Consumer Credit
Legal Centre NSW

July 2009

Submission in response to the

Inquiry into the Trade Practices Amendment (Australian Consumer Law) Bill 2009

by

Insurance Law Service

A project of the

Consumer Credit Legal Centre (NSW) Inc

About the Insurance Law Service ("ILS")

The Consumer Credit Legal Centre is a community legal centre that also maintains a project called the Insurance Law Service ("ILS"). The ILS is a pilot project funded by the Legal Aid Commission of NSW, the Law and Justice Foundation of NSW and the Victoria Law Foundation. It has recently been granted funding for the 2009/2010 financial year from the Commonwealth Attorney-General's Department.

The service has so far given advice or information to over 2,000 consumers in relation to insurance issues, and provided casework assistance to nearly 130 consumers. While over 70% of our work has been for NSW residents, we are available nationally and over 20% of our assistance has been given to consumers from other states, giving us a broader perspective than a state based service.

ILS strongly supports the intention of the Trade Practices Amendment (Australian Consumer Law) Bill 2009 (the "Bill").

The main purpose of this submission is to comment on the issue of general insurance contracts being excluded from being regulated by the Bill. ILS strongly believes that the Bill must also apply to general insurance contracts.

Background

At pages 31-32 of the Explanatory Memorandum for the Bill there is a section which states

Effect of Insurance Contracts Act 1984 on certain consumer contracts

> *2.100 Section 15 of the Insurance Contracts Act 1984 provides that a contract of insurance (as defined by that Act) is not capable of being made the subject of relief under any Commonwealth Act, a State Act or an Act or Ordinance of a Territory. In this context 'relief' means relief in the form of:*
>
> - *the judicial review of a contract on the ground that it is harsh, oppressive, unconscionable, unjust, unfair or inequitable; or*
> - *relief for insureds from the consequences in law of making a misrepresentation,*
>
> *but does not include relief in the form of compensatory damages. The effect of section 15 is to mean that the unfair contract terms provisions of either the ACL or the ASIC Act do not apply to contracts of insurance covered by the Insurance Contracts Act 1984, to the extent that that Act applies.*

The difficulty is that the Explanatory Memorandum does not go on to discuss the reasoning behind this exclusion or whether any further action needs to be taken to amend section 15 of the Insurance Contracts Act 1984 ("ICA") to rectify this exclusion.

The ICA does not provide any consumer protection measures for consumers in relation to unfair terms. The ICA does provide for a duty of utmost good faith but this does not protect consumers from unfair terms. The duty of utmost good faith does not provide a consumer with a remedy who has been affected by an unfair term.

The effect is that consumers with insurance contracts under the ICA do not have adequate protection from unfair terms. This is a very poor outcome for those consumers.

The use of unfair terms by the Insurance Industry

Unfortunately, insurance contracts are one of the areas of most concern for the use of unfair terms.

Please find attached (as Annexure A) a copy of the Panel Chair's Report in the 2004 Annual Review for the Insurance Enquiries and Complaints Scheme (now the Financial Ombudsman Service). The scheme considers disputes from consumers about general insurance products. The matters raised in this report have been a recurrent theme in subsequent reports.

The Panel Report at page 25 states:

> *"In his report, the Panel Chair, Peter Hardham, illustrated a number of instances where the Panel has made decisions which, whilst legally correct, may be viewed as unfair or harsh."*

A summary of examples of unfair terms covered in this report are provided below:

- *An applicant who lost a $50,000 car damage claim because he did not disclose one speeding offence prior to policy renewal.*

  How many consumers would miss this at renewal!

- *A landlord was not covered by his policy when the tenant burned down the home. This is because of an exclusion for damage caused by an invitee.*

  This is a potential public interest problem for policy holders who are landlords. Landlords can be faced with very irresponsible tenants who cause considerable property damage. Landlords expect to be covered and yet may not be. It also means this exclusion can affect lenders with a mortgage over the property in question.

- *The injured worker who could not claim disablement benefits as the policy provided cover only if disablement occurred within 12 months of the incident giving rise to the claim.*

  Very unfair term given public hospital waiting lists!

- *The travel insurance policy that only covers injury sustained at the departure terminal subject to his establishing he travelled to the point of departure by public conveyance.*

The insurance cover is clearly illusory due to the use of unfair terms.

The above report clearly confirms that:

1) There are problems with the use of unfair terms in the insurance industry

2) The current law including the ICA does not address the use of unfair terms

3) The Duty of Utmost Good Faith does not address the problem of unfair terms

4) The industry dispute resolution scheme has concerns about the use of unfair terms and unfair and harsh results for consumers

Problem areas in the Insurance Industry

There are some types of insurance where it is extremely difficult to claim simply because the contract terms are so unfair. Some examples are:

1) Travel Insurance
2) Consumer Credit Insurance
3) Uninsured Motorist Extension in 3rd party property damage car insurance policies.

Travel Insurance

Travel Insurance has a well earned reputation of being difficult to claim on – as a proportion of claims made, it has the second highest rate of claims rejection at 8.6%. Out of a total 169,329 claims made during 2006/07, this means over 14,000 claims rejected[1]. A common problem with travel insurance is claims being denied because the consumer did not fully supervise their luggage in a "public place". Of course, if the luggage is always fully supervised it is much less likely to be stolen. The use of the term effectively means that consumers are often left with no cover simply because they averted their eyes for a few minutes. An example being travellers rushing between terminals found a bag had gone missing on a train. The Financial Ombudsman Service (FOS) decided that the term operated to exclude cover.[2]

Consumer Credit Insurance

Consumer credit insurance has the highest claims rejection rate as a proportion of total claims made. 10.65% of a total 18,945 claims lodged in 2006/07 were rejected. This figure represents the difficulties consumers face in claiming on these policies, suggesting the existence of unfair terms.

[1] FOS – General Insurance Annual Report, 2006/07
[2] Financial Ombudsman Service, General Insurance Division, Determination Case no: 38421 at www.fos.org.au

Uninsured Motorist Extension

This is a cover included in third party property damage insurance policies. It covers when an uninsured motorist collides with the insured and that other motorist is at fault in the accident.

In an AAMI policy it states:

> *The amount covered for the uninsured motorist extension is the current market value of your car up to $3000.*
> *We will pay up to the amount covered for accidental loss or damage to your car caused by an uninsured third party motorist provided:*
>
> *We accept you would be legally entitled to recover more than 50% of the cost of repairs to your car from the owner or driver of the other vehicle, and*
>
> *You have satisfied us that the owner or driver of the other vehicle is not insured against that cost, and*
>
> *You can give us the registration number of the other vehicle and the name and address of its driver.*

This is a very unfairly drafted terms.

Condition 1 required AAMI to "accept" that the other driver is at fault. ILS is currently involved in a case where our client has obtained a court judgment against the other driver and AAMI still does not "accept" the other driver was at fault. It is possible for the insurance company to just simply refuse to accept that the other driver was at fault despite evidence to the contrary.

Condition 2 can also be very unfair. How does a consumer produce evidence that a driver is uninsured apart from the fact that the other driver said they are uninsured? In a recent case ILS has just become aware of the other driver was unlicenced and drunk (and did have comprehensive insurance) but was uninsured because the policy excluded drunk and unlicenced driving. The other driver's insurance company refuses to give a letter confirming they have refused the claim. The client's insurance company will not pay out on the Uninsured Motorist Extension without the letter.

These are unfair terms and are also standard policy terms in a standard form contract.

Standard form contracts

Insurance contracts are standard form contracts for consumers. If there is an unfair term in an insurance contract it will appear in every other insurance contract of the same type as it is a standard term.

The most important aspect of the Bill is the ability to make unfair terms void across standard contracts. The ICA does not have any legislative power to perform this function. By excluding contracts covered by the ICA it means that consumers of insurance are being denied effective consumer protection from unfair terms.

It also means that consumers in general insurance contracts have no effective way of driving systemic industry change of the use of unfair contract terms.

It is essential that consumers of general insurance have the same access to the consumer protections in the Bill as applies to other consumer contracts.

Recommendation

Insert a provision in the Bill either expressly providing for the provisions in Schedule 3 Part 1 (once enacted) to apply insurance contracts despite anything to the contrary in section 15 of the Insurance Contracts Act 1984 OR

Amend section 15 of the Insurance Contracts Act 1984 to provide that the Bill is NOT excluded and can regulate insurance contracts

If you have any questions please do not hesitate to contact Katherine Lane on 02 82041350 or at Katherine_lane@clc.net.au.

Yours faithfully,

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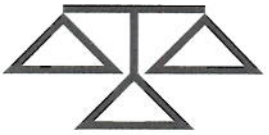


2004 ANNUAL REVIEW

THE GENERAL INSURANCE ENQUIRIES
AND COMPLAINTS SCHEME

INSURANCE ENQUIRIES AND COMPLAINTS LIMITED

Panel Chair's Report

Peter Hardham
Panel Chair

Life is not always fair! In my time as Panel Chair, I have found the overwhelming majority of decisions produced by IEC decision-makers are both legally correct and fair and reasonable. However, in a small number of cases this is simply not possible. The reason is because in many respects the concept of what is fair and reasonable does not sit comfortably with legal correctness.

Harsh Decisions

Some examples of decisions issued by the Panel which, in my opinion, are both legally correct and harsh are as follows:

- **An applicant who lost a $50,000 car damage claim because he did not disclose one speeding offence prior to policy renewal.** He already had four speeding/traffic offences at the time of policy inception, but this history was within the insurer's underwriting guidelines. It was the fifth offence that occurred between policy inception and policy renewal, that caused him to become an unacceptable risk. Like many members of the community he was not aware of his disclosure obligations at renewal and did not observe a requirement contained within the body of the renewal notice that he should inform the insurer of any changes in his driving history for the period between policy inception and renewal. The insurer was able to establish that a person with his driving history was unacceptable to it and therefore the Panel determined the claim in its favour.
- **A landlord who found he did not have cover under his policy, when the tenant burned down his home.** The policy was described as a home buildings policy and did not make the conceptual distinction between a home in which the policyholder resided, and a home that was tenanted. The policy excluded the insurer from liability when an invitee to the premises destroyed the property. Such an exclusion would entitle an insurer to deny liability for a damage claim if perpetrated by a tradesman, visitor, guest, distant relative or any other person who is able to gain entry to the property with the express or implied consent of the insured, his tenant, family relative etc. I wonder whether financial institutions who lend substantial monies to investors using the property, including the buildings, as security would feel comfortable when their borrower's insurance cover has these shortcomings.
- **The injured worker who could not claim disablement benefits as the policy provided cover only if disablement occurred within 12 months of the incident giving rise to the claim.** In this instance, the applicant was unable to have treatment for a significant injury during the 12-month period immediately after the injury was sustained because of waiting lists within the public hospital system. He was able to keep working until hospitalised and was disabled after surgery. The Panel found the insurer was entitled to rely on the policy limitation.
- **The policyholder who relied on travel insurance benefits provided pursuant to a 'free travel policy' who sustained a severe back injury while staying at a friend's home in the course of his journey.** On making the claim, he discovered he was only covered in respect of any injury sustained at the departure terminal subject to his establishing he had travelled to the point of departure by public conveyance. In other words, he was not even covered if he walked there!

It is obvious insurance cover cannot apply in all circumstances and there are many borderline disputes which can produce inequitable and unfair results. The Panel was reinforced in that view when it investigated many flood-related claims as a significant number of policyholders who made such claims were unaware they were not covered for flood damage, notwithstanding their homes were built in close proximity to creeks and rivers.

Panel Chair's Report

However, in my experience, many members of the community reasonably believe they are covered by an insurance policy when in fact a close and careful perusal of the policy reveals no cover exists in many instances. The man who was unaware of his disclosure obligations at renewal, and failed in a $50,000 claim because of one minor speeding offence, would surely fall within that category. I believe it is the role of the Panel and IEC decision-makers, to draw attention to these traps, and endeavour to create community awareness of them. I would also urge insurers, with tough underwriting practices, to clearly convey these matters to their customers. This makes good business sense as well as minimising the opportunity for major hardship.

Insurance Contracts Act Review

At the time of writing, the Insurance Contracts Act is under review. Decision-makers have participated in the review process and made submissions to the Review Committee. In that process, attention has been drawn to what decision-makers perceive to be areas where the Act could operate more effectively and fairly. The principal issues identified include:

- Lack of community awareness of the need to make disclosure at policy renewal, and a recommendation the Act be changed to require uniform disclosure obligations at all relevant times, namely policy inception, renewal, variation, reinstatement or extension and the requirement confined to answering specific questions and disclosure of 'exceptional circumstances'.
- The discretion for a decision-maker to 'forgive' a 'little bit of fraud' in cases of fraudulent non-disclosure/misrepresentation does not apply in cases where the failure to disclose or the misrepresentation was innocent. This, in my opinion, provides an advantage to the guilty over the innocent.
- Ensuring the Act provides adequate protection for third parties i.e. persons who are entitled to the benefits of an insurance contract, but who are not parties to it.
- Raising for discussion the adequacy or otherwise of standard cover, and whether standard cover be replaced by an obligation on insurers to clearly inform/highlight to the insured of unusual, unexpected or unreasonable terms.
- The injustices facing innocent co-insureds whose former spouses or partners destroy matrimonial property. This issue has been the subject of frequent comment in earlier Annual Reviews.

Financial Services Reform Act

The impact of this legislation on dispute resolution has not reached decision-makers as yet. My preliminary opinion is that FSRA Disclosure Statements simply add to the length of the policy proposal. I have stated many times that the major cause of insurance disputation is a failure of communication between the insurer and the insured. It is my hope the new legislation will have the effect of enhancing that process rather than compounding it.

Relationship with the Stakeholders

There remains a perception the Scheme expects too much of insurers in that it makes technical decisions and there are instances of inconsistency in decision-making. I understand it is necessary to address criticisms when they occur and there is an opportunity for major insurers to raise these issues at the Industry Liaison Meetings which are held approximately twice yearly. It is also important that consumer organisations have the opportunity to enter into dialogue with decision-makers and members of the Consumer Movement have periodically organised forums where practitioners in the field can participate in the process of raising and analysing the ever-changing nature of issues that result in disputation. A number of these issues are contained in the Panel Report included in this review.

Other Matters

Panel Chair's Report

I have attended conferences and meetings with members of other ADR schemes in the past 12 months. It was interesting to observe their procedures and the commonality of the problems that other decision-makers share with their stakeholders. We can all learn from these exchanges. It would be constructive for a dialogue to take place between the appropriate parties in order to determine to what degree further co-operation and the sharing of resources can occur, particularly as many insurers also engage in banking and providing financial advice. We all seem to have differing procedures, jurisdictional limits and timeframes in resolving disputes. Is this desirable or is it important for each scheme to retain their individuality? Do we have too many ADR schemes?

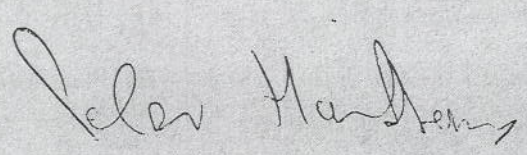
Upgraded Industry Code of Practice

In June the Insurance Council of Australia issued a draft new General Insurance Code of Practice for public comment. The Panel welcomed such a development, particularly as the new Code recognises the need for its members to provide detailed reasons for denying claims as well as improved claims handling processes and other benefits. We look forward to following the progress of the draft Code.

Internal

There has been a considerable number of changes at IEC over the past 12 months. Michael Arnold, the Referee, left after seven years and commenced his role as National Panel Chair at FICS. Michael has made an enormous contribution to the development of the role of Referee and in establishing dialogue with all stakeholders. His well-considered and analytical determinations, as well as his colourful public presentations, are already being missed. Susanne Liden and Jenny Lawton also retired from their positions as Consumer Representatives to the Panel. They have both served the Panel well and made a significant impact on the quality and thoroughness of decision-making. With the decrease in the number of matters coming to the Panel for determination, it has been necessary to appoint one Consumer Representative at this stage. In this regard, it has been reassuring to experience the return of one of the original Panel members, Brendan Pentony. Brendan brings to the Panel ten years experience as a Panel member and, in his comeback role, is the longest serving member of the Panel. With so much change afoot, it has been affirming to see the return to the very effective Panel membership of Denis Trafford, Brendan and myself, supported by Geoffrey Peacock. I also thank the Case Managers, management team and Personal Assistants for their effective support.

The more things change, the more they stay the same!



Peter Hardham, Panel Chair

Panel Report

Is there more law than justice?

In his report, the Panel Chair, Peter Hardham, illustrated a number of instances where the Panel has made decisions which, whilst legally correct, may be viewed as unfair or harsh. This raises the question as to whether there is more law than justice in some areas of insurance law and practice. In other words, does the law produce results which the community might regard as providing an unjust result? One of the major changes that has occurred in the past five to ten years is the increasing resort to new technology in the marketing, selling and administration of insurance. The telephone and all it has to offer has been of crucial significance in this process.

On the other hand, in our opinion, community awareness of the nature and impact of insurance has not progressed. The great majority of people do not read insurance policies which continue to grow in size, a process which may well be nourished by the implications of the Financial Services Reform Act. In fact, the pace of life which modern technology accelerates means that most people do not even look at such basic documents as policy schedules, certificates and renewal notices, except to determine the premium. The communication process between insurer and insureds has thus become more difficult, a phenomenon which has been discussed in previous reviews.

Of the examples of harshness briefly analysed in the Panel Chair's report, if the policyholder had been aware of the obligations after having meticulously read the relevant documentation (all 100 pages of it), the hardship may have been avoided. In our opinion, we should not always blame the policyholder for this neglect as many policies and associated documentation fail in the communication process. In this review, the Panel wants to analyse these issues more comprehensively within the context of changing lifestyles, new regulation, changing expectations and awareness of insurance. We will then attempt to focus specifically on how communication breakdown and misunderstanding occur between insurers and their policyholders.

1. Unoccupancy

The Panel continues to deal with many disputes where issues of unoccupancy arise. In the Panel's reviews in 1998 and 1999, we commented on this concept, particularly on the meaning of that term as determined by the courts. In our opinion, there are a number of reasons why this subject can cause confusion and dispute. Firstly, there may be misunderstanding as to the meaning of the term, which is sometimes compounded by its being artificially defined in the policy; secondly, many insurers will provide cover if they are notified that a building is unoccupied albeit on specific terms, which in turn raises underwriting issues; thirdly, many policies do not set out clearly what cover, if any, applies when a building is unoccupied.

The majority of policies provide full cover if a building is unoccupied for less than 60 days. Thereafter, the situation becomes complex, if not murky. A number of these issues manifested from the facts raised for determination, in case no. 18508. In that dispute, the issue involved was whether the insurer was entitled to deny a claim because the home had been unoccupied for more than 60 days, in which case, cover for theft, which was the event giving rise to the claim, was excluded. There was a dispute between the parties as to whether the claimants were provided with a copy of the policy wording but, in any event, the Panel noted the policy was a 96-page document. Clause 2.4 of the policy, on page 23, stated that if the home was unoccupied for 60 days or more, 'special conditions and possibly restrictions on cover apply'. However, clause 1.9 at page 39 stated there was no cover for theft from a residential home which was unoccupied. No reference was contained in this clause to the 60 days period for which cover was provided in clause 2.2. The Panel also noted the term 'unoccupied' was specially defined as being established if 'no-one is living in the home'.

As was pointed out in the Panel's review in 1999, the term 'unoccupied' has been judicially defined as meaning something quite different from the term 'not living in'. The courts have stated 'occupancy' may be constituted by such matters as 'the regular daily presence of someone in the building' and the words 'become unoccupied' must relate to the 'absence of physical presence in the building' as distinct from 'physical presence outside the building'. (See *Mazourca v Atlantic & British General Insurance (1971)* Lloyd's reports, a decision of the House of Lords.) In the Panel's opinion, this subtle but critical difference would not be clearly understood by most policyholders.

In this dispute, the issue also arose as to whether the insurer would have provided cover if the full circumstances in relation to occupancy of the property had been disclosed. Examination of the insurer's underwriting material revealed a considerable discretion existed for the underwriter to grant cover for unoccupancy e.g. if the owners were currently seeking a tenant for the property or if it was being renovated. In these circumstances, the underwriter would be expected to provide cover. However, there was no material before the Panel as to how that discretion would have been applied in the facts of the case. In all the circumstances, the Panel found the insurer should indemnify the claimant in response to the claim because the insurer had not established it had clearly communicated the nature and extent of the cover that would be provided in the event unoccupancy was established, nor had it demonstrated in accordance with its underwriting procedures, that it would not have provided cover in the event the full facts and circumstances had been made known to it.

In the Panel's opinion, the following matters ought to be considered by an insurer in a dispute centred upon whether a building was unoccupied for an excessive period of time.

1. Has the building been unoccupied within the meaning of that term as judicially defined for a period of in excess of the period allowable under the policy?
2. If the term 'unoccupancy' is specifically or artificially defined in the policy, has that meaning been properly conveyed to the policyholder?
3. In the event there is a discretion to grant cover (which, in the Panel's opinion, is the case with most policies) when the unoccupancy period has been exceeded, how would that discretion have been exercised in the circumstances relevant to the particular dispute?
4. If it is alleged there has been a failure to disclose unoccupancy of the premises, the details of the precise question asked and answer provided is required, as well as details of what the insurer would have done if full disclosure had been made.
5. In the event the policy exclusion is established, it is still necessary to demonstrate as required by section 54 of the Insurance Contracts Act, that the fact of unoccupancy was capable of causing or contributing to the loss. In many instances e.g. a fire or burglary, this may not be difficult. However, if for example, a number of burglaries also occurred in nearby occupied properties, then this may be more difficult to prove.

Changes in lifestyle result in properties being unoccupied whilst people travel, own a second house, or renovate and redesign. In our opinion, this is an important area of the law which gives rise to potentially large claims. We believe it requires careful attention.

2. Landlord's Insurance

As mentioned in the Panel Chair's report, the Panel has had to determine a number of disputes between landlords and their insurers as a result of the activities of violent, irresponsible, drunken and pyromaniacal tenants. This has led us to researching and analysing landlord insurance cover available in the marketplace. In this process, we have uncovered three types of landlord cover.

The first is actual landlords insurance which is specifically designed to address the problems faced by landlords that are likely to be the subject of an insurance claim and includes cover for rent default and certain types of malicious damage. The second is a combined landlord's and household insurance policy, which is clearly described in those terms. The third is a home buildings policy, which included almost as an afterthought, add-on landlord benefits.

The Panel considered the terms of one such policy in Determination No. 18021. After doing so, the Panel ascertained the only reference to landlord's cover, was at pages 43 and 44 of the policy. Apart from this reference, for all other intents and purposes, it was marketed as a typical home buildings insurance policy, which would be covered by the standard cover provisions of the Insurance Contracts Act Regulations.

These policies are primarily designed for the owner-occupier and are regularly sold over the telephone. In the particular policy considered by the Panel, the term 'home' was defined as 'any fully enclosed building (with walls and a roof) used primarily for domestic purposes at the site that can be locked up'. The policy however, contained an exclusion of the type often found in home buildings policies which excluded intentional damage by persons living in the home or who have entered the home with the consent of the insured.

The Panel can understand an insurer not wanting to insure events that arise out of intentional or malicious acts of policyholders or their family members and invitees, because the owner/occupier policyholder should be able to exercise control over persons who live in the property or their guests. However, a landlord is an entirely different situation.

In the first place, whilst the landlord has the ultimate decision as to the persons to whom he is agreeable to lease the property, he is frequently dependent upon others, such as an estate agent for this purpose. Many persons may behave well during the process of negotiating a lease, but may behave differently during the vicissitudes of domestic life. Most leases give the tenant the exclusive right to occupy the premises with only limited rights of inspection by the landlord. He therefore has no control over what persons the tenant invites onto the premises, or what they do there.

In these circumstances, the Panel believes that any insurance policy which is marketed and sold as a home buildings policy and is primarily designed for owner/occupiers, should clearly inform a landlord that intentional and malicious damage, and particularly, fire damage perpetrated by invitees/tenants is excluded. No doubt the mortgagee or financier of the premises would also like to know in what circumstances a property destroyed by fire may be covered. In Determination No. 18021, the policyholder had no idea that tenant's damage was excluded and failed in his claim to the Panel for fire damage caused by one of his tenants.

For these reasons, the Panel recommends the industry give attention to this growing area of disputation and potential inequity and consider providing landlord's insurance in a policy designed for that purpose. The issue of communication of policy terms has been addressed in the new Code of Practice and also by the committee undertaking a review of the Insurance Contracts Act. The issue of proper communication of potentially devastating and unexpected policy terms is one of ongoing interest and concern for the Panel.

3. Cancellation of Policies

The Insurance Contracts Act sets out the obligations of the insurer if it wishes to cancel an insurance policy (see sections 59–63 of the Insurance Contracts Act 1984). However, the effect of these sections is that the policy must be cancelled in writing and only in specific situations. However, the Act does not deal in any way with the obligations and responsibility of the parties when the insured wants to cancel the insurance contract.

In these circumstances, the common law prevails, the effect of which is that the terms of the policy are paramount. In accordance with its Terms of Reference, the Panel is obliged to consider good insurance practice unless the terms of the policy are sufficiently specific. It is also important to determine whether there is one or more insured persons, or whether each party has rights in relation to a request in cancellation of the policy. In this regard, there is legal authority to proposition that each party to a contract must join in the request for termination or cancellation even if the insurance policy is a contract of composite insurance as opposed to joint insurance, unless the terms of the policy specifically permit one co-insured to terminate the policy unilaterally. (See Sutton *Insurance Law in Australia 3rd Edition* at pages 616 and following). However in many instances the policy is silent on this issue.

In Determination No. 17735, the claimant contacted the insurer by telephone on 29 May 2003 and requested the insurer cancel the policy as he said he had sold the insured vehicle. However, he claimed as a result of the advice he received from the insurer's representative during the telephone conversation that he understood the policy would cover the vehicle until 2 June 2003. On 30 May 2003, the vehicle was involved in a collision and was damaged. The claimant made a claim which was denied by the insurer on the ground there was no policy in force at the time, as it had been cancelled by telephone as from 29 May.

It appeared to the Panel the reason why the discussion allegedly occurred to defer cancellation of the policy was due to the fact the sale of the vehicle was likely to take several days to complete. Because the claimant believed the policy was in force for the additional few days, he continued to drive the vehicle which was still in his possession pending completion of the sale. The relevant terms of the policy provided:

> *'If you sell or give away your vehicle ... this policy comes to an end without any notice to you'.*

The insurer's representative was equivocal as to what was said over the telephone but the insurer's file notes reveal it recorded the fact the claimant wanted:

> *'The policy cancelled effective 1.06.03. Somehow this policy was cancelled 29.05.03 and on 30.05.03 cust tried to lodge a claim'.*

On this factual basis, the Panel concluded the policy was in existence at the date of the accident.

However, in making the Determination the Panel stated the following:

> *'... the Panel has grave concern about the cancellation processes adopted by the insurer. In the opinion of the Panel, consistent with good insurance practice, it is essential for an insurer to ask a policyholder to cancel an insurance policy in writing. This would not only avoid misunderstandings and conflicts between the parties as is the case in this instance but it also protects an insurer from unauthorised uninformed or inappropriate actions by a party to an insurance policy. In any event, the policy terms do not specifically authorise a verbal cancellation of the policy but simply provide an insured person "can cancel this policy by telling us". These comments by the Panel are made in the context the Insurance Contracts Act provides very specific and detailed procedures before an insurer can cancel a contract, and it appears to the Panel incongruous an insurer can simply allow an insured person to cancel an important contract such as a contract of insurance verbally, when it is required to do so in writing.'*

We believe this is a sensible approach to the issue as well as being legally correct and consistent with good insurance practice. The issue of cancellation becomes even more complicated when there are two or more insured parties and their interests become intertwined if conflict arises between them, such as following a relationship or partnership breakdown. In these circumstances, it is crucial for an insurer to understand clearly the intentions of each party.

The facts and issues considered in the above Determination demonstrate how confusion and misunderstanding can arise during a telephone conversation, so that, even if there is a general agreement between the parties the policy is to come to an end, there may be conflict as to when it was agreed this would occur. Every day the Panel deals with circumstances where parties to a telephone conversation have a completely different understanding as to the contents of the conversation and in many instances the insurer's own computer-generated records are only partially complete.

Other factual issues that have been encountered by the Panel on this subject include an insurer accepting a purported cancellation of a policy by an intellectually impaired insured person, disputes as to whether a purported cancellation by one spouse was binding on the other, and other similar issues arising from relationship breakdown.

The Panel has received criticism from one insurer that, with the greater use of the telephone to transact insurance, it is anachronistic to adhere to past practices of requiring confirmation in writing of a request to cancel a policy. The Panel does not accept this criticism because modern technology and the availability of email, facsimile transmission and other means of rapid communication make it a lot easier for timely and effective communication in writing.

4. Insurance and Tumultuous Relationships

It has been estimated almost one in three marriages ends in divorce, and many other relationships conducted outside the scope of marriage are even more volatile. The nature of relationships is also changing as more people share houses in a whole range of circumstances, family members come and go, people separate and reconcile or engage in serial monogamy, or move beyond the constraints of that concept. Many of these relationships do not end well and unresolved feelings may find their outlet in acts of vengeance and violence of sometimes tragic proportions.

Panel Report

In the last 12 months, the Panel has encountered arson being committed in the course of murders, suicides and other forms of violence. Claims based on facts within this category are usually large and the innocent party not only has to deal with the legacy of the violence, the loss of the property, but also the capricious and distressing challenges of insurance disputation.

Some of the issues involved in these situations include the following:

(a) Did the perpetrator of the fire/act of destruction have the necessary intention to cause the damage? e.g. were they psychiatrically disturbed or severely intoxicated?

(b) Was the policy a joint or composite policy and/or should, as a matter of law, the policy be treated as insuring separate interests or one interest?

(c) If the policy is to be treated as insuring separate interests, what is the nature of those interests? e.g. did each party own half, or who owned the furniture and personal items destroyed?

These questions can be extraordinarily difficult for the relevant tribunal to answer whether it be a court or the Panel. The law is not clear in these areas e.g. if the traditional approach applies, policies are generally deemed to be joint, but if the 'socially realistic' is to apply, it is likely the interests will be regarded as separate (see the cases of *MMI General Insurance v Baktoo* [2000] NSW Cas 70, *Holmes v GRE Insurance Ltd* [1988] Tas R147 and *Maulder v National Insurance Co New Zealand Limited* [1993] 2NZ LR351 and also the discussion in Professor Sutton 3rd Edition paragraph 3.151).

The Panel has demonstrated an inclination to adopting the socially realistic approach. As a general rule, we have difficulty in accepting that parties who have chosen to sever their relationship and lead separate and financially independent lives sometimes involving other people, should be regarded as jointly insuring the damaged property, particularly when that property has been maintained by the remaining party. In cases where the relationship has not so clearly ended and there remains a degree of ongoing financial sharing (e.g. where children are involved), the factual situation may be less clear.

These issues were raised before the committee reviewing the Insurance Contracts Act and in their issues paper, they acknowledged the immense social and legal problems involved in this area. However, they decided it was not a matter for legislative intervention at this time.

The committee acknowledged the merits of the IEC's submission which included a suggestion that in cases of this type, a decision-maker (whether it be the court or the Panel) ought to have a discretion similar to that involved with sections 31 and 56 of the Act to empower a decision-maker to make a decision which is 'just and equitable in the circumstances' if it would be 'harsh and unfair' to do so on the basis of a traditional legalistic basis (adopting the words of section 56). In the Panel's opinion, until the superior courts have effectively grappled with these problems, they need to be confronted in a practical way. The Panel offers these suggestions:

1. Policyholders should be made aware of the need to notify their insurers where there is a change in the insured relationship insofar as it relates to the occupation of the property. When couples separate they will usually tell the gas, electricity and telephone companies but not the insurance company. If the person remaining in the house notifies the insurer the parties are no longer sharing, the occupation and upkeep of the property, then in our view the insurer should, in the normal course of events, agree to change the proprietorship of the policy and release the departing partner from the obligations and benefits under the policy. At the same time it would be sensible for the insurer to enquire of the insured (it would constitute a variation of the policy so as to activate disclosure obligations) whether there was any matter within their knowledge that was likely to affect the risk, and whether the sum insured (especially for contents) needs to be varied.
2. It would be helpful if, at policy renewal, in addition to the standard underwriting questions, the policyholder was asked whether there have been any changes in the use and occupation of the property since the last renewal.
3. Many policies define the term 'you' as including the insured parties. In some instances, the arsonist insured had long since left the property whereas they remained as one of the insured parties, but the Panel was obliged to find for the insurer simply because the arsonist fell within the definition of 'you'. If the processes referred to above were followed, this injustice would have been avoided. (See the case studies referred to under the heading *'Domestic Arson – Keeping the home fires burning'* in the Panel Report for 2003.)

The Panel believes these suggested procedures would be helpful both to the insurer and insured, as it would clarify the rights and obligations of all parties including the individual who has left the property.

Another related problem, which is confronting the Panel with increasing frequency, is where a new person arrives at a property and brings with them substantial and valuable personal items and might also make a substantial financial contribution to the property without the policyholder making any change to the policy. In many claims brought on behalf of these persons, the Panel has had no alternative other than to find for the insurer because the goods lost or damaged, were simply not covered by the policy.

Other issues may arise as to the insurer's obligations to the departed partner who leaves goods behind, and with respect to wedding gifts. Once again, the Panel believes it would be helpful if public consciousness was increased to encourage the notification/disclosure of these matters to insurers, and/or at renewal, and the questioning process suggested above, may also avert any potential miscommunications and unhappiness.

A process of notification of this type is also important to undertake with jointly owned movables such as motor vehicles, caravans, boats etc. Many insurers have found themselves in the dilemma of not knowing whom to pay when damage or loss of items of this nature occurs and both parties claim the proceeds. In some situations, an insurer has been required to pay a second time, when a payment was made to one party without the authority of the other, particularly when the second party has notified the insured the lost/damaged goods were within their possession and control.

The underlying theme of all these suggestions is the need for bilateral communication between insured and insurer and our encouragement to the industry and other interested parties in facilitating that process. Our ultimate hope is there will be as much justice as law if some of these observations and recommendations are adopted.