FEDERAL COURT OF AUSTRALIA

AIA Australia Ltd v Lancaster [2017] FCA 962

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| File number: |  |
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| Judge: | **ALLSOP CJ** |
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| Date of judgment: | 18 August 2017 |
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| Catchwords: | **SUPERANNUATION** – appeal against determination by Superannuation Complaints Tribunal – entitlement of fund member to income protection benefit under insurance policy held by fund – calculation of benefit payable by reference to income – income had increased at date of disablement but neither trustee or insurer notified at that date – insurer calculated benefit based on income advised to it – Tribunal ordered benefit be calculated based on increased salary – whether Tribunal determination inconsistent with terms of insurance policy |
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| Legislation: | *Insurance Contracts Act 1984* (Cth), ss 37, 53, 57  *Superannuation (Resolution of Complaints) Act 1993* (Cth), ss 14, 37, 46  *Insurance Contracts Regulations 1985* (Cth), r 32 |
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| Cases cited: | *Alcoa of Australia Retirement Plan Pty Ltd v Thompson* [2002] FCA 256; 116 FCR 139  *Board of Trustees of the State Public Sector Superannuation Scheme v Edington* [2011] FCAFC 8; 119 ALD 472  *Cameron v Board of Trustees of the State Public Sector Superannuation Scheme* [2003] FCAFC 214; 130 FCR 122  *Dumitrov v SC Johnson & Son Superannuation Pty Ltd* [2006] NSWSC 1372  *Dumitrov v SC Johnson & Son Superannuation Pty Ltd (No 2)* [2007] NSWSC 42  *Federation Insurance Ltd v Banks* [1984] VR 525  *Hornsby v Military Superannuation & Benefits Board of Trustees (No 1)* [2003] FCA 54; 126 FCR 484  *Mercer Superannuation (Australia) Ltd v Billinghurst* [2016] FCA 1274  *Nguyen v QBE Insurance Ltd* [2007] SASC 454; 215 FLR 447  *Noel v Cook* [2004] FCA 479  *Retail Employees Superannuation Pty Ltd v Crocker* [2001] FCA 1330; 48 ATR 359 |
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| Date of hearing: | Determined on the papers |
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| Date of last submissions: | 12 May 2017 |
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| Registry: |  |
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| Division: |  |
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| National Practice Area: |  |
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| Sub-area: | Insurance List |
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| Category: | Catchwords |
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| Number of paragraphs: | 48 |
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| Counsel for the Applicant: | Mr D Villa |
|  |  |
| Solicitor for the Applicant: | TurksLegal |
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| Counsel for the First Respondent: | The First Respondent did not appear beyond the first case management hearing |
|  |  |
| Counsel for the Second Respondent: | The Second Respondent did not appear |

ORDERS

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|  | | NSD 122 of 2017 |
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| BETWEEN: | AIA AUSTRALIA LTD  Applicant | |
| AND: | RONAN LANCASTER  First Respondent  MARITIME SUPER PTY LTD  Second Respondent | |

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| --- | --- |
| JUDGE: | ALLSOP CJ |
| DATE OF ORDER: | 18 AUGUST 2017 |

THE COURT ORDERS THAT:

1. The determination of the Superannuation Complaints Tribunal dated 6 December 2016 be set aside.
2. In lieu thereof, order that:
   1. The decision of the applicant be affirmed.
   2. The decision of the second respondent be affirmed.
   3. The complaint made by the first respondent to the Superannuation Complaints Tribunal otherwise be dismissed.
3. There be no order as to costs.

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

REASONS FOR JUDGMENT

ALLSOP CJ:

1. This is an appeal by the applicant insurer, AIA Australia Ltd, against a determination by the Superannuation Complaints Tribunal (the Tribunal) dated 6 December 2016 setting aside a decision by the insurer as affirmed by the second respondent, Maritime Super Pty Ltd (as trustee of the Maritime Super Fund) rejecting a claim by the first respondent, Mr Lancaster, to have the benefit payable to him under a policy of income protection insurance determined by reference to his actual salary at the date of disablement, rather than that which was properly notified to the insurer at the date of disablement.

## Background

1. The facts surrounding this appeal were not the subject of any major disagreement between the parties. Mr Lancaster commenced employment as a stevedore with Patrick Stevedores Holdings Pty Ltd on 2 June 2006. He was a member of the Maritime Super Fund from 1 December 2004. Maritime Super Pty Ltd, as trustee of the Maritime Super Fund, was the owner of an income protection insurance policy issued by the applicant for the benefit of members of the Maritime Super Fund. That policy was effective from 31 March 2012. In January 2013, Mr Lancaster suffered a back injury during the course of his work, described by his doctor as “disc prolapse and degeneration of [the] lumbar spine”. He ceased work in May 2013 as a result of this injury and lodged a claim for income protection benefits under the policy. The insurer and trustee accepted Mr Lancaster’s claim, and paid him the income protection benefits it considered him to be entitled to under the policy. The insurer accepted 3 May 2013 as the date of Mr Lancaster’s disablement.
2. The payments made to Mr Lancaster were payments that were determined by reference to an “Amount Insured”, which was based on an annual salary of $44,849. This had been Mr Lancaster’s annual salary up until 3 September 2012, where it increased to approximately $97,000 due to a change in the category of his employment. This salary increase was not notified to the insurer or to the trustee by either Mr Lancaster or his employer when it occurred.
3. The policy that applies in Mr Lancaster’s case was the subject of several items of correspondence sent to Mr Lancaster as a member of the Maritime Super Fund both prior to and after his disablement. On 2 April 2012, a letter was sent to members of the Maritime Super Fund advising of the income protection insurance policy that had been taken out with the applicant that was effective from 31 March 2012. The letter enclosed an “Insurance Update” which contained the following relevant information:

**Salary details**

Under the new rules, the premiums for cover are based on occupation and the sum insured, and not on a percentage of contributions. Refer to the definition of Income on the following page for information about the type of salary amounts you can insure.

If we don’t have a salary recorded for you, a default cover level reflecting a salary of $4,000 per month (which will provide a benefit of $3,000 per month) will be used. It’s important to let us know your salary so you don’t end up over- or under-insured. To update your salary details, complete the AIA Australia Insurance Variation form and return it to us.

…

**New definitions of Income**

…

In the event of a claim, Income will be calculated at the date of disability.

…

For many members, the new definition may effectively increase the Income we use to calculate their Income Protection benefit. However, **please note that the Income Protection benefit payable will be limited to the sum insured, so it is important that you advise us of your correct salary to take advantage of the potential increase in benefit.**

(emphasis added)

1. The trustee also wrote to Mr Lancaster on 2 July 2012 and provided him with an opportunity to update his salary details. Any change was to be effective from 1 July 2012. That letter contained the following cautionary statement:

Please note that in the event of a claim your Income Protection benefit will be limited to 75% of the Salary we have recorded against your account, therefore it’s important you advise the Fund of your correct Salary.

1. On 10 September 2012, Mr Lancaster was also provided with an “Annual Statement” by the trustee, which was said to be effective as at 30 June 2012. This statement noted that the salary recorded for Mr Lancaster was $44,849.48 and included a reminder that he needed to keep his salary details up to date.
2. Mr Lancaster’s salary increased from 3 September 2012, though this was not notified to the insurer or trustee by either him or his employer. In Mr Lancaster’s defence, attention should be drawn to the fact that the statement said it was effective as at 30 June 2012, prior to his salary increase. He also maintained that he believed his employer would have notified the insurer and trustee of his increased salary. However, on 13 June 2013 – subsequent to his injury but before he made his claim – Mr Lancaster received a letter entitled “Your Voluntary Income Protection Insurance for 2013/2014”. Relevantly, it stated that:

Your Voluntary Income Protection Insurance cover is due for renewal on 1 July 2013 and you now have the opportunity to provide new salary information to update your sum insured.

Currently, **we have your salary recorded as $44,849.48 and we will automatically renew your Income Protection Insurance at 1 July 2013 for 75% of this amount** (to a maximum monthly benefit of $20,000).

However, **if your salary has changed (up or down)** or you receive other Income which you would like insured, **you should complete the enclosed *Income Statement for Income Protection Insurance form***.

**All increases in cover are subject to acceptance by the Insurer**. You will be required to complete the attached insurance form before the Insurer can assess your application for additional cover.

(emphasis added)

1. On 18 June 2013, Mr Lancaster advised Maritime Super that his salary had increased and completed the relevant form required to apply for increased income protection cover. The form provided that Mr Lancaster was stating his income “at the date of this declaration” and the declaration also stated:

I understand that this request is subject to the terms of the insurance policy. I understand that if my ‘income’ has increased, I must complete an [insurer] insurance form for the Insurer to assess my application for an increase in cover. **I understand that my Income Protection Insurance cover will not increase until accepted by the Insurer** …

(emphasis added)

1. On 5 September 2013, Mr Lancaster lodged a claim for income protection benefits under the policy. The claim was accepted in September 2013 and calculated by reference to an annual salary of $44,489, as this was the salary notified to the applicant at the time of Mr Lancaster’s disablement. No notification was made by Mr Lancaster’s employer to the trustee of the increase in his salary until 6 November 2013. Maritime Super affirmed the applicant’s decision in October 2014 and then again in November 2014 following a review. Mr Lancaster then filed complaints against these decisions with the Tribunal.

## The policy terms

1. The “Policy Schedule” in cl 2 outlined when “Benefits” were payable under the policy as follows:

**Benefits**

**When Payable**

In the event of disablement of an Insured Member, Benefits are payable as provided for in Schedule 1. The Benefit will be determined as at the date that the Insured Member ceased employment as a result of an Injury or Sickness.

1. “Benefits” were defined in cl 3 as “the Benefits set out in the Policy Schedule and Schedule 1”. Schedule 1, which relates to “Benefits and Offset Benefits”, sets out three classes of Benefit: “Total Disability Benefit”, “Partial Disability Benefit” and an “Offset Benefit”. Mr Lancaster was paid a “Total Disability Benefit” as he had ceased work. The obligation for the applicant to pay a “Total Disability Benefit” was provided for in Schedule 1 relevantly as follows:

**Total Disability Benefit**

1. If an Insured Member suffers Total Disability, the Company will, subject to the terms and conditions of this Supplementary Policy, pay a Monthly Benefit as set out in the Policy Schedule.

…

1. Thus, the policy required the insurer to pay a “Monthly Benefit” to Mr Lancaster. The “Monthly Benefit” was outlined in the “Policy Schedule” as being one of the following:

**Monthly Benefit**

The lesser of:

1. 75% of the Insured Member’s Income; or
2. $20,000 per month; or
3. the Amount Insured.

The [insurer] reserves the right to limit increases in the Amount Insured per Insured Member to 30% in any 12 month period.

1. The “Policy Schedule” also provided for a “Default Monthly Benefit” to be paid where no details of income at all have been supplied. This did not apply in the present case, as the trustee had supplied income details to the applicant and insured an amount on this basis.
2. The “Amount Insured” was the relevant amount in Mr Lancaster’s case, as it provided the smallest “Monthly Benefit” out of the three metrics set out in the “Policy Schedule”. “Amount Insured” was defined in cl 3 as follows:

**Amount Insured** means the amount of Income Protection cover, comprising the Default Cover and/or any Voluntary Cover granted by the [insurer] to the Insured Member in accordance with the Eligibility Conditions and subject to changes to that amount determined in accordance with the Supplementary Policy terms and conditions, the Trust Deed and determinations made by or on behalf of the Policy Owner.

1. Clause 3 of the policy also defined the terms “Default Cover” and “Voluntary Cover” as follows:

**Default Cover** means the Income Protection cover automatically provided to the Insured Member in accordance with the Eligibility Conditions and includes the Default Monthly Benefit, where applicable, as described in the Policy Schedule.

...

**Voluntary Cover** means cover available under the Eligibility Conditions in addition to the Default Cover or any other cover an Insured Member or an Employer requests and/or is accepted for on application to the Company, and includes the Default Monthly Benefit, where applicable, as described in the Policy Schedule.

1. The cover relevant to Mr Lancaster was “Voluntary Cover”, with a particular amount having been insured based on Mr Lancaster’s income.
2. “Income” was defined as follows in cl 3 of the policy:

**Income** means:

*For permanent employees:*

the salary package paid to an Insured Member by an Employer including salary, fees, regular bonuses, regular commissions, regular overtime, shift allowances and items in lieu of cash (for e.g. salary sacrificed items) but excluding mandatory superannuation contributions and unearned income (e.g. investment or interest income).

Bonuses, overtime earnings and commissions will be calculated based on the average of the last three years received by the Insured Member from their Employer.

**In the event of a claim, Income will be calculated at the date of disability.**

…

(emphasis added)

1. The relevant “Eligibility Conditions” that applied to Mr Lancaster were provided in cl 4 as follows:

**4. Eligibility conditions**

**4.1 General**

The Eligibility Conditions are subject to the terms and conditions of this Supplementary Policy.

…

**4.3 Existing Accumulation Plus, Accumulation Basic, Accumulation Standard and Permanent (Defined Benefit) Members**

All Existing Accumulation Plus, Accumulation Basic, Accumulation Standard and Permanent (Defined Benefit) Members who had cover on the day immediately prior to the Effective Date, will be automatically insured from the Effective Date subject to the 30 day Waiting Period provided that the Insured Member still meets the Eligibility Conditions as defined in Clause 4.9 subject to the following:

1. Unless conditions (b) or (c) applies, from the Effective Date, the cover provided will be the Default Monthly Benefit as described in the Policy Schedule.
2. If the Insured Member or his/her Participating Employer provides their Income details:

* on or before the 4 May 2012, then cover provided from the Effective Date will be the Monthly Benefit as described in the Policy Schedule.
* before 30 June 2012, the cover provided will be the Monthly Benefit as described in the Policy Schedule, effective from 1 July 2012.

1. Any changes to Income advised by the Insured Member or his/her Participating Employer after 30 June 2012, will be subject to the Member providing Evidence of Insurability.

…

1. Pursuant to cl 4.3(b), with the details of Mr Lancaster’s original income having been provided to the applicant, the benefit payable to Mr Lancaster was the “Monthly Benefit”. As noted, this equalled the “Amount Insured” under the policy.
2. Clause 4.3(c) refers to the “Insured Member” providing “Evidence of Insurability” in respect of any changes to “Income” after 30 June 2012. This phrase was defined as follows in cl 3:

**Evidence of Insurability** means such evidence of health and such other particulars of a Member as the [insurer] may require at the time the Member first becomes an Insured Member and at any subsequent time when the Amount Insured of that Insured Member is increased or reinstated, to enable the [insurer] to determine whether an Insured Member is to be accepted for any insurance and the terms of such acceptance.

1. In addition, the “General Conditions” that governed the policy were contained in cl 5. The relevant clauses from the “General Conditions” were as follows:

**5 General Conditions**

…

* 1. **Application for Cover & Cover Terms**

1. Where an Insured Member:

…

1. has an Amount Insured which has increased by more than 30% in the previous 12 month period (in respect of Default and Voluntary Cover);

…

the Insured Member must make application for cover to the [insurer] by:

1. completing the required form;
2. providing the [insurer] with Evidence of Insurability, including but not limited to evidence of health condition by medical test(s) (including those determined by the [insurer] as mandatory based on the Insured Member’s age and the total amount of cover sought); and
3. meeting any other Evidence of Insurability requirements as determined by the [insurer] from time to time.

…

* 1. **Commencement of Cover**

…

f) The following:

…

1. Where the Amount Insured has increased by more than 30% in the previous 12 month period;

…

(other than Existing Cover at the Effective Date) will commence upon:

1. the [insurer’s] acceptance of the risk following assessment of the Insured Member’s application; or
2. the [insurer] advises the Policy Owner of acceptance of the Insured Member’s agreement in writing of any special terms or conditions applied by the [insurer].
3. Where the Insured Member’s cover increases as a result of an increase in the Insured Member’s Income and the new cover amount is no more than:

i) In respect of Default Cover, the Automatic Acceptance Limit; or

ii) Any Forward Underwriting Limit determined by the Company (including under takeover terms) in respect of income replacement insurance in respect of the Insured Member (including under the Previous Insurance Arrangements);

and the increase is no more than 1.3 times the Amount Insured at the later of the cover commencement date and the date 12 months earlier, the increase in cover will commence from the date the increase in cover is notified to the Policy Owner in a form acceptable to the Policy Owner.

…

## The Tribunal determination

1. Mr Lancaster’s complaints were under s 14 of the *Superannuation (Resolution of Complaints) Act 1993* (Cth) (the Act). The powers of the Tribunal in dealing with such complaints are provided for in s 37 of the Act. Section 37(2)(a) requires the Tribunal to review the decisions of both the trustee and the insurer. For that purpose, the Tribunal has all the powers, obligations and discretions conferred upon the insurer: s 37(2)(b) of the Act. Under s 37(6), the Tribunal must affirm a decision of the trustee or insurer if it is satisfied that in its operation in relation to the complainant the decision was fair and reasonable in the circumstances. And, critically, in making its determination under s 37(3) of the Act, s 37(5) provides that the Tribunal cannot do anything that would be “contrary to law, the governing rules of the fund concerned and, if a contract of insurance between an insurer and trustee is involved, to the terms of the contract.”
2. In [28] of its determination, the Tribunal identified that its task under s 37(6) of the Act in Mr Lancaster’s case was to “determine whether the decisions of the Trustee and the Insurer declining the Complainant’s request to have his [insurance protection] benefit based on a higher salary than the salary used by them to calculate his benefit were fair and reasonable in their operation in relation to [Mr Lancaster] in the circumstances.” It noted at [38] that much of the dispute before it concerned who bore responsibility for notifying the trustee of Mr Lancaster’s salary increase in September 2012.
3. At [40] of its determination, the Tribunal concluded that the insurer had “correctly” calculated the “Monthly Benefit” payable to Mr Lancaster on the information available to it at the time by basing it upon the “Amount Insured”. Furthermore, it recognised at [41]-[42] that although the definition of “Income” in cl 3 stated that “Income” would be calculated at the “date of disability”, the increase in Mr Lancaster’s income could only have increased the benefit payable to him “if the Amount Insured increased i.e. it had to be advised to the Insurer by the Trustee as an increase in the amount to be insured and been accepted by the Insurer”.
4. Having reached this conclusion that the benefit was correctly calculated, the Tribunal returned to the question of which of the parties should have notified the trustee and insurer of Mr Lancaster’s increased income. Its reasoning on this point, despite its earlier conclusion about the calculation of the benefit, was central to the Tribunal’s ultimate determination. It is convenient to set out the bulk of the Tribunal’s reasoning on these points in full:

43. The Tribunal further noted that under clause 5.13 of the Policy, the Insurer expected the Trustee to supply it with certain information, including the level of insurance cover required for members. Although this provision of information is to occur on an annual basis to guarantee renewal of the Policy, the Tribunal considered that the Policy allowed for updated information to be provided by a member, an employer or the Trustee between these reports.

44. It appeared to the Tribunal that, if the Policy requires that a member's income as at the date of disablement should be used as part of the formula for calculating the IP benefit then it would be reasonable for the Insurer or the Trustee to ask members for this information when completing the claim forms.

45. In [Mr Lancaster’s] situation, he advised that he did not receive the Fund's form asking for notification of salary increases in July 2012. However at that stage he had not had an increase anyway. When next sent a form in June 2013 he did complete it. The Trustee submitted that [Mr Lancaster] received his 2012 Annual Statement in September 2012 and that, as it showed his salary prior to the increase, he should have been alerted to update the information.

46. However, the Tribunal noted that the Annual Statement reflected benefits and information effective at 1 July 2012 and all the information was correct at that date. The Tribunal accepts [Mr Lancaster’s] argument that the Statement, of itself, did not alert him to the fact that he should notify the Fund of his salary increase.

47. The Tribunal noted that [Mr Lancaster] advised the Fund in June 2013 of his increase and completed the application for increased insurance required by the Insurer. The Trustee submitted that [Mr Lancaster’s] records were updated and it was noted that the increased salary was shown on [Mr Lancaster’s] I July 2013 Annual Statement.

48. The Tribunal was not provided with a copy of the application for increased insurance for the Insurer but the Tribunal was of the opinion that, if the Insurer accepted the increased salary for IP benefits for [Mr Lancaster] in June 2013, then there was no reason to assume it would not have been accepted had it been lodged in September 2012.

49. The Tribunal noted that both the Fund and the Insurer were aware of [Mr Lancaster’s] salary increase prior to the lodgement of his IP claim but not the effective date. However the Tribunal is of the opinion that, once the claim was made, it should have been clear that such a large increase would have been unlikely to occur after [Mr Lancaster] had been injured and was on restricted duties. **Therefore inquiries should have been made by the Insurer to ascertain whether the increase was effective prior to the date of disablement.**

…

51. **The Tribunal accepts the Trustee’s submission that it is the responsibility of members of the Fund to update their salary information and information was provided to members in this regard.** However the Tribunal is also sympathetic to [Mr Lancaster’s] argument that, in his case there was an unusual situation as a large number of members were changing their employment status at the same time. **The Tribunal is of the opinion that it was reasonable of [Mr Lancaster] to assume that the Employer would have notified the Fund of the new salaries and that the Fund would have notified the Insurer.**

52. The Tribunal considered that the purpose of an IP benefit is to allow a member to be able to meet his/her normal monthly expenses while not able to work due to illness or injury. It is therefore incumbent on the provider of such a benefit to ensure income information is current for the calculation of benefits.

(emphasis added)

1. This process of reasoning led the Tribunal to the following conclusion at [53] despite acknowledging that the benefit had been calculated in accordance with the policy:

53. The Tribunal was satisfied that in all the circumstances, **while the benefit was calculated in accordance with the Policy**, the Insurer had notification of an increased salary for the Complainant and **it would have been fair and reasonable of the Insurer to query the effective date of this increase as it had doubled from the salary it used to calculate his benefit**. Such an inquiry would have led to an increased IP benefit being paid to [Mr Lancaster] which better reflected his pre-injury income.

(emphasis added)

1. As the insurer did not make such inquiries, the Tribunal determined at [55] that the decisions were not fair and reasonable. At [59] of its determination it set aside the decisions under review and substituted its own decision, to the effect that the income protection benefit payable to Mr Lancaster was to be calculated based on his increased salary effective at the date of his disablement. It did so although it was aware that it could not make a decision contrary to the rules of the fund or the insurance policy: see [57] of the determination. It also determined at [61]-[63] that compound interest was payable on the sums withheld.

## The appeal to this Court

1. Taking issue with the determination by the Tribunal, the insurer as applicant filed an application for extension of time in which to appeal on 27 January 2017. The application was placed on the Insurance List and the first case management hearing was held on 27 March 2017. At that hearing, the applicant and Mr Lancaster were represented by counsel and solicitors. Maritime Super, as the second respondent, did not appear and has not entered an appearance at any stage of these proceedings.
2. At the conclusion of the hearing, I made orders extending the time in which to file a notice of appeal, and a notice of appeal was filed by the applicant on 28 March 2017. Counsel for the first respondent indicated at the hearing that Mr Lancaster did not wish to participate in the appeal, and he was excused from any further attendance. The applicant was required to file submissions and the material upon which it sought to rely and provision was made for the filing of material by the second respondent if it was minded to participate. It did not file any material. Subject to the parties requesting an oral hearing, I reserved the matter to be dealt with on the papers.
3. The grounds of appeal relied upon by the applicant were principally focused on the proper construction of the policy and, as set out in the notice of appeal, were as follows:
4. The Tribunal erred in law in failing to find that the relevant decision for the purposes of section 37(2) of the *Superannuation (Resolution of Complaints) Act 1993* was the decision by the Applicant to calculate the Monthly Benefit in accordance with the terms of the Policy.
5. The Tribunal erred in law in failing to find that upon the proper construction of the Policy, the Monthly Benefit payable by the Applicant in respect of the First Respondent was the Amount Insured by reference to the Income last notified to the Applicant as at the date the applicant ceased employment as a result of his injury.
6. The Tribunal erred in law in failing to have regard to the effect of clause 5.8 of the Policy.
7. The Tribunal erred in law by having regard to an irrelevant consideration, *viz* the effective date of the increase in the First Respondent’s salary.
8. The Tribunal erred in law in finding that the effective date of the increase in the First Respondent’s Income was a relevant consideration for the Applicant to have made inquiries about.
9. The Tribunal erred in law in finding that the effective date of the increase in the First Respondent’s Income was a relevant consideration for the purposes of the Tribunal determining what was fair or reasonable as between the Applicant and First Respondent.
10. The Tribunal erred in law by finding that the Applicant was liable to pay interest on a compounding basis, which basis is contrary to the effect of section 57 of the *Insurance Contracts Act 1984* and regulation 32 of the *Insurance Contracts Regulations 1985.*
11. An appeal to this Court under s 46(1) of the Act lies only in respect of a question of law. The applicant submitted that the grounds of appeal it relied upon were, in substance, allegations of a failure by the Tribunal to properly construe the terms of the policy. It was submitted that the proper construction of a contract of insurance is a question of law, relying upon *Federation Insurance Ltd v Banks* [1984] VR 525 at 533 per Kaye J, and so the issues were within the scope of the appeal allowed for by s 46(1). I accept that questions of whether the Tribunal misconstrued the terms of the policy and made a determination contrary to those terms amount to questions of law in this context.
12. The applicant’s principal submission was that the Tribunal had erred in setting aside the decisions under review as the determination made by the Tribunal was inconsistent with the terms of the policy. Reference was made to s 37(5) and (6) of the Act and also to my decision in *Retail Employees Superannuation Pty Ltd v Crocker* [2001] FCA 1330; 48 ATR 359 at 366- 367 [27]-[33], where I discussed the relationship between the terms of an insurance policy and the task of the Tribunal in determining whether a decision made by a trustee or insurer is fair and reasonable in the context of a complaint under the Act. In *Crocker* [2001] FCA 1330; 48 ATR 359*,* I outlined the essential principles regarding this interrelationship as follows:

[27] The task of the Tribunal and the meaning of the phrase “unfair or unreasonable” are inextricably intertwined and both are governed by the Act, and, especially, by s 37. It is the decision of the Trustee, recognising its obligation to act in conformity with the governing rules of the fund, and the decision of the Insurer, recognising its obligation (and entitlement) to act in conformity with the terms of the relevant policy, which must be reviewed for unfairness or unreasonableness. The unfairness or unreasonableness must be of the decision (as expanded by s 4) under, and in conformity with, the governing rules or the terms of the policy. It is not some other perceived (rightly or wrongly) unfairness or unreasonableness in and about the conduct of the fund.

[28] The question as to whether a decision was unfair or unreasonable cannot be judged otherwise than by having regard to the conformity of the decision with the governing rules of the fund and the terms of the policy. The conformity of the decision with those matters is therefore a relevant consideration in the sense discussed in *Minister for Aboriginal Affairs v Peko-Wallsend* (1986) 162 CLR 24 at 39-40 and see *Telstra Corp Ltd v Seven Cable Television Pty Ltd* (2000) 178 ALR 707 (special leave refused on 20 August 2001). If conformity with the governing rules or the terms of the policy required the very decision, which was made, to be made, the strictures of subs 37(5), the universe of possible conduct under subs 37(3) and the balance of the Act, including subs 37(6), would require a conclusion of the Tribunal that the decision was not unfair or unreasonable. It could not be otherwise, as it would, on this hypothesis, be the only decision capable of being reached by the Trustee or the Insurer in the light of the governing rules or terms of the policy; or, put another way, any determination under para 37(3)(b), para 37(3)(c) or para 37(3)(d) would involve the Tribunal doing an act contrary to the governing rules or the terms of the policy.

[29] It may be that a decision of a trustee or an insurer is in conformity with, but not required by, the governing rules of the fund or the terms of the policy. This may be because the decision could be described as one of a discretionary character: see s 14AA of the Act and Merkel J in *Collins v AMP, supra* at 578-79. For myself, I would prefer not to use any dichotomy between discretionary and non-discretionary decisions as a tool in this analysis. I do not think that the presence of s 14AA mandates it. The presence of s 14AA is to be understood for reasons other than any which make the terminology used within it a compulsory tool for analysis of the understanding by the Tribunal of its task: see *National Mutual v Campbell, supra* at 568-70 [21] to [30] and *Seafarers’ Retirement Fund v Oppenhuis, supra* at 596-98. It may be that the decision of a trustee or an insurer is in conformity with, but not required by, the governing rules or policy terms not because there was involved any exercise of discretion, properly so-called, but because the decision was one which so involves elements of fact, degree, opinion or value judgment that different minds can legitimately differ in reaching a decision or because one aspect of the rules or policy terms, but not another, has been the foundation of the decision. A decision of a trustee or an insurer about a matter of judgment, for instance one involving weighing competing expert or lay opinion about a state of affairs, might be lawful and in conformity with the governing rules and policy terms. It might be described as “correct” in that it was the product of an inquiry directed to the right question and in that there was material available to support it. In this, perhaps limited, sense the decision was correct and was open to be made. However, the Tribunal is not engaged in a form of judicial review. It reviews the decision (as expanded by s 4) complained of from the position of the trustee or insurer (paras 37(1)(a) and 37(2)(b)). The Tribunal may find, in its opinion, in some degree (see subs 37(4)), the decision to be unfair or unreasonable and may act under subs 37(3) to give effect to its view of the merits as long as subs 37(5) is not infringed. It seems to me that this analysis accords with the approach described by the Full Court in *National Mutual v Campbell, supra* at 570-71 [32] and [33] and see also Kirby J in *Attorney-General v Breckler* (1999) 197 CLR 83 at 129 [88]. It seems to me that the very use of the words “unfair” and “unreasonable” in their breadth, individually and in the composite phrase “unfair or unreasonable”, supports this view: see, in other contexts, *George Mitchell (Chesterhall) Ltd v Finney Lock Seeds Ltd* [1983] 2 AC 803 at 815-16, and Samuels JA in *Antonovic v Volker* (1986) 7 NSWLR 150 at 154-55.

[30] … In many cases, for non-discretionary questions, the governing rules or policy terms will only yield a single result.

[31] The Tribunal's task is not to engage in ascertaining generally the rights of the parties, nor is it to engage in some form of judicial review of the decision of the trustee or insurer. Rather it is to form a view, from the perspective of the trustee or insurer, as to whether the decision of either was (recognising the overriding framework given by the governing rules and policy terms, respectively) unfair or unreasonable.

[32] Thus, essential to the task before the Tribunal, as a consideration mandated by the terms of s 37, is an inquiry as to whether the decision by the trustee or insurer was in conformity with the governing rules or the terms of the policy. If the Tribunal finds that the decision is contrary to the governing rules or the terms of the policy it may well be an easy step to conclude that it is unfair or unreasonable. I do not need to decide whether a finding by the Tribunal that the trustee's or insurer's decision was contrary to the governing rules or policy terms required a finding of unfairness or unreasonableness: cf Merkel J in *Collins v AMP*, supra at 578-579 and Sundberg J in *Wilkinson*, supra at 492. If the Tribunal finds that the decision of the trustee or the insurer is in conformity, with and required, by the governing rules or policy terms, in the sense which I have discussed above, it cannot other than find or be satisfied that the decision is fair and reasonable. If the Tribunal finds that the decision of the trustee or the insurer is in conformity with, but not required by, the governing rules on policy terms, in the sense which I have discussed above, it may proceed, in effect, to supplant the decision of the trustee or insurer with its view of the merits, bearing in mind the limitations of subs 37(4) and subs 37(5).

[33] Certainly, what the Tribunal is not entitled to do is to make a determination reflecting its view of the rights of the parties inter se, if that is contrary to the terms of the governing rules or policy terms.

1. The principles outlined in that passage have been adopted by judges of this Court on a number of subsequent occasions: see, eg. *Alcoa of Australia Retirement Plan Pty Ltd v Thompson* [2002] FCA 256; 116 FCR 139 per Nicholson J; *Cameron v Board of Trustees of the State Public Sector Superannuation Scheme* [2003] FCAFC 214; 130 FCR 122 per Whitlam, Kiefel and Dowsett JJ; *Hornsby v Military Superannuation & Benefits Board of Trustees (No 1)* [2003] FCA 54; 126 FCR 484 per Mansfield J; *Noel v Cook* [2004] FCA 479 per Bennett J; *Board of Trustees of the State Public Sector Superannuation Scheme v Edington* [2011] FCAFC 8; 119 ALD 472 per Kenny and Lander JJ; *Mercer Superannuation (Australia) Ltd v Billinghurst* [2016] FCA 1274 per Moshinsky J.
2. Within this framework, the applicant submitted that the determination made by the Tribunal was inconsistent with the terms of the policy and so transgressed upon the boundaries imposed on the Tribunal’s proper task by s 37(5) and (6).
3. It was submitted that cl 5.8(f) of the “General Conditions” of the policy, set out at [21] above, applied in Mr Lancaster’s case, and that the Tribunal’s determination was inconsistent with this clause properly construed. Clause 5.8(f) provided that where the “Amount Insured” increased by more than 30% in the previous 12 months, coverage of the increased amount only commences upon the insurer accepting the risk following an application by Mr Lancaster as the insured, or upon the insurer advising the trustee of acceptance by Mr Lancaster of any special terms or conditions applied by the insurer. The applicant submitted that the change in the “Amount Insured” from one calculated by reference to his previous salary of $44,849 as compared to one calculated by reference to his increased salary of $97,000 was a change of more than 30% in the “Amount Insured” and that the requisite steps to obtain coverage of the increased amount had not been taken prior to Mr Lancaster’s disablement.
4. Furthermore, the applicant highlighted that according to the “Policy Schedule”, the “Benefit will be determined as at the date that the Insured Member ceased employment as a result of an Injury or Sickness”. This date was 3 May 2013. It was after the salary increase, but before any notification of that increase was made to the applicant. Accordingly, there could be no increase in coverage and so the benefit fell to be calculated based on Mr Lancaster’s previous salary as notified to the applicant.
5. Clause 5.8(f) was headed “Commencement of Cover”. It outlines where particular cover under the policy commences, and so can correctly be seen to be critically important to whether Mr Lancaster was entitled to benefits calculated according to his original or increased salary. Clause 5.8(f) in its terms is clear that a change in the “Amount Insured” by more than 30% did not take effect until notification is made to the insurer and the increase is accepted. Whether the insurer would have accepted the increase as a matter of course is not the right question. The question is the proper construction of the clause, as this sets the parameters for the Tribunal’s exercise of its powers. Properly construed, as the increase in the “Amount Insured” would be more than 30% the increased cover did not commence until these events had occurred. They had not occurred at the date of Mr Lancaster’s disablement.
6. In support of its preferred construction, the applicant also submitted that this result was consistent with the effect of other clauses contained within the policy and that properly construed these clauses provided that any increase in coverage following notification of an increase in income is to take effect from the date of notification of that increase to the insurer, rather than the actual date of increase. Reference was made to the following other clauses:

* Clause 4.3(c), one of the “Eligibility Conditions”, which provided that any increase in coverage due to changes in income after 30 June 2012 would be subject to the insured member providing “Evidence of Insurability” to the insurer;
* Clause 5.7(a), one of the “General Conditions”, which provided that where there was an increase in the “Amount Insured” by more than 30% in the past 12 months, the insured member must make an application for increased cover and provide, amongst other material, “Evidence of Insurability”;
* Clause 5.8(g), one of the “General Conditions” , which provided that where there was an increase in the “Amount Insured” due to an increase in income but that increase does not exceed 30%, the increase still only takes effect from the date of notification of the increase in income, although Evidence of Insurability does not need to be provided. It was submitted that it would be inconsistent with this clause if, in respect of an increase in coverage of more than 30%, notification did not have to occur before the increase could take effect.

1. Considered in the context of the policy as a whole, the intention appeared to be that increases in coverage due to an increase in income will not simply occur automatically, and there must be some notification or additional step taken. This is consistent with the construction of cl 5.8(f) reached above.
2. It is clear, therefore, that properly construed cl 5.8(f) required an application to be made to the applicant, and for that application to be accepted, before Mr Lancaster’s coverage could be increased due to his increased salary. The benefit payable to him therefore fell to be determined based on the salary recorded, and accepted, by the applicant at the date of his disablement, this being the actual “Amount Insured”. As noted above, the Tribunal itself accepted that the insurer had correctly calculated the benefit payable to Mr Lancaster in accordance with the policy when it did exactly that.
3. Accordingly, I am satisfied that the determination of the Tribunal to set aside the decisions of the insurer and Maritime Super and substitute a benefit calculated by reference to Mr Lancaster’s increased salary as if the increased coverage had been accepted was inconsistent with the terms of the policy, properly construed, and principally with cl 5.8(f). As I stated in *Crocker* [2001] FCA 1330; 48 ATR 359 at 367 [31]-[33], the Tribunal cannot make a determination that is contrary to the terms of the relevant insurance policy. The decisions of the insurer and Maritime Super were consistent with the policy, and indeed were required by cl 5.8(f) of it.
4. Despite this, I accept how Mr Lancaster may justifiably have a sense of grievance about the handling of his claim by the applicant and Maritime Super, and in the approach of his then employer to notifying both of these parties of his increased salary, the policy being owned by Maritime Super as trustee and being entered into for Mr Lancaster’s benefit as a member of the Maritime Super Fund. This dispute may not involve a large sum of money to the insurer, though, if I may respectfully say so, from the point of view of Mr Lancaster it might. Within this context, the determination of the Tribunal can be well understood. The observations made by the Tribunal that it was reasonable to assume that the employer informed the applicant and for the applicant to make inquiries are legitimate and pragmatic ones. However, I return to what I said in *Crocker* [2001] FCA 1330; 48 ATR 359 at 367 [33] that whatever the Tribunal’s “view of the rights of the parties inter se” it cannot make a determination reflecting this view “if that is contrary to the terms of the governing rules or policy terms”. The Tribunal erred in making a decision that was inconsistent with the terms of the policy, properly construed.
5. The argument of this appeal was limited by the fact that neither of the respondents participated. The submissions of the applicant were directed solely to issues of construction. I accept they have been of substantial assistance and that they have put forward the proper construction of the policy. However, it may be that several issues regarding provisions of the *Insurance Contracts Act 1984* (Cth) potentially arise in a case such as the present. The first of these relates to the “unusual terms” provision in s 37 of that Act. It provides that an insurer may not rely upon a contractual provision “of a kind not usually included in contracts of insurance that providing similar insurance cover unless, before the contract was entered into, the insurer clearly informed the insured in writing of the effect of the provision…”. I am not suggesting that cl 5.8(f) or any of the similar terms would be an unusual term within s 37. There was no argument or evidence to that effect on this appeal and the difficulties of establishing a clause as such can be seen in cases such as *Dumitrov v SC Johnson & Son Superannuation Pty Ltd* [2006] NSWSC 1372 at [12]-[18] per Gzell J.
6. Secondly, there is a question as to whether s 53 of the *Insurance Contracts Act 1984* (Cth) might have been said to be potentially relevant. Section 53 provides that where a provision in an insurance contract permits the insurer to unilaterally vary the contract to the prejudice of a person other than the insurer, the provision is void. There may be have been an issue as to whether the clauses relating to the commencement of increased coverage have this effect, in particularly cl 5.8(f) in that it permitted the insurer to determine unilaterally whether it accepted the increased risk presented by an insured’s salary increase and that such increased cover only commenced upon that acceptance.
7. These provisions were not the subject of submissions. It is therefore not appropriate to express a concluded view as to the relevance of these provisions or indeed the prospects of an argument based upon them being successful. However, I highlight them as issues that could have potentially been relevant in this appeal and, indeed, before the Tribunal in determining whether the decisions were fair and reasonable, within the parameters of the law and terms of the policy.
8. While strictly unnecessary to deal with given my conclusion regarding the Tribunal’s determination, the applicant also contended that the Tribunal erred by holding that Mr Lancaster was entitled to compound interest under s 57 of the *Insurance Contracts Act 1984* (Cth). Regulation 32 of the *Insurance Contracts Regulations 1985* (Cth) sets out how interest is to be calculated under that section. The general position is that simple interest is to be awarded under those provisions in respect of sums withheld, not compound interest: see *Nguyen v QBE Insurance Ltd* [2007] SASC 454; 215 FLR 447 at 451-452 [27]-[30] per Duggan J; *Dumitrov v S C Johnson & Son Superannuation Pty Ltd (No 2)* [2007] NSWSC 42 at [22]-[33] per Gzell J. Therefore, the applicant’s submission on this point can also be accepted.
9. It was conceded by the applicant that, as Mr Lancaster did not defend the appeal, s 46(5) of the Act requires that there be no order for costs against him. Accordingly, there will be no order as to costs.

## Orders

1. In the light of the conclusions I have reached, I will make the following orders:
2. The determination of the Superannuation Complaints Tribunal dated 6 December 2016 be set aside.
3. In lieu thereof, order that:
   1. The decision of the applicant be affirmed.
   2. The decision of the second respondent be affirmed.
   3. The complaint made by the first respondent to the Superannuation Complaints Tribunal otherwise be dismissed.
4. There be no order as to costs.

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| I certify that the preceding forty-eight (48) numbered paragraphs are a true copy of the Reasons for Judgment herein of the Honourable Chief Justice Allsop. |

Associate:

Dated: 18 August 2017