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CHAMBERS

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BRIEF CASE NOTE

MetLife Insurance Ltd v Marie Hart and Aware Super Pty Ltd and the Superannuation Complaints Tribunal [2021] FCA 410 (30 April 2021)

Introduction

This Federal Court appeal concerned whether the Superannuation Complaints Tribunal (the Tribunal) made an error 'on a question of law' in respect of: (1) the concept of a 'constructive rejection' of a claim; (2) the 'on risk' issue; and, (3) the application of the definition of Total and Permanent Disablement (TPD). His Honour Justice Derrington upheld MetLife's appeal on all grounds.

Background

Ms Hart was a member of the New South Wales Police Force (NSWPF) from 2003 until her discharge 2016.

In 2005, MetLife issued an insurance policy (the Policy) to the trustee of a superannuation fund (Aware Super), of which Ms Hart was an insured member.

In 2007, Ms Hart claimed to have sustained a back injury, which was caused by her wearing her gun belt. Accordingly, in 2010, the NSWPF re-deployed her into a Permanently Restricted Duties role as an Exhibits Officer.

Relevantly, in 2011, the Policy terminated. A deed (which adopted the IFSA Terms) between MetLife and Aware Super governed how the cover provided by the Policy transferred from MetLife (as the out-going insurer) to a new insurer (referred to as the in-coming insurer).

Three years later, in mid-2014, Ms Hart was diagnosed with Post Traumatic Stress Disorder (PTSD) and that condition, not the back injury, caused her to cease work in late-2014.

In 2018, Ms Hart claimed a TPD Benefit from MetLife under the Policy by reason of her back injury *and her PTSD*. However, she refused to co-operate with MetLife's requests that she provide records which were relevant to her claim or attend any medical examination.

In 2020, the Tribunal determined that MetLife had 'constructively declined' Ms Hart's claim and that MetLife ought to have paid her claim. MetLife appealed the Tribunal's whole decision to the Federal Court.

The Policy definition of TPD

The Policy definition of TPD is set out in the Addendum below. In order for that definition to have been met, both the First Limb of the definition and the Second Limb of the definition must have been satisfied.

The IFSA Terms

The key provisions of the IFSA Terms were cls 7.1, 13.3 and 13.4, which are also set out in the Addendum below. It was common ground that the IFSA Terms formed part of the Policy.

Superannuation (Resolution of Complaints) Act 1993 (Cth) (the Act)

Section 37 of the Act is also set out in the Addendum below. That is the provision which conferred the relevant powers on the Tribunal. The essence of the Tribunal's relevant function was to identify and remediate any unfairness or unreasonableness that existed in relation to the decision which was the subject of a complaint.[1] His Honour considered that the

[1] [29].

entitlement of parties to make submissions to the Tribunal 'must' have given rise to an 'obligation' on the Tribunal to consider such submissions.[2]

A 'question of law'

There was a dispute as to whether MetLife's appeal raised an error on a 'question of law'. His Honour acknowledged that defining what constitutes a 'question of law' is 'elusive', particularly in the present matter where, pursuant to s 37 of the Act, the 'question of law' concept needed to consider both statutory rules and the legal rights of private parties pursuant to contract (being the Policy and the IFSA Terms).[3]

However, his Honour found that the issues raised by MetLife primarily concerned the proper application of the Policy and the IFSA Terms and that such issues did properly give rise to the present appeal on questions of law.[4]

'Constructive rejection'

His Honour noted that, here, the two questions of law were, firstly, what is the true nature of a 'constructive rejection' of a claim under a life policy? Secondly, was there a 'decision' for the purposes of s 37(2)(a) of the Act?[5]

The concept of a constructive rejection has been considered in previous decisions of the Supreme Court of NSW concerning the Policy[6] and his Honour noted those decisions with apparent approval.[7] His Honour described the test for whether a constructive rejection had occurred to be 'whether, in the manner in which it dealt with the claim, MetLife breached its duties of good faith and fair dealing'.[8]

His Honour said that, when addressing whether there had been a constructive rejection, it was necessary to contextualise MetLife's conduct in assessing Ms Hart's claim. Accordingly, analysing this issue is highly fact specific to the claim in question, and a full chronology of the sequence of events and communications is required. Ultimately, his Honour found that Ms Hart 'refused to co-operate' when MetLife sought to investigate her claim[9] whereas MetLife had dealt with her claim in an 'expeditious and professional manner' which did not cause delay.[10]

His Honour concluded that the Tribunal misunderstood the concept of a constructive decline and asked itself the wrong questions as to how a constructive rejection might arise.[11] The Tribunal erroneously attributed the delay of others to MetLife and wrongly considered MetLife's investigations to be unreasonable (because the Tribunal did not appreciate the 'on risk' issue, noted below).

On risk

A central point in this appeal was whether the Tribunal erred by failing to find that MetLife was not on risk in respect of Ms Hart's PTSD. His Honour observed that the IFSA Terms limited the extent to which MetLife remained on risk in respect of claims made pursuant to the Policy but made after the Policy terminated; MetLife was only on risk for such claims which related to the injury or illness which incapacitated the insured member from work (see the definition of 'not at work' in the IFSA Terms), essentially, when the Policy terminated.

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[2] [30].
[3] [31].
[4] [34].
[5] [35].
[6] *Shuetrim v FSS Trustee Corporation* [2015] NSWSC 464 at [153] (partly overturned on other grounds on appeal: *TAL Life Ltd v Shuetrim* (2016) 91 NSWLR 439), *Hellessey v MetLife Insurance Ltd* [2017] NSWSC 1284 at [131]-[134]) and *Sargeant v FSS Trustee Corporation and MetLife Insurance Ltd* [2018] NSWSC 1997 at [101]-[104].
[7] [42]-[45].
[8] [71].
[9] [2], [11]-[12].
[10] [3].
[11] [77].

When the Policy terminated in 2011, Ms Hart was incapacitated from her work by reason of her back injury only, not because of her PTSD which was diagnosed in 2014. Accordingly, MetLife did not remain on risk in respect of her PTSD because her PTSD was not related to her back injury.

His Honour found that Ms Hart ceased work permanently in 2014 because of her PTSD[12] and that the Tribunal failed to appreciate the consequences of the IFSA Terms, which governed how MetLife ceased being 'on risk' in respect of the Policy.[13]

His Honour considered that the consequences of this failure were that the Tribunal: failed to identify and ask itself the correct questions; and, erroneously concluded that MetLife's investigations were unfair and unreasonable, as noted above.

For instance, his Honour accepted that the Tribunal did not ask itself, firstly, what medical condition caused Ms Hart to be 'not at work' when the Policy terminated? Nor, secondly, were the conditions in respect of which she claimed TPD related to that condition?[14]

His Honour found that the Tribunal applied the wrong test as to whether MetLife was liable, and that this error vitiated the Tribunal's decision.

Application of the definition of TPD in the Policy

MetLife had submitted to the Tribunal that Ms Hart did not satisfy the First Limb of the definition of TPD by reason of any injury or illness for which MetLife was on risk because the cause of her absence from work during the initial six months was her PTSD rather than her back injury.

In that regard, his Honour agreed that 'the real difficulty for Ms Hart' was that, as MetLife's 'liability became limited following the takeover date [1 October 2011] as provided by the [IFSA Terms], and she was not absent from work for six months as a result of her back pain, **MetLife has no liability in respect of the claim** (emphasis added).'[15]

In view of that finding, his Honour did not need to determine whether the *same* injury or illness must satisfy both the First Limb and the Second Limb of the definition of TPD in the Policy.[16] His Honour considered that this interpretation accorded 'some coherency' but could not 'be taken too far'. However, even when his Honour endeavoured to illustrate a theoretical example in which the two Limbs were satisfied by different injuries or illnesses, he then acknowledged that 'such a scenario is really only concerned with one originating cause.'

Outcome

His Honour upheld MetLife's appeal on all grounds, being in respect of the 'constructive rejection',[17] the 'fundamental ground' concerning the on risk issue,[18] and in respect of the application of the definition of TPD.[19] Accordingly, the Court set aside the Tribunal's decision and remitted the matter to the Tribunal or other appropriate body (namely, the Australian Financial Complaints Authority) to be determined according to law and his Honour's reasons. MetLife sought no order in respect of costs and therefore no orders regarding costs were made.

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May 2021

[12] [8], see also [2].
[13] [2].
[14] [102].
[15] [127].
[16] See [121]-[125].
[17] [77].
[18] [112].
[19] [131].

ADDENDUM

The Policy definition of TPD

The Policy had provided that 'While covered under this Policy Total and Permanent Disablement shall have the following meaning:…In the case of an Insured Member whose Normal Hours are 15 hours each week or more at the time of the Insured Event giving rise to the claim –

['the First Limb'] the Insured Member having been absent from their Occupation with the Employer through injury or illness for six consecutive months and

['the Second Limb'] having provided proof to our satisfaction that the Insured Member has become incapacitated to such an extent as to render the Insured Member unlikely ever to engage in any gainful profession, trade or occupation for which the Insured Member is reasonably qualified by reason of education, training or experience.'

The IFSA Terms

Clause 7 was entitled "Definitions" and clause 7.1 provided as follows:

> 7.1 In this Guidance Note: …
>
> "at work" means the member is actively performing all the duties of his usual occupation with the Employer and is not in receipt of and/or entitled to claim income support benefits from any source including workers' compensation benefits, statutory transport accident benefits and disability income benefits. A member who does not meet these requirements is correspondingly described as *"not at work"*.
>
> "new events cover" means cover other than cover in relation to the medical condition or any directly or indirectly related condition arising from sickness or injury which has caused the insured member either: - to be *not at work* on the working day immediately preceding the takeover date…

Clause 13 was entitled "TPD cover provided by the incoming/previous insurer". Clauses 13.3 and 13.4 provided as follows:

> 13.3 *Insured members* who are *not at work* on the member's normal working day immediately preceding the takeover date due to sickness or injury will be provided with *new events cover* with the incoming insurer from the *takeover date*.
>
> 13.4 The previous insurer remains 'on risk' to provide cover for any TPD claim arising from any condition caused by sickness or injury, which is not *new events cover*.

Superannuation (Resolution of Complaints) Act 1993 (Cth) (the Act)

Section 37 of the Act conferred the Tribunal with powers and it provided as follows:

> (1) For the purpose of reviewing a decision of the trustee of a fund that is the subject of a complaint under section 14:
>
> (a) the Tribunal has all the powers, obligations and discretions that are conferred on the trustee; and
>
> (b) subject to subsection (6), must make a determination in accordance with subsection (3).
>
> (2) If an insurer or other decision-maker has been joined as a party to a complaint under section 14:

(a) the Tribunal must, when reviewing the trustee's decision, also review any decision of the insurer or other decision-maker that is relevant to the complaint; and

(b) for that purpose, has all the powers, obligations and discretions that are conferred on the insurer or other decision-maker; and

(c) subject to subsection (6), must make a determination in accordance with subsection (3).

(3) On reviewing the decision of a trustee, insurer or other decision-maker that is the subject of, or relevant to, a complaint under section 14, the Tribunal must make a determination in writing:

(a) affirming the decision; or

(b) remitting the matter to which the decision relates to the trustee, insurer or other decision-maker for reconsideration in accordance with the directions of the Tribunal; or

(c) varying the decision; or

(d) setting aside the decision and substituting a decision for the decision so set aside.

(4) The Tribunal may only exercise its determination-making power under subsection (3) for the purpose of placing the complainant as nearly as practicable in such a position that the unfairness, unreasonableness, or both, that the Tribunal has determined to exist in relation to the trustee's decision that is the subject of the complaint no longer exists.

(5) The Tribunal must not do anything under subsection (3) that would be contrary to law, to the governing rules of the fund concerned and, if a contract of insurance between an insurer and trustee is involved, to the terms of the contract.

(6) The Tribunal must affirm a decision referred to under subsection (3) if it is satisfied that the decision, in its operation in relation to:

(a) the complainant; and

(b) so far as concerns a complaint regarding the payment of a death benefit--any person (other than the complainant, a trustee, insurer or decision-maker) who:

(i) has become a party to the complaint; and

(ii) has an interest in the death benefit or claims to be, or to be entitled to benefits through, a person having an interest in the death benefit;

was fair and reasonable in the circumstances.