

BURROWES and Company

Barristers and Solicitors

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DEFINING 'HEART ATTACK'

A common issue that we deal with is whether or not an insured has had a 'heart attack' as defined under their policy. Developments in medical testing associated with a heart attack means that many policies are outdated in this respect, causing uncertainty to insurers and insureds.

Common policy wordings

A common example of a problematic policy wording is:

'Heart Attack' means:

- (a) clinical features consistent with a heart attack;
- (b) electrocardiogram (ECG) changes; and
- (c) diagnostic elevation of cardiac enzymes.

Many insureds will have had "clinical features" consistent with a heart attack, but because doctors no longer test for cardiac enzyme changes as a matter of course, they may not strictly fall within the scope of the policy wording. The issue then becomes how to assess the insured's heart attack claim under the terms of the policy.

Modern measurements

Currently diagnostic testing of heart attacks is conducted by using precise imaging techniques and measuring elevations in Troponin I and T levels. These techniques provide far more sensitive measurements of muscle damage than outdated cardiac enzyme tests and allow doctors to record relatively small heart attacks.

The difficulty for insurers comes in assessing the severity of a heart attack with the currently used techniques and measurements which are not referred to in the policy.

British Cardiac Society Report

The British Cardiac Society commissioned a report in 2004 to address a similar problem with outdated policy wordings in Britain. The report tried to establish an equivalency rating between traditional cardiac enzyme levels and modern Troponin levels, by comparing an analysis of 804 patients who had had both enzyme and Troponin testing. The report concluded that Troponin levels reading higher than 0.5ng/ml would equate to a "heart attack" using traditional cardiac enzyme measurements.

Recent ISO interpretation

A number of ISO case notes over the past couple of years have mentioned the Troponin equivalency rating in assessing heart attack claims. The British Cardiac Society Report was referred to in a number of cases and the decisions had been very consistent in approach on this basis.

However at the recent Life Insurance Conference in Auckland, the Ombudsman said that the evidence as to what is an equivalent measurement between Troponin and cardiac enzymes was not as clear as was previously thought, and she did not know how the ISO would decide future cases on this issue.

Summary

The key point to note is that there is some potential uncertainty in this area, and insurers will need to be aware of the issue until it becomes more settled. Nevertheless, the British Cardiac Society Report and the recent ISO cases do provide a guideline that insurers can look to when assessing a claim where there are only Troponin measurements available.

FINANCIAL SERVICE PROVIDERS

The Financial Service Providers (Pre-Implementation Adjustments) Bill was passed into law on 23 June 2010. This article deals with the recent Select Committee Report on the Bill. The next bulletin will deal with the complete Bill as enacted.

The Select Committee heard a number of industry submissions on the initial Bill and these were reflected in the proposed amendments. The Committee recommended significant changes which will seriously affect compliance requirements for many insurers.

Definitions

The Select Committee has recommended a number of changes to definitions within the Bill to try and clarify the responsibilities of financial service providers.

“Financial advice”

The Committee has recommended inserting a new clause 9 so that the Bill will only capture financial advisers giving advice in the ‘ordinary course of business.’ This amendment will help clarify that advisers are not liable in situations where a consumer is not expecting to receive financial advice on a commercial basis.

“Guidance”

The word guidance had been removed from the Bill to clarify the distinction between advisers giving mere information and those giving actual advice. Under clause 10, an adviser must “make a recommendation or give an opinion in relation to disposing of or acquiring a financial product” in order to fall within the scope of the Bill.

Further to this, clause 10(3) sets out that advisors will not be liable where they:

- give advice or opinion on a class of products;
- give procedural advice on how to dispose or acquire a product; and
- ‘transmit’ the advice of another person.

“Internal advice”

Advice within an organisation will not be caught by the regime. This ensures that only advice to retail clients is regulated. Advice between a QFE and its nominated representatives for example will no longer be regulated.

Exemption for “Incidental service”

Any financial advice given incidentally, as part of other non-financial advice business, will be exempt. Business which is secondary to an adviser’s core business will not be regulated. Such examples could be car rental companies discussing car insurance or retail assistants discussing hire purchase agreements

Product classifications (category one v category two)

A number of simple products have been reclassified as category two products, meaning that nominated representatives of QFEs and registered advisers will be able

to give advice regarding these products. They include:

- shares in co-operative companies;
- call credit union shares; and
- non-investment linked policies of insurance.

However an investment-linked contract of insurance will be deemed a category one product.

Financial planning services

This provision will help clarify the responsibilities of insurers who conduct a full needs analysis of their client’s financial position so as to give comprehensive insurance advice.

The Committee has recommended changing the scope of the regime to only capture investment based planning services. If an adviser does not address the investment planning needs of a client then they will no longer be providing a financial planning service. A person provides a financial planning service only if their advice directly relates to investment matters, not if the advice relates to non-investment linked policies of insurance.

This is intended to focus attention towards the investment nature of the service being provided. If an adviser recommends the purchase or disposal of even one product they will be seen to be providing a comprehensive planning service and will be required to comply with the Bill.

Exemptions

Exemption-making powers

The Select Committee has recommended inserting clause 148 which extends the exemption-making powers of the Securities Commission.

This provision allows the Securities Commission to exempt any person, class of persons or activity from complying with any section of the FAA or from complying with obligations to register under the FSPA.

The Securities Commission must ensure that no exemption interferes with the public protection of consumers and the commission must notify the public of all exemptions via gazette publication.

Scope of the Regime

Territorial Scope

The Committee has recommended that the FAA should apply to all financial advice received in New Zealand, whether or not that service is provided from within New Zealand. This means that overseas based insurers will still need to abide by the Act.

The Committee has also recommended there should be compulsory duties for New Zealand based advisers

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providing a service to overseas customers to exercise due care and skill and not mislead clients. This is pursuant to sections 33 and 34 of the FAA. As regards the FSPA, all people based in New Zealand who provide financial services will be bound by the Act.

This will mean that all New Zealand based insurance companies giving financial advice abroad will be bound to exercise due care and skill and abide by the entire FSPA. All other insurers providing advice to New Zealand clients will be bound fully by both Acts.

Wholesale Clients

One of the significant changes in the Select Committee Report is the recommendation for a new class of wholesale clients which would be exempt from the Bill's provisions.

The Select Committee has recommended that advisers working with "financially sophisticated" wholesale clients should be exempt from many of the Bill's provisions, as this type of client is not the "unsophisticated" investor the Act is trying to protect. The Committee has suggested that protecting wholesale clients under the regime as well, would only work to stifle this "sophisticated end of the market."

Wholesale investors have been defined under clause 6A as:

- people who receive financial advice in their business and who conduct business as a financial adviser or financial service provider; or
- people whose primary business is to habitually invest money; or
- an entity that has gross assets of over \$1 million or an annual turnover of the same amount.

To become an eligible wholesale investor the client must be an entity or individual which has certified in writing that they have "sufficient knowledge, skills, or experience in financial matters to assess the value and risks of financial products." This certification must be accepted by an adviser.

Advisers dealing solely with wholesale clients will still be subject to a duty to act with due care, skill, and diligence and a duty to not engage in misleading or deceptive behaviour. However these advisers will not be required to be individually authorised, or be part of a dispute resolution scheme. Nor will they be subject to the FAA's code of professional conduct.

Advice from Entities—Class advice

The Select Committee has recommended amending the FAA so that entities would still be able to provide class advice. This would protect advice such as brochures and online planning services which are aimed at a generic class of consumers, as opposed to specific consumers.

This would effectively impose lower regulatory standards on financial entities. However entities would still be obliged to act with due care and skill and not engage in misleading or deceptive conduct. Also there would still be scope under clause 12 of the Bill for future regulations to impose more stringent standards.

Personalised services from entities

The Committee has also recommended clarifying that entities are allowed to provide financial adviser services under the FAA. This is subject to the advice coming from an appropriate individual financial adviser.

Qualifying Financial Entities

The Select Committee has made some significant recommendations as regards the structure and function of QFEs under the FAA.

Groups of entities

The Committee has recommended that a group of entities should be able to operate under the 'umbrella' of a single QFE; a situation which was previously not accommodated by the FAA. This would allow employees of group members to give advice without each entity requiring QFE status. This will inevitably decrease compliance costs.

Under such a group structure, the group would be required to nominate a number of "lead partner entities" which would be made jointly and severally liable for compliance by the entire group.

Clause 7 would also be amended to allow an employee or nominated representative of a QFE to provide advice on a product issued or promoted by another entity within the same QFE group. This has helped clarify that nominated representatives are not able to be a nominated representative of more than one QFE and cannot sell products of another unrelated entity.

Consumer protection

There will be a number of procedural requirements for an entity to register as a QFE. Entities must ensure that they:

- discharge ongoing compliance obligations;
- comply with any terms and conditions of the grant of QFE status; and
- maintain procedures to ensure clients receive adequate consumer protection.

QFE providers which provide category one products must also ensure they abide by similar standards to those imposed on advisers under the FAA's code of professional conduct.

Securities Commission powers

The Committee has recommended the insertion of clause 27A to strengthen the power of the Securities Commission to monitor and enforce the FAA. This

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would allow the Securities Commission the power to:

- place temporary bans on advisers for consistent breaches;
- enforce action against individuals and QFEs;
- publicise any action taken;
- apply to the High Court to restrain or ban certain entities and individuals from acting.

Disclosure

Added flexibility and disclosure

The Select Committee has recommended implementing more flexible disclosure provisions so that different advisers in completely different situations would not be subject to the same disclosure requirements.

The Committee made no specific recommendations but suggested that supplementary regulations could look to impose more flexible provisions in the future. They suggested regulations could be introduced for example, which would not require an adviser to make a disclosure if their advice on a category 2 product did not lead to a sale.

They also recommended that secondary regulation could be imposed which would require advisers selling category 2 products to provide a disclosure statement to clients indicating any fees or material interests from the sale.

Transitional amendments

The Committee recommended amending the FAA so that advisers working for prospective QFE members do not have to register until the Act comes into force. In regards to the FSPA, the Committee also recommended amending its commencement provisions so the Act could be phased in by Order in Council.

Conclusion

The Committee has taken heed of a number of insurance industry submissions. In particular the recommendations on wholesale clients, group QFEs and financial planning services will make the Bill more workable for insurance providers. The amended regime should provide a more economically realistic regulatory model which has the ability to still protect those 'mum and dad' investors who require protection.

PRUDENTIAL SUPERVISION

The Finance and Expenditure Committee has recently released its report on the Insurance (Prudential Supervision) Bill. The Committee has recommended a number of changes, in particular to the nature and scope of licensing obligations and prudential regulations, which for the most part have improved the Bill.

Licensing of Insurers

Scope of licensing requirements

The Committee recommended deleting clause 7(3) and amending clause 7(1) of the Bill so as to narrow its scope. This will exempt some groups such as discretionary mutual organisations who were never intended to be captured by the Bill.

The Committee has also recommended requiring overseas people who are not bodies corporate, but who carry on insurance business in New Zealand, to be licensed. Clause 8(1)(a)(iia) clarifies that overseas people who are not bodies corporate (ie: credit unions and friendly societies) will still be carrying on business in New Zealand.

Exemptions

One significant change to the Bill is the exemption of "small insurers" from certain requirements of the Bill. Small insurers will be defined by the amount of annual gross premium income they receive. The threshold for

exemption will likely be between \$1million and \$1.5 million but will be specified in later regulations.

Small insurers will still have to:

- obtain a licence;
- meet fit and proper standards;
- fulfil risk management requirements; and
- appoint an actuary.

But small insurers will be exempt from:

- financial strength ratings;
- statutory funds requirements;
- some financial reporting requirements; and
- minimum capital requirements.

Clause 8A would also give the Reserve Bank the power to declare some groups exempt from licensing requirements where they enter into one-off insurance contracts which are secondary to their core business. This is in accordance with a similar 'incidental' provision in the recent Financial Service Providers (Pre-Implementation Adjustments) Bill. Reserve Bank approval and rejection must be fully explained as pursuant to clause 228.

Standard requirements for overseas insurers

The Committee has recommended the Reserve Bank have the right to exempt foreign insurers from fit and proper standards, solvency standards and statutory

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fund requirements. The Reserve Bank must be completely satisfied that prudential regulatory and supervision standards of the insurer's host country are of an equal standard to New Zealand's. The Committee has recommended that a list of approved overseas jurisdictions should be prearranged by regulation so as to stop duplication of procedural requirements.

Clause 16 also sets out only bodies corporate carrying on insurance business in New Zealand are eligible to apply for a licence. This is intended to stop overseas insurers using New Zealand registration as a shelter for international activity.

Solvency and minimum capital requirements

The Committee has recommended an amendment to Clause 18(1). The Reserve Bank must be satisfied of minimum capital amounts, as specified in the solvency standard, before a company will be given a licence.

The Reserve Bank will also impose solvency standards that require an insurer to maintain a minimum margin of assets in proportion to its liabilities. The recent Select Committee Report has recommended insurers should be able to calculate this proportion as either a ratio of assets to liabilities, or a set amount.

Fit and proper policy

The Committee has recommended removing a lot of the specifications for being deemed fit and proper and placing these specifications in regulation. This is intended to create a more flexible regime for determining who may be fit and proper and allows for change.

Insurers will need to develop a fit and proper policy which clearly specifies the qualifications, requirements, and other criteria of a particular position, including matters relating to a person's character, competence, and experience relative to the duties of the position.

Control, transfers and amalgamations

If a person becomes a "holding entity" of an insurer or obtains over 50 percent or more of the insurer's voting rights that person must inform the Reserve Bank about a change of control.

The Committee has also recommended amending clause 45(1) to reduce costs connected with transfer and amalgamation approvals. The Bank must now only obtain reasonable costs associated with preparing reports. A time limit of 20 days will also apply to all transfer and amalgamation approval requests. These recommendations are intended to create more efficient regulatory standards.

Prudential Regulations

Solvency standards

The scope of reporting has been extended so that some

matters relating to solvency standards and minimum capital requirements must be included in reporting.

The Committee has also recommended an insurer should inform the Bank 'as soon as reasonably practicable' if it believes it will most likely not meet solvency standards within the next three years. If an insurer fails to comply with prescribed solvency standards it will be liable to a fine of up to \$500,000.

The Committee has also recommended extending the concept of solvency standards to include minimum capital requirements. This is an important addition and will place some pressure on financially smaller insurance firms. While the actual amounts have not yet been confirmed, the Committee has said the amounts will be proportionately smaller than those in Australia.

There have been some indications that the minimum capital required for a New Zealand insurer will be \$2 million, whereas in Australia the minimum is \$5 million for fire and general insurance, and \$10 million for life insurance.

Financial strength ratings

The Committee has recommended the Bill should not be so onerous in its regulatory requirements regarding financial strength ratings. Financial strength ratings should only relate to the ability of the insurer to meet liabilities under contracts of insurance.

Ratings will be able to be disclosed via an intermediary which should decrease compliance costs. Also the maximum penalty for failing to disclose a financial rating to new clients has been decreased from \$500,000 to \$100,000.

Further, if an insurer receives a ratings downgrade it will be able to publish that downgrade publicly, rather than being required to give individual disclosure to each policyholder. Failing to disclose a downgrade will still carry a fine of up to \$500,000.

Risk management plans

The Committee has recommended insurers should be able to notify the Reserve Bank after a change is made to their risk management programme, as opposed to requiring prior consent, if change is urgently required.

Actuary appointment

Under the Bill there is a requirement that all insurers appoint an actuary. The actuary must be a fit and proper person as regards the insurer's fit and proper policy.

The Committee has recommended extending the 6 week period which an insurer has to replace an actuary should the insurer require the extension and should the Reserve Bank approve it.

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PRUDENTIAL SUPERVISION

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Supply of financial statements

Interim financial statements will need to be provided to the Reserve Bank five months after the insurer's accounting period ends. The Select Committee report has stated interim reports will need to be prepared in the same way yearly financial statements are prepared.

Statutory Funds

The Committee has also recommended a number of changes as regards statutory funds.

Firstly the word "policyholder" has been replaced with "insured person" throughout the Bill to clarify that its focus is on the protection of insured people.

The Bill also sets out that insurers providing composite policies must use a statutory fund. However the Committee has recommended that if less than 25% of the premiums from a 'line of policies' are being paid in respect of life insurance cover then the insurer will not be required to establish a statutory fund.

Policies lasting less than one year will also be exempt from the requirement to use a statutory fund. While this goes some way to reducing compliance costs it is still a more burdensome requirement than the equivalent Australian legislation which exempts policies under three years.

The Committee has recommended amending clause 97 to allow future regulations to provide technical detail on liabilities relating to investment performance guarantees. The Reserve Bank has also recommended inserting provisions to allow for the transfer of assets upon the establishment of a statutory fund.

Disclosure

The Select Committee has recommended amendments to clause 25 to impose further disclosure obligations on actuaries and auditors. Past and present actuaries and auditors must disclose information about an insurer's solvency and provide information to the Reserve Bank should it think an insurer is operating fraudulently or is likely to fail to maintain a solvency margin at any time in the next 3 years.

Other Matters

Recovery plans

The Committee has recommended amending clause 141 so that the Reserve Bank would have the power to make an insurer prepare a recovery plan should the Bank believe the insurer is likely to:

- fail a solvency margin; or
- not act in a prudent manner; or
- fail to comply with any requirement imposed on it by the Act.

The intent of this provision is to indicate that a recovery plan should be the first step in the distress management process. More serious measures are intended to be used as secondary means. However the Reserve Bank does not have to request a recovery plan should it feel that a recovery plan would impede on their ability to act quickly in a crisis.

Constitutional requirements

A number of submissions were made regarding the initial Bill that made it an offence to have a constitutional provision allowing the insurer to act in the best interests of its holding company. Under that provision a number of insurers' constitutions would have needed to be amended.

The Select Committee has recommended this should no longer be an offence and the relevant provision should instead have no legal effect. This would allow insurers to act in the best interests of policyholders without requiring constitutional amendment. For example a licensed insurer which is a subsidiary would be able to ignore requests for a dividend payment from a holding company if it is not in the best interests of the subsidiary, even though there may be a constitutional provision requiring the subsidiary to act in the best interests of the holding company.

Transitional matters

The Committee recommended amending transitional provisions so an insurer could get approval from the Reserve Bank for a portfolio transfer within an 18 month period following the assent of the Bill.

The Committee also recommended inserting sub-clause 229(1)(pa) to allow for any necessary transitional provisions to be made by Order in Council in relation to rules governing statutory funds.

These provisions should allow insurers time to restructure their current business systems so as to comply with the Bill.

Summary

The Committee's recommendations have addressed some of the concerns raised by industry submissions. Amendments to Fit and Proper requirements and constitutional requirements for example have made the Bill more workable and transitional amendments will also mean that insurers have a more realistic timeframe to work within.

However there are still some concerns, in particular with composite policies and Reserve Bank discretionary powers, which will need to be worked through by insurers. Insurers must look to develop effective compliance strategies so they are not caught out by the impending new law.

ISO UPDATE

Changes in the ISO's terms of reference and rules

The ISO has recently changed its rules in order to accommodate the new Financial Service Providers (Registration and Dispute Resolution) Act 2008 ("the Act").

Under the Act approved financial advisers and qualifying financial entities (QFE's) must be part of an approved dispute resolution scheme. The ISO has recently received approval from the Ministry of Consumer Affairs to be an approved scheme under the Act.

The changes to the rules allow the ISO to include non-insurance financial advisers and brokers. This will almost certainly increase the number of participants in the ISO scheme substantially, and should lead to cost savings for participants.

Case Summaries of Interest

113236 – Registering a change in ownership

In 1995 the insured transferred ownership of a policy to himself, his wife and another person as trustees of a trust. In 2007 he contacted the insurer wanting to record a change in ownership, as a new trustee had been appointed to the trust. He provided the insurer with a copy of the deed appointing the new trustee.

The insurer advised the insured that it required all three original trustees to sign the transfer before it could register the change. However the problem was that the third trustee could not be found. The insurer advised the insured that it would have to obtain orders from the High Court in respect of the transfer if the third trustee could not be found. The insured objected to this requirement.

Section 43(1) of the Life Insurance Act 1908 requires transfers to be signed by the transferor and transferee.

The ISO referred to this section in its advice, advising that all three transferors and all three transferees would need to sign the transfer. Otherwise the insured would need to obtain permission from the High Court in order to transfer ownership of the policy.

The complaint was not upheld.

113565 – Duty of disclosure

The insured arranged mortgage protection cover in March 2007 and made a claim in November of that same year for bowel cancer. The insurer avoided the policy from inception for non-disclosure of raised Prostate Specific Antigen (PSA) prior to the commencement of the policy.

The insured disclosed that he had recently had his usual biannual blood tests, but that he had not received the results. The day before the policy commenced the insured saw his doctor and was told that his PSA was "slightly raised". He was advised to come back within two months for repeat blood tests.

An insured has a duty of utmost good faith at common law to disclose any known information which may be material to a prudent insurer. However the contract of insurance can limit that duty of disclosure.

In this instance the ISO held that the insurance contract asked specific questions which did limit the insured's duty to disclose. The insurer's questioning did not indicate that it was interested in any pending tests or results that the insured had, unless the insured was diagnosed with one of the listed conditions in the policy. At the time the insured learnt of the raised PSA levels he had not been diagnosed with any form of cancer. In fact the Doctor had told the insured that the raised PSA levels were nothing to worry about.

Accordingly the insured's claim was upheld.

DISCOVERY

The recent Australian Supreme Court decision of *Halpin & Ors v Lumley General Insurance Ltd* addresses concerns about the rules regarding withholding information in the lead up to litigation in Australia. This decision, if followed in New Zealand, would give insurance companies dealing with fraudulent claimants the power to withhold some limited information until trial to avoid the insured tailoring their evidence. This could be useful for information such as surveillance footage.

Background

In the *Halpin* case, the insured made a claim under their home and contents policy for the alleged theft of some valuable sporting memorabilia. The insurer refused to pay out on the claim, arguing that the

insured had deliberately provided false information as regards the ownership and value of the items. The matter proceeded towards litigation.

Discovery

In general terms, there is an obligation of discovery on both parties to disclose all material information to the other party in the lead up to a court trial. At issue for the Supreme Court was whether the insurer could refuse to release particular items of evidence which it intended to use at trial, on the basis that the insured would tailor their evidence if full discovery was made.

The rationale for obligatory disclosure is that each party will be able to better represent their argument if

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DISCOVERY

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they have prior consideration of what evidence will arise. In this sense discovery helps with efficiency in the court room by reducing the need for adjournments and other delays.

Full discovery also promotes out of court settlement, as each party is able to better realise the relative strengths and weaknesses of their case if all of the information is out in the open.

The Decision

In coming to the decision that the insurer could withhold some limited information in this case, the Court cited a number of previous Australian decisions which had established that in certain circumstances the obligation for discovery could be waived. These sort of circumstances would exist where the “interests of justice would not be served by producing documents”.

In particular the Court in *Ng v Goldberg* held that it would be unfair to “deprive the defendant of a legitimate advantage to test the plaintiff’s story” in instances “where the defendant has taken pains to prepare material to attack the credit of the plaintiff”. This approach addresses concerns that forcing disclosure would tempt the insured into tailoring their evidence to suit the newly disclosed material.

Summary

This finding gives optimism to insurers dealing with cases of fraud where they may want to keep information hidden until trial. The decision allows

insurers in Australia to withhold certain documents where those documents have been specifically prepared to challenge important parts of the insured’s case, and where they may tempt the insured into tailoring their defence to them.

While the decision will be of considerable interest to insurers in New Zealand, we do have to be realistic about the potential weight that this decision will have in the New Zealand context, and the types of information that it could realistically be applied to.

Where an insurer has come to a decision regarding a claim on the basis of certain information that it has obtained, and that information is adverse to the position of the insured, the insurer will generally have an obligation to provide that information to the insured and allow the insured to respond before it makes a final decision in respect of a claim. In a practical sense therefore, any information that has formed the grounds for a decision to decline a claim could not be withheld.

Furthermore, the New Zealand courts tend to avoid the ambush approach to litigation in favour of the “cards on the table” approach, and this decision would be inconsistent with that idea. The reason that the open approach to litigation is favoured by the Courts is because it is thought to facilitate settlement at an early stage, as both parties are put in a position whereby they can assess the other side’s evidence against their own. In light of this overarching objective, the *Halpin* decision may not be overly persuasive in the New Zealand context.

INTEREST AND LATE PAYMENTS

Newey v First Superannuation Pty Ltd [2009] NSWSC 1100 dealt with an insurer delaying a claim in order to verify an injury, and a subsequent action from the insured for interest payments for the period of delay.

Background

In 2003 the insured suffered a back injury and made a claim for total and permanent disablement. The claim was lodged on 13 March 2008, but was not accepted and paid until 13 August 2009. The insured claimed interest of \$4,500 for the period between his claim and the late payment.

The insurer had deferred payment because there was a chance that the insured may have been able to return to work following an operation, which it found was likely to take place. However, the claim was accepted after the insured had had the operation on an emergency basis, and it had proved unsuccessful.

In respect of the interest claim, the Court held that the condition of the policy was only met when the insurer

held an opinion to that effect. To have been entitled to earlier payment, the insured would have had to prove that at some stage prior to payment:

- (a) the insurer held the opinion that the insured was totally and permanently disabled, or
- (b) if the insurer was acting reasonably it would have held that opinion.

The plaintiff was unable to establish that the claim should have been determined at an earlier time, or that the insurer had acted unreasonably in awaiting the outcome of the operation that it reasonably expected may enable the insured to return to work.

Conclusion

If a claimant is likely to undergo surgery or other treatment, and there is evidence that the claimant may be able to return to work following this treatment, then it is likely that deferring payment for total and permanent disablement will be reasonable, and an insurer will not be required to pay interest for any reasonable deferral period.

MANDATORY INTERIM INJUNCTIONS

Case summary from *Pilkington v Fidelity Life Assurance Company Limited* HC WN [7 April 2009]

Pilkington v Fidelity Life Assurance Company Limited [2009] is a recent High Court case dealing with an application by the insured for a mandatory injunction forcing their insurer to continue paying them.

Background

The case related to an income protection claim. The insured made a claim for generalised anxiety disorder, panic attacks, and developing phobias regarding health institutions. The claim was initially approved, but the insurer later cancelled the policy. Subsequent investigations indicated there had been material non-disclosure by the insured regarding his mental illness and having earned income.

The insured then applied for an interim mandatory injunction at the Wellington High Court to force the insurer to keep making payments. The insured argued that if payments were not reinstated then he would fall into “immediate and complete financial ruin”.

Injunctions

Traditionally the granting of interim mandatory injunctions has been seldom and exceptional. Eichelbaum CJ affirmed this approach in *Soft-Tech International Pty Limited v Ball*, stating that “...interim mandatory injunctions are rare indeed, and interim mandatory injunctions having the effect of a final order and involving the payment of a sum of money which

normally would be described as a debt, in my experience are completely novel...”.

Nevertheless Williams J in the present case stated that if he had been satisfied that the insured would face “immediate and complete financial ruin” as a result of not receiving further payments, then he would have allowed for such an interim mandatory injunction.

However the court held that in these circumstances there was insufficient evidence to indicate that such financial ruin would arise. The Court noted that the insured would need to make full and frank disclosure of financial circumstances in order to be granted such an interim remedy. In this case the defendant had not acted in such a manner, but had rather made untrue and incomplete disclosures.

Implications

This approach by Williams J indicates that the circumstances required for the issuing of interim mandatory injunctions, which demand the payment of money, may not be as rare as previously thought. The decision suggests that an insurer may well be liable to make payments under a mandatory interim injunction if the Courts are satisfied that:

- on the balance of probabilities the insured faces immediate and complete financial ruin, and
- the insured has made full and frank disclosure of their financial circumstances.

HEALTH INFORMATION

The Assistant Privacy Commissioner, Katrine Evans, gave a recent address at the New Zealand Life Insurance Conference, regarding the collection of medical information from insured clients.

Privacy Commission recommendations

The main concern of the Privacy Commissioner is that insurers should only be collecting necessary medical information, not ancillary information irrelevant to the matter being investigated. The Assistant Commissioner suggested insurers should be collecting information they “have to have”, not information which would be “nice to have.”

Privacy in the courts

However there is some leeway for health insurers to request non-claim related information in certain circumstances. A recent Human Rights Tribunal case, *Gibbons v Accident Compensation Corporation* (2009), held that an insurer was justified in seeking non-injury related information about a client.

The agency involved in this dispute had requested non-claim related medical information, in this case the client’s prescription history, in order to assess the validity of a claim for a new prescription medicine.

Rule 1 of the *Health Information Privacy Code 1994* states that “health information must not be collected by any health agency unless the collection of the information is necessary...”. The Tribunal held that obtaining the client’s previous prescription history was reasonably ‘necessary’ for the agency to determine the actual therapeutic value of the requested medicine. They noted that other medicines being taken by a claimant could limit the effectiveness of the medicine claimed and as such previously prescribed medicines would be relevant.

The tribunal stated that any decision to fund medicine “can only be made with the benefit of full information about the claimant’s condition, including any other medicines which are being taken...”. As such the agency was deemed to be acting within the limits of Rule 1 when they requested information relating to any other prescribed medicines taken by their client.

Summary

A fine line must be drawn in order to determine what information is necessary and what is not when insurers are requesting personal health information.

LIMITATION PERIODS

Two recent decisions of the High Court help highlight the current approach being taken by New Zealand courts, in respect to determining which date the limitation period begins in insurance claims.

Sovereign v Scott (No 2) HC Rotorua (26 February 2010) dealt with the issue of when time begins to run in respect of a Critical Illness claim for Limitations Act 1950 purposes.

Background

The insurer had issued a Critical Illness policy in 1994 which provided a benefit of \$100,000 in the event of a “stroke”, as defined by the policy. In January 1997 the insured suffered a subarachnoid haemorrhage, but was declined cover on the basis that there was no significant or permanent damage, as required by the policy definition of “stroke”.

In 2006, nine years after the injury occurred and after numerous rejections by the insurer and the ISO, the insured brought the matter before the Courts.

The insured was unsuccessful in the High Court, the Court striking out his claim for being out of time under the Limitation Act 1950. This was the No 1 decision reported in our December 2009 Insurance Bulletin.

In the No 2 decision, the insured applied for leave to appeal to the Court of Appeal.

Limitation Act 1950

The issue was whether the claimant had a reasonable argument that his claim was not statute barred for not having been brought within the requisite six year limitation period from the cause of action, as required by the Limitations Act 1950.

The determination of the issue rested on whether the “cause of action” began at the time when the insured event happened, or at a later date when proof of entitlement was available.

The High Court took a similar approach to a line of English authority referred to in *Arnold v American International Assurance Company Ltd* HC AK CIV 2008-404-6987 (“Arnold”), in holding that a policy of indemnity begins as soon as the insured event occurs, unless there are contrary policy terms in place. If the time ran from when the insured could establish their entitlement, then the insured could effectively “postpone the operation of the Limitations Act” by delaying their application. This would give the insured an inequitable control over the claims process.

Accordingly the insured was denied leave to appeal to the Court of Appeal.

In another Limitation Act case, *Singh v Sovereign* HC Auckland (26 January 2010), the Court had to consider when time begins to run for Limitation Act claims in respect of a policy avoided from inception for non-disclosure.

Background

The claimant took out cover over the life of his mother in April 2001. He did not disclose to the insurer that the life insured was not a New Zealand resident, but a Fijian resident. The insurer did not insure non-New Zealand residents.

In June 2004, the claimant’s mother died. The claimant made a claim under the policy for death benefits. Sovereign avoided the policy from inception on the basis of non-disclosure of the mother’s residency status and declined the claim.

Mr Singh argued that he had informed Sovereign that his mother was awaiting residency at the time of application, and that Sovereign had breached its duty of care by misrepresenting to him that his mother would be covered under that policy.

Sovereign conceded that a duty of reasonable care was owed to the claimant in this instance, but argued that proceedings in respect of the breach were time barred pursuant to the Limitations Act 1950.

Decision

The Court agreed with Sovereign and held that time began to run for Limitation Act purpose not when the insured event (the death) occurred, but from the date that the breach of the duty of care occurred (i.e. the policy inception date).

Christiansen AJ stated that “the cause of action accrues from the date of damage”. It does not matter whether the plaintiff knows of that damage. The material date is the date when the negligent behaviour occurs, not when the claimant discovers the damage.

Summary

If a claimant brings proceedings for a breach of the insurer’s duty of care then the cause of action will run from the date when the breach occurred, for example the policy inception date. However if an action is brought by a claimant in respect of an insurer not upholding its obligations under the policy, then the cause of action will run from the date the event occurs.

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