

BURROWES and Company



Barristers and Solicitors

Insurance Bulletin

January 2011

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What Date Does a Policy Commence?

Frazer v National Mutual Life Association [2010] NSW SC45 is an Australian case which held that for disclosure purposes an insurance policy will not begin until the company formally accepts the insured's application by issuing a policy. Up until that date the applicant still has a duty of disclosure to the insurer. Although an Australian precedent, the case provides a persuasive precedent for New Zealand insurers looking to prove that a material event occurred before the date of commencement and so should have been disclosed.

Background

Dates and times are particularly significant in this case. The arguments of both the insured and the insurer rely heavily on a number of key dates.

Frazer lodged an application for an Income Protection (IP) policy on 11 December 2007. He was consequently charged a premium the following day, 12 December 2007. The premium payment was automatically deducted from his account. The application was then reviewed by the insurer who raised some issues. Frazer had disclosed in his application that he worked with explosives and understandably National Mutual wished to alter their standard IP terms to include an appropriate exclusion.

Accordingly, revised acceptance terms were sent to Frazer. These were signed on 21 December 2007. The revised application had been assigned a policy number and this was written at the top of the documents. Frazer completed the documents and returned them to National Mutual. National Mutual did not receive the revised application until 8 January 2008, and subsequently issued the revised policy on 11 January 2008.

In the meantime a number of significant medical events had taken place. Previous to even lodging the initial application Frazer had consulted a doctor regarding sadness and possible depression and had been prescribed valium. On 11 December 2007, the same day he made the application, he was also referred by his doctor to a colorectal specialist due to complaints of bleeding. Frazer had a family history of bowel cancer, however his colonoscopy results came back clear on 17 March 2008.

On 4 January 2008, before the insurer received the revised application, the insured was further diagnosed with "major depression" and was prescribed anti-depressants. Due to his severe depression Frazer struggled with work and on 22 February 2008 was unable to continue working. He subsequently made a claim under his National Mutual IP policy on 8 March 2008.

Claim

National Mutual denied the claim on a number of grounds. Their first argument was there had been material non-disclosure and secondly he had a pre-existing condition. Frazer's personal statement disclosed no history of mental health issues, anticipated tests or medical examinations.

In regards to non-disclosure, the insurer argued that there had been no disclosure of Frazer's medical consultations for depression prior to 11 December 2007, no disclosure of his medical diagnosis of depression on 4 January 2008 and no disclosure of his referral to a colorectal specialist on 11 December 2007.

The insurer argued that the policy did not commence

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2010 ISO Complaints Handling Workshop

Between 15 and 19 November 2010, the ISO held a series of complaints handling workshops throughout New Zealand. Nina Harding, of Nina Harding Mediation Services, presented the workshop and provided those in attendance with an in-depth analysis of recent developments in complaints handling.

Nina began by looking at the recent proliferation of general complaints throughout New Zealand and Australia. She noted that complaints had dramatically increased in Australia over the past five years and suggested that a similar trend would likely develop here.

The workshop looked at a number of techniques employees can use when handling a complaint. These techniques included the use of active listening and empathy to keep a customer on side, the avoidance of confrontation or accusation and the taking of time to identify and understand the customer's problem. Nina emphasised that a complaint, if handled well, can actually provide a company with a good opportunity to bring a customer back on board with the company.

Another key area Nina focussed on was the development of appropriate internal complaints processes to complement the ISO's external service.

It is a requirement of the ISO that each member have an appropriate internal complaints procedure. The workshop highlighted that dealing with a complaint well in the first instance can save an insurer a lot of time and hassle down the line. Nina suggested one of the best ways for a company to reduce complaint costs is by providing further training to front-line employees who directly handle complaints, so that they are able to better identify and deal with those complaints. This will inevitably reduce the number of complaints proceeding to internal and external bodies and thus reduce complaint costs. Nina also talked of the benefits of complaint recording mechanisms to help identify complaint trends and allow a company to better target areas requiring change.

Nina also looked at how best to deal with high-need, litigious complainants. She focussed on the best methods for identifying these complainants and looked at various techniques to deal with them. A useful tool suggested by Nina was the development of a workplace strategy to deal with high-need customers. She also gave some tips on the best way to deliver bad news to a customer, giving pointers for example on the best time to deliver bad news - the morning.

Non-Disclosure and Materiality

Kenan Berk v Westpac Securities Administration Ltd & Anor (2010) NSWSC 28 is an Australian case where the insured made a claim for total and permanent disability (TPD) benefits under a Westpac policy. Westpac rejected the claim because of non-disclosure by the insured. The case helps clarify how an insurer can avoid an insurance policy on grounds of non-disclosure. It also sheds light on whether the original underwriter of the policy must give evidence at trial in order to prove the materiality of a non-disclosure.

Background

Berk was born in Turkey, but came to Australia in 1974. In 1990, while under the employment of BHP, Berk was injured in a blast furnace accident. Due to extensive neck injuries and post traumatic stress Berk made an application and received payment under a compensation claim (from an earlier, non-Westpac policy). In 1991 he returned to lighter duties at work, but was again injured whilst lifting tables. The subsequent back injury from this incident led to the advancement of the insured's post traumatic stress to a state of depression.

He eventually ceased work with BHP in 1996, receiving a benefit under his BHP superannuation fund.

In 2002 Berk took out a TPD policy with Westpac for \$500,000.00. The policy required Berk to fill out a personal statement which asked if he had previously suffered any stress, depression, back injuries or neck injuries. Each question was answered no, contradicting Berk's previous medical history. In 2005 the insured suffered a further back injury whilst at work and made a subsequent application under his 2002 Westpac TPD policy.

Law

Section 29(2) of the Insurance Contracts Act 1984 (Australian legislation) allows an insurer to avoid a contract where there has been fraudulent misrepresentation. The equivalent New Zealand provision is section 4 of the Insurance Law Reform Act 1977 which allows an insurer to avoid a life policy if there has been fraudulent misstatement.

Claim

Westpac denied the claim on the basis there had been fraudulent misrepresentation from the customer, and also that there was no TPD.

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Non-Disclosure and Materiality

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The personal statement of Berk clearly contradicted his previous medical history. In his statement he had misrepresented that he had not previously suffered any depression, back injuries or neck injuries. Furthermore he had stated that he had not visited a doctor within the past five years or ever claimed any insurance benefit. This was despite Berk previously having frequent doctor's visits and making a number of insurance claims.

In fact, in the early stages of the trial Berk admitted that the failure to disclose this information did amount to a misrepresentation. However, he argued that he had relayed all relevant information to the agent and the agent had then incorrectly filled in the statement on his behalf.

Nevertheless, Berk went on to change his story on many occasions, later suggesting that he had never even been asked these questions. Berk's evidence was highly inconsistent and changeable. As a result, the Court eventually concluded that Berk had in fact filled out the statement himself.

As Berk had already admitted the non-disclosure was a misrepresentation, Westpac only needed to show that the misrepresentation was material and that they would not have entered into the policy had they had full disclosure. In proving this Westpac did not have

access to the evidence of the original underwriter, who was now overseas. Accordingly, they had to rely on the evidence of two current senior Westpac underwriters, who stated that they would not have entered into the policy had they had full disclosure. The Court looked at whether it was in order to not have the original underwriter give evidence.

At Court

The Court held that another underwriter was able to give evidence as to whether they would have accepted the application, provided they gave their opinion by following the underwriting guidelines of the insurer at the time the application was made. The Courts said that the original underwriter will be the best source of evidence to prove materiality. However where it is overly burdensome to source the original underwriter, then a current underwriter of the company, using previous policy guidelines, will be sufficient.

Implication

This case provides a good example of where inconsistent statements of a plaintiff can be used to indicate there has been fraudulent misrepresentation, or in New Zealand's case, fraudulent misstatement. Importantly, it also provides a precedent which an insurer can rely on in order to argue that any underwriter of the insurer should be able to give evidence as to the materiality of a misstatement.

Can a Part-Time Employee be TPD?

Manglicmot v Commonwealth Bank Officers Superannuation Corporation [2010] NSWSC 363 is an Australian case dealing with whether a trustee of an Australian superannuation scheme fulfilled its duties owed to members entering into new life insurance policies. Despite the focus towards trustee duties in this case, it is still relevant to New Zealand insurers in terms of establishing whether a total and permanent disability (TPD) claimant, who can still work part-time, is in fact "totally and permanently" disabled.

Background

Manglicmot worked in full-time employment for the Commonwealth Bank (the Bank) from 1998. In 2000 he suffered various injuries and returned to work at the Bank part-time for 15 hours per week. He accepted redundancy in August 2003 while working part-time and made a subsequent claim for \$120,000.00 on the basis that he was unable to work full-time as a bank teller because of his various injuries suffered.

Claim

By the time the claim was made in 2003 the group's life insurer had changed and the scope of cover had been slightly varied. The TPD definition in the subsequent policy was more restrictive than the

original. The secondary policy included a specific exclusion for cover if the insured was able to resume work on a part-time basis. Clearly the insured had been able to work part-time since his injuries and it was evident that he was still able to do so.

At Court

The Court held that the trustee of the scheme had not breached their duty of good faith by changing insurers, as the policies still had very similar protection and the members had benefited by premium reductions. Accordingly the second policy was held to be the relevant one and the insured was precluded from cover. The interesting point for New Zealand insurers is that the Court also looked at whether the original policy term would have also excluded those able to work part-time, even though there was no specific exclusion for part-time workers.

To be covered, the original policy required an insured to be "... unable ever to engage in or work for reward in any occupation or work which he or she is reasonably capable of performing by reason of education, training or experience."

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Can a Part-Time Employee be TPD?

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The Court stated that a policy definition which is silent to part-time work should not automatically imply that the employee will be covered if they cannot work full-time, but can still work part-time. This is a move away from a previous line of Australian cases which held that TPD cover will extend to those still able to work part-time.

In this case Rein J stated that context was important. As the insured had been engaged in part-time work before he ceased work, and was still able to work in that capacity after making his claim, the court suggested his capacity to work had not diminished. Rein J also felt that interpreting the term to exclude those still able to work part-time would be more consistent with the notion of “total and permanent” disability and not being able to do “any work”.

The Court did not make a final decision as to whether the definition should extend to part-time work as it was

not determinative to their decision in this case to deny the claim. However, Rein J did state there were a number of reasons why the courts should interpret words such as “unable to ever engage in any work” to exclude cover to those who can still work part-time.

Implications

Although an Australian precedent, this case may help insurers seeking to deny a disability claim where a claimant is still able to work part-time. Context will be relevant to any decision an insurer makes and evidence which can show the insured’s role prior to the disablement is largely similar to the work the insured is capable of performing after, may help to show the insured is still able to engage in “any” occupation or work.

The case also highlights that insurers should be careful with policy wording. One way to avoid the above problem would have been to ensure the policy wording made clear that total and permanent disability cover will not extend to those still able to work part-time.

What Date Does a Policy Commence?

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until after the insurer issued the policy on 11 January 2008. Accordingly, Frazer would have been under a duty to disclose the above information, especially the diagnosis of “major depression” on 4 January 2008.

Frazer argued that the policy commenced prior to 11 January 2008 and that he consequently had no duty of disclosure. He suggested the policy was accepted on 12 December 2007, when a premium was automatically deducted from his account. Or, alternatively on 21 December 2007, when he was sent the revised application for acceptance with policy number attached.

He argued that any doctor’s visits before 21 December had only been for intermittent sadness, not depression, and accordingly these did not require disclosure. Also, because he felt the policy was accepted prior to his diagnosis of depression on 4 January 2008, he did not feel that he was required to disclose this diagnosis either. Lastly, Frazer argued that at no time did he think he was being tested for a serious illness such as bowel cancer, but instead thought the colonoscopy was standard testing. Accordingly, Frazer felt he had not made material non-disclosure at any stage.

At Court

The issue for the Court was whether the policy commenced prior to 11 January 2008 and whether there had been any material non-disclosure before the commencement date. Taking into account the various dates, the Court held that the policy did commence on 11 January 2008, the date when the insurer accepted the application. Until that date the insurer was still assessing the application.

The Court held “...until the proposal is accepted and the insurer issues a policy, there is no concluded contract.” Until the application was accepted by National Mutual on 11 January 2010, there was still time for them to make further enquiries of Frazer or otherwise walk away from the contract. The Court held that the premium deduction made on 12 December 2007 was more of a deposit than a premium payment and that the policy number written on the revised application was insufficient to indicate commencement.

As such Frazer was obliged to disclose the diagnosis of 4 January, as the policy had not yet commenced. The Court also suggested that, had the insurer fallen through on non-disclosure, they could have still successfully argued there was a pre-existing condition of depression. This highlights the importance of having a second line of argument in litigation, should the first line of argument not be accepted.

Lastly, the Court also indicated, as in *Kenan Berk v Westpac Securities Administration Ltd & Anor*, that an insurer does not need the evidence of the original underwriter to show that an undisclosed matter would have been material.

Implications

The major implication is that this case sets a persuasive precedent for there being a continuing duty of disclosure from the completion of the application, up until the execution or issuance of the contract even though a premium has been paid. Although an Australian precedent, it will be a persuasive reference case. The case also highlights the benefit of arguing a “pre-existing condition” as an alternative defence to a non-disclosure or misstatement case.

Financial Ombudsman Service (Australia) – Fraudulent Claim

The Financial Ombudsman Service (FOS) is the Australian equivalent of New Zealand's Insurance and Savings Ombudsman. FOS deals with a wide array of financial services including general and life insurance. It provides an accessible, fair and independent dispute resolution service for members and their customers. The service is free to customers and works as a secondary scheme to an insurer's internal complaints handling system.

Case Number 22760 - Fraudulent Non-Disclosure

The complainant had taken out Income Protection cover for severe or partial disablement. The complainant then suffered a disc protrusion and was unable to return to work. They subsequently claimed under their IP policy.

The insurer conducted investigations into the complainant's claim to ascertain whether the insured had made full disclosure in their application. After a period of investigation the insurer made a decision to avoid the policy on the grounds that there had been material and fraudulent non-disclosure of previous medical treatments.

The complainant had received treatment for back and neck pain over a period of three years, up to November 1999, and had also received treatment for stress/anxiety throughout 1998. This was only two years before the complainant had completed their application form, on 13 August 2001. The insurer stated that they would not have offered the policy on the same terms had there been full disclosure.

The Complaint

The complainant argued that their insurance broker had completed the forms and therefore they had not personally been fraudulent. The complainant said they had answered the questions asked of them as honestly as possible, and had simply been unable to recall their previous treatments at the time of questioning. The complainant argued they had not acted fraudulently as previous treatments had simply been forgotten.

Panel

The FOS panel relied heavily on the recent nature of the injuries suffered by the complainant, in making their decision. They found it difficult to believe that such prolonged treatments, which would have significantly affected the complainant's day to day life, could have been so easily forgotten. During this time the complainant had made three claims for worker's compensation, two in relation to back and neck pain and one in relation to stress/anxiety. The panel found it hard to reconcile that these significant events could have so readily slipped the complainant's mind.

The panel also held that the non-disclosure would have been material to the insurer in deciding whether to provide cover. The complainant had previously suffered severe back injuries which had been primarily aggravated by their job. The complainant remained in that employment during the period of their application

and up until the time they suffered a disc protrusion. The panel held that this distinct relationship between work and injury would have been a particularly material matter to the insurer.

Implications

This case indicates how a dispute resolution provider in New Zealand would potentially handle a similar complaint. Where a complainant argues they were not aware of the materiality of an event it will be helpful to emphasise the recentness of the event as well as the importance of it in the complainant's day to day life. It also provides a good example of where disclosure would have been particularly material to an insurer.

Case Number 21270 - Fraudulent Progress Reports

The complainant had taken out a salary continuance insurance policy. Under that policy, he was entitled to a disability benefit should he be unable to engage in any gainful business activity or occupation.

On 25 December 1999 the complainant was involved in a motor vehicle accident. As a result of that accident he was unable to return to work in any capacity. On 5 June 2000 he made an income protection claim under the policy. Ultimately his application was accepted and from then until his policy was avoided he was paid a monthly benefit. Throughout this period the complainant continued to be unfit to return to his previous employment.

In 2005 the complainant became involved with a business owned by his wife. Prior to setting up the business, which primarily ran a restaurant, he had asked questions of the insurer about whether his benefit payments would be affected if he became a director or a part-time employee of the company. The insurer responded that any income earned by the complainant would offset the amount being paid to him monthly, as pursuant to the Proportional Benefit provision under the policy.

Despite these questions, the complainant continued to answer no to questions on his progress reports about whether he had returned to work, or was receiving any income. Accordingly, the insurer conducted extensive surveillance of the complainant throughout 2005 and 2006. This surveillance indicated that the complainant was regularly present at the restaurant, greeting guests, clearing tables and serving food. He was also surveyed purchasing food for the restaurant and generally working in a managerial role.

On the basis of this surveillance, the insurer ceased monthly payments in March 2006. Benefits were cancelled on the grounds that the complainant had deliberately given false answers to questions in his progress reports asking whether the complainant had returned to work.

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Financial Ombudsman Service (Australia) – Fraudulent Claim

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The insured suggested that had they known the complainant had returned to work, they would have reassessed and likely decreased the complainant's monthly payments.

The Complaint

The complainant argued that he thought the questions regarding work only related to paid work. He had advised the insurer that he would be having some involvement with his spouse's restaurant. He was not paid for this work and he did not own the restaurant. He also argued that his contributions to the business were infrequent, light and not essential to the functioning of the business. Accordingly, he felt he had not deliberately answered the questions incorrectly as he was not being paid for the minimal work he was doing.

The insurer claimed, however, that the complainant had answered the various questions in a deliberately misleading fashion so as to avoid any reduction in his disability benefit payment. The insurer argued he was managing the restaurant but not receiving income in order to circumvent receiving partial payments. The complainant's wife had no involvement with the restaurant, but yet was the named owner. The insurer suggested she was owner only in name and that the complainant was indirectly receiving income. The insurer noted that in 2007, after the avoidance of the policy, the complainant was paid an income for performing the same role.

The insured argued the complainant had deliberately concealed his activities from the insurer and misled the insurer as to his involvement in the business. The insurer suggested that he did so because he was aware that he would have received decreased benefit payments and was trying to circumvent the Proportionate Benefit income provisions of the policy.

Panel

The panel held that the complainant had not been completely honest in respects of their roles undertaken at the restaurant. However, it held that the insurer had not been able to prove sufficiently that the complainant acted fraudulently.

The panel felt there was sufficient evidence given by the complainant to prove he honestly believed he was entitled to undertake unpaid work and did not need to disclose this. The fact that the complainant and his wife had structured their affairs to their maximum financial advantage was not tantamount to fraud. The panel also held that it was significant that the complainant had made his involvement in the restaurant known to the insurer. The complainant put the insurer on notice as to his involvement, which would not typically be the action of somebody with fraudulent intent.

Implications

This case provides a good example for insurers wishing to avoid a claim where an insured has returned to some form of work. The intention of the insured will be particularly relevant in determining whether they acted fraudulently. If an insured can prove they honestly believed they were not misleading their insurer in completing their progress reports, they will unlikely be held to be acting fraudulently.

Case Number 19534 – Claiming under Interim Cover and Existing Policy

The complainant owned a life insurance policy over his wife's life, Policy A. His wife then applied for further cover, Policy B, but with a different insurer. The insurance policy had a condition on replacement cover which stated that the insured must cancel any other life insurance policies which they own over their own life. Although Policy A was owned by the complainant, the wife stated in her application that she already had life cover (Policy A). The insurer agreed to provide interim cover while they were assessing the application. However, before they agreed to issue Policy B the wife died.

The husband subsequently made two applications, under both Policy A and Policy B. Policy A was paid out, despite the policy having lapsed by the date of death. The insurer of Policy B however denied the interim cover on the basis that Policy B would only come into force if Policy A was not in force. As the policy was paid out, they argued that Policy A was still in force and therefore they did not owe any cover. They argued it would be unfair in the circumstances for the complainant to receive benefits under two policies, when one of them was a "replacement policy".

The issue for the panel was whether Policy A had to have not been in force for Policy B to then be payable. This point was contestable as Policy A had been owned by the complainant, not the wife, and it had lapsed at the time of the wife's death.

The Complaint

The insurer argued that in the circumstances it would not be fair to provide the complainant with double cover, as Policy A had already been paid out. The argument of fairness is also relevant to ISO decisions in New Zealand. Clause 5.7 of the ISO's Terms of Reference states that the ISO must make all decisions in reference to what is fair and reasonable.

The complainant however argued that Policy A had lapsed at the date of death and so Policy B was now in force. Failing that, the complainant argued that Policy A was not taken out by the wife but by him and so the policy was not hers to replace. Accordingly, the interim cover should have applied.

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Total Permanent Invalidity

Finch v Telstra Super Pty Ltd [2010] HCA 36 related to a claim by the insured for a total and permanent invalidity (TPI) benefit. Finch was entitled to an insurance benefit under the Telstra Super scheme if he ceased to be an employee of Telstra because of TPI. The claim was denied by the trustee of Telstra Super Pty Ltd on the grounds that the insured had not been “continuously absent from all active work” for a period of six months, as was required by the policy. The main issue for the High Court of Australia was whether the insured had to be absent from work with Telstra for six months, or whether the term “all work” meant that he could be absent from work with any employer for six months.

Background

Finch was born in England a male, named Alan. Throughout his youth he had problems with his identity and subsequently during his later adolescent years took hormone tablets to promote his female characteristics. At the age of 19 he moved to Australia as a woman, named Helen. At the age of 21 he underwent gender reassignment surgery in Australia. During this time he had found employment with Telstra as a call-centre manager and had joined up to their superannuation scheme, a scheme which included TPI cover.

Finch later became severely depressed and unhappy with his gender reassignment. As a consequence he commenced sick leave from Telstra in September 1996 and eventually returned to work as a male, Alan. In September 1997 his position was made redundant, but he was offered another position. He was very depressed at this point and accepted an offer of redundancy on 23 January 1998. He later submitted evidence showing that at the time he left employment with Telstra he had a severe psychological condition.

In the following six months he worked in limited capacities, first for Foxtel and then for Qantas. While at Qantas, Finch came into contact with a male employee he had had intimate relations with whilst he had been known as Helen. Finch subsequently received death threats from the other employee. He was “psychologically devastated” by the events.

He subsequently left employment with Qantas on 19 May 2000 and was unable to return to any form of work. Accordingly, he made a claim under his prior Telstra TPI policy, on the basis that he had been TPI when he left work at Telstra, and that his subsequent employment had been a failed rehabilitative attempt to return to work.

The Claim

On 21 March 2002 the trustee of the Telstra scheme declined the claim. The trustee declined the claim on the grounds that Finch did not meet the requirements of the policy as he had returned to work after leaving Telstra and so was “capable of returning to work”. As such he had not been “continuously absent from all active work” for a period of six months. The trustee did not seek Finch’s own account of events and did not consider whether his return to work had been a failed

rehabilitative attempt to return to work.

Finch however claimed that his work with Qantas and Foxtel had only been a failed rehabilitative attempt to return to work. He claimed that he spent a large proportion of his time on stress/sick leave and so effectively did not return to work. He argued that before applying for cover under the policy, he had been continuously absent from work for 6 months and so did meet the requirements of the policy.

At Court

At Court, the trustee of the superannuation scheme argued the claim could not succeed as the insured had not been absent from work for 6 months before leaving Telstra. To be covered under the policy Finch was required to have been absent from “all active work for a period of at least six months...” and be “unlikely ever to engage in any gainful work” of the type currently engaged in. In denying the claim Telstra relied on the fact that Finch had subsequently spent time working for both Foxtel and Qantas.

The issue for the Court was whether the period had to occur before he left Telstra.

Decision

The High Court held it was not necessary for the entire 6 month period of leave to have occurred before Finch left Telstra. The Court held that the use of the term “all active work” was not limited to work for Telstra. They stated that a member of the scheme could cease to be an employee of Telstra because of TPI, if looking back, the reason they left Telstra was because of TPI, even if they may not have met all conditions of the policy when they left (e.g. had not been absent from work for 6 months), but had when they made a claim (e.g. been absent from work with Telstra for 6 months). The Court inferred from the policy wording that Telstra would have specifically limited the terms of the policy if its intention had been to not cover situations such as the one Finch found himself in. Elsewhere in the policy Deed, provisions specifically mentioned absence from active employment with the employer.

Because the trustee of the Super scheme had rejected the claim on the basis that Finch had not been out of employment for six months, the matter was reverted back to them for further consideration. The Court suggested the trustee should reconsider whether Finch was likely “ever to engage in any gainful work”; taking into account that Finch fulfilled the six month absence criteria. They also suggested the trustee of the scheme should consider whether Finch’s subsequent employment had been a failed rehabilitative attempt.

Implications

The case emphasises the importance of having clear and consistent policy wording, as an unclear policy term may eventually be interpreted to the detriment of the insurer. If an insurer intends to restrict cover for a particular situation, such as when the employer has not been absent from work for a period of time, then the policy should clearly specify this.

The Developing Regulatory Framework

FAA and FSPA Regulations

Cabinet has recently released for consultation, Draft Regulations on the Financial Advisers and Financial Service Providers (Registration and Dispute Resolution) Acts 2008 (FAA and FSPA). The following regulations will be of specific interest to insurers:

- the definition of investment linked contracts of insurance;
- exemptions from the FSPA for related companies; and
- disclosure regulations for financial advisers.

Investment-linked contracts of insurance

Investment-linked contracts of insurance are classified under the FAA as Category 1 products. All other insurance products are classified as Category 2. Category 1 products can only be dealt with by authorised financial advisers or QFE advisers if the product is provided by the QFE. As such this definition will be pertinent to those insurers looking to avoid costly authorisation for their advisers.

The Draft Regulations propose to define investment-linked contracts of insurance as any contracts other than pure risk contracts. A pure risk contract is then defined as "a policy under which an amount exceeding the sum of any unexpired premiums paid to the insurer is payable to the policyholder only if, during the term of the policy, an insured contingent event occurs." Such an event will include death, illness, disablement, or redundancy of the life insured.

This broad definition is a move away from the previous one which defined what exactly would constitute an investment-linked contract. There is the possibility that this definition will capture more insurance policies under Category 1 products. There have subsequently been some questions raised throughout the insurance industry.

Exemptions for Related Entities

The draft regulations have recommended that companies which provide financial services to related companies should not be required to comply with the FSPA. This is because these companies are effectively acting as a single business and so there is no real money laundering or consumer risks associated with those services.

The Securities Commission has also released a guidance note on their power to grant exemptions under the FAA. The Commission is looking specifically at exemption requests from those who feel the costs of compliance would be unreasonable or unjustifiable in their circumstance and those already subject to similar regulations under an overseas jurisdiction.

Disclosure Regulations

The Paper also made a number of recommendations in relation to the disclosure regulations required by the FAA. These regulations have since been enacted under the Financial Advisers (Disclosure) Regulations 2010. The regulations impose different standards for each of the three classes of adviser.

Registered financial advisers (RFAs) will only need to provide a single disclosure statement with less onerous disclosure obligations than those of the authorised

financial adviser (AFA). The disclosure statement will only need to specify the type of adviser they are and set out the adviser's internal complaints procedure system and external dispute resolution scheme.

Qualified financial entity (QFE) advisers will have different disclosure requirements from both the RFA and the AFA. Unless specifically requested by a client, a QFE adviser does not have to provide a written disclosure statement, provided they make disclosure by other means. This will allow advisers to give verbal disclosure, for example over the telephone. In an insurance context this verbal disclosure is expected to be made by a short automated message at the start of a call, before the adviser even talks to the customer.

In making disclosure, a QFE adviser must disclose the details of the QFE, its internal and external complaints procedures, and anything else required to be disclosed in the QFE's terms of being granted QFE status. The amount of information required to be disclosed has been purposefully limited. This is a result of submissions that extensive disclosure would have disproportionately increased the time taken on each telephone call and would have consequently reduced call-centre productivity.

Each class of adviser must make disclosure before providing the service, or if not practicable before, as soon as practicable after providing it (section 22(1)(a)). This allows RFAs, as well as QFE advisers, to still give advice over the telephone and then make disclosure afterwards.

Sample disclosure statements setting out the specific disclosure requirements can be found in the Financial Advisers (Disclosure) Regulations 2010.

I(PS) Act 2010 - Notice of Intention to Carry on Business in Insurance

The deadline for completing a notice of intention to carry on insurance in New Zealand, and accordingly be subject to the relatively low compliance standards required by the provisional licence provisions, expired on 5 January 2011. Any insurer which has not yet given its notice of intention will be required to proceed directly to full licensing and comply with the full requirements of the Act upfront and within tighter timeframes.

Commencement Order

By 1 February 2011 insurers will be able to apply to the Reserve Bank for a provisional licence. In order to be granted a provisional licence the insurer will have to have in place certain standards such as a compliant fit and proper policy and a compliant risk management programme. By 8 March 2012 insurers will need to have applied for a provisional licence.

The provisions relating to statutory funds will come into force on or about 30 June 2011 and the main requirement to be licensed in section 15 of the Act will come into force on or about 7 March 2012.

If you have any queries regarding any of the above regulations as they relate to the FAA, FSPA and I(PS) Act please contact us.

Fire Damage – Negligence by Tenant’s Employees

Sheehan v Watson [2010] NZCA 454 relates to the ability of a landlord to bring proceedings against a tenant’s employee, for damage caused through negligence. In this instance a fire had been caused as a result of the negligence of the tenant’s employees. The issue for the Court was whether a tenant’s exemption under section 269 of the Property Law Act 2007, where the landlord is insured for damage, also extended to that tenant’s agents or employees. This decision is relevant to fire insurers in particular, who will normally be the driving force behind a landlord in this type of litigation.

Background

This matter was brought before the court by the Otahuhu Joint Venture Partnership (OJVP), an entity which owned industrial premises in Otahuhu. On March 14, 2008 these premises were destroyed by a fire which had been caused by the negligent actions of Watson and Robinson, employees of the tenant. OJVP subsequently sued for repair costs of \$122,874.00.

Watson and Robinson relied on section 269 of the Property Law Act 2007 which provides that a tenant will be exonerated from liability for damage caused by negligence, if the landlord is insured for that damage. The exception to this limited liability is when the damage is caused intentionally by the tenant or through the tenant’s illegal actions. However in this case there was no evidence of intent, only negligence. The defendants argued this exemption extends to the agent, and consequently the employee, of the tenant.

OJVP on the other hand argued that as there is no specific reference to agents in the legislation, then employees are still liable to the landlord for damage caused by negligence.

At Court

In this particular circumstance the Court looked beyond the specific wording of the legislation to

determine whether the exemption under section 269 extended to the employees of the tenant. The Court looked at the Law Commission reports surrounding the implementation of the Property Law Act 2007. Those reports indicated that Parliament had intended to implement reforms which clearly limited a landlord’s right to sue for damage caused through tenant negligence. *“The clear intent of the reform was to put the risk of loss on the lessor [landlord] and to take away the right of the insurer to be subrogated to the position of the lessor and thus be able to sue the lessee [tenant].”* This was justified by the economic reality that tenants effectively pay the landlord’s insurance through their rental payments.

The reports never contemplated a landlord bringing proceedings against a tenant’s agent or employee for damages. The Court however stated that not extending cover to agents would result in an absurdity that would clearly contradict the intention of Parliament; that intention being the restriction of the landlord’s ability to bring proceedings against the tenant. The Court highlighted that the tenant will normally act through its agents and accordingly damage will most often be caused by an agent; *“the lessee’s agents should be entitled to the same protection the lessee is, when that is consistent with the purposes of the legislation.”*

The Court held that the tenant’s exemption for liability to a landlord, or indirectly their insurer, under section 269 of the Property Law Act 2007, will also extend to an employee of a tenant. The Court also held that employees will have no duty of care to the landlord.

Implications

This case helps clarify that landlords will not have an ability to seek redress for damage caused by the negligent actions of a tenant’s agent. This will have implications, particularly for fire and general insurers, who may have intended to recover part payment from a tenant’s agent for repair costs caused by an agent’s negligent actions.

Financial Ombudsman Service (Australia) – Fraudulent Claim

Continued from page 6.

He argued it was irrelevant that the insurers of Policy A had decided to pay out.

Panel

The Panel held that Policy A was still in force, even though it had lapsed, because there were still outstanding premiums on the policy, the reason why it had initially been paid out. In the original insurer’s eyes Policy A was still in force. Accordingly, it would be unfair in the circumstances to enforce a contract

which proposed to only provide cover should the original contract not give coverage. As Policy A did respond, Policy B was deemed to not yet be in force.

Implications

This matter highlights the overall fairness context through which panels will assess a complaint. It also re-emphasises the point that the fairness argument is not just intended to protect consumers. An insurer can still bring an unfairness argument before the panel and succeed, even though they did not in this case.

The Benefit of Calderbank Offers

In the recent Court of Appeal decision of *Bluestar Print Group (NZ) Ltd v David Mitchell* the Court reversed a previous ruling that Bluestar should have to pay Mitchell's legal costs. Bluestar had made a reasonable settlement offer some months prior to trial. The Court held that this Calderbank offer was reasonable in the circumstances and should have been sufficient to vindicate Mitchell.

This finding is relevant to insurers as it suggests insurers may successfully obtain legal costs if they make a reasonable Calderbank offer prior to settlement. The case also establishes that a Calderbank offer to pay reasonable compensation, but without an apology or acknowledgment of wrongdoing, may still be sufficient vindication to a customer if the main focus of that customer is monetary compensation.

Calderbank Offer

A Calderbank offer is a settlement offer made before trial. The offer will be privileged until the end of litigation when it comes to determining awards for court costs. At that time a Court can consider any previous Calderbank offers in determining whether the plaintiff should be awarded costs.

Rule 14.11(4) of the High Court Rules states that the Court can take into account a Calderbank offer which is "close to" the benefit obtained in judgment, when assessing whether to award legal costs to the plaintiff. Stevens J held that "Courts should not be burdened by litigants who choose to reject reasonable settlement offers, proceed with litigation and then fail to achieve any more than was previously offered". If the Calderbank offer is close to the final damages awarded, the normal effect will be that "the costs position is reversed", e.g.: the plaintiff will have to pay costs.

Background

Mitchell was dismissed from Bluestar and sought compensation before the Employment Relations Authority of \$100,000.00 for hurt and humiliation as well as \$400,000.00 in exemplary damages.

Before the Authority investigation, Mitchell was offered a full and final settlement offer of \$13,000.00 as compensation for his hurt and humiliation. The offer

was a Calderbank offer as it was "without prejudice save as to costs". This offer was not responded to by Mitchell.

At Court

The Employment Relations Authority awarded \$6,000.00 to Mitchell but ignored Mitchell's exemplary damages claim for \$400,000.00. Mitchell appealed to the Employment Court. At the Employment Court, Mitchell's complaint was upheld and he was awarded costs of \$10,000.00 for hurt and humiliation (a reduction from the original \$13,000.00 offer from Bluestar), as well as legal costs. The Calderbank offer was not taken into account by the Employment Court in considering legal costs, as the court did not believe the offer had taken into account the personal vindication element "at the heart of Mr Mitchell's claim." The offer was not accompanied by any apology or acknowledgement of fault and the Court felt that Mitchell's claim was not motivated by money.

At the Court of Appeal, the Court upheld that there had been unjustified constructive dismissal. However, the Court of Appeal did take the Calderbank offer into consideration when assessing the apportionment of legal costs. The Court held that Bluestar's offer had taken into account the vindication aspect of Mitchell's claim, as they determined that Mitchell's claim had been primarily motivated by money (as indicated by the excessive exemplary damages claim). Accordingly, the Court found that the initial offer of \$13,000.00 had been reasonable in the circumstances and while purely monetary in nature, was sufficient to vindicate Mitchell for his hurt and humiliation.

Implications

This case highlights the advantage of making a Calderbank offer prior to settlement as it can help mitigate future legal costs. It also helps clarify that a Calderbank offer to pay reasonable compensation, but without acknowledgment of wrongdoing, may still be sufficient vindication to a customer where the primary focus of that customer is monetary compensation. This monetary focus will likely be evident in most insurance claims before the Courts.



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Burrowes and Company wish to acknowledge the contributions of Staff Solicitors Sharee Cavanaugh and Simon Wilson in preparing this bulletin.