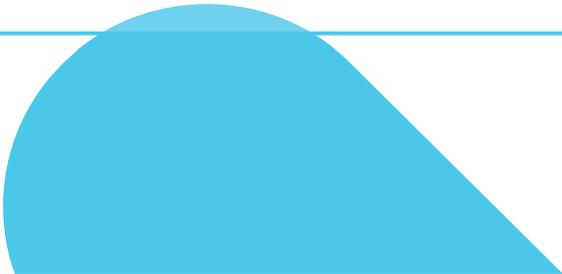


The AFCA Approach to section 54 of the Insurance Contracts Act

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We have created a series of AFCA Approach documents, such as this one, to help consumers and financial firms better understand how we reach decisions about key issues.

These documents explain the way we approach some common issues and complaint types that we see at AFCA. However, it is important to understand that each complaint that comes to us is unique, so this information is a guide only. No determination (decision) can be seen as a precedent for future cases, and no AFCA Approach document can cover everything you might want to know about key issues.



1 At a glance

1.1 Scope

This approach outlines how we apply section 54 of the *Insurance Contracts Act 1984* (ICA) to insurance complaints. The approach has been adopted from AFCA's predecessor scheme the Financial Ombudsman Service.

Who should read this document?

- 1 Financial firms, consumers and consumer representatives who have an insurance complaint at AFCA involving technical policy exclusions.
- 2 Lawyers and other professionals who are assisting the insurance claims process.
- 3 Anyone who wants to understand how AFCA applies legal principles, industry codes and good industry practice when considering insurance complaints involving s54.

Summary of our approach

Section 54 has been described by legal commentators as a broad remedial provision. It applies to contracts which permit an insurer to refuse to pay a claim because of some act or omission of the complainant or another person after the contract was entered into.

When applying section 54 to complaints at AFCA, we will ask:

- What are the inherent limitations and restrictions within the claim?
- Is there an act or omission that occurred after the contract was entered into that the financial firm is relying upon?
- Could the act reasonably be regarded as being capable of causing or contributing to the loss?
- If yes, was the act either:
 - > necessary to protect the safety of the person or preserve property or
 - > could not reasonably be avoided?
- If no, has the financial firm been prejudiced by the act and what is the extent of the prejudice?

When considering a complaint and the application of section 54, AFCA determines the complaint on the basis of what is fair in all the circumstances having regard to the relevant legal principles, the terms of the policy, good industry practice including relevant industry codes and prior AFCA or predecessor scheme decisions (although we are not bound by these).

If the complaint falls within AFCA's definition of a superannuation complaint an AFCA decision maker can only make a determination for the purpose of placing the complainant as nearly as practicable in a position where the unfairness and/or unreasonableness no longer exists. In addition, an AFCA decision maker must not do anything that would be contrary to law, the governing rules of the fund or, if a contract of insurance between the trustee and an insurer is involved, the terms of the insurance contract.

We have included an approach guide on page 12, which will assist you when considering the application of section 54 to a claim.

2 In detail

2.1 What is the purpose of section 54 of the *Insurance Contracts Act 1984*?

The High Court in *Maxwell v Highway Hauliers Pty Ltd* [2014] HCA 33 finally settled the questions surrounding the application of section 54 of the Insurance Contracts Act 1984 (ICA). The purpose as decided in this case is as follows:

“Section 54 takes its starting point as nothing more than the existence of a claim and of a contract, the effect of which is that the insurer may refuse to pay the claim by reason of some act which the insured (or someone else) has done or omitted to do after the contract was entered into.”

Section 54 is engaged when the doing of an act or the making of an omission would excuse an insurer from an obligation to pay a claim for a loss actually suffered by an insured.

Section 54(1) is remedial in nature. The objects of the section include striking a fair balance between the interest of an insurer and an insured with respect to a contractual term designed to protect the insurer from an increase in risk during the period of insurance cover. That balance is to be struck irrespective of the form of that contractual term.

No difference is to be drawn between a term framed:

- as an obligation of the insured (e.g. the insured is under an obligation to keep the motor vehicle in a roadworthy condition)
- as a continuing warranty of the insured (e.g. the insured warrants he will keep the motor vehicle in a roadworthy condition)
- as a temporal exclusion from cover (e.g. this cover will not apply while the motor vehicle is unroadworthy) or
- as a limitation on a defined risk (e.g. this contract provides cover for the motor vehicle whilst it is roadworthy).

2.2 What is an inherent restriction or limitation in a claim?

Section 54 does not operate to relieve a complainant of restrictions or limitations that are inherent in the claim. An inherent restriction or limitation in a claim is a restriction or limitation which must necessarily be acknowledged in the making of the claim having regard to the type of insurance.

It is not a question of restriction or limitation on the scope of cover but on restrictions or limitations that relate to the facts of the particular claim.

In determining whether there are any inherent restrictions or limitations on a claim, AFCA adopts the following approach by identifying:

- the nature of the policy (i.e. is the policy a claim made and notified policy, an occurrence or event based policy, or a discovery policy).
- the particulars of the actual claim made (i.e. the claim must be a claim under a relevant contract of insurance).

What constitutes an insured event under the policy will be decided on the facts of the actual claim. The restrictions or limitations that are inherent in a particular claim will vary according to the type or kind of insurance in issue, not the scope of cover. Some examples follow:

- In a claims made and notified policy, the inherent limitation or restriction is that the indemnity can only be sought in relation to a demand made on an complainant by a third party during the period of cover. If no such demand has been made, then the claim will not satisfy the causal requirements in section 54(1).
- In a 'discovery contract' it is necessary that the indemnity sought relates to an occurrence of which the complainant became aware during the period of cover.
- In a typical occurrence/event based insurance policy the relevant restriction or limitation will be that an event occurred during the period of cover.

A simple example of this approach when looking at an occurrence/event based policy is as follows:

- an insured takes out a policy insuring a motorbike for theft. Theft is defined to include keeping the item secured in a locked facility. The motorbike is stolen during the period of insurance and the financial firm denies the claim as the motorbike was not secured in a locked facility.

In this situation, there is no inherent restriction or limitation. This is because the motorbike was stolen during the period of insurance. The requirement to keep the motorbike secured in a locked facility, would be considered a policy condition and section 54 would be engaged.

2.3 Identify the relevant act or omission

Once satisfied that no relevant restriction or limitation of a policy applies in the event of an occurrence/event based policy, the event occurred during the course of cover, the next issue is to identify the relevant act or omission.

What are the characteristics of the act or omission?

The relevant act or omission must occur after the contract was entered into. An act or omission is an act or omission of the complainant or some other person. That person does not necessarily have to be related to the claim but can be some other third party.

An omission is the non-performance of an act which, if done, would disentitle the insurer to refuse to pay a claim.

Liability will not be imposed on a financial firm to provide indemnity in respect of a risk which was never intended to be within cover but which is somehow associated with an act or omission.

For example:

- failure to renew a policy.
- failure to nominate a particular vehicle for cover under a policy.
- failure to add jewellery to a specified list of items, will not engage section 54(1).

On the other hand, acts or omissions such as:

- failure to undergo surgery within a relevant 12 month period under a sickness and accident policy.
- failure to remove keys from a vehicle.
- allowing an unlicensed or unqualified driver to drive the vehicle.
- driving an unroadworthy vehicle.

may be considered relevant acts or omissions and therefore engage the operation of section 54(1) of the Act.

2.4 Could the act or omission reasonably be regarded as capable of causing or contributing to the loss?

Once section 54(1) of the Act is engaged, we need to consider the application of section 54(2) of the Act.

Under section 54(2) of the Act the financial firm needs to show that the act or omission could reasonably be regarded as capable of causing or contributing to the loss.

This is not a high threshold. It does not require the financial firm to show the act actually caused the loss. It is enough to show that it could reasonably be regarded as being capable of doing so.

Obviously, there must be some information provided that satisfies such a test but that will vary depending on the type of complaint involved.

For example, in a travel policy claim, a complainant is injured in an accident when driving a motorcycle while unlicensed. The financial firm will need to show that the fact that the complainant was unlicensed could reasonably be regarded as being capable of causing or contributing to the loss. Information as to the complainant's prior riding experience, circumstances of the accident, road conditions etc will be required.

Whether or not a particular act or omission could reasonably be regarded as being capable of causing or contributing to a loss is a question of fact to be considered in each individual complaint. An act or omission that did cause or contribute to the loss would in most circumstances invoke section 54(2) of the Act.

If the financial firm establishes the act or omission could reasonably be regarded as being capable of causing or contributing to the loss then it can refuse the claim subject to the exceptions set out under section 54(3), section 54(4) and section 54(5) of the Act.

2.5 What are the exceptions to section 54(2)?

Once section 54(2) of the Act is engaged, the onus shifts to the complainant to show that the relevant act or omission falls within any of the four exceptions below:

- It did not cause or contribute to the loss-section 54(3). For example, an complainant driving under the influence of alcohol is hit from behind while stationary.
- Some part of the loss that gave rise to the claim was not caused by the act-section 54(4). In these circumstances, the insurer may not refuse to pay the claim in relation to that part of the loss which was not caused by reason only of the act. For example, an unroadworthy vehicle is in an accident when brakes fail. While parked at the side of road following the accident a third party vehicle hits the complainant's vehicle. The financial firm may refuse a claim for damage from the first accident (subject to the policy wording) but would be liable for damage from second accident.
- The act was necessary to protect the safety of a person or to preserve property. For example, a complainant has to deliberately bulldoze a garage to prevent fire spreading. The financial firm could not deny a claim for deliberate and intentional damage to the garage.
- It was not reasonably possible for the person not to do the act (section 54(5)).

AFCA will consider the application of sections 54(3), section 54(4) and section 54(5) of the Act, once it has considered the application of section 54(2).

2.6 If section 54(2) does not apply financial firm must show extent of prejudice

If section 54(2) does not apply, then it is necessary to revert to the application of section 54(1). The onus is then on the financial firm to establish the extent to which it has been prejudiced as a result of the act.

Prejudice may be established in many varieties. Normally it will be dealt with in respect of the premium although in some circumstances, it may be with respect to the claim decision.

It is important to note that the financial firm must prove the extent of its actual prejudice. It is not enough for it to say it is likely to have been prejudiced by an act.

In the event that the financial firm cannot show any prejudice, then section 54(1) will apply and the financial firm will be liable to meet the complainant's claim.

If the financial firm can establish prejudice then it can reduce its liability to the extent that it has been prejudiced. Normally the extent of prejudice will be additional premium, additional excess or related repair cost.

In some circumstances, however, this can be to the full value of the claim.

How is this applied in practice?

The application of section 54 and prejudice can result in different outcomes depending on the evidence and factual background.

For example an complainant has repaired damaged property without giving the financial firm the opportunity to inspect it (the 'act'). This is a breach of a policy condition and the financial firm could rely on this to deny the claim under the policy.

The Act however could not reasonably be regarded as being capable of causing or contributing to the loss and therefore the issue of prejudice arises.

If the evidence shows the loss was covered by the policy and the costs are reasonable, then the 'act' has not prejudiced the financial firm. Section 54 would apply to the complainant's benefit.

However, if the costs were unreasonable, the financial firm could establish prejudice if it can show it would have repaired the damage for a lesser amount. Therefore, its prejudice is to the extent the costs are unreasonable.

In certain circumstances, it is possible the financial firm could show the 'act' has prejudiced it to the full extent of the claim. For instance:

- it is unclear whether the loss was covered by the policy
- there are no photographs of the damage
- the contractor who repaired the property can provide no reasonable evidence.

In this instance the act would have prejudiced the financial firm's ability to investigate whether the policy responded to the claim. Further, the possibility that the policy may not respond was real as opposed to being remote or speculative.

3 Context

The case studies below are based on determinations by one of AFCA's predecessor schemes, the Financial Ombudsman Service. While previous determinations (by AFCA or by its predecessor schemes) are not binding precedents, where relevant they will inform AFCA's approach to an issue.

3.1 Case studies

Case 1

A household member was involved in a motor vehicle accident when driving the insured vehicle. The financial firm declined the claim as the driver was not a nominated driver under the policy.

The issue was whether a household member not nominated under a policy should be excluded from cover. The household member had only returned home during the currency of the policy.

Section 54(1) was found to apply as the relevant act was determined as the failure to nominate the person as a nominated driver during the period of insurance. Equally, the act could have been allowing an uninsured driver to drive the vehicle.

As there was no evidence that driver was not an acceptable risk or would not have been insured by the financial firm if nominated there was no prejudice to the financial firm. FOS found in favour of the complainant.

Case 2

The complainant had a blood alcohol level of .05. The financial firm declined the claim relying on an exclusion relation to driving under the influence of alcohol.

The only relevant information was that the complainant had a BAC of over .05.

The financial firm did not present any evidence to show that the complainant's blood alcohol level could reasonably be regarded as being capable of causing or contributing to the accident. There was no evidence of the impact of the alcohol.

As the financial firm had not established the act could reasonably be regarded as being capable of causing or contributing to the loss, section 54(2) did not apply.

Case 3

This case involved a claim under a mortgage protection policy. The complainant became unemployed but was not certified by Centrelink. The financial firm declined the claim as the policy required the complainant to be certified unemployed by Centrelink to be eligible to claim.

FOS determined that section 54(2) did not apply as the relevant act (not being certified unemployed by Centrelink) could not reasonably be regarded as being capable of causing or contributing to the loss given:

- the specific and senior nature of the complainant's employment
- the complainant's demonstrated efforts in looking for and finding new employment.

Section 54(1) applied. As no prejudice was identified the financial firm was liable for the claim.

Case 4

The complainant held a sickness and accident policy and lodged a claim for total temporary disability (TTD) benefits following surgery.

The policy required the injury to occur during the period of insurance and the TTD to occur within 12 months of the injury. The complainant did not have surgery until 18 months after the occurrence of the injury.

It was determined that the failure to undergo surgery which would have rendered the complainant TTD was an omission for the purposes of section 54, in that it was the non-performance of an act which if done would have disentitled the financial firm to refuse the claim.

There was no complaint that if the complainant had had surgery when he initially attended hospital, cover would have been provided. There was no complaint that the omission of surgery was something that the complainant could not reasonably avoid given the hospital waiting list at the time.

The act could not reasonably be regarded as being capable of causing or contributing to the loss. It was an act the complainant could not reasonably avoid.

It was considered there was no prejudice suffered by the financial firm.

The determination recognised that the decision may be different if the complainant had not attended the hospital or sought surgery until after the 12 months had elapsed.

3.2 References

Definitions

Term	Definition
Financial firm	A bank or credit provider that is a Member of AFCA
ICA	<i>Insurance Contracts Act 1984</i>

Useful documents

Document type	Title
Insurance Contracts Act	This Commonwealth statute can be found here: http://www.comlaw.gov.au/
Austlii	Austlii is a free resource that contains a full extract of most of the judgments issued in Australia over the past 20 years: http://www.austlii.edu.au/