

risk *e* business

A L U C A



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A regular Newsletter of the Australian Life Underwriters and Claims Association

ALUCA 2010 CONFERENCE NEWS

The 2010 Conference has its own new logo - a fitting image for the theme.



The conference will be held 23 - 27 October 2010 in the tranquil surroundings of Novotel Twin Waters, Maroochydore, Queensland. Delegates will be able to relax, unwind and concentrate on the topics included in the great program



The Financial Member Only Registration period will open in May - don't forget to make sure your membership subscription is up to date by the end of March!

See inside this edition for further conference news.

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EDITOR'S NOTE

Hi there everyone and welcome to a brand new year, and a big ALUCA Conference year. We are just 7 months away and the programming at the current time is looking like it will be one of the best ALUCA conferences ever. Work has continued on behind the scenes and notifications for early bookings will be sent out in the not too distant future.

As we head into the third month of the year, 2010 has already seen the completion of another highly successful ICLAM Congress. The Congress was held in Cape Town during February, and one of the highlights of the conference was a Keynote presentation provided by the father of Critical Illness, Dr Marius Barnard. I was in the very fortunate position of being able to attend the conference and hear Dr Barnard speak. I also managed to get a picture taken with Dr Barnard, and thought I would share this with you all.



Anyway, on to the March edition of RiskeBusiness, we once again have a terrific edition covering topics across a wide range of professional specialties. The current edition includes articles from members and guests that include the following:

- the winning paper from the annual Turks Claims and Underwriting competition
- Skin Sterol and Cardio-vascular disease Screening
- Tele-underwriting and the best fit for your business
- a Life Insurance Legal Update case study
- our regular "5 Minutes With..." section
- The Burden of Chronic Disease in Australia and the Relevance of Critical Illness Insurance
- a Legal case study on Avoidance of a Policy without a case review from the original underwriter
- and a postcard from an ex-pat based in London for the next few years

I am sure that you will agree, it is another great edition of RiskeBusiness. The ALUCA Committee acknowledges and appreciates all contributors to the RiskeBusiness newsletter and we encourage all members to consider writing an article for publication.

Cheers for now and stay safe.

Matthew Ramjan



ALUCA TurksLegal Scholarship Winning Paper Gavin Lai

Senior Product Manager, Tower Australia

QUESTION 3 – Retail versus Group Cover

The group risk market has increased rapidly in the last few years with the result that for most Australians, group life cover through their superannuation fund now represents their base cover. Is group cover becoming seen as an alternative to individual life cover?

What are the relative strengths and weaknesses from the point of view of the customer of obtaining cover via a group scheme versus an individual life and / or disability policy? What are the problems for the customer with group cover if this is their only form of life or disability insurance?

Your answer should deal with such issues as the relative cost of cover, the flexibility of benefit design and the use of pre-existing condition clauses, guarantees of renewal and so on. We would particularly like you to consider the benefits and pitfalls of using pre-existing conditions exclusion clauses as a means of managing the risks usually addressed in the process of underwriting as part of your answer.

1. Introduction

The past few years have seen a gradual paradigm shift in the insurance market. Often seen as a 'poor cousin' of retail insurance lines, the group insurance market has entered a remarkable growth phase which shows no sign of abating.

The keen insurer interest and resulting competitive tension are the products of increasing engagement from superannuation funds; proof of one unmistakable fact – superannuation fund trustees see the provision of life insurance as an important part of their role as caretakers of members' interests.

The fundamental dynamics of group insurance explain both the current boom, the unique advantages that group cover offers many members who benefit from this cover, and provide insight into how specific 'tools' such as pre-existing condition exclusions have become an integral part of group insurance benefit designs.

This paper explores the reasons behind the current group insurance 'renaissance' period, examines how members have benefited from this boom, and explains how group insurance products incorporate pre-existing condition exclusions in order to manage risk unique to the group market.

As group life arrangements within superannuation funds makes have been the largest driver of group insurance premium growth, this paper concentrates on this sector.

2. How group insurance has come into its own

An examination of the motivations of the main participants in the group insurance market provides an understanding of how and why group cover is not only an alternative to individual insurance cover, but constitutes a thriving individual market segment in itself.

2.1. Consumers

For many people, group cover is not only an alternative to individual insurance cover – it is the only alternative they will ever contemplate. In a recent industry survey, 66% of fund members surveyed did not hold personal insurance outside of super¹, and only about 60% of those members consulted anyone about their insurance cover choices². Since life insurance cover under super is predominantly on an automatic basis (i.e. members receive and pay for a default level of cover without making a conscious decision to elect that cover), it is reasonable to assume that most members would have not life cover at all if not for their mandated group cover.

2.2. Fund trustees

Whilst the provision of benefits upon the death or disability of members has always been part of a super fund trustee's mandate – recently trustees have shown almost universal acceptance of the fundamental importance of life insurance cover as a key component for their product.

¹ IFF & AIST Member Insurance Research, Sweeney Research, Presented for The Superannuation Insurance Symposium, 3 June 2008, page 28.

² IFF & AIST Member Insurance Research, Sweeney Research, Presented for The Superannuation Insurance Symposium, 3 June 2008, page 31.

This trustee focus on insurance has roots in both paternal and commercial values. As trustees' understanding of their members' needs and motivations has evolved, industry action has highlighted the 'underinsurance problem'³ – the widespread gap between members' insurance needs and their actual insurance cover levels – trustees accept the vital role they play as distributors and purchasers (on members' behalf) of life insurance protection.

Competition in the super fund market has seen insurance becoming a product differentiator to attract employers and rollovers, with the quality of a fund's insurance offering forming part of the standard criteria examined by specialist fund rating service providers.⁴

2.3. Insurers

Group risk premiums have experienced annualised growth of 24% each year since 2005, compared to 22% in individual lump sum and 11% in retail disability premiums. These strong performance figures, for both individual and group are remarkable considering the onset of the global financial crisis.

Group & individual total premium growth⁵

	Annual premium increase (%)			
	2005/06	2006/07	2007/08	2008/09
Individual lump sum	13.2%	11.7%	12.6%	15.8%
Individual disability	8.2%	8.4%	9.4%	11.2%
Group risk	10.4%	19.3%	18.3%	25.3%

These figures show the group insurance segment is showing no signs of slowing, and why insurers are competing fiercely to secure group life mandates.

3. Life insurance risks

To understand how group insurance differs from individual insurance, the aspects of group insurance that allow insurers to provide cover on more generous terms than would be available under an individual policy, and the integral role pre-existing condition exclusions play in the facilitation of group coverage, it is useful to establish the key risk factors involved in the decision to accept the insurance risk for a particular person.

The table below comparing group and individual retail risk factors illustrates how both products are based on a different combination of risks, and therefore require a different approach to the mitigation and control of those risks.

Risk factors Group vs Retail

Severity	Higher risk ←	→ Lower risk
Extreme ↓	No medical evidence required	Full health assessment
	Active insurance cover choice	Default, automatic cover choice
	Cover for all causes	Cover for new causes
	Working status not required	Must be working to obtain cover
	Higher cover amounts	Lower cover amounts

Key

RETAIL
GROUP

4. Benefits of group cover

4.1. Price

Group insurance cover is generally significantly cheaper than individual insurance; a 2008 comparison conducted by IFS Insurance Broking found premiums under industry funds to be up to 35% cheaper than under underlying retail premium rates.⁶

³ See IFSA TNS Research Investigating the issue of underinsurance in Australia, 2005, and the IFSA Lifewise campaign.

⁴ See Chant West Fund Ratings, or SuperRatings, for example.

⁵ The Life Insurance Industry Report, Plan For Life, October 2009, Table 4.2.8, In-Force Annual Premiums – Group Risk Business, 4.2.4, In-Force Annual Premium – Individual Risk Lump Sum Business, Table 4.2.5, In-Force Annual Premium – Individual Risk Income Business.

This price comparison does not take into account extra product features which are incorporated into individual life policies and cannot be offered under a group insurance policy.

Group insurance cover is a tax effective method of purchasing life cover, as premiums are paid from concessional taxed superannuation money, and customers pay for premiums from preserved superannuation money rather than being added to the daily budget.

4.2. Accessibility

Group insurance customers enjoy superior access to life cover. Superannuation fund members generally receive cover automatically, and without occupational limitation. In the group insurance context, insurers are able to assess the risk of insuring a group comprised of individuals who would each constitute a risk to great to insure under an individual policy – using information specific to that group (such as past claims) to enable cover to be offered to the members of the group. In this way, a group of underground miners, for example, can obtain cover under a group insurance policy – unlikely under an individual policy.

4.3. Better claim outcomes

At the point of claim, group policy members enjoy the benefit of the following factors weighing the odds against insurers:

4.3.1. Trustees

A fund trustee is bound under trust law and the terms of the superannuation fund trust deed to treat a claimant's interests as paramount, regardless of any commercial relationship the trustee may have with an insurer.

The trustee as policyowner and client of the insurer is in an extremely influential position from an insurer's perspective; this relationship serves to encourage the best possible claims decisions.

4.3.2. Choice of forums

Insurers can be required to deal with complaints from group insurance members in court, in the Superannuation Complaints Tribunal, or the Financial Ombudsman Service. Representation at any of these forums is costly from the insurer's perspective. In addition, the latter two, being non-judicial bodies, are not strictly bound by the doctrine of legal precedent making the outcomes within such forums arguably less certain.

5. Drawbacks of group cover

5.1. Lack of advice

Members who obtain cover through their superannuation fund have likely not received any form of professional advice as to the quality, quantum or suitability of the life cover they purchase. In many cases, the decision as to what cover they receive has been made by the trustee – the trustee determines which insurer to engage, what products are offered, how much cover the member will pay, and to some extent, how much the member will spend on the cover.

Members are also reliant on the trustee to promote and explain the features of the cover, and members do not have the time to compare the terms of the cover against other competitors (a service that any superannuation fund trustee would understandably prefer to avoid).

5.2. Benefit payment

Claims under superannuation are generally more time consuming than under retail. In addition to the insurer's claims assessment process, claims under a group superannuation policy involve an additional assessment process – the trustees' – which has the potential to create further delays.

Trustees must for each claim, even if approved by the insurer, as to whether a relevant superannuation condition of release has been met – which can lead to situations where the insurer assesses a claim and determines payment should be made, whilst the trustee disagrees and refuses to pay the proceeds to the claimant!

Members have less control over the distribution of insurance proceeds within group insurance – superannuation trustees control the distribution unless binding nominations are made (which are time consuming and involved to maintain).

Group insurance benefits are subject to the taxation – only a limited class of beneficiaries such as dependents are eligible to receive life insurance proceeds tax-free. This limitation reduces the options available to members who require flexibility to support their estate planning requirements.

6. Pre-existing condition exclusions

The use of PECs is an effective response to the unique group insurance market requirements, where customers have relatively little contact with their funds let alone the fund's insurance provider.

A key risk for any life insurer is the potential for customers to purchase insurance having prior knowledge of health factors that increase their likelihood of suffering a claim event – this knowledge, if available to the insurer would increase the cost of providing insurance to this member (or dissuade the insurer from providing insurance altogether). Traditionally, life insurers redress this information imbalance or asymmetry⁷ and the possibility of adverse selection by underwriting proposed lives insured – but the nature of the group insurance market has required insurers to offset this risk through alternative means – including the use of pre-existing condition exclusions to set distinct boundaries on the risks assumed.

A pre-existing condition exclusion ('PEC') is a policy mechanism that allows insurers to restrict the risk covered under the policy; allowing the insurer to exclude coverage for any cause which may have arisen prior to the date the cover started. By removing coverage for any cause prior to the date cover starts under the group policy; the insurer is able to remove the need for some information at all – addressing the information asymmetry concern.

Arguably, a PEC forms part of a straightforward, transparent insurance process, whereby the insurer effectively spells out the terms of its acceptance of the life insurance cover. Proposed insured members are given the opportunity to self-assess or self-underwrite their cover, which is less invasive than medical underwriting.

Whilst PECs provide insurers with the required reduction of risk, they are a blunt instrument, and one that is often misunderstood, is difficult to apply, and viewed as unfairly biased toward the insurer.

Claimants are often unaware or have not properly understood the nature of the exclusions applied to their coverage – leading to a poor outcome for members. The fact that PECs are investigated and relied upon at the time of claim creates animosity on the part of members, who view them as a "get out clause"⁸ for insurers seeking to avoid claims.

Members of group policies generally rely on information contained within Product Disclosure Statements (it is rare for members to access an underlying group insurance policy document), which often present technical information such as PEC terms in simplified 'plain English' fashion, which can create confusion – made worse by the fact that most members do not consult a professional when cover is purchased.

The breadth of application of a PEC can further exacerbate negative views of this device. PECs are often based on objective tests, for example, "no cover for disablement arising from a pre-existing medical condition". This creates two potential problems, when applied to the subjective member's perspective.

Was the member aware of the medical condition? The Insurance Contract Act 1984 imports into any PEC an awareness requirement, but the test is based on whether the insured person or a reasonable person in the circumstances would have had awareness. The hypothetical reasonable person test raises the standard of awareness and can have manifestly unfair outcomes from a member's point of view.

What is a pre-existing condition? Sometimes it is extremely difficult to identify whether a condition is suffered after the commencement of cover – and often requires an artificial and often technical dissection of a member's circumstances – a process of reasoning which cannot possibly be expected of members at the point that cover originally commenced.

7. PECs within the group context

The below survey of the top 10 superannuation funds (by membership) indicates the almost universal use of some form of PEC (the exception actually goes further and provides a blanket exclusion for TPD). By analysing the results of this survey, it is clear that whilst the form and expression of PECs under group insurance varies – it is possible to extrapolate the following principles which support the observations above.

7.1. Terminology

"Limited Cover", "New Events Cover", or an exclusion for "Pre-Existing Conditions" will have the effect of excluding coverage for claims arising from injury or illness that becomes apparent or occurs after the date cover commences under the fund.

7.2. Scope

The scope of a PEC can range widely, through a combination of the following aspects:

Exclusion periods: which introduce a window period during which coverage is limited. For example, a PEC may apply for a member who has had a previous TPD claim forever, whilst for a member who receives cover more than 6 months after starting work, the PEC may apply for 12 months.

Review limits: The terms of the PEC itself may limit how far the insurer can apply an exclusion. For example, a PEC may be described as any condition that arising within the 12 month period prior to the commencement of cover under the policy. This can have practical benefits for both insurer (who is not obliged to delve into a

⁷ Akerlof, George A. (1970), The Market for 'Lemons': Quality Uncertainty and the Market Mechanism, Quarterly Journal of Economics

⁸ FICS Adjudication 16495, page 6.

claimant's distant past) and members, who are not expected to recall old events, and who become entitled to full coverage where the increased risk due to a past event decreases with the passage of time.

7.3. Risk factors

Blanket application: The most conservative offering observed provide for PEC for all members regardless of any other circumstances.

Employment: By far the most common risk factor on which a PEC rests is the absence from employment – which support the above proposition that employment is treated as a proxy for good health.

Previous TPD claim: The receipt of a past total and permanent disablement claim is shown under some funds as an risk indicator.

Existence of alternative auto cover: Cover is subject to a PEC under some funds where default coverage is held by a member under another superannuation fund. The risk factor here is possibly the risk that members in poor health will take advantage of default cover arrangements and accumulate multiple cover amounts.

Market survey – Pre-existing conditions

	Fund name	Fund class ⁹	Insurer	When does a PEC apply?	PEC expiry	Cover Type
TOP TEN FUNDS (BY MEMBERSHIP) ¹⁰	REST	Industry	AIG	Limited Cover if when cover starts: 1. Have received a TPD benefit before (and can only receive Basic Cover). 2. Not in "active employment" upon commencement.	Upon return to "active employment" for 2 consecutive months.	DTPD IP
	Australian Super	Industry	CommInsure	Limited Cover if when cover starts: 1. Have received a TPD benefit before. 2. Not in "active employment" upon commencement. 3. Join more than 6 months after starting work.	In situation: 1. Indefinitely. 2. Upon return to "active employment". 3. After 12 months consecutive membership.	DTPD IP*
	Sunsuper	Industry	Suncorp	If a member has automatic cover under another super fund, no DTPD due to Pre-Existing Condition or Illness .	Indefinitely (investigation limited to 12 months prior)	DTPD
	HOST-PLUS	Industry	ING	New Events cover if when cover starts: 1. They are away from work. 2. Are working in a reduced capacity	Upon resumption of normal duties with the employer	DTPD
	AMP Flexible Lifetime Super	Retail	AMP	New Events cover if off work when cover starts.	Return to work performing normal duties for 6 consecutive months.	DTPD IP
	HESTA Super Fund	Industry	ING	New Events cover applies to all default cover.	Indefinitely until underwritten and removed.	DTPD IP
	Cbus	Industry	Hannover	If not in "active employment" then no TPD applies.	Not applicable.	DTPD
	First State Superannuation Scheme	Industry	Metlife	Limited Cover if when cover starts: 1. Have received a TPD benefit before. 2. Not in "active employment" upon commencement.	Not applicable	DTPD
	QSuper	Public sector	TOWER	For all members: During 1 st 2 years: no payment for Pre-Existing Medical Condition . Between 2 nd – 7 th year: Partial payment for Pre-Existing Medical Condition . After 7 years: No restriction	7 years.	DTPD
	MLC The Employee Retirement Plan	Retail	MLC	For all members: No benefit payable within 2 years of becoming a member if due to a Pre-Existing Condition .	Applies for 2 years from joining.	DTPD IP

The market survey above has shown that PEC terms are quite diverse, and insurers appear willing to tailor these terms. This may be in line with assumptions about the underlying risk profile of the group, commercial pressures, or the individual insurer's risk appetite.

⁹ Based on functional classifications summarised by APRA in "Statistics – Classification of superannuation entities", 4 May 2005

¹⁰ Rainmaker, SelectingSuper website, "Super funds with the most members - Largest superannuation funds sorted by their total membership", <http://www.selectingsuper.com.au/Top_10_Size_Membership.html>

8. Conclusion

The need for the wider community to hold life cover is unquestionable, and group insurance plays a fundamental role in providing this cover. Group insurance is built around the proposition that cover can be provided to large group on an automatic basis at low cost, which makes it a viable alternative to members who need some minimum form of no-frills cover.

Provision of cover on an automatic basis maximises the number of members covered, but it increases the risk of adverse selection; risks normally addressed by underwriting in the retail context, and group insurers address this risk through the use of employment as a proxy for good health, limiting the level of cover available on an automatic basis, and the use of liability limiting tools such as PECs.

The rapid growth in the group insurance market, and corresponding competitive tension, as well as increased interest from trustees should see a continued increase in the amount of cover provided to members, as well as continued improvements to the quality of coverage – and if this does not result in the rebalancing more in favour of members with respect to PEC and other risk control terms – the end still justifies the means.



Gavin Lai, Technical Product Manager with Tower Australia, is pictured here at the award presentation in December 2009, with runners up Vanessa Back and Anna Norwood, both from CommInsure.



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Skin Sterol and screening for cardiovascular disease.

Chris Ball
CMO, Gen Re, UK Office

An individual's cholesterol profile measured in their blood is recognised as a risk factor for a wide range of vascular disorders including some of the leading causes of mortality world wide, particularly heart attack and stroke. Clear correlations between the levels of cholesterol in a person's blood and their cardio-vascular risk profile have been established for many years. As a result an applicant's lipid profile is of great interest to insurers and results of tests are routinely sought and ordered where recent tests are not available or concern about medication compliance is present.



The collection of this type of evidence by insurance industry is a source of long and continued discussion. The effectiveness of the application forms, teleunderwriting, doctors' reports and full medicals for identifying risk are much debated, as is the cost-effectiveness of undertaking these screening procedures, particularly when they are invasive. Obtaining tests is inconvenient for the applicant, slows down the underwriting process and costs money. Thus simple, non-invasive tests that give reliable results quickly are much sought after. The Cotinine test is an example of a simple non-invasive test that provides quick results with enough specificity to be of use to the underwriter and at a price that is not prohibitive to the company. Smoking is such an important risk issue that investment in testing is certainly cost-effective. The measurement of cholesterol in the skin (SC), known as 'skin sterol', has been put forward as a candidate to eliminate the need for blood testing. This paper seeks to examine the claims for this test and its usefulness for risk assessment.

Skin Sterol

Large amounts of cholesterol are found in the skin (about 10% of the total body cholesterol) where it is known as 'skin sterol'. The sterol makes skin resistant to the absorption of water-soluble molecules that are likely to be toxic. In addition to keeping water out, sterol helps to keep water in so that loss of water through skin evaporation is limited to about a half to one pint per day.

Cholesterol is excreted primarily as bile salts but the second most important excretion route is through the skin. The skin replaces itself every thirty days, so the skin sterol is not a reflection of short term intake of cholesterol (unlike blood testing) and there is no need to fast before testing (although it should be noted that there is growing evidence that fasting before blood testing does not alter the risk stratification significantly - The Emerging Risk Factors Collaboration 2009).

There are two principal methods for testing skin sterol. The 'point of care' test consists of placing a drop of a synthetic copolymer of horseradish peroxidase and digitonin on the cleansed palm of the hand. After a short incubation period an indicator solution is added and the intensity of the blue colour is read off as a measure of the skin sterol. The test has advantages of being easily available, non-invasive and providing a quick result. A second method consists of sampling the skin by 'tape stripping'. The tape is then sent to a laboratory where the sterol is measured.

How good a predictor of cardiovascular risk is skin sterol?

This is not the place for a detailed review of the ins and outs of risk screening tests but a number of important points need to be borne in mind. The sensitivity and specificity and hence predictive power of a given screening test will be different depending upon the prevalence of disease within a given population. The test must also be shown to be related to some gold standard against which clinicians can judge the utility of the test: this may be a particular test but also an event such as death, stroke or heart attack that the test is aimed at predicting.

Perhaps the most powerful paper that relates SC to a gold standard of angiographically defined cardiovascular disease is that of Sprecher et al (2003). In this study SC was measured and evaluated against those with 50% or more stenosis in their coronary vessels. The SC was higher in those with 50%+ stenosis and it is suggested for every 10 units of SC 7% additional risk was added to the traditional Framingham risk assessment, a finding supported by Mancini et al (2002). The same group found that SC correlated with a

history of myocardial infarction (MI) and could be used as a way of monitoring response to cholesterol lowering therapy (Sprecher et al 2002).

Tzou et al (2005) suggest that SC identifies increased carotid intima-media thickness in asymptomatic adults. The subjects of this study were asymptomatic but were referred for investigation of their coronary artery thickness and were not a random population sample. 81 subjects were assessed and the skin sterol was found to be associated with increased carotid intimal thickness after adjusting for the Framingham risk score. This study was extended in a way to address concerns over the sample size (Stein et al 2008) to include 565 subjects. A high level of skin sterol (>110 U) was associated with a 2.2 fold increase in risk of carotid intimal thickness above the 75th centile and a 2.5fold increase in the odds of having a carotid plaque. The authors argue that SC was a better predictor of intimal thickness and the presence of plaques than total blood cholesterol and similar to other well recognised risks for cardiovascular disease. The data excluded a set of results because all the variance in the results was attributable to a single operator. This highlights the importance of ensuring that the tester has proper technique.

Reiter et al (2007) reach a different conclusion. They were unable to demonstrate any relation between skin sterol and the presence of either cerebrovascular disease (including carotid disease) or peripheral vascular disease. In an earlier study the same team (Reiter et al 2006) measured the SC against a number of biological and clinical measures related to cardiovascular risk. Whilst the test itself performed with good precision, no significant link could be identified between the SC in subjects that had clinical or biological indicators of risk and those who did not. Neither univariate analysis nor multiple regressions identified a significant influence of age, sex, serum lipids, body fat status, smoking or diabetes mellitus on SC. Unlike Sprecher (2002) they were unable to use the SC to distinguish between those with and without a history of MI. The authors concluded that 'the perception of this parameter as an established marker of vascular disease is premature'.

Vadiya et al (2003) noted that where the subject was Caucasian SC is higher in those with calcium in their coronary arteries but not in Afro-Americans. The subjects were recruited from a multi-ethnic study of atherosclerosis.

The Prepare study (<http://www.theamu/events>, <http://www.americanheart.org/presenter.jhtml?identifier=305582>) is of most interest as it recruited from a population of Americans who were applying for life insurance. The study was large with over 9000 participants. The principal findings of the study were that: (1) the SC levels correlated with the Framingham risk score in smokers but not non-smokers, (2) SC was correlated with the total cholesterol:HDL ratio (once again the correlation was most marked in smokers), (3) smokers with an elevated SC are likely to have other markers of cardiovascular risk and (4) smokers with a low SC are likely to have similar cardiovascular risk factors as non-smokers.

The authors suggest that SC measurements could serve as trigger for engaging in greater exploration of risk particularly where the applicant also has a +ve Cotinine test. Blood testing could be targeted where it is most likely to produce useful information. The second suggestion is that those with a low SC could be automatically 'screened in' to a better risk class with preferential rates. Only 4% of these would have an TC:HDL ratio of >6. This would produce more competitive pricing.

Conclusion.

The question arises as to why there is relatively little use of this technology in clinical or insurance practice. The SC testing has regulatory approval in the US, Canada and Europe for use in risk assessment.

The main manufacturers of the test suggested well over 500 million cholesterol tests are performed each year worldwide so there is certainly a market for this type of testing. Near patient testing has a number of advantages with all tests performed at one time, and they can be relayed electronically directly into smart underwriting systems. SC testing meets many of the criteria for this sort of testing. The test is non-invasive, can be read on the spot and does not need the applicant to fast so there are many attractive features to the process. However insurers' interest can often extend beyond their applicant's lipid profile. Most blood tests will include a range of measures to explore the risk profile that cannot be measured in any other way (renal function, blood sugar, inflammatory markers etc). As these systems are well established and relatively cheap there is little incentive to change current practice.

Many studies of SC testing are supported by the principal manufacturer of the tests. There are often concerns, however unjustified, that industry sponsored trials are likely to present with positive results which,

coupled with a perceived bias amongst journals to publish only positive studies, frequently leaves the medical profession sceptical of new technologies (Bekelman , Li & Gross 2003, Barbui et al (2004)).

The cause is not helped by the negative findings of an independent study (Reiter et al 2007). The majority of the studies presented are in clinical populations where the prevalence of problems is likely to be raised. In this circumstance screening tests tend to work better than in the more general population.

Perhaps however the main issue is that the use of SC screening as yet is not supported by any long term outcome studies. The data so far looks at the relation between the SC and other markers of risk not the risk itself. This is clearly a good place to start and there is little point in continuing to support a programme that does not have this kind of validity. Compare the studies above with a recent review of traditional lipid screening incorporating 302 430 subjects with 2.79 million person-years of follow-up during which there were 8857 nonfatal myocardial infarctions, 3928 coronary heart disease deaths, 2534 ischemic strokes, 513 hemorrhagic strokes, and 2536 unclassified strokes (The Emerging Risk Factors Collaboration 2009). This is not to say that in time evidence over the long term of the utility of SC as a risk predictor will not accumulate, merely that it is not there yet.

The measurement of SC is potentially an important tool in the assessment of cardiovascular risk both in the clinical sphere and for insurance companies, but there remains some way to go before the data available supports its routine use in the measurement of cardiovascular risk.

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This information was compiled by Dr C J Ball and is intended to provide background information to our clients as well as to our professional staff. All the information that is contained in this article has been very carefully researched and compiled to the best of our knowledge. Nevertheless, no responsibility is accepted for its accuracy, completeness or currency. In particular, this information does not constitute legal or other professional advice and cannot serve as a substitute for such advice.

Chris Ball studied medicine at the Middlesex Hospital Medical School in London, qualifying in 1983. His initial training was in Primary Care Medicine followed by specialist training in psychiatry. His current Consultant post is with the South London and Maudsley Foundation Trust. His association with GenRe is now over ten years with the initial preparation of first Long Term Care Underwriting Manual and he has been CMO with the company for the last seven years. He has written extensively on mental health and insurance matters as well as running seminars at industry meetings.

Tele-underwriting – What is “Best Fit” for your Business

Vanessa Dobson
Underwriting Development Manager
Munich Re



Emerging from the shadows

It would seem fair to say that the humble underwriter has undergone a slow but steady evolution over the past 15-20 years. Once described as ivory tower-dwellers participating in secret handshakes and consulting hidden manuscripts, the modern Underwriter appears almost like a different species. And whilst a scant few of us may not have heard this first-hand, we are all probably aware that from the adviser's side of the fence the underwriter was considered a member of the BPU (Business Prevention Unit). Slowly, but surely, the ivory tower crumbled away - underwriters began calling advisers to “discuss” underwriting decisions, underwriters were included in adviser gatherings to educate advisers in how the underwriting process worked, field underwriters began travelling far and wide to visit advisers and their clients to offer advice and assistance, and some insurers even allowed advisers to visit the underwriters in their offices to discuss cases. All of which would be enough to make some Chief Underwriters of years past turn in their graves (metaphorically, of course).

And now, we have the latest metamorphosis of the underwriter – the tele-underwriter - calling the applicants directly to discuss aspects of their applications, or even to collect the entire personal statement over the phone (effectively removing the adviser from this part of the overall risk transaction process). It is clear that tele-underwriting is set to remain as a key ingredient in the underwriting process. How did we arrive at this point, what are the trends in this space, and can *any* underwriter become a tele-underwriter?

Unless one has been closely involved with tele-underwriting and/or tele-interviewing, chances are overhearing conversations amongst colleagues involving phrases such as “Big T” and “Little t” may be a trifle confusing. Tele-underwriting is not a new concept and has been practiced in the US for many years and in the UK for several. It is also now firmly in place within the Australian market (with a few insurers employing this practice in a limited way for over 10 years), but there are different types and varied approaches to the use of this tool. Let's take a closer look at the terminology first:

‘Little t’ An application form (either paper or electronic) is completed by an applicant. If necessary, the applicant is later called by a tele-underwriter to obtain more detailed information regarding certain medical conditions, occupational duties, pursuits or other relevant material - thus avoiding the need for paper questionnaires to be sent to the applicant for completion and, very often, replacing the need for a doctor's report (PMAR). In the current Australian market these types of calls are typically made by in-house underwriters.

‘Big T’ The personal statement section of an application is completed by the applicant “over the phone” (within some electronic underwriting offerings an applicant can opt to pass their case on to a tele-interviewer very early in the process). The applicant is interviewed via telephone by a qualified nurse, trained underwriter or tele-operative who asks all of the questions within the personal statement. Each of these professionals brings their own expertise to this role, and it is important the insurer determines which preference most suits their business needs.

“The concept of Big 'T' is ... designed to remove the responsibility from the intermediary in asking sensitive health and lifestyle-related questions and to assist in the drive for straight-through processing, a critical success factor in today's competitive market.”¹

¹ Paul Gyseman, Chief Underwriter, Munich Re UK, <http://www.ifaonline.co.uk/cover/feature/1300185/the-secret>

Benefits of tele-underwriting

“Tele-underwriting is the key in helping keep non-disclosure to a minimum”².

Many of us will be familiar with the stated benefits of tele-underwriting: the evidence of increased disclosures from the applicant as compared to a traditional paper application, the costs saved by the insurer (largely due to less PMARS being requested), a more efficient end-to-end process gained by reducing the time cases spend in suspense, plus the wide support of this tool (particularly the Little t model) from advisers. An interesting by-product of tele-underwriting is that more policies tend to complete because “not-proceeded-with” (NPWs) cases are less likely to occur – possibly due to the speed with which policies are completed. Another factor, perhaps a little less widely-known amongst those performing the tele-underwriting, is the impact their activities have on reinsurance premiums. Some reinsurers offer premium-discounts to insurers who implement tele-underwriting due to the confidence placed in the higher-quality disclosures. Additionally, the impact of a recorded tele-interview on claims management is very significant. A leading UK tele-underwriting service provider stated in early 2009 that they “still have zero contested claims on the 65,000 interviews completed to-date”³.

When examining any business process to assess how it compares to a “best-practice” model, there are, by necessity, several factors which need to be measured. In the tele-underwriting process the use of voice recording, plus scripts and rules for the tele-underwriters may all be observed and measured. The comprehensiveness of the information obtained by tele-underwriters can also be quantified by means of determining whether or not all the necessary questions were asked - and sufficient answers to those questions obtained. However, can significant factors such as the building of rapport with an applicant, and the tele-underwriter’s ability to manage the conversation be measured?

It is likely that most of us have experienced a telephone conversation with a tele-marketer, or salesperson, which has been clumsy, awkward, and irritating. On rare occasions we may be surprised by a pleasant, fairly seamless, and satisfactory conversation with a good outcome for all involved. The content of the above conversations may have been identical, however, the *experience* was far from similar.

In addition to the positive experience, however, is the necessity for the underwriter to arrive at an appropriate assessment based on the disclosures obtained during the interview. This requirement will, by necessity, require some re-training of the underwriter. Due to the unique nature of an applicant’s personal and/or medical history, the tele-underwriter will be required to respond to an applicant’s disclosures by asking the most relevant questions. These drilldown questions (and the answers given) will not necessarily neatly correlate to existing underwriting manuals. Most underwriting manuals provide decision-making guidelines based on the clinical diagnosis of a condition, rather than the symptoms, treatment and/or interventions an applicant will disclose to the tele-underwriter.

As more and more insurers commence tele-underwriting and tele-interviewing, it would seem that the main differentiator between companies will not only be the technology and/or the process behind the scenes – but the skills and qualities of the individuals making the calls. The financial outlay for implementing a tele-underwriting process is considerable, and if it does not include funds earmarked for the training of the tele-underwriters then a company may experience significantly less return than expected on their investment. Whilst generally distribution channels have been positive and welcoming of the tele-underwriting process, a valid concern raised by advisers was that of “*poor quality interviewers alienating the customer*”⁴. An adviser will not want to hand over a hard-won case to a team of tele-underwriters in whom he or she lacks confidence.

Whilst the proportion of advisers who have experienced tele-underwriting appears to be steadily increasing each year, it is our experience, to date, that the take-up rate amongst advisers of the “Big T” model has been relatively low. Effectively, a tele-interviewing service allows the adviser to focus his or her energy on the aspects of the application process which require the adviser’s particular expertise – providing financial advice. The time-saving afforded the adviser also allows opportunity for more clients visits, hence more

² Financial Ombudsman Service, UK, 2008. <http://www.soa.org/professional-development/archive/2009-san-antonio-tele.aspx>
“Teleunderwriting - A Global View”

³ Morgan Ash, Winter 2009 Newsletter, available at www.MorganAsh.com

⁴ “Teleunderwriting – A Global View”, Susie Cour-Palais, Society of Actuaries Fifth Annual Teleunderwriting Seminar February 2009.
www.soa.org/professional-development/archive/2009-san-antonio-tele.aspx.

sales. Even allowing for the fact that there is a particular breed of adviser who will not relinquish control of any part of the application process to an insurer, it is our opinion the significant service provided by an insurer via tele-interviewing requires more aggressive positioning to the sales force.

Best fit

Of course, an insurer may choose to outsource all of the required tele-underwriting and/or tele-interviewing to a third-party. With experienced people, and processes, already in place these providers can allow an insurer to move into this space with relative ease. It would appear prudent that those in charge of determining the underwriting philosophy and risk appetite of an insurer should firstly identify which stage of the underwriting process they most wish to make gains in. This will assist in directing the type of tele-underwriting and/or tele-interviewing the insurer chooses to engage in, and whether or not it can be performed in-house utilizing the talent and experience of professional underwriters. If we observe our colleagues in the UK and the USA, the use of a combination of in-house tele-underwriters and external tele-interviewers appears to be commonplace.

It would appear that simply implementing in-house tele-underwriting in our businesses, without investment in the appropriate training of those employed to perform this valuable task, would be short-sighted. Given the documented benefits of an excellent tele-underwriting process – the cost savings, the support from distribution channels and reinsurers - the time and effort spent in ensuring tele-underwriters are provided with the best tools to empower them in their endeavours should prove worthwhile. Tele-underwriting requires an extension of an underwriter's existing skill set and, in some cases, acquiring a completely new set of skills – such as building rapport with applicants and conversation management. Some underwriters naturally possess these skills, but many do not, and, understandably, the idea of calling applicants directly to discuss their lifestyle and/or medical history may leave some underwriters wondering if they are somehow being punished! Confidence may be the key factor here. Conversation management, of course, is of particular importance when it comes to responding to applicants who state that they “do not know” the answer to a specific question. An essential factor which needs to be addressed in this scenario is the potential for the underwriter to “lead” the applicant by inappropriately probing further, or by offering suggestions to the applicant as to what the answer might be. In addition, a skilled underwriter will be alert to any other relevant material the applicant may disclose during the course of the telephone conversation. By providing underwriters with the best environment in which to learn more interviewing skills, and to receive expert guidance on how to build rapport and manage a conversation, should both raise the underwriters' level of confidence and minimize opportunities for the underwriters' actions to impact on the insurer's potential exposure.

In addition to service providers such as UHG, with their team of professional callers, several other national companies provide specialized training in cognitive interviewing skills and questioning techniques and will tailor their workshops to meet the needs of individual clients.

Whichever path an insurer decides to take, it is necessary that tele-underwriting fits in with the insurer's existing processes. For best results, it is also paramount that ongoing review and analysis of the tele-underwriting process be prioritized. Like any business measure, improvements can always be made - but great improvements are usually made following a great understanding of the measure in question.

It is MRA's intention to host a Tele-underwriting Workshop during the first quarter of 2010. The workshop will concentrate on skill-sets and interviewing techniques, plus legal opinion and industry trends. Further details will be released shortly. For any expressions of interest, please contact Vanessa Dobson (vdobson@munichre.com).

Vanessa Dobson (Underwriting Development Manager)

Following the completion of a Bachelor of Arts degree, Vanessa began her underwriting career in 1995 with an international direct insurer in Wellington, NZ, prior to moving to Sydney in 2000 where she remained within the direct insurance market. Commencing employment with Munich Re Australasia in July 2003, Vanessa worked within the underwriting team providing risk assessments and conducting underwriting reviews for MRA clients. Vanessa's current role as Underwriting Development Manager primarily involves managing MRA's automated underwriting approach, assisting MRA's clients with electronic rules-based underwriting and analysis, and studying the process and impact of tele-underwriting in our market.

Life Insurance Update – Christmas Came Early for Telstra Super

Gerry Davies
Partner, Moray & Agnew



Construction of deed – Member not eligible for TPD benefit as not continuously absent from work for 6 months at date of cessation – Trustee gave matter real and genuine consideration – Date of assessment

Telstra Super Pty Ltd - v - Finch [2009] VSCA 318 (23 December 2009)

INTRODUCTION/ SUMMARY

In November 2008, we reported on the decision of Byrne J of the Victorian Supreme Court in *Finch v Telstra Super Pty Ltd* [2008] VSC 481, concerning a TPD claim by Alan Finch who had undergone two bouts of gender reassignment surgery (male to female, then female to male). Finch succeeded at trial in his claim that he was TPD when he left Telstra, notwithstanding the fact that he worked at Foxtel and Qantas after leaving Telstra.

On 23 December 2009, the Victorian Court of Appeal unanimously overturned Byrne J's decision. It found that, *inter alia*, Finch was required by the terms of the deed to have been continually absent from work as a result of disablement for a period of six months while he was an employee of Telstra. Byrne J had concluded, to the contrary, that it was sufficient for the continuous absence to have taken place at the date of the trustee's determination.

FACTS

Finch was born a male, named Alan. He underwent gender reassignment surgery at the age of 21.

In 1992, Finch commenced employment with Telstra as a female, named Helen. He commenced sick leave in 1996, after experiencing dissatisfaction with his female sexuality and reassuming a male personality. Some months later, he returned to work at Telstra as a male, named Alan. He then underwent the necessary surgery to effect the detransition to his original sex.

In September 1997, Finch was successful in obtaining another position at Telstra Mobilenet which was to commence in December. This position was not taken up by Finch.

In January 1998, Finch accepted a redundancy and ceased employment with Telstra, at the age of 30. The evidence indicated that Finch was very depressed at this point.

In February 1999, Finch commenced full time employment as a male with Foxtel, but resigned within weeks for 'personal reasons'. In November 1999, he commenced employment as a male with Qantas, working 20 hours per week before increasing his hours to 24 hours per week.

In May 2000, Finch's employment with Qantas was terminated in unusual circumstances. Finch encountered a male employee with whom Finch had been intimate when he was Helen. This was a traumatic experience for both men. Finch received death threats and was left psychologically devastated.

TPD CLAIM

When his Qantas employment was terminated, Finch submitted a TPD claim to the trustee of the Telstra Super Scheme. The deed provided that Finch was entitled to the benefit if he ceased to be an employee of Telstra because of TPD.

To meet the TPD definition, Finch had to establish disablement as a result of which: He had been continuously absent from all active work for at least 6 months; In the trustee's opinion, he had ceased to be a Telstra employee and was unlikely ever to engage in any gainful work for which he was reasonably qualified by education, training or experience.

Finch submitted reports from 3 psychiatrists who were unanimous in their view that Finch was unlikely ever to work again due to a severe psychological condition.

The trustee obtained statements from two of Finch's managers at Telstra who indicated that '*at the time of separation Mr Finch was fit for duty and not a TPD candidate*'. The trustee also relied heavily on the fact that Finch obtained employment at Foxtel and Qantas after he ceased working at Telstra.

The trustee declined the claim on the basis that: Finch was capable of performing his normal duties; Finch had been the successful applicant for a position with Telstra Mobilenet; and Finch had obtained employment with both Foxtel and Qantas demonstrating that he was capable of gainful work.

Finch subsequently submitted evidence supporting the proposition that his work with Foxtel and Qantas was a failed rehabilitation effort. However, the CEO of Telstra Super informed the trustee's claims committee that Finch had informed him that Finch's employment with Qantas had been a '*real job*'. This prompted the trustee to decline the claim on the same grounds.

TRIAL JUDGE'S DECISION

Finch issued proceedings seeking a declaration that the trustee's determinations were void.

Construction Point

The trustee argued that Finch's claim must fail based on the terms of the deed which required Finch to have ceased to be an employee because of TPD. According to the trustee, this meant that TPD must have existed in January 1998, when Finch ceased employment with Telstra. The trustee argued that Finch had not, prior to ceasing employment with Telstra, been continuously absent from work for 6 months, as required by the TPD definition.

Byrne J found that Finch was not required to have been continuously absent from work for 6 months, prior to ceasing employment with Telstra. It was sufficient for the continuous absence to have taken place by the time of the trustee's determination.

Good faith and genuine consideration

Byrne J found that it was open to a reasonable trustee to conclude that the plaintiff's ability to obtain employment with Foxtel and Qantas demonstrated that the prognosis of the psychiatrists was not borne out by experience.

Nevertheless, his Honour found that the determinations were void as the trustee failed to decide the question in good faith and to give the question genuine consideration. He stated that: The trustee made no inquiry as to the circumstances of Finch's last months at Telstra, aside from the bald statements of the managers. In particular, the trustee did not invite Finch to provide his own harrowing account.

The trustee too readily concluded that Finch's success in obtaining work at Foxtel and Qantas demonstrated that he did not meet the definition of TPD, without inviting Finch to comment on whether this work was merely a failed rehabilitation attempt.

COURT OF APPEAL'S DECISION

The Court of Appeal unanimously overturned Byrne J's decision.

Construction Point

The Court of Appeal found that Finch was required by the terms of the deed to have been continually absent from work as a result of disablement for a period of 6 months while he was an employee of Telstra.

Finch had not been continuously absent from work for 6 months at the time he ceased employment with Telstra, as required by the TPD definition. According to the Court of Appeal, it followed that he did not cease to be an employee of Telstra because of TPD, as required by the deed.

Finch argued that this construction of the deed could produce absurd or illogical results. For example, if a Telstra employee had a catastrophic accident which led to immediate cessation of employment, the employee had no entitlement to a TPD benefit. The Court of Appeal did not consider that this construction of the deed would necessarily produce absurd or illogical results, as the deed reposed a discretion in the trustee and the employer to waive the six month absence requirement.

Good faith and genuine consideration

In light of this conclusion on the construction point, the trustee's appeal succeeded regardless of any deficiencies in its determinations. Nevertheless, Hansen AJA also expressed his views on whether there were any deficiencies in the trustee's determinations.

Hansen AJA found that Byrne J erred in concluding that the trustee failed to give the matter real and genuine consideration. While this aspect of the decision turned on the facts, Hansen AJA concluded that there was nothing that required the trustee to make the further investigations which Byrne J considered to be necessary. Further, he found that it had not been demonstrated that any gaps or errors in the trustee's information were sufficiently extensive to give rise to an inference that the trustee did not give real and genuine consideration to the exercise of its discretion.

In reaching this conclusion, the following important points arise from Hansen AJA's judgment:

'... the mere fact that a trustee makes an error as to a fact or some other matter or does not make all inquiries that may have been open to be made is not sufficient reason for the Court to set aside a determination that was made in good faith, upon real and genuine consideration and for a proper purpose.'

Hansen AJA did not accept the contention that the trustee's reliance on the fact that Telstra had itself accepted Finch for another position within the company was inappropriate. His Honour held that it was relevant as it indicated that Telstra regarded Finch as being capable of working as at the time he left the company, which was relevant to assessing his future prospects of working;

Hansen AJA stated that, although the trustee's reasons in its letter declining the claim did not strictly follow the wording of the definition in the deed, they did not obscure the relevant issue.

Relevant Date

Hansen AJA noted that Byrne J had stated that the unlikelihood of a return to work must be assessed at the time of cessation, although the assessment may have regard to events subsequent. Byrne J had cited *Maciejewski v Telstra Super* and *Heitman v Guardian Assurance*

Co in support of this proposition. Byrne J's approach was also consistent with the approach of Brereton J in *Halloran v Harwood Nominees*.

While noting that nothing turned on the point, Hansen AJA appears to have taken issue with Byrne J's position on this point. Hansen AJA stated that:

'... it is artificial to characterise the trustee's opinion as one assessing the unlikelihood at the time of ceasing employment. In my view, the trustee must consider whether, as a result of the disablement, the member has ceased to be an employee and is unlikely to engage in gainful work. The trustee's task is to make an assessment as to what is likely in the future, but taking into account past events for that purpose.'

CONCLUSION/ IMPLICATIONS

The decision illustrates that, depending on the wording of the deed, a member may be precluded from recovering a TPD benefit if the member has not been continuously absent from work for 6 months at the time of cessation of employment.

The decision also provides some comfort to trustees that a soundly based decision will not necessarily be set aside due to relatively minor procedural or linguistic oversights. However, the decision is unlikely to put an end to the debate as to the date of assessment in terms of assessing future employability.

Gerry Davies is the national head of Moray & Agnew's Life Insurance practice group. He advises on the full spectrum of products, including income protection, TPD, trauma, term life and personal accident.

Prior to joining Moray & Agnew, Gerry was an in-house solicitor at AXA where he specialised in life insurance claims. Insurers commend Gerry for "quality of advice", "accessibility" and for "achieving the best possible outcomes".

Gerry also provides up-to -the-minute bulletins to the life insurance industry on key legal developments, as well as internal training which is tailored to the particular insurer's needs. Gerry can be reached on 03 8687 7325, or at gdavies@moray.com.au

The logo for IMO, consisting of the letters 'i', 'm', and 'o' written in a large, stylized, cursive font. A small 'TM' trademark symbol is located to the upper right of the 'o'.

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5 Minutes with...

Andrew Hagger
Director and Executive General
Manager, MLC



1. What was your first job?

David Jones, in the glassware, chinaware and silverware section. I was in high school, and the money helped pay for my social life and what was, I thought at the time, a trendy wardrobe.

2. What has been the worst employment in your working career and why?

I have been blessed not to have had any bad jobs.

3. Apart from your current role, what has been the best job you ever had and why?

I enjoyed an amazing run at PricewaterhouseCoopers over a 20 year period, working in nearly 40 countries and being involved in some tremendously exciting assignments. My time in East & Southern Africa, in the early 1990s, stands out to me many years later as it was very rewarding to see the positive impact of some of the projects I worked on upon the everyday lives of African people.

4. How long have you been involved in the life insurance industry and in what capacities?

I began only recently in the industry when I was appointed by Steve Tucker to be the executive general manager of MLC's insurance business in May 2009, and that same role has expanded through our acquisition of Aviva.

5. In your eyes, what have been the highlights and lowlights in the industry during your tenure?

The highlight is that the industry is on the move. Technology, Consolidation, Investment, Innovation - just consider how they're all changing the insurance industry landscape as we know it! There are many examples of fresh initiatives across the industry, both big and small, over the past 12 months. A highlight for us at MLC has been the launch of Best Doctors as a service accompanying our Critical Illness product, and winning the Life Insurance Company of the year, based on our proven sustainability. For me personally, there have been no lowlights.

6. What do you see as the main challenges that will be faced by life insurance companies in the future?

The biggest challenge will be to make the right choices - whether that be in underwriting, product development, recruitment & development, technology advances, process improvements, etc - in a way that increases our ability to provide affordable insurance in a sustainable way for more Australians. We will also need to continue to navigate the regulatory environment and legislative frameworks.

7. What effect do you see the current global financial crisis having on the industry, both now and in the future?

The industry has been shaken and stirred in Australia, but has remained pretty resilient through the GFC. We all know that, at times of crisis, any imprudent decisions of the past (eg in product features, pricing or simply poor underwriting) come home to roost, and serves as a reminder that our competitive steps in this industry should be founded on logic, value, creation and sustainability. The industry is at its best when these critical elements are balanced, giving our customers and our shareholders truly sustainable value

8. How do you see advisors and technology working together into the future? Do you believe that electronic processing of underwriting and claims will assist or hinder the industry?

I am a big believer in technological progress. I think that we'll see very major changes in technology in our industry over the next 10 years, and these will go hand in hand with the deepening of the professions of Underwriting and Claims. And that's exciting for the industry and exciting for our clients.

9. What value do you place on professional qualifications for underwriters and claims assessors?

High Value, naturally. Once upon a time, just before I was admitted to the partnership of PricewaterhouseCoopers, I spent two years part-time gaining a Masters of Applied Finance because I knew I needed more skills and education to be the best I could be. The value is all in the operationalising of the qualification, and if there is a spectrum of "those who have a quest for qualifications" and "those who can meaningfully operationalise their qualification", it's pretty obvious which end of the spectrum I go for.

10. In your view, how important are the underwriting and claims functions, particularly in this tough economic environment?

Every part of our business is important, and even more so during tough economic conditions. We are honoured in the Life Insurance industry to have a truly noble purpose. It's during these tough times, when our customers turn to us in their time of need. If we don't manage our underwriting prudently and our claims management processes are not there for our customers, then we are not delivering on our purpose.

11. What can we do in underwriting and claims to increase our professionalism?

This is the golden question that Frank Lombardo and I had the pleasure of putting to Tracey Crowe when appointing her as our Head of Professional Development in addition to her Chief Underwriting role. I come from 20 years in professional services, and it was clear very quickly on coming into the life insurance industry that Underwriting and Claims were quality professions. Like all professions, they need investment and hard work to attract and develop quality people. Tracey's plans for MLC staff are fantastic and I'm very excited about how we are going to deepen the professionalism of Underwriting and Claims at MLC. We want to ensure it's the best place in the industry to grow and develop, and we're determined about that.

12. In your view, how important is it to continue education, training and development of staff even when the economic situation is placing pressure on budgets?

Vitally important! In fact, our plans are not just to continue, but indeed, to "up the ante" through the initiatives Tracey Crowe and our team are putting together.

13. If you were ALUCA president for a day, what would you do to enhance ALUCA's service to its members?

I'd spend 60% of the day talking with the members in small groups to seek their ideas, and I'm sure that, through their feedback, they'd put me on the right track for what to do with the remaining 40%!

Andrew Hagger is the Executive General Manager, Insurance, and is a Director of MLC. As EGM, Insurance, Andrew is responsible for all of MLC's Underwriting, Claims, Administration and insurance product development.

Andrew joined the NAB group in 2008, after serving 21 years at PricewaterhouseCoopers in a number of capacities, including as Melbourne Managing Partner, and as a member of PwC's Firmwide Leadership Team.

He is currently Chair of the Olivia Newton-John Cancer & Wellness Centre Appeal Committee, and is on the boards of the Melbourne International Jazz Festival and the Centre for Books, Writing & Ideas. Previously, Andrew was a board member of The Global Foundation and of the Christian Schools Association.

Andrew has a Masters of Applied Finance degree (Macquarie University), a Bachelor of Economics degree (University of Adelaide) and is an Associate of the Institute of Chartered Accountants in Australia.

Andrew is married to Pam and has three children. He has a keen interest in sport, music and the arts.

The burden of chronic diseases in Australia and the relevance of Critical Illness insurance

Aamer Fattah
Medical Scientist & Researcher
Life Insurance, Sydney, Australia.



Preamble

In a healthcare setting, a critical illness may be defined as being (or relating to) a disease or health condition involving a danger of death of the affected patient.

A critical illness may follow an 'acute' clinical course, characterised by a sudden onset of symptoms followed by rapid deterioration, then resolution within a brief timeframe (usually days or weeks). For example, a patient may suffer a 'minor' heart attack with relatively mild symptoms, indicating several days of hospitalisation and further medical follow-up in an outpatient setting.

Critical illness could also follow a 'chronic' course, with a relatively longer duration of symptoms (typically months to years), or a frequent recurrence of symptoms over a long period of time, often with a slowly-progressing escalation of symptoms to reflect the increasing seriousness of the underlying physiologic disease process.

When an initial critical illness follows a chronic course, it may be described as a 'chronic critical illness', which is not necessarily synonymous with 'chronic disease'.

Following the same example provided earlier and notwithstanding that the initial heart attack was relatively minor, the same patient could develop serious health complications due to a co-existing and longstanding medical condition, such as chronic obstructive pulmonary disease (COPD). In such cases, a patient would require more intensive medical care for a longer duration of time, possibly involving multiple medical procedures and a relatively longer length of stay in hospital.

In contrast to a specific and brief critical illness 'episode', chronic medical conditions follow a slowly-progressing course of variable duration, usually with an increasing burden of symptoms spanning several years. The 'chronic disease' label is typically used to describe a broad range of degenerative invasive diseases, certain infections, some mental health conditions and longstanding inflammatory processes.

It is important to note that a chronic medical condition could (following a variable period of time) trigger an acute critical illness event. On the other hand, an acute health condition could initially emerge as an episode of critical illness and persist as a longstanding (or chronic) critical illness or disease.

The burden of chronic diseases in Australia

The *Australian Institute of Health and Welfare* (AIHW) describes chronic disease as an illness or health condition characterised by:

- Complicated relationships between cause and effect,
- Several pre-disposing risk factors,
- Long duration of 'latency', being the time interval between the initial onset of disease and the appearance (or exacerbation) of symptoms,
- Long duration of illness, and
- Causing impairment of functions and disability.

On the 16th of November 2006, the AIHW released a detailed report titled '*Chronic diseases and associated risk factors in Australia, 2006*', which elucidated certain patterns of chronic diseases in Australia and the prevalence of specific risk indicators (such as smoking or obesity) in context of different age groups, geographical locations and socioeconomic factors.

Chronic diseases are very common in the Australian population, a trend that reflects the inherently long-term duration of such health conditions. Following analyses of data from the *National Health Survey* of 2004-2005, the AIHW found that 77% of all survey respondents were affected by at least one long-term health condition, which was defined as a condition that had lasted (or was expected to last) for at least 6 months.

When the AIHW analysed responses from only people aged 15 years and over, the prevalence of at least one chronic condition increased to 86%. It was noted that such diseases could also be problematic in younger Australians, with approximately 10% of children aged 14 years and under reported to be affected by three or more chronic health conditions.

The AIHW found that certain chronic health conditions posed a significant burden of disease in Australia in terms of morbidity (the incidence of disease or 'rate' of sickness), mortality (the proportion of deaths in the population) and economic impact.

Twelve health conditions were highlighted as significant contributing factors to the burden of chronic disease in Australia, whilst also being amenable to preventative health measures:

- Ischaemic heart disease (IHD)
- Stroke
- Lung cancer
- Colorectal cancer
- Depression
- Type 2 diabetes mellitus
- Arthritis
- Osteoporosis
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Chronic kidney disease (CKD)
- Oral disease

Not unexpectedly, certain chronic diseases were found to affect a relatively greater proportion of Australians at old age, including conditions such as IHD, stroke, Type 2 diabetes mellitus, osteoarthritis and osteoporosis. Then again, middle-aged Australians were also found to be relatively more prone to specific chronic health conditions, such as depression, CKD and IHD.

The good (and the not so good) news

In their report, the AIHW authors observed that bowel cancer incidence rates had increased over the preceding decade, to the extent that it was the second most common cancer affecting Australians; however, patient survival rates were also noted to have improved over that period.

Increases in both incidence rates and patient survival durations could be attributed to a variety of developments that occurred over the same timeframe, including several important medical advances in the diagnosis and treatment of bowel cancer, such as the implementation of enhanced screening guidelines, the increasing availability of new diagnostic techniques (such as familial genetic testing), together with the evolution of more effective treatment methods and novel chemotherapy drugs.

Of course, an increased duration of survival is inherently perceived as a positive development; however, it also most likely reflects that individual bowel cancer patients are increasingly required to cope with residual symptoms or complications of this condition, for a longer period of time. In effect, the statistics indicate that bowel cancer is becoming a chronic disease for an increasing number of Australians.

An 'obesity epidemic' in certain developed countries was previously reported in the medical literature and the news media. During the decade from 1995 to 2005, 'obesity' was observed to increase from 11% to 18% in the Australian male population and from 11% to 15% in females.

When the classification categories of 'overweight' and 'obesity' were combined, the data reflected that approximately 60% of males and 40% of females, were either overweight or obese as at 2004-2005.

Contemporary medical research has established that the Body Mass Index classifications of 'overweight' or 'obese' confer increased future risks of a person developing several life-limiting diseases, including IHD, stroke and Type 2 diabetes mellitus.

The data in the AIHW report also indicated that the proportion of Australians affected by Type 2 diabetes mellitus has more than doubled in the preceding 10 years, from 2% in 1995, to nearly 5% in 2005. This rise is consistent with the increasing obesity trend.

Chronic diseases and disability

As noted earlier, the defining characteristics of chronic diseases include the resultant functional limitations and disabilities associated with impaired health, which could (at a certain point in time) limit an affected patient's full and productive participation in the workforce.

In another recent report (published in 2009) titled '*Chronic disease and participation in work*', the AIHW outlined conservative estimates of the annual economic burden in Australia arising from decreased participation in employment, absenteeism, or the death of persons who were affected with a chronic disease (based on data derived from the *National Health Survey of 2004-2005*).

In their report, the AIHW authors highlighted the increasing prevalence of chronic diseases in Australia, in view of a corresponding increasing prevalence of certain risk factors (such as obesity) and the nation's ageing population. The authors also reported several other key findings, including:

- Compared to unaffected individuals (and after adjusting data to account for age and gender), chronic diseases in affected people meant that they were:
 - (a) Around 60% more likely not to participate in the labour force,
 - (b) Less likely to be employed on a full-time basis, and
 - (c) More likely to be unemployed.
- In affected men, chronic diseases meant that they had more than twice the likelihood of not working (compared to unaffected men),
- Each year, Australia lost an estimated 537,000 person-years of full-time employment, a loss attributed to the impact of chronic diseases on workplace participation,
- Of the total aforementioned loss, the most significant proportions associated with specific chronic diseases were estimated at:
 - (a) 40% associated with arthritis,
 - (b) 25% with depression,
 - (c) 10% with asthma, and
 - (d) 10% with COPD.

The impact of disability in Australia's children

In a May 2005 report titled *'A Picture of Australia's Children'*, the AIHW outlined that there were approximately 3.9 million Australian children aged 14 years or under as at 2003, comprising around 20% of the total population at the time.

As noted earlier, the AIHW had later reported that around 10% of Australian children aged 14 years or less, were affected by three or more chronic health conditions as at 2004-2005, a finding that reflects the considerable burden of chronic diseases in this age group.

Chronic diseases in childhood (and their associated disabilities) not only have an adverse impact on the life experiences of an affected child, but also on siblings and family life in general, in view of the social, psychological and financial stressors of supporting and caring for a child affected by a disability. In their May 2005 report, the AIHW authors noted that *"chronic conditions such as diabetes, asthma and cancer often need to be managed on a daily basis by both children and their carers"*.

Moreover, parents providing such care often find it difficult (if not impossible) to maintain full-time employment in the circumstances, giving rise to financial and relationship difficulties. Financial strain is an especially important factor as it may directly exacerbate such difficulties, due to a lack of funds for essential health services or independence aids that could enhance a disabled child's quality of life.

The relevance of Critical Illness insurance

Critical Illness insurance products (also described as 'Trauma' or 'Dread Diseases' insurance) are designed with the primary intent of paying a benefit in the event of a 'serious' medical illness in the future which does not cause the immediate death of the life insured. In many cases, such critical illness events do not necessarily reflect a terminal medical prognosis.

Several Critical Illness insurance products are available in Australia, which (in most cases) differ mainly in terms of the numbers of 'included' (or named) medical events, the corresponding benefit definitions and the pricing of insurance premiums.

Certain products also provide benefits for critical illness events affecting an insured child (or the child of an adult life insured), including congenital conditions, developmental problems and other diseases that cause significant illness and disability.

The twelve medical conditions identified by the AIHW (as significant contributing causes of the burden of chronic diseases) are listed in the table below, together with some of the relevant benefits currently provided under Critical Illness insurance products available in Australia:

Table 1. The twelve medical conditions identified by the AIHW as significant contributing causes of the burden of chronic diseases in Australia, with some of the relevant benefits provided under Critical Illness insurance products.

Conditions specified by the AIHW:	Relevant ¹ Critical Illness insurance benefits ² :
Ischaemic heart disease	Angioplasty, Aorta repair, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart valve surgery, Heart transplant, Open heart surgery, Out of hospital cardiac arrest, Primary pulmonary hypertension
Stroke	Stroke, Coma, Loss of independence
Lung cancer	Malignant cancer, Pneumonectomy
Colorectal cancer	Malignant cancer, Small bowel transplant
Depression	<i>Several specified benefits include scope to cover events or complications of depression (such as attempted suicide), including benefits for Coma, Intensive care, Loss of independence or Paralysis</i>
Type 2 diabetes mellitus	<i>Certain insurers pay a benefit for this condition</i>
Arthritis	Severe rheumatoid arthritis
Osteoporosis	Severe osteoporosis
Asthma, Chronic obstructive pulmonary disease	Chronic lung failure, Lung transplant, Pneumonectomy
Chronic kidney disease	Chronic kidney failure, kidney transplant
Oral Disease	<i>Certain specified benefits have a scope to provide cover for events which may arise as direct complications of oral disease, for example, Meningococcal septicaemia</i>

1. Explanatory note: where a Critical Illness insurance product provides a benefit for a specified medical condition, the relevant benefit definition will often stipulate exact requirements that must be met in order for a benefit to be paid. Moreover, the requirements defined for each benefit may differ from the contemporary medical definition for the relevant medical condition. Benefit requirements for the same specified medical conditions, may also differ between the Critical Illness products offered by different insurers.

2. In view of the large and variable number of available benefits, this list is not comprehensive and does not include all the relevant benefits specified under every Critical Illness insurance product in Australia. Furthermore, most Critical Illness insurance products include other specific benefits which are not listed in this table.

Epilogue

Considering the well-established relationships between specific chronic diseases and their correlated health complications, it is reasonable to expect that an increasing burden of chronic diseases in Australia would (in most cases) also reflect higher incidence rates of associated critical illness events.

An ageing population and current epidemiology trends reflect that increasing numbers of Australians will likely become affected with chronic diseases in the future, so it is reasonable to expect that the associated economic burden would also tend to rise, including factors such as healthcare costs and loss of future earning potential due to long-term disabilities.

The Honourable Chris Pearce (Shadow Minister for Financial Services, Superannuation and Corporate Law) delivered a pertinent speech at the recent *Lifewise* campaign, launched by the *Investment and Financial Services Association* (IFSA) in May 2009. In his speech, Mr Pearce highlighted the current “*inadequate take-up of trauma insurance*” and “*worrying level of apathy surrounding trauma underinsurance*”.

The Critical Illness underinsurance trend in Australia is an issue of immense concern, especially in context of the current and future economic burden of chronic diseases and corresponding critical illness events. However, the same (underinsurance) trend inherently reflects a substantive opportunity, in terms of addressing the foreseeable economic effects of the increasing disease burden.

Noting that “*Superannuation offers a unique vehicle for providing essential insurance cover for all Australians*” and “*gives most Australians access to insurance at competitive prices, often without needing to be underwritten*”, Mr Pearce went on to say that “*the time has come to look at how we can expand insurance through superannuation to make trauma insurance available to many more Australian families*”.

In view of the sheer magnitude of the chronic diseases burden in Australia and the population-wide scope of Critical Illness insurance benefits, there is a substantive opportunity to ameliorate the associated economic impact through the introduction of relatively minor legislative changes, to enable life insurers to boost delivery of Critical Illness insurance benefits through superannuation-linked products or riders.

To paraphrase comments made by Dr Marius Barnard (the surgeon who created Critical Illness insurance) in a recent interview: whilst medical practitioners are integral to addressing the physical aspects of a patient’s critical illness, life insurers could also play an important and synergistic role as ‘financial doctors’, by delivering on the promise of financial protection afforded through specific Critical Illness insurance benefits.

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Original Underwriter not Required - Court Upholds an Insurer's Right To Avoid Under s29(2) of the ICA



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Summary

In *Kenan Berk v Westpac Securities Administration Ltd & Anor* the Supreme Court of NSW has found that a life insurer was entitled to avoid a policy pursuant to s29(2) of the *Insurance Contracts Act 1984 (Cth)* (**the Act**) for fraudulent misrepresentation and non-disclosure.

The judgment is noteworthy because it clarifies one controversial point with respect to the nature of the underwriting evidence required under s29(2) — namely, that a life insurer does not necessarily have to call the original underwriter to establish that it would not have offered the policy on the same terms.

The case was unusual because the insured made the concession that if the answers on the application were his, then he was guilty of fraud. Nonetheless the judgment still demonstrates that some truthful answers in an application document does not of itself lead to an inference that the insured has not been fraudulent.

Who Does This Impact?

Claims and legal teams of life insurers.

What Action Should Be Taken?

Insurers should be aware that a successful defence of an avoidance under s29(2) is possible in the right circumstances.

Facts

The insured claimed a TPD benefit on a life policy held with the insurer. The insurer avoided the policy under s29(2) of the Act on the grounds that at the time of applying for cover, the insured had misrepresented his medical history.

The insured brought proceedings challenging the insurer's decision to avoid the policy and seeking payment of the TPD benefit. The application for cover by the insured did not disclose any medical history despite the fact that he had a significant history of neck and back problems which had caused him to be off work for a number of months as well as having suffered from depression.

The insured claimed that he advised the insurer's agent (**the agent**) of his past conditions prior to the application being completed.

The insured also claimed that the agent ticked the "No" boxes on the application relating to his medical history. The agent denied these allegations. Significantly, the insured accepted that if there was a finding that the answers in the application were given by him, then they were given fraudulently (presumably because they were plainly incorrect given his medical history).

This concession by the insured meant that the critical issue before the Court was whether the Court should accept the insured's or the agent's version of events as to how the application was completed.

Insured's Evidence Rejected

Nicholas J rejected the insured's evidence as to the completion of the application and preferred the agent's version of events. His Honour found the insured's evidence to be contradictory, inherently improbable and inconsistent with his past version of events. The insured had argued that he acted honestly in giving information in the application as to his general practitioner's details and including details of being a smoker and that such conduct was inconsistent with an intention to mislead the insurer and supported his claim that he disclosed his relevant medical history to the agent.

The insured also contended that signing the privacy consent form authorising investigation of his medical history demonstrated the unlikelihood of trying to deceive the insurer.

These submissions were rejected.

Nicholas J concluded that the insured fraudulently failed to disclose and misrepresented answers in the application because the insured had conceded the Court would have to find him fraudulent if it accepted he provided the answers recorded in the application.

Underwriting Hurdle

Nicholas J acknowledged that the insurer's right to avoid the policy under s29(2) depended not only on proving fraud but also upon the insurer showing it would not have entered into the same contract if the truth about the insured's medical history had been known.

To establish this point the insurer called expert underwriting evidence. The expert underwriting evidence established that cover would have been declined if the truth had been known because the insured was an unacceptable risk. This opinion was supported by the insurer's underwriting guidelines applicable at the relevant time.

The underwriter who accepted the insured's application for cover was overseas and did not give evidence. Nonetheless Nicholas J held:

...the answers in sections L and M of the person statement were misrepresentations or non-disclosures likely to induce an underwriter to write the contract...the inference is inevitable... the probability of inducement was established without the evidence of the original underwriter.

Implications

Prior inconsistent statements, changing and implausible explanations for critical events and a poor performance in the witness stand, ensured that the insured's version of events would not be believed. From there, the finding of fraud in the application process was inevitable and the insurer's stance was vindicated.

Life insurers contemplating avoidance or defending avoidances under s29(2) can take the following points of guidance from the decision:

- There has been some level of uncertainty in s29 matters as to whether the insurer must present evidence from the actual underwriter who wrote the risk, in order to show what it would have done had it known the true facts. In this case, the Court had no difficulty accepting evidence from underwriters other than the original underwriter, as to what the insurer would have done had the truth been known.

As such, the case is authority for the proposition that the evidence from the original underwriter is not essential. That said, it would still be preferable to obtain evidence from the original underwriter if it is practical to do so less any adverse inferences be drawn. Also, if another underwriter is used it is clearly desirable that they be familiar with the insurer's underwriting practices at the relevant time. Finally, it would appear a court is more likely to accept evidence from an underwriter other than the original underwriter when an insurer produces a supportive underwriting manual applicable at the relevant time (as the insurer did in this case) as such evidence will be difficult to impeach.

The insurer submitted (as many insureds do in similar circumstances) that honest answers in other parts of the application, including revealing the correct details of his treating doctor, was inconsistent with a fraudulent intent. He also submitted that the provision of an authority to the insurer enabling it to obtain his

medical records was also inconsistent with an intention to deceive. These submissions held no weight with the Court.

In the circumstances, one could draw the second point of guidance as being that truthful answers elsewhere in an Application document, which if investigated, could have alerted the insurer to misrepresented or undisclosed matters, are not necessarily inconsistent with a fraudulent intent. This would be particularly so if the insurer has no intention of making any further enquiries of the application.

Lastly it was perhaps surprising that the insured did not seek to rely on s31 of the Act which allows a court to disregard an avoidance under s29(2) where it would be unfair and harsh not to do so and the prejudice to the insurer is insignificant. Presumably the insured felt s31 would not have been of any use because the insurer in this case with its underwriting evidence was able to establish significant prejudice.

Citation

Kenan Berk v Westpac Securities Administration Ltd & Anor (2010) NSWSC

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InsureIntell

One of ALUCA's main goals is to ensure the ongoing formal and informal education of insurance professionals across the Australian and New Zealand market. We encourage all claims and underwriting professionals to remain abreast of insurance and medical issues by reviewing and searching out articles related to their discipline. As such, the ALUCA webpage has a special section set aside with relevant links to appropriate webpages. With this in mind, we would like to inform the membership that a new link has been added to the Links page to a website that allows all members to register and view the contents for free. Full details follow below:

A New - Free - Resource

www.insureintell.com is a brand new, 100% free information portal dedicated to the global mortality and morbidity risk management community.

Created by ALUCA member Hank George, and Kathleen McGrath, it encompasses a wide array of technical content as well as continuously-updated links to a broad range of articles, papers, surveys, commentaries, etc., published elsewhere on the Internet.

All ALUCA members are invited to visit InsureIntell. Those who opt to register will receive alerts each time significant new content is added.



ALUCA Conference 2010 Update

Hi ALUCA colleagues,

Well here we are and it's 2010 already. What did you say 2010! That means it must be just over 7 months until the ALUCA Conference officially starts on the evening of 23rd October at the Novotel Twin Waters Resort in Maroochydore.

You are probably saying to yourself "I already know where the conference is to be held and that the title is **"Generations Change...The next wave"** but what will the conference program be providing to me as an ALUCA member and a claims, underwriting, product or other type of risk insurance professional that will make me more effective as both an individual and a corporate professional to handle the challenges ahead?" The answers to this broad question will be the cornerstone of the conference program.

2010 is the start of a new decade which is already seeing major demographic, economic, legislative, medical and technological changes and this wave of change will only accelerate across all the markets in which ALUCA members are working. This momentum has also affected the ALUCA Conference and as a result the structure of the conference program has slightly changed to mirror the needs of the ALUCA professional in these new times.

When the full program is released you will see that each day has an overriding theme ranging from the environment in which we all currently work through to the future of the life risk industry and how we as risk insurance professionals prepare ourselves fully to manage what will be major changes we are likely to be presented.

The Conference Plenary Sessions are now designed to identify the key higher level issues that will impact us all whether we are in underwriting, claims, product, legal or elsewhere and will set the scene for the specific technical topics to be covered in the Concurrent Sessions. They will all be directly relevant to conference delegates. We will cover issues such as the impact of demographic, political, economic, legislative, technological and medical changes on the risk insurance industry both now and in the future and how we as professionals must prepare ourselves for such change. Among the Plenary Session presenters will be a leading social demographer, a panel of CEOs representing the Australian and New Zealand markets, a panel of risk insurance and technology experts and a professor of medical statistics who is leading an international study on the major health trends.

The Concurrent Sessions will be broken down into specific streams such as Underwriting, Claims or Product/General and this will allow delegates to either follow one discipline stream or mix their choices in order to broaden their perspective as a professional. These sessions will be both technically informative and highly interactive. They are where your professional colleagues will be able to provide insight into specific topics based on their experience and knowledge and allow you to consider their views and offer your own. Concurrent Session topics will cover areas such as Economic Trends in Underwriting, Claims: Relationships Matter, Group Trends – the shape of the Product and the shape of distribution ahead, the "Group" Claims Management Model, Impact of Straight through Underwriting, Trauma Experience, Severity Based Trauma products and much more. There will be something for everyone in all aspects of risk management.

This gives you just a brief insight into what you can expect from the next ALUCA Conference and how the program has been re-structured to provide you both the necessary broader view of the industry and profession in which you work and the issues both macro and micro that will be washing over us in this period of dramatic change. Now is the time to see and debate how these issues might affect our ability to perform our work in risk management.

I am sure that your excitement has been so ignited that you will be preparing yourself for the opening of registration to ensure you secure your spot at the conference. Just remember that you need to have paid your ALUCA membership subscription by the end of March to ensure you are eligible to participate in the Member only registration period when registrations open in May.

Stay tuned for further conference details which will be heading your way in the not too distant future.

Kind regards,

Brian Sussman
Conference Program Chair



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THE LAST PAGE(s) Postcards from the Edge

An Aussie in London (one of the thousands!)

Hi everyone,

When Matthew and Alison asked me to write this I counted back how long I've been here and can't believe it's already been over four months! In some ways it has gone very fast indeed, but in others it feels like I've been here forever.

I'll get the weather report out of the way – it's the first topic of conversation for every local over here, and they're all astounded that I would move here from Australia's fine weather. Anyone who knows me knows that I hate heat, so this climate suits me perfectly, though I do have to admit to a new appreciation of the Poms' love of sunshine, given that over the past month I've seen only three days of it. It has been the coldest winter they've had for over 20 years, and as if to spite all those people who told me that it never snows in London, we've had record amounts over December and January. Global warming? When does that start??

I'm working in the global underwriting team of Swiss Re, based in London, but really I think it should be called the Commonwealth team – aside from me, we have a Canadian, a South African, an Indian, a Kiwi and only three Poms. We just need Fiji to complete the set. All I can say is, Australia had better start or continue doing well in rugby, cricket and soccer, or my life will be plagued with hassle about it.

The team I'm in, and the work I'm doing, allows me to have contact with my colleagues all over the world, which gives me insight into each of their markets. After being here just a week I went to Tel Aviv to audit our Israel team. (Their market and products are not too different from Australia's, though the sums insured are much lower). Being located in London I have more immediate access to the UK market, but I have been able to liaise with the rest of the world, and it's been interesting to see what goes on in the US and Canada, and to see the impact of some of the EU directives on the various European markets. I'm looking forward to going to New York later in the year to visit our American team.

Setting up life in a new city by yourself is at once exciting and a challenge. I don't have a car (you really don't need one in London), so doing any sort of shopping – furniture, grocery – requires a bit of planning (am on a first name basis with the Sainsbury's delivery man). I've also been doing my bit to keep the Swedish economy propped up by visiting Ikea at least 4 times; they're thinking of putting photos of my flat into their next catalogue.



The view from my window

And again a few weeks later!

I live in Highbury/Islington, very near to Arsenal's home ground (for anyone who cares). It's a lovely area, has a long main street filled with shops, restaurants and pubs, which I spend hours exploring (I won't tell you in what proportion). My flat is right on a big park which I walk around to get to work each day, and it's always filled with people either jogging or walking their dogs (both appear to be the national pastimes).

London is a fantastic place to live, there is always so much going on – markets, shows, museums, and of course, fabulous pubs, with no poker machines!

It's also in the perfect location for me to pursue my number one passion – travel. After the first few months of setting up life here I've finally gone into full planning mode. I just came back from Iceland this past weekend (where I met a real Aussie sheila from Darwin – what are the chances??), and am planning trips to Croatia, Slovenia, Lake Como, Bermuda, Miami, Ireland, Paris and the rest of Scandinavia, and that's just this year. It is such a novelty to be able to pay such a small amount of money to fly to some of these places or catch a train in just a few hours, and so be able to easily just nip over for a long weekend. I've also had a constant stream of visitors so far, and am looking forward to more coming my way.



Well that's about it from me. I hope everyone is well, and if you're in my neck of the woods, make sure you let me know.

Tracy Cunningham
Swiss Re, London Office