirely appropriate use of language to refer to this as TAL's claims handling service. That usage would accord with the usage in the privacy disclosure in the initial claim form: see [35] above: that "the personal information is collected from … you to enable TAL … to provide … the service requested", viz, to provide the claims processing requested or the claims processing and payment requested. See also the covering letter's final paragraph: "We're here to help."

158 In this way, the claims handling process and the delivery of the Claims Pack can be said to be part of a service or facility provided or conferred.

159 Other cases to which ASIC referred took the matter no further. In *Australian Securities and Investments Commission v Superannuation Warehouse Australia Pty Ltd* [2015] FCA 1167; 109 ACSR 199, the defendant engaged in the business of providing online services associated with establishing and administering self-managed superannuation funds.

160 *Australian Securities and Investments Commission v Accounts Control Management Services Pty Ltd* [2012] FCA 1164 concerned the methods used by a debt collector to pursue debtors. The defendant debt collector would ring up the debtors. The telephone calls would not be pleasant experiences for the debtors. Generally, untruths were told and harassment occurred. The question was whether the debt collector was providing a financial service. In many of the calls a payment plan would be arranged whereby the debt could be paid off in instalments. At [341]–[345] Perram J explained, quite simply, why there was a service:

> 341 The question then becomes whether, as ASIC submitted, defendants had, to use the language of s 12BAB(1)(g), 'provid[ed] a service that is otherwise supplied in relation to a financial product' (if so, it will be recalled, they would be taken to provide a financial service).
>
> 342 ASIC submitted that by providing on-going credit to the debtors the defendants were providing a 'service' and that 'service' was supplied 'in relation to a financial product' viz the loan and credit card contracts. I accept the latter submission given the breadth of the words 'in relation to'. Attention can, therefore, be confined to whether the defendants provided a 'service' consisting of on-going credit.
>
> 343 'Service' is defined in s 12BA(1) to include 'any rights (including rights in relation to, and interests in, real or personal property), benefits, privileges or facilities that are, or are to be, provided, granted or conferred in trade or commerce', subject to some irrelevant exceptions.
>
> 344 I accept that the granting to each debtor of more time to pay was the granting of a right (namely, the right to relieved of the immediate obligation to pay) and that this occurred in trade or commerce. An essential part of each collections officer's job was to get the debtors on to payment plans. Necessarily, the provision of a payment plan was, albeit in an unusual sense, the provision of credit. No doubt it is difficult to view the unpleasant calls the debtors received as a service but those calls were not the service but rather merely an encouragement to take the service up.
>
> 345 It follows that I conclude that there was a provision of a financial service to each debtor on each occasion that more time was extended.

161 *Australian Competition and Consumer Commission v Telstra Corporation Limited* [2018] FCA 571 at [2] and [37] takes the matter no further, being concerned with s 12BAB(1)(b) – providing the financial service by dealing in a financial product.

162 I conclude that the better view is that claims handling and the requiring of information from the insured is part of a facility or service conferred or provided to the insured by the insurer that is otherwise supplied in relation to a financial product.

163 Thus, if there was a representation that was false or misleading it was in contravention of s 12DB(1).

164 The same conclusion should follow for s 12DA(1). The misrepresentation about rights to delay claims handling or to withhold payment of benefits made in connection with the gathering of information to assess the claims must, for s 12DA(1) to be engaged, be "in relation to financial services". The word "supply" or "provide" does not appear. But, as I have said, the definition of the phrase "financial service" in s 12BA(1) is that it "has the meaning given by s 12BAB". Section 12BAB(1) begins with a question: "**When does a person provide a *financial service*?**" and then continues: "For the purposes of this Division [and subject to the regulations authorised by subs (2)] a person provides financial advice if they:".

165 The question arises, in the light of the terms of the definition of "financial service" in s 12BA(1) and how that is dealt with in s 12BAB(1) by reference to using the word "provides", whether a "financial service" can be the financial product itself. The difficulty with an affirmative conclusion to that question is that s 12BAB(1)(b) (with s 12BAB(7)) says that dealing in the product (issuing the policy) is providing a financial service.

166 There is a clear difference in scope and extent between "in relation to the policy" and "in relation to the issue of the policy". TAL submitted (briefly) that the proper construction of s 12DA(1), with s 12BAB(1)(b), was the latter. As I read the submissions of ASIC, in particular paras 47 and 48 of the marked up "Plaintiff's Closing Submissions", I do not perceive any different approach. I also consider that it is the correct approach; a product is not a service. "Financial product" and "financial services" are separately defined. The reason the phrase "financial services" is defined by including a verb (the word "provide") is that the concept of the service in ordinary language embodies providing or issuing the policy or product or contract. The policy is a contractual arrangement. A financial service (by someone) involves a notion not of a status or arrangement, but the action or conduct of serving, helping or benefiting (see *The Shorter Oxford Dictionary* at p 1950). Thus "in relation to financial services" means (relevantly here, drawing on s 12BAB(1)(b)) "in relation to providing a financial product", that is, issuing the policy. TAL's conduct was not in connection with the issuing of the policy: see above in relation to s 12DB(1). Nor do I think that the conduct was

in relation to the issuing of the policy (s 12DA(1) with s 12BAB(1)(b)). Though, I do consider the conduct would be in relation to the *policy* (that is, the benefits that it provides) and thus it would be conduct "in relation to a financial product". But that is not what s 12DA(1) (informed by s 12BAB(1)(b)) says.

167 Given my view, however, that the claims handling process or seeking information by the delivery of the Claims Pack is a "service otherwise supplied in relation to a financial product", there is conduct in relation to financial services drawing on s 12BAB(1)(g).

168 Thus, if the misrepresentations were made, both ss 12DA(1) and 12DB(1) were contravened.

169 May I say that if ASIC is to have the general administration of the *Insurance Contracts Act*, there would seem every reason to ensure that it would have the authority to complain of misrepresentations to insureds made in the process of claims handling, as occurred here, on this hypothesis. I have not sought to give any overly broad construction to the legislation to bring this about. The drafter has chosen (perhaps been forced to choose, because of the need to draw a bright line of demarcation between the responsibilities of ASIC and the ACCC) to use interlocking definitions with, if I may respectfully say, wordy and repetitive precision. This produces time-consuming complexity (not only for judges, but more importantly, for citizens who have to pay to have the legislation interpreted, almost deciphered). The interlocking and complex expression of quite simple human concepts leads on this occasion to a degree of complexity in analysis. In legislation that is closely structured and finely worded the importance of text may be paramount: *Joffe v The Queen*; *Stromer v The Queen* [2012] NSWCCA 277; 82 NSWLR 510 at 518 [36]. That does not mean context and purpose is irrelevant: *Quikfund (Australia) Pty Ltd v Airmark Consolidators Pty Ltd* [2014] FCAFC 70; 312 ALR 254 at 270 [75]. As Learned Hand J said in *Helvering v Gregory* 69 F2d 809 at 810 (2nd Cir 1934): "as the articulation of a statute increases, the room for interpretation must contract".

The second part of the case against TAL: the lack of the utmost good faith contrary to s 13 of the *Insurance Contracts Act*

Jurisdiction and power

170 TAL put the submission that the Court had no jurisdiction to entertain the suit or claim for declarations because there was no "matter" in the Constitutional sense before the Court. Such a submission should ordinarily be dealt with first. I reject the submission for the reasons at the

end of the judgment. It is more convenient to deal with the matter in this way in that the argument on jurisdiction can be dealt with in a context informed by a discussion of the claims.

The claims outlined

171 Any breach of s 13(2) of the *Insurance Contracts Act* in 2013 or 2014 did and does not attract penal consequences. ASIC seeks declaratory relief as part of its general administration of the Act. TAL contests its authority to seek declaratory relief. I will come to those arguments.

172 A lack of honesty is not a pre-requisite for the conclusion that there has been a lack of the utmost good faith. I adopt what I said in *Delor Vue Apartments* 379 ALR 117 at 191–192 [342]–[345] about the obligation of good faith:

> 342 The above conclusion is reinforced by the separate consideration of the conduct of Allianz in 2018 in resiling from its earlier stated position, as a breach of the obligation of good faith as contained in s 13 of the Act. The obligation of good faith is as the statute says the "utmost good faith". A lack of honesty is not a prerequisite. In *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1; 237 ALR 420; 62 ACSR 609; [2007] HCA 36 (*CGU v AMP*) three judgments of the Court dealt with the matter. Chief Justice Gleeson and Crennan J said the following at 235 CLR 12 [15]:
>
> > **We accept the wider view of the requirement of utmost good faith adopted by the majority in the Full Court, in preference to the view that absence of good faith is limited to dishonesty**. In particular, we accept 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. The classic example of an insured's obligation of utmost good faith is a requirement of full disclosure to an insurer, that is to say, a requirement to pay regard to the legitimate interests of the insurer. Conversely, an insurer's statutory obligation to act with utmost good faith may require an insurer to act, **consistently with commercial standards of decency and fairness**, with due regard to the interests of the insured. Such an obligation may well affect the conduct of an insurer in making a timely response to a claim for indemnity.
> >
> > (Emphasis added and footnotes omitted.)
>
> 343 Justices Callinan and Heydon said at [257]:
>
> > At the outset we should say that we agree with the Chief Justice and Crennan J that a lack of utmost good faith is not to be equated with dishonesty only. The analogy may not be taken too far, but the sort of conduct that might constitute an absence of utmost good faith may have elements in common with an absence of clean hands according to equitable doctrine which requires that a plaintiff seeking relief not himself be guilty of tainted relevant conduct. We have referred to the doctrine of clean hands because, as with another equitable doctrine, that he who seeks equity must do equity, it invokes notions of reciprocity which are of relevance here. **That is not to say that conduct falling short of actual impropriety might not constitute an absence of utmost good faith of the kind which the Insurance Act demands. Something less than that might well do so.** Utmost good faith will usually require something more than passivity: it will usually require affirmative or

positive action on the part of a person owing a duty of it. It is not necessary, however for the purposes of this case, to attempt any comprehensive definition of the duty, or to canvass the ranges of conduct which might fall within, or outside s 13 of the Insurance Act.

(Emphasis added.)

344 Justice Kirby (in dissent) said the following about good faith at [130], [131] and [139]:

No one doubts that the absence of honesty on the part of an insurer (or insured) will, if proved, attract the provisions of s 13 of the Act. However, this does not mean that a want of honesty is a universal feature of a want of the utmost good faith in this context.

…

In my view, the **criteria of dishonesty, caprice and unreasonableness more accurately express the ambit of what constitutes a breach of s 13 of the Act.**

…

In particular, the broad view which the Full Court majority took concerning the operation of s 13 of the Act is one that this Court should endorse. It sets the correct, desirable and lawful standard for the efficient, reasonably prompt, candid and business-like processing of claims for insurance indemnity in this country.

(Emphasis added and footnotes omitted.)

345 The views of the Full Court as to the breadth of the obligation, with which Gleeson CJ and Crennan J, and Kirby J agreed, were set out by Emmett J (with whose reasons Moore J agreed) in *AMP Financial Planning Pty Ltd v CGU Insurance Ltd* (2005) 146 FCR 447; 55 ACSR 305; [2005] FCAFC 185 at [87] and [89]–[91]:

While a want of honesty will constitute a failure to act with the utmost good faith, **want of honesty is not necessary in order to establish a failure to act with the utmost good faith** in the context of a contract of insurance. **The notion of acting in good faith entails acting with honesty *and* propriety.** Lack of propriety does not necessarily entail lack of honesty. Further, **the concept of *utmost* good faith involves something more than *mere* good faith.**

…

The precise content of the concept of utmost good faith depends on the legal context in which it is used. In the context of insurance, **the phrase encompasses notions of fairness, reasonableness and community standards of decency and fair dealing. While dishonest conduct will constitute a breach of the duty of utmost good faith, so will capricious or unreasonable conduct.** While an essential element of honesty may be at the head of the concept of utmost good faith, dishonesty is not a prerequisite for a breach of the duty (see, for example, *Kelly v New Zealand Insurance Ltd* (1996) 130 FLR 97 at 111-112).

A failure to make a prompt admission of liability to meet a sound claim for indemnity and to make payment promptly may be a failure to act with the

> utmost good faith on the part of an insurer. Of course, where the insurer is awaiting details that are necessary for the making of a decision whether to accept liability to indemnify or to determine the quantum of its liability, the position would be different (see *Moss v Sun Alliance Australia Ltd* (1990) 55 SASR 145 at 154; 93 ALR 592 at 602). A failure by an insurer to make and communicate within a reasonable time a decision of acceptance or rejection of a claim for indemnity, by reason of negligence or unjustified and unwarrantable suspicion as to the bona fides of the claim by the insured, may constitute a failure on the part of the insurer to act towards the insured with the utmost good faith in dealing with the claim.
>
> Putting it another way, acting with *utmost* good faith involves more than merely acting honestly: Otherwise, the word utmost would have no effect. Failure to make a timely decision to accept or reject a claim by an insured for indemnity under a policy can amount to a failure to act towards the insured with the utmost good faith, even if the failure results not from an attempt to achieve an ulterior purpose but results merely from a failure to proceed reasonably promptly when all relevant material is at hand, sufficient to enable a decision on the claim to be made and communicated to the insured (see, eg, *Gutteridge v Commonwealth*, unreported, Supreme Court of Queensland, Ambrose J, 25 June 1993).
>
> (Emphasis added.)

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. It is, however, helpful to recognise from articulated fact situations how the standard can be taken to be breached. Fairness, decency and fair dealing are normative standards judged by reference to community expectations. Unfairness or a lack of decent treatment may take many forms. Arbitrary, capricious and unreasonable conduct may well inform a conclusion of unfairness sufficient to fall short of community expectations of fairness and decency. The obligation upon insurers and the content of the duty in any given case is informed, in part, by the important part insurance and insurers play in the life of the commercial community and of the general community. People rely upon it and them for their commercial and personal stability and wellbeing.

174 The first allegation by ASIC of a breach of s 13(2) was in para 25 of the Amended Concise Statement that TAL breached s 13(2) when it made the Claims Pack Representation which was false. For the reasons earlier given that allegation must fail. There was no relevant representation. If there were, I have concluded that it was false as to the execution of the Medicare Australia Authority, but not otherwise. In such circumstances, I do not conclude that it would have been a breach of s 13(2) to make that incorrect representation. There was no suggestion that it was deliberately false or other than innocently made. In the context of an entitlement to require the medical authority and to make the representation in relation to that

right, I do not consider requiring associated medical records from Medicare breached any community standards of decency or fairness.

175 The second way ASIC contended that TAL breached s 13(2) is "by the manner in which, on 3 July 2014, it avoided the Policy": para 26 of the Amended Concise Statement. This was elaborated upon in section C of the Amended Concise Statement, which was headed: the "Primary legal grounds for the relief sought". Section C1 dealt with the "Claims Pack Representation". Section C2, entitled "Seeking and Acquiring Information", comprised para 36 as follows:

> In requesting the Second Insured's medical records as referred to in paragraphs 17 to 19 above, with reliance upon executed authorities obtained further to the contraventions referred to in paragraphs 29 to 31 above, TAL breached the requirements of the ICA pursuant to s 13(2) of the ICA, in that it failed to comply with the provision requiring each party to the contract of insurance to act towards the other party, in respect of each matter arising under or in relation to the contract of insurance, with the utmost good faith.

176 Paragraphs 17–19 to which reference was made were as follows:

> 17 In the meantime, and without notifying the Second Insured, TAL began investigating whether there were grounds to avoid the Policy by reason of non-disclosure or misrepresentation prior to entry into the contract of insurance.
>
> 18 Relying upon the executed authorities, on 8 January 2014 and 5 May 2014, TAL requested (and subsequently obtained) the Second Insured's medical records. TAL did not limit its investigation to the Second Insured's gynaecological health. Rather, TAL requested copies of the Second Insured's:
>
> (a) Medicare and Pharmaceutical Benefit Scheme histories for the period 23 December 2008 to 23 December 2013 (with which request TAL sent an executed authority to release Medicare and Pharmaceutical Benefits Scheme claims information as to the Second Insured's Medicare claims history for the period 1 February 1984 to 23 December 2013 and PBS claims history for the period 1 May 2002 to 23 December 2013);
>
> (b) clinical records from her general practitioner, [Dr D];
>
> (c) records from her private health insurer, Medibank Private;
>
> (d) clinical notes from [Dr M],
>
> and obtained copies of the Second Insured's:
>
> (e) Medicare and Pharmaceutical Benefit Scheme histories for the period 1 March 2009 to 23 December 2013;
>
> (f) records from Medibank Private for the period 12 June 2009 to 15 January 2014;
>
> (g) documents referred to in (b) and (d) above.
>
> 19 On or about 22 January 2014, TAL received medical notes from the Second

> Insured's general practitioner. The medical notes included references to the Second Insured having seen a psychologist on several occasions between 16 January 2008 and 7 August 2009, to address depressive symptoms arising, *inter alia*, out of the break-up of a long term relationship.

177 The claim of a breach of s 13(2) in para 36 (which is to be understood as the second and separate breach of s 13(2)) can be seen to be linked to the asserted breach of s 13(2) by the Claims Pack misrepresentation. I have rejected that latter breach. The request for information "as referred to in paragraphs 17 to 19" raised further issues: the commencement of an investigation about whether there were grounds to avoid the policy, without notifying the Second Insured (para 17); relying on the executed authorities from 8 January to 5 May 2014 to request medical records, including the request to obtain Dr M's records, and the lack of a limitation of that investigation to the Second Insured's gynaecological health (para 18); and the receipt of information regarding mental health (para 19).

178 Reading paras 17–19 and 36 fairly, ASIC directed this (second) part of the claim for breach of s 13(2) to *requesting* the Second Insured's medical records. The linkage of these requests to the authorities obtained by way of the alleged breach of s 13(2) (by the alleged misrepresentation) is important. Nowhere was there articulated in the Amended Concise Statement a case that even if the authorities were originally (in December 2013) rightfully requested in wide terms it was wrong and beyond the limit of the authorities that were signed by the Second Insured later to seek information (as was done on 5 May 2014, at least) and to use any information obtained (whenever it had been requested) for the purpose of an investigation as to whether there were grounds to avoid the policy, as opposed to assessing the claim for disability.

179 The next (third) alleged breach of s 13(2) was that the avoidance was not soundly based in medical opinion. This claim is contained in paras 36A, 36B and 37(a)(i) and (ii):

> 36A The medical records on which TAL based its RUO comprised brief summary entries relating to the Second Insured's complaints and treatment over the period from around September 2007 to 20 December 2013. They did not provide sufficiently detailed information to facilitate any reliable conclusion as to whether the Second Insured had at any time suffered from a "Recurrent depressive disorder" within the meaning of the TAL underwriting guidelines.
>
> 36B Alternatively, the medical records obtained by TAL did not provide sufficiently detailed information to facilitate any reliable conclusion as to whether the Second Insured suffered from a "Recurrent depressive disorder" within five years of the date of her proposal for insurance.
>
> 37 In avoiding the Policy in the Avoidance Letter on the basis of purported non-disclosure or misrepresentation:

(a) with reliance upon the medical history of the Second Insured:

(i) as described in paragraph 36A or alternatively paragraph 36B above; and/or

(ii) as acquired by TAL further to the contraventions referred to in paragraphs 29 to 31 and 36 above; …

180 For this claim the evidence of Dr Phillips and Mr Bird was central.

181 The next (fourth) alleged breach of s 13(2) was that the avoidance was effected on the basis of purported non-disclosure or misrepresentation without giving the Second Insured any notice of the investigation or concern and without affording her an opportunity to address any concerns of TAL: see para 37(b)(i) and (ii), as follows;

> In avoiding the Policy in the Avoidance Letter on the basis of purported non-disclosure or misrepresentation:
>
> …
>
> (b) without first:
>
> (i) giving notice to the Second Insured of its retrospective investigation into her medical history; and/or
>
> (ii) affording the Second Insured any or any reasonable opportunity to address concerns as to non-disclosure, …

182 The next (fifth) alleged breach of s 13(2) concerned the terms and context of the letter of avoidance of 3 July 2014. This claim is contained in para 39(a), (b) and (c):

> In alleging, in the Avoidance Letter, that the Second Insured had breached her "duty of good faith" pursuant to s 13 of the ICA:
>
> (a) with reliance upon the medical history of the Second Insured as described in paragraph 36A or alternatively paragraph 36B, above; and/or
>
> (b) without regard to the manner in which information had been collected for the purpose of the Second Insured's insurance proposal, as referred to in paragraphs 3 to 5 above; and/or
>
> (c) without first:
>
> (i) giving notice to the Second Insured of its retrospective investigation into her medical history; and/or
>
> (ii) affording the Second Insured any or any reasonable opportunity to address concerns as to non-disclosure, …

183 The last (sixth) alleged breach of s 13(2) also concerned the terms of the avoidance letter in threatening to seek recovery of moneys paid to the Second Insured. This claim is contained in para 40:

> In impliedly threatening to, or indicating it was more likely to, seek recovery of

> amounts paid out by TAL pursuant to the policy, in the event the Second Insured sought to challenge the avoidance of the policy …

Consideration

184 Although I have divided the lack of good faith case into six parts the claims of breach of s 13(2) are interrelated.

185 ASIC saw Ms KR's views on 7 January 2014 as central: her "strategy and decision". This was said to provide important context for assessing whether TAL acted with the utmost good faith in circumstances where the underwriter had not investigated the blood tests, and instead of seeking further explanation, it had "set about covertly investigating" whether there was a basis to avoid the policy. I agree with this focus, to the extent that it may explain why TAL approached the matter as it did. The suspicion evident on 7 January 2014 informed how TAL behaved thereafter.

The first alleged breach of s 13(2)

186 The submissions of ASIC sought to colour this conduct by the misrepresentations. I reject that connection. I do not consider that there was any lack of good faith in requesting the authorities in December 2013.

The second alleged breach of s 13(2)

187 The requests on 8 January 2014 ([41] and [43] above) and 5 May 2014 ([54] above) of Medicare and UHG can be seen to be substantially in furtherance of the strategy of investigation of the question of non-disclosure. This can be seen by the acceptance of the claim on 9 January 2014 ([44] above).

188 Just as the Amended Concise Statement contains no pleaded case that by using the authorities provided and the information obtained for the purpose of furthering the investigation of the validity of the policy TAL acted in breach of s 13(2), the submissions made no such claim. If the terms of a policy made it clear that such personal information could be used for such purpose, beyond assessing the medical condition by reference to policy terms, there could (generally or in the usual case) be no breach of s 13(2). But the policy here had no such term. If Campbell J in *Stealth* was correct, as I consider he was, a deep and important question arises in such circumstances. Echoes of such notion of using the information obtained for a wrongful purpose will appear later in these reasons as a refrain in dealing with procedural fairness, but as a separate basis for a claim for a breach of s 13(2), such was not made in this case.

189 As pleaded and as run the lack of good faith in the requesting of information in 2014 up to May was hinged on the lack of good faith in the misrepresentation case. There was no latter breach. Thus there was no breach in requesting the records of Dr D and Dr M.

The third and fourth alleged breaches of s 13(2)

190 I have already discussed the retrospective underwriting decision and the criticisms of Dr Phillips. As I have said there, the quality of the retrospective underwriting decision cannot be separated or divorced from the failure to give the Second Insured a proper opportunity to provide information relevant to the decision.

191 The question posed by s 29(3) was whether TAL would not have been prepared to enter into the income protection contract on any terms if the non-disclosure or misrepresentation had not occurred. This was not a question for a doctor, however eminent; it was an underwriting question. It was, however, an underwriting question with medical considerations and to be addressed in a medical context.

192 TAL was faced with the task of deciding whether to avoid. It was bound to a contract of insurance in which there was a term that it was obliged to act towards the Second Insured with the utmost good faith, in respect of a matter arising under or in relation to the contract. A decision to invoke a right or an asserted right under s 29(3) to avoid the contract is a matter in relation to the contract. TAL was therefore obliged to act towards the Second Insured with the utmost good faith in how it went about deciding and dealing with the question.

193 Standards of decency, fairness, fair dealing and reasonableness demanded that the Second Insured be given a proper opportunity to put matters to TAL: to explain what happened. This policy was of great importance to her. She was now gravely afflicted by cancer. First of all, there had to be a misrepresentation or non-disclosure by the Second Insured. TAL submitted that that was common ground. ASIC said it need not be decided. Its case, however, rather assumed it. I have already expressed my view that there was grave doubt that there was any misrepresentation by the Second Insured in the conversation. There was, however, a misrepresentation in the written application (reduced from the conversation) which the Second Insured had the opportunity to read, which she was advised to read carefully, and which, on the evidence, she approved by giving a "verbal signature": see [19] above.

194 As to whether the cover would have been given at all had disclosure been made, in one sense that was not a question for Mr Bird. He was not the underwriter who accepted the risk. His

job was to do his best to recreate reality. If the Second Insured had been given the opportunity to explain the situation fully and to put the records and her condition in context, perhaps with the views of the doctors and psychologist, there may have been a decision other than one to avoid the policy. The guidelines were not inflexible. It does not, however, matter for this proceeding. Even if the decision had been to avoid, the Second Insured would at least have been treated decently and fairly, and with dignity. This lack of decent and fair treatment can be seen in the covert way the investigation was carried out for four months, and the lack of an opportunity to influence the decision before it was made. That the avoidance was legitimate or not is not the point. The question is how the Second Insured was treated by TAL. Thus the question is not whether Mr Bird reached the "correct" conclusion. It is whether the process that was undertaken, of which his work was part, in its context, reflected acting with the utmost good faith.

195 A decision whether to grant cover was an underwriting decision. It was not a question for a medical professional. TAL had guidelines derived from its reinsurer to assist it. Underwriters must examine these questions, at least at the time of originally writing the insurance, from their own position and perspective. At the point of consideration of a right under s 29(3) there is another context. The question is: Would the cover have been written on any terms? But the attempt to answer must be approached and undertaken with the utmost good faith. I do not consider that in reaching his views, Mr Bird was so bereft of information or his approach so unreasonable, capricious or arbitrary as to have exhibited a lack of commercial decency and fairness. He was not cross-examined to the effect that his attempt was not bona-fide. What this process lacked was input from the Second Insured. Decency and fairness required such here. On the material he had before him there were grounds to conclude that an underwriter at TAL would not have written the policy, on any terms, if he or she had had before him or her information of the kind in Dr D's and Dr M's notes. But if the disclosure had been made contemporaneously in 2013 by the Second Insured answering affirmatively that there was some history of depression, TAL would have asked for medical notes, and the Second Insured would have had the opportunity to put all the medical notes into a proper human context, by her recollections and the opinions of medical and health professionals. As Mr Bird's evidence revealed, the guidelines were just that: guidelines. They were not inflexible rules.

196 I am fortified by the evidence of Ms van Eeden and TAL's considered position at the Royal Commission in my view that TAL failed to act towards the Second Insured with the utmost

good faith in failing to tell her of the investigation and in failing to afford her a proper opportunity to address TAL and any material it was relying on prior to any decision to avoid.

197 It is impossible to be prescriptive in advance as to how decent and fair conduct by an insurer should be judged in all cases. Here, it was plain to TAL that the Second Insured was an honest person suffering from a catastrophic illness within the terms of the policy. A decision to avoid was not just an underwriting decision whether to take a risk or not. It was one which could affect financially and emotionally (and so the health of) a person suffering a catastrophic illness. In these circumstances, a decision to assess what would have been done a year before would begin with getting the most reliable evidence as to what would have happened at that time. This would include informing the Second Insured of TAL's concerns and giving her an opportunity to put to TAL what she considered she should, perhaps with relevant advice. This would best mimic what would have happened had disclosure been made in 2013. This was not catered for in fairness and decency by having some internal review function after a considered decision to avoid.

198 Insureds are not only risks; they are people. Section 13 recognises this: "act towards" each other.

199 TAL failed to act towards the Second Insured with decency and fairness in reaching its decision without giving the Second Insured a *proper* opportunity to put material to TAL. I also consider, though it can be seen as part of the same breach, that TAL should have told the Second Insured of the investigation and their concerns and that the failure to do so in the circumstances was likewise failing to treat her with decency and fairness. TAL failed thereby to act towards the Second Insured with the utmost good faith.

200 In reaching these conclusions I am not intending personal criticism of Mr Bird. He conducted his exercise within the parameters that he was given.

The fifth and sixth alleged breaches of s 13(2)

201 These can be dealt with shortly. It is clear that the Second Insured was treated without decency or fairness in being told she had acted without good faith. It was, in these circumstances, a groundless and hurtful statement. TAL was rightly contrite at the Royal Commission about this matter. It breached its duty in s 13.

202 Likewise, there was a lack of decency and fairness in the threat of recovery of over $24,000. The payments were all made after the commencement of an investigation by TAL into the

validity of the policy on the grounds of possible non-disclosure or misrepresentation. In the light of the failure to tell the Second Insured of the investigation (with the possible consequences of obligation to repay, should there be an avoidance) she had no reason to believe that she could not spend these modest sums in sustaining herself. She was given no opportunity to arrange her affairs to protect herself.

203 In these circumstances, to threaten the possibility of recovery of such a sum against a woman of modest means suffering a catastrophic illness was harsh and unfair and lacked a degree of common decency. The knowledge of a possible future avoidance in circumstances of a possible change of position by expenditure of the payee would, to a reasonable and fair person in the position of TAL, reveal a likely weakness in any right of recovery.

204 TAL did not act towards the Second Insured with fairness and decency in this regard. It was rightly contrite at the Royal Commission. It breached its duty in s 13.

The question of declaratory relief: jurisdiction, power and discretion

205 As between TAL and the Second Insured the policy stands avoided *ab initio*. As between them there is no controversy that there is no longer a contract of insurance and that it was avoided *ab initio*.

206 Section 21 of the *Federal Court of Australia Act 1976* (Cth) authorises the Court to "make binding declarations of right, whether or not any consequential relief is or could be claimed".

207 Section 13(1) of the *Insurance Contracts Act* implies a contractual term of the utmost good faith into the contract of insurance. Section 13(2) provides that a failure to comply with the term in subs (1) is a breach of the Act under subs (2).

208 Thus, for there to be a breach of s 13(2) there must be a contract of insurance. TAL submitted that as a consequence of the agreement as to avoidance between TAL and the Second Insured there was no "matter" arising under s 13, at least for the second to sixth ways the lack of good faith case was put. (As to the first way, this was an extension or part of the first part of the case: the Claims Pack Representation case.)

209 It was submitted that there could only be a "matter" if there was an extant controversy involving the parties to the contract, at least in the absence of express statutory provision such as in the current provision: s 75A(1) of the *Insurance Contracts Act*. Here the matter has settled between TAL and the Second Insured. The two parties to the real controversy had agreed that the

contract was to be treated as avoided *ab initio*. TAL submitted that this was an agreement that, or the position in law was that, "there was never in fact a contract between them."

210 In all these circumstances, TAL submitted that the Court had no jurisdiction and no power to make a binding declaration of right about a breach of a contract that the parties agree is void *ab initio*. It was submitted that there is no justiciable matter.

211 This last aspect of the submission raised a matter arising under or involving the interpretation of the Constitution and involved the question of the jurisdiction of the Court, and not just the Court's power to grant relief.

212 No notice under s 78B of the *Judiciary Act 1903* (Cth) had been given prior to, or at the conclusion of, the hearing. It should have been. I should have picked the matter up. The written outline of opening submissions only obliquely raised the question of "matter" (see para 148); the gravamen of the written submission was power (see para 150). The weight of the oral submissions, however, was "matter" and jurisdiction. The nature of a matter and whether it exists in relevant terms is a Constitutional question.

213 Section 78B(1) provides that:

> … it is the duty of the court not to proceed in the cause unless and until the court is satisfied that notice of the cause, specifying the nature of the matter has been given to the Attorneys-General of the Commonwealth and of the States, and a reasonable time has elapsed since the giving of the notice for consideration by the Attorneys-General, of the question of intervention in the proceedings or removal of the cause to the High Court.

214 Section 78B(2)(c) provides that in the meantime the Court:

> may continue to hear evidence and argument concerning matters severable from any matter arising under the Constitution or involving its interpretation.

215 In the light of these provisions it was not appropriate for me to deliver judgment, on any part of the "cause", until the Attorneys-General had been given notice and a reasonable opportunity to consider their respective positions. This was attended to by the parties in late January.

216 The notice to the Attorneys-General, which was sent by the parties after its form was approved by the Court, stated that the Court was of the opinion that 35 days was a reasonable time under s 78B(1). As at 5 March 2021 (42 days after notice was given), the parties had received responses from the Attorneys-General of Tasmania, South Australia, Western Australia and Queensland, none of whom intended to intervene or make submissions in the proceeding. Given the lack of substantive response received from them to date, I proceed on the basis that

the Attorneys-General of the Commonwealth, New South Wales, Victoria, Australian Capital Territory and Northern Territory do not wish to intervene.

217 The *Insurance Contracts Act* is administered by ASIC. As the regulator, ASIC has standing to seek declarations even without express statutory foundation: *Australian Securities and Investments Commission v Australian Lending Centre Pty Ltd (No 3)* [2012] FCA 43; 213 FCR 380 at 441 [271], citing *Australian Competition and Consumer Commission v Goldy Motors Pty Ltd* [2000] FCA 1885; [2001] 23 ATPR 41-801 at [30]; and *Australian Competition and Consumer Commission v Kaye* [2004] FCA 1363 at [199].

218 Though these cases may not have analysed the question from the point of view of "matter", they can be seen to stand for the proposition that a provision such as s 11A of the *Insurance Contracts Act* gives a regulator standing to seek declaratory relief.

219 ASIC, for the purposes of general administration, has the power to do all things that are necessary or convenient in connection with the administration of the Act: s 11B of the *Insurance Contracts Act*. It has power to sue in its own name: s 8(1)(d) of the ASIC Act.

220 It is too narrow a focus to say there never was a contract. There was a contract of insurance until avoidance took place. The claims by ASIC did not contest the avoidance, but ASIC did not concede that TAL validly avoided the policy. It seeks no orders about the avoidance. The party to the contract (the Second Insured) has agreed with TAL that the relations between them are that the contract is avoided *ab initio.* To make out its complaint ASIC does not need to prove that there were no grounds to avoid. The conclusion drawn by Mr Bird may have been, ultimately, correct: that the underwriter in 2013 would not have accepted the risk of the Second Insured on any terms. That does not affect the legitimacy of the criticism of TAL by ASIC: the criticism of the way it treated the Second Insured, the way it acted towards her for the purposes of s 13(1), and so s 13(2), in reaching that decision and in how it communicated the decision. If ASIC has standing and power to bring such a claim it cannot be said that there is no matter or controversy between the parties. "Matter" and standing are intertwined; the latter is subsumed in the former: *Plaintiff S10/2011 v Minister for Immigration and Citizenship* [2012] HCA 31; 246 CLR 636 at 659 [68]; *Pape v Federal Commissioner of Taxation* [2009] HCA 23; 238 CLR 1 at 35 [50]–[51], 68 [152] and 99 [272]–[273]. The past behaviour of an insurer that contravened the standard required by s 13 but does not at the time of suit affect the rights of the insured is not necessarily hypothetical. ASIC has a statutory duty in its general administration that includes a duty, as far as it is able, to bring about and oversee compliance

with the Act. Exacting or encouraging proper standards of contractual behaviour required by the *Insurance Contracts Act* by insurers lies at the heart of ASIC's responsibility as a regulator with the general administration of the *Insurance Contracts Act*.

221 The regulator seeks a declaration that, when the contract was on foot and when TAL was considering and dealing with its position, that is when it was engaged in a matter in relation to the then extant contract (for the purposes of s 13(1)), TAL failed to comply with the term implied by s 13(1) in its then extant contract, and thereby breached s 13(2).

222 The conclusion that ASIC has standing may be drawn from an implication from s 11A, fortified by s 11B, that "general administration" includes taking such necessary and reasonable steps to administer the Act by supervising and regulating the conduct dealt with by the Act, including insurers' conduct under s 13. This is the foundation for the existence of a controversy or matter between ASIC and TAL. ASIC wishes to assert and see publicly declared that TAL failed to meet the standard required of it by statute.

223 Section 21 of the *Federal Court of Australia Act* is wide enough to encompass a declaration sought by a regulator to vindicate the public interest in encouraging compliance by a party and others with an Act of public importance which the regulator has a statutory responsibility to administer. The phrase "declaration of right" should not be construed narrowly and extends to any situation involving the field of legal relations: *Johnco Nominees Pty Ltd v Albury-Wodonga (NSW) Corporation* [1977] 1 NSWLR 43 at 65E–F. See also *Sankey v Whitlam* [1978] HCA 43; 142 CLR 1 at 23. It extends to obligations and duties of a party the bringing about or encouragement of compliance with which is within the remit of the regulator in its statutory duty of general administration.

224 If the last proposition not be correct the regulator has standing by its position from s 11A of the *Insurance Contracts Act* to invoke a superior court of record and a court of law and equity (such as the Federal Court of Australia by s 5 of the *Federal Court of Australia Act*) to exercise the power that such a court has from its status (and subject to there being a justiciable controversy between the regulator and the party) to grant declaratory relief: *Ainsworth v Criminal Justice Commission* [1992] HCA 10; 175 CLR 564 at 581–582. The power can be expressed as inhering or implied within the statute (s 5(2) of the *Federal Court of Australia Act*) that creates the Court as a superior court of law and equity: cf *Re Macks*; *Ex parte Saint* [2000] HCA 62; 204 CLR 158 at 178 [23], 185–186 [53], 235–236 [214] and [216].

225 Nothing in the Full Court's decision in *ACCC v MSY Technology* 201 FCR 378 is to the contrary of the above.

226 There is both jurisdiction and power to make the declarations sought. It was submitted that it was not appropriate, whether for the purposes of s 23 of the *Federal Court of Australia Act* or otherwise, to make them. I reject that submission. Properly framed, such declarations would assist the regulator in achieving or encouraging compliance with the Act by the formal recognition of the Court of the breach of duty involved. That the Second Insured has settled her differences with TAL does not remove TAL from the legitimate gaze of ASIC, as regulator, and of the Court, with a controversy before it, to vindicate a law of the Parliament in the public interest.

The form of declaratory relief

227 The declarations sought by ASIC were set out in its Amended Originating Process and in an annexure to its closing submissions dated 14 October 2020. As I remarked at [3] above, the earlier version read like a pleading, identifying with lengthy specificity each factor said to give rise to each contravention. Caution should be taken to such an approach, lest the detail detract from the purpose of the declaration: *Australian Securities and Investments Commission v Dover Financial Advisers Pty Ltd (No 2)* [2019] FCA 2151; 140 ACSR 635 at 637 [9], or the declaration be mistaken as an attempt to record in summary form the conclusions reached by the Court in the reasons for judgment: *Wurramunda Village* 105 FCR at 440 [8]. As I earlier said, conclusions about particular facts should not be translated into general rules that might then (wrongly) be sought to be applied to different factual contexts. That said, understanding the reach of the required statutory standard of behaviour of the utmost good faith is assisted by the articulation in different fact contexts as to why it has been breached. I also refer to the following observations of Dowsett J in *Australian Competition and Consumer Commission v Danoz Direct Pty Ltd* [2003] FCA 881; 60 IPR 296 at [260]:

> … it is important that any declaration be framed so as to convey a limited and accurate message to those who have an interest in its subject matter. It is unlikely that any good purpose will be served by numerous declarations which merely repeat the various misrepresentations and the various occasions on which they were made. The most effective form of declaration will accurately reflect the impugned conduct in a concise way. …

Justice Dowsett's observations have been referred to in many decisions, including *Australian Competition and Consumer Commission v Dataline.Net.Au Pty Ltd* [2006] FCA 1427; 236 ALR 665 at 682 [63] per Kiefel J and *Australian Securities and Investments Commission v*

Westpac Banking Corporation (No 3) [2018] FCA 1701; 131 ACSR 585 at 592 [38] per Beach J.

228 I recently addressed the form of appropriate declaratory relief for contravention of s 13(2) of the *Insurance Contracts Act* in *Australian Securities and Investments Commission v Youi Pty Ltd* [2020] FCA 1701 at [68]–[69]:

> 68 … ASIC is the appropriate party to seek declarations as the statutory regulator. The form of declaratory relief should identify, for the purposes of both the defendant and others in the industry, that conduct of this character is a breach of the important duty of good faith and will be exposed to the community as such. In that way, declarations assist to clarify the law's application, warn others of the dangers of contravening conduct and alert other insureds to their rights.
>
> 69 The dispute over one or multiple declarations I consider to be a matter of style rather than substance. The repetitious formality in the multiple declarations first suggested by ASIC blinds rather than illuminates others in understanding what happened. The single declaration is sufficient to express the different occasions and different conduct that amounted to the contravening conduct. The terms of declarations of right whether in private or public law can be seen to define or shape the features or content of the right or duty at issue. The terms of the declaration as to contravention in a regulatory context do not have that defining character. Rather, they assist in clarifying the nature of the contravention as a foundation for other relief such as penalties or as describing the nature of the contravention for the public purposes referred to in [68] above. The form of the declaration should specifically and succinctly identify the gist of the relevant conduct and its relationship to contravention: *Rural Press Ltd v Australian Competition & Consumer Commission* [2003] HCA 75; 216 CLR 53 at 91 [89]–[90].

229 I will give ASIC an opportunity to consider the form of declaration in relation to the breaches of s 13(2), in the light of my reasons for judgment. If there is a dispute between the parties as to the proposed wording of the declaratory relief, the parties should file short submissions as to their position. I will also hear the parties on costs.

230 The orders will be:

(1) Within 14 days the plaintiff file and serve proposed declarations and orders otherwise, including dealing with costs, whereby such declarations and orders dispose of the Amended Originating Process by the making of declarations as to the breach of s 13 of the *Insurance Contracts Act 1984* (Cth) by the defendant, and by otherwise dismissing the proceeding.

(2) If within a further 14 days there is no agreement as to the appropriate form of declaration and orders for costs, the proceeding be relisted by arrangement with the Associate to the Chief Justice for argument as to the form of declaration and orders.

(3) Volume 4 of the Court Book be admitted and marked as Confidential Exhibit D.

I certify that the preceding two hundred and thirty (230) numbered paragraphs are a true copy of the Reasons for Judgment of the Honourable Chief Justice Allsop.

Associate: 

Dated: 9 March 2021