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## **The progressive evolution of Australian insurers' duty of utmost good faith to third party claimants**

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Over recent decades, the significance of third parties in the insurance contractual relationship has progressively increased. In Australia, challenges by claimants with entitlements under group life insurance policies providing total and permanent disablement (TPD) benefits, which are commonly arranged by trustees of superannuation funds to provide benefits to incapacitated members, have been a key driver of this trend. Several cases where third party claimants have successfully challenged the decision-making processes of insurers in declining TPD claims have provided useful clarifications of the nature, extent and limits of Australian insurers' post-contractual duties of utmost good faith. Through a progressive review of the key Australian authorities, this article examines the examples of conduct by insurers that have been held to breach the duty of utmost good faith. It also shows that through recognising the standing of third parties, several of these decisions have provided the impetus for amendments to the Insurance Contracts Act 1984 (Cth), which now recognises that insurers also owe the duty of utmost good faith to third party claimants.

### **Introduction**

When Lord Mansfield issued his seminal judgment of *Carter v Boehm* in 1766 declaring that '... good faith forbids either party, by concealing what he privately knows, to draw the other into a bargain from his ignorance of the fact, and his believing the contrary',<sup>1</sup> he most probably did not foresee that in time, these rights and obligations could also come to apply to third parties. The significance of third parties in the insurance contractual relationship has progressively increased over recent decades. In Australia, challenges by claimants with entitlements under group life insurance policies providing total and permanent disablement (TPD) benefits, which are commonly arranged by trustees of superannuation funds to provide benefits to incapacitated members who satisfy the policy criteria,<sup>2</sup> have been a key driver of this trend. The challenges of articulating the nature, extent and limits of the duty of utmost good faith have been acknowledged by many commentators.<sup>3</sup> However, as this article shows through a progressive review of the key Australian authorities, several cases where third party claimants have challenged the decision-making processes of insurers in determining claims have assisted in clarifying the nature and extent of the insurer's post-contractual duty of utmost good faith. Examples of conduct that has been held to breach this duty has included the failure to consider the correct questions required by the policies, and to take account of relevant information, in determining claims; the failure to advise assessing medical practitioners of the relevant policy criteria; failing to inform claimants of the basis for declining claims, and not providing claimants with opportunities to respond to insurers' decisions. As this article also explains, several of these decisions have provided the impetus for amendments to the Insurance Contracts Act 1984 (Cth) which have now given legislative recognition to the application of the duty of utmost good faith to third party claimants.

### **Pre-ICA 1984**

One of the earliest and most influential Australian decisions dealing with the post-contractual duty of utmost good faith<sup>4</sup> was *Distillers Co Bio-Chemicals (Australia) Pty Ltd v Ajax Insurance Co Ltd*.<sup>5</sup> In this case the insured had faced numerous third party claims relating to birth defects which were attributable to tablets it had imported from an overseas manufacturer. In a 2:1 decision, the High Court of Australia (HCA) dismissed two grounds of appeal against the earlier

decision of Helsham J in the NSW Supreme Court. After answering the first ground of appeal by determining that the ingestion of Distaval tablets by the claimants constituted one 'occurrence' as defined by the policy (thereby limiting the insurer's liability limited to £50,000 (\$100,000)), Stephen J addressed the second ground of appeal. This concerned the interpretation of a clause in the policy requiring the insured to obtain the consent of the insurer before settling claims. In upholding the validity of this clause, Stephen J briefly noted that the insurer's duty of good faith required it to have 'due regard' to interests of its insured, as well as its own interests, in the exercise of powers under the contract of insurance.<sup>6</sup> Stephen J's view was adopted by the Australian Law Reform Commission (ALRC), which had noted the absence of reported Australian decisions applying the duty to the payment of claims. Accordingly, the ALRC's report recommended that 'Legislation should make it clear that the duty of good faith applies to all aspects of the relationship between insurer and insured, including the settlement of claims'.<sup>7</sup> However the ALRC did not explore whether the duty should extend to third parties. The ALRC's recommendations were implemented in the Insurance Contracts Act 1984 (Cth) (ICA), which introduced s 13 (which implied the duty of utmost good faith to all contracts subject to the ICA), as well as providing third parties with certain rights to claim on insurance policies under ss 48, 49 and 51. Although the ICA entered into force on 1 January 1986, it was more than 10 years before s 13 of the ICA was directly considered in relation to a claim by a third party beneficiary.

The decision of *Trident General Insurance Co Ltd v McNiece Bros Pty Ltd*<sup>8</sup> represented a significant development in recognising the standing of third parties to claim on insurance policies. In dismissing the insurer's appeal, the majority<sup>9</sup> held that McNiece Bros Pty Ltd (a sub-contractor on a major road construction project) which had incurred liabilities in respect of a worker injured on a road construction site in 1979 (well before the entry into force of the ICA), was able to claim on the contract works liability policy which had been entered into by the principal contractor (Blue Circle Southern Cement Ltd). In his separate judgment, Toohey J reasoned that:

When an insurer issues a liability insurance policy, identifying the assured in terms that evidence an intention on the part of both insurer and assured that the policy will indemnify as well those with whom the assured contracts for the purpose of the venture covered by the policy, and it is reasonable to expect that such a contractor may order its affairs by reference to the existence of the policy, the contractor may sue the insurer on the policy, notwithstanding that consideration may not have moved from the contractor to the insurer and notwithstanding that the contractor is not a party to the contract between the insurer and assured.<sup>10</sup> (Emphasis added)

*Trident* represented a landmark in the development of Australian contract law through recognising exceptions to the doctrine of privity of contract. As noted below the principles from *Trident* have also been cited in several cases where third party beneficiaries have challenged the declination of claims for TPD benefits.

In *Edwards v Hunter Valley Co-op Dairy Co Ltd*<sup>11</sup> the claimant had been injured in a road accident and later ceased work with his employer. He subsequently lodged a claim for total and permanent disablement benefits under a policy which had been arranged with Zurich by the trustee of the employer's superannuation fund, and entered into before the ICA came into effect. The Zurich policy defined 'total and permanent disablement' as:

such state of bodily or mental incapacity resulting from accident, injury or illness or disease as has necessitated the Life Insured's absence from his or her employment for six consecutive months (the waiting period) and will in the opinion of Zurich Australian Life Insurance Ltd after consideration of such medical or other evidence as it may require, continue to render the Life Insured incapable of resuming his or her previous occupation or engaging in any other occupation for which he or she is qualified by his or her knowledge or training.<sup>12</sup>

Zurich declined the claim, basing its decision on a specialist medical report which concluded that the claimant was '... probably not fit for work of a heavy physical nature, but work of a more sedentary nature would be within his capabilities should the opportunity ever present itself' -- and thereby determined the claimant did not meet the policy requirements of 'total incapacity'.<sup>13</sup> In taking this approach, McLelland J held that Zurich had failed to consider the correct question required under the policy, namely the limitation on the claimant's capability of resuming or engaging in 'any other occupation ... for which he ... is qualified by his ... knowledge or training'. His Honour noted there was very

little evidence showing that Zurich had considered the claimant's 'knowledge or training' to support the conclusion that he was qualified for 'work of a more sedentary nature', and concluded Zurich had determined the claimant's 'capacity for engaging in an occupation' by reference solely to his physical condition and without regard to his qualification by knowledge or training as required under the policy. This meant that Zurich had not formed the required opinion regarding the claimant's disablement through determining the correct question<sup>14</sup> as required by the policy.

Following the observations of Stephen J in *Distillers*, McLelland J reiterated that the duty of good faith<sup>15</sup> and fair dealing required Zurich to have due regard for the interests of the claimant. As Zurich was in default of its obligations through failing to consider the question required by the policy, his Honour declared the claimant to be totally and permanently disabled within the meaning of the policy. Despite the brevity of the judgment, *Edwards* was significant in being one of the earliest recognitions by Australian courts of the duty of good faith requiring insurers to have due regard for the interests of third party claimants, with later decisions developing this principle further.

In *Chammas v Harwood Nominees Pty Ltd*,<sup>16</sup> the claimant (a former employee of CSR) was entitled to a lump sum disablement benefit through his membership of a retirement fund administered by Harwood Nominees Pty Ltd, which was both the trustee and the insurer for the fund. Following *Edwards*, Hodgson J noted that as the insurer, Harwood was under a duty of good faith and fair dealing which required it to have due regard for the interests of the claimant. This duty required Harwood to determine the correct question, and to act fairly and reasonably in determining the claim.

Although his Honour considered that the correct question as required by the policy had been asked, Hodgson J held that Harwood had breached its duty of good faith and fair dealing in its declinature of the former employee's incapacitation claim through failing to make adequate inquiries in relation to the medical reports it received. While noting that '... an insurer cannot be expected to consider a matter such as this in the full detail that might occur in a court case',<sup>17</sup> his Honour held that the combination of Harwood's lack of enquiries made of the assessing medical practitioners (through merely 'rubber stamping' the doctors' reports); its lack of consideration of the claimant's capabilities for future work based on his existing qualifications and experience; and its failure to provide the claimant with an opportunity to comment on an adverse medical report, or to provide further information in support of his claim, showed that Harwood had failed to act fairly and reasonably in determining his claim.<sup>18</sup> Having made this determination, Hodgson J then proceeded to determine the claim on the evidence before the court, concluding the claimant to be incapacitated in accordance with the policy definition.

In *CE Heath Casualty & General Insurance Ltd v Grey*,<sup>19</sup> the NSW Court of Appeal allowed CE Heath's appeal against an earlier NSWSC trial decision.<sup>20</sup> Rogers CJ had held that former directors of Compass Airlines who were subject to civil proceedings brought by the Australian Securities Commission (ASC) were not parties to the company's directors and officers (D&O) insurance policy, and were therefore not subject to pre-contractual disclosure obligations under s 21 of the ICA. This had meant that CE Heath was unable to rely on the former directors' failure to disclose the initiation of the ASC proceedings in order to avoid its liability to indemnify the directors for their legal costs in defending these proceedings. After analysing the terms of the D&O policy, Mahoney JA (with whom Clarke and Meagher JJA agreed) held that the former directors of Compass were parties to the insurance contract. Accordingly the former directors were subject to the duty of disclosure under s 21 of the ICA -- which allowed CE Heath to avoid the policy by reason of their non-disclosure of the ASC proceedings.<sup>21</sup>

Mahoney JA went on to consider the position in the event that the former directors had been deemed not to be parties to the insurance contract. After considering the remarks of Lord Mansfield in *Carter v Boehm*,<sup>22</sup> as well as what he termed 'trust cases' and 'benefit cases',<sup>23</sup> his Honour reasoned that third parties entitled to take the benefit of a contract of insurance may be subject to the duty of utmost good faith -- with the extent of this duty depending on the circumstances of each case. He considered that in the circumstances of the case before the court (where the policy entitled the directors to claim benefits under the policy), the duty of good faith could require third parties in the position of the former directors to disclose relevant information to the insurer. Additionally, through noting the remarks of Stephen J in *Distillers*, who had held that the duty of good faith also applied to the exercise by an insurer of rights under a contract, Mahoney JA also briefly reasoned that the duty of good faith could apply to the determination of claims against the

policy by third parties.<sup>24</sup> Although Mahoney JA's remarks were obiter, they represent a further stage in the evolution of utmost good faith in relation to third parties -- and as explained below, have been applied in several later cases involving claims by third parties.

## ICA s 13 cases

The decision of Hunter J in *Wyllie v National Mutual Life Association of Australasia Ltd*<sup>25</sup> was a significant progression in the application of the duty of utmost good faith in relation to claims by third parties, as it was the first decision to directly apply s 13 of the ICA in the determination of a disputed claim by a third party claimant. Mr Wyllie, an accountant, was entitled to TPD benefits under a group life assurance scheme which had been arranged by the trustee of his employer's superannuation fund. After suffering a stroke, Mr Wyllie lodged a claim for TPD benefits under the group life assurance policy. The insurer requested Mr Wyllie's treating doctor to provide a 'detailed medical report' on his condition, his current and anticipated level of disability and the types of work which he might be capable of in the future -- but did not inform the doctor of the TPD definition in the policy.<sup>26</sup> The doctor's report to the insurer noted that she anticipated Mr Wyllie could be capable of performing accounting work, but only under supervision given the nature of his cognitive defects. After declining Mr Wyllie's claim, the insurer refused to provide him with the doctor's report to review and comment upon, stating it had been provided 'solely and confidentially' for the use of the insurer.

After noting the determinations from *Trident*, *Edwards* and *Chammas*, and the reasoning of Mahoney JA in *C E Heath v Grey*, Hunter J held that the insurer was under a duty of good faith and fair dealing, which required it to have due regard to Mr Wyllie's interests in determining the claim.<sup>27</sup> He reasoned that:

Where s 13 of the [ICA] imports a duty into a contract of insurance upon parties to the contract to act with the utmost good faith towards each other 'in respect of any matter arising under or in relation' to the contract, it is extremely difficult to see how such a duty of the insurer is not extended as an 'incident of the relationship' in respect of a third party in the position of the plaintiff under the conversion option of the policy: in this instance, in respect of the performance of the contract by the insurer.<sup>28</sup>

Applying these considerations to the case before him, Hunter J concluded that the insurer had failed to act reasonably, fairly or in good faith in its assessment of Mr Wyllie's claim. This had been due to the insurer's misconception that it was simply required to obtain medical reports on Mr Wyllie's medical condition and then together with the statements from Mr Wyllie and his former employer, determine whether he was totally and permanently disabled within the meaning of the policy.<sup>29</sup> His Honour also criticised the insurer's failure to make further inquiries about the restricted, closely supervised work that Mr Wyllie had actually been performing in the months after his stroke recovery.<sup>30</sup> He concluded that if the insurer had acted in accordance with its obligations and had due regard to Mr Wyllie's interests, it could not have formed a positive opinion that he was not totally and permanently disabled within the meaning of the group life assurance policy.<sup>31</sup>

One of the first cases to apply the principles from *Wyllie* was the decision of the Full Court of the Western Australian Supreme Court in *Beverley v Tyndall Life Insurance Co Ltd*,<sup>32</sup> although this did not involve a disputed claim by a third party. In this case, the insured had entered into a life insurance policy which provided benefits in the event of total and permanent disability. The insurer had obtained additional medical reports and had relied upon these reports when declining the insured's claim for TPD benefits following a back injury -- but did not disclose these reports to the insured.<sup>33</sup>

In their separate but concurring judgments, after considering the principles from *Wyllie* and the earlier decisions including *Distillers*, *Edwards* and *Chammas*, both Malcolm CJ and Ipp J (with whom Anderson J agreed) considered this non-disclosure to constitute a breach of the insurer's duty of good faith and fair dealing towards the insured. Malcolm CJ reasoned that the rationale for the insurer's duty of utmost good faith was that in determining claims, the insurer is 'in a very real sense acting as a judge in the insurer's own cause', and explained that the duty of good faith extended to acting fairly in the assessment and determination of the claim.<sup>34</sup> In consequence of the insurer's breach of its duty, the insurer's declination of Ms Beverley's claim was set aside and judgment was entered in her favour.<sup>35</sup>

The 2000 decision by the South Australian District Court in *Szuster v HEST Australia Ltd*<sup>36</sup> involved analogous background facts to *Wyllie* and *Beverley*. Judge Herriman found that the insurer's conduct in declining three separate claims for TPD benefits under a policy arranged by the trustee of a superannuation fund breached its duty of good faith and fair dealing to a former nurse who had suffered a back injury. While the decision represents the most extensive judicial assessment of the insurer's duty of good faith, Judge Herriman's reasoning on this point has been subsequently criticised.

After considering the determinations from the earlier decisions including *Edwards*, *Chammas*, *Wyllie* and *Beverley*, Judge Herriman took a very extensive view of the insurer's duty of good faith. Noting the imbalance of power, resources and business understanding between the parties, his Honour opined that the duty required an insurer to take all appropriate steps to ensure that the claimant is made aware of the type of material the insurer wishes to consider in reaching its opinion; is provided with copies of all relevant materials which the insurer itself has, whether or not it intends to rely upon them; and is afforded an opportunity to put submissions to the insurer on all matters favourable or unfavourable to the claimant.<sup>37</sup> However this extensive view was subsequently criticised for exceeding the previous authorities. In *Sayseng v Kellogg Superannuation Pty Ltd*, Bryson J clarified that the duty of good faith does not oblige insurers to act in the manner required of public authorities who must afford natural justice to persons affected by prospective decisions, nor to follow specific procedures such as conducting hearings or give claimants an opportunity for personal attendance, legal representation or examination of witnesses.<sup>38</sup>

Judge Herriman noted with concern that one of the assessing doctors had not been provided with the TPD definition in the policy; the reports by the other doctors treating the claimant; nor had he been informed about a return to work plan developed for the claimant. Nor had the insurer provided the claimant with copies of the medical reports it relied upon to decline the claims in order for her to comment upon. His Honour determined the insurer had failed to consider the correct question required by the policy -- which involved considering not only the claimant's capacity to undertake work for which she was qualified -- but also the reasonable availability of that work, and the likelihood that she would be able to undertake such work with her back condition. The combination of these failures lead Judge Herriman to conclude that in declining the TPD claims, the insurer had had not acted fairly, in good faith or reasonably.<sup>39</sup> Given these failures, on the evidence before the court he declared the claimant to be totally and permanently disabled within the meaning of the policy.<sup>40</sup>

The decision of Bryson J in *Sayseng v Kellogg Superannuation Pty Ltd*<sup>41</sup> represented a further evolution in illustrating the duty of good faith owed by insurers in determining TPD claims by third party claimants.<sup>42</sup> Mr Sayseng, a former employee of Kelloggs, lodged a claim for TPD benefits under a group life policy which had been arranged by the trustee of his employer's superannuation fund due to a back condition. In declining his claim, the insurer relied significantly on the video surveillance footage obtained by a private inquiry agent. The insurer passed this video footage to a medical specialist and to an occupational physiotherapist, who both concluded the video footage indicated that Mr Sayseng had exaggerated the severity of his back condition. However despite the insurer passing this information on to the trustee, Mr Sayseng was not informed of this video footage, nor of the reports by the medical specialist and the occupational physiotherapist.<sup>43</sup>

Following the reasoning of Mahoney JA in *CE Heath v Grey*, Bryson J determined that although as a third party claimant Mr Sayseng did not fall directly within the scope of s 13 of the ICA, he had standing to bring proceedings against the insurer for breaching its duty of good faith in determining his claim -- given that that the structure of the insurance arrangements in the group life contract meant that a fair decision could not be made without dealing fairly with him as a claimant.<sup>44</sup> His Honour then applied the reasoning of McLelland J from *Edwards* to summarise the insurer's obligations under the policy in determining Mr Sayseng's claim. These obligations included determining the correct question; having due regard for the interests of Mr Sayseng as a claimant as well as those of the trustee; and acting reasonably in forming its opinion about Mr Sayseng's degree of disablement. He also noted that if the insurer's decision was shown to be unreasonable on the material available to it, the matter could be determined by the court based on the available evidence.<sup>45</sup>

After noting that in *Chammas, Wyllie and Beverley* it had been held to be unfair for insurers to rely upon detailed medical reports as a basis for refusing claims without giving claimants an opportunity to comment upon such reports, Bryson J held that the insurer had breached its duty of good faith and fair dealing in its declination of Mr Sayseng's claim,<sup>46</sup> and ordered the holding of further proceedings to determine the claim.<sup>47</sup>

Together with *Trident* and Mahoney JA's reasoning in *CE Heath v Grey*, Bryson J's recognition of the standing of Mr Sayseng to challenge the effectiveness of the insurer's determination was cited by the landmark Milne Cameron Report for amendments to the Insurance Contracts Act 1984 to extend the (post-contractual) duty of utmost good faith to third party beneficiaries.<sup>48</sup> After a considerable delay, these recommendations were finally implemented through the Insurance Contracts Amendment Act 2013 (Cth). These amendments specifically extended the post-contractual duty of utmost good faith to 'third party beneficiaries'<sup>49</sup> through inserting subss 13(3) and 13(4) into the ICA. These amendments received Royal Assent on 28 June 2013 and apply to contracts entered into after 28 June 2013.<sup>50</sup>

Bryson J's determination was upheld on appeal in *Hannover Life Re of Australasia Ltd v Sayseng*.<sup>51</sup> Santow JA (with whom Spigelman CJ and Tobias JA agreed) expressed his approval of the obiter reasoning by Mahoney JA in *CE Heath v Grey*<sup>52</sup> that an insurer's duty of utmost good faith could extend to third party claimants such as Mr Sayseng.<sup>53</sup> Santow JA also agreed with the trial judge's application of the principles from *Edwards* in relation to Hannover's duty of good faith to Mr Sayseng,<sup>54</sup> and also held that Mr Sayseng's expectation of being owed a duty of utmost good faith by Hannover was supported by the reasoning of Mason CJ, Wilson and Toohey JJ in *Trident*.<sup>55</sup> Proceeding from this basis, Santow JA agreed with the trial judge that Hannover's conduct in declining the TPD claim breached its duty of utmost good faith towards Mr Sayseng.<sup>56</sup>

## Post-Sayseng

In *Dumitrov v SC Johnson & Son Superannuation Pty Ltd*,<sup>57</sup> Gzell J of the NSW Supreme Court sharply criticised the decision-making process of Hannover Life Re of Australia (Hannover) in declining a TPD claim under a policy arranged by the trustee of his employer's superannuation fund by a Mr Dumitrov, a process worker and line setter with limited English skills and work experience who had injured his wrist and forearm at work. His Honour found that Hannover's failure to make further inquiries in relation to medical reports constituted a breach of its duty of utmost good faith.

Based on the earlier decisions of *Wyllie* and *Hannover v Sayseng*, Gzell J considered that that it was now 'beyond doubt' that even though he was not a party to the contract, Mr Dumitrov was owed a duty of utmost good faith by Hannover.<sup>58</sup> His Honour also noted that the question of whether an insurer has discharged its duty of utmost good faith will depend on the particular circumstances of each case.<sup>59</sup> From this basis he noted with concern that one of the doctors to whom Hannover had referred Mr Dumitrov for assessment was not provided with the TPD definition in the policy;<sup>60</sup> that Mr Dumitrov was not informed of the information he needed to present to substantiate his claim; and that he had not been provided with an opportunity to respond before Hannover made its final determination.<sup>61</sup> A further concern was that Hannover had failed to make further inquiries in relation to an orthopaedic surgeon's report from that was favourable to Mr Dumitrov's claim. Hannover had largely dismissed this report (which had assessed Mr Dumitrov as 'unfit for work' on the basis that did not specifically discuss whether Mr Dumitrov was 'unable to ever engage in or work for reward in any occupation or work which he or she is reasonably capable of performing by reason of education, training or experience' as required by the policy).<sup>62</sup>

At trial, Hannover's senior claims manager explained that when reviewing Mr Dumitrov's claim 'I was asked to conduct a review of the file from the trustees. I wasn't asked to reinvestigate'.<sup>63</sup> However Gzell J rejected this explanation, concluding that Hannover was bound to reinvestigate after receiving the surgeon's report, and that rather than reasonably and fairly considering whether Mr Dumitrov fell within the TPD definition in the policy, it had merely formed the view that Hannover's earlier rejection of Mr Dumitrov's claim was justified on an analysis of the material on Mr Dumitrov's file.<sup>64</sup> In the circumstances, this failure to further investigate constituted a breach of Hannover's duty to act with utmost good faith towards Mr Dumitrov.<sup>65</sup>

His Honour also held that Hannover had failed to act fairly and reasonably through rejecting a report by another medical specialist who had considered that Mr Dumitrov was totally and permanently disabled. Hannover's claims manager had noted that the occupational physician had appeared to misinterpret the TPD definition in the policy, but did not follow this up further with the occupational physician.<sup>66</sup> Furthermore, Gzell J critically noted that Hannover's claims manager had placed undue weight on Mr Dumitrov's apparent exaggeration of his symptoms and his lack of motivation to return to work, and insufficient weight on the reports from the assessing medical specialists. His Honour concluded that 'Not only did Hannover misconceive its duty and fail to carry out a re-examination, but also the review of the file was unfairly biased against Mr Dumitrov'.<sup>67</sup> Having determined that Hannover had breached its duty of utmost good faith,<sup>68</sup> Gzell J determined from the evidence before the court that Mr Dumitrov was totally and permanently disabled within the meaning of the policy.<sup>69</sup> In a subsequent decision, Mr Dumitrov was awarded interest under s 57 of the ICA to compensate for Hannover's unreasonable withholding of insurance monies in relation to his claim.<sup>70</sup>

In *CGU Workers Compensation (NSW) Ltd v Garcia*,<sup>71</sup> the NSW Court of Appeal over-turned an earlier NSW District Court finding that the insurer had breached both a tortious duty of good faith, and an implied contractual term of good faith, in discontinuing a worker's compensation payments following the insurer's receipt of new information from an investigator and an orthopaedic surgeon which was not favourable to the worker's claim. After reviewing the background circumstances, Mason P, with whom Hodgson and Santow JJA agreed, helpfully clarified that an insurer's duty to act in good faith is 'wider than the duty not to act dishonestly or fraudulently; but narrower than a fiduciary duty requiring the obligee to put the other party's interest above its own'.<sup>72</sup>

After pointing out that the NSW statutory scheme, not principles of contract or tort law, regulated the rights and obligations of insurers, employers and workers,<sup>73</sup> his Honour sharply criticised the trial judge's generation of a novel tort of good faith,<sup>74</sup> noting that the case law in Australia and the United Kingdom had been hostile to the reception of such a tort.<sup>75</sup> For similar reasons Mason P also rejected arguments about the existence of an implied contractual duty of good faith in the workers' compensation policy under consideration.<sup>76</sup> With these legal considerations clarified, he determined that on the evidence before the court, the insurer had been justified in its decision to discontinue the worker's compensation payments.<sup>77</sup>

Also handed down in 2007 was the landmark decision of the High Court of Australia in *CGU Insurance Ltd v AMP Financial Planning Pty Ltd*.<sup>78</sup> This case did not involve questions about the insurer's duty of utmost good faith to third party claimants, but rather considered the insurer's handling of a complex claim against its insured, AMP Financial Planning Pty Ltd. While the decision has been extensively critiqued elsewhere,<sup>79</sup> for the purposes of this article it is relevant to note that the reasoning of the majority judges<sup>80</sup> highlights that the duty of utmost good faith requires that the insurer's rights and obligations must be assessed strictly in accordance with the contract -- nothing less but also nothing more. As shown in a number of the cases in this article, several insurers have breached the duty of utmost good faith through their failure to strictly adhere to the definitions of total and permanent disablement when assessing claims.

Among the numerous cases of insurers breaching their duties of utmost good faith in determining TPD claims by third party claimants, *Erzurumlu v Kellogg Superannuation Pty Ltd*<sup>81</sup> provides an example of conduct by an insurer which did not breach these obligations. Following two back injuries at work in 2003, Mr Erzurumlu ceased full-time work in February 2005 following the withdrawal of suitable duties by his employer Kelloggs.<sup>82</sup> In 2003 he had reached a settlement with Kelloggs in relation to a lump sum compensation claim under s 66 of the Workers Compensation Act 1987 (NSW) on the basis that he suffered a 25% permanent impairment of his back, 25% loss of efficient use of his right leg and 8% permanent loss of the efficient use of his right arm,<sup>83</sup> and underwent extensive medical assessments between 2003 and 2005. In December 2008 he lodged a claim for TPD benefits under a group life insurance policy which had been arranged by the trustee of the Kelloggs Superannuation fund,<sup>84</sup> which defined 'total and permanent disablement' to mean:

having been absent from work through injury or illness for an initial period of six (6) consecutive months and in our opinion being incapacitated to such an extent as to render the Insured Person unable ever to engage in or work for reward in any occupation or work which he or she is reasonably capable of performing by reason of education, training or experience.<sup>85</sup>

The insurer declined Mr Erzurumlu's claim based on the medical reports contained in his workers' compensation claim file from 2005, and also images from his public webpage showing him riding motorbikes.<sup>86</sup> In dismissing Mr Erzurumlu's challenge to the insurer's decision, Ball J was satisfied that the insurer had drawn Mr Erzurumlu's attention to the material that it intended to rely upon in determining his claim, and that it was not unreasonable for the insurer to rely on the publicly available image on Mr Erzurumlu's webpage showing him riding motorbikes.<sup>87</sup> His Honour also considered it was reasonable for the insurer to rely upon the medical reports in Mr Erzurumlu's workers' compensation file from 2005, rather than obtaining its own independent medical assessments. These medical reports from 2005 provided evidence of his medical condition 6 months after ceasing work with Kelloggs, as required by the group life insurance policy, and had concluded that Mr Erzurumlu could still undertake work, albeit with lifting restrictions.<sup>88</sup> Given that there had been significant changes to Mr Erzurumlu's back condition and the economy relevant to his former working role in the intervening 3 years between his cessation with Kelloggs and his lodgement of the TPD claim, his Honour concluded the insurer had not acted unreasonably in rejecting the claim, and dismissed Mr Erzurumlu's application.<sup>89</sup>

*Lazarevic v United Super Pty Ltd*<sup>90</sup> involved an insurer's failure to consider the correct question required by the policy, and the failure to follow up and further investigate uncertainties arising from medical reports. The decision also provides guidance on the obligations of insurers when drawing upon expert medical evidence in the determination of TPD claims. In this case Mr Lazarevic, a scaffolding worker with limited English skills and no other experience or qualifications, had lodged a claim for TPD benefits under a policy arranged by the trustee of his union superannuation fund after he sustained a back injury in the course of his employment.

While noting that the insurer had identified several alternative roles to which it considered Mr Lazarevic might be suited, including as a process operator, a crane operator and forklift operator, Hallen J accepted Mr Lazarevic's submission that he had no qualifications, nor licensed experience in these roles,<sup>91</sup> and his assertions that driving a forklift could exacerbate his back injuries.<sup>92</sup> His Honour also criticised the insurer's failure to make further inquiries in relation to a report submitted by an assessing occupational physician consultant, which had recommended making a further evaluation of Mr Lazarevic's condition and work capacity at a later date to ascertain his degree of disablement.<sup>93</sup>

Based on his review of *Edwards* and *Sayseng*, Hallen J distilled nine obligations of insurers in determining TPD claims involving the consideration of expert medical evidence. These were:

- (a) The insurer must consider, and determine, the correct question or questions. This essentially requires the correct interpretation of the policy of insurance.
- (b) If the insurer seeks an opinion from an expert, it must provide the expert with all of the information that is relevant to the expert's opinion.
- (c) Where an expert opinion is sought, the expert must also be asked the right questions.
- (d) Asking the right questions of the expert, however, does not require the insurer to ask the expert to address specific provisions in the policy. The insurer is itself making the ultimate decision, and not delegating the decision making to the expert. The critical enquiry for the court is whether the insurer, ultimately, has addressed the correct questions either directly, or indirectly with the aid of the expert's opinion, and has taken account of the relevant information either directly, or indirectly, in respect of relevant information assessed by the expert.
- (e) The insurer is under a duty to act in good faith and to observe fair dealing in respect of both the trustee and the insured.
- (f) As part of this duty, the insurer must have due regard for the interests of the insured. However, this duty is contractual, not fiduciary. This duty is analogous to the duty of a mortgagee exercising a power of sale of mortgage property.
- (g) Where a state of affairs governing entitlement of the insured to a benefit is to be determined after a consideration by the insurer, the insurer must act reasonably in considering the matter and in coming to its conclusion.
- (h) If the view taken by the insurer can be shown to have been unreasonable on the material before it, the



insurer's decision can be successfully attacked.

- (i) If the insurer's decision is successfully attacked, the matter upon which its opinion was required becomes one for determination by the court.<sup>94</sup>

After considering the medical evidence and Mr Lazarevic's very limited work experience, Hallen J determined him to be totally and permanently disabled within the meaning of the policy, and considered the decisions of the trustee and insurer in rejecting his claim to have been unreasonable.<sup>95</sup> In particular, his Honour was critical of the failure by the trustee and the insurer to have undertaken actual labour and market analyses with potential employers to assess the likelihood of Mr Lazarevic obtaining employment in the roles that had been suggested for him.<sup>96</sup> He noted that 'As in *Baker*,<sup>97</sup> the insurer and the trustee appears to have grasped at the possibility, or theory, of the availability of some work, and refrained from turning its mind to the question whether, in the real world, Mr Lazarevic was ever likely to obtain such work'.<sup>98</sup>

Following shortly after *Lazarevic, Banovic v United Super Pty Ltd*<sup>99</sup> involved similar background circumstances and failures by the insurer to act fairly and reasonably in determining a TPD claim. Mr Banovic was a formwork labourer aged in his 50s with little other experience or work skills and limited English who sustained serious injuries to his upper arm and shoulder in the course of his employment.

In a wide-ranging review of the case law applicable to the determination of TPD claims, Hall J noted from *Chammas* that the capacity of a claimant to undertake the particular work suggested by trustees and insurers 'must be examined in a realistic and not a mere theoretical way'.<sup>100</sup> With these considerations in mind, his Honour noted in relation to the insurer's view that Mr Banovic was suited to forklift driving, that he had obtained his forklift licence 2 years after his accident, which was at a later time than the 6-month TPD qualifying period under the policy.<sup>101</sup> He also noted critically that Mr Banovic had no prior experience or training for the 'process worker', 'light packer' or delivery driver roles which the insurer suggested as suitable; that his poor English skills would be an impediment to gaining such roles; and that none of the assessing medical practitioners were asked to address his fitness for such roles. For these reasons his Honour determined that the trustee and insurer had failed to correctly consider Mr Banovic's claim against the TPD definition in the policy.<sup>102</sup>

Furthermore, the insurer's failure to include a medical opinion from an orthopaedic surgeon favourable to Mr Banovic, which had assessed his future work capacity as 'severely compromised by the effects of his injury' and which had advised he 'avoid strenuous and repetitive tasks' meant that a fair and objective appraisal of Mr Banovic's claim was unable to be made.<sup>103</sup> Having concluded that the trustee and insurer had failed to act reasonably in determining his TPD claim,<sup>104</sup> Hall J proceeded to determine Mr Banovic's TPD claim based on the evidence before the court -- concluding that he satisfied the TPD definition under the policy.<sup>105</sup>

Similar concerns about insurers misinterpreting medical reports arose in *Shuetrim v FSS Trustee Corporation*,<sup>106</sup> which involved a disputed TPD claim by a former police officer who was medically discharged due to an anxiety disorder and an elbow injury which were both incurred during his work with the NSW police force. In this case Mr Sheutrim was covered by two policies which provided TPD benefits -- a 'Basic Policy' issued by TAL Life which was available to all members of the first state superannuation scheme, and a 'Police -- Blue Ribbon Policy' issued by MetLife which provided additional cover for NSW police officers.<sup>107</sup> Stevenson J determined that the trustee and both insurers had committed procedural unfairness in declining Mr Sheutrim's claim.

As a result of his two medical conditions, Mr Sheutrim underwent surgery, psychological and psychiatric treatment, and attended numerous medical consultations. The evaluations of his degree of impairment by the assessing medical specialists was mixed. He also participated in a vocational assessment evaluation with a psychologist who noted several roles to which he might be suited given his skills and previous experience (including as a mechanic before he joined the NSW police force) -- but concluded that 'many of these occupations were not in accordance with his functional and psychological tolerances based on a review of available medical evidence'.<sup>108</sup>

TAL and MetLife both rejected Mr Sheutrim's claim for TPD benefits under the respective policies.<sup>109</sup> Stevenson J noted with concern that in its declinature of Mr Sheutrim's claim, TAL had been selective in the medical and other evidence it had relied upon. This included failing to consider some of the medical reports regarding his elbow condition; disregarding medical reports which had assessed his future work capacity as 'unknown'; and misinterpreting the conclusions from the report of his vocational assessment evaluation by disregarding the effect of his medical and psychological conditions on his work capacity.<sup>110</sup> His Honour concluded that TAL's consideration of the claim was 'so unreasonable as to constitute a breach of its duties of good faith and fair dealing to Mr Sheutrim'.<sup>111</sup> He made similar criticisms of the decision-making process of MetLife, which had also failed to properly consider the vocational assessment evaluation report in declining Mr Sheutrim's claim<sup>112</sup> -- which also constituted a breach of its duties of good faith and fair dealing to Mr Sheutrim.<sup>113</sup> After reviewing the medical and other evidence before the court, Stevenson J determined that Mr Sheutrim was totally and permanently disabled within the meaning of both the TAL and MetLife policies.<sup>114</sup> Both TAL and MetLife have filed notices of intention to appeal this decision.<sup>115</sup>

*Panos v FSS Trustee Corp*<sup>116</sup> involved a somewhat unique set of facts, in that a very large volume of medical evidence was considered, much of it having been submitted to the insurer on behalf of the claimant by his solicitors. In this case Ball J determined the insurer had breached its duty of utmost good faith through failing to specifically identify the information in the claim file (in this case, a vague medical report) which the insurer considered to be adverse to Mr Panos' claim, and through its failure to allow him sufficient time to provide further information to respond to a request for comment and further information in relation to his claim.

Mr Panos, a nursing assistant with very basic education whose his previous work experience had been limited to semiskilled jobs in which he had utilised his physical abilities, had been involved in two separate motor vehicle accidents whilst travelling to work. Through these accidents he sustained back, shoulder and psychological injuries which caused him considerable pain and restricted his ability to drive, sit and stand.

In its first declinature of Mr Panos' claim, the Insurer set out its decision in a detailed letter considering all of the medical and allied health reports.<sup>117</sup> The insurer had earlier sent Mr Panos a 'procedural fairness letter' which listed all of the 127 documents that had been considered in the determination of his claim, and invited him to make further submissions regarding these reports, which stated that 'We particularly draw your attention to the material in this list which may be adverse to your claim'. In this 'procedural fairness letter' the insurer gave Mr Panos less than 2 days to make such further submissions.<sup>118</sup>

Ball J determined that in taking these approaches, the insurer did not process Mr Panos' claim with the utmost good faith, and set aside its decision to reject the claim. He characterised the insurer's approach in giving Mr Panos only 2 days to respond to the request for further information to support his claim as 'manifestly inadequate',<sup>119</sup> and was also critical of the insurer's letter which had stated 'We particularly draw your attention to the material in this list which may be adverse to your claim' -- but which did not specifically identify any materials which the insurer considered to be adverse to Mr Panos' claim.<sup>120</sup>

After noting from *Chammas* that while insurers were not expected to afford 'natural justice in the full sense' to claimants,<sup>121</sup> his Honour explained that '... some attention to the requirements of natural justice is part of fairness and reasonableness in dealing with a case such as this'.<sup>122</sup> Applying these principles to Mr Panos' case, he continued to explain that:

Reasonable fairness required that the Insurer would provide the Trustee and Mr Panos with at least a concise outline of its position in relation to the evidence that it regarded to be significant, including as to:

- o the medical evidence that it preferred,
- o the aspects of Mr Panos' statements that it questioned,
- o the extent of Mr Panos' disabilities that it accepted, and
- o the approach it was minded to take concerning the real prospects that Mr Panos would actually gain employment that was reasonably suitable on the basis of his education, training and experience, and then give Mr Panos adequate time to make a focused response.<sup>123</sup>

Ball J also criticised the insurer's failure to make further inquiries in relation to a medical report that was generalised and which lacked specificity about Mr Panos' condition,<sup>124</sup> and its failure to consider two further medical reports (which had stated, albeit in generalised terms without further explanation that Mr Panos would never return to work) which were obtained during Mr Panos' court proceedings.<sup>125</sup> Having determined the insurer's conduct to have breached its duty of utmost good faith, his Honour then proceeded to consider whether Mr Panos was totally and permanently disabled within the meaning of the policy definition based on the evidence before him -- ultimately finding that he did not satisfy the policy definition.<sup>126</sup> Before making this determination, Ball J set out a very useful clarification of the decision-making process expected of insurers in determining TPD claims in order to satisfy the duty of utmost good faith:

[268] The process that must be applied by the Insurer is akin to administrative determination. The process is not adversarial. The applicant is required to provide materials to assist the Insurer to reach the necessary satisfaction. There is no burden of proof on the applicant in the strict sense. The process is in some respects inquisitorial, but with the difference that the Insurer has a positive duty to act with utmost good faith (as does the Trustee, and by implication, the applicant). The process is in some respects collaborative. The Insurer must take reasonable steps to ensure that it protects the interests of the applicant, and not just its own. The Insurer's consideration of the issues need not comply with all of the strictures to which a judicial determination is subject; in particular, the rules of evidence. The Insurer does not need to publish reasons that satisfy the requirements applicable to the reasons necessary to support a judicial decision. The Insurer must give adequate and clear reasons, but their validity will not be determined by the court as if on appeal.

[269] Importantly, the Insurer may have regard to its own expertise, so far as that expertise is adequate to support a proper determination, and does not require independent expert evidence.

[270] The Insurer may resolve uncertainties and conflicts of opinion by commissioning further investigations, and interrogating the experts, who have already provided opinion evidence.

[271] While, in a practical sense, the applicant has a burden to put sufficient material before the Insurer, it is not expected that the applicant will bear the cost burden of a full forensic investigation and proof. Much of the cost of the determination will be an overhead of the Insurer (or the Trustee).

[272] The nature and amount of the supporting material that the applicant will be required to provide to the Trustee, for provision to the Insurer, will depend upon the facts of each case, and there is no basis for making valid generalisations.<sup>127</sup>

In *Ziogos v FSS Trustee Corp (as trustee of First State Superannuation Scheme)*,<sup>128</sup> Ball J found the insurer had breached its duty of utmost good faith in declining a claim for TPD benefits by a former NSW police officer who was suffering from post-traumatic stress disorder (PTSD) as a result of her police work. In its investigation of the claim, the insurer considered reports from psychiatrists and psychologists, and also arranged for video surveillance of Ms Ziogos' daily activities.

While noting that one of the psychologists who had assessed Ms Ziogos had concluded that her PTSD was 'treatable', and expressed his hope that she might recover over time,<sup>129</sup> his Honour held that it was unreasonable for the insurer to rely upon such views about her possible future recovery. He concluded that the psychologist's report had applied the wrong test by considering what her capacity for future work might be in the event that her condition were to improve, rather than what was likely to be her current work capacity given her PTSD condition. In his view, the psychologist had placed undue emphasis on the possibility that Ms Ziogos might recover given her age -- she was 37 years of age as at the date of her TPD claim, with at least 28 years until the normal retirement age of 65.<sup>130</sup> Ball J was also critical of weight afforded by the insurer to the views of an assessing psychiatrist who had opined that Ms Ziogos would be able to return to work if she was supported with the appropriate specialist treatment, considering this view to be merely speculative.<sup>131</sup> Finally his Honour considered the insurer's reliance on video surveillance (which had showed her

undertaking activities such as walking her dog, shopping and visiting relatives, despite her claims that she often had difficulties getting out of bed) to be unreasonable -- as such activities bore no relationship to the activities she would need to undertake in the course of employment.<sup>132</sup> Having determined that the insurer had acted unreasonably and in breach of its duty of utmost good faith,<sup>133</sup> Ball J determined Ms Ziogos to be totally and permanently disabled within the meaning of the policy.<sup>134</sup>

## Conclusion

Through its review of the above decisions and legislative developments, this article has shown a progressive trend towards the recognition that insurers owe the duty of utmost good faith to third party beneficiaries, as well as towards insured parties, in the determination of claims. These decisions provide a range of useful examples of the conduct by insurers that has been held to breach the duty of utmost good faith, with the concepts of fairness, reasonableness and transparency being consistent themes in the cases noted above. The article highlights the need for insurers to carefully and accurately apply the correct policy questions when determining claims; advising assessing medical practitioners and other experts about the relevant policy criteria required to be satisfied; informing claimants about the basis for declining claims, and providing claimants with opportunities to respond to insurers' decisions before finalising claims. While the nature, extent and limits of the duty of utmost good faith have been acknowledged as challenging to conclusively delimit, the cases discussed in this article provide some very useful examples of the considerations that insurers should be mindful of to avoid breaching the duty.

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1 *Carter v Boehm* [1558-1774] All ER Rep 183; (1766) 3 Burr 1905 at 1909-10; 1 Wm BI 593; 97 ER 1162 at 1164.

2 For a comprehensive discussion on total and permanent disablement insurance, see W I B Enright and R Merkin, *Sutton on Insurance Law*, 4th ed, Law Book Co, 2015, vol 2, ch 21, 'Life Insurance', particularly, p 577-612.

3 As B McGivern notes, studies to have acknowledged these challenges include F Hawke, 'Utmost Good Faith -- What does it really mean?' (1994) 6 *ILJ* 91; K Godfrey, 'The duty of utmost good faith: The great unknown of modern insurance law' (2002) 14 *ILJ* 1; M Mills, 'Duty of Utmost Good Faith: The 'sleeper' of insurance obligations' (2006) 80 *ALJ* 387; R Natrass, 'Extending the unfair contract terms laws to insurance contracts: Is the duty of good faith fair enough?' (2012) 23 *ILJ* 299 at 303; and B McGivern, 'Coming to the party: The evolution of post-contractual duties of utmost good faith under the ICA' (2013) 24 *ILJ* 159.

4 B McGivern, 'Coming to the party: The evolution of post-contractual duties of utmost good faith under the ICA' (2013) 24 *ILJ* 159 at 162.

5 (1974) 130 CLR 1; 2 ALR 321; 48 ALJR 136; BC7400010.

6 *Ibid*, at CLR 29; ALR 343.

7 Australian Law Reform Commission, *Insurance Contracts*, ALRC Report20, Australian Government Publishing Service, 1982, at [328].

8 (1988) 165 CLR 107; 80 ALR 574; 5 ANZ Ins Cas 60-873; BC8802625.

9 Mason CJ, Wilson, Toohey and Gaudron JJ held that the appeal should be dismissed; and Brennan, Deane and Dawson JJ held that it should be allowed.

10 *Trident General Insurance Co Ltd v McNiece Bros Pty Ltd* (1988) 165 CLR 107 at 172; 80 ALR 574 at 621; 5 ANZ Ins Cas 60-873; BC8802625.

11 (1992) 7 ANZ Ins Cas 61-113; BC9201930.

12 *Ibid*, at 77,534.

13 *Ibid*, at 77,537.

14 On this point McLelland J cited *Butcher v Port* (1985) 3 ANZ Ins Cas 60-638; 1 NZLR 491 at 496 and 504 -- where the NZ Court of Appeal had held that where the formation of an opinion by the insurer is in the nature of a condition of its liability, the insurer cannot rely on

the non-fulfilment of that condition if that non-fulfilment was prevented by its own default: *ibid*, at 77,537

15 His Honour commented that the duty of good faith was 'analogous to the duty that a mortgagee is subject to when exercising a power of sale of mortgaged property, and to the duty to which a controlling shareholder is subject to when exercising a right to procure the passage of a resolution influencing the interests of shareholders at a general meeting: *Peters' American Delicacy Company Limited v Heath* (1939) 61 CLR 457 at 502-4; *Edwards v Hunter Valley Co-op Dairy Co Ltd*, *ibid*, at 77,536.

16 (1993) 7 ANZ Ins Cas 61-175; BC9301704.

17 *Ibid*, at 78,001.

18 *Ibid*, at 78,000.

19 (1993) 32 NSWLR 25; 7 ANZ Ins Cas 61-199; BC9305253.

20 *Carden v CE Heath Casualty & General Insurance Ltd* (1992) 7 ANZ Ins Cas 61-147; BC9201463.

21 *C E Heath Casualty & General Insurance Ltd v Grey* (1993) 32 NSWLR 25 at 32-6; 7 ANZ Ins Cas 61-199 at 78,272-6.

22 [1558-1774] All ER Rep 183; (1766) 3 Burr 1905 at 1909-10; 1 Wm BI 593; 97 ER 1162 at 1164.

23 *C E Heath Casualty & General Insurance Ltd v Grey* (1993) 32 NSWLR 25 at 37-8; 7 ANZ Ins Cas 61-199 at 78,276-7.

24 *Ibid*, at NSWLR 39-40; ANZ Ins Cas at 78,277-9.

25 (1997) 217 ALR 324; BC9703063.

26 *Ibid*, at 328.

27 *Ibid*, at 328-30.

28 *Ibid*, at 340.

29 *Ibid*, at 341.

30 *Ibid*, at 341-2.

31 *Ibid*, at 360.

32 (1999) 21 WAR 327; 10 ANZ Ins Cas 61-453; [1999] WASCA 198; BC9906479.

33 *Ibid*, at ANZ Ins Cas 75,194-6.

34 *Ibid*, at 75,192.

35 *Ibid*, at 75,205.

36 (2000) 207 LSJS 35; [2000] SADC 2.

37 *Ibid*, at [41].

38 *Sayseng v Kellogg Superannuation Pty Ltd* [2003] NSWSC 945; BC200306802 at [86]-[87].

39 *Szuster v HEST Australia Ltd* (2000) 207 LSJS 35; [2000] SADC 2 at [104], [113]-[114], [134], [157] and [164].

40 *Ibid*, at [169].

41 [2003] NSWSC 945; BC200306802.

42 For a detailed critique of this case, see T Scott, 'Implications of *Hannover v Sayseng*: Third parties and the duty of the utmost good faith' (2006) 17 *ILJ* 48.

43 *Sayseng v Kellogg Superannuation Pty Ltd* [2003] NSWSC 945; BC200306802 at [26]-[28] and [93].

44 *Ibid*, at [79]-[80] and [89].

45 *Ibid*, at [81]-[82].

46 *Ibid*, at [88] and [94]-[95].

47 *Ibid*, at [97]. In a later determination, Nicholas J held that Mr Sayseng was totally and permanently disabled within the meaning of the policy: *Sayseng v Kellogg Superannuation Pty Ltd* (2007) 213 FLR 174; 14 ANZ Ins Cas 61-738; [2007] NSWSC 857; BC200706317.

48 A Cameron and N Milne, *Review of the Insurance Contracts Act 1984 (Cth) Final Report on Second Stage: Provisions other than s 54*, June 2004, at 10.4-10.5.

49 The Insurance Contracts Amendment Act 2013 (Cth) introduced the term 'third party beneficiary' into the ICA -- which s 11 defines as 'under a contract of insurance, means a person who is not a party to the contract but is specified or referred to in the contract, whether by name or otherwise, as a person to whom the benefit of the insurance cover provided by the contract extends'.

50 For commentary on these amendments, see R Box and T Webster, 'Evolution not revolution -- Insurance Contracts Amendment Act finally passed' (2013) 28(8) *ILB* 114.

51 (2005) 13 ANZ Ins Cas 90-123; [2005] NSWCA 214; BC200504681.

52 (1993) 32 NSWLR 25 at 37-8; 7 ANZ Ins Cas 61-199; BC9305253.

53 *Hannover Life Re of Australasia Ltd v Sayseng* (2005) 13 ANZ Ins Cas 90-123 at 86,620; [2005] NSWCA 214; BC200504681 at [39].

54 *Ibid*, at [47]-[51].

55 *Ibid*, at [56]-[72].

56 *Ibid*, at [73]-[89].

57 [2006] NSWSC 1372; BC200610354.

58 *Ibid*, at [5].

59 *Ibid*, at [26].

60 *Ibid*, at [24] and [58].

61 *Ibid*, at [28] and [40].

62 *Ibid*, at [28], [35] and [50]-[51].

63 *Ibid*, at [41].

64 *Ibid*, at [41].

65 *Ibid*, at [57].

66 *Ibid*, at [59]-[62].

67 *Ibid*, at [64]-[65].

68 *Ibid*, at [66].

69 *Ibid*, at [69]-[82].

70 *Dumitrov v SC Johnson & Son Superannuation Pty Ltd (No 2)* (2007) 14 ANZ Ins Cas 61-722; [2007] NSWSC 42; BC200700485.

71 (2007) 69 NSWLR 680; 14 ANZ Ins Cas 61-746; (2007) Aust Torts Reports 81-908; [2007] NSWCA 193; BC200706429.

72 Ibid, at [60].

73 Ibid, at [84]-[101].

74 Ibid, at [105].

75 Ibid, at [102]-[129].

76 Ibid, at [145].

77 Ibid, at [149]-[156].

78 (2007) 235 CLR 1; 62 ACSR 609; [2007] HCA 36; BC200707214.

79 See, eg, M Ellis, 'Utmost good faith: The scope and application of s 13 of the Insurance Contracts Act in the wake of *CGU v AMP*' (2009) 20 *ILJ* 922; B McGivern, 'Coming to the party: The evolution of post-contractual duties of utmost good faith under the ICA' (2013) 24 *ILJ* 159.

80 Per Gleeson CJ and Crennan J (joint judgment); Callinan and Heydon JJ (joint judgment) cf Kirby (in dissent).

81 [2013] NSWSC 1115; BC201311971.

82 Ibid, at [22]-[23].

83 Ibid, at [13].

84 Ibid, at [68].

85 Ibid, at [5].

86 Ibid, at [37]-[44].

87 Ibid, at [64]-[66].

88 Ibid, at [68].

89 Ibid, at [70], [82] and [83].

90 [2014] NSWSC 96; BC201400772.

91 Ibid, at [38], [130].

92 Ibid, at [85].

93 Ibid, at [75].

94 Ibid, at [101].

95 Ibid, at [125]-[129].

96 Ibid, at [147].

97 *Baker v Local Government Superannuation Scheme Pty Ltd* [2007] NSWSC 1173; BC200708964 at [109] per McDougall J.

98 *Lazarevic v United Super Pty Ltd* [2014] NSWSC 96; BC201400772 at [148].

99 *Banovic v United Super Pty Ltd* [2014] NSWSC 1470; BC201411315.

100 Ibid, at [77].

101 Ibid, at [85].

102 Ibid, at [179], [184] and [187].

103 Ibid, at [182].

104 Ibid, at [205]-[216].

105 Ibid, at [217]-[274].

106 [2015] NSWSC 464; BC201503032.

107 Ibid, at [5]-[6].

108 Ibid, at [137].

109 Ibid, at [201] and [240].

110 Ibid, at [202]-[229].

111 Ibid, at [230].

112 Ibid, at [231]-[247].

113 Ibid, at [248]-[249].

114 Ibid, at [251]-[308].

115 *Shuetrim v FSS Trustee Corporation* [2015] NSWSC 811; BC201505516.

116 [2015] NSWSC 1217; BC201508183.

117 Ibid, at [42].

118 Ibid, at [37] and [51].

119 Ibid, at [224] and [229].

120 Ibid, at [226]-[227].

121 On this point, see the remarks of Bryson J in *Sayseng v Kellogg Superannuation Pty Ltd* [2003] NSWSC 945; BC200306802 at [86]-[87].

122 *Panos v FSS Trustee Corp* [2015] NSWSC 1217; BC201508183 at [231].

123 Ibid, at [233].

124 Ibid, at [234]-[243].

125 Ibid, at [248]-[255].

126 Ibid, at [266]-[471].

127 Ibid, at [268]-[272].

128 [2015] NSWSC 1385; BC201509333.

129 Ibid, at [24].

130 Ibid, at [102].

131 Ibid, at [103].

132 Ibid, at [104].



133 Ibid, at [100].

134 Ibid, at [106]-[126].

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