

BURROWES and Company

Barristers and Solicitors

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COLLECTION OF MEDICAL NOTES BY INSURERS

The Office of the Privacy Commissioner has recently concluded its inquiry into the practice of insurers in obtaining medical notes. The Commissioner has released a report together with a media statement setting out its view in this difficult area.

The joint efforts of the industry and the Privacy Commissioner to prepare a standard form Privacy Act authorisation and a brochure explaining the nature of the authority given to insurers by members of the public are ongoing.

The report entitled "Collection of medical notes by insurers – Inquiry by the Privacy Commissioner" together with the media statement "Collecting full medical notes? Think twice" was released on 29 June 2009. Both the report and statement can be found at the Privacy Commissioner's website www.privacy.org.nz.

The inquiry followed a request from the New Zealand Medical Association (NZMA) for the Privacy Commissioner to look into the practice of insurers requesting full medical notes when deciding whether to accept a risk or whether to accept a claim.

The NZMA raised concerns as to whether some information requested by insurers was necessary for the purposes of underwriting and claims assessment and whether consumers were being fully informed about the uses to which the authorisations were being put.

The conclusion reached by the Privacy Commissioner as set out in the report, is that insurers collecting full medical notes are at risk of breaching the Health Information Privacy Code.

The Commissioner has warned insurers to be careful not to obtain more information than is necessary for it to make its underwriting or claims decisions.

To this end, the Commissioner has recommended that asking for specific information might be the more appropriate approach. However, it is often difficult for insurers to know what questions to ask when it has been provided with insufficient information by the insured, either at the time of application or at claim time.

The Commissioner has recognised that in some cases full medical notes will need to be obtained, but has also noted that this should be the exception rather than the rule.

The other clear directive to insurers coming out of the inquiry is that the forms of authorisation currently used are not giving consumers or medical practitioners a clear enough explanation of what it is that is being authorised and why.

As earlier noted, the industry is working with the Commissioner to agree a standard form wording that will achieve this objective together with a brochure explaining the scope of the authorisation and the use of medical information by insurers.

LEGISLATION UPDATE

As industry members will be aware, there is a lot of action in the legislative environment at the moment. Here is a quick update on what is happening and the timeframes going forward:

Taxation (International Taxation, Life Insurance and Remedial Matters) Bill

This Bill makes changes to the basis for taxation of life insurance business, providing for taxation of the 'policyholder base' and the 'shareholder base' separately. The Bill was introduced in July 2008 and has taken until August 2009 to get the point of passing its second reading. The life insurance taxation measures make up only a relatively small part of this 800+ page omnibus Bill, and so matters have been slow to progress. As a result the initial date for coming into force of the relevant provision on 1 July 2009 has been revised at this stage to 1 July 2010.

The most recent developments include two Supplementary Order Papers dated 4 and 25 August 2009. The Supplementary Order Paper of 4 August clarifies the policy intent of the current provisions that allow life insurance companies to access refunds of overpaid tax in particular circumstances.

The Bill is expected to be passed into law in about September 2009.

Insurance (Prudential Supervision) Bill

This Bill provides for the licensing and supervision of insurers by the Reserve Bank and will set prudential regulation and solvency level requirements for insurers.

The Reserve Bank released a draft Bill for in April 2009 and submissions closed on 22 June 2009. Following analysis of the input of key stakeholders, the Bill is expected to be introduced into Parliament in late 2009. Further submissions will be made by the industry at the Select Committee stage.

Financial Advisers Act 2008 and Financial Service Providers (Registration and Dispute Resolution) Act 2008

Both of these Acts were passed through the house in September 2008 and are due to come into force in December 2010. They collectively provide for the registration and regulation of Financial Advisers and dispute resolution services for complaints about financial advisers.

There are a number of government departments and specialist bodies involved in the implementation of the Financial Advisers regime including the Companies Office, Minister of Consumer Affairs, the Code Committee, Securities Commission and Minister of Commerce.

The industry recently made submissions to the Minister of Consumer Affairs on the discussion papers *Draft*

Guidelines to Assist Schemes Applying to Become an Approved Dispute Resolution Scheme under the Financial Service Providers (Registration and Dispute Resolution) Act 2008 and *Proposed Reserve Dispute Resolution Scheme under the Financial Service Providers (Registration and Dispute Resolution) Act 2008*. Submissions closed on 31 July 2009.

The industry has also made submissions to the Minister of Commerce on the *Financial Advisers Act 2008: Disclosure Regulations Discussion Document*. Submissions closed on 12 August 2009. Feedback has also been provided to the Securities Commission following the release of the *Staff Paper on Regulating and Supervising Financial Advisers*. Submissions closed on 30 July 2009.

Annabel Cotton has been appointed as the Commissioner for Financial Advisers, and in July 2009 she announced the appointment of the 10 members of the Code Committee. The Code Committee will now be working to draft the Code of Professional Conduct for authorised financial advisers. This is expected to be drafted by early 2010.

The Financial Advisers Amendment Act 2009 was also passed on 28 July and made minor amendments to the Financial Advisers Act 2008 to remedy errors that have come to light since the Act was passed. The changes are limited, but include the following changes: The meaning of financial advice has been clarified so that it does not include anything contained in a disclosure statement for the purpose of the Retirement Villages Act 1993; and The jurisdictional extent of the Act has been clarified (restoring wording originally agreed by Parliament).

Anti-Money Laundering and Countering Financing of Terrorism Bill

This Bill aims to bring New Zealand into line with its international obligations regarding Anti-Money Laundering and Countering Financing of Terrorism. Critically, from the point of view of insurers, the Bill provides for minimum standards of Customer Due Diligence / customer identification procedures to be completed.

The draft AML/CFT Bill was introduced into Parliament in June 2009 and was released for submissions. Submissions closed on 6 August 2009. The Foreign Affairs, Defence and Trade Committee is due to report the Bill back to the House on 15 September 2009. A key change that the industry will be looking for once the Bill is reported back is a general exclusion from Customer Due Diligence requirements for pure-risk insurance products. Submissions have been made by various industry bodies on this, and other issues.

Once passed, the AML/CFT Act is expected to have a 2 year lead-in phase.

2008 ISO CASE SUMMARIES

The Insurance and Savings Ombudsman case summaries for 2008 have been released and are available at the ISO's website www.iombudsman.org.nz. We have selected a few cases of interest for brief summary here.

113101

The insured arranged income protection insurance in 2003. In 2006 he made a claim for severe anxiety. After the insurer had declined the claim, an independent psychiatrist confirmed that though the insured was able to work, he was not able to return to his previous job.

The ISO adopted the 2 staged approach propounded in *Edwards v The Hunter Valley Co-op Dairy Co* (1992). The first stage assesses whether the insurer has acted reasonably in forming or declining to form an opinion about whether the claimant meets the requirements set out in the policy definition. If not, the ISO evaluates the medical evidence and makes its own decision. According to the policy, to prove that the insured was eligible for the Total Disability benefit he had to prove: that he was suffering from a sickness, which was the sole reason he was unable to work in his usual occupation for more than 10 hours per week, and he did not continue to receive more than 75% of his monthly average pre-disability earnings.

The Case Manager found that the medical opinion the insurer had relied upon, though focussing on the correct questions, was insufficient evidence to determine the insured's entitlement having regard to the wording of the policy. After independent assessments, it was concluded that the insured did fulfil the relevant requirements, as the policy did not rule out ability to work in any other occupation. The claim was settled.

112271

This case involved a claim for cancer where the cancer was diagnosed and the claim made when the insured was 61 years old and in circumstances where over under the policy ceased at age 60. The insurer declined the claim as the insured's cover had ceased the previous year when D had turned 60, in accordance with the policy. The insured argued that the insurer was under an obligation to notify in writing that the cover had ceased.

The Ombudsman disagreed, given the clear and unequivocal policy wording which constituted sufficient notice, and considered that the insurer had not misled the insured in any way. The claim was not upheld.

112479

The insured had life and disability cover, and made a claim for depression. The insurer accepted the claim, but then advised that it was avoiding the disability cover from inception due to material non-disclosure. The insured had not disclosed his previous use of marijuana and Ritalin. The drug use had been regular but had stopped some 5 to 6 years before the applica-

tion. The insured answered 'no' to the question of had he "ever used...any drug not prescribed by a doctor".

The insured raised the issue of materiality. A fact is material if it would influence the mind of a prudent insurer in deciding whether or not to accept a proposal for insurance, and, if so, on what terms. It is a question of fact, and the onus of proof is on the insurer. 3 independent underwriters, when presented with the facts, had indicated that the drug use would have affected their decision to insure him. The insured's lawyer argued that the insurer would merely have added an exclusion to the policy, but even this is sufficient to show it was material to the insurer. The insurer was entitled to decline the claim.

113247

The insured made a claim under his loan protection insurance policy for lower back injury and disc prolapse. On receipt of medical information, the insurer declined the claim and applied exclusions to the policy for 'lumbar and cervical spine, diverticulitis, migraines and sinus disorder.' The insured had failed to disclose regular chiropractic treatment and a recent visit to his GP for low back pain. The insurer declined his claim and imposed an exclusion for the lower back on the policy.

The Ombudsman reminded the insurer that the primary remedy for non-disclosure is avoidance from inception. There was nothing in the policy or at common law entitling it to decline the claim and add exclusions to the policy. It could offer such an arrangement to the insured, but could not insist upon it as its remedy. Complaint partially upheld.

112620

The insured had arranged disability cover with the insurer through a broker, with benefits to age 60. A claim was subsequently made and accepted under the policy for disability and the insured remained on claim for 7 years. In December 2006 the insurer advised the insured that the benefit payments would soon stop as the policy only covered her to age 60. The insured responded stating her wish to "exercise her option to extend the policy until December 2012". The insurer informed the insured that the option to extend could only be selected at the commencement of the policy, and could not now be altered.

The assessment found that, on the basis of the policy, the insurer was entitled to end the payments at age 60. The insured claimed that she has been misinformed by her broker. Although she had initially expressed intent to be insured until age 65, the broker had stated that he arranged cover to 60 in order to make it affordable for her. She had initialled the offer of cover to 60 and accepted the terms without selecting the extension. It was explicitly stated in the policy that the optional extended benefit only applied if it appeared in the Schedule, which it did not. The complaint was not upheld.

REMEDIES FOR NON-DISCLOSURE

The Australian case of *Robert Virag v United Super Fund PTY Ltd and Hannover Life re of Australasia Ltd* [2009] VCC deals with a group life insurer's remedies if a member breaches their duty of disclosure when applying for additional (underwritten) TPD cover.

Background Facts

The plaintiff joined the superannuation fund in 1999 and was automatically accepted for three 'units' of death and TPD cover by virtue of his employment. In 2005, following an information session with the insurer, he applied to increase the TPD cover from three 'units' to ten. On the proposal he answered 'no' to the question of whether he had suffered any mental or nervous disorder or any disease or injury to the back.

The Claim

The plaintiff injured his lumbar spine in April 2006 and submitted a claim for TPD. The insurer formed the view that there had been non-disclosure by the plaintiff at the time of application for increase in cover and sought to avoid the additional seven units of cover taken out in 2005. Only months before the application to increase was completed, the insured had suffered a muscle strain in his lower back as a consequence of heavy lifting which required a prescription and time off work. The insured has also suffered panic attacks as a result of workplace stress and the stress associated with trying to quit smoking.

The Issues

The central issue in the case was whether the

Australian *Insurance Contracts Act 1984* ("ICA") applied. Having determined that that ICA did apply, the Court turned to determine the question of whether the plaintiff complied with the relevant duty of disclosure (the ICA applying a different standard than the common law) when he applied to increase his cover in 2005.

Discussion and Result

The Court found that it was not satisfied the plaintiff knew, or ought to have known, that his panic attacks and back condition were relevant to the insurer's decision whether to accept risk. It found that the panic attacks were no more than a "normal response" to work stress and attempts to give up smoking and the back condition was a mere "transient episode of back pain."

The remedies available to the insurer had there been a breach of non-disclosure were those found in the ICA. The Court found that the ICA creates a fictional single contract and a remedy to the insurer in respect of that cover. If there is various cover, the insurer must demonstrate that if it had known all the true facts it would not have offered all of the various cover under the policy.

Implications

The Australian Federal Government has released a draft Bill to amend the ICA to ensure that non-disclosure by an existing scheme member will allow the insurer to avoid parts of cover it would not have issued if it had known the true facts.

LATE NOTIFICATION OF CLAIMS

The case of *Arnold v American International Assurance Co (Bermuda) Ltd (trading as AIG Life)* HC AK CIV-2008-404-006987 (4 June 2009) concerned a late application made for Terminal Illness benefits.

Background Facts

The plaintiff and his wife took out a joint life insurance policy with AIG in 1999. The policy included benefits for Terminal Illness. The relevant provision of the policy provided as follows:

Should the Life Insured be diagnosed by a Medical Physician registered with the Medical Council of New Zealand (but excluding a physician who is him/herself the Life Assured, spouse or lineal relative of the Life Assured), as having an illness which is likely to result in the death of the Life Assured within 12 months of diagnosis, a lump sum up to the amount of the Flexi-term Benefit will be paid. Benefit will be reduced by the amount of benefit paid.

Mrs Arnold was diagnosed with a terminal illness in early 2001 and died as a result of that illness in April

2005. The policy had been cancelled at the request of the insured in June 2001, it being common ground in the litigation that the cancellation had occurred after Mrs Arnold was diagnosed with the terminal illness.

The Claim

Mr Arnold submitted a claim for Terminal Illness benefits under the policy in September 2007, more than 6 years after the diagnosis had been made and also more than 6 years after the policy had been cancelled. AIG declined the claim and Mr Arnold sued.

The Issue

The question for the Court in this case was whether or not AIG was entitled to have the proceedings against it struck out (prevented from continuing) on the grounds that the insured was out of time in bringing his claim under the policy. The Limitation Act 1950 provides that a Court action founded on contract (including an insurance contract) cannot be brought after 6 years have expired from the time that the 'cause of action accrues.'

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HOW TO DETERMINE THE COST OF RECONSTRUCTING LOST FILES?

In the recent decision of *WHK (NZ) Limited v Allianz New Zealand Limited* HC INV CIV-2007-425-440 (10 March 2009) the High Court considered what information is relevant in determining the cost of reconstructing lost files.

Background Facts

The case arose out of an insurance claim following a fire at an accountancy firm in which a substantial number of the firm's client files were destroyed. The relevant insurance policy had two parts, the first providing cover for material damage and the second providing cover for business interruption costs. The firm claimed under the material damage provisions for indemnification in respect of the loss of the files.

The Claim

The firm claimed that the damage was to be quantified by reference to the pre-fire costs incurred in creating those files. It claimed that, however it calculated those costs, the costs were substantially in excess of the limit of cover under the policy of \$2.627 million.

Discussion

The insurer however contended that the cost to be claimed should reflect the post-fire cost of reconstructing the files that the firm actually elected to recreate. To that end, the insurer sought discovery of documents evidencing the actual costs incurred by the firm post-fire in reproducing client files. The firm resisted that request on the basis that the post-fire reconstruction figures were irrelevant and the work and cost that would be involved in producing that information would be vexatious and oppressive. It limited the scope of its claim under the policy to reflect only the pre-fire cost of constructing the files. For that reason the Court found the post-fire reconstruction costs irrelevant to the proceedings and so would not make an order for discovery in respect of it.

Result

The matter will now go a substantive hearing to determine whether the insured is entitled to indemnity on the basis of the pre-fire costs of creating the client files.

LATE NOTIFICATION OF CLAIMS

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The critical issue for the Court then was when the cause of action accrued – at the time of diagnosis of terminal illness, or at the time that the claim was notified to AIG.

Discussion

The policy did not stipulate a time within which a claim was required to be brought. In the absence of any specific contractual provision, the provisions of the Limitation Act apply.

The insured argued that a clause should have been implied into the policy to clarify that time did not begin to run for the purposes of the Limitation Act until the insured had notified AIG of the claim. The basis for such a clause was said to be the "invariable practice" in the life insurance industry that claims were not met by an insurer until the insurer had been notified of the event giving rise to the claim.

AIG disagreed that such a clause could be read-in to the contract and argued that the cause of action must have accrued at the time that the diagnosis was made. Otherwise, an insured could circumvent the Limitation Act by simply failing to bring a claim. This would not make any commercial sense.

The Court noted that insurers base their reserves from non-notified claims under life policies on anticipated claims within a limited period of time. These calculations would be extremely difficult if the potential for claims under any given policy was open-ended.

Result

The Court found in favour of AIG and struck out the proceedings. In doing so the Judge noted that "I cannot accept that the parties would have intended to let the insured decide when to bring a claim, regardless of the Limitation Act." The cause of action accrued at the time of diagnosis, not at the time of bringing the claim.

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