CRITICAL ILLNESS: DIAGNOSIS, OCCURRENCE AND EVIDENCE

Key points

- Determining whether a 'critical illness / trauma' policy requires occurrence or diagnosis of a condition within the policy period will always be a matter of contractual construction.
- However, if diagnosis is to be required, it is likely that clear language will be needed to achieve this effect.
- When seeking to prove the timing of the occurrence of a condition, parties may need to consider adducing statistical evidence; expert evidence; and evidence linking broader data to the individual insured.

A certain amount of attention has been placed upon the correct approach to critical illness / trauma benefits, in light of a decision by AFCA last year.

The issue at hand is two-fold.

Firstly, there has been debate about what precisely is required to qualify for a CI benefit.

Secondly, questions have been raised about what kind of evidence ought be marshalled in support of, or in defence of, the claim.

WHAT IS REQUIRED?

AFCA's Determination

The case before AFCA, being Case No. 674068, involved a life insured who (it was accepted) had developed a malignant cancer by the time her claim was lodged.

However, the life insured had voluntarily cancelled her cover on 14 February 2018 - and her diagnosis with cancer did not occur until July / August 2018.

Accordingly, the first question posed to AFCA was: What precisely must take place during the period of cover?

Unsurprisingly, the answer to this question turns on the exact terms of the policy.

The most significant clause in the relevant policy was as follows (**the First Provision**):

> *When we will pay*
>
> *If the Life Insured suffers a Critical Condition (see below) while this insurance is in force, we will pay you the Critical Illness Benefit…*

Later, under a list of Critical Conditions, the policy provided that (**the Second Provision**):

> *The Life Insured first has a Critical Condition … when the condition is first diagnosed as meeting its definition.*

Later still, the policy provided that (**the Third Provision**):

> *All critical conditions must be diagnosed by a specialist and confirmed by [the insurer's] medical adviser.*

The insurer argued that a benefit was only payable if life insured had actually been diagnosed with malignant cancer during the period of cover.

However, AFCA concluded that the life insured needed only show that a malignant cancer was present, while her cover subsisted.

AFCA placed emphasis of the use of the phrase *suffers a Critical Condition* in the First Provision, which governed when the insurer would pay a benefit. It held that this phrase did not require a diagnosis to be made.

The Second Provision, which indicated that an insured *first has* a Critical Condition when it is diagnosed, was not thought to detract from the language of the First Provision.

Importantly, the Second Provision did not immediately follow the First Provision in the layout of the policy. Moreover, the phrase *has a Critical Condition* was meaningfully different from the phrase *suffers a Critical Condition*.

Therefore, it was not accepted that the Second Provision was intended to shed light on the meaning of the First Provision. It merely fixed a time for payment of any benefit, but did not modify the operation of the earlier clause.

Presumably, a similar view was taken of the Third Provision, although not specifically addressed.

Application to other policies

AFCA's findings cannot be automatically applied to all critical illness or trauma policies. As can be seen from the discussion above, the language and layout of the policy at hand was crucial to AFCA's conclusions.

The available takeaway is that careful attention must be paid to the wording and formatting of a policy. In another case, it may well be that the policy at hand does clearly express that an insured event occurs only upon diagnosis.

It should be noted that, even if the policy does so, AFCA will explore whether section 54 operated upon the provision; and care should therefore be taken to ensure that the need for a diagnosis is expressed as an inherent element of the insured event. That, however, is a separate issue…

EVIDENCE

The second consideration raised by AFCA's determination is a conceptual one: If a policy requires only that a life insured 'suffer from' a condition during the period of cover, how can a claim be assessed, when the relevant diagnosis occurs well after cover has ended?

The reality is that this will involve a case-by-case factual analysis. There will rarely be a neat answer to such issues - but a determination will need be made, on the balance of probabilities, of whether the claimed condition was present before cover ended. That task will, of course, become more difficult where diagnosis is made well after the conclusion of the relevant policy.

The type of evidence likely to be beneficial in resolving these factual questions would usually be:

- Statistical evidence, demonstrating the typical progression of the illness at hand.
- This evidence would seek to show that the relevant illness normally proceeds along a particular timeframe, or usually acquires particular characteristics or markers along a predictable chronology.
- Expert evidence, discussing the available statistics and providing an opinion about the individual life insured in light of that data. This would need to take into account any particular characteristics of the life insured which might suggest a faster or slower progression of disease than reflected in the statistical data, as well as a consideration of any symptoms historically reported by the life insured, which might (with the benefit of hindsight) be attributed to the now-diagnosed disease.

To an extent, all of this evidence will be unsatisfactory, in that it will call for a degree of conjecture. Questions of this type are not susceptible to an absolute demonstration of proof. That is, however, no bar to factual findings being made. Indeed, Courts are no strangers to making determinations based on imperfect evidence.

The challenge from an insurer's perspective is that doctors treating an insured may provide imprecise opinions that an illness was present during the period of cover. Conclusions to this effect are sometimes stated by treating doctors, with only modest explanation.

Faced with such reports, an insurer will probably have to bear a disproportionate burden to adduce persuasive, statistically-based, expert evidence, which shows that it is unlikely that the illness existed in the necessary form before cover ended.

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