FEDERAL COURT OF AUSTRALIA

Sharma v H.E.S.T. Australia Ltd [2022] FCA 536

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| File number(s): | VID 549 of 2021 |
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| Judgment of: | **MCELWAINE J** |
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| Date of judgment: | 13 May 2022 |
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| Catchwords: | **INSURANCE –** appeal against Australian Financial Complaints Authority Limited (**AFCA**) determination affirming decision of Trustee and insurer to deny payment of additional death and income protection benefits of deceased policy holder on the basis of fraudulent misrepresentation – whether AFCA erred in interpreting ss 29 and 33 of *Insurance Contracts Act 1984* (Cth) – whether AFCA erred in concluding that common law or equitable principles may operate in cases of fraudulent misrepresentation in group life policies where there is a change of insurer despite s 33 – whether conclusion that decision of insurer to avoid individual group life policy and of trustee to affirm avoidance were each fair and reasonable in operation was reached on a correct understanding of the law – AFCA materially erred in law – appeal allowed – matter remitted for redetermination |
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| Legislation: | *Acts Interpretation Act 1901* (Cth) s 15A  *Corporations Act 2001* (Cth) ss 1050, 1051, 1053, 1054, 1055,1057  *Insurance Contracts Act 1984***(**Cth) ss 7, 12, 13, 21, 22, 25, 26, 29, 32, 33  *Insurance Contracts Amendment Act 2013* (Cth) ss 3, 25, 29  *Life Insurance Act 1995* (Cth) ss 190, 194, 195  *Retirement Savings Accounts Act 1997* (Cth)  *Superannuation (Resolution of Complaints) Act 1993* (Cth).  *Superannuation Supervision Act 1999* (Cth)  Explanatory Memorandum, *Insurance Contracts Amendment Bill 2013* |
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| Cases cited: | *Advance (NSW) Insurance Agencies Pty Ltd v Matthews* (1989) 166 CLR 606  *ASIC v National Exchange Pty Ltd* (2005) 148 FCR 132  *Babatiskos v Car Owner’s Mutual Insurance Co Ltd* [1970] VR 297  *Britton v Royal Insurance Co* (1866) 4 F & F 905  *C E Heath Casualty & General Insurance Ltd v Grey (*1993) 32 NSWLR 25  *Carr v Western Australia* (2007) 232 CLR 138; [2007] HCA 47  *Carter v Boehm* (1766) 3 Burr 1905: 97 ER 1162  *CGU Insurance Ltd v AMP Financial Planning* (2007) 235 CLR 1  *CIC Insurance Ltd v Barwon Regional Water Authority* [1999] 1 VR 683: [1998] VSCA 77  *Commercial Banking Company of Sydney Ltd v R H Brown & Co* (1971) 126 CLR 337  *Craig v South Australia* (1995) 184 CLR 163  *Esanda Finance Corporation Limited v Peat Marwick Hungerfords* (1997) 188 CLR 241  *Graham v Colonial Mutual Assurance Society Ltd (No 2)* [2014] FCA 717  *Hanover Life Re of Australasia Ltd v Sayseng* (2005) 13 ANZ Insurance Cases 90-123  *Haritos v Federal Commissioner of Taxation* (2015) 233 FCR 315; [2015] FCAFC 92  *In The Matter of the Colonial Mutual Life Assurance Society Limited* [2021] FCA 394  *Ipstar Australia Pty Ltd v APS Satellite Pty Ltd* (2018) 356 ALR 440  *Jones v Dumbrell* [1981] VR 199  *Macquarie Underwriting Pty Ltd v Permanent Custodians Ltd* (2007) 240 ALR 519; [2007] FCAFC 60  *Manifest Shipping Co Ltd v Uni Polaris Insurance Co Ltd* [2003] 1 AC 469  *May v Platt* [1900] 1 Ch 616  *Montclair v MetLife Insurance Ltd* [2015] VSC 306  *QSuper Board v Australian Financial Complaints Authority Limited* (2020) 276 FCR 97; [2020] FCAFC 55  *R v Connell; Ex parte The Hetton Bellbird Collieries Ltd* (1944) 69 CLR 407  *Rushton v Commonwealth Superannuation Corporation (No 3)* [2021] FCA 358  *Sharma v LGSS Pty Ltd* [2018] FCA 167, Gleeson J  *Snedden v Minister for Justice* (2014) 230 FCR 82; [2014] FCAFC 156  *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362; [2017] HCA 34  *Taylor v Owners of Strata Plan No 11564* (2014) 253 CLR 531; [2014] HCA 9  *Tiep Thi To v Australian Associated Motor Insurers Ltd* (2001) 3 VR 279; [2001] VSCA 48  *Tonto Home Loans Australia Pty Ltd v Tavares* [2011] NSWCA 389  *Tuite v Administrative Appeals Tribunal* (1993) 40 FCR 483  *Wan v BT Funds Management Limited* [2022] FCA  *Wanson v Comcare* (2020) 276 FCR 613; [2020] FCAFC 76.  KR Handley, *Spencer Bower & Handley:* *Actionable Misrepresentation* (5th ed, LexisNexis, 2014)  RP Meagher, *Meagher, Gummow and Lehane’s Equity: Doctrines and Remedies* (4th Ed, LexisNexis Australia, 2002)  WIB Enright and RM Merkin, *Sutton on Insurance Law* (4th Ed, Thomson Reuters, 2015) |
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| Division: | General Division |
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| Registry: | Victoria |
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| National Practice Area: | Commercial and Corporations |
|  |  |
| Sub-area: | Commercial Contracts, Banking, Finance and Insurance |
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| Number of paragraphs: | 120 |
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| Date of last submission/s: | 22 April 2022 |
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| Date of hearing: | 11-12 April 2022 |
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| Counsel for the Appellant: | Mr P Bingham |
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| Solicitor for the Appellant: | Maurice Blackburn |
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| Counsel for the Second Respondent: | Mr DA Lloyd SC  Ms A Avery-Williams |
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| Solicitor for the Second Respondent: | TurksLegal |

ORDERS

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|  | | VID 549 of 2021 |
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| BETWEEN: | PRAGYA SHARMA  Appellant | |
| AND: | H.E.S.T AUSTRALIA LTD  First Respondent  AIA AUSTRALIA LIMITED  Second Respondent  AUSTRALIAN FINANCIAL COMPLAINTS AUTHORITY LIMITED  Third Respondent | |

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| order made by: | MCELWAINE J |
| DATE OF ORDER: | 13 May 2022 |

THE COURT ORDERS THAT:

1. The appeal is allowed.

2. The determination of Australian Financial Complaints Limited in case numbers 693811 and 711994 is set aside.

3. The complaint made by the appellant is remitted to Australian Financial Complaints Limited to be determined again in accordance with these reasons.

4. The parties are to file submissions as to costs, not exceeding two pages, within seven days of the publication of these reasons, in the event that the question of costs is not agreed.

5. If there is no agreement, the costs of the appeal will be determined on the papers.

Note: Entry of orders is dealt with in Rule 39.32 of the *Federal Court Rules 2011*.

REASONS FOR JUDGMENT

MCELWAINE J:

1 Australian Financial Complaints Authority Limited (**AFCA**) is the operator of the external dispute resolution scheme for which an authorisation is in force pursuant part 7.10A of the *Corporations Act 2001* (Cth) (**Corporations Act**). By s 1050 of the *Corporations Act*, the Minister may ‘by notifiable instrument, authorise an external dispute resolution scheme’ if satisfied that certain requirements are met. The relevant history of the establishment of the AFCA scheme is set out in the decision of the Full Court in *QSuper Board v Australian Financial Complaints Authority Limited* (2020) 276 FCR 97; [2020] FCAFC 55 (Moshinsky, Bromwich and Derrington JJ) (**QSuper**). A regulated superannuation fund under the *Superannuation Supervision Act 1999* (Cth) (**Supervision Act**) and the holder of an Australian Financial Services Licence under the *Corporations Act* may be the subject of complaints made by a person as provided for at s 1053 of the *Corporations Act* relating to superannuation, which includes complaints about decisions made by trustees of a regulated superannuation fund and decisions made by an insurer relating to a contract of insurance where the premiums are paid from an RSA (meaning a retirement savings account as defined in the *Retirement Savings Accounts Act 1997* (Cth)). As explained in QSuper at [17], the effect of the regulatory scheme of the *Corporations Act*: ‘is that if an entity is both a regulated superannuation fund under the *Supervision Act* and the holder of an AFSL, the determination of superannuation complaints made by members of funds which have joined AFCA is provided for and conducted pursuant to the CA and AFCA’s complaint resolution scheme rules.”

2 H.E.S.T Australia Limited (**Trustee**) is the trustee of the H.E.S.T Australia Superannuation Fund (**Fund**) that was established pursuant to a deed of trust dated 30 July 1987 and which relevantly is administered in accordance with the consolidated Fund Rules, effective as at 29 January 2009 as a schedule to the trust deed. It is a regulated superannuation fund.

3 On 14 January 2020, Mrs Pragya Sharma caused to be made to AFCA a complaint in her capacity as administrator of the estate of Dr Deepak Sharma (**Estate**) to the effect that the Trustee, and in turn the insurer to the Trustee, had each failed to pay the death benefits which Dr Sharma was entitled to receive as a member of the Fund. AFCA, on 21 September 2021, determined that the decision of the insurer not to pay certain insurance benefits and the decision of the Trustee whereby it adopted the decision of the insurer were each fair and reasonable in all of the circumstances and, accordingly, affirmed those decisions purportedly in accordance with s 1055(3) of the *Corporations Act* (**the Determination**).

4 The Determination adopts the nomenclature of “insurer 1,” a reference to OnePath Life Limited (**OnePath**) and “insurer 2,” a reference to AIA Australia Limited (**AIA**) which is confusing. AFCA reasoned that AIA “took over from” OnePath, when in fact there “was actually an intervening insurer” but despite this change and “for simplicity (instead of adding in a third insurer),” AFCA treated AIA as having “taken over the accrued rights and obligations” of the third insurer. In these reasons it is important to understand that between 1 November 2000 and 30 November 2011, ING Life Limited, as it was known but which later changed its name to OnePath, provided group life cover for the benefit of members of the Fund. With effect from 1 December 2011, the Colonial Mutual Life Assurance Society Limited, which traded as CommInsure, agreed to provide group life cover for the benefit of the members of the Fund upon the terms of the ING Life Limited policy, but subject to certain amendments. CommInsure remained the insurer of the Trustee until 1 April 2021, which is the date on which the life insurance business of CommInsure was transferred to AIA pursuant to s 194 of the *Life Insurance Act 1995* (Cth) as approved by this Court: *In The Matter of the Colonial Mutual Life Assurance Society Limited* [2021] FCA 394, Allsop CJ (**Re CML**).

5 Mrs Sharma appeals the Determination pursuant to s 1057 of the *Corporations Act*, which limits that right to a question of law. The Trustee, as the first respondent and AFCA as the third, have each filed a submitting notice, save as to costs. AIA, the second respondent, seeks to uphold the Determination and also relies on a Notice of Contention.

6 For the reasons that follow, I have concluded that AFCA materially misdirected itself in law, the appeal is allowed and the complaint is remitted to AFCA for determination according to law.

# BACKGROUND

7 The deed of trust which established the Fund is a simple document. Pursuant to it there was established the Health Employees Superannuation Trust Australia, and clause (I) relevantly states the Fund object as:

solely for the purpose of the provision of superannuation benefits for such persons who being eligible make application for membership of the Plan and become members thereof in manner more particularly hereinafter provided in the event of their permanent retirement from gainful employment or leaving the industry or in the circumstances of incapacity from work attributable to illness or accident…(sic).

8 The consolidated rules of the Fund, which appear as a schedule to the trust deed as at 29 January 2009, provide for the Trustee to effect insurance at clause 7, which relevantly provides (without correcting grammatical infelicities):

7.1 The Trustee may arrange with an Insurance Company for all or part of some or all of the Death or Disablement Benefits payable under these Rules to be secured by means of a Policy or Policies.

7.2 A Policy arranged pursuant to Rule 7.1 may be on such terms and conditions as the Trustee approves and the Trustee shall pay all premiums and receive from the Insurance Company all payments refunds and other moneys and shall distribute all moneys received pursuant to that Policy in accordance with these Rules.

7.3 If at any time:

(a) the Trustee is of the opinion that it is not reasonably practicable to obtain or maintain a Policy in respect of a Member on terms acceptable to it; or

(b) an Insurance Company declines to provide or increase or otherwise reduces terminates or withholds Group Life Insurance under a Policy in respect of a Member or declines to admit a claim for the whole or part of the Group Life Insurance effected in respect of that Member;

any Death or Disablement Benefit payable to or in respect of that Member shall be reduced to the extent that Group Life Insurance is not obtained, provided, increased or maintained or a claim is not admitted in respect of that Member.

9 On 10 November 2009, the Trustee entered into a group life insurance policy with ING Life Limited. In broad summary, that policy provided for the payment of death benefits, terminal illness benefits and total and permanent disability benefits in respect of an insured member of the Fund. The Trustee accepted the obligation to pay the premiums. It defined a member as a person who was accepted as a member of the Fund from time to time. ING Life Limited later changed its name to OnePath, but remained the insurer of the group life policy and for the benefit of the members of the Fund until 30 November 2011.

10 On 26 July 2010, Dr Sharma became a member of the Fund. In that capacity he became entitled to receive the benefit of the base cover as provided for in the group life policy. Like each member of the Fund, he was not required to submit to any form of medical examination and nor was he required to make any form of declaration as to the state of his health to the Trustee or the insurer. That beneficial aspect of group life insurance policies was described by the Law Commission (Consultation Paper 182) and The Scottish Law Commission (Discussion paper 134) in the Joint Consultation Paper (2007): *Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured*, at paragraph 6.13 as:

Group insurances are underwritten on a different basis to individual contracts. In particular there is less concern about the risk presented by individuals, since this is less significant when viewed within a pool of employees. Typically, an insurer will grant a level of “free cover”. This is cover granted to each member without individual underwriting - that is, without collecting any information from the member or from other sources such as the employer or the member’s doctor. Certain basic requirements must still be satisfied. These basic requirements might include the fact that the member is within a given age range or not on sick leave on the day the policy commences.

11 On 22 March 2011, Dr Sharma made a separate application for additional death, total and permanent disablement and income protection insurance cover pursuant to the rules of the Fund. On a document described as an application form, which bore the logo of the Trustee and named OnePath Life Ltd, he answered a number of standard form questions, including questions relevant to his cardiovascular and respiratory systems. To the question whether he had ever been diagnosed with, had symptoms or signs of or had sought treatment for “heart trouble, murmur, chest pain, palpitations” he answered “no.” The application form, as required by the *Insurance Contracts Act 1984* (Cth) (**ICA**), set out his duty of disclosure, being that he must disclose “every matter that you know, or could reasonably be expected to know, is relevant to the insurer’s decision whether to accept the risk of insurance and, if so, on what terms.”

12 On 12 July 2011, the Trustee advised Dr Sharma in writing that his “online application to increase your insurance” had been accepted with effect from 11 July 2011 by OnePath. The benefits as advised by the Trustee comprised $1,544,000 for fixed death cover, $1,500,000 for fixed total and permanent disablement cover and a monthly maximum benefit of $19,975 for income protection insurance for 47 months.

13 On 9 March 2017, Dr Sharma lodged a terminal illness claim with the Trustee. Following his death by heart failure on 21 April 2017, CommInsure accepted the terminal illness claim for default cover. However, on 12 July 2017 CommInsure wrote to the Estate with concerns regarding the additional cover. On 16 August 2017, CommInsure notified the Estate that it had decided to avoid or cancel the additional cover and would refund premiums paid in respect of it. Between August 2017 and March 2019, the Trustee and CommInsure each reviewed the decision to avoid the additional cover, and affirmed it. On 17 July 2019, Mrs Sharma made an internal complaint to the Fund. Mrs Sharma then, on 14 January 2020, made her complaint to AFCA which resulted in the Determination.

14 Mrs Sharma filed her notice of appeal with this Court on 27 September 2021. It was heard before me on 11 and 12 April 2022.

# THE AFCA DETERMINATION

15 AFCA made the following findings of fact based on the materials submitted to it. OnePath required Dr Sharma, for its underwriting purposes, to complete an online application form and in so doing to respond truthfully to questions relating to his health. Dr Sharma gave untruthful negative answers to questions relevantly directed to his past medical history including the following:

Have you EVER had any of the following:

High blood pressure, chest pain, high cholesterol, stroke, rheumatic fever or any heart or vascular complaint?

Have you required medical treatment, including surgery, for any illness or injury not mentioned above?

Any other illness, injury, operation or disability?

16 Each of his negative answers were not only false, but fraudulent. Dr Sharma had a surgical procedure in 1999 when three stents were placed into two different sections of his coronary arteries, in consequence of suffering a myocardial infarction. He failed to mention this in his application. Further, as a general practitioner, Dr Sharma knew, or should have known, that a previous myocardial infarction that required surgical intervention and stents was a serious condition, not analogous to mild chest pain. A reasonable person in the position of Dr Sharma at the time would have appreciated that this medical condition was relevant to the “heart trouble” and “heart and vascular complaint” questions. AFCA reasoned that “it was beyond reasonable belief that the deceased may have forgotten about this condition or the stents.”

17 AFCA further found that these answers were fraudulent as they, at least, amounted to reckless indifference on the part of Dr Sharma.

18 Having found those facts, AFCA reasoned as follows. First, s 29 of the ICA could not be relied upon as a reason for not paying the claim either in its original form as lodged by Dr Sharma or as subsequently modified in consequence of his death and for the benefit of the Estate. It construed s 29 of the ICA as inapplicable to the contract of insurance between CommInsure and the Trustee of 1 December 2011: Dr Sharma did not make a false statement to CommInsure under the later contract of insurance. In its view, the decision of this Court in *Sharma v LGSS Pty Ltd* [2018] FCA 167, Gleeson J, (**LGSS**) required it to conclude that “only the insurer to which a misrepresentation was made can rely on it to enliven the remedy to avoid” as provided for at s 29.

19 Secondly, there was no clear evidence to support a finding that any earlier misrepresentation made by Dr Sharma was of continuing effect which was relied upon by CommInsure when it became the insurer of the group scheme.

20 Thirdly, and in any event, there was no sufficient evidence to conclude, as required by s 29(1)(c), that CommInsure “would have entered into the contract even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into.” AFCA found that CommInsure “did not reassess the risk of the members at the takeover date.”

21 Fourthly, and despite each of these findings, AFCA found that the decision “not to pay additional insurance benefits is, in its operation in relation to the complainant, fair and reasonable in all of the circumstances.” In essence AFCA reasoned that the ICA “does not properly contemplate a situation in which an insurer takes over risk from another insurer in a superannuation group life setting,” that s 7 of the ICA “indicates that the ICA does not intend to affect the operation of any other law, common law or equity, unless the ICA conveys that intent expressly or by necessary intendment” and that it “could not conclude that section 33 operated (either expressly or by necessary intendment) to exclude an insurer’s rights under the general law (prior to the amendments to the ICA), in circumstances where the insurer has assumed cover, for an already insured member, from another insurer in the superannuation group life context.”

22 Just what other common law or equitable remedies AFCA had in mind is not satisfactorily revealed in the Determination. It accepted that a misrepresentation may have continuing effect, “it would have been within the contemplation of the deceased that the trustee’s insurer (and subsequent insurers) would have relied on his statements in his application for the purpose of deciding whether to accept the risk of providing additional cover and whether to pay a claim based on the additional cover,” and that there was reliance by CommInsure (despite that the underwriting risk posed by Dr Sharma was not reassessed). In consequence the decision to refuse to pay the additional benefits claim was fair and reasonable. To the extent that AFCA revealed its reasoning for that conclusion it said:

This is because there is no unfairness or unreasonableness in refusing to pay insurance benefits in respect of the deceased or his beneficiaries (including the complainant) where the ICA does not contemplate a change of group insurers, in a superannuation context, and the common law or equity would allow insurer 2 to recover those benefits due to the deceased’s fraudulent misrepresentation. The panel accepts insurer 2 may have rights in common law and equity to recover any loss that it incurs from paying out additional insurance benefits obtained by the deceased’s fraudulent misrepresentations, due to its detrimental reliance on those misrepresentations in continuing his additional cover when it would not have provided cover if the deceased’s cardiac history had been correctly represented. Conversely, the panel considers that it would be unfair and unreasonable to require the insurer to pay the additional benefits only to then seek recovery of them.

23 No authority was cited in support of any of those propositions. There is a material and unexplained change in language in that paragraph: in one sentence AFCA states that the insurer “would” have recovery rights, but in the next states that it “may” have such rights. I make each of those observations mindful that “the determining factor is not the lawfulness of the decision, but its fairness or reasonableness in its operation in relation to the complainant” QSuper at [64]. See also *Rushton v Commonwealth Superannuation Corporation (No 3)* [2021] FCA 358 at [50], Rares J and *Wan v BT Funds Management Limited* [2022] FCA 302 at [96-98], Anastassiou J. However, by s 1055(7)(a) of the Corporations Act AFCA “must not make a determination of a superannuation complaint that would be contrary to law.” As these reasons explain, the excursion that AFCA undertook into the common law or equitable rights that it referenced proceeded on a misunderstanding of the statutory scheme of Division 3 of the ICA which caused it to materially err in law in affirming the decision of CommInsure pursuant to s 1055(3) of the Corporations Act. That error was so fundamental in this case so as to make it unnecessary for me to address the tension that in my view exists between acceptance that lawfulness of the decision is not the determining factor and obedience to s 1055(7)(a).

24 Finally, AFCA confirmed the decision of the Trustee (whereby it agreed with the decision of the insurer) was neither unfair nor unreasonable in its operation in all of the circumstances. Why it did so is unclear. The Determination simply concludes, without reasons, that “while the panel does not agree with the reasoning of the trustee, it is satisfied that the decision is, in its operation in relation to the complaint, fair and reasonable in all the circumstances.” No point was taken before me about the absence of reasons for that conclusion, the failure of AFCA to give separate consideration to the Trustee’s decision nor the conflation of the separate decisions. Accordingly, I do not embark upon consideration of these as relevant issues in this appeal.

# GROUNDS OF APPEAL

25 The appellant frames the following as the questions of law that arise in this appeal:

a. Whether, AFCA having found that it was not satisfied that s. 29(i)(c) of the Insurance Contracts Act 1985 (“ICA”) applied, s. 26(2) of the ICA prevented a conclusion that the deceased made a misrepresentation to the Second Respondent (“AIA”) in December 2011?

b. Whether there was any evidence that, alternatively whether the findings do not provide a sufficient basis for the conclusion that the deceased made a fraudulent misrepresentation to AIA in December 2011 **or that conclusion was irrational**?

c. Whether there was any evidence that, alternatively whether the findings do not provide a sufficient basis for the finding that AIA relied upon a misrepresentation by the deceased in providing cover to the deceased in December 2011 under a group insurance contract with the First Respondent (“the policy”).

d. Whether s. 33 of the ICA would prevent AIA from taking an action for damages for deceit at common law or in equity against the estate of the deceased?

e. Whether there was any evidence that a court approved transfer scheme transferred to AIA a cause of action for damages for deceit at common law or in equity against the estate of the deceased in respect of misrepresentation by the deceased in December 2011?

f. Whether:

1. there was any evidence that, alternatively whether the findings do not provide a sufficient basis for the determination that it was fair and reasonable for AIA;

2. it was contrary to law and to the terms of the policy and in breach of s. 1055(7) of the Corporations Act 2001 for AFCA to determine that it was fair and reasonable for AIA not to pay benefits under the policy to the First Respondent because the common law or equity would allow AIA to recover those benefits from the estate of the deceased due to the deceased’s fraudulent misrepresentation?

(The emphasised words were inserted by way of amendment during argument).

26 Building upon these questions, the appellant’s grounds of appeal are:

1. AFCA found that it was not satisfied that s. 29(i)(c) of the ICA applied. It determined that the deceased made a misrepresentation to AIA in December 2011. It should have determined that s. 26(2) of the ICA prevented a finding that the deceased made a misrepresentation to AIA in December 2011.

2. AFCA concluded that the deceased made a fraudulent misrepresentation to AIA in December 2011. There was no evidence that, alternatively the findings do not provide a sufficient basis for the conclusion that, the deceased made a fraudulent misrepresentation to AIA in December 2011.

3. AFCA concluded that AIA relied upon a misrepresentation by the deceased in providing cover to him under the policy in December 2011. There was no evidence that, alternatively the findings do not provide a sufficient basis for the conclusion that, AIA relied upon a misrepresentation by the deceased in providing cover to the deceased in December 2011 under the policy.

4. AFCA found that AIA was entitled to and would have recovered damages for deceit at common law or in equity against the estate of the deceased. S. 33 of the ICA would have deprived AIA of any such entitlement and/or prevented AIA from taking any such action.

5. AFCA found that a court approved transfer scheme transferred to AIA a cause of action for damages for deceit at common law or in equity against the estate of the deceased in respect of a misrepresentation by the deceased in December 2011. There was no evidence that any court approved transfer scheme effected any such transfer.

6. AFCA determined that it was reasonable for AIA not to pay the benefits payable under the policy to the First Respondent because the common law or equity would allow AIA to recover those benefits from the estate of the deceased due to the deceased’s fraudulent misrepresentation. But there was no evidence for, alternatively the findings do not provide a sufficient basis for that determination. Further, that determination was contrary to law and contrary to the terms of the policy and in breach of s. 1055(7) of the Corporations Act 2001.

27 To my mind, the central question of law is whether AFCA misdirected itself in law in reasoning to its ultimate conclusions which is the gravamen of questions of law (a) and (d) and grounds 1 and 4.

## Notice of Contention

28 AIA relies on a Notice of Contention that the Determination should be affirmed on grounds other than those relied on by AFCA. Those grounds are as follows:

1. The AFCA erred in law in Section 2.3 of its Determination in relation to case numbers 693811 and 711994 (**the Determination**) in finding that the Colonial Mutual Life Assurance Society Limited (**CommInsure**) was not entitled to avoid the Death/Terminal Illness Cover and Total and Permanent Disablement Cover under the group life insurance policy bearing policy number K006454 and the Income Protection Cover under the group income protection policy bearing policy number K006455 in respect of the late Mr Deepak Sharma (**Mr Sharma**), insofar as such cover was above automatic acceptance limits, (**the Additional Cover**) pursuant to s 29(2) of the *Insurance Contracts Act 1984* (Cth) (**the ICA**). On a proper construction and application of s 29(2) of the ICA, the AFCA should have found that CommInsure was entitled to avoid the Additional Cover under s29(2) of the ICA because:

a. The late Mr Sharma made a misrepresentation to OnePath Life Limited (OnePath), before it entered into the Additional Cover, by reason of each of his negative answers to the following questions (collectively the Misrepresentations) in the application completed on 22 March 2011 and the Personal Statement completed on 21 April 2011:

The application completed on 22 March 2011:

Have you ever been diagnosed with, had symptoms or signs of, or sought (or intend to seek) medical advice, treatment or investigations for:

Heart trouble, murmur, chest pain, palpitations?

The Personal Statement completed on 21 April 2011:

D3 Have you EVER had any of the following:

b. High blood pressure, chest pain, high cholesterol, stroke, rheumatic fever or any heart or vascular complaint?

y. Have you required medical treatment, including surgery, for any illness or injury not mentioned above?

z. Any other illness, injury, operation or disability?

b. One or more of the Misrepresentations were properly characterised as continuing misrepresentations and were made to CommInsure before it entered into the Additional Cover with effect from 1 December 2011;

c. One or more of the Misrepresentations were properly characterised as fraudulent;

d. On a proper construction and application of s25 of the ICA, the Misrepresentations that were fraudulent were made to CommInsure by the First AIA; and

e. Had one or more of the fraudulent Misrepresentations not been made to CommInsure, CommInsure would not have entered into the Additional Cover on the same terms.

2. In the alternative to paragraph 1 above, the AFCA erred in law in Section 2.3 of the Determination in finding that CommInsure was not entitled to avoid the Additional Cover pursuant to s29(2) of the ICA as it ought to have found that, on a proper construction and application of s29(2) of the ICA, CommInsure was entitled to avoid the Additional Cover pursuant to s29(2) because:

a. The late Mr Sharma made the Misrepresentations to OnePath before OnePath entered into the Additional Cover with effect from 19 May 2011;

b. One or more of the Misrepresentations were properly characterised as fraudulent;

c. On a proper construction and application of s25 of the ICA, the Misrepresentations that were fraudulent were made by the First AIA to OnePath;

d. Had one or more of the fraudulent Misrepresentations not been made to OnePath, OnePath would not have entered into the Additional Cover on the same terms; and e. On a proper construction and application of s29 of the ICA, 'the insurer' under s29 of the ICA includes not only the insurer who accepted the risk of providing insurance cover and to whom the relevant misrepresentation was made but also the insurer that ultimately assumes the risk of providing the relevant insurance cover. That is, 'the insurer' for the purpose of ss29(1)(b) and (c) of the ICA is OnePath and 'the insurer' for the purpose of s29(2) of the ICA is CommInsure.

3. In the alternative to paragraphs 1 and 2 above, the AFCA erred in law in Section 2.4 of the Determination in finding that, CommInsure was not entitled to avoid the Additional Cover, at common law. The AFCA should have found that CommInsure was entitled to avoid the Additional Cover, at common law, because:

a. The late Mr Sharma made one or more of the Misrepresentations to OnePath before it entered into the Additional Cover with effect from 19 May 2011;

b. The late Mr Sharma owed a duty of good faith and fair dealing to CommInsure, at common law, before CommInsure entered into the Additional Cover with effect from 1 December 2011; and

c. The late Mr Sharma breached his duty of good faith and fair dealing, which he owed to CommInsure, by failing to inform CommInsure of one or more of the Misrepresentations before it entered into the Additional Cover with effect from 1 December 2011.

# CONSIDERATION

29 At the outset it is important to understand the scheme pursuant to which AFCA operates and the nature of an appeal which may be made to this Court, each pursuant to the *Corporations Act*. The Minister, by a Notifiable Instrument published on 23 April 2018, and titled: *AFCA Scheme Authorisation 2018*, authorised the external dispute resolution scheme of AFCA for the purposes of s 1050 (1). That Instrument was amended on 30 June 2019 and 25 April 2020, but not in any presently relevant respect. The Minister was satisfied that each of the mandatory requirements at s 1051 will be met. Those requirements include that there is a complaints mechanism that “is appropriately accessible to persons dissatisfied with members of the scheme” and that “complaints against members of the scheme are resolved (including by making determinations relating to such complaints) in a way that is fair, efficient, timely and independent”: s 1051(4)(a) and (b). A mandatory requirement of the AFCA scheme is that determinations bind the members, but not complainants: s 1051(4)(e).

30 Section 1053 specifies when a person may make a complaint pursuant to the scheme. For present purposes a complaint relating to superannuation may be made if the complaint is that the trustee of a regulated superannuation fund has made a decision relating to a member, or a former member, “that is or was unfair or unreasonable” or that “a decision of an insurer relating to a contract of insurance where the premiums are paid from an RSA is or was unfair or unreasonable”: s 1053(1)(a) and (h). A complaint of that character is a superannuation complaint: s 1053(3). Once a superannuation complaint is made, AFCA may join parties to the complaint, including an insurer (s 1054), may obtain information and documents by notice in writing to a person (s 1054A), may require attendance at a conciliation conference (s 1054B) and may give directions as to who may attend a meeting held by AFCA relating to the complaint (s 1054BA). AFCA is required to make a determination of a superannuation complaint as required by s 1055 which provides:

**1055 Making a determination**

(1) In making a determination of a superannuation complaint, AFCA has, subject to this section, all the powers, obligations and discretions that are conferred on the trustee, insurer, RSA provider or other person who:

(a) made a decision to which the complaint relates; or

(b) engaged in conduct (including any act, omission or representation) to which the complaint relates.

*Affirming decisions or conduct*

(2) AFCA must affirm a decision or conduct (except a decision relating to the payment of a death benefit) if AFCA is satisfied that:

(a) the decision, in its operation in relation to the complainant; or

(b) the conduct;

was fair and reasonable in all the circumstances.

(3) AFCA must affirm a decision relating to the payment of a death benefit if AFCA is satisfied that the decision, in its operation in relation to:

(a) the complainant; and

(b) any other person joined under subsection 1056A (3) as a party to the complaint;

was fair and reasonable in all the circumstances.

*Varying etc. decisions or conduct*

(4) If AFCA is satisfied that:

(a) a decision (except a decision relating to the payment of a death benefit), in its operation in relation to the complainant; or

(b) conduct;

is unfair or unreasonable, or both, AFCA may take any one or more of the actions mentioned in subsection (6), but only for the purpose of placing the complainant, as nearly as practicable, in such a position that the unfairness, unreasonableness, or both, no longer exists.

(5) If AFCA is satisfied that a decision relating to the payment of a death benefit, in its operation in relation to:

(a) the complainant; and

(b) any other person joined under subsection 1056A (3) as a party to the complaint;

is unfair or unreasonable, or both, AFCA may take any one or more of the actions mentioned in subsection (6), but only for the purpose of placing the complainant (and any other person so joined as a party), as nearly as practicable, in such a position that the unfairness, unreasonableness, or both, no longer exists.

(6) AFCA may, under subsection (4) or (5), do any of the following:

(a) vary the decision;

(b) set aside the decision and:

(i) substitute a decision for the decision so set aside; or

(ii) remit the decision to the person who made it for reconsideration in accordance with any directions or recommendations of AFCA;

(c) if the complainant was unfairly or unreasonably admitted into a life policy fund:

(i) require a party to the complaint to repay all money, or particular money, received under the life policy to which the complaint relates; or

(ii) set aside the whole or part of the terms or conditions of the life policy in their application to the complainant; or

(iii) vary the governing rules of the life policy fund in their application to the complainant; or

(iv) cancel the complainant's membership of the life policy fund or of any sub-plan of the fund;

(d) if the complainant was unfairly or unreasonably sold an annuity policy, contract of insurance or RSA:

(i) require a party to the complaint to repay all money, or particular money, received under the annuity policy, contract or RSA; or

(ii) set aside the whole or part of the terms or conditions of the annuity policy, contract or RSA in their application to the complainant; or

(iii) vary the terms or conditions of the annuity policy, contract or RSA in their application to the complainant.

*Limitations on determinations*

(7) AFCA must not make a determination of a superannuation complaint that would be contrary to:

(a) law; or

(b) subject to paragraph (6)(c), the governing rules of a regulated superannuation fund or an approved deposit fund to which the complaint relates; or

(c) subject to paragraph (6)(d), the terms and conditions of an annuity policy, contract of insurance or RSA to which the complaint relates.

31 By s 1056, certain limitations apply to superannuation complaints in relation to the payment of death benefits, including that the complainant must have an interest in the death benefit.

32 In QSuper the Full Court concluded that AFCA does not impermissibly exercise the judicial power of the Commonwealth pursuant to Ch III of the Constitution because the making of a determination upon a complaint as required by s 1055 “does not adjudicate upon existing legal rights,” no order is made “to remediate for any breach which is detected” and that “all that the section requires, in cases such as the present, is to consider the operative effect of a trustee’s decisions in relation to a member and determine whether it operates “unfairly or unreasonably, or both” in relation to a member. If it reaches the conclusion that it does it will create new rights as between the parties for the purpose of removing the unfairness or unreasonableness”: [184].

33 As earlier explained by the Full Court, in reaching that state of satisfaction, AFCA is not concerned with whether the decision of a trustee or an insurer is legally correct but only whether it operates unfairly or unreasonably in the particular circumstances: the focus is upon the operative effect of the decision: [153-155]. This is not to say that AFCA is precluded from considering the legal rights or obligations of the parties to a complaint [156]. Although by s 1055(7) AFCA must not make a determination of a superannuation complaint that would be contrary to law or, with limited exceptions, to the governing rules that apply to a regulated superannuation fund, AFCA may be required to consider the legal position of the parties as explained at [157]:

AFCA may make decisions or form opinions as to the application of various statutory provisions and the rights of the parties arising inter se under the fund’s trust deed. But such decisions or opinions are merely steps in the determination of whether the operation of the trustee’s decision is fair and reasonable. Alternatively put, AFCA’s opinions about those matters are “a step in arriving at the ultimate conclusions… intended to regulate the future rights of the parties.”

(Citations omitted).

34 A party to a superannuation complaint may appeal to this Court on a question of law from a determination made by AFCA: s 1057. This Court may make such orders as it thinks appropriate in the determination of the appeal, including orders that affirm or set aside the determination or that the matter be remitted to be determined again by AFCA: s 1057(3) and (4).

35 It follows that if in determining a superannuation complaint, AFCA materially misdirects itself as to the legal rights or obligations of the parties in order to found the statutorily required state of satisfaction (that a decision in its operation in relation to the complainant was fair and reasonable in all of the circumstances), the determination is reviewable for legal error: *Craig v South Australia* (1995) 184 CLR 163 at 179. The question that is squarely raised by paragraph (d) as a question of law and ground 4 in the notice of appeal is whether AFCA misdirected itself as to the meaning or effect of s 33 of the ICA which, in turn, requires analysis of several provisions in Part IV of the ICA.

36 In this appeal I am concerned with the statutory scheme which operated prior to the amendments made by the *Insurance Contracts Amendment Act 2013* (Cth) (**Amendment Act**), the relevant provisions of which commenced on 28 June 2014. These reasons do not analyse whether those amendments may now produce a different outcome.

37 Division 3 of Part IV of the ICA is concerned with remedies for non-disclosure and misrepresentation. In broad summary, and in order to deal with complications which arise from policies where group life insurance is provided to members of a superannuation scheme (the insured is ordinarily a corporate trustee, each life insured is an individual member, each member will join the scheme at different points in time and there is no contract between the individual members and the insurer) the ICA operates to create certain statutory fictions. By s 25 misrepresentations by a prospective life insured are deemed to be made by the insured. It provided:

**25 Misrepresentation by life insured**

Where, during the negotiations for a contract of life insurance but before it was entered into, a misrepresentation was made to the insurer by a person who, under the contract, became the life insured or one of the life insureds, this Act has effect as though the misrepresentation had been so made by the insured.

38 Section 29 confers rights to avoid a contract for non-disclosure and misrepresentation, but also limits the exercise of those rights in defined circumstances. Relevantly it provided:

**29 Life insurance**

(1) This section applies where the person who became the insured under a contract of life insurance upon the contract being entered into:

(a) failed to comply with the duty of disclosure; or

(b) made a misrepresentation to the insurer before the contract was entered into;

but does not apply where:

(c) the insurer would have entered into the contract even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into; or

(d) the failure or misrepresentation was in respect of the date of birth of one or more of the life insureds.

(2) If the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.

(3) If the insurer would not have been prepared to enter into a contract of life insurance with the insured on any terms if the duty of disclosure had been complied with or the misrepresentation had not been made, the insurer may, within 3 years after the contract was entered into, avoid the contract.

39 Subparagraph (4) conferred a right upon the insurer, where a contract is not avoided, to vary the sum insured by reference to a statutory formula.

40 Section 32 extended the operation of the Division to non-disclosures or misrepresentations under blanket superannuation contracts when made by proposed members. It recognised that a blanket contract of insurance is ordinarily entered into before individual members join a scheme and thus before there is any non-disclosure or misrepresentation by an individual member. In that circumstance, the fiction of individual contracts is created between the insurer and the trustee and which are deemed entered into when each member joins the scheme. It provided:

**32 Non-disclosure or misrepresentation by member of scheme**

This Division extends to the case where there was a failure to comply with the duty of disclosure, or a misrepresentation was made, to the insurer under a blanket superannuation contract in respect of the proposed member of the relevant superannuation or retirement scheme as though:

(a) the insurance cover provided by that contract in respect of that member were provided by an individual superannuation contract between the insurer as insurer and the trustee for the purposes of the scheme as the insured; and

(b) that contract had been entered into at the time when the proposed member became a member of the scheme.

41 AIA submits, and the appellant disputes, that s 27A is also relevant because, although introduced by the *Amendment Act*, it has retrospective operation. Its effect is to unbundle different categories of risk, forms of protection and cover for two or more life insureds and treats each as a separate contract of insurance. It provides:

**27A Certain contracts of life insurance may be treated as if they comprised 2 or more separate contracts of life insurance**

(1) If:

(a) a contract of life insurance includes 2 or more groups of provisions (for example, provisions that are grouped into 2 or more separate parts); and

(b) each group of provisions could form a single contract of life insurance;

then this Division applies as if each group of provisions were a separate contract of life insurance.

(2) If:

(a) a contract of life insurance includes 2 or more groups of provisions (for example, provisions that are grouped into 2 or more separate parts); and

(b) because of subsection (1), this Division applies as if each group of provisions were a separate contract of life insurance; and

(c) the contract also includes provisions (related provisions) that relate to or affect the operation of one or more of the groups of provisions referred to in paragraph (a);

then the related provisions are, for the purposes of this Division, to be regarded as provisions included in each relevant separate contract of life insurance referred to in paragraph (b).

(3) If a contract of life insurance provides insurance cover in relation to 2 or more life insureds, this Division applies as if the insurance cover provided in relation to each life insured were provided by a separate contract of life insurance.

(4) If a contract of life insurance provides:

(a) insurance cover in relation to a life insured that is underwritten on particular terms; and

(b) insurance cover in relation to that life insured that:

(i) is not underwritten; or

(ii) is underwritten on different terms;

then this Division applies as if the insurance cover referred to in paragraph (a) and the insurance cover referred to in paragraph (b) were each provided by a separate contract of life insurance.

42 This provision was inserted by schedule 5 of the *Amendment Act*, of which clause 3 provides:

**3 Application**

(1) The amendments made by this Part apply to a contract of life insurance whether originally entered into before or after the commencement of this item.

(2) The amendments made by this Part do not affect any proceedings in progress at the commencement of this item in relation to a contract of life insurance or any appeal in relation to such proceedings.

43 Whilst the application of s 27A to contracts of life insurance entered into before 28 June 2013 is clear, the parties differ as to its operation in this case. The appellant submits that the provision does not “unbundle” every contract of life insurance no matter when it was entered into. Rather, it is limited in its operation to misrepresentations made by a life insured after 28 June 2013. Put another way, the submission is that a group life contract entered into before 28 June 2013, may be “unbundled” where an individual life insured makes a misrepresentation after that date. In contrast, AIA submits that s 27A applies to the fictional individual contract of life insurance that arose when Dr Sharma first became a scheme member in 2011 and as subsequently varied upon acceptance of his application for additional cover.

44 The appellant argues that the difficulty with the submission of AIA is that s 27A is in Division 3 which is concerned with various remedies for non-disclosure and misrepresentation. In contrast, Divisions 1 and 2 contain the substantive provisions which define and mark out the boundaries of the insured’s duty of disclosure (s 21), the obligation of an insurer to inform a prospective insured of that duty (s 22), the effect of ambiguous questions (s 23) and, importantly in the context of this case, misrepresentations by a life insured that are taken to made by the insured pursuant to s 25 which is confined in its operation to the period during “negotiations for a contract of life insurance but before it was entered into.” On that construction it does not apply to a group life insurance contract that is already in place. In contrast AIA submits that the retrospective application clause is plain and unambiguous in meaning and acceptance of the appellant’s submission leads to the curious outcome that s 27A applies to contracts created by the substantive provision (unbundled) but only if the fictitious contract was created after 28 June 2013.

45 The extrinsic materials do not engage with these difficulties. The Explanatory Memorandum to the *Insurance Contracts Amendment Bill 2013* (**Explanatory Memorandum**) at clauses 1.103- 1.112 identifies the intent of the various subclauses of s 27A. Relevantly it was said:

1.104 Contracts of life insurance often “bundle” different types of protection against more than one type of insurable event resulting from death, sickness or accident in the one contract. An application seeking cover for each type of insurable event will be “unbundled” for separate consideration by an insurer in relation to each type of risk, and different factors will be taken into account as part of the underwriting process.

1.106 Any misrepresentation or nondisclosure of that affects one aspect of the insurance cover may not be relevant to the other. However, as currently drafted, the remedies that are available, such as for avoidance or variation of the contract, must be applied to the contract as a whole. This can be to the significant disadvantage of an insured and unnecessarily restrict the remedial options for an insurer.

1.110 Similarly, new section 27A also provides that if a contract of life insurance provides insurance cover in relation to 2 or more life insureds, the insurance cover provided in relation to each type of life insured is taken to be provided by separate contracts of life insurance.

46 However, as observed by the authors of *Sutton on Insurance Law* (4th Ed, Thomson Reuters 2015) at [21.830] (**Sutton on Insurance Law**); “An important issue is that while ss 9 and 10 apply to the whole of the ICA, s 27A only applies to misrepresentation or non-disclosure remedies under Div 3, Pt IV but surely it must apply to the whole of Part IV. It also would need to apply to Part VII on cancellation because the same principle would apply to Part VII and the two parts are linked. Section 27A should also apply to ss 35 and 37, and Part VIII also needs to be considered so that the subrogation elements are not lost or become circular.” The logic of that criticism of the drafting is compelling.

47 In their submissions, the parties each gave examples of how the competing contentions would produce irrational or inconsistent outcomes. Ultimately, I have not found it necessary to interrogate hypothetical examples to resolve the constructional choice that is presented. The starting point is the natural meaning of the statutory text, its context and the purpose of the provision: *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362; [2017] HCA 34 at [14], Kiefel CJ, Nettle and Gordon JJ. To the extent to which the purpose or object of the statute is relevantly identifiable, then one must interpret individual provisions to “best achieve the purpose or object” by application of s 15A of the *Acts Interpretation Act 1901* (Cth). Section 27A was designed, according to Explanatory Memorandum at [1.103], “to make the remedies more flexible and tailored than those that are currently available” and which self-evidently seeks to balance the competing interests of the life insured and the insurer. Paragraph [1.131] of the Explanatory Memorandum which specifically deals with the application provision is no more than an ellipsis of the clause.

48 The balancing of interests between insurer and insured purpose does not relevantly assist me for the reason expressed by Gleeson CJ in *Carr v Western Australia* (2007) 232 CLR 138; [2007] HCA 47 at [5] that: “Where the problem is one of doubt about the extent to which legislation achieves a purpose, stating the purpose is unlikely to solve the problem.”

49 Section 27A is clear in its retrospective application to “a contract of life insurance” entered into before or after 28 June 2013, and in my view it must follow that it is not limited to members who fail to comply with the duty of disclosure, or who make misrepresentations, after that date primarily because it operates to create separate contracts of life insurance. The construction contended for by the appellant artificially carves out a subset of members who failed to comply with the duty of disclosure or made misrepresentations before 28 June 2013, despite the express statement that the amendment is not limited by that date. The appellant’s construction is contrary to the textual meaning and is internally inconsistent. The remedy provisions operate generally upon every statutory separate contract of life insurance: it is entirely artificial to confine the operation of s 27A to members who join a fund after 28 June 2013 when the provision applies to contracts entered into before that date.

50 Finally, s 33 provides:

**33 No other remedies**

The provisions of this Division are exclusive of any right that the insurer has otherwise than under this Act in respect of a failure by the insured to disclose a matter to the insurer before the contract was entered into and in respect of a misrepresentation or incorrect statement.

51 I return to consider how this provision operates in this case in detail in the balance of these reasons.

## The Decisions, the Complaint and other Preliminary Matters

52 On 6 July 2017, CommInsure corresponded with the executors of the Estate. In substance the insurer summarised the extent of the investigations that it had undertaken into the medical history of Dr Sharma and stated that OnePath, in reliance upon the answers given by Dr Sharma in his application of 22 March 2011, had agreed to provide additional cover to him as a member of the Fund. The correspondence also recorded advice from OnePath to the effect that if Dr Sharma had fully disclosed his previous medical history, then the underwriters would have declined the application for additional death, total and permanent disablement and income protection insurance. The letter invited further representations before the making of a final decision as to whether the insurer would seek to avoid the contract of life insurance.

53 It is not apparent that further information was provided by the Estate. In further correspondence of 16 August 2017, CommInsure advised the Estate that it had concluded its assessment of the claim and had decided to “avoid the late Mr Sharma’s increased Life/Terminal illness, IP and additional TPD covers pursuant to s 29(2) of the Insurance Contracts Act, on the basis that if he had complied with the duty of disclosure increased Life/terminal Illness, IP and additional TPD cover would not have been offered to him on any terms.” In an earlier paragraph, the decision is expressed as avoidance or cancellation from inception, but nothing in my view turns on any difference in apparent meaning. What is clear is that CommInsure made that decision pursuant to s 29(2) of the ICA which provides that an insurer “may avoid” the contract for fraudulent non-disclosure or misrepresentation.

54 Separately, the Trustee resolved on 30 August 2017 that: “as per the terms and conditions of the policy, all additional cover above the default amount should be declined as per section 21 of the ICA due to the misrepresentations made on the late member’s application” (sic). I infer the reference to s 21 was intended to be to s 29.

55 Various forms of internal review and assessment were then engaged in, which need not be essayed in these reasons save to observe that the claim was not resolved to the satisfaction of the Estate. On 21 March 2019, the Trustee corresponded with the Estate, advised that it had reviewed the decision of the insurer “so that every member gets a fair result” but had concluded that “as per the terms and conditions of the policy, we regret to advise all cover above the default amount has been avoided from inception on the basis of non-disclosure of the relevant medical history when applying for additional insurance cover.”

56 On 14 January 2020, the legal practitioners for Mrs Sharma lodged a complaint with AFCA and named her as the complainant. It was framed as a complaint about the decision of the Trustee, although in the complaint summary one sees various references to OnePath and CommInsure and the decision of the latter to avoid the policy. Mrs Sharma sought compensation in the amount of $1,673,225.00.

## The Insurers

57 As has been noted, Dr Sharma applied to increase his level of cover pursuant to the Fund on 22 March 2011 when OnePath was the insurer. It accepted his application on 11 July 2011 and remained the insurer to the Fund until 30 November 2011. On 1 December 2011, CommInsure entered into a contract of group life insurance with the Trustee for the benefit of the members of the Fund. CommInsure contracted with the Trustee to provide indemnity upon the terms of the OnePath policy subject to certain amendments which are of no present relevance.

58 During argument, counsel for the appellant repeatedly emphasised that CommInsure did not underwrite the individual risks of the various members of the Fund and did not otherwise undertake an assessment of those risks. Counsel for AIA accepted the correctness of that submission but argued that “even if it didn’t look at the misrepresentations, it suffered loss because it never would have been in the position of taking Dr Sharma as a life insured, but for his false representation to OnePath.” AFCA found that CommInsure “did not reassess the risk of the members and instead appears to have assumed cover based on the risk assessments conducted by (OnePath).”

59 AFCA records in the Determination that AIA was joined as the “financial firm,” but does not explain when or how that occurred, save that there is a reference to a “takeover” of the life insurance business by AIA “pursuant to a court approved life insurance scheme transfer.” That is a reference to the scheme transfer approved by this Court in Re CML with effect from 1 April 2021. The terms of the approved scheme include the following:

3. On and from the scheme effective date, AIAA becomes the issuer of the CMLA Life Policies and CMLA ceases to be the issuer of the CMLA Life Policies.

4. On and from the scheme effective date:

(a) the CMLA life policy owners cease to be CMLA life policy owners and become AIAA life policy owners; and

(b) the rights and liabilities of the CMLA a life policy owners will become the same in all respects as they would have been if:

(i) the applications on which the CMLA a life policies were based had been made to and accepted by AIAA instead of CMLA; and

(ii) the CMLA life policies had originally been issued by AIAA instead of CMLA.

60 Section 190 of *the Life Insurance Act* *1995* (Cth) provides that: “No part of the life insurance business of a life company” may be transferred to or amalgamated with the business of another company except pursuant to a scheme that is confirmed by this Court. By s 195, a scheme once confirmed “becomes binding on all persons.”

## Resolution of the Complaint by AFCA

61 I have summarised above the essential steps in the exposed reasoning of AFCA which led it to affirm the respective decisions of CommInsure and the Trustee. To address the questions of law raised in this appeal it is necessary to interrogate that reasoning in greater detail. The appellant does not contend that AFCA misdirected itself in law in concluding that Dr Sharma fraudulently misrepresented his medical history in his application of 22 March 2011. The application form that contains those false statements is addressed to the Trustee and to OnePath. The form, conformably with s 22 of the ICA, set out the insured’s duty of disclosure and contained an acknowledgement by Dr Sharma to the effect that understood that duty.

62 AIA submitted to AFCA that the Trustee provided the application form to OnePath, it had that document when it considered the proposal and must be taken to have relied upon it, and it would not have offered a policy of insurance to Dr Sharma had he disclosed his relevant medical history. AFCA expressed difficulty with the evidence relied upon by AIA to establish the causal link required by s 29(1)(c) of the ICA and concluded that it “could not be satisfied that paragraph 29(1)(c)…did not apply.” Further, AFCA determined that it was not open to AIA to avoid the contract of insurance for the reason that s 29 requires that the misrepresentation must be made to the insurer who seeks to avoid the policy. OnePath did not do so in this case. For that proposition AFCA relied on certain obiter observations of Gleeson J in LGSS at [46], [48-49] and [61]. Her Honour was concerned with an appeal from a determination of the Superannuation Complaints Tribunal which affirmed as fair and reasonable the decision of an insurer to avoid a policy of additional life insurance for non-disclosure by the life insured and with the decision of the trustee of the group policy to deny the payment of benefits for the same reason.

63 In that case Mr Sharma was a municipal employee and a member of a group superannuation scheme. LGSS Pty Ltd was the trustee. He applied for membership on 22 March 2007 when Prefsure Life Limited was the insurer. He failed to disclose relevant aspects of his medical history, including a diagnosis of major depression in 2003. His application for membership to the group scheme was accepted. With effect from 1 March 2009, TAL Limited entered into a group life contract with the trustee. In 2012, Mr Sharma lodged a claim for payment of a TPD benefit based on his medical condition of depressive disorder and with an onset date of May 2007. On 16 January 2015, TAL advised that it had elected to avoid the policy pursuant to s 29(2) of the ICA for fraudulent misrepresentation and/or non-disclosure. On 5 February 2015, the trustee advised Mr Sharma that it accepted the decision of TAL.

64 Mr Sharma lodged a complaint with the Tribunal pursuant to the scheme which then operated under the *Superannuation (Resolution of Complaints) Act 1993* (Cth). The Tribunal reasoned that it was open to TAL to conclude that Mr Sharma had not complied with his duty of disclosure, that in consequence it could invoke s 29(2) to avoid the contract and the decisions of the trustee and of TAL in their respective operation were each fair and reasonable in the circumstances.

65 Her Honour allowed the appeal and remitted the complaint to the Tribunal. She did so because the Tribunal reasoned, at least implicitly, that Mr Sharma owed a duty of disclosure to the insurer pursuant to s 21 before 1 March 2009. He did not as he was not “the insured” within the meaning of the provision: the trustee was. Her Honour then dealt with other arguments, including a notice of contention by TAL to the effect that Mr Sharma made fraudulent misrepresentations within the meaning of s 25 and which must be taken to have been made to TAL. Her Honour did not decide those contentions for the reasons that she set out at paragraphs [61] and [62]:

The facts found by the Tribunal do not enable me to determine whether s 25 may have any relevant operation. In order to decide whether s 25 applies it would be necessary to make findings about the following:

1. whether the statements in the 22 March 2007 form were communicated to an insurer;

2. if communicated to an insurer, whether the statements were misrepresentations made to that insurer by Mr Sharma; and

3. whether any such misrepresentations were made during the negotiations for a contract of life insurance but before it was entered into.

Without the proper factual foundation to consider the application of s 25, there is no utility in granting leave to rely on the notice of contention.

66 Before me AIA argues in support of ground 2 of the Notice of Contention, that the reference to the insurer in s 29(2) should be construed as not limited to the initial insurer on risk, but as extending to the insurer who ultimately is on risk when a claim is made.

67 Returning to the Determination, AFCA concluded that the decisions of AIA and of the Trustee were each fair and reasonable in their operation in the circumstances for three linked reasons. The first appears under the heading “the ICA did not adequately contemplate this situation” and which includes the following:

It is no secret that there have been challenges with applying the ICA framework to a group insurance context, and this has been recognised by Parliament….

These issues appear to be heightened where there has been an assumption of cover by a subsequent insurer.

This is because, on a strict reading of section 29 (2), an insurer wanting to exercise the remedy to avoid cover obtained through a fraudulent misrepresentation can only do so if they have been the recipient of the fraudulent misrepresentation. However, it is highly common (and arguably encouraged by the legislative covenants in the Superannuation Industry (Supervision) Act 1993) for a superannuation trustee to change group insurers from time to time. It would also be rare to find a situation when a new group insurer re-underwrites or reassesses the risk of the insured members that were given cover under the former insurance arrangements with the previous group insurer. AFCA is not aware of any instance in which this has occurred.

In these circumstances, it would be hard to conceive of a situation where a new group insurer would be the actual recipient of a fraudulent misrepresentation from a fund member granted cover under previous arrangements, even though for all intents and purposes the insured member’s cover continues to be in force regardless of whether there has been a change in insurer. To the insured member, it does not matter whether insurer A or insurer B carries the risk. However, under a strict reading of section 29 (2) of the ICA, there appear to be significant consequences for insurer B, if it assumes risk from insurer A without further underwriting, as it is technically deprived of a remedy in relation to fraudulent misrepresentation.

If the ICA operated as an exclusive code in this situation it means that a person who makes a fraudulent misrepresentation may, simply because of the change of insurer (in the language of the ICA), end up benefiting from that fraudulent misrepresentation.

These anomalies indicate that the ICA does not properly contemplate a situation in which an insurer takes over risk from another insurer in a superannuation group life setting.

68 The second reason, under the heading “section 33 does not bar insurer 2 from exercising rights under the general law in this situation,” includes the following:

Section 7 of the ICA indicates that the ICA does not intend to affect the operation of any other law, common law or equity, unless the ICA conveys that intent expressly or by necessary intendment.

Section 33 appears to be one such provision that expresses an intention to limit the rights of an insurer, in relation to disclosure failings by an insured and in respect of a misrepresentation or incorrect statement, to those set out in the Division.

Section 32 also operated to extend the Division to specifically take into superannuation group insurance settings. However, prior to the amendments to that section (which came into effect after the deceased obtained his additional cover), section 32 only extended to a situation “in respect of a proposed member of the relevant superannuation… Scheme.” That is, it only covered situations where a person was not already a member of a superannuation fund.

Therefore, section 32 of the ICA (as it was) did not appear to contemplate circumstances in which a member was already a member of the superannuation scheme and made an application for cover or additional cover.

These challenges appear to have been partly ameliorated by the retrospective inclusion of section 27A of the ICA, which essentially “unbundled” the group contract, including in respect of obtaining additional cover once a person was already a member of the scheme. However, as noted above, section 27A does not appear to adequately contemplate circumstances in which there is a change in insurer in the superannuation group life context. Further, section 32 did not clearly purport to extend the application of the Division to this situation.

Therefore, noting the clear expression of intention in section 7 of the ICA, the panel could not conclude that section 33 operated (either expressly or by necessary intendment) to exclude an insurer’s rights under the general law (prior to the amendments to the ICA), in circumstances where the insurer has assumed cover, for an already insured member, from another insurer in the superannuation group life context.

69 The third is that AFCA reasoned, in the terms that I have set out above, that common law or equitable remedies were available, that the fraudulent misrepresentation of Dr Sharma was of continuing effect and that the CommInsure in fact relied upon the misrepresentations to its detriment. Just how AFCA reached those conclusions is somewhat obscure. The expressed reasons include the following:

Both equity and common law have relevant application to this matter. While the remedy of rescission may not have application, a party who suffers a loss as a result of fraudulent misrepresentation can take action for damages under the tort of deceit in common law.

While AFCA’s role is not to determine whether an action in the tort of deceit could be made out, or an equitable remedy could have been obtained in a court, it is notable that, had insurer 2 paid out additional benefits based on insurance cover obtained by fraudulent misrepresentation, then it may be open to the insurer to seek recovery of the benefits paid in an action for damages.

Further, equity has always had flexible application to ameliorate the harsh consequences of the strict application of the common law. It is also operated to protect parties from fraud, including where perpetuated unintentionally by the application of statute.

The panel considered that the technical issues, encountered by applying the ICA, were less of an issue when considering the general law position. This is because the panel accepted the trustee’s submissions that a misrepresentation can, at common law, be continuing especially in circumstances where the insurer was contemplated as falling within a class of persons who may rely on that misrepresentation.…

The panel considered this submission and accepted that it was possible for a misrepresentation to be continuing under the general law in the insurance context. This is because…. the deceased made a fraudulent misrepresentation for the purpose of obtaining insurance cover. It is unlikely he cared whether it was insurer 1, insurer 2, or another insurer altogether, that relied on his false answers to provide additional cover; instead, the deceased’s focus in making the misrepresentations was to obtain additional cover through his superannuation arrangements.

The panel therefore considered it would have been within the contemplation of the deceased that the trustee’s insurer (and subsequent insurers) would have relied on his statements in his application for the purpose of deciding whether to accept the risk of providing additional cover and whether to pay a claim based on the additional cover.

70 On the question of reliance by AIA, AFCA sought additional evidence. It was provided with underwriting guidelines of the CommInsure, which it treated as confidential evidence. By reference to that document it expressed its satisfaction that: “The application of the guidelines to the deceased’s circumstances prior to obtaining the additional cover, led to a conclusion that death and IP cover would have been declined by insurer 2 had it known about the deceased’s cardiac history. Therefore, the panel is satisfied that the misrepresentation made by the deceased to insurer 1 has had continuing effect because insurer 2 was within the class of persons who might reasonably be contemplated as relying, and did in fact rely, on that misrepresentation to its detriment.”

71 For these reasons AFCA concluded that the decisions of CommInsure, and the Trustee did not operate unfairly or unreasonably because AIA either had or may have rights recovery rights “in common law or equity” of the character that it mentioned.

## The Issues in this Appeal

72 It is convenient to begin with questions of law (a) and (d) and grounds of appeal 1 and 4 (together with the grounds in the Notice of Contention) because, as these reasons will show, they are dispositive of the appeal and the balance questions and grounds either rest on a false premise or raise hypothetical questions that are unnecessary to determine. In proceeding in that way it is important to focus on the decisions the subject of the complaint as marking out the statutory jurisdiction of AFCA upon the superannuation complaint made to it. The first decision was made by CommInsure and notified to the Estate by correspondence dated 16 August 2017. After reciting relevant history, CommInsure stated, inter alia, that:

We refer to our letter of 12 July 2017 in which we set out in detail the relevant medical history that was not disclosed to us at the time the late Mr Sharma applied for his insurance cover, and the corresponding questions in the application for insurance that required the disclosure of that medical history.

We have now concluded our assessment of the claim. We regret to advise that the result of the assessment is that the Terminal Illness/Life, Income Protection and Total & Permanent Disability cover above the default level of cover has been avoided, or cancelled from inception, on the basis of the non-disclosure of the relevant medical history when applying for additional insurance cover.

This decision does not impact the automatic, default level of cover provided to all eligible members…

Section 29 of the Insurance Contracts Act provides that, in certain circumstances, where an applicant for insurance has failed to comply with their duty of disclosure an insurer may, among other things, avoid the policy or affected cover, which has the effect of cancelling the policy or cover from inception as if it had never been in force.

In the circumstances, we have determined to avoid the late Mr Sharma’s increased Life/Terminal Illness, IP and additional TPD covers pursuant to s 29(2) of the Insurance Contracts Act, on the basis that if he had complied with the duty of disclosure increased Life/Terminal Illness, IP and additional TPD cover would not have been offered to him on any terms.

This means that the increased Life/Terminal Illness, IP and additional TPD cover have been cancelled from inception as if they were never in force.

Premiums paid in respect of the avoided covers will be refunded to the Estate.

73 The second decision is evidenced in the minutes of meeting of the Trustee dated 30 August 2017, which record the following:

The claim was last reviewed by the claims review committee on 12/07/2017. The Trustee resolved to agree, as per the terms and conditions of the policy, all additional cover above the default amount should be declined as per the section 21 of the Insurance Contracts Act 1984 due to the misrepresentation made on the late member’s application……The Trustee agrees the decision made by the insurer is fair and reasonable. The late member would not be entitled to additional cover if he had disclosed his full health/medical history.

## Question (a) and Ground 1 of the Notice of Appeal and Ground 2 of the Notice of Contention

74 This question and ground raise the interrelationship of ss 26(2) and 29(1)(c) of the ICA, assuming that AFCA correctly concluded that s 29(1)(c) does not apply, which is challenged by the second contention of AIA. At the outset AIA submits that this question does not arise because AFCA does not adjudicate upon or finally determine rights under the ICA; its function is limited to considering the operative effect of the decision of the insurer and the Trustee and that “the decisive factor” in the Determination is that a fraudulent misrepresentation was made to OnePath. I do not accept that threshold submission. It is clear from the reasons of AFCA which I have set out that the overall conclusion that the decisions were each fair and reasonable in all the circumstances rests upon the several conclusions that s 29 does not apply, the scheme of the ICA does adequately address the common circumstance of a change of group insurers and that common law or equitable remedies may or can be resorted to because s 33 does not operate to exclude remedies of that type. If those conclusions were wrong, then AFCA materially misdirected itself to conclude that the decisions were in their operation fair and reasonable in all the circumstances because AIA may (or would) have common law or equitable recovery rights for loss that it would suffer on payment of the claim.

75 In my view, AFCA reached the correct conclusion that s 29 of the ICA did not apply and Gleeson J was correct to reason in LGGS, albeit obiter, that upon a proper construction the insurer in that section means the insurer to whom the misrepresentation was made, either directly by the life insured or by the insured by operation of s 25. The starting point is the insured’s duty of disclosure at s 21 which is cast as a duty of the insured to the insurer before a contract of insurance is entered into. It is a duty to disclose “every matter” known to the insured that, inter alia, is relevant to the decision of the insurer that is relevant to acceptance of the risk. Correspondingly, it is the duty of the insurer, before a contract of insurance is entered into, to inform the insured of that duty pursuant to s 22. For life insurance, the effect of s 25 is that any misrepresentation made by the life insured to the insurer during the negotiations for a contract of life insurance is treated as if made by the insured.

76 For group life policies, the effect of the statutory scheme is as follows. Section 27A(3) creates separate contracts of life insurance so that remedies for non-disclosure and misrepresentation may be exercised by an insurer without avoiding the group contract. Section 32 extends the remedies in Division 3 where a misrepresentation was made to the insurer under a blanket superannuation contract in respect of a proposed member by creating the fiction of an individual superannuation contract “between the insurer as insurer and the trustee for the purposes of the scheme as the insured” and then deems that contract to have been entered into on the date that each proposed member became a member of the scheme.

77 It is an essential element of the coherent operation of these provisions that the duty of disclosure is owed to an identifiable insurer at a defined point in time (before the contract is entered into), is discharged when the insured discloses matters relevantly known (or which a reasonable person in the circumstances could be expected to know) as relevant to the decision of that insurer at that time to accept the risk and, if so, on what terms. And, where a misrepresentation is made during the negotiating period for a contract of life insurance by a life insured, the misrepresentation is deemed to have been made by the insured. It is compliance with the duty of disclosure or the making of misrepresentations by a proposed life insured which is central to the operation of s 29. Expressly the focus of that duty and the effect of the making of a misrepresentation is upon an identifiable insurer at an identifiable point in time, and not a subsequent insurer which assumes the risk at a later point in time.

78 For these reasons I do not accept the submission of AIA that because the ICA fails to deal with the common practice of the change of insurers for group life contracts, that a purposeful construction should be adopted to address a legislative lacuna. I am not satisfied that any provision of the ICA discloses the purpose that AIA argues for. The most useful extrinsic material is the Final Report by Alan Cameron AM and Nancy Milne of their *Review of the Insurance Contracts Act 1984, Second Stage Provisions Other than Section 54*, of June 2004. Part 7 extensively deals with submissions and recommendations relating to s 29. The authors recommended that life insurance contracts be “unbundled” at paragraph 7.1. There is no mention of difficulty where insurers change over time. Part 10 is concerned with non-disclosure or misrepresentation by members of group schemes. The recommendation was that s 32 be amended to extend the remedies for non-disclosure and misrepresentation where it occurs between the date that a life insured becomes a scheme member and applies for cover and there is no mention of any issue where there is a change of insurer over time.

79 The purposive approach urged by AIA sits well beyond the interpretation function of this Court which is constrained in the manner described by Gageler and Keane JJ in *Taylor v Owners of Strata Plan No 11564* (2014) 253 CLR 531; [2014] HCA 9 at [65], in dissent as to the result, but not as to the correct approach:

The constructional task remains throughout to expound the meaning of the statutory text, not to divine unexpressed legislative intention or to remedy perceived legislative inattention. Construction is not speculation, and it is not repair.

80 The identified lacuna is a matter for Parliament to address, if at all. I dismiss ground 2 of the Notice of Contention.

81 That leaves for consideration under issue (a) and ground 1 of the Notice of Appeal, s 26(2) of the ICA which is not mentioned in the Determination. The appellant argues that s 26(2) precludes the finding of AFCA that Dr Sharma made a misrepresentation to AIA in December 2011.

82 AFCA did not make the finding asserted. As I have noted, there is confusion in the Determination that flows from adoption of the nomenclature of “insurer 1,” a reference to OnePath, “insurer 2,” a reference to AIA and the failure to separately refer to CommInsure as the insurer that made the decision the subject of the complaint. Properly understood, AFCA found that Dr Sharma made a fraudulent misrepresentation to OnePath. That finding is set out in part 2.3 of the Determination where it is said:

The problem with insurer 2’s position is there is no clear evidence before AFCA that there was a misrepresentation made by the life insured to the insurer seeking to exercise the remedy in section 29(2) (insurer 2). Even if AFCA accepts the above propositions they do not allow AFCA to find that there was a misrepresentation by the deceased to insurer 2.

83 Conversely, what AFCA said in part 2.4 of the Determination is that the misrepresentation made by Dr Sharma in March 2011 had continuing effect, when on 1 December 2011, CommInsure contracted with the Trustee to be the insurer of the Fund. AFCA reasoned that it was within the class of persons within the contemplation of Dr Sharma as likely to subsequently rely on his misrepresentation and it did in fact rely on it, despite the earlier finding in part 2.3 of the Determination that CommInsure did not reassess the risk of any Fund member. But that reasoning is relevant only to the common law or equitable rights findings that, as found by AFCA, sit outside Division 3 of the ICA. In these reasons, I conclude that AFCA erred in that conclusion and the appeal must be allowed. Understood in this way, the appellant’s s 26(2) argument does not arise on question (a) or ground 1.

84 For these reasons, it is unnecessary to determine ground 1.

## Question (d), Ground 4 and Grounds 1 and 3 of the Notice of Contention

85 Having concluded that no misrepresentation was made to AIA, and therefore s 29(2) could not be relied on by it to avoid the separate contract with Dr Sharma, AFCA then considered whether the decision by CommInsure to deny cover, and the concurrence of the Trustee, were nonetheless in their respective operation fair and reasonable in all the circumstances by reference to the issue that it framed in part 2.4 of the Determination: whether “the common law or equity would allow insurer 2 to recover those benefits due to the deceased’s fraudulent misrepresentation.”

86 Central to the reasoning which then follows, is that AFCA concluded that s 33 of the ICA does not operate “either expressly or by necessary intendment to exclude an insurer’s rights under the general law (prior to the amendments to the ICA), in circumstances where the insurer has assumed cover, for an already insured member, from another superannuation insurer in the superannuation group life context.” That conclusion is anchored by the earlier observation that the ICA “does not properly contemplate a situation in which an insurer takes over risk from another insurer in a superannuation group life setting.”

87 At common law, a misrepresentation or failure to disclose a material fact (breach of the duty of utmost good faith) may entitle an insurer to rescind or avoid a contract of insurance: see generally; *Babatiskos v Car Owner’s Mutual Insurance Co Ltd* [1970] VR 297 and *Sutton on Insurance Law* at [7.1140]. Similarly, in equity the general remedy for fraudulent misrepresentation is rescission: *Meagher, Gummow and Lehane’s Equity: Doctrines and Remedies* (4th ed) at [24-015]. The issue is whether s 33 of the ICA operates an exclusive code so as to displace the operation of these principles in this case? I have concluded that it does.

88 The statutory language could not be clearer: the provisions of Division 3 “are exclusive of any other right that the insurer has otherwise than under this Act” in respect of, inter alia, “a misrepresentation or incorrect statement.” In *Advance (NSW) Insurance Agencies Pty Ltd v Matthews* (1989) 166 CLR 606, the High Court was concerned with a fraudulent failure to disclose past claims history by one co-insured. Of the effect of s 33, Mason CJ, Dawson, Toohey and Gaudron JJ said at 615:

The evident intention of the legislature is to replace the antecedent common law regulating non-disclosure, misrepresentations and incorrect statements by insured persons before entry into a contract with the provisions of Pt IV. To that extent Pt IV is a statutory code which replaces the common law. Accordingly, the circumstances in which it is legitimate to resort to the antecedent common law for the purpose of interpreting the statute are extremely limited.

89 The Full Court of this Court in *Macquarie Underwriting Pty Ltd v Permanent Custodians Ltd* (2007) 240 ALR 519; [2007] FCAFC 60 at [27], Allsop, and Buchannan JJ, (**Macquarie Underwriting**) emphasised the limiting effect of s 33:

The effect of s 33 is to limit remedies for non-disclosure and misrepresentation to those provided by the *Insurance Contracts Act* itself. Of particular relevance is s 28 which, whilst permitting avoidance of an insurance contract in the event of a fraudulent non-disclosure or misrepresentation, otherwise limits the protection of an insurer’s interests to reduction of the claim ‘*to the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred or the misrepresentation had not been made*’ (s 28(3)). It is now clear on the authorities that this reduction can, if the evidence permits the conclusion, be to zero.

90 See also – *Graham v Colonial Mutual Assurance Society Ltd (No 2)* [ 2014] FCA 717 at [19], McKerracher J; *Montclair v MetLife Insurance Ltd* [2015] VSC 306 at [42], Ginnane J *and Sutton On Insurance Law* at [7.1180].

91 I cannot accept as correct the reasoning of AFCA that s 33 does not operate as a code so as to exclude general common law or equitable principles. Whilst s 7 of the ICA states that is the “intention of the Parliament that this Act is not, except in so far as this Act, expressly or by necessary intendment, otherwise provides, to affect the operation of any other law of the Commonwealth… or the operation of any principle or rule of the common law (including the law of merchant) or of equity,” I am clearly of the view that s 33 is a contrary expression of intent in that the remedies for non-disclosure and misrepresentation in Division 3 of Pt IV operate as an exclusive code, save for rights of the insurer “otherwise than under this Act.” So understood, it is simply not to the point that AFCA concluded that the provisions of Division 3 do not operate “adequately” or “properly” where a subsequent insurer assumes the risk of misrepresentation or non-disclosure of a person who became a group member when an earlier insurer was on risk and therefore resort could be had to general common law or equitable principles to fill the gap.

92 AFCA, and AIA on this appeal, also relied upon ss 27A and 32 in support of the conclusion that Division 3 does not operate as a code. Whilst I have concluded that s 27A operates retrospectively upon the contract of life insurance entered into as a result of the application for increased cover made by Dr Sharma in March 2011, and hence by subparagraph (3) it applies the provisions of the Division as if “the insurance cover provided in relation to each life insured were provided by a separate contract of life insurance,” it does not address the lacuna in the legislative scheme that exists on the facts of this case. That is because s 32, as applied by s 27A, is only applicable to a failure to comply with the duty of disclosure or a misrepresentation “made, to the insurer under a blanket superannuation contract in respect of a proposed member” for the straightforward reason that when Dr Sharma made his application for additional cover, he was a member of the Fund and did not have the status of a proposed member.

93 I deal next with the reasoning of AFCA that AIA either “would have” or “may have” common law or equitable rights to “recover benefits due to the deceased’s fraudulent misrepresentation” or to “recover any loss that it incurs from paying out additional insurance benefits obtained by the deceased’s fraudulent misrepresentations, due to its detrimental reliance on those misrepresentations in continuing his additional cover.” In the Determination this is the second step in the reasoning (the first being the conclusion that Division 3 does not operate as a code) which founds the state of satisfaction required by s 1055(3) of the Corporations Act and affirmation of the decision of CommInsure. In proceeding as it did, AFCA plainly formed the opinion as a step in its decisional process about what might be the rights of the insurer and the life insured at law or in equity without identifying the principle that it had in mind by reference to any authority, or how it may operate and in what circumstance.

94 That reasoning proceeds on the misunderstanding of the effect of s 33 that I have identified. AFCA posed for itself the wrong question. It should have concluded that s 33 operates a code, the effect of which was to limit the rights of AIA to those provided for in the ICA. Its conclusion that s 29 could not be relied on to avoid the contract, should then have led it to consider whether AIA, and before it CommInsure, had any other right on the facts found under the ICA. AFCA overlooked the words “otherwise than under this Act’ in s33. As the Full Court stated in *Macquarie Underwriting* at [27] other remedies may be provided for in the ICA for non-disclosure or misrepresentation.

95 A further error is that AFCA engaged in no more than pure speculation on a question central to the state of statutory satisfaction required by s 1055(3). As is well understood, where an administrative decision-maker is required to form an opinion or be satisfied “as a condition of the exercise of power,” the decision must proceed upon a correct understanding of the law: *R v Connell; Ex parte The Hetton Bellbird Collieries Ltd* (1944) 69 CLR 407 at 430, Latham CJ. In this appeal I am not concerned with whether any misunderstanding of the law by AFCA amounts to jurisdictional error (cf *Snedden v Minister for Justice* (2014) 230 FCR 82: [2014] FCAFC 156 at [153] – [155] and [164]) as the appeal right that is conferred on a party to a superannuation complaint is “on a question of law” and is to be understood in accordance with *Haritos v Federal Commissioner of Taxation* (2015) 233 FCR 315; [2015] FCAFC 92 where at [123] the Court (Allsop CJ, Kenny, Besanko, Robertson and Mortimer JJ) referenced with approval the reasoning of Davies J in *Tuite v Administrative Appeals Tribunal* (1993) 40 FCR 483 at 484 that a question of law extends to “the enunciation of the principle of the common law or equity” relevant to the decision. See also *Wanson v Comcare* (2020) 276 FCR 613; [2020] FCAFC 76 at [36]- [39] (Katzmann, Anastassiou and Abraham JJ). To speculate as to what the law might be does not demonstrate that AFCA correctly understood the law that applies.

96 Moreover, the statutory requirement not to make a determination of a superannuation complaint that would be contrary to law (s 1055(7)) implicitly requires that AFCA, where it considers a legal principle to be relevant to its decisional task, proceed by correctly identifying and stating the principle in order to comply with that obligation.

97 In responding to these difficulties, AIA submits that Dr Sharma breached his duty of utmost good faith with the consequence that CommInsure “would have common law remedies to avoid the contract” in that CommInsure “would also have had remedies for unconscionable conduct within the meaning of the unwritten law, or statute.” That argument is embraced by ground 3 of the Notice of Contention. I was referred to a number of authorities for the respective propositions that a non-party to a contract of insurance may have the benefit of the insurer’s obligation of utmost good faith (*Hanover Life Re of Australasia Ltd v Sayseng* (2005) 13 ANZ Insurance Cases 90-123), that an insurer may, (despite the absence of a statutory duty of non-disclosure of a third party beneficiary who is not a party to the contract, but with a right to receive the proceeds pursuant to s 48), resist a claim for the payment of benefits by that non-party based on non-disclosure or misrepresentation of the third party ( *C E Heath Casualty & General Insurance Ltd v Grey* (1993) 32 NSWLR 25), and to cases that are more generally concerned with remedies for unconscionable conduct within the meaning of the common law or statutory provisions (*ASIC v National Exchange Pty Ltd* (2005) 148 FCR 132; *Ipstar Australia Pty Ltd v APS Satellite Pty Ltd* (2018) 356 ALR 440 and *Tonto Home Loans Australia Pty Ltd v Tavares* [2011] NSWCA 389). In oral argument, counsel for AIA, elided his submissions on fraud with the duty of good faith in insurance contracts, which was not something put to or considered by AFCA.

98 For the reasons I have given, I reject those submissions to the extent they rely on general common law or equitable principles. However, in part those submissions extend to statutory remedies and is capable of refinement as follows. Section 13 of the ICA implies into contracts of insurance a duty of utmost good faith which requires “each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith,” the common law antecedent of which may be traced to the celebrated decision of Lord Mansfield in *Carter v Boehm* (1766) 3 Burr 1905: 97 ER 1162. That duty has pre and post-contractual effect. Counsel for AIA relied upon *Tiep Thi To v Australian Associated Motor Insurers Ltd* (2001) 3 VR 279; [2001] VSCA 48, where Buchannan JA, in the context of a fraudulent claim, observed at [15] that at common law;

The Courts’ attitude to fraudulent claims is a manifestation of the fundamental principle of insurance law that the utmost good faith must be observed by each party, the importance of which has often been emphasised. For example, Scrutton, L.J. said of marine insurance:

"Now, insurance is a contract of the utmost good faith, and it is of the gravest importance to commerce that that position should be observed.

Again, Park, J. said of life insurance:

"It is absolutely necessary that there should be the purest good faith between the parties and the most accurate representation of all material particulars."

Their Lordships were speaking of a proponent's duty of disclosure to an insurer contemplating issuing a policy of insurance, but the requirement of the utmost good faith applies equally to events after as well as before the conclusion of the contract of insurance, and the justification for the requirement is the same in both cases.

(Citations omitted).

99 In addition there is the general statement of Farwell J that fraud “unravels everything” in *May v Platt* [1900] 1 Ch 616 at 623 and the jury direction of Willes J in *Britton v Royal Insurance Co* (1866) 4 F & F 905 at 908-909: “if there is a wilful falsehood and fraud in the claim, the insured forfeits all whatever on the policy” which reflects the overall policy of the common law to discourage fraud: *Manifest Shipping Co Ltd v Uni Polaris Insurance Co Ltd* [2003] 1 AC 469 at [62]-[63], Lord Hobhouse.

100 There are several responses to the submissions as now put by AIA. First, s 12 of the ICA at the relevant time provided:

The effect of this Part is not limited or restricted in any way by any other law, including the subsequent provisions of this Act, but this Part does not have the effect of imposing on an insured, in relation to the disclosure of a matter to the insurer, a duty other than the duty of disclosure.

101 Whether s 12 operates as a “statutory carve-out for the duty of disclosure…so that any failure to disclose falls within s 21 rather than s 13(1)” (*Sutton on Insurance Law* at [6.20]) is unsettled. In *CIC Insurance Ltd v Barwon Regional Water Authority* [1999] 1 VR 683: [1998] VSCA 77 (a case concerning the failure of an insured to correctly declare the value of the insured property), Ormiston JA at [40] (with whom Phillips and Kenny JJA agreed) considered it arguable that a failure to disclose may also be concurrently regarded as breach of the duty of utmost good faith. Relevantly he reasoned that:

Section 12, being the first of the statutory provisions dealing with the duty of utmost good faith, expressly says that Part II "does not have the effect of imposing on an insured, in relation to the disclosure of a matter to the insurer, a duty other than the duty of disclosure". On their face the words are curiously expressed but the reference to "duty of disclosure" is confined by the definition in s.11(1) of the Act to the duty referred to in s.21 of the Act, namely the first and principal section contained in Part IV relating to the duty of disclosure. The obligation to disclose imposed by that part of the Act is extensive but carefully worked out so as to have regard to the respective rights and obligations of insurer and insured. Section 12 is merely intended to ensure that ss.12, 13 and 14 do not place a higher duty on an insured than is otherwise required under Part IV. It does not, however, follow that failure to make proper disclosure may not be seen for certain purposes, at least, as a breach of the duty of utmost good faith, even if that might have the effect of providing an alternative remedy for a failure to make disclosure to those remedies which appear in Part IV. Although it may be argued that these are but two sides of the same coin leading to remedies which are not mutually exclusive, it is not necessary to resolve these matters.

102 If that is correct, then this remedy is “otherwise” provided for in the ICA within the meaning of s 33 and may be open to be relied on by AIA. AFCA gave no consideration to that, doubtless because AIA did not clearly articulate that argument to it in this way.

103 Secondly, it is said in *Sutton on Insurance Law* at [7.1180] that an action for damages may be open for breach of the implied statutory term of good faith. On the finding of fraudulent misrepresentation of AFCA, there may be arguments that the claim by the Estate, is one made in breach of the implied term for which s 13 provides once it is understood that the duty provided for at s 13 is not confined to dishonesty: *CGU Insurance Ltd v AMP Financial Planning* (2007) 235 CLR 1. In that decision Callinan and Heydon JJ at [257] stated:

At the outset we should say that we agree with the Chief Justice and Crennan J that a lack of utmost good faith is not to be equated with dishonesty only. The analogy may not be taken too far, but the sort of conduct that might constitute an absence of utmost good faith may have elements in common with an absence of clean hands according to equitable doctrine which requires that a plaintiff seeking relief not himself be guilty of tainted relevant conduct. We have referred to the doctrine of clean hands because, as with another equitable doctrine, that he who seeks equity must do equity, it invokes notions of reciprocity which are of relevance here. That is not to say that conduct falling short of actual impropriety might not constitute an absence of utmost good faith of the kind which the Insurance Act demands. Something less than that might well do so. Utmost good faith will usually require something more than passivity: it will usually require affirmative or positive action on the part of a person owing a duty of it.

104 In argument before me AIA submitted that: “Equity will intervene in a case of fraud, misrepresentation, or unfair dealing” and that submission might be understood as a contention about breach of the statutory implied term of utmost good faith, either by Dr Sharma or in the post contract conduct of the Estate, if it be concluded that maintenance of the claim amounts to having unclean hands. AFCA may have had this, or some similar principle, in mind when it referenced other rights at common law or in equity to redress the consequence of the fraudulent misrepresentation of Dr Sharma. However, the unsatisfactory nature of its reasoning based on a misunderstanding of s 33 of the Act does permit me to form that conclusion.

105 Thirdly, it is not for me to form a view about the possible application of those broader principles as affording an answer to the Trustee or to AIA in response to the complaint. These matters may be considered relevant by AFCA, once it proceeds upon a correct understanding of the law and makes relevant findings of fact in accordance with the materials and arguments put to it by the parties. The appeal to this Court is on the identified a questions of law from the Determination of AFCA and the issue is whether it materially erred in law. It is not a general “judicial review” of the decision of CommInsure or the Trustee: *Wan v BT Funds Management Limited* [2022] FCA 302 at [87], Anastassiou J.

106 The decision of CommInsure the subject of the superannuation complaint is the decision to avoid or cancel from inception the additional benefits that were agreed to be provided in consequence of the application made by Dr Sharma in March 2011 as set out in the correspondence to the Estate of 16 August 2017. Having correctly concluded that CommInsure could not avoid the contract pursuant to s 29, AFCA ought to have confined its subsequent consideration of other principles to those that may arise by operation of the ICA and not by speculating about other common law or equitable principles that are not provided for in the Act.

107 The same error infects the conclusion of AFCA that the Trustee was correct to concur with the decision of CommInsure, albeit with the obvious mistake in the minute that references s 21 rather than s 29 of the ICA.

108 For these reasons, I find that AFCA materially misdirected itself as to the meaning and effect of s 33 of the ICA, which misunderstanding underpins its ultimate conclusion of fairness and reasonableness. It also misunderstood the limits of its statutory jurisdiction to determine the superannuation complaint made to it. It erred in law, and I uphold ground 4 of the appeal.

109 This brings me to grounds 1 and 3 of the Notice of Contention. On the first, AIA argues that AFCA erred in part 2.3 of the Determination in finding that CommInsure was not entitled to avoid the additional cover under the group life policy for Dr Sharma for the reason that the misrepresentation that he made to OnePath in March 2011 was fraudulent and was a continuing misrepresentation made to CommInsure prior to 1 December 2011. On that submission, s 25 of the ICA should be construed as operating to the effect that the Trustee made the same misrepresentation to CommInsure before it contracted to be the insurer of the Fund.

110 As a general proposition a misrepresentation may have continuing effect until it is withdrawn or the truth is discovered: *Commercial Banking Company of Sydney Ltd v R H Brown & Co* (1971) 126 CLR 337 at 343-344, Menzies J; *Jones v Dumbrell* [1981] VR 199 at 203, Smith J and *Spencer Bower & Handley:* *Actionable Misrepresentation* (5th ed) at [4.09- 4.10]. Moreover, as explained by Brennan CJ in *Esanda Finance Corporation Limited v Peat Marwick Hungerfords* (1997) 188 CLR 241 at 252 a defendant may be liable for a misrepresentation made not only to a particular person but extending to a member of an identified class of persons known or reasonably known to the defendant.

111 Those principles do not assist AIA because s 29 cannot be relied on and Division 3 of the ICA is a code. The statutory scheme simply does not afford not afford the remedy of avoidance in favour of CommInsure.

112 As to ground 3 of the Notice of Contention, I reject it to the extent that I have concluded that there is no common law right of avoidance of the statutory contract between OnePath and Dr Sharma, or any subsequent insurer, for the reasons I have stated in relation to the operation of s 29 and Division 3 of the ICA. As to the balance of this contention, for the reasons that I have given, AFCA erred in not confining its attention to other remedies that may be open under the ICA for breach of the statutory implied term of utmost good faith at s13. On remittal, it will be a matter for AFCA to determine whether AIA may put arguments and evidence on that question, and if so how Mrs Sharma may be permitted to respond.

## Question (b) and Ground 2 of the Appeal

113 The appellant contends that there was no evidence to support the finding of AFCA that Dr Sharma made a fraudulent misrepresentation to AIA in December 2011 or the findings that were made do not support that conclusion. During argument this ground was amended to embrace an irrationality contention. AIA correctly submits that as framed this question and ground do not arise: Dr Sharma made false statements to OnePath in his application of 22 March 2011, which application OnePath accepted on 11 July 2011. December 2011 is only relevant in that CommInsure became the insurer to the trustee of the group scheme with effect from 1 December 2011.

114 However, in argument the appellant broadened the scope of this contention somewhat to assert that AFCA erred in accepting a proposition put to it by AIA to the effect that the March 2011 misrepresentation continued.

115 It is not necessary to address this question and ground in detail. Each pose hypothetical questions given my findings on the inapplicability of s 29 and the operation of Division 3 of the ICA as a code. Accordingly, I decline to decide whether Dr Sharma made a misrepresentation to CommInsure in December 2011 and or to AIA in April 2021 as unnecessary to resolve the Notice of Appeal or the Notice of Contention.

## Question (c) and Ground 3

116 For the same reasons as I have given in answer to question (b) and ground 2, the issues raised are hypothetical and unnecessary to answer.

## Question (e) and Ground 5

117 AFCA as an administrative decision-making body is not bound by the rules of evidence and may inform itself as it sees fit: *AFCA Complaint Resolution Scheme Rules* (2019), rule A 14.3. The appellant complains that there was no evidence of the transfer of the life insurance business to AIA. It is referenced, somewhat obliquely, in part 3.6 of the Determination. In any event there is no merit in this question or ground: approval of the transfer is a matter of public record and the fact that the transfer scheme was approved is a matter of law as set out in the reasons of Allsop CJ in Re CML.

118 I dismiss this ground.

## Question (f) and ground 6

119 In my view this question and ground do not add to the arguments I have accepted under question (d) and ground 4 and do not require separate consideration.

# CONCLUSION

120 I uphold the appeal. The appellant seeks relief in the form of remitter, which is clearly appropriate. I order as follows:

1. The appeal is allowed.

2. The determination of Australian Financial Complaints Limited in case numbers 693811 and 711994 is set aside.

3. The complaint made by the appellant is remitted to Australian Financial Complaints Limited to be determined again in accordance with these reasons.

4. The parties are to file submissions as to costs, not exceeding two pages, within seven days of the publication of these reasons, in the event that the question of costs is not agreed.

5. If there is no agreement, the costs of the appeal will be determined on the papers.

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| I certify that the preceding one hundred and twenty (120) numbered paragraphs are a true copy of the Reasons for Judgment of the Honourable Justice McElwaine. |

Associate:

Dated: 13 May 2022