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LEARNING MODULE

FSI102
INSURANCE LAW
AND REGULATION

(v03.01)

AUSTRALIAN AND NEW ZEALAND INSTITUTE OF INSURANCE AND FINANCE

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Module introduction

Welcome

Welcome to *FSI102 Insurance Law and Regulation*. This learning module is one of five that make up the Certificate IV in Financial Services (General Insurance). The other four are:

- *FSI101 Serving the Customer*
- *FSI103 Insurance Products*
- *FSI104 Introduction to Underwriting*
- *FSI105 Claims Handling*

When you successfully complete this course, you will achieve a nationally recognised AQF qualification, and membership of the Institute as an ANZIIF (Associate). You will find more information about the course in the Institute Course Handbook.

What you will learn

The insurance industry has always valued knowledge. Accurate, detailed information is an essential tool in assessing and managing risk. In this module, we provide the knowledge you need to achieve the learning outcomes—or we show you where to find it. But knowledge is only half of the learning equation. Practical skills are just as important, so we also include in the module plenty of hands-on activities and tasks that help you apply the knowledge to familiar situations in your workplace. We encourage you to engage fully in both aspects of your learning—both the theory and the practice—to gain the most from your studies.

Learning outcomes

This module provides underpinning knowledge for your work in all other modules.

When you have successfully completed this module, you should be able to:

- understand underlying legal concepts
- understand and apply relevant laws and regulations
- understand and apply relevant codes and principles.

Competency standards

Competency standards refer to the skills you will have achieved when you complete your modules.

The competency standards covered in this module are:

FNBF05A Apply health and safety practices in the workplace

About this learning module

Content

This module consists of seven sections.

Section 1: Insurance basics

This first section considers legal concepts underlying your insurance practice.

Section 2: The legal framework

This section looks at the main Acts governing the general insurance industry.

Section 3: The Financial Services Reform Act and Regulations

In section 3, we introduce the recent legislative changes that will have a lasting effect on your insurance practice.

Section 4: The code

Section 4 discusses the part played by the General Insurance Code of Practice in your work.

Section 5: Resolving disputes

In this section, we examine the industry requirements for effective dispute resolution.

Section 6: Privacy

This section looks at the privacy principles in the General Insurance Privacy Code.

Section 7: A safe workplace

Section 7 explores the requirements of Occupational Health and Safety legislation.

Materials

This module contains one learning module workbook and two learning resource books.

- This workbook is the FSI102 *Insurance Law and Regulations Learning Module*—This is the key text for you to study. **You will be assessed on the material in this learning module workbook.**

The learning resource books contain excerpts from insurance Acts and Regulations and consist of:

- the FSI102 *Insurance Law and Regulations Volume 1 Resource Book (Blue cover)*—This is a reference book for you to use when necessary. It deals with legislation applying to people who **have not** transferred to operate under the new licensing regime introduced by the Financial Services Reform Act 2002.
- the FSI102 *Insurance Law and Regulations Volume 2 Resource Book (Gold cover)*—This is also a reference book for you to use when necessary. It deals with legislation applying to people who **have** transferred to operate under the new licensing regime introduced by the Financial Services Reform Act 2002.

Further details on how best to use these resources can be found at the beginning of *FSI102 Insurance Law and Regulations Volume 2 Resource Book (Gold cover)*

Information about the assignment and the examination for this module will be provided on a separate sheet.

If you have not received all of the required materials, contact the Institute on (61 3) 9629 4021 or email student@theinstitute.com.au for help.

Prerequisites

There are no prerequisites for this module.

Using this learning module

This module provides you with a complete self-paced learning program to help you achieve success in your studies. Its designed as a workbook to involve you actively in your learning. Here are some suggestions for making the best use of the learning module.

Study techniques

Before you begin to work through the module, read the learning outcomes. They will give focus to your learning and tell you exactly where you are heading. To get the best from your study time, read and absorb the information in the module, making notes in your own words as you do.

Each section includes information, case studies, activities and self help questions. These are designed to help you gain the knowledge and skills outlined at the beginning of the module. Make sure you take the time to complete all the activities and self help questions, but do not submit them for assessment. The activities help you apply what you have learned to your daily work. The self help questions offer you feedback and help to reinforce your learning. Answers to self help questions are provided at the end of each section. The best study technique of all is to talk to your co-workers about the information, ideas and activities in the module, and put them into practice in your workplace.

Work steadily through the module at your own pace. The time you take to complete it will depend on your own individual learning style.

Studying on your own

There are many advantages to self-paced, independent study: a full set of learning materials is provided, and you study when and where you want. You can also plan your study time to fit in with other commitments like work or family.

However, there are also challenges. Learning on your own requires discipline and motivation. Here are some tips:

Plan—Make a study schedule and stick to it. Set specific times each week for study and keep them free of other activities. Make a note of due dates for assignment/s and the exam, and plan for extra study time then.

Manage your time—Set aside a reasonable amount of time each week for study—but don't be too ambitious or you won't be able to keep up the pace. Work in productive blocks of time with regular rests.

Organise yourself—Have your study materials organised in one place and keep your notes clearly labeled and sorted. Work through the topics in your learning module systematically and seek help for difficulties straight away. Never leave this until later.

Find a suitable place to study—Most people need order and quiet to study effectively, so try to find a suitable place to do your work—preferably somewhere where you can leave your study materials out until next time.

Ask for help if you need it—No matter what the difficulty is, seek help from your colleagues and friends, or contact the Institute—and don't give up!

Your workplace

Some of the activities and learning strategies in this module ask you to draw on your workplace experience. However, you may not currently be employed in the insurance industry. If this is the case, don't worry. The Institute can help you put in place strategies to ensure you are not disadvantaged. To enquire, contact the Institute.

Resources

The Institute has on-line services to help you with your studies. You can access the Institute website at:

www.theinstitute.com.au

Don't forget that your colleagues and co-workers are important resources too. Their experience and knowledge may be helpful to you as you work through this module. Your workplace may also have its own resources. Ask your supervisor about how to access them.

About assessment

There are two parts to the assessment of this module:

- assignment/s
- and
- an examination.

Assignments

Assignments are an opportunity for you to demonstrate your understanding of topics in the module and to apply them in a practical, workplace context. Generally, assignments will require you to respond to questions based on practical examples or case studies. They'll generally require reflection and analysis rather than the recall of facts. In framing answers to assignment questions, you should draw on the theory learned in the module plus any relevant workplace experience.

Details of assignments, including when, how and where to lodge them, will be provided to you on a separate sheet.

Examination

The examination is designed to assess your knowledge and understanding of the content of the module. It may require you to answer multiple-choice questions, provide longer, written responses or a combination of both types of response. Further information about the examination style will be sent to you before the examination date.

Preparing for the exam

The secret of exam success is to be well prepared. Here are some tips.

- Study the module until you understand all the material thoroughly.
- Aim to understand—don't try to rote learn.
- Discuss difficult ideas and concepts with experienced colleagues.
- Revise frequently.
- Master difficult material before going on.
- Work steadily over the whole semester.
- Avoid cramming.
- Complete the activities and the assignments.

Sitting the exam

Here are some useful things to know when sitting your examination.

- Before you start, make a quick survey of the exam paper to see how many questions there are, how difficult each one is, and the value given to each question.
- Read and follow all the instructions.
- Read all the questions carefully.
- Think carefully as you choose an answer.
- Allocate your time carefully. If some questions attract more marks than others, allow more time for those which have the highest value. Answer the easiest questions first. Don't spend too much time on questions you can't answer—come back to them later.
- Make sure you haven't missed any part of the paper.
- If possible, take time at the end to review your answers.
- When you have answered the last question, don't hand in your exam straight away. Read it over again. Also re-read the instructions and make sure you have followed them.

Examination times

Examinations will be held each semester in all Australian capital cities and other selected cities around the world.

Details of examination dates, times and locations will be supplied on a separate sheet before your exam. If you do not receive this information, please contact the Institute.

We hope you find your study of this module productive and we wish you well in your assessment tasks.

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Section 1

Insurance basics

Introduction

From the parking ticket to workplace safety, from the planning permit to family break-up, and in many other ways, laws affect our daily lives.

Everyone knows something about the law, even though there doesn't seem to be a universally acceptable definition of it. Among the many recommended definitions, one that is popularly used is that:

Law is a body of rules, developed over a long period of time, regulating people's interactions with each other and by which both the affairs of a community are organised and the general well-being of the community are maintained.

This definition is a start to understanding some of the basics of insurance law, but we obviously need to go further. In this section, we will try to develop a more complete understanding of insurance law by covering key concepts that underpin all insurance contracts.

After completing this section you should be able to:

- understand the basic legal system in Australia
- understand the law of contracts
- understand key legal concepts including 'duty of utmost good faith', 'insurable interest' and 'duty of disclosure'.

Classification of laws

There are two main types of legal systems in the Western world: civil law systems and common law systems. Civil law emphasises a complete code of written laws whereas the common law system relies more on the decision-making of judges.

Civil law is used in most European countries whereas common law is used in Australia, England and many countries colonised by the English. Law-making under the common law system occurs in two main ways: through case law (also known as judge-made law) and by statute law (which means those laws made by Parliament).

Case law

Case law involves the making of law by judges sitting in court and deciding disputes or actions before them. A later judge will pick up and apply the law developed in earlier cases.

Administering the law

Generally, Australian courts deal with two areas of law: criminal and civil (not to be confused with the overall system used by most European countries).

A criminal case is brought before the courts by the State, in the name of the Crown. The Crown can bring a proceeding against a person or an entity, known as the accused, for committing a crime. The Crown must establish the guilt of the accused beyond a reasonable doubt.

A civil case involves an individual or entity bringing an action against another individual or entity.

We can divide civil law into public law (which involves government bodies etc.) and private law (which involves individuals, companies, etc.).

Disputes involving insurance policies are private civil disputes.

The doctrine of precedent

An important characteristic of the common law system is the doctrine of precedent. Under the doctrine, previous court decisions are available for other judges to use as guidelines for arriving at decisions in current cases.

The doctrine of precedent operates within the court hierarchy. This means that the decisions of higher courts are binding on lower courts where they are considering similar facts, circumstances, legislation etc. Therefore, only an equal or higher court than that which set the original precedent can overrule a precedent.

In Australia, the highest court is the High Court of Australia and the lowest court is the local magistrates court or its equivalent.

The doctrine of precedent evolved from a basic argument resting on fairness and equality: if 'Jill Smith' was treated in a certain way yesterday, then 'Tan Nguyen' ought to be treated in the same way today in a similar case. The doctrine also provides an element of certainty in the law.

Statute law

The second way that laws are made under the common law system is by statute. This is law made by Parliament or other government bodies (such as local government or statutory authorities) to whom Parliament has delegated power to legislate. The law made by Parliament is usually referred to as statute law, whereas the law made by the other bodies is in the form of local laws, orders, rules and regulations.

Relationship with case law

Statutes and delegated legislation assume the existence of case law and in many instances they include case law principles. For example, insurance law includes the common law principle of 'utmost good faith'.

Statute law has also had a big part to play in modifying and up-dating case law which doesn't meet current social standards. The *Insurance Contracts Act 1984* (Cwlth) was, generally, introduced to redress the unequal bargaining power between insured and insurer, which case law wasn't able to redress as quickly.

Where statute law and case law are in conflict (i.e. they do not agree on a point of law), statute law will prevail. Further, where federal laws conflict with the laws of other governments or bodies, the federal law will prevail.

How statute law is made

The first step in making a parliamentary law is that somebody within the parliament makes a proposal for new legislation. The proposed law (known

as a Bill) is given three readings by each House of Parliament. It must be passed by both Houses before it becomes an Act of Parliament and part of statute law. Once an Act of Parliament comes into being it remains in force until it is repealed (i.e. cancelled) by a later Act of Parliament. Some Acts also include a 'sunset clause' which specifies an expiry date.

How statute law is interpreted

Despite the push towards 'plain English' in statutes, they are still complex sources of law and courts have the important role of interpreting what the parliament meant when it passed these laws. For example, section 66 of the *Insurance Contracts Act 1984 (Cth)* raises problems of interpretation with its phrase:

serious or wilful misconduct

There is no definition in this Act of this phrase and ambiguities in definition can arise when considering that wilful (i.e. intentional) misconduct may not necessarily be serious. So courts have stepped in to determine what this phrase means. Courts are mainly guided by the following sources when interpreting statutes:

- the objectives/aims section and definitions section in the Acts
- any Explanatory Memorandum to the Act
- parliamentary speeches—these often disclose the purpose of the Act
- earlier cases where identical or similar wording or legislation has been considered.



Self help question 1.1

To test your understanding of the materials covered so far, try and identify whether the following brief scenarios are examples of case law or statute law.

- 1 You receive a parking fine in your local shopping strip.
- 2 You are made to pay damages to your neighbours after you knock down their fence.

- 3 Your employer's licence to practice insurance is revoked because of insolvency.
- 4 You are stopped from building a second storey on your house because it doesn't meet local building guidelines.

Answers are provided at the end of this section.

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Contract law

Case law and statute law, as previously mentioned, are two general sources of law. Within these sources sit specific legal areas such as family law, criminal law, environmental law and so on.

Contract law is also a specific legal area that, among other things, regulates dealings between manufacturers and suppliers, employers and employees, property owners and tenants and insurance companies and consumers.

Both Commonwealth and State parliaments have passed many Acts which cover the law of contracts, and courts have an abundance of precedents covering the interpretation of all sorts of contractual arrangements.

What is a contract?

The law often uses the terms 'contract' and 'agreement' to mean one and the same thing. However, even though every contract involves agreement in some way, not every agreement results in a contract recognised as such by the law. For instance, some agreements are not contracts because the parties involved don't intend to create legal relations (e.g. many public competitions, going out on a date).

On the other hand, a contract can exist regardless of the parties' wishes. For example, with compulsory third-party insurance, the insured and the insurance company have no choice about the contents of the contract. So, one aspect of the agreement element (the actual terms of the contract) may be missing, but the agreement is still present.

What are the essential elements of a contract?

There are six elements needed:

- 1 *an intention to contract*—by their promises, the parties must intend to create legally enforceable obligations.
- 2 *agreement between the parties*—this involves an offer by one party and an acceptance by the other.
- 3 *consideration*—the party who accepts the promise must provide consideration (i.e. usually, but not necessarily, a payment) for the promise.
- 4 *legal capacity*—the parties must be legally capable of entering into a contractual relationship. Examples of people without legal capacity are people under eighteen years old, bankrupts and the intellectually disabled.
- 5 *legality of purpose*—e.g. a contract to commit a crime has no legal standing.
- 6 *consent*—the contract must be a ‘genuine expression’ of the parties’ intentions. A contract that appears valid may not be if consent to the contract was based on:
 - *mistake*—when someone agrees to a contract based on a personal misunderstanding of the requirements of the contract.
 - *misrepresentation*—similar to a mistake in that the agreement to the contract is based on a misunderstanding, but in this case the misunderstanding is caused by the other party. The misrepresentation might be fraudulent or innocent.
 - *duress*—actual or threatened violence to a party’s immediate family; threats against goods or property; economic pressure to gain a benefit not in the contract.
 - *unconscionability*—behaviour that is unethical or unfair. In practice, courts will set aside a contract as being unconscionable where there has been an abuse by one party of its superior bargaining position in its dealings with the other party.

Now complete the following, brief self help questions to test your understanding of the essential elements of a contract.



Self help question 1.2

Do the following scenarios represent valid contracts? Give reasons for your answer.

- 1 An insurer issues a policy on a motor vehicle. In the first six months of the contract, the insured makes six claims costing \$8000 in total. As the premium charged by the insurer was only \$500, the insurer writes to the insured stating that, as the premium (the consideration) was quite inadequate, the contract is not valid.
- 2 Bert badly wanted to buy a block of land owned by Yousef, but Yousef did not want to sell. Bert finally got Yousef to agree to the sale and sign the papers when he told him that he would make public Yousef's criminal history if he did not sell.
- 3 A travelling salesperson took out insurance to cover against speeding fines she often got as she drove around the state on business.

Answers are provided at the end of this section.

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Making an insurance contract

Insurance contracts must conform with the general requirements for contracts, but they also include requirements particular to insurance.

What is an insurance contract?

An insurance contract usually comprises the proposal, the policy wording and the policy schedule.

As well as the general requirements for contracts outlined above, an insurance contract includes:

- *an insurer*—the insurance company or underwriter prepared to cover all or a part of the insured's loss
- *a premium*—the payment, calculated according to the nature of the risk, that the insured makes to the insurer in return for cover against possible future loss

- *indemnity*—the agreement from insurers to return the insured to their pre-loss position following events specified in the contract. This is normally achieved by monetary compensation or by protecting the insured from possible legal liability. (Some contracts, such as personal accident insurance and life insurance are not contracts of indemnity.)
- *a risk*—the potential loss to an insured through a defined event such as fire, accident, theft or legal liability.

You are probably very familiar with these insurance terms and use them often. They are fundamental to every insurance contract.

In Australia, most insurance contracts are also covered by specific statutes. We will now consider the essential parts of legislation that cover insurance contracts.

Basic principles of general insurance law

While the basic principles of insurance law can be found in the common law, statute law has taken over a large part of the insurance law area, replacing and changing case-based principles. Statute law includes:

- *Marine Insurance Act 1909* (Cth)
- *Insurance Contracts Act 1984* (Cth) (the Contracts Act)
- *Insurance (Agents and Brokers) Act 1984* (Cth) (the Agents and Brokers Act).

The Contracts Act has the greatest impact on the making of an insurance contract. We will now look at the key aspects of this Act.

The Contracts Act

Before the Contracts Act came into effect, the law in relation to insurance contracts was widely considered to be out-dated, inconsistent, ineffective and inequitable. In 1976, the Australian Law Reform Commission was asked to investigate the area of insurance contracts. In its report, the Commission recommended that a national legislative regime was needed.

The Contracts Act does not cover the entire field of insurance contracts. It does not apply to:

- contracts of insurance entered into before 1 January 1986
- reinsurance
- insurance of registered health benefits under Part VI of the *National Health Act 1953* (Cth)
- insurance by a friendly society
- workers' compensation insurance
- compulsory third party motor vehicle liability insurance
- marine insurance
- insurance dealing with aircraft involved in commercial operations
- insurance by the Export Finance and Insurance Corporation
- contracts of insurance where the insurer is a State Government Insurance Office or the Territory Insurance Office.

So the Contracts Act applies to all other insurance contracts. Section 10 of the Contracts Act also extends the Act's coverage to cases where a contract contains other conditions or terms that are not insurance-based and contracts that are not primarily insurance contracts but which contain insurance conditions or terms.



Activity 1.1

Go to the Contracts Act in the resource booklet and read section 10 for an example of such a contract.

Does this sort of cover apply to any other insurance lines your company provides?

• • • • •

We will now look at the important insurance concepts which underly all your insurance practice.

Utmost good faith

Utmost good faith is an implied term in every contract to which the Act applies. An implied term does not have to be actually printed in a policy. It is imposed by law and has the same effect as if it was printed.

The provision requires the parties to an insurance contract to act towards each other with the utmost good faith at all times.

The Act does not define what 'utmost good faith' is but it has to do with questions of fairness, integrity and generally acting in ways that protect and further the interests of the other party.

Breaches of insurance law such as non-disclosure (also in the Contracts Act) and unconscionable conduct (covered in the *Australian Securities and Investments Commission Act 1989* (Cth)) would also be breaches of the duty of utmost good faith.

However, because utmost good faith addresses the more general issue of maintaining a moral relationship in the insurance contract, it can include issues of fairness that fall outside other specific sections of the various Acts.

For example, an insurer who seeks to rely on a policy provision to deny a claim might meet all the formal requirements of pre-contract notification, but still breach the duty of good faith if the notification was too difficult to understand. (The Code of Practice is relevant to this issue because it requires insurers to use plain language and good presentation to assist consumers' understanding.)



Activity 1.2

Read the following case study and then answer the following self help question.

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Case study 1.1

Scenario

The claimant completed an application form on 4 May 1995 for Crisis Recovery Cash Plan insurance cover for a sum insured of \$50 000. In response to a question on the document, he indicated that he required cover for his wife.

The policy was issued in the claimant's name only on 29 May 1995. On 8 June 1995, the claimant raised a query with the insurer concerning the cover for his wife. His file contained a memorandum dated 8 June 1995 from an officer of the company to the regional direct marketing manager stating:

[Manager of Card Services] will be contacting you about an unhappy Crisis Recovery Member. His name: [claimant], his complaint: misleading Application form re spouse.

On 22 March 1996, his wife was diagnosed with metastatic melanoma and she subsequently died on 27 April 1996.

Insurer's position

The insurer denied a claim made under the policy for the sum insured of \$50 000 on the ground that there was no policy in force for the claimant's wife at the time of her diagnosis with cancer.

The insurer acknowledged that the claimant had contacted it about one week after receiving his policy schedule, which clearly indicated that he was the only insured person. The claimant had the opportunity at that time to request another enrolment form for completion by his wife. According to its records, no further contact was made by the claimant until 15 April 1996.

Claimant's position

The claimant maintains that he applied for the insurance cover for his wife and is entitled to payment of the claim.

The application form clearly states that he wanted cover for his wife as well as himself. He maintains that after receiving the policy in his name only, he followed up with a phone call to try and have his wife included in the policy.

The insurer apparently neglected to alter its records after his telephone call to verify spouse cover and failed to send any follow up paper work. He had been in the practice of including his wife in other policies taken out with the insurer.

Issues in dispute

Whether by virtue of the claimant's completed application form and subsequent contact with the insurer, the insurer is bound to provide cover for the claimant's wife from 4 May 1995.

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Self help question 1.3

The concept of utmost good faith is a little vague, but based on what you know about it from the above explanation, what do you think the IEC's determination was in this case? Give reasons for your answer.

Answers are provided at the end of this section.

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Insurable interest

At common law, for an insurance contract to be valid the insured had to have an insurable interest (a legal or equitable economic interest) in the subject matter of insurance. For example, under a home building policy, the homebuyer has a legal interest as the insured party and the lending bank has an equitable interest because they still own part of the house. Both therefore have an insurable interest in the house and may recover part of the insurance payment in the event of a fire.

At common law, this insurable interest had to be present at the time the contract was entered into. This requirement could create problems for the insured as is highlighted in the following case study.



Case study 1.2

The case of *Macaura v Northern Assurance Co Ltd* [1925]

Macaura owned a timber yard. The timber in the yard was covered by an insurance policy in Macaura's name. However, the timber had been sold to a company in which he was the only shareholder. A fire broke out in the timber yard, destroying the timber.

When Macaura tried to claim on the insurance policy, Northern Assurance refused to pay, arguing that Macaura had no insurable interest in the timber. This dispute was taken to Court.

The Court held that Northern Assurance didn't have to pay. The company was a separate legal body from that of its shareholders, and whilst the company was the owner of the timber (therefore having an insurable interest), it had no policy. On the other hand, Macaura had a policy but he had no insurable interest because the timber had been sold to the company.

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Activity 1.3

This case pre-dates the Contracts Act. Today it would be necessary to consider the Macaura case in light of the provisions of sections 16 and 17 of the Contracts Act.

Read sections 16 and 17 of the Contracts Act in the resource booklet and then answer the following self help question.

• • • • •



Self help question 1.4

Would Macaura's case be decided differently today? What grounds do you have for your answer?

Answers provided at the end of this section.

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Third party interests

Third parties are persons other than the insured (the party entering into the insurance contract) who have an interest in the subject matter of the insurance contract. For example:

- ‘disclosed drivers’ who are persons, normally noted in a motor vehicle policy, driving the vehicle with the insured’s consent
- members of the insured’s family, who are living with the insured, have their property covered under the insured’s house and contents policy
- mortgagees, who have a charge over the house as security for a loan.

Sections 20 and 48 of the Contracts Act were enacted because of difficulties encountered by third parties seeking to recover under policies.



Activity 1.4

Read sections 20 and 48 of Contracts Act in the resource booklet.

In the light of these two sections of the Act, think about who might have third party interests under the insurance policy/ies covering your home and contents.

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Disclosure and misrepresentation

Both the duty of disclosure and misrepresentation are concerned with the quality of information provided by customers in insurance applications.

The duty of disclosure aims to ensure that customers provide insurers with all the relevant information that enables the insurer to make an accurate assessment of the risk.

To make an accurate assessment of the risk, insurers must also be confident that the information disclosed truthfully represents the relevant facts. If the information is not true, it is a misrepresentation.

Disclosure

There are two parts to the duty of disclosure. Customers must:

- disclose matters they know to be relevant to the policy
- disclose matters that a ‘reasonable person in the circumstances’ would know to be relevant to the insurer.

The second part of the duty has been of concern to Insurance Enquiries and Complaints Ltd (IEC) and consumer groups because of the difficulty interpreting what a ‘reasonable person in the circumstances’ means. This has made compliance difficult for customers. The industry Codes of Practice and section 21A of the Contracts Act impose obligations on insurers to assist customers to comply with their duty of disclosure.

Under section 21A (which applies to prescribed insurance policies), insurers must ask customers specific questions about the risk when arranging new business. If a customer fails to give specific, relevant information to general questions, the insurer can’t claim there has been non-disclosure.

For example, a motor-insurance proposal form might include the request:

Please provide any information that is relevant to your application.

A customer might not include two-year-old drink driving charges because they genuinely think the charges are irrelevant to a current car insurance policy.

If the insurer thought this was relevant information, they would have to ask a specific question such as:

Have you been charged with any traffic offences within the last five years?

There are certain matters that customers don’t have to disclose. For example, they don’t have to disclose matters of common knowledge and the Act holds insurers to have waived compliance with the duty of disclosure if they don’t follow up missing or obviously incorrect information.

For the duty of disclosure to apply, insurers must clearly inform customers of the duty before they enter the contract—and the Contracts Act provides a form of words that insurers can use for this. If the insurer doesn’t clearly inform the customer, it is possible for the customer to be exempt from complying with the duty of disclosure.

When the duty arises

The duty arises both under the Contracts Act and under the common law.

The Contracts Act

Under the Contracts Act, the duty arises when the insured 'enters into' a contract. This clearly arises when a new contract is agreed upon, but, under section 11 of the Act, 'entering into a contract of (general) insurance' also includes:

- renewal
- extension
- variation, or
- reinstatement.

Common law

On top of the requirements under the Contracts Act, there is a common condition included in insurance policies/contracts that the insured must disclose to insurers any change in circumstances that could increase the insured risk.



Activity 1.5

Read sections 21, 21A and 22 of the Contracts Act in the resource booklet and then consider the following case study and self help question.

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Case study 1.3

Scenario

The claimant arranged a comprehensive motor cycle policy on a 1995 Harley Davidson over the phone effective from 28 January 1999. The bike was insured for an agreed value of \$22 000 and the policy was subject to a \$500 basic excess.

On 21 February 1999, the bike was damaged when the rider lost control of it and it then slid into a fence. The insurer assessed the damage at \$8834. The insurer denied the claim on the basis of the claimant's non-disclosure.

The insurer's underwriting agency transacts all new business over the telephone and there is no evidence of the details of the initial discussion of the proposal. The sales person involved moved to a new employer and the insurer was not aware of his contact details.

Claimant's position

- 1 When the claimant contacted the insurer's agent by telephone to arrange the cover on the bike, at no stage was he queried about his driving history or whether he had a current driver's licence.
- 2 The claimant answered all the questions asked both openly and honestly.
- 3 The insurer failed to comply with its obligation to request answers to specific questions that were relevant to its decision to accept the insurance.
- 4 The insurer can only rely on section 28(2) of the Contracts Act, where the insured's failure to comply with the duty of disclosure was fraudulent.

Insurer's position

At the time the claimant arranged the insurance, he failed to disclose his traffic history. If the insurer had been informed of his traffic history, the cover would not have been issued. The insurer provided its policy wording on duty of disclosure from pages ten and eleven of its policy booklet.

Issues in dispute

Does the claimant's non-disclosure of his driving record entitle the insurer to reduce its liability to nil under section 28(3) of the Contracts Act?

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Self help question 1.5

What do you think the IEC's decision would be in this case? What reasons do you have for your answer?

A suggested answer is provided at the end of this section.

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Misrepresentation

At common law, an insurer could avoid a contract where the insured (or the insured's agent) had misrepresented facts that an insurer relied on to make a decision about whether or not to accept the proposal and if so, on what terms.

The courts generally considered an insured's statement was a misrepresentation if it was untrue. This applied even if a 'reasonable person' would have thought that the statement was true when it was made.

Under the Contracts Act

The Contracts Act significantly affects the insurer's right to a legal remedy based on misrepresentation. There are three key changes to the common law position. The Act does not consider an insured's disclosure to be misrepresentation if:

- a question on the proposal is ambiguous—that is, it is open to more than one interpretation—and as a result the insured's answer doesn't provide the information the insurer is after
- an insured genuinely believes a statement to be true when he or she completes the proposal form (and a reasonable person in the circumstances would also believe it)
- an insured fails to answer, or gives an obviously incomplete or incorrect answer, to a question in a proposal (also see section 21).



Activity 1.6

Read sections 23, 26 and 27 of the Contracts Act in the resource booklet and then consider the following case study and self help question.

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Case study 1.4

Scenario

The 73 year old claimant arranged travel insurance to cover a holiday commencing on 9 August 1998. Following completion of a proposal form for pre-existing medical cover, the insurer extended the policy to include cover for pre-existing medical conditions of hypertension and non-insulin dependent diabetes. On 6 August 1998, the claimant suffered chest pains and sought medical attention. His doctor diagnosed the condition as unstable angina and advised that he cancel his travel.

The insurer refused the claim of \$4910 for cancellation fees incurred by the claimant because the claimant had not included his angina condition on the proposal for pre-existing medical cover. The claimant maintains that, because he had indicated he suffered with a heart condition on the pre-existing medical application form, he had disclosed the condition to the insurer.

Issues in dispute

Whether the claimant's angina heart condition was an undisclosed pre-existing medical condition.

Insurer's position

The claimant indicated 'yes' on the application form in response to a question asking had he been diagnosed with heart disease of any kind. The form continues on under the heading 'PRE-EXISTING MEDICAL CONDITION DETAILS'. The area contains spaces for 4 conditions in which the claimant advised that he had high blood pressure and was diabetic. Consequently an assessment was completed based on these two medical conditions as provided by the claimant and/or the doctor.

Although the medication Cardazem can be prescribed for the treatment of angina, it also can be used to treat high blood pressure. The medication was listed on the form under 'high blood pressure'. It was reasonable to accept that the claimant intended the 'yes' tick in the heart disease box to be linked to his blood pressure condition due to the absence of any other information regarding pre-existing conditions. If the medication had been prescribed for angina, the claimant had the responsibility to provide this information.

The claimant failed to advise that he suffered from the pre-existing medical condition of angina therefore denying the insurer the opportunity for full and proper assessment of the application. The trip was cancelled due to an undisclosed pre-existing medical condition and consequently the claim was denied.

Claimant's position

He had indicated on the application form that he had a heart problem. He did not believe that it was necessary to repeat himself later in the document. As blood pressure is the cause for his angina, medication was listed with his blood pressure medication on the form.

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Self help question 1.6

What do you think the IEC's decision would be in this case? Give reasons for your answer with reference to relevant sections of the Contracts Act.

A suggested answer is provided at the end of this section.

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Remedies

Division 3 of Part IV of the Contracts Act deals with remedies for non-disclosure and misrepresentation in contracts of general insurance.

Section 28 applies where the non-disclosure or misrepresentation has happened before the contract was entered into. However it doesn't apply where the insurer would have entered into the contract for the same premium and on the same terms, whether or not the non-disclosure or misrepresentation happened. For example, the non-disclosure of a pre-existing medical condition such as asthma should not affect a comprehensive motor insurance policy.

Critical to the question of whether the insurer would not have entered into the contract is the existence of underwriting guidelines, and evidence of the rejection or acceptance of other similar proposals.

If the non-disclosure or misrepresentation was fraudulent, the insurer can avoid the contract of insurance.

If insurers are unable to avoid the policy, they might still be able to reduce the amount payable so that they are in the same position they would be in if there had been no non-disclosure or misrepresentation.



Self help question 1.7

To test your understanding of the issues of non-disclosure and misrepresentation, answer the following self help questions.

- 1 For all classes of new business an insured can ignore any question stated in general terms, for example, 'is there anything else you should tell us'? True/False
- 2 The duty of disclosure only applies when an insured is entering into a new contract. True/False
- 3 A consumer wanting flood insurance would need to inform the insurer of local rainfall patterns. True/False
- 4 An insurer can't avoid a contract if an insured makes a statement in his or her application that a reasonable person in the circumstances would have believed to be true, but which the insurer later finds to be untrue. True/False

Answers are provided at the end of this section.

• • • • •

Classes of business

Prescribed contracts

The Contracts Act specifies the standard cover and minimum amounts that must be provided by insurers under six prescribed classes of business. The cover required is set out in the Contracts Act Regulations. The prescribed classes are:

- private motor vehicle
- home buildings
- home contents
- sickness and accident
- consumer credit
- travel.

An insurer can give less than the standard cover, but under section 35 it must inform the insured in writing of any variations before the contract is entered into. Failure to provide this information means that standard cover prevails for claims purposes.

An insurer can comply with section 35 by providing the insured with a copy of the policy document.

Non-prescribed contracts

For classes of business other than the prescribed classes, an insurer must clearly inform the insured in writing, before the contract is entered into, of any unusual terms not normally found in such a contract. The insurer is under no obligation to clearly inform the insured where a broker is involved—it's up to the broker to provide the information.



Activity 1.7

Read section 35 of the Contracts Act in the resource booklet then consider the following case study and self help questions.

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Case study 1.5

Scenario

The claimant extended the policy, which covered his photographic equipment, while he was working in Bali between 2 July 1998 and 15 July 1998. On arrival at Denpasar airport on 15 July 1998, part of his luggage was missing. The claimant placed his surfboard and camera equipment on to a trolley which he parked at the airline luggage section counter while he located and recovered his lost luggage from an area behind the counter. When he returned to the trolley the camera equipment was missing.

A claim of \$13 000 for the stolen equipment was denied by the insurer on the ground that the claimant had left the equipment unattended when the theft occurred.

Issues in dispute

Whether the claimant had left his photographic equipment unattended at the time of the theft.

Insurer's position

The claimant's camera equipment was left unattended on a trolley in the airport while he was collecting lost luggage. The policy does not cover equipment left unattended.

The broker's records indicate that a policy document was sent to the claimant when the policy was taken out in 1995.

The policy documents included the following overseas extension:

When indicated on the schedule this policy is extended to provide loss or damage cover for those items listed outside the Commonwealth of Australia and New Zealand.

We will not pay, however, for loss or damage...to equipment left unattended.

Claimant's position

A key part of the claimant's position was that the insurer had failed to advise him of the terms of the cover when he extended the policy to cover overseas travel. He did not receive the policy documents until two months after the claim was lodged. Had he been aware of the conditions of cover he would have purchased a more comprehensive policy.

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Self help question 1.8

The claimant asserts that he was not informed about the nature of the variation from the standard policy. How does this affect his case under section 35? (Also see the relevant Contract Act regulations in the appendix to the resource booklet.)

A suggested answer is provided at the end of this section.

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Activity 1.8

To become familiar with the different parts of standard policies, read the standard cover provisions from the Insurance Contract Regulations in the resource booklet and then answer the following self help questions.

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Self help questions 1.9

- 1 Van Ng visited relatives in Vietnam. Monsoonal floods delayed his return by a week and he lost a week's pay.

Can Van claim the lost pay under the 'prescribed contracts' section of standard travel cover?

- 2 A drunken brawl erupted outside Sylvia's house. A large stone came through the lounge room window. It also broke a precious vase and the television.

Can Sylvia claim under the 'prescribed events' section of her standard home contents cover?

- 3 Rudy was driving home when he ran over some nails placed on the road by some children. The nails destroyed three of his tyres valued at \$600.

Can Rudy claim the cost according to the 'exclusions' section of the standard motor vehicle insurance cover?

4 Sharon's house is largely destroyed by fire. The family has to move in to a motel for a week while Sharon finds alternative accommodation.

Is this cost covered under the 'minimum amounts' section of home buildings insurance?

Suggested answers are provided at the end of this section.

• • • • •

Expiry and renewal

At common law, the insurer was not obliged to give any notice to the insured of the expiry of the policy (unless it happened to be a life insurance policy). This led to legal problems because insured persons often assumed that they were still covered and acted as if they were.

Section 58 of the Contracts Act has changed the position at common law and insurers are now obliged to notify the insured of the expiry of the contract.

Under section 58, the insurer must give the insured at least 14 days written notice of:

- the expiry date and time of the policy
- whether or not it wants to continue covering the insured.

Where the insurer has failed to notify the insured, the insurer is obliged to cover the insured until whichever is earliest of the following:

- the insurer cancels the policy
- the insured arranges cover with another insurance company
- a period equal to the original period of insurance (usually twelve months) expires.

A renewed insurance contract is, in effect, a new contract. It replaces the pre-existing or original contract but usually adopts the same terms and conditions.

The insured should disclose all material facts arising between the date of the original contract and the date of the renewal, as they could affect the insurer's willingness to accept risk.



Activity 1.9

What usually happens in your practice?

How long before the expiry date do you usually send out the renewal notice?

Do you allow a certain number of days of grace beyond the expiry date within which a renewal premium is paid to avoid having to process a 'new' insurance contract (with a gap in the cover), as distinct from a 'renewed' insurance contract (with no gap in the cover)?

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Activity 1.10

Renewal of policies has been a source of a number of complaints to the IEC. Read through section 58 of the Contracts Act in the resource booklet and then consider the following case study and self help question.

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Case study 1.6

Scenario

The claimant's motor vehicle policy expired at 4.00 p.m. on 1 March 1999. On 4 March 1999, she was involved in an accident which caused damage to her vehicle and three other vehicles. The insurer refused her claim because the policy had not been renewed and was therefore expired at the time of the accident. The damage was estimated at between \$15 000 and \$20 000.

Issues in dispute

Whether the claimant's policy was in force at the time of the accident.

Insurer's position

A renewal notice was prepared on 5 February 1999 and mailed to the claimant on 10 February 1999 to her last known address. As the payment was not received, a further notice was prepared on 5 March 1999 confirming the policy expired on 1 March 1999.

Renewal documentation clearly stated that if payment was received after the expiry date and time, then cover could only start from the date and time that the payment was received.

The claimant had been late with her renewal by fifteen days in 1996, twenty five in 1997 and six in 1998.

The policy had not been paid on time and the insurer was not prepared to backdate the cover.

Claimant's position

She had been insured with the insurer for more than ten years and had a good claims record. Her renewal notice had been sent to the wrong address—it was received by her blind neighbour. A friend of the blind neighbour dropped the notice in the claimant's letterbox after the expiry date.

She was working part-time as a cleaner and didn't have enough money to cover the repair bill.

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Self help question 1.10

What do you think the IEC would have decided in this case? Give reasons for your answer.

A suggested answer is provided at the end of this section.

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Cancellation

Insurers have limited grounds for cancelling policies. Notice of cancellation must be given in writing and takes effect at the earlier of either three business days from the time the notice is received, or when the insured arranges alternative insurance. Where a policy term requires a longer period of cancellation notice, the insurer must provide the notice within such a period.

Insurers can only cancel a policy retrospectively in cases of fraudulent non-disclosure or fraudulent misrepresentation that occurred before the contract took effect. In all other cases an insurer can only cancel prospectively.

Cancellations attempted in contravention of the Act are void and the insurer remains on risk until the insured takes alternative insurance or the insurer cancels correctly.

An insurer normally must give its reason for cancelling a policy when requested to do so in writing.



Activity 1.11

Read section 60 of the Contracts Act in the resource booklet and then answer the following questions.

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Self help question 1.11

Which of the following is *not* grounds for cancellation under the Contracts Act?

- 1 The insured failed to disclose convictions for burglary on application for home contents insurance.

- 2 The insured has made seven claims against the motor vehicle policy in nine months.
- 3 The insured made a fraudulent claim against travel insurance with another insurance company.

Suggested answers are provided at the end of this section.

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Indemnity, subrogation and contribution

Indemnity

Indemnity is a common law principle that concerns the insured's entitlements under a policy of insurance. The aim of indemnity is to return the insured to their pre-loss position.

There are four basic methods of providing an indemnity:

- cash settlement
- replacement—with goods like jewellery and fur coats, that have zero or minimal deduction for wear and tear, the insurer may be better off replacing these goods from an appropriate retailer (often at a discount).
- repair—with motor car insurance, the repair bill is often settled directly between the insurer and the motor repairer.
- reinstatement—you would usually find this in property insurance. It involves the restoration or rebuilding of buildings to their former condition.

Subrogation

The doctrine of subrogation is an aspect of indemnity. It puts the insurer 'into the shoes' of the insured, but only after the insurer has indemnified the insured for his or her loss. It does not apply to non-indemnity policies such as life insurance, personal accident and sickness insurance and disability insurance.

Through subrogation, the insurer has all the rights of the insured against a third party who may have been responsible for the damage giving rise to the claim. This doctrine also ensures that the insured cannot make a profit on the loss by also bringing an action against a negligent third party.

On receiving a proper indemnity against costs, an insured has a duty to:

- allow the insurer to use his or her name in proceedings against the third party
- give all necessary assistance to the insurer to successfully prosecute the third party.

Here's a simple case of subrogation.



Case study 1.7

Bourke's Metal is a small metal working business in Adelaide. One day a worker is burning waste in the factory incinerator when some burning paper escapes and flies across the fence into a neighbour's yard. The paper starts a fire in some rubbish next to the neighbour's house. The fire spreads and causes considerable damage to the house.

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Self help question 1.12

Using your knowledge of an insurer's subrogation rights, *very briefly* describe what steps the houseowner's insurer would probably take in this case.

A suggested answer is provided at the end of this section.

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An insurer's subrogation rights are limited. Under sections 65 and 66 of the Contracts Act, an insurer has limited subrogation rights where the third party:

- has a personal relationship with the insured that might stop the insured taking action
- uses the insured's motor car with his or her consent
- is an employee of the insured.

In these circumstances, the insurer has no rights of subrogation unless the third party has his or her own insurance to cover the liability. If the third party has the cover, the insurer can claim up to the sum insured by the third party.

If the third party doesn't have cover, the insurer would have to pay the insured's claim with no recovery action against the negligent person available to it unless there had been serious or wilful misconduct.

Contribution

Contribution refers to a situation where the insured has taken out two or more policies in relation to the same risk, and the total amount of the policies exceeds the actual loss incurred by the insured. In these circumstances, the insured has a choice between which insurer to claim from.

Where one of the insurers does not provide full indemnity, the insured can claim the balance from the other insurer(s). The insurer who has indemnified the insured, can claim contribution from the other insurer(s) so that the loss is shared equally.

However, section 76 prevents the insured from recovering more than the loss. Also common law prevents an insured from making a profit by being over-compensated.

Average

A 'subject to average' clause (or a similar clause) often appears in insurance policies. Its purpose is to make sure that the insured takes out cover for the full value of the property and that the insurer receives the correct premium for the risk. If this is not done, then the amount the insured receives in relation to a claim is reduced proportionally. In a 'subject to average' clause, the insured take responsibility for a proportion of their own risk.

The Contracts Act contains provisions in relation to the use of average clauses. Such clauses can only be enforced if the insurer has clearly informed the insured in writing, before the contract was entered into, of the nature and effect of the clause.

Homeowners have some leeway—generally, as long as they have cover for at least 80% of the property value, they can claim for 100% of the loss. If they're insured for less than 80% of the property value, the proportion of the loss that they can claim for is reduced. The formula used to work out the proportion claimable can be seen in the following case study.



Case study 1.8

Con Paxos owned a flat valued at \$160 000, but he only had it insured for \$120 000. A bad storm severely damaged the flat and caused \$80 000 worth of damage. Under the average provisions of Con's policy, the insurer would only be covered for part of the loss. The formula for calculating average is set out in the Contracts Act as follows:

Formula	In Con's case	
$\frac{\text{Loss} \times \text{Sum insured}}{80\% \text{ of value}}$	$\frac{\$80\,000 \times \$120\,000}{\$128\,000}$	= \$75 000

• • • • •



Self help question 1.13

Stella Vettori insures her \$1.5 million block of units for \$1 million. A fire in an adjoining property spreads to her units and causes \$80 000 damage. What amount will Stella be entitled to under the average provision in her policy? Use the formula in case study 1.8 above to calculate your answer.

An answer is provided at the end of this section.

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Information and disclosure requirements

The following is a summary of the notice provisions under the Contracts Act with which insurers must comply.

Notice Provision	Section
Duty of Disclosure Notice	22
Variation from prescribed cover	35
Unusual terms & conditions	37
Instalment policies:	
(a) Where a claim may not be paid for non-payment of premium	39
(b) Rights of an insurer to cancel for non-payment of premium	62
Requirement to advise insurer of circumstances that may give rise to a claim under liability contract	40
Nature and effect of the average clause	44
Notice that only the interests of named insured will be covered	49
Notice that a policy excludes cover where the insured has entered into a contract that prejudices the insurer's rights of subrogation	68(1)
Provision of a copy of the contract, where requested by the insured	74



Activity 1.12

The above sections of the Contracts Act will be important throughout your work in the insurance industry.

Go to your resource booklet and read them again so you become familiar with these requirements.

Photocopy the notice provision list and keep them as a checklist for documents you provide to your customers.

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The Agents and Brokers Act

The Agents and Brokers Act provides the key legal requirements for insurance intermediaries (although this will change under the Financial Services Reform legislation—as discussed in sections 2 and 3). Insurance intermediaries are either agents (who represent the insurer) or brokers (who usually represent the insured). Agents include employees of the insurer, and independent contractors.

In this section, we will only cover those parts of the Act that have an impact on insurers' responsibilities.

Agents

Under the Agents and Brokers Act, agents are the legal representatives of insurance companies. Their prime function is to introduce business to the company and, in some instances, assist with the collection of premiums.

Section 11 of the Act clearly makes the insurer responsible for the actions of an agent and the agent's employees, even if the agent acts outside the given authority.

The Act prescribes that intermediaries, other than brokers, are agents of the insurer in any matters relating to insurance.

Under the Act all agents must have a written agency agreement with the insurer. The insurer can take legal action against an agent for breach of the agency agreement under the usual laws of contract.

Brokers

While the agent developed from a need of the insurance company to develop new business, the broker developed from the needs of customers for professional advice on insurance.

Brokers are full-time, experienced insurance people whose business it is to know what policy protection is available in the insurance market. They help clients with issues such as the assessment of the risk, risk details, premiums applicable and terms of insurance.

They also help clients make claims, and they advise clients on ways in which they can improve the various risks such as by the implementation of safety procedures and devices.

The Agents and Brokers Act requires all brokers to be registered, and to comply with statutory requirements regarding maintenance of accounts, treatment of money received and other issues. (Agents do not have to register like this.)

The one category of broker that is different from the rest is a Lloyd's broker. It's not possible for the public to insure directly with Lloyd's—they must place their insurance through a Lloyd's broker.

A broker's liability

A broker is liable for damages if a client can show that he or she has suffered damage because of the broker's professional negligence. A broker is negligent if he or she fails to ensure that the insured complies with the duty of disclosure under section 21 of the Contracts Act.

The Agents and Brokers Act makes the insurer liable for the premium paid to the broker by a client if the broker does not pass it onto the insurer. In this case, the insurer would be liable to continue the policy. It would then seek to recover the premium from the broker who has a liability to pay the premium to the insurer. In many cases, this type of event follows a bankruptcy of the broker.

Binders

A broker is usually the customer's agent. An exception to this is where a broker operates under what is known as a binder agreement with an insurer. A binder agreement is an arrangement whereby the insurer gives authority to a broker to enter into contracts and settle claims on the insurer's behalf.

When a broker is acting under a binder agreement, the Act requires the broker to declare this arrangement to the customer before the customer enters into the contract and before the broker starts to deal with the claim.

Using the information above, consider the following case study and self help questions.



Case study 1.9

Adam Cheung used a broker to help him find the best available home and contents policy. Six months after taking out the policy, his home was burgled and Adam lost \$3000 worth of electrical equipment.

The insurance company rejected Adam's claim because he had failed to disclose previous burglaries.

Adam sued his broker on the grounds that the broker had not informed him of his duty of disclosure.

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Self help question 1.14

- 1 Is Adam justified in suing his broker? Give reasons for your answer with reference to the Agents and Brokers Act.
- 2 How would the situation be different if Adam had used an agent instead of a broker?

Suggested answers are provided at the end of this section.

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Summary

Throughout this module we will be looking at the various legal requirements you will face in your work in the insurance industry. These legal requirements are based on underlying legal principles and practices and it is these key concepts that we have looked at in this first section.

Firstly, we briefly considered the different types of laws that exist in Australia—particularly focussing on the differences between contract and statute law. We then narrowed down our discussion to the particular nature of contract and statute law affecting the insurance industry.

The main emphasis in this section has been on the Insurance Contracts Act and the key concepts it contains—these are concepts that you probably deal with every day in one way or another.

In the following section we consider the broader legal framework within which you work.

Answers to self help questions

Self help question 1.1

- 1 Statute law—made by local government.
- 2 Case law.
- 3 Statute law—government authority (APRA).
- 4 Statute law—local government again.

Self help questions 1.2

- 1 The insurer's approach is incorrect. The law is not concerned with the adequacy of the consideration—merely that there is a consideration.
- 2 The contract is not valid because Yousef signed it under duress—Yousef has not given 'genuine consent'.
- 3 The contract is not valid because the cover is for an illegal purpose—speeding fines being criminal penalties.

Self help question 1.3

Outcome

In applying the elements of legal principle, good insurance practice and utmost good faith, the Panel held that the insurer was obliged to indemnify the claimant. The Panel further determined that the insurer was entitled to any premium it would have otherwise charged for the risk if it had issued the policy as requested by the claimant.

Reasons

The Panel was satisfied that the claimant intended to include his wife in the cover provided by the policy. He had included her on the application form and at a later date (before his spouse's illness was diagnosed) he followed up the matter of cover with the insurer. There was no evidence to show that the insurer acted on the several requests

for cover either to proceed with the cover or to advise the claimant that it would not provide cover.

In the Panel's opinion, in accordance with the duty of utmost good faith, the insurer was obliged to state clearly and unequivocally its response to the applicant's application, and if for some reason it didn't want to provide cover for the wife, it should clearly have said so. The Panel also found the insurer's actions or inactions, were not consistent with good insurance practice.

Self help question 1.4

Macaura could almost certainly make a successful claim under the Contracts Act.

Under section 17, he would have to convince the court that he had suffered a pecuniary or economic loss because of the loss, by his company, of the timber. He should be able to do this.

Under section 16 of the Act it is no longer necessary to have an interest at law or in equity in the property at the time the contract was entered into as it was before the Contracts Act.

Self help question 1.5

Outcome

The Panel concluded that the insurer did not clearly inform the claimant of the duty of disclosure and the insurer could not therefore exercise its rights in relation to its allegation of innocent non-disclosure. The Panel therefore determined that the insurer was to indemnify the claimant in relation to the claim as set out in the policy provisions.

Reasons

- 1 There was a lack of evidence as to whether or not the insurer informed the claimant over the phone of his duty of disclosure before entering the contract.
- 2 The appropriate 'Duty of Disclosure' statement contained on pages 10 and 11 of the insurer's policy booklet failed to *clearly* inform the insured and should be moved to a more prominent position in the booklet.

Self help question 1.6

Outcome

The Panel determined that the claimant was entitled to be indemnified under the contract. Any refund due to the claimant after cancelling his travel arrangements was to be deducted from his entitlements under the policy.

Reasons

The panel found there was little guidance concerning the extent to which a disclosed 'heart disease' condition had to be elaborated upon. The claimant had advised the insurer on the pre-existing medical conditions application form that the claimant suffered from heart disease. It was open to the insurer to seek further information concerning the specific nature of the condition and the insurer failed to do so.

The claimant stated that he understood that it was not necessary to repeat details of his heart condition later in the document. The Panel was satisfied that a reasonable person would have understood the questions to have the meaning that the claimant stated that he understood it to have. Therefore the claimant was entitled to the protection provided by section 23 of the Act.

Self help question 1.7

- 1 True. An insured may well answer the question as best as possible, but the question is not specific enough and the insurer can't hold the consumer for non-disclosure if particular information is missing.
- 2 False. The duty of disclosure also applies when a contract is renewed, extended or varied. There is also generally a contractual requirement that the insured disclose any increase to the insured risk.
- 3 False. This is information that an insurer should know in the course of its business—section 21(2).
- 4 True. Only fraudulent misrepresentation makes a contract voidable.

Self help question 1.8

The claimant is aiming to avoid the policy restriction included in the 'overseas extension' to the policy.

Under section 35, if the policy wording provides less cover than that prescribed in the standard policy, the insurer must clearly inform the consumer in writing (before entering into the contract) of the variation. If it doesn't, the standard cover remains in force.

In this case, the standard cover includes cover for:

25(b) loss of or damage to personal belongings that occurs while the insured person is on the specified journey

Self help question 1.9

- 1 No. Van would need to get an extension on the standard policy for this cover.
- 2 No. The damage to the lounge room window would not be recoverable under the prescribed events of the standard Home Contents Insurance policy because the window forms part of the building (it could be covered by the standard Home Buildings Insurance policy).

Yes. The damage to the television and vase could be covered under either r. 14(a)(vii) which covers damage from 'riot or civil commotion' or under 14(b) which covers 'accidental damage that is breakage of glass forming part of an item of furniture (including fixed or unfixed glass table tops), at a time when it is in the residential building or on the site of the residential building.'

- 3 No. Under r. 7(d) there is an exclusion for 'the tyres of the motor vehicle being damaged by application of brakes or by road punctures, cuts or bursting'.

However, there is legal opinion that holds that because the nails were placed on the road on purpose, it could be interpreted as a malicious act which could be covered as accidental damage within the terms of Prescribed Events in r. 6.

- 4 Probably. r. 12(2)(c) includes cover for 'emergency accommodation' in the event of the loss of a home.

Self help question 1.10

Outcome

The Panel determined that because the insurer had not received instructions to renew the policy, it was not liable for the claim.

Reasons

The insurer had provided satisfactory evidence that it sent a renewal notice to the claimant on 10 February 1999 at her correct address. The claimant's history of late renewal, while not strictly relevant, provided some circumstantial evidence that the claimant might not have returned her renewal on time. The Panel was also satisfied that the insurer does not extend cover beyond the expiry date of the policy.

The insurer had therefore met its legal obligations.

Self help question 1.11

The answer is 2. The number of claims under a policy is part of the risk that insurers take on. It could be a factor considered at renewal time however.

Self help question 1.12

The insurer would need to pay the houseowner's claim and then use its right of subrogation to make a claim against the factory owner for the amount.

Self help question 1.13

Formula	In Stella's case	
$\frac{\text{Loss} \times \text{Sum insured}}{80\% \text{ of value}}$	$\frac{\$80\,000 \times \$1\,000\,000}{\$1\,200\,000}$	= \$66 667

Self help question 1.14

- 1 Adam can sue his broker. It is brokers' responsibility to inform their clients of the duty of disclosure. If the insured breach the duty of disclosure because their broker doesn't inform them of the duty, the insurer can deny the insured's claim. The insured would have to sue the broker to recover the loss.
- 2 If it had been an agent who failed to inform Adam of his duty of disclosure, Adam could still claim against the insurer. Under section 11 of the Act, the insurer is responsible for the actions (or inactions) of its agents.

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Section 2

The legal framework

Introduction

In Australia, the operations of general insurers are regulated by the legal system. Almost everything you do as an insurance operator is affected by a system of laws and their relevant regulations.

The Australian Constitution gives the Commonwealth Government power to make laws relating to insurance. Consequently, most insurance legislation is Commonwealth legislation rather than legislation from the states and territories.

After completing this section you should have a working understanding of the effect on your work of the following key Acts:

- *Insurance Act 1973* (Cth)
- *Insurance Contracts Act 1984* (Cth)
- *Insurance (Agents and Brokers) Act 1984* (Cth)
- *Australian Securities and Investments Commission Act 1989* (Cth)
- *Trade Practices Act 1974* (Cth).

Key bodies

Since 1998, two regulatory bodies have administered all but the last of these Acts.

APRA

The Australian Prudential Regulation Authority (APRA) is responsible for administering the Insurance Act. The main aim of this Act is to ensure that general insurers remain solvent and have the capacity to pay claims. Any company that wishes to transact general insurance business in Australia must apply to APRA for a licence, and meet certain criteria. Those companies or bodies granted a licence must regularly provide financial details to APRA. As a result, APRA has a very detailed knowledge of insurance companies and their operations, and it keeps this information current by the regular returns that insurers submit.

ASIC

The Australian Securities and Investments Commission (ASIC) administers:

- the Insurance Contracts Act (the Contracts Act)
- the Insurance (Agents and Brokers) Act (the Agents and Brokers Act)
- the Australian Securities and Investments Commission Act (ASIC Act)
- and the Corporations Act.

The main aim of these Acts is consumer protection.

Other bodies

Because insurers are businesses, they are also answerable to those bodies that regulate business in general—e.g. the Australian Competition and Consumer Commission (the ACCC), which administers the *Trade Practices Act 1974*, also has an important role to play in the regulation of the insurance industry.

So, what are the laws that govern your work in the insurance industry? Let's look at some of the key ones now.

The Insurance Act

In the late 1960s and early 1970s many poorly capitalised, poorly managed, specialist motor vehicle and workers' compensation insurers were formed and ultimately collapsed into insolvency. The Government moved quickly to supervise the insurance industry more actively. Their first step was the passing of the Insurance Act in 1973.

The underlying purpose of this Act is to create public confidence in the insurance industry. It aims to ensure that insurance companies will be able to meet all claims under their policies. Recent changes to the Act via the *General Insurance Reform Act 2001* (Cth), have sought to strengthen insurers' viability by toughening prudential requirements and by increasing the monitoring and enforcement of the Act.

These changes come into force at the start of July 2002. Insurers seeking authorisation after that date will need to meet the new requirements, but insurers with existing authorisation will have until July 2004 to make the transition to the new requirements. Until that transition is made, these insurers will be covered by the requirements existing before the enactment of the General Insurance Reform Act.

We'll cover both sets of requirements in this discussion.

Details of the 'old' Act

The Insurance Act oversees and regulates the operation of insurance companies to ensure they remain financially stable. The Act provides for:

- the licensing of general insurance companies
- minimum deposits of capital and tests for the solvency of insurance companies
- annual returns of financial information from insurance companies
- the requirement that companies have approved reinsurance arrangements in force
- collection of statistics on the performance of the insurance companies
- regulation and monitoring.

Requirements under the 'old' Act

The Insurance Act aims to protect policyholders by making sure that general insurance companies are able to meet all their liabilities—particularly the payment of claims. The Act does this by limiting entry to the general insurance market to companies which are able to meet the minimum financial and operational requirements.

Key effects of the Act are that:

- a company is prohibited from carrying on insurance business unless it meets the financial requirements of the Act (sections 23, 29, 30–34A)
- a company must establish and maintain sound accounting and information systems to comply with the Act (sections 40 and 44)
- a company must focus on the quality and value of assets when it prepares accounts (sections 30–33)
- APRA has the power to investigate companies whose solvency is thought to be at risk (Part V)
- when it is granted a licence, a company is obliged to comply with the Code of Practice (the Code applies to specific classes of business—as listed in section 4 of this module) (section 113).

The solvency margin

Evolving from the Act is the Solvency Margin Concept. This is a mathematical formula whereby a general insurance company's financial situation can be measured to assess its viability. The details for measuring a company's solvency margin are set out in section 29 of the Act.

In practice, working out the solvency margin is quite complex, but the essential requirement is that a company's assets must exceed its liabilities by whichever is the greatest of:

- \$2 000 000
- 20% of premium income during its preceding financial year
- 15% of outstanding claims provisions as at the end of its last financial year.

You can get a general idea of how this solvency margin works in the following case study.



Case study 2.1

Sandridge and Bay Insurance is a Melbourne-based insurance company incorporated in Australia. It has assets of \$135 000 000, liabilities of \$113 000 000, premium income of \$75 000 000 and outstanding claims provisions of \$110 000 000.

Sandridge and Bay's assets exceed its liabilities by \$22 000 000. This is clearly greater than \$2 000 000. It is greater than 20% of its premium income—20% of \$75 000,000 is \$15 000 000. It is greater than 15% of their outstanding claims—15% of \$110 000 000 is \$16 500 000. If their figures are reliable, Sandridge and Bay Insurance would pass the solvency margin test.

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Activity 2.1

Read and study the extracts from sections 23 to 62 of the Insurance Act 1973 in your resource booklet and make notes on any legal requirements that affect your day-to-day work.

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Self help question 2.1

Now answer the following questions on details of the Act to reinforce your understanding.

- 1 Stone Insurance is an insurance company incorporated in Australia. It has: assets of \$250 000 000, liabilities of \$190 000 000, premium income of \$240 000 000 and outstanding claims provisions of \$200 000 000. Does it meet the solvency requirements set out in section 29 of the Insurance Act?
- 2 What else would Stone Insurance have to do to meet APRA's requirements under section 29?
- 3 What action could APRA take if it disagreed with some of Stone's asset valuations? (section 33) Why might an insurer overvalue its assets?
- 4 Under section 44, how often does Stone need to lodge statements of its assets and liabilities?
- 5 If Stone fails to meet its solvency requirements, what sorts of action can APRA take under section 62 of the Act? (Just find three.)

Suggested answers are provided at the end of this section.

• • • • •

General Insurance Reform Act

The General Insurance Reform Act amends the Insurance Act to bring insurers under a three-tier regulatory system overseen by APRA:

- on the top tier is the Insurance Act, which sets out the principles of the system
- then there are the Prudential Standards which set out more precisely what APRA requires of insurers
- the final tier includes the guidance notes which set out how to apply the Prudential Standards.

The following discussion looks at the general requirements for insurers outlined in the Act and then provides a summary of the Prudential Standards (GPS). Finally we discuss the guidelines for authorisation that insurers must follow.

(A more detailed discussion of these issues is available in the General Insurance section of the APRA website at: www.apra.gov.au)

The ‘new’ Insurance Act

Under the changes to the Insurance Act:

- insurers will have to use a risk-based method to show they have the capital necessary to keep operating. They will need to have systems in place to identify, manage and monitor the particular risks associated with their business. These standards will also apply to insurers’ subsidiaries.
- APRA will have the power to make, vary and revoke prudential standards—this makes the requirements easier to adapt to changing circumstances.
- non-operating holding companies (i.e. companies that have as their business the ownership or control of other companies) that have insurers as subsidiaries will also have to get a licence and meet APRA’s conditions. Such controls aim to ensure that insurers’ solvency is not compromised by other such companies’ financial management.
- if an insurer’s senior management and board can’t satisfy APRA that they’re ‘fit and proper’ to manage the business, APRA can remove them. This also applies to non-operating holding companies and subsidiaries.
- insurers have to appoint APRA-approved actuaries and auditors from whom APRA will be able to request information directly.

The Prudential Standards

At the time of writing, APRA has published seven General Insurance Prudential Standards.

GPS 110—Capital adequacy for general insurers

This sets out how to calculate an insurer’s minimum capital requirements based on an assessment of the company’s insurance risk, investment risk and concentration risk.

GPS 120—Assets in Australia for general insurers

Under section 28 of the ‘new’ Insurance Act (and GPS 110), insurers must hold enough assets in Australia to cover their Australian liabilities. The Act sets out a number of assets and liabilities that are to be treated as being ‘in Australia’ (see section 116A) and GPS 120 sets out additional requirements.

GPS 210—Liability valuation for general insurers

GPS 210 sets out principles by which insurers’ actuaries can value the insurers’ liabilities in a realistic and consistent way. Generally, the valuation of insurers’ liabilities will be made up of:

- an estimate of outstanding claims liabilities
- an estimate of premium liabilities (future claims payments arising from future events under existing policies), and
- an allowance (a risk margin) made for variation from the estimates.

GPS 220—Risk management for general insurers

GPS 220 introduces a new regime to ensure insurers are well managed, have access to appropriate independent expertise and have a system for identifying, managing and monitoring risks that may reduce the ability of the insurer to meet its obligations to policyholders. Detailed requirements for this standard are in the Guidance Notes.

GPS 230—Reinsurance arrangements for general insurers

This standard establishes a new regime to ensure that an insurer has in place prudent reinsurance arrangements. The insurer’s board and senior management must develop, implement and maintain a Reinsurance Management Strategy to ensure that the insurer can meet its obligations.

GPS 410—Transfer and amalgamation of insurance business for general insurers

GPS 410 sets out specific requirements in relation to the transfer or amalgamation of a general insurer’s insurance business. The requirements are designed to ensure that people affected by the transfer or amalgamation are given accurate information about it and provided with the opportunity to obtain more detailed information if they want it.

GPS 900—Early approvals of auditors and actuaries

This is a transitional prudential standard. It aims to facilitate a smooth administrative transfer to the regime under the new Insurance Act. To facilitate the approval process this Standard specifies eligibility, fitness and propriety criteria for the positions of Approved Auditor and Approved Actuary of a general insurer.

Authorisation of general insurers

APRA has also issued guidelines for the authorisation of general insurers—the guidelines summarise the requirements under the prudential standards. They set down the minimum criteria to be addressed by applicants.

To become authorised, insurers must at least:

- maintain a minimum capital requirement of \$5 million (up from the ‘old’ minimum requirement of \$2 million), but it could be more, depending on the size and complexity of the business operations
- appoint an APRA-approved auditor and actuary

- ensure their directors and general officers are eligible and ‘fit and proper’ to hold their positions
- establish a Board Audit Committee
- get APRA approval for their business plan and financial projections, and
- satisfy APRA that they have viable risk management and reinsurance strategies in place.



Activity 2.2

If you haven't done so already, visit APRA's site at: www.apra.gov.au and browse through the general insurance information.



The Insurance Act deals only with financial matters which affect a company's financial stability. However, other legislation deals with the relationship between insurers and their clients to ensure insurers treat clients fairly. The first of these Acts is the Contracts Act.

The Contracts Act

As you've already seen in section 1 'Insurance basics', the Contracts Act sets standards for the fair operation of insurance contracts in Australia.

Its basic purpose is to ensure:

that a fair and reasonable balance is struck between the interests of insurers, insureds and other members of the public and so that provisions included in such contracts, and the practices of insurers in relation to such contracts, operate fairly, and for related purposes.

Communication

The Contracts Act aims to increase communication between the insurer and the consumer. It achieves this by imposing on both insurers and insured three main requirements:

- the duty of utmost good faith—where each party must act honourably towards the other (sections 13 and 14)
- the duty of disclosure—whereby the insured must give the insurer all relevant information which might affect the contract (sections 21, 21A and 22)
- the standard cover provisions which set out standard policy wording and coverage—these provisions are a ‘safety net’ of minimum requirements for certain insurance covers. Insurance companies must clearly inform consumers if less cover is provided (sections 34 and 35).

You have examined these three concepts earlier in this module when we covered basic insurance principles. You might find it useful to revisit this earlier section now to reinforce your understanding of them. To help you with this, read the following case studies and answer the questions that follow.



Case study 2.2

(See sections 13 and 14 of the Contracts Act in the resource booklet)

An insured was unable to work because of an abscess on his back. Over a two-month period, he made 22 visits to his medical clinic for dressings—this was necessary because there was a delay in his admission to hospital for an operation. After he eventually had the operation, the insurer denied his claim on a consumer credit policy because he had not been confined to his house (as required by the policy). According to the insurer, the fact that the insured was able to visit his doctor meant that he was not confined to his house.

• • • • •



Self help question 2.2

- 1 Do you think this represents a breach of the duty of utmost good faith?
- 2 What grounds do you have for your decision?

Answers are provided at the end of this section.

• • • • •



Case study 2.3

(See section 21 of the Contracts Act in the resource booklet.)

John submitted a proposal form to an insurer for motor insurance. He left the 'past accidents' question blank. The cover was accepted. Some time later John had an accident and claimed on the policy. When completing the claims form he revealed that he had been in six accidents over the past year. Had the insurance company been aware of this when the cover was proposed it would have declined the cover.

• • • • •



Self help question 2.3

- 1 Can the insurer deny the claim because of John's non-disclosure?
- 2 What particular points from the Act support your response?

Suggested answers are provided at the end of this section.

• • • • •

Enforcing the Contracts Act

As you saw earlier, the Australian Securities and Investments Commission (ASIC) monitors and regulates consumer protection matters covered by the Contracts Act. ASIC has the power to:

- enforce the provisions of the Act
- intervene on behalf of the insured
- take legal action where this is in the public interest.

ASIC also promotes awareness among insurers and consumers of the rights and obligations conferred on them by the Act, and it monitors and promotes dispute resolution processes.

The Agents and Brokers Act

The Agents and Brokers Act has been repealed by Schedule 1, item 245 of the *Financial Services Reform (Consequential Provisions) Act 2001* (Cth) (CP Act). The repeal comes into effect from March 11, 2002, but there is a transition period in which many agents and brokers will still be regulated under the Agents and Brokers Act (some will come under the new Corporations Act). So, for the immediate future at least, it's useful to understand the requirements on agents and brokers under the Act.

The Agents and Brokers Act is aimed at regulating the practices of insurance intermediaries (agents and brokers) with a view to strengthening the financial stability of the industry overall. It does this by making insurers responsible for the actions of agents, and by monitoring the financial stability of brokers.

Protecting the public

The Agents and Brokers Act seeks to:

- protect consumers against the negligence or misconduct of an employee, agent or broker
- minimise losses to the insuring public because of broker default
- set standards of conduct and quality of advice offered by employees, agents and brokers.

Like the consumer protection matters covered by the Contracts Act, the Agents and Brokers Act is administered by ASIC. ASIC's responsibilities include:

- registration of brokers and foreign insurance agents
- monitoring brokers' and foreign insurance agents' solvency
- monitoring the discharge of agents' and brokers' obligations as insurance intermediaries.

The ASIC Act

The ASIC Act started life in 1989 as the *Australian Securities Commission Act 1989*, but was amended in 1998 to become the Australian Securities and Investments Commission Act (the ASIC Act). Recent legislative changes under the FSR Act amend the ASIC Act (extending those sections relating to unconscionable conduct and consumer protection from the conduct of corporations to that of any person), but its central purpose remains the same.

ASIC and consumer protection

ASIC has sole responsibility for consumer protection in relation to financial services (which includes insurance). It is responsible for:

- monitoring and promoting market integrity and consumer protection in the Australian financial system—including insurance
- regulating financial services.

ASIC also works with insurance industry bodies to provide guidance on the training requirements for insurance representatives. This guidance is provided in Frequently Asked Questions (FAQs) on their website at www.asic.gov.au or from the ASIC Infoline on 1300 300 630.

The ASIC Act and you

The ASIC Act covers sales behaviour. In business dealings, it prohibits:

- unconscionable conduct, harassment and coercion
- misleading or deceptive conduct—including false representations.

These aspects of sales behaviour are particularly important to you as an insurance representative.

Unconscionable conduct, harassment and coercion

Unconscionable conduct, harassment and coercion are prohibited by sections 12CB and 12DJ of the Act.

Unconscionable conduct means exploiting a weaker party in the course of doing business. It applies mainly to face-to-face dealings with customers. Unconscionable conduct includes behaviour which goes beyond normal hard commercial dealing and breaches the concept of good conscience.

Harassment and coercion are more extreme forms of unconscionable conduct. They include physical force or threats to try to influence someone to buy a product or service. There is clearly no place for this in insurance practice.

As an insurance employee, it's your duty to behave fairly towards the customer.

- Make sure you understand what you are trying to sell and do not gloss over any restrictive or harsh terms.
- Clearly explain the effect of the transaction and the important terms and conditions in the contract.
- Give the customer material that accurately explains the transaction.
- Advise customers to obtain independent expert advice if the transaction is complex.
- Take reasonable steps to verify that customers are capable of meeting their obligations.

Here is a case study (taken from an ASIC media release) which raises issues central to unconscionable conduct. Read the case study and then answer the questions which follow.



Case study 2.4

Issued on: Thursday 16 November 2000

ASIC OBTAINS COURT ORDERS OVER INSURANCE SELLING IN ABORIGINAL COMMUNITIES

The Australian Securities and Investments Commission today obtained consent orders in the Federal Court of Australia against a US company trading in Australia as Combined Insurance Company of Australia (Combined). The orders follow an ASIC investigation into the marketing and sale of Combined insurance policies in a number of Aboriginal communities.

The Court also noted that an enforceable undertaking from Combined had been accepted by ASIC on 13 November 2000.

'ASIC's Court action followed an investigation into allegations that inappropriate insurance policies were sold to members of remote Aboriginal communities in circumstances which were unfair and may have been misleading and deceptive,' said Peter Kell, Director of ASIC's Office of Consumer Protection.

ASIC's investigation found that agents of Combined sold accident insurance policies and sickness policies to members of at least 18 Aboriginal communities in NSW, Victoria, Western Australia, Tasmania and Queensland. The investigation focused on communities in Cumberagunja, Moama, Lake Cargelligo, Condobolin, Bourke and Werrimull.

The accident insurance policy covered policyholders for a range of injuries caused by an accident while travelling on a plane, monorail, bus, train, tram, truck, car, or travelling in an elevator. As most Aboriginal communities were located in remote or rural areas, ASIC considered that few members of the communities would have the opportunity to travel by these means.

ASIC obtained evidence in support of its claim which suggested that, when selling insurance policies to Aboriginal communities, some agents:

- failed to properly explain the insurance in their presentations to consumers
- represented that the insurance had benefits or uses it did not have

- completed policies on behalf of some consumers without their knowledge
- used unfair pressure or influence to sell the insurance, and
- completed policy forms for individuals based upon presentations about the insurance given to groups of consumers.

ASIC was concerned that some of the consumers had difficulty reading or understanding the insurance; that policies were sold for children in circumstances where the insurance did not cover them; and that some consumers may not have needed the insurance as they were already entitled to other payments, such as workers' compensation...

• • • • •



Self help question 2.4

Identify which sections and subsections of the ASIC Act ASIC could have considered in this case. Indicate to which parts of the case study the particular law would apply.

A suggested answer is provided at the end of this section.

• • • • •

Misleading or deceptive conduct

Misleading conduct includes telling lies about a product or service, omitting information, or telling only part of the truth. It's your responsibility not to do or say anything that is likely to mislead the customer. This holds true even if you don't intend to mislead—'a statement is misleading if it leads (or indeed may lead) into error an ordinary member of the public who is likely to read it'.

Notice that the measure is 'an ordinary member of the public'—so you must make sure you use plain, non-technical language in all your spoken and written communications with customers.

Guidelines for sales behaviour

Do:

- tell the truth—the whole truth
- only make realistic claims about a policy
- do your best to make sure customers understand
- speak up if you think a customer might be misled
- make sure the small print will never come as a surprise
- make sure that the customer’s overall impression always reflects the written contract
- quote only opinions that you genuinely hold at the time, and that are within your authority to give.

Do not:

- say that insurance cover has benefits it does not have
- make an untrue or misleading statement about the need for insurance cover
- do anything likely to mislead customers or the insured about what’s in the policy, or how suitable the cover is for them
- mislead customers or insured about their right to a claim.

You can breach the law by failing to say or do something as well as by saying or doing something misleading. So half-truths and non-disclosures can breach consumer protection laws too. And remember, your company is liable for any false or misleading statements or acts made on its behalf by you, its employee.

ASIC has power to take representative actions on behalf of customers of financial services in respect of misleading or deceptive conduct.



Activity 2.3

Find the guidelines for appropriate sales behaviour that your company has in place and compare them with the guidelines we provided above.

Do your company’s guidelines adequately address the ASIC Act’s requirements for sales behaviour? If not, how might they be improved?

• • • • •

Examples of false or misleading representations

- 1 A motor car insurance policy has a higher excess where the driver at the time of any accident is under 21. That information is omitted from the conversation by the insurer when the policy is sold.
- 2 An agent selling an insurance policy fails to tell customers that they will be required to pay an excess even if they are not at fault.
- 3 An insurer offers a gift for all customers to take out insurance in a certain month, but refuses to honour the offer to a third of the new customers because it ran out of gifts.
- 4 A well-known media identity says, 'This is the best value insurance policy in the market.' However, he has never read the policy and doesn't insure with the company. He has also never read any of the competitors' products.
- 5 A campaign for the sale of Home Loan Protection Insurance to small businesses includes the following statement: 'You must have Home Loan Protection Insurance to survive the bad times. It will take all your cares and worries away if you cannot work due to accident or illness.' However, the advertisement does not say that the payments are made for only 12 months. This means that there is a substantial risk that the customer will believe that the cover afforded by the policy would be indefinite. Such a belief would be wrong and the statement would therefore be misleading or deceptive.

Guidelines for representations

Representations can be written, spoken or visual, and they should follow these guidelines:

- Policy documents and promotional materials must clearly explain what is covered and the extent of the cover.
- Any unusual terms, exemptions and qualifications must be made clear to customers.
- Premiums to be paid must be clearly identified.
- The characteristics of different types of policies must be made clear to the customer.
- Any advertising that compares products or services must be accurate.
- All documents should state that the company is liable for any false or misleading statements made on its behalf by its employees or agents.



Activity 2.4

From your workplace, find a number of policy documents, advertising and promotional materials that have been prepared for customers.

Examine each of the documents in light of the guidelines above on written representations.

Did the advertising material meet the guidelines?

What additions or alterations would be necessary to meet the full list of requirements for representations under the ASIC Act?

• • • • •

More about documents

Sections of the Contracts Act also deal with your responsibilities for disclosure and obtaining information from customers. Note that sections 4 and 5—'Policy Documentation' and 'Claims Handling'—of the Code of Practice set out requirements in relation to:

- policy documentation
- proposals
- customer information brochures
- claim forms.

These requirements are designed to help insurers comply with the ASIC Act.

The Trade Practices Act

The Trade Practices Act is administered by the Australian Competition and Consumer Commission (ACCC). It encourages fair and ethical competition and efficiency in business and aims to give customers choices in price, quality and service.

The Trade Practices Act is a Commonwealth Act and essentially applies to corporations. It is 'mirrored' by a Fair Trading Act in each state and territory—for example, *Fair Trading Act 1999* (Vic) and *Fair Trading Act 1987* (NSW)—which applies to individuals.

As we discussed earlier, a number of consumer protection measures formerly contained in the Trade Practices Act, are now contained in the ASIC Act. However, there are still parts of the Act of which you, as an insurance representative, need to be aware.

The Trade Practices Act is primarily concerned with:

- the promotion, maintenance, and protection of competition
- the protection of consumers.

In relation to goods and services, it regulates arrangements or understandings between competitors that lessen competition and restrict an open market. It also protects customers in their dealings with business by prohibiting certain kinds of conduct by corporations in 'trade and commerce'.

Key parts of the Act

The main provisions of the Act that concern you as an insurer are those dealing with restrictive trade practices or anti-competitive conduct.

Part IV of the Act deals with restrictive trade practices. The main sections here are:

- 45A and 45C which deal with agreements lessening competition and with price-fixing
- 47 which deals with exclusive dealing (requiring a customer to deal with a particular company).

Price fixing and anti-competitive conduct

We can see price fixing and anti-competitive conduct in the following circumstances:

- uniform terms of trade (e.g. identical policy wordings) or pricing (e.g. price increases or premium discounts by competitors at the same time)
- the period of time during which any uniformity continues and the pattern of uniformity (e.g. year after year or whenever premiums are adjusted)
- whether there is any time lag between a price (or discount) change by one competitor and that of another
- identical price quotations in bids for underwriting
- a pattern of only quoting uncompetitive terms which may evidence an agreement not to undercut
- evidence of an opportunity to reach an understanding, e.g. business or social meetings between competitors
- standardisation of competing products
- competing underwriters agreeing on premiums to be recommended to brokers of their products
- competing underwriters agreeing to control supply or to control product or geographic market shares where such an agreement has the effect of fixing or maintaining prices
- two insurance companies agreeing to follow the price lead of another insurance company.



Case study 2.5

Joe Collins is the CEO of Brighton Insurance. He meets Robert Southey, the CEO of Austral Insurance, at a social function and they have a brief chat before moving on. Joe later overhears Robert having a long conversation with Monica Armstrong of Sunrise Insurance.

He hears them talking about the increasing difficulty of operating an insurance business in such a competitive environment and how it would be good to find some way to increase long-term financial security.

Joe thinks nothing more of it until he learns that Austral and Sunrise have recently increased their prices by the same amount and that they both offer the same premium discounts.

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Self help question 2.5

Is Robert and Monica's conduct in this case study a breach of the Trade Practices Act?

A suggested answer is provided at the end of this section.

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Exclusive dealing

Exclusive dealing was widely used in the insurance industry before the introduction of the Trade Practices Act.

A common form of the practice involved finance companies insisting that customers take out insurance with a subsidiary insurance company. Building societies would also insist that property insurance be taken out with a preferred insurer. There were numerous other situations where this occurred.

This practice is prohibited under the Trade Practices Act unless specific authorisation is obtained.

Under section 47, insurers must not:

- require that customers not deal with one of their competitors
- provide a service on the grounds that the customer will also purchase another service from a particular company or person
- require a customer to purchase insurance from a nominated insurer
- make the provision of other non-insurance services (such as finance) conditional upon the customer taking out insurance with a nominated insurer.

Some examples of exclusive dealing (third line forcing) from the insurance industry can be seen in the following case studies.



Case study 2.6

MAS Insurance is a general insurer in the Shilton group. MAS refuses to supply sickness and accident insurance unless customers also take out life insurance with another company in the group—McLaren’s Life Insurance.

• • • • •



Case study 2.7

Mary O’Connor has a car accident and she approaches her insurer, CAR Insurance, to make a claim. An employee tells Mary she must take her car to Fairweather Auto for repairs or CAR will not pay on the claim.

(This would not be exclusive dealing (third line forcing) if the ‘recommended’ repairer was the cheapest of a range of quotes. In that case, CAR could not refuse to pay the claim, but it could refuse to pay Mary any more than Fairweather Auto’s quote.)

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Activity 2.5

Read Part IV (sections 45–47) of the Trade Practices Act dealing with restrictive trade practices.

Think about trading practices in your workplace. Now answer the following questions.

- 1 Are there any activities that you think contradict the broad intention of this part of the Act?
- 2 If so, what are these practices?
- 3 Which part of the Act applies to them?
- 4 How might these practices be altered to more closely match the intention of the Act?

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Key differences between consumer Acts

Note that the ASIC Act and the Trade Practices Act are mainly relevant to conduct during the period leading up to the creation of an insurance contract (called pre-contractual conduct).

The Contracts Act is the main authority for resolving disputes once an insurance contract has been entered into.

Credit-related insurance

Each state in Australia has legislation covering credit-related insurance based on the Queensland *Consumer Credit Code*. The various legislative regimes are known as the Uniform Consumer Credit Code (UCCC). The UCCC, in general terms, regulates the provision of credit (or finance) to consumers for personal or domestic purposes. Part 8 of the UCCC particularly applies to insurance related credit.

The main source of concern for the IEC has been to do with complaints from consumers taking out consumer credit insurance. This is insurance taken out when entering a credit contract—e.g. buying a car—so that, in the event of accident, unemployment or death, the consumer can continue to pay off their debt.

Consumers regularly allege that they are told they have to take out particular insurance in order to be granted a loan.

An example of this practice can be seen in the following case study.



Case study 2.8

Anne Pang was buying a car. She arranged for a loan through the car dealer. The dealer just included the price of insurance in the loan.

When Ms Pang signed the loan application, which included her insurance premium, she was probably not even aware of the insurance.

Once the loan contract was approved, the agent completed the loan contract and the insurance proposal in the absence of Ms Pang based on

information contained in the loan application. He then got Ms Pang back in to sign both documents.

This was done in the space of a few minutes on a Friday evening when the agent had a queue of customers waiting. According to the agent, Ms Pang had the proposal and policy terms for 'one minute, if that', before signing. The agent acknowledged that in his rush, he forgot to give Ms Pang a copy of her policy terms to keep.

Ms Pang had about one minute in which to notice that insurance had been included in the deal and to read the proposal, her duty of disclosure, the policy variations from standard cover and the notice of a 'free look' period.

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While this appears an extreme example, there are constant allegations of 'forcing' and other unacceptable practices in the selling of consumer credit insurance.

Section 133 of the UCCC explicitly prevents a credit provider or supplier from requiring a consumer/debtor to take out insurance with a particular insurance company or to take out insurance with unreasonable terms. (This could also raise questions under section 47 of the Trade Practices Act.)

Other key sections of the Code concern notification requirements, limits placed on premiums and commissions and issues surrounding the termination of the credit contract.



Activity 2.6

We do not discuss these other sections in detail. To familiarise yourself with these requirements, go to the resource booklet, read the relevant sections of the UCCC and then answer the following self help questions.

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Self help question 2.6

Which section of the Uniform Consumer Credit Code has the insurance company breached in the following cases? Refer to the *Consumer Credit Code* in your resource booklet.

The company:

- 1 does not supply a copy of the insurance contract to the debtor
- 2 refuses to return the unused mortgaged property insurance premium when the debtor finishes the credit contract
- 3 rejects a debtor's insurance proposal, but doesn't inform the debtor or credit provider of the rejection.
- 4 pays a car dealer 25% commission for placing insurance business with it

Suggested answers are provided at the end of this section.

• • • • •

The FSR Act

The Act comes into force from March 2002—together with the Financial Services Reform (Consequential Provisions) Act (CP Act) which sets out the process of transition to the full implementation of the FSR Act. The FSR Act aims to bring a broad range of financial products and services under one regulator—the Australian Securities and Investments Commission (ASIC).

In general, the new regulatory system aims to:

- allow consumers to make informed choices when buying financial products and services—disclosure requirements are important here
- ensure the knowledge, skills and integrity of providers of financial products and services—providers will need to ensure ongoing training appropriate to their activities and client needs (training done more than five years ago generally needs updating)
- ensure financial markets are fair and procedures are transparent
- provide effective means of settling disputes.

The effects on the insurance industry will be very significant indeed and so we provide a much more detailed account of the changes in Section three of this module. (ASIC updates can be found on its website at www.asic.gov.au).

Other relevant Acts

There are sections in other Commonwealth, State and Territory Acts which relate to other aspects of insurance. These include:

- *Marine Insurance Act 1909* (Cth)
- workers' compensation and compulsory third party motor accident insurance legislation
- Corporations Act
- anti-discrimination laws

There could be a number of others, depending on which state or territory you work in.



Activity 2.7

Find out what laws, other than the key ones discussed in some detail above, affect your day-to-day operations. Find out what the key provisions of the Acts mean for your work activities. Make a list of your obligations under these laws and file it for ready reference.

Note: If you work outside Australia, do this activity in relation to local laws that affect insurance operators in your country, state or region.

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Summary

In this section, we have had a brief look at those aspects of insurance legislation which affect your day-to-day work. Firstly, we looked at the Insurance Act and prudential requirements for insurers.

We then discussed the requirements under the Contracts Act for insurers and insureds to act with 'utmost good faith' towards each other and to disclose information openly.

After a quick discussion of the obligations on agents and brokers under the Agents and Brokers Act, we spent some time looking at the laws governing sales behaviour. These are to be found in the ASIC Act and the Trade Practices Act.

This is by no means a complete picture of the laws that govern insurance practice—for that you will need to go to the Acts themselves and/or consult with a legal expert.

The central theme is that the onus is on insurers and their employees to act with good faith towards their clients. This is clearly a sound basis for any business to operate under.

In the following section, we consider the FSR Act and its implications for the insurance industry.

Answers to self help questions

Self help questions 2.1

Section 29(1)(b)—where the body corporate is incorporated in Australia—imposes a condition that the value of a company's assets shall at all times exceed the amount of its liabilities by not less than:

- (i) \$2 000 000; or
- (ii) 20% of its premium income during its last preceding financial year; or
- (iii) 15% of its outstanding claims provision as at the end of its last financial year;

whichever is the greatest.

1 Stone's assets exceed its liabilities by \$60 000 000. This is clearly greater than \$2 000 000. It is greater than 20% of its premium income—20% of \$240 000 000 is \$48 000 000. It is also greater than 15% of its outstanding claims—15% of \$200 000 000 is \$30 000 000. Stone Insurance would pass the solvency margin test.

2 Under section 29(1)(d), a company would normally need to have APRA approved reinsurance arrangements. Under section 29(1)(e) they would need to inform APRA of any changes to the details recorded in the registration application within 21 days of it happening.

3 Under section 33 (3), if APRA consider a valuation inaccurate, they can specify a value they think is more accurate (with the Federal Treasurer's agreement). This could be done to prevent companies overvaluing assets to give a false sense of their solvency margin.

4 Under section 44 (4), a company must provide quarterly statements of assets and liabilities—i.e.

(4) A body corporate authorized under this Act to carry on insurance business shall, within the period of 6 weeks after each 31 March, 30 June, 30 September and 31 December, lodge with APRA:

- (a) a statement of assets and liabilities on that day; and
- (b) a statement of premiums and claims in respect of insurance business carried on by it during the period of 3 months ending on that day.

There are also annual Statutory accounts to submit as determined by APRA.

- 5 APRA's powers are quite broad. It may direct a company that can't meet its liabilities or which contravenes or fails to comply with a provision of the Act to:
- (a) stop issuing policies
 - (b) stop renewing policies
 - (c) stop underwriting specified classes of business
 - (d) stop renewing specified classes of business
 - (e) not dispose of or otherwise deal with specified assets
 - (f) dispose of certain assets within a specified period
 - (g) increase its provisions for unearned incomes or claims
 - (h) make (if possible) certain reinsurance arrangements as specified by APRA
 - (i) increase its paid-up capital by calling on partly-paid capital
 - (j) limit the ability of the company to enter into any agreement for the sale or disposal of its business or restructure the company.

Self help question 2.2

- 1 The insurer has, in this case, breached the duty of 'utmost good faith'.
- 2 While the insurance company's interpretation might be literally correct, a court found that the insured was entitled to visit a doctor for treatment without breaching the conditions of the policy.

Self help question 2.3

- 1 The insurer can't deny the claim. Because the insurer did not act over the unanswered question it has waived compliance with the duty of disclosure for this question. The cover is therefore valid and the claim must be met.
- 2 Under section 21(3), it is up to the insurer to follow up on incomplete proposal forms. If it doesn't, it is assumed that the insurer accepts the risk based on the presented proposal form.

Self help question 2.4

ASIC could have considered section 12CB(2)(c) which requires that an insurer considers whether the customer understood the contract entered

into. In this particular case, it is possible that misunderstandings could have arisen because:

- English is not the customer's first language
- insurance might not be part of the community's broader cultural knowledge.

There might also be a breach of 12CB(2)(a) and (2)(d) which deal with whether there was any undue influence or pressure exerted by the insurer. We can't tell precisely from the case study, but there is certainly room for such behaviour where the bargaining positions are unequal.

A postscript to the case

The Court orders required Combined to:

- send corrective notices, approved by ASIC, to affected policyholders
- offer explanations, with the assistance of an Aboriginal facilitator, about the insurance and the proceedings to members of those communities in which insurance was sold
- offer policyholders the option of obtaining a refund of premiums
- offer policyholders the option of obtaining independent advice about the insurance policy from a financial counsellor
- impose conditions on the way in which its agents sell group insurance in Aboriginal communities, including meeting relevant standards in the Life Insurance Code of Conduct
- establish a Hotline for inquiries from policyholders (1300 300 480).

'ASIC had also accepted an enforceable undertaking from Combined, designed to protect consumers in the future,' said Mr Kell.

'Combined has agreed to implement a complaints resolution procedure to deal with any complaints from people who purchased an insurance policy as a result of a Combined presentation to an Aboriginal community.'

'Combined will review its education and training programs and its compliance programs to ensure that its representatives are fully trained and aware of their responsibilities under the law.'

'The company has also agreed to fund the preparation of educational material by ASIC to help inform Aboriginal consumers of the issues to consider when purchasing insurance,' said Mr Kell.

Self help question 2.5

The Australian Competition and Consumer Commission would need more information. It is possible that Austral and Sunrise made the changes to prices and premiums independently, but the circumstantial evidence certainly makes the changes look suspicious.

Self help questions 2.6

- 1 Section 136
- 2 Section 139
- 3 Section 137
- 4 Section 135

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Section 3

Financial Services Reform Act and Regulations

Introduction

This section will provide you with an overview of key concepts and requirements contained in the Financial Services Reform Act (FSR Act).

After completing this section, you should be able to:

- explain the rationale behind the legislation
- outline how the legislation impacts upon those who provide financial services within the general insurance industry
- explain the relationships between the FSR Act, the Contracts Act, and the General Insurance Code of Practice
- explain the licensing requirements of the legislation
- explain the disclosure requirements.

Overview of the legislation

The FSR Act adds a new chapter 7 to the *Corporations Act 2001* (Cth)*. The legislation became effective on 11 March 2002, but there are transition arrangements that enable affected persons to make the change to the new regime after that date.

* Throughout the text we refer to the operation of the legislative changes brought in by the FSR Act. While these changes are introduced by the FSR Act, they actually sit within other Acts (the Corporations Act in particular) and as they become more established it will be more accurate to refer to the particular amended Act.

The key parts of the new financial services regime are:

- the FSR Act—and, as suggested above, the Corporations Act
- the *Financial Services Reform (Consequential Provisions) Act 2001* (Cth) (the CP Act)
- Corporations Amendment Regulations 2001 (No. 4) (Regulations referred to throughout this section can be found in ‘Appendix B’ of *Learning Resource, Volume 2.*)
- ASIC Policy Statements.

The purpose of the new financial services regime can best be summarised by considering the text of s. 760A of the FSR Act, which sets out the object of the new chapter 7. It reads, in part:

The main objective of this Chapter is to promote:

- (a) confident and informed decision making by consumers of financial products and services while facilitating efficiency, flexibility and innovation in the provision of those products and services; and
- (b) fairness, honesty and professionalism by those who provide financial services;

How are these objectives achieved?

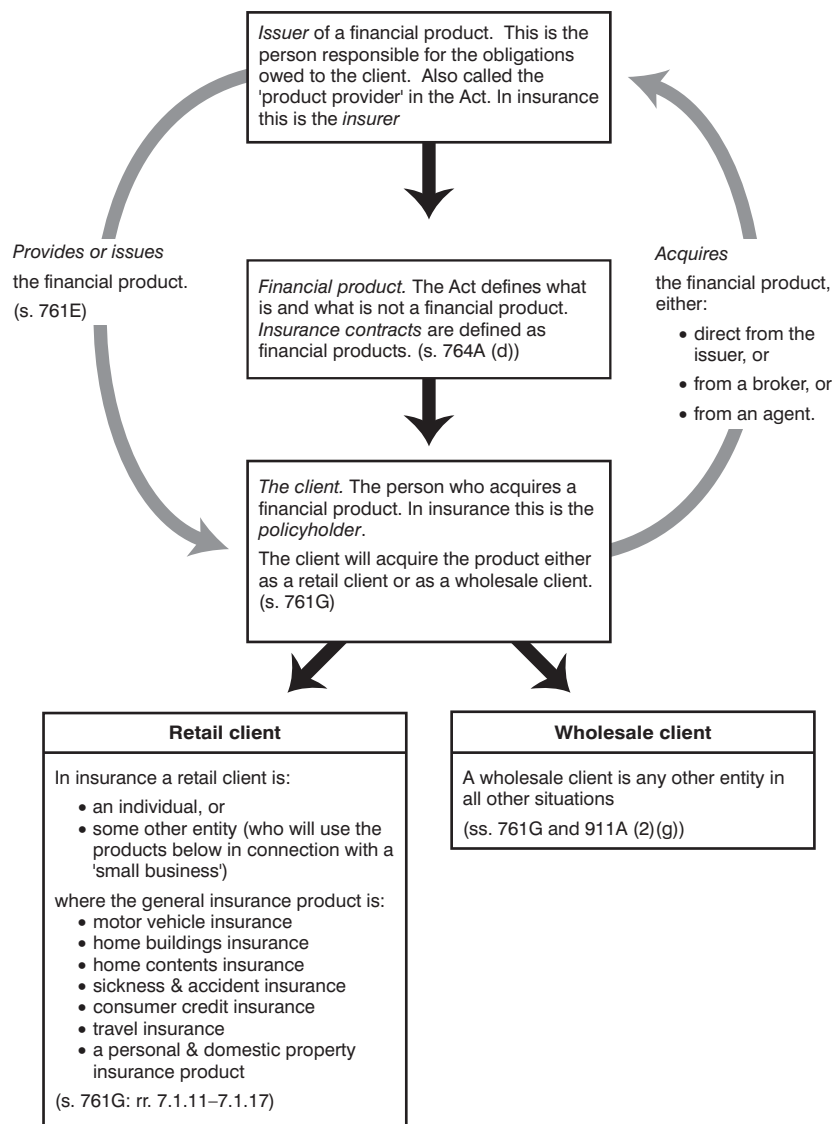
The legislation has introduced a number of important new concepts that promote consumer confidence and increase the professionalism of service providers. The concepts we will consider here are:

- the difference between ‘retail’ and ‘wholesale’ clients
- the requirement for service providers to:
 - take into account their clients’ relevant personal circumstances, or
 - warn clients if this has not been done
- product disclosure statements and other disclosures
- the requirements for licensing and authorising of service providers and the role of ASIC in these processes.

Issuing of financial products

It's important to keep in mind that the FSR Act applies to the provision of financial products and services in general. Unlike the Contracts Act or the Agents and Brokers Act, the FSR Act is not specific to the insurance industry.

The following diagram will give you an overview of the key FSR Act concepts concerning the provision of financial products.



We'll now look at the parts of this diagram in some detail. We need to consider:

- the implications of the FSR Act for the issuer of a financial product
- what a financial product is
- what it means to acquire a financial product, and
- what retail and wholesale clients are.

The issuer of a financial product

An Australian financial services (AFS) licence must be held by anyone carrying on a financial services business in Australia (s. 911A). Financial services are defined in s. 766A as including:

- providing financial product advice, or
- dealing in a financial product (which includes issuing a financial product).

The following case study provides an examples of the sorts of services we mean.



Case study 3.1

Federal Insurance Company Ltd operates in both the intermediary market and the direct market. Its call centre offers a wide range of products directly to the public. Its brokers and agents division actively promotes the distribution of insurance products through professional intermediaries.

Federal Insurance, although it is licensed by APRA under the Insurance Act 1973, also requires an AFS licence from ASIC because its employees are actively involved in:

- a) *providing financial product advice*—employees constantly make recommendations, issue reports, and give opinions and their opinions are intended to influence clients' decisions in relation to Federal's products.
- b) *dealing in financial products*—they issue insurance products as a normal function of their daily operations.

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Exemptions

Anyone engaging in activities such as those described in case study 3.1 will require an AFS licence from ASIC unless they're exempt under Division 4, ss. 766A–766C of the FSR Act—e.g. licensees' employees and authorised representatives are exempt.

What is a financial product?

The answer to this question is clearly set out in the Act. Under s. 764A(1)(d), a contract of general insurance is a financial product.

Section 765A specifies what are NOT classed as a financial products. The list includes certain types of insurance such as:

- health insurance as defined under the National Health Act 1953
- insurance provided by the Commonwealth
- State or Territory insurance
- insurance entered into by the Export Finance & Insurance Corporation
- reinsurance
- a benefit provided by an association of employees
- a contract of insurance issued by an employer to an employee
- contracts providing funeral benefit.

This is similar to the Contracts Act, which also excludes coverage of certain forms of insurance. However, there are three areas of difference:

- a) *insurance entered into by friendly societies*—the Contracts Act doesn't apply, but under the FSR Act there is no such exception and these insurances fall within the Act's definition of a financial product.
- b) *workers compensation or Compulsory Third Party (CTP) insurance*—the Contracts Act doesn't apply. Neither does the FSR Act apply where such insurance is provided by a State or Territory government scheme, but if private sector insurers underwrite these classes then the FSR Act definition of 'financial product' will apply.
- c) *contracts of insurance to which the Marine Insurance Act 1909 applies*—the only form of marine insurance the Contracts Act applies to is pleasure craft insurance (this is because this class has been excluded from the Marine Insurance Act). However, under the FSR Act all marine insurance is included in the definition of a financial product.

Acquiring a financial product

Clients acquire a financial product (e.g. a policy) from the issuer of that product. In terms of the legislation, insurance policyholders don't acquire their policies from their brokers or through an agent—intermediaries or underwriting agencies are simply the means by which issuers decide to provide their financial products. The issuer of a financial product is always responsible for the obligations owed under the terms of the product. (s. 761E(4))



Case study 3.2

XYZ Insurance Brokers have a binder with Federal Insurance Company. Federal Insurance does not issue policies to XYZ's clients because it has delegated that responsibility to XYZ under the terms of the binder. XYZ's employees regularly issue policies directly to clients.

Under the FSR Act, Federal Insurance is regarded as the *issuer* of the financial product because Federal is the entity responsible to the client for the obligations owed under the terms of the financial product (the policy).

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Renewals

Section 761E(2) of the Act states that a financial product is issued to a person 'when it is first issued, granted or otherwise made available to a person'. You must bear in mind that the FSR Act operates in partnership with the Contracts Act and that under the Contracts Act each renewal is a separate contract—therefore each renewal should be classed as the issuing of a financial product.

Retail and wholesale clients

The FSR Act distinguishes between ‘retail’ and ‘wholesale’ clients. Whilst the differences between these types of clients are straightforward, the consequences of the distinction are far-reaching. Remember that the legislation is all about confident and informed decision-making by consumers in a context of fairness, honesty and professionalism by those who provide financial services.

Retail clients

The FSR Act is clearly (but not exclusively) weighted towards protection of retail clients—this is reflected in the key consumer protection provisions that are restricted to retail clients. These provisions mainly have to do with new forms of disclosure aimed at helping clients make informed choices. For example, here is a list of what the FSR Act requires when it comes to providing products or services to retail clients:

- licensees must have a dispute resolution system in place, conforming to the Act’s requirements (s. 912A).
- licensees must have arrangements in place for compensating persons for loss or damage suffered because of breaches of the relevant obligations under chapter 7. These arrangements must comply with any relevant regulations or be approved in writing by ASIC (s. 912B). Professional indemnity insurance is an example of what is meant here, and r. 10.2.44 requires insurance brokers to maintain an acceptable contract of such insurance.
- licensees (or their representatives) must provide clients with a Financial Services Guide (FSG—see the discussion of disclosure requirements later in this section for a detailed account of the ‘FSG’) in situations where the authorising licensee has authorised its distribution (ss. 941A and 941B). There are some exemptions from this requirement—e.g. where the client has already received the information; the providing entity is the issuer dealing in its own products; the financial product advice is given in a public forum.
- licensees and their representatives can only give personal advice if the provider has:
 - determined the client’s relevant personal circumstances, and
 - made reasonable inquiries in relation to personal circumstances
 - given consideration to, and conducted an investigation of, the information obtained, and then
 - provided appropriate advice
 - warned the client if advice was based on incomplete or inaccurate information, and also warned the client to consider the appropriateness of the advice for their relevant personal circumstances (ss. 944A, 945A, 945B)

- a Statement of Advice (SoA—again, see the later discussion on disclosure requirements for more detail on the SoA) is required if the provider of advice is a licensee or an authorised representative (s. 946A)
- if general advice is provided, a warning must be given that no account has been taken of the client's objectives, financial situation or needs, hence the client must consider the appropriateness of the advice. If the advice concerns a particular product then a Product Disclosure Statement (PDS—see the later discussion of disclosure requirements for a more detailed account of the PDS) should be provided to the client (s. 949A(2))
- where any personal advice recommending a particular product is provided, a Product Disclosure Statement is required (s. 1012A)
- the client has the right, in stated circumstances, to return the product and get a full refund within 14 days under the cooling-off provisions as outlined in ss. 1019A and 1019B (unless the product is an excluded product as set out in r. 7.9.64).

It's clear that important protections are provided by the Act for retail clients. When you understand what defines a client as 'retail' then by that definition a wholesale client is any other person or entity.

To summarise, under s. 761G(5), a retail client is either:

- an individual who seeks to acquire specified personal classes of insurance, or
- an entity such as a company, a business, or a partnership, that seeks to acquire specified personal classes of insurances for use in connection with a small business—small business is defined in s. 761G(12) as a business employing fewer than 100 people (if the business includes the manufacturing of goods) or 20 people in all other cases.

Types of 'retail' insurance

Note that regardless of whether the client is an individual or otherwise, it's the type of insurance concerned that's important. In order for the client to be classed as a retail client, the insurance must be one of the personal classes listed in the legislation. The FSR Act does not use the term 'prescribed contract' (as used in the Contracts Act) when referring to these specified personal lines classes.

Section 761G(5) lists the types of general insurance products that affect whether or not someone is regarded as a retail client (and rr. 7.1.11–7.1.16 provide more detailed explanations of the covers under each of these products). The specified classes of business are:

- motor vehicle insurance
- home buildings insurance
- home contents insurance
- sickness and accident insurance
- consumer credit insurance
- travel insurance
- personal and domestic property insurance. This refers to property wholly or predominantly used for personal, domestic or household purposes. Property includes such things as moveables, valuables, caravans, mobile homes, trailers, marine pleasure craft, horses, pets mobile phones. This is a slightly broader list than that set out in the General Insurance Code of Practice.

Consumer or retail client?

The FSR Act is broader than both the General Insurance Code of Practice and the Contracts Act when it comes to:

- the clients identified for protection, and
- the scope of insurance contracts to which protection attaches.

The General Insurance Code of Practice defines a ‘consumer’ as an individual who enters into an insurance contract wholly or exclusively for that consumer’s private or domestic use. The FSR Act is somewhat broader in its application than the Code in two ways:

- the Code only applies when the insured (consumer) is a private individual purchasing insurance in a non-business setting
- the Code applies to the six main prescribed classes as defined under s. 34 of the Contracts Act, and in the Act’s regulations.

You’ll note that the FSR Act doesn’t use the term ‘consumer’ but uses a broader term—‘retail client’. As we stated previously, the General Insurance Code of Practice’s more restrictive term consumer refers to a private individual purchasing insurance in a non-business or non-trade setting.

However, the FSR Act’s broader retail client definition does embrace some small-business insurance. This means that the definition of what has traditionally been understood by prescribed contract must be broadened to include some business usage.

The following table will show you how the specified classes of personal lines insurance under the FSR Act are broader than the classes of insurance known as the prescribed contracts under the Contracts Act and the Code.

	Prescribed contracts provisions under the Contracts Act	Retail client insurance products under the FSR Act
Generally	The regulations for each prescribed contract stipulate that the insured (or one of the insured) must be a natural person—similar to the Code’s definition of ‘consumer’.	The insured can be an individual or some other entity—e.g. a company, a trust, a partnership, or registered business entity.
Motor vehicle insurance	Insured must be a natural person—so restricted business usage is contemplated e.g. sole trader	Insured can be a company, partnership, etc—so a broader business usage is permitted.
Home buildings insurance	Insurance Contracts Regulation 2(1) excludes a building let or rented as a business and which is not the principal residence of the insured.	Corporations Regulation 7.1.12 does not exclude let or rented buildings—nor does it require the insured to use the home building as the principal residence.



Activity 3.1

For this activity you will need access to both the Insurance Contracts Regulations (you can find relevant regulations in 'Appendix A' of *Learning Resource, Volume 2*) and the new Corporations Amendment Regulations 2001 (No. 4) (relevant regulations are in 'Appendix B' of *Learning Resource, Volume 2*).

Select a prescribed contract to use in this activity and then refer to r. 2 in the Contracts Regulations in the learning resource. Note the contents of the definition contained in r. 2, if any, that relate to your selected prescribed contract.

Next, find and read the appropriate regulation (r. 5ff) that relates to your selected prescribed contract.

Now refer to Division 2 of the new Corporations Amendment Regulations 2001. Find the appropriate regulation that relates to your prescribed contract, (rr. 7.1.11 ff.).

Write down the ways in which the FSR legislation has broadened the application of your selected prescribed contract. Note how trade or business usage of the prescribed contract has been provided for under the FSR legislation.

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Self help question 3.1

- 1 Which of the following is correct? The main purpose of the Financial Services Reform Act is to promote:
 - a) financial stability of providers of financial services through increased professionalism and reduced levels of consumer complaints.
 - b) confident and informed decision-making by consumers and to reduce the level of consumer complaints.
 - c) confident and informed decision-making by consumers and fairness, honesty and professionalism by those who provide financial services.

- 2 For purposes of the Act, the one who physically issues a policy is deemed to be the issuer of the financial product. True/False?
- 3 The essential difference between a retail client and wholesale client is the manner in which the product was obtained, e.g. direct from an insurer or through an intermediary. True/False?
- 4 Insurers do not require an Australian financial services licence because they are already licensed by APRA (under the Insurance Act 1973). True/False?
- 5 The FSR Act lists certain types of personal lines classes as 'prescribed contracts' in much the same way as they are defined under the Contracts Act. True/False?
- 6 The FSR Act has, in effect, a broader definition of consumer than is found under the General Insurance Code of Practice. True/False?
- 7 The FSR Act applies to a broader range of insurances than the Contracts Act. True/False?

Suggested answers are provided at the end of this section.

• • • • •

Wholesale clients

A wholesale client is any person or entity other than a retail client who acquires a financial product or service. You have seen that the FSR Act is weighted towards the retail client because the key disclosure requirements only apply to retail clients.

Let's now consider how the legislation offers protection to wholesale clients. The following case study provides a start to our discussion.



Case study 3.3

Deep Sea Cruises Pty Ltd operates three cruise and charter boats around the Great Barrier Reef. It employs 18 staff and tourism is its principal business activity and source of income.

It has acquired commercial marine hull insurance on its boats.

Deep Sea Cruises is a small business pursuant to s. 761G(12) of the FSR Act, because it employs fewer than 20 people. However, in order to be classed as a retail client, Deep Sea Cruises must:

- a) acquire a marine pleasure craft policy on property that is wholly or predominantly used for personal, domestic or household purposes, and
- b) use that policy in connection with its small business.

Clearly Deep Sea Cruises cannot meet this definition. It is, therefore, a wholesale client for purposes of the legislation. But Deep Sea Cruises also currently falls outside of the ambit of:

- the Contracts Act—the commercial marine hull policies it acquired are covered by the Marine Insurance Act, and hence excluded from the Contracts Act
- the General Insurance Code of Practice—the Code defines ‘consumer’ as an individual, and the class of business concerned is also outside the Code.

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So how can the FSR Act promote confident and informed decision-making by wholesale clients such as Deep Sea Cruises?

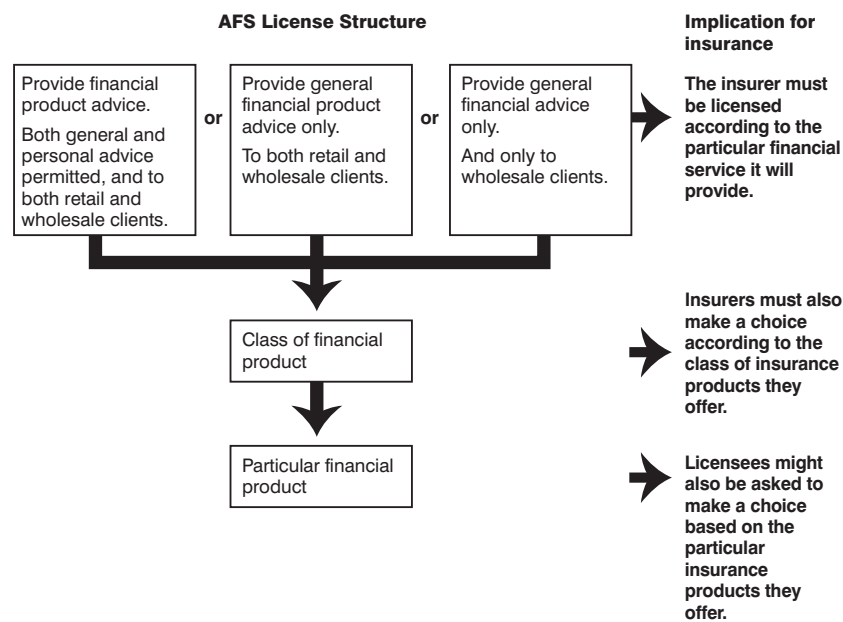
One of the ways in which the FSR Act affects wholesale clients is in the important area of licensing and authorisation of service providers. It’s important to note that the licensing and authorisation requirements apply fully to the provision of financial products or services to both retail and wholesale clients. For example, the broker or underwriting agency that may have been involved in the provision of financial products or advice to Deep Sea Cruises would have to be either:

- a licensee, or
- the representative of a licensee, (e.g. employee, director) or
- an authorised representative of a licensee.

Licence authorisations

There are a number of choices that applicants need to make when applying for a licence. These choices depend on what type of advice the applicant intends to provide.

The authorisations are split into three levels and it's necessary for applicants to be clear about what kinds of licence they require.



Licensees can only provide those services that are covered by their licences. Representatives can only provide financial services that are delegated to them by their licensee. There can only be a delegation of those services if the delegated services are covered by the licensee's licence.

Both wholesale and retail clients benefit from the regimented environment created under the FSR legislation. The focus is on:

- appropriate delegation of authority
- control of such delegation, and
- the promotion of fairness, honesty and professionalism by those who provide financial services.

Let's check your understanding of the distinction between retail and wholesale clients by reading the following case study and completing the accompanying self help question.



Case study 3.4

Carter and Bellows Pty Ltd make a range of wrought iron security grills and doors. The company employs forty seven staff in its Charters Towers plant. A broker has arranged the following policies to cover the assets and liabilities of the business:

- an ISR policy to cover the buildings, plant equipment and business interruption
- a broadform liability policy
- sickness and accident insurance for the directors
- travel insurance for the directors and service representatives
- motor vehicle insurance for the fleet of sedans and four goods carrying vehicles
- a householders insurance policy to cover two tenanted dwellings adjacent to the property (these properties were acquired for future expansion of the factory).

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Self help question 3.2

- 1 Is Carter and Bellows Pty Ltd a 'small business' within the FSR Act definition?
- 2 Classify Carter and Bellows Pty Ltd as either a retail client or a wholesale client for purposes of each of the policies it has acquired.

Suggested answers are provided at the end of this section.

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So far we have considered:

- the main objects of the legislation, which are the promotion of confident decision-making by consumers and fairness, honesty and professionalism by those who provide financial services
- the distinctions between retail and wholesale client, so far as general insurance is concerned
- the specific disclosure and consumer protection provisions that accrue to retail clients
- how the legislation offers protection to wholesale clients.

Now we will consider some of the ways in which the legislation promotes confident decision-making by consumers and increased professionalism of service providers. It does this via the licensing and authorisation mechanisms, and through the disclosure requirements.

Licensing and authorising of service providers

As mentioned earlier, s. 911A of the FSR Act requires all persons who carry on a financial services business to hold an AFS licence covering the services provided. Let's now spend some time considering in more depth what it means to provide financial services.

Section 766A of the Act is headed 'When does a person provide a financial service?' This is an important question. Financial service is provided if you:

- a) *provide financial product advice*—and this is defined in s. 766B as a recommendation, a statement of opinion, or a report that is intended to influence (or that someone would reasonably think is intended to influence) a person in making a decision about financial products.
- b) *deal in a financial product*—and this is defined in s. 766C (in part) as issuing, varying or disposing of a financial product.

The Act distinguishes between two different types of product advice (s. 766B):

- a) *personal advice*—this is financial advice that a provider gives a client (or that a reasonable person might expect the provider to give) in response to one or more of the client's particular financial objectives, circumstances or needs (this includes advice given electronically).

- b) *general advice*—this is simply financial product advice that is not personal advice, e.g. information contained in a brochure, or newspaper advertisement. (Section 911A sets out the *limited* circumstances under which it is possible to give general advice and not require a licence to do so.)

In simple terms, no one can provide financial product advice unless they are:

- the holder of an AFS licence covering the service provided, or
- a director or employee of a person who is licensed, or
- an authorised representative of a person who is licensed, or
- some other person acting on the licensee’s behalf.

This is true regardless of whether you are providing products or services to a retail or wholesale client. There is a narrow exemption however—no licence is necessary if:

- the person providing advice is regulated by APRA, and
- the service provided is one in relation to which APRA has regulatory or supervisory responsibility, and
- the service is provided to a wholesale client. (s. 911A(2)(g))

While the difference between personal and general advice appears to be clear-cut, in practice it’s a grey area. Probably the safest course of action is to take the view that any individual product or class-specific advice to clients is personal advice.



Case study 3.5

Jenny Chan, call centre advisor for Federal Insurance Co., receives a phone call from Julie Brown. Julie is calling about her home insurance policy, which is due shortly. She wants a quote from Federal. She has a 145 square metre, brick home in a metropolitan area.

Jenny advises Julie to consider a replacement sum insured of \$130 000—Jenny arrived at this figure from computer generated calculations that suggest a sum insured based on size, construction and postcode.

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Self help question 3.3

Has Jenny provided financial product advice within the meaning of the FSR legislation?

A suggested answer is provided at the end of this section.

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Case study 3.6

John Chanter writes a regular column in the local newspaper dealing with general insurance matters. John retired after 35 years in the insurance industry and he is well regarded in his community. Readers write to John with their concerns and questions and he answers all letters as best he can. John publishes abridged details of the best letters he receives each month, along with his answers. John is paid a retainer by the newspaper for his journalistic services.

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Self help question 3.4

- 1 Is John carrying on a financial services business within the meaning of the FSR legislation?
- 2 Does John require an AFS licence?

Suggested answers are provided at the end of this section.

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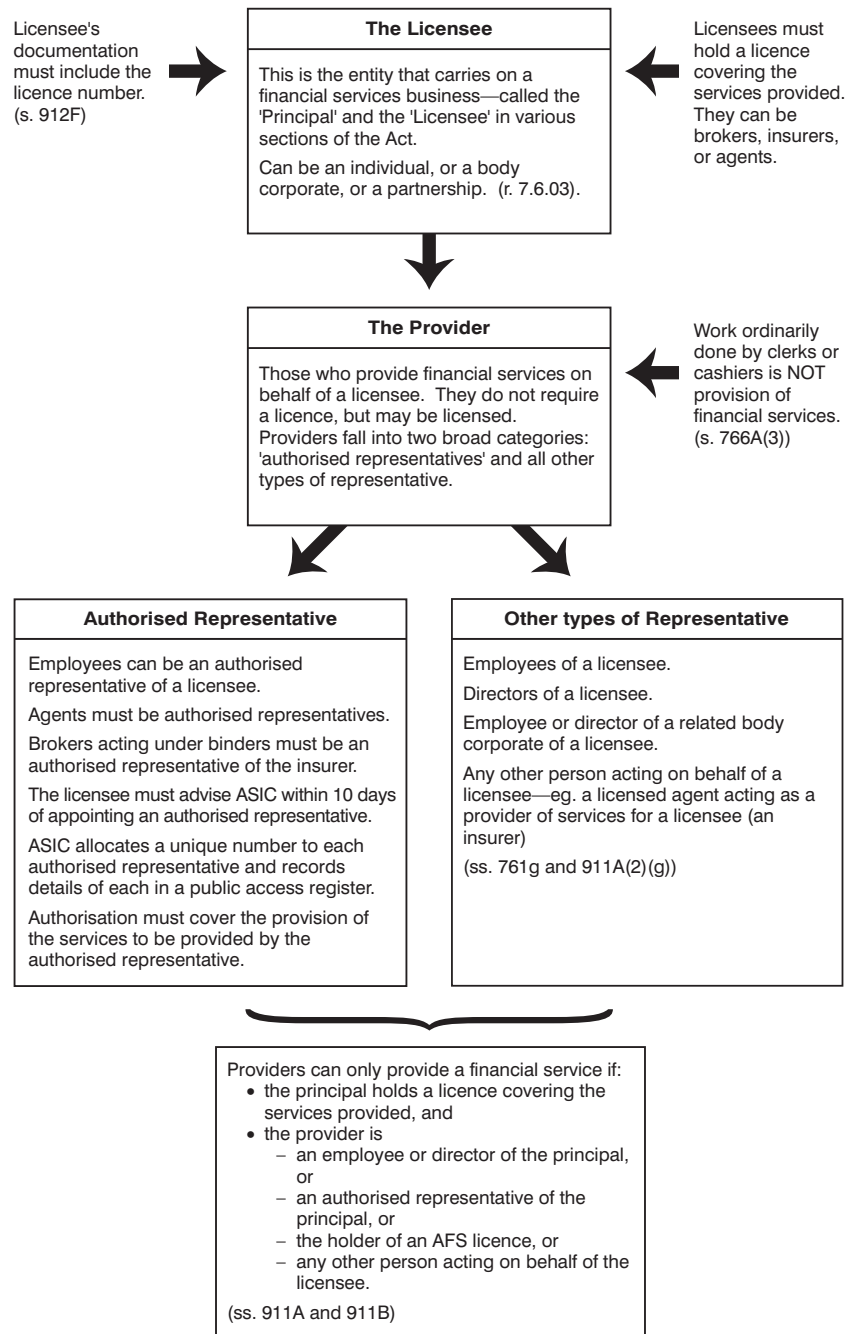
In summary, you have seen that:

- if you provide advice intended to influence a client, or that could reasonably be regarded as being intended to influence a client, then you have provided financial product advice
- the Act makes a distinction between personal advice and general advice. Personal advice is advice given in circumstances where one or more of the client's objectives, financial situation and needs have been considered by the person providing advice
- no-one can give personal advice unless they are:
 - the holder of an AFS licence, or
 - a director or employee of a licensee, or
 - an authorised representative of a licensee.

The following are important points to remember:

- Not every representative who provides a financial service has to be an authorised representative—you can be an employee of an AFS licensee.
- Not every person who provides a financial service has to have a licence—you can be an employee or an authorised representative of a licensee such as an insurer or a broker.
- As a rule, under s. 916D of the Act, a licensee can't be the authorised representative of another licensee. However, s. 916E allows an insurer (a licensee) to enter into a binder with a broker (another licensee) in contravention of the general rule.
- Those who provide insurers with claims handling and/or settling services (e.g. assessors, investigators) don't need a licence. (r. 7.6.01(1)(j) and s. 911A(2)(k)).

The table below provides a framework for understanding the key licensing provisions of the FSR Act.



We'll now consider the key implications of FSR legislation for the main players in the above diagram: licensees and intermediaries.

Obligations of licensees

Section 912A and Part 7.6 of the Regulations set out the obligations of licensees. In brief, a licensee must:

- do all things necessary to ensure that financial services covered by the licence are provided efficiently, honestly and fairly
- comply with the licence conditions and financial laws
- take reasonable steps to ensure its representatives comply with financial services laws
- maintain competence to provide financial services
- ensure its representatives are adequately trained and competent to provide services
- have a complying disputes resolution system in place for retail clients
- maintain a record of training that each representative has undertaken, including training undertaken before the representative became a representative of the licensee (r. 7.6.04)
- take reasonable steps to ensure its authorised representatives supply a copy of their authorisation on request by any person within 10 days. (r. 7.6.04).

Some of these issues are also covered in the Code of Practice, but because they appear in the FSR legislation there is legislative 'clout' attached.

If licensees fail to meet their obligations, ASIC has powers under the banning or disqualification provisions of Part 7.6, Division 8 of the FSR Act to prohibit them from providing any financial services or specified financial services in specified circumstances or capacities.

Implications for intermediaries

Brokers

Brokers are already subject to licensing requirements under the Agents and Brokers Act. Under the new FSR regime, brokers will need to become AFS licensees and their licence under the Agents and Brokers Act will terminate.

An AFS licensee can authorise its own representatives and will be responsible for their conduct. As discussed previously, a licensee generally can't be the authorised representative of another licensee (s. 916D), but there is an exception under s. 916E for brokers (who will generally be licensees themselves) acting under a binder to an insurer.

There are three main consequences of brokers becoming an insurer's authorised representatives:

- 1 they must only provide financial services covered by the terms of their authorisation from the licensee and, as with any other authorised representative:
 - people have the right to ask to see a copy of their formal authorisation, and
 - ASIC obtains their details.
- 2 they act on behalf of the insurer and not the insured
- 3 the licensee remains liable for what the broker does, even where the broker acts outside the scope of the binder.

Agents

Agents derive their authorisations under written agreements issued by insurers in accordance with s. 10 of the Agents and Brokers Act. However, Schedule 1, item 245 of the Financial Services Reform (Consequential Provisions) Act (the CP Act) has repealed the Agents and Brokers Act.

Under the CP Act, agents have several choices for authorisation leading up to March 2004 when everyone must comply with the new regulatory regime:

- they can continue to operate under the Agents and Brokers Act on behalf of one or more of their principals until the end of the transition period—after which they can become an authorised representative of one or more principals, or
- during the transition period they can lodge an opt-in notice with ASIC in respect to one or more of their authorising agreements with insurers under the Agents and Brokers Act and become an authorised representative of a licensee under the new regime, or
- they can apply for a standard AFS licence under the new regulatory regime, or
- multi-agents can apply for a qualified AFS licence.

Agents as authorised representatives

Insurance agents will most commonly provide advice as authorised representatives of the licensees (insurers) they represent (where it might be just as common for staff involved in providing advice within a broking firm to do so as employees).

If an agency is set up as an incorporated body, e.g. Harry & Son Insurance Agency Pty Ltd, then the employees of the agency can't be the authorised representatives of the agency because of s. 916B(1). All agency staff who provide financial services must become authorised representatives of a licensee (an insurer). Section 916B(3) provides that where an agent is an incorporated body, and where the agency has the express written approval of the licensee, the agency can provide written authorisation to its employees to provide financial services on behalf of the licensee. Such authorised employees become authorised representatives of the licensee.

Section 916C provides that an agent can be the authorised representative of more than one licensee, but only if each of those licensees has consented.

Licensees must notify ASIC of the following details of all authorised representatives within 10 business days of the person being authorised:

- the representatives name and business address
- details of the authorisation—including the date on which it was made and what the representative is authorised to do on behalf of the licensee
- details of any other licensee the representative is authorised to represent. (s. 916F)

Section 916G provides that ASIC may give a licensee information (which it might reasonably believe to be true) about any representative that ASIC believes is, or will be, a representative of the licensee. The Act, therefore, contemplates an active surveillance approach by ASIC to help the licensee make decisions about authorising representatives.

Note also that:

- licensees and representatives are required to provide assistance to ASIC in response to all reasonable requests for information relating to compliance with financial services laws (s. 912E)
- it's a condition of a licensee's licence that the licensee must take reasonable steps to ensure that their authorised representatives (on request and free of charge) supply a copy of their authorisation to whoever requests it (r. 7.6.04(h)).
- licensees are liable for the actions of their authorised representatives (and any other of their representatives) whether or not the representative's conduct was within their authority (ss. 917A and 917B).

ASIC's role is clearly central in the operation of the new legislation. Other significant ASIC roles with regard to authorised representatives for you to remember are that ASIC:

- maintains a public access register of all authorised representatives—details of which are set out in r. 7.6.05
- allocates a number to each authorised representative (r. 7.6.05)—it's not clear whether ASIC expects this number to appear on client documentation as is the case with the licensee's number
- requires licensees to maintain a record of training each representative has undertaken (r. 7.6.04(d))
- requires a licensee to make reasonable inquiry to satisfy itself as to the representative's identity and whether the representative has already been allocated a number by ASIC (r. 7.6.04(e)).

Agents as licensees

Certain agents may wish to obtain a licence and the legislation provides for this. A person (called the provider) can provide financial services on behalf of a person who carries on a financial services business (an insurer) in situations where the provider holds their own AFS licence (s. 911B(1)(d)).

A licensed agent would use his or her licence as a means of providing financial services on behalf of an insurer, but not in the capacity of an authorised representative of the insurer, provided of course that the insurer's licence covered the services to be provided.

Why would an agent want to be a licensee?

Underwriting agencies, and managing agents could want to become licensees to better satisfy their business objectives under the new regime. As an AFS licensee, the agent could authorise its own representatives or enter into arrangements with other representatives.

Division 6 of the FSR Act, (s. 917Aff), sets out the liability of licensees for the acts of their representatives. An insurer would remain liable for the acts of a licensed agent in much the same way as it would be for one of its authorised representatives. However, a licensed agent would come under the direct supervision of ASIC.

Agents with a qualified AFS licence

During the two year transition period, multi-agents (i.e. those agents who represent more than one insurer) can apply for a qualified AFS licence. Briefly, the effect of a qualified license is that it enables an agent to become an AFS licensee without having to *initially* meet the requirements of licensees regarding competency and the requirement to ensure their representatives are adequately trained and are competent to provide financial services.

Such qualified licensees are not bound by the general obligations relating to competence and training provisions set out in s. 912A(1) of the FSR Act. This must be clearly stated in their financial services guide (FSG—see below).

Such qualified licensees must, of course, meet the full competency requirements by the end of the transition period.

Restrictions on how a business is described

Before we finish this sub-section, it's worthwhile spending a little time pointing out some restrictions that licensees need to be aware of when describing their financial services business.

Section 923A prohibits anyone from describing their financial services business as *independent*, *impartial* or *unbiased* unless they DON'T receive:

- commission
- remuneration on the basis of volume of business placed with the issuer of a product, or
- other gifts or benefits from an issuer

AND such a person operates:

- free from any direct or indirect restrictions relating to the financial product in respect of which they provide services, and
- without any conflict of interest that might arise out of an association or relationship with an issuer.

Section 923B also prohibits the use of the terms *insurance broker*, *insurance broking*, or *general insurance broker* in connection with a financial services business unless the person is authorised to use such words or expressions in their AFS licence.

Hence a broker would have to apply for authorisation to use such words when applying for a licence.



Case study 3.7

Adelaide & Melbourne Insurance Brokers Pty Ltd operate a binder with Federal Insurance Co for home and motor insurance. They place a newspaper advertisement for six consecutive days, which states in part:

Phone Adelaide & Melbourne Insurance brokers for impartial and unbiased advice before you renew your policies.

Every day the advertisement runs in the newspaper constitutes an offence under the legislation—the broker receives commission from Federal Insurance and acts under the terms of a binder arrangement. Such arrangements breach restrictions relating to the description of services offered by Adelaide & Melbourne.

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For some useful examples of the licensing provisions of the Act, read the following table.

Situation	Relevant Act references	What must I do in order to be able to provide financial services?					
		Nothing—you cannot provide financial services	Be an employee or a director of a licensee, or body corporate related to a licensee	Have my own AFS licence		Be an authorised representative of a licensee	
				Yes	No	Yes	No
I am an assessor & investigator involved in handling claims.	Reg 7.6.01(j) Sect 911A(2)(k)	✓			✓		✓
I work for a broker and handle new business under a binder.	911A(b) 911B(1) & (2) 916E				✓		✓
I work in a call centre for Federal Insurance handling personal lines. Federal has its own Licence.	911B(1)(a)		✓		✓		✓
I am a cashier with Federal Insurance Co.	766A(3)	✓			✓		✓
I manage the filing system for Jerry Fernandez Ins Brokers and do some accounts work.	766(3)	✓			✓		✓
I am an insurance surveyor. Sometimes I make recommendations directly to clients of Federal, for whom I work .	766B(1)	✓			✓		✓
I operate Triple O Ins Agency, providing a wide range of services under a binder with Federal Insurance Co.	911B(1)(b)				✓	✓	✓
I work for Jerry Fernandez Insurance Brokers handling clients.	911B(1)(a)		✓			✓	✓
I am Jerry Fernandez, owner of the firm.	911A(1)				✓		
I am an employee of Triple O Agency.	916B				✓		✓

To summarise, we have considered:

- how the new regime will affect brokers and agents
- the operation of binders under the FSR legislation
- how brokers will generally need to obtain an AFS licence
- the several licensing options available for agents (however, it has been noted that agents will generally become authorised representatives of the insurers they represent)
- the implications for agents of operating as authorised representatives.

Now we will consider the key disclosure documents introduced as part of the FSR Act.

Disclosures

The Contracts Act has greatly increased the disclosure requirements of insurers, and now the FSR Act promotes even further disclosure. The three disclosure documents prescribed by the FRS Act are:

- the Financial Services Guide
- the Statement of Advice
- the Product Disclosure statement.

Financial Services Guide (s. 941)

The providing entity (the authorised representative) has the obligation for both preparing the FSG and ensuring that it's given to all retail clients. This must only happen, however, if the licensee has authorised its distribution by the representative. Licensees have a general duty as part of their licence obligations to ensure these processes are complied with.

There are certain situations when FSG are not required, and other conditions regarding its use can be found in s. 941 of the Act.

As a general rule, the FSG must be given as soon as practicable after it becomes apparent to the providing entity (the authorised representative) that the financial service will be (or is likely to be) provided to the client (s. 941D). In any event it must be given to the client before the financial service is provided.

What's in the FSG?

There are two versions of the FSG, one for use by a licensee and one for use by an authorised representative. The FSG is to be in writing (this includes electronic form). Here is an idea of the generic contents of the FSG:

- the name and contact details of the licensee/representative (and issuer if the Guide is a representative's version)
- a statement setting out how clients can provide information to the above
- information about the services the above are authorised to provide
- information about for whom the representative acts
- information about remuneration or other benefits received as a result of providing the services—rr. 7.7.04 and 7.7.07 set out in more detail what is expected here
- information about associations or relationships with issuers
- information about the relevant dispute resolution system
- if a binder is involved, a statement is required that identifies and explains the significance of the services being provided under the binder
- a statement that describes the purpose and content of the FSG, and if appropriate, informs the client that they may also receive a Statement of Advice and/or a Product Disclosure Statement and describes the purpose and content of these documents
- the date on which the FSG was prepared.

The purpose of the FSG is to provide clients with basic information concerning the entities he or she will be dealing with, and the nature of any associations between them. Remuneration details, and other data is provided to enable a meaningful decision to be made as to whether or not the client ought to proceed with the business relationship. There is also information about how complaints are dealt with in case the business relationship fails.

Statement of Advice (ss. 946A–947C)

A provider issues this document to a retail client when providing personal advice. Remember, personal advice is financial product advice given in circumstances where the provider of that advice has considered one or more of the client’s financial objectives, circumstances or needs (s. 766B(3)). Section 944Aff refers to the giving of personal advice to a retail customer.

The Act requires the provider of personal advice to have a reasonable basis for that advice. The provider of advice is to:

- determine the client’s relevant personal circumstances
- make reasonable enquiries in relation to those circumstances
- having regard to the information obtained, give consideration to the information and conduct such investigations as are warranted, and then
- provide appropriate advice to the client.

The process outlined is simply documented via a Statement of Advice (SoA). Again, there are two versions of the SoA—one for use by a licensee and one for use by an authorised representative. Similar information is involved—the Act holds the providing entity responsible for ensuring the SoA is given to the client when the advice is given, or as soon as practicable thereafter.

What’s in a SoA?

A Statement of Advice includes (ss. 947B–947C):

- a statement setting out the advice
- information on the basis on which the advice was given
- the name and contact details of the providing entity
- information regarding remuneration or other benefits to be received
- information about other interests or associations or relationships between the provider and insurer
- a warning if incomplete or inaccurate information was involved in the process.

The SoA must be worded and presented in a clear, concise and effective manner (s. 944B(6)).

Product Disclosure Statement (ss. 1013ff)

The Product Disclosure Statement (PDS) is prepared by the issuer of a financial product—in your case the insurer. It's given either by the issuer or the licensee or authorised representative to the client at or before the time when the offer is made to the client.

The PDS is required in all cases where personal advice is given to a retail client in the context of recommending a particular product (ss. 1013C and 1013D).

What's in a PDS?

A Product Disclosure Statement includes:

- a statement setting out the name and contact details of the product issuer
- information about significant benefits the client is entitled to, and the circumstances under which benefits may be provided
- information concerning any significant risks associated with holding the product
- the cost of the product
- information about any costs the client may have to pay subsequent to acquiring the product
- information about any significant characteristics, features, rights, terms, conditions, and obligations
- information about the dispute resolution process
- if an unauthorised foreign insurer, or if the product is consumer credit insurance, the regulations contain additional information that must be given (this information was required under the Contracts Act and the Agents and Brokers Act)
- the date of preparation.

All of the above information must be presented to the client in a clear, concise and effective manner.

It seems clear that insurers can largely comply with this requirement via their policy wordings.



Self help question 3.6

- 1 Which of the following statements is correct?
 - a) A Financial Services Guide is a document prepared by the entity providing financial services and given to the client (retail or wholesale). The Guide sets out product information.
 - b) A Financial Services Guide is a document prepared by the entity providing financial services and given to the client (wholesale only). The Guide sets out essential information on such things as remuneration, associations with insurers and how binders work.
 - c) A Financial Services Guide is a document prepared by the entity providing financial services and given to the client (retail only). The Guide sets out essential information on such things as remuneration, associations with insurers and how binders work.

- 2 A Statement of Advice is only required in situations where personal advice is given to a retail client. The Advice documents the basis upon which the provider has formulated his or her recommendations to the client. True/False?

- 3 A Product Disclosure Statement is required in all cases where personal advice is given to a retail client. True/False?

- 4 A Financial Services Guide is not required in situations where an insurer is dealing directly with a client and the product is one of the insurer's own products. However, a Product Disclosure Statement is still required. True/False?

- 5 The Product Disclosure Statement gives the client information about the particular *product* being recommended met by a policy document. True/False?

Answers are provided at the end of the section.

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Training provisions and PS146

Supporting the new FSR legislation are ASIC Policy Statements (PS)—PS 146 is particularly important.

We have seen that the FSR Act requires financial services licensees to:

- maintain the competence to provide those financial services, and
- ensure that their representatives are adequately trained and competent to provide those financial services.

PS146 provides guidance on how licensees can meet these obligations—it applies to all natural persons who provide personal or general financial product advice to retail clients.

ASIC requires all licensees to ensure that those who provide financial product advice have either:

- a) completed training courses at a level appropriate to the complexity of their activities and their client's needs—two tiers have been specified:
 - *Tier 1* is the higher level training and is required by people advising on all financial products except those listed under Tier 2
 - *Tier 2* training is required by people advising on general insurance products, except accident and sickness.

ASIC has listed approved courses on the ASIC Training Register that will meet their requirements.

- b) been individually assessed as competent by an authorised assessor—only those with at least five years relevant experience over the immediate past eight years are eligible for this option.

Summary

In this section we have considered the ways in which the new financial services reform legislation promotes confident and informed decision-making by consumers and fairness, honesty and professionalism by those who provide financial services.

Having completed this section you should be able to:

- explain the rationale behind the legislation
- outline how the legislation impacts upon those who provide financial services within the general insurance industry
- explain the relationships between the FSR Act, Contracts Act, and General Insurance Code of Practice
- explain the licensing requirements of the legislation
- explain the disclosure requirements.

Answers to self help questions

Self help question 3.1

- 1 C.
- 2 False. The issuer of a financial product is the one who is responsible to the client for the obligations owed under the terms of the financial product.
- 3 False. The essential difference between a retail client and a wholesale client is determined by two factors operating in tandem. These factors can be expressed in these questions:
 - Who is the acquirer of the policy?
 - If it's someone other than an individual, will the policy be used in connection with a small business?
 - Is the product in question one of the specified personal lines insurance products?
- 4 False. Anyone carrying on a financial services business, as defined, must have an Australian financial services licence, including authorised insurers.
- 5 False. The FSR legislation doesn't use the term 'prescribed contract'. The specified personal lines classes under the FSR Act are very similar to the prescribed classes under the Contracts Act but there are differences, essentially to cater for small business usage of such products.
- 6 True. The Code restricts 'consumer' to an individual, whereas the FSR Act embraces companies, partnerships and the like.
- 7 True. All marine insurance (e.g. commercial hull and pleasure craft) is included.

Self help question 3.2

- 1 Yes. Carter & Bellows is a manufacturer of goods employing fewer than 100 people, so it comes within the definition of 'small business' (s. 761G(12)).

- 2 The critical question in deciding whether we are looking at a retail client situation or a wholesale client situation is 'will the insurance product be used in connection with the business and is it one of the specified products?'
 - a) ISR policy—wholesale client

 - b) Broadform liability policy—wholesale client

 - c) Sickness and accident policy—retail client

 - d) Travel policy—retail client

 - e) Motor vehicle—most probably retail client in respect to the sedans, wholesale client in respect to the goods carrying vehicles exceeding 2 tonnes. Section 761G(b)(i) provides that a financial product or service is provided to a person as a retail client if the product is a motor vehicle insurance product, as defined in the regulations. Regulation 7.1.11 defines what is meant by a motor vehicle insurance product and any vehicle which exceeds 2 tonnes carrying capacity is excluded from the definition of 'motor vehicle'. A similar situation could arise under package policies which cover a mixture of personal and commercial insurances.

 - f) Household policy—retail client.

Self help question 3.3

No. The circumstances of this case study are used in s. 766B(6) of the FSR Act to illustrate what would not constitute the making of a recommendation. The information provided to Julie does not of itself constitute advice intended to influence Julie to make a decision relating to Federal's home insurance policy. We see, then, that it is possible to share information about insurance without actually providing personal advice.

Self help question 3.4

- 1 Yes, most likely. His replies, both private and public, could reasonably be regarded as being intended to influence a person or persons in making decisions in relation to a particular financial product or class of products (s. 766B).
- 2 Probably, and for these reasons:
 - a) John appears to be operating a business providing financial advice. There are exemptions from the need to hold a licence set out in s. 911A(2) of the Act but John's situation does not appear to fit any of the exemptions.
 - b) John is not really in a position to be acting as an authorised representative of a licensee, or as an employee of a licensee. He is retired and is presumably writing his column in his capacity as a sole trader, or perhaps as a management services company.

Self help question 3.5

- 1 False. A representative can be an employee or director of a licensee, or an authorised representative of a licensee.
- 2 As a general rule, true. There is one exception to the rule and that is binders. A broker who has a binder can be both a licensee and an authorised representative of a licensee insurer.
- 3 True.
- 4 False.
- 5 False. The other licensees must give their consent to the agent's representation arrangements.
- 6 False. There are no automatic authorisations under the legislation. The Act requires certain things to be done before and after a licensee decides to authorise a representative.

- 7 a A
- b A
- c B
- d Most commonly B, but A is also a possibility.
- e C
- f C
- g C
- h C

Self help question 3.6

- 1 C)
- 2 True
- 3 True
- 4 True
- 5 True

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Section 4

The code

Introduction

In the previous two sections, we looked at the laws that general insurers work under in Australia. As well as these laws, there is also industry self-regulation under the General Insurance Code of Practice (the Code). The Code was developed by the Insurance Council of Australia Ltd (ICA) and is administered by Insurance Enquiries and Complaints Limited (IEC).

Just what role the Code will play under the FSR legislation is not yet clear. The following discussion reflects the functioning of the Code at the time of writing.

It is important to note that the Code does not apply to all types of insurance contracts. It applies to most classes of personal insurance, but insurers are free to extend the Code to any class.

All of the prescribed contracts under section 34 of the Insurance Contracts Act are covered. These are described in the Insurance Contract Regulations as:

- motor vehicle (comprehensive, third party property damage only or extended third party property damage policies)
- home buildings
- home contents
- sickness and accident
- consumer credit
- travel.

What follows is a summary of key parts of the Code. You can find a complete version of the Code as an appendix in the learning resource.

After completing this section, you should be able to:

- understand the underlying purpose of the Code
- understand and apply the day-to-day requirements of the Code in relation to:
 - training
 - claims
 - dispute resolution
 - provision of clear information.

Objectives of the Code

The Code was originally voluntary, but since changes to the Insurance Act in 1997, it's been virtually compulsory for insurers to operate under an approved Code of Practice—insurers don't have to operate under the Code, but if they don't there's a \$22 000 fine each day they trade! (The Code is no longer 'compulsory' under the FSR Act.)

The Code's essential aim is to raise service standards in the general insurance industry by:

- describing standards of good practice and service
- promoting disclosure of information so:
 - consumers can make informed choices about products
 - consumers know about their rights and obligations under insurance contracts
- requiring that employees and agents receive ongoing training
- requiring that insurers have fair procedures for resolving consumer disputes
- including consumer views in the administration and development of the Code.

The ICA has developed the General Insurance Code of Practice Guidelines to help insurance companies understand their obligations under the Code. The guidelines are available from the IEC at:

P.O. Box 561	3/56 Pitt Street
Collins Street West	Sydney 2000
Melbourne 8007	Tel: (02) 9251 4456
Tel: (03) 9629 4109	Fax: (02) 9251 4453
Fax: (03) 9621 2060	

National Toll Free Telephone No. 1300 363 683

Principles

Of course, the above objectives are affected by a number of other factors. The objectives have to be applied alongside what the Code describes as Principles. These are:

- the requirements of insurance companies to meet the prudential standards established under the Insurance Act*
- the fact that both insurance contracts and arrangements between consumers, insurers and insurance intermediaries are governed by the Contracts Act and the Agents and Brokers Act*
- the duty of utmost good faith and the fact that the insurance contract governs the relationship between the consumer and the insurance company*
- the need to promote competition and cost efficiency in the general insurance industry
- the need to protect consumers and insurance companies from increased costs resulting from acts of fraud
- the need to ensure flexibility in the development and enhancement of products and services for consumers
- the need for consumers to be made aware of the provisions of the Code.

* We have discussed the key legal requirements in sections one and two of this module.

How the Code affects you

The main requirements of the Code are that:

- you must have the appropriate knowledge and skills for the products and services you are providing—this includes getting appropriate training
- you must only give advice on those products and services for which your employer has given you authority
- policy documents are in plain language and easily available to consumers
- claims processes are accessible, free and quick

- investigators, assessors, collection agents and loss adjusters must disclose their role to customers and they must act in a professional manner
- internal dispute resolution processes must be in place and be accessible, free and quick.

Training and instruction

You are the public face of your employer and the law makes your employer liable for your conduct. For these reasons, the Code makes your employer responsible for making sure you receive adequate training to successfully provide insurance services to consumers.

You must not provide advice on any product for which you have not been trained to give advice.

This training must provide:

- appropriate skill and knowledge for the particular services you provide—e.g. arranging insurance, handling claims or resolving disputes
- familiarity with the Code.

Authority levels

Of course, the skills and knowledge that you need will depend on:

- the functions you are expected to perform
- the authority you are given by the insurer
- the class or type of product that you are authorised to sell
- the services that you are authorised to perform.

For example, if you are an underwriting intermediary, your skills and knowledge will need to be wider than the skills and knowledge of someone who collects premiums and proposals but does not advise consumers.



Activity 4.1

Has your training adequately prepared you for the four areas of your job mentioned above? If not, is such training accessible if you want it? Is training encouraged in your workplace? Is training 'ongoing' i.e. how often is it updated?

• • • • •

Of course, these four areas might not be the only ones you need training in. You should receive training in whatever skills are necessary for the particular insurance contracts and services you deal with.

The Code allows insurers to provide training and/or instruction. The instruction may be provided in:

- on-the-job training
- procedure manuals
- procedure guidelines in documents which you use daily. For example, underwriting guidelines.

Policy documentation

Under section 4 of the Code, insurers have to make sure that their documents are written in plain language and designed in a way that enables consumers to understand the terms and conditions easily.

Documents included here are:

- promotional material
- proposal or application forms
- interim contracts (cover notes)
- policy wordings
- policy certificates or schedules
- endorsements
- renewal documents
- claim forms
- statutory notices required under the Contracts Act. These will include:
 - the disclosure notice under section 22
 - notices about prescribed contracts (section 35) and unusual terms (section 37)
 - the renewal notice under section 58.

Indeed, any communication with your clients should be clear and well set out.

There are many benefits to using plain language. For your company, plain language:

- shows your clients that you care about communicating with them and creates a positive, professional image
- saves you time by reducing your:
 - need to request more information from customers
 - need to handle enquiries and complaints
 - time spent processing forms
- provides better quality information for management
- saves printing costs
- makes it easier to translate documents into community languages.



Activity 4.2

Read the following checklists for the development of plain language documents and then use them to analyse two or three documents from your office. Do your documents meet the requirements for plain language?

If possible, compare the same documents from your office with similar documents from ten years ago. Are there noticeable changes to the way the documents are written?

• • • • •

Basic tips on writing plain language documents

Use everyday language

- It's easier to understand and much more reader-friendly.
- If you need to use technical terms, also explain the term in everyday language.
- Write directly to the reader. Use 'we' and 'you' rather than 'the company' and 'the client/customer'.
- Avoid words like 'heretofore', 'herein' and 'aforementioned'.

Use short sentences and paragraphs

- Have only one or two ideas in each sentence.
- Use only as many words as necessary. Limit your sentences to no more than fifteen words if possible.
- Use brief paragraphs, with one main topic in each.

Use active rather than passive voice

'We will reply to your claim within two weeks' rather than 'Claims will be processed within two weeks'.

This makes the sentence clearer and more personal for the customer.

Avoid overcapitalisation

'The claims department manager presented its annual report at last week's annual general meeting' rather than 'The Claims Department Manager presented its Annual Report at last weeks Annual General Meeting'.

Avoid ambiguity

A sign on the London underground used to say: 'Dogs must be carried at all times.'

Does this mean that everyone using the underground must carry a dog? Or does it mean that *if* you are travelling with a dog, you must carry it at all times?

Tell readers where they can get more information

Your documents should give readers as much information as they need to know, but people could still have questions so you should always tell them where they can get more information or advice.

The above tips are very brief. For a more complete introduction to creating plain language documents, you could visit the website of the Department of Education Training and Youth Affairs at:

http://www.detya.gov.au/archive/publications/plain_en/contents.htm. There is also a link to other publications dealing with the topic at the end of the web page.

Collecting information

One important area that the Code discusses is how information is collected in proposals and by other means such as the phone.

Under the Contracts Act, the insurer must tell the customer, before the contract is entered into, about the duty of disclosure and the consequences of not complying with it. The Code reinforces this and takes it a step further. Apart from the above obligations under the Act, proposal forms must:

- identify the usual information the insurer wants to know before agreeing to insure (i.e. the questions must ask for specific rather than general information)
- put the questions in plain language and, where necessary, provide information about how to answer them
- give enough space or opportunity to answer the questions and if this is not possible, tell the customer how the additional information can be given.



Activity 4.3

The legislation on disclosure is important for you to know. To refresh your understanding of the law surrounding disclosure, go to the Contracts Act excerpts in the resource booklet and answer the following questions.

• • • • •



Self help question 4.1

- 1 Which section of the Insurance Contracts Act sets out the requirements for consumers to provide all information relevant to the insurance?
- 2 Which section requires the insurer to inform consumers of the duty to provide all relevant information?
- 3 Which section requires the insurer to ask specific questions in their proposal forms if consumers are to be held liable for non-disclosure?

Suggested answers are provided at the end of this section.

• • • • •

The following case study raises the issue of disclosure. Read the case study and then answer the self help question after it.



Case study 4.1

Brian King was completing an application for home and contents insurance with the help of John Dunn an insurance agent with Black Rock Insurance. John was in a hurry to make a later appointment and was going through the questions more quickly than he normally would have done.

He asked Brian if his house was 'well secured'. Brian said that he had never had any trouble with break-ins before and that he thought the house was very secure. John moved on to the next question.

Three months later, Brian was robbed. He put in a claim a week later. Black Rock rejected the claim based on their assessor's report that there were no deadlocks or keyed window locks installed in the house as required in the policy. Black Rock based its rejection of the claim on the fact that Brian had not disclosed this very relevant information.

• • • • •



Self help question 4.2

Is Black Rock's decision justified under the Code or the Contracts Act?
Give reasons for your answer.

A suggested answer is provided at the end of this section.

• • • • •

Declined cover

The Code includes important provisions regarding customers who have been adversely affected by insurers' decisions to decline cover. It does it in two steps:

- 1 Where an insurer refuses cover or renewal for a reason not related to the assessment of the risk, it must tell the customer that this is the reason. For example, you would have to tell customers if you stopped insuring houses in a particular geographic area because your offices had closed in that region.
- 2 The insurer can't require a consumer to disclose these types of prior refusals in an application. It means that a consumer's application for insurance is not disadvantaged by such refusals. This will mean re-writing the relevant question on proposals or adding a note to the effect that the question does not require this information.

If an insurer declines cover, it should inform the consumer that the Insurance Enquiries and Complaints Ltd (IEC) keeps a list of insurers that write particular classes of insurance. The National Insurance Brokers Association (NIBA) can also provide information about how and where to obtain insurance.

The Code's coverage of proposals and declined cover is an example of the benefits of a Code over legislation. The Code can be changed more easily than legislation and the industry can therefore respond quicker if gaps in the legislation are identified. The industry might issue guidelines or, if necessary, change the Code.

• • • • •



Activity 4.4

Find a current proposal form in your office.

Does this particular proposal form include information for consumers on declined cover?

• • • • •

Renewal notices

Apart from the general obligation in relation to renewal documents (see Part VII of the Contracts Act in the resource booklet) insurers also have to highlight any changes to the policy (including wording, rates and risk factors) on renewal. They must do this in plain language so that consumers can understand it.

Claim forms and handling

(What follows is a brief outline of the Code's requirements for claims handling. We cover general claims processes in more detail in the module *Serving the customer*).

When handling claims, insurers must:

- make documentation (such as claim forms or claim procedures) readily available and free of charge
- use plain language and design
- promptly consider and respond to the claim (normally this will be within fifteen days of receipt of a claim) and keep consumers informed about the progress of the claim
- promptly let the consumer know the decision made on the claim or if further information is needed
- promptly provide the consumer with reasons for a rejected claim
- inform consumers about dispute resolution procedures (internal and external).

As you can see, there is an emphasis on processing claims promptly and keeping the insured informed from the initial response to the final decision.

Supervision of service providers

Insurers must make sure that their investigators, assessors, collection agents and loss adjusters:

- operate in a professional manner
- tell consumers of their status and for which insurer they are acting
- comply with the law and the Code
- have the expertise necessary for their authority.

Any complaint against a service provider must be handled by the insurer under its internal dispute resolution processes. However, this does not prevent a complaint being dealt with externally. Any licensing authority (for investigators) or professional body (for assessor and loss adjusters) may have its own complaint procedures.

Investigators, assessors, collection agents and loss adjusters have to be formally approved by an insurer. An insurer must make sure it only uses those it has approved.

Dispute resolution

The Code is about good relations. One of the quickest ways to damage a good relationship is to enter into a dispute. One of the surest ways to damage a relationship beyond repair is to let a dispute escalate.

The Code says insurers must have an internal dispute resolution process. The Code does not prescribe what the process is to be. However, it does indicate the features that the process should have. (See the next section—*Resolving disputes*—for a more complete discussion of these processes.)

The following case studies highlight some key issues covered in the Code. Read the case studies and then answer the self help questions after them.



Case study 4.2

Mary had her home contents insured with Market Insurance Ltd for some years. When she made a claim, Market told her that her policy had lapsed three months previously. When she said that she had not received a renewal notice, Market admitted it had not sent a notice. They refused to pay the claim on the grounds that it was still Mary's responsibility to renew the policy.

• • • • •



Self help question 4.3

Is the company right? Why/Why not?

A suggested answer is provided at the end of this section.

• • • • •



Case study 4.3

William applied for motor insurance from Ringwood Insurance. On his proposal, he did not disclose that he had been declined renewal of his policy by Argo Insurance—this was after Argo had moved out of the motor insurance field.

When William made a claim against his Ringwood Insurance policy, Ringwood rejected his claim because he had not disclosed his previous declined renewal from Argo.

• • • • •



Self help question 4.4

Is the insurer correct in denying the claim? Why/Why not?

A suggested answer is provided at the end of this section.

• • • • •



Case study 4.4

On 21 October, Wendy had a car accident on the way home from work. She put in a claim to Acme Insurance two days later. On December 21, Wendy received a letter from Acme saying that her claim was unsuccessful.

• • • • •



Self help question 4.5

What part/s of the Code have Acme breached here?

A suggested answer is provided at the end of this section.

• • • • •

Summary

In this section, we have discussed the role of the General Insurance Code of Practice in setting standards of practice for the insurance industry. The Code aims to ensure that insurers always keep consumers' interests in mind in day-to-day operations. This includes providing consumers with plain-language documents and consistent and prompt claims and dispute procedures.

Alongside these practices, the Code requires that all staff maintain ongoing education and training to ensure that they have up-to-date knowledge of the laws, policies and products.

The aims of the Code are really a common sense approach to managing an effective insurance business and the Code is a useful guide for good insurance practice even if you do not work in Australia. Following the Code effectively will build consumer confidence in the company and in the industry in general.

Answers to self help questions

Self help question 4.1

- 1 Section 21
- 2 Section 22
- 3 Section 21A

Self help question 4.2

Black Rock is not justified in rejecting the claim. Under section 21A of the Contracts Act and section 4.2 (a) of the Code, the onus is on the insurer to ask specific questions about what is covered under the policy. In this case, because the agent did not specifically ask whether or not Brian's house had keyed window locks and deadlocks, Brian is not liable for non-disclosure.

Self help question 4.3

No. If the insurance company fails to give the customer a written notice of renewal within 14 days then the cover remains in force subject to certain limitations.

Self help question 4.4

No. The Code of Practice states that a customer is not required to disclose a declinature that relates to matters other than the assessment of the risk.

Self help question 4.5

Acme did not:

- respond to Wendy's claim within fifteen working days—5.1(c)
- keep Wendy informed about the progress of her claim—5.1(d)
- provide Wendy with their reasons for rejecting her claim or information about dispute resolution processes available to her—5.1(g).

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Section 5

Resolving disputes

Introduction

One of the quickest ways to damage a good relationship is to get into a dispute. This is the last thing that you need to happen if you want to maintain good customer relations.

In this section, we will look at what procedures you need to have in place to handle disputes effectively.

After you complete this section, you should be able to:

- understand the formal requirements for internal and external dispute resolution
- participate effectively in your company's dispute resolution processes.

What is a dispute?

The definition of 'dispute' in the General Insurance Code of Practice has two parts:

- the initial complaint and request for a remedy
- the change into a dispute if you can't resolve the complaint.

So, you need to have a two-part process in place. First of all, you need to have effective strategies for dealing with the initial complaint. Ideally, this is where most problems can be solved.

The second stage of the process is only necessary if the first stage is unsuccessful and the complaint becomes a dispute. Then you need to have an internal dispute resolution process in place.



Case Study 5.1

Don Barrett is angry because his insurance claim has been reduced, and so he phones the insurance company. The insurance company explains the reason for its decision and politely tells him that they will not alter it. Mr Barrett is initially satisfied with the explanation the insurance company gives him.

However, after discussing the matter with a friend, he becomes very annoyed again with the reduction of his claim, and telephones the insurance company to tell it of his dissatisfaction. Mr Barrett tells the insurance company that he is not prepared to accept the decision and wants to take the matter further.

• • • • •



Self help question 5.1

Is this a complaint or a dispute?

An suggested answer is provided at the end of this section.

• • • • •

Handling complaints

Your company should have guidelines for handling complaints. If you carry out the guidelines fairly and consistently, customers will have confidence in the process. This will add to customer satisfaction with your company.

Different companies will have different procedures in place, but there are a number of common requirements for an effective complaint process:

- identifying the complaint
- recording the complaint
- resolving or referring the complaint.

We will look at these in a little more detail.

What is the complaint?

It seems obvious, but before you can fix a complaint, you have to be sure what the complaint is. Key skills you need here are:

- active listening skills—this means listening carefully to each word the customer says without interrupting. Taking notes could help as well.
- double checking that you understand—to confirm facts, you can paraphrase what the customer says and/or ask questions. You need to make sure you are both talking about the same thing.
- controlling your tone of voice and body language—sometimes complaints can become very tense and without even knowing it you might be speaking and acting aggressively. This can make matters worse and prevent you from listening effectively. You need to ‘take a deep breath’ and start listening again.

Writing it down

Once you are confident you understand exactly what the problem is, you need to record it. You need to:

- write down the complaint and check that the customer agrees with what you have written
- collect any documents that could provide information about the complaint. This could include police reports, letters, repair quotations, complaint records, contracts, statements of terms and conditions, information booklets, receipts, warranties, and so on
- record the complaint in a complaint register. This register will include details such as the date and time of the complaint, the customer’s details, the nature of the complaint, the name of the person dealing with the complaint, the proposed action and time frames.



Activity 5.1

Find your office complaint register. Does it include all the information referred to above? What are the most common causes of complaints? What percentage of complaints has gone on to become disputes?

• • • • •

Resolving or referring?

Whether you try to resolve the complaint or you refer it to someone else will depend on your company's policy and procedure for handling complaints. You should be quite clear about what your responsibilities are.

In general, some complaints could be the result of simple errors—such as a misprint or an adding mistake—that you could fix quickly. More complicated problems might need to be referred on to someone with more training in this area.

If you refer a complaint on, you have to make sure that you:

- provide the person responsible with all the relevant information
- keep the customer informed about what is happening. This involves regularly checking with your colleague to see what progress has been made with the complaint and then passing this information on to the insured.

Making improvements

Because you are one of the first people to whom a customer will complain to, you will be one of the first to notice recurring complaints. If different customers are raising the same sorts of complaints, there might be a problem with company documents or procedures. The company needs to know this so it can fix the problem. You should pass on this information so that the company can constantly improve its processes.

To test your understanding of points covered so far in this section, read the following case study and then answer the self help question after it.



Case study 5.2

Karen is working on the counter at Bullwinkle Insurance. An obviously angry customer (Kevin Butcher) approaches and says he wants to speak to the manager. Karen asks him what the problem is and he tells her that he has been waiting over six weeks to hear about his insurance claim for flood damage to his house.

Karen says she will look into it for him and asks him for details. Mr Butcher becomes agitated and yells out that he already made a complaint three weeks ago but nothing has happened. Karen starts to get upset as well and her voice starts to rise, but she realises in time, apologises and asks him to explain his complaint again.

Mr Butcher explains that a freak hailstorm broke his roof and that heavy rain then flooded his laundry and hallway. The rain has ruined an expensive hallway carpet and he will have to replace the whole thing. Karen manages to calm Mr Butcher down and promises to get back to him the next day.

She finds the complaints register and finds a recorded claim for 'flooded lawn'. There is no name of the employee who took the complaint or to whom the complaint was passed. Karen tracks down the file to Jane Downer in the claims department. The file contains Mr Butcher's written complaint. Karen corrects the report and arranges with Jane to prioritise the complaint.

Karen then gets back to Mr Butcher the next day and informs him of the progress being made. His claim is approved within two weeks. Mr Butcher is satisfied and the matter stops there.

• • • • •



Self help question 5.2

- 1 What things went wrong with the handling of Mr Butcher's complaint?
- 2 What things were done well?

Suggested answers are provided at the end of this section.

• • • • •



Activity 5.2

Find your company guidelines for complaint procedures and compare them to the general guidelines you have studied so far in this section. If you were confronted with a similar level of complaint as in the above case study, would you be expected to resolve it or would you need to refer it on. According to your company guidelines, to whom would you have to refer the complaints?

• • • • •

If your company has an effective complaint resolution process in place, many complaints will be resolved in this initial stage. However, if the customer is still dissatisfied, the complaint formally becomes a dispute and needs to go through to the second stage—the internal dispute resolution process.

Handling disputes

The General Insurance Code of Practice requires that insurers have an Internal Dispute Resolution (IDR) process in place. The Code doesn't prescribe the process, but the following steps are common.

Managing the process

When all attempts at resolution by the claims officer/team leader have failed to satisfy the claimant, a dispute is referred to an IDR officer. The IDR officer:

- calls upon any personnel or experience within (or outside) the company to help reach a decision
- forwards a letter to the claimant explaining that the file is now part of the IDR process

- reviews and investigates all aspects of the file
- must try to resolve the dispute within 15 days of receiving the file.
Contact with the claimant can be by telephone, in writing or in a face-to-face meeting.
- advises the claimant of the decision. If the claimant doesn't accept the decision, the IDR officer must inform the claimant that he or she can refer the disputed claim to the Claims Review Panel of the IEC. (It is also possible to proceed to other bodies such as the courts).

Communicating the process

Your employer must make available a brochure that explains:

- the IDR procedures you have in place
- how long it will normally take to handle the dispute
- that an appropriately qualified officer will handle the dispute.
Remember that a major objective of the Code is to make sure that employees don't operate outside the scope of their expertise.

If you work outside Australia, you might not have these same requirements. However, disputes will always happen and you need to be prepared for them. Your company should have some procedures for handling complaints, even though they might not be the same as the examples given here.

As we said above, there is no standardised IDR procedure and so the wording in the brochures will be different for each company. However, because all insurers in Australia must follow the Code, you will find that there are many similarities in the procedures set out in company brochures. We will have a look at a couple of samples.



Case study 5.3

Sample brochure wordings of IDR processes

Sandridge Insurance

Here's what to do if an unresolved complaint or dispute arises.

Contact one of our Dispute Resolution representatives. They have the knowledge, authority and experience to deal with your dispute.

We ask that you or someone on your behalf contact our representatives in writing with details of your dispute and send them to:

Internal Dispute Resolution
Sandridge Insurance
GPO Box 1342
PERTH 6001

We will:

- conduct a full review of your dispute
- discuss and clarify any issues in the dispute with you
- try and resolve your dispute
- provide you with a response within fifteen (15) working days
- explain the course of action available to you if you are not satisfied with our internal procedures
- act on any agreed solution
- keep your dispute confidential.

If you are not satisfied with our internal dispute resolution process

If your complaint concerns a claim—you can contact the General Insurance Enquiries and Complaints Scheme office on 1300 363 683 and have the matter referred to the Claims Review Panel. This is a free service and its decision will be binding on us up to a certain amount.

If it does not concern a claim—our Dispute Resolution Representative can let you know about alternatives.

King's Insurance

Let us know if you have a complaint.

We will refer it to a person who has the authority to deal with it and who:

- will listen closely to your concerns.
- will be independent.
- will resolve your complaint as soon as possible—usually within 24 hours.

If this person cannot resolve your complaint satisfactorily, we will refer it to the relevant State Operational Manager who will contact you within five working days.

If the complaint is still not resolved satisfactorily, we will refer your concern to the General Manager in Head Office who will send you our final decision in writing within fifteen working days from the date you first lodged your complaint.

And if your complaint is still unresolved...

Most complaints are resolved by this stage, but if you are still dissatisfied, you can get your complaint dealt with externally. Options include mediation, arbitration or legal action.

You can also raise certain claims related complaints directly with the General Insurance Claims Review Panel. This is an independent body and the service is free.

To take advantage of this service, you must contact the Panel within three months of receiving our final decision. We will accept the Panel's decision.

You still have the option of legal action if you do not accept the Panel's decision.

Their address is:

General Insurance Claims Review
Panel
PO Box 561
Market Street Post Office
Melbourne VIC 8007

Or you can phone them on:

1300 363 683



Activity 5.3

Find the brochure, or other documents, which set out your company's internal dispute resolution procedures. Is it easily available to the public? Does it clearly set out the information as required under the Code of Practice?

What training is necessary in your workplace to handle the dispute process?

• • • • •

If the internal dispute resolution process does not resolve the dispute, you must then refer the insured to the external dispute resolution processes available.

Unresolved disputes

The IEC

In Australia, an unresolved dispute can be referred to the General Insurance Enquiries and Complaints Scheme. The Scheme is administered by the Insurance Enquiries and Complaints Ltd (IEC). The IEC is a company, made up of members from participating general insurers.

Disputes might be heard by a Referee, an Adjudicator or a Panel. An Adjudicator can make binding determinations up to \$A3000 and a Panel up to \$A120 000. In certain circumstances a Panel or Referee can make recommendations for amounts up to \$A290 000.

Other points relevant to the scheme are:

- Claimants are not bound by the determinations of the Panel, Referee or Adjudicator and retain their right to take legal action against the insurer.
- The dispute handling arrangements have been put in place to benefit natural persons, not corporations—although it is possible for small businesses to take part in the scheme.
- Insured third parties to a motor claim can also access the scheme for a small fee for disputed claims up to \$3000

- All participating insurers have agreed to the procedures to be followed to resolve disputes.
- Determinations made by the Panel, Referee or Adjudicator are binding on insurers.
- The scheme is funded by the participating insurers and so there is no cost to claimants (i.e. policyholders of participating companies).

External resolution process

If a claimant wants to have a dispute handled externally, he or she must contact the IEC within three months of your IDR decision. Once this happens, the process is as follows:

- The claimant will be asked to fill out a simple form giving the relevant details of the dispute.
- A Case Manager will investigate the claimant's case and prepare the necessary material for consideration under the Scheme.
- A determination will be issued informing the customer and the insurance company of the decision.
- The claimant has one month in which to accept or reject the decision.
- If the claimant accepts the decision, the insurance company must pay the amount involved within one calendar month of the signed agreement.
- If the claimant doesn't accept the determination, it won't be binding on the insurance company.
- The claimant can reject the determination, and seek alternative legal remedies.

We have presented a summary of the IEC procedures here. If you want a more complete picture of the Scheme, you can find it on the IEC website at www.iecltd.com.au/tor/index.html or you can contact them by telephone on 1300 363 683.

The IEC also provides very useful practice notes which include such things as copies of particular documents that you would need to provide to the IEC and the roles of various IEC personnel. You can find these at www.iecltd.com.au/practice/index.html.

Before we finish, we'd like you to consider a case study of a complaint that went before the IEC in 1999. Read the case study and then answer the following self help questions.



Case study 5.4

The insured submitted a claim after discovering that contents had been stolen from a tenanted property and that the building had also been damaged.

The matter was first reported to IEC after a dispute had arisen between the assessor and the insured who had requested the matter be referred to the insurer's Internal Dispute Resolution process. The insurer delayed a decision which resulted in the matter being referred to IEC for assistance.

Investigations were carried out as to the reasons for the delay and it was found that the assessor, to whom the request for IDR had been addressed, had delayed passing this on to the insurer.

During the course of the investigation it was also ascertained that:

- it took the assessor almost three weeks to submit the report after attending the insured and the premises
- it was nearly five weeks from the time of the first report to the second report
- it was almost another month before the assessor's further report was submitted to the insurer
- it then took a further month for the next report to be submitted
- three and a half weeks later the assessor recommended payment to the insured
- the company took two weeks to make a decision on the assessor's report
- whilst the assessor may have had difficulty in obtaining information, this did not warrant the extensive delays leading to the settlement of the claim
- it was obvious that the company was not keeping to the benchmarks set.

• • • • •



Self help question 5.3

- 1 Turn to section 5 of the Code of Practice in the resource. What sub-sections have been breached here?
- 2 Has there been a breach of section 6 as well?

Suggested answers are provided at the end of this section.

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Other bodies

Other regulatory bodies can investigate a customer's complaint against an insurance company, its agents or employees, to ensure that it is complying with legislation. Examples of regulatory bodies are:

- the Human Rights and Equal Opportunity Commission
- the Privacy Commission
- the Australian Securities and Investment Commission
- the Small Claims Tribunal
- the Australian Competition and Consumer Commission

There are many more bodies and alternative sources to investigate a claimant's complaint.

Summary

Nobody likes to be confronted with complaints, but they are inevitable. You can treat complaints positively by using them as an opportunity to get feedback about possible improvements in company practices. And if you handle complaints efficiently, you can build consumer confidence in your business.

In this section, we looked at the three stages of dealing with complaints and disputes. We first considered the skills and procedures that are important when dealing with the initial complaint. This is the stage at which you will probably have most input into the complaint process.

We then discussed what happens when claimants are unsatisfied with the outcomes of the initial complaint process. Where a complaint is unresolved, it formally becomes a dispute and this sets off the need for an Internal Dispute Resolution (IDR) process. In Australia, this is a formal requirement of the General Insurance Code of Practice.

Finally, we briefly examined the external dispute resolution processes of the Insurance Enquiries and Complaints Ltd. (IEC).

Answers to self help questions

Self help question 5.1

Mr Barrett's case changes from a complaint to a dispute when he changes his mind about accepting the insurer's initial decision and he decides to take the matter further.

Self help question 5.2

Well handled

Karen is working on the counter at Bullwinkle Insurance. An obviously angry customer (Kevin Butcher) approaches and says he wants to speak to the manager. Karen asks him what the problem is and he tells her that he has been waiting over six weeks to hear about his insurance claim for flood damage to his house.

Karen's awareness of her reactions prevents escalation of conflict

Karen says she will look into it for him and asks him for details. Mr Butcher becomes agitated and yells out that he already made a complaint 3 weeks ago but nothing has happened. Karen starts to get upset as well and her voice starts to rise, but she realises in time, apologises and asks him to explain his complaint again.

Mr Butcher explains that a freak hailstorm broke his roof and that heavy rain flooded his laundry and hallway. The rain has ruined an expensive hallway carpet and he will have to replace the whole thing. Karen manages to calm Mr Butcher down and promises to get back to him the next day.

She finds the complaints register and finds a recorded claim for 'flooded lawn'. There is no name of the employee who took the complaint or to whom the complaint was passed on. Karen tracks down file to Jane Downer in the claims department.

The file contains Mr Butcher's written complaint. Karen corrects the report and provides extra information—arranges with Jane to prioritise the complaint.

Karen rescues situation. Takes customer seriously. Follows up promptly. Follows protocol. Keeps customer informed.

Karen then gets back to Mr Butcher the next day and informs him of the progress being made. His claim is approved within two weeks.

Mr Butcher is satisfied and the matter stops there.

Badly handled

Recording of information faulty—not effectively checked with customer. Important information missing. Mistake not followed up on earlier.

Missing documentation—contract, terms and conditions, information booklets, receipts etc. Jane has not chased up the missing information.

Self help question 5.3

1 The company has not complied with:

- Sections 5.1(a)(iii) (failing to respond to requests for assistance in making a claim)
- 5.1(d) (insurers must keep the consumer informed of the progress of the claim)
- 5.1(e) (all information required by the insurer has been provided and the insurer should advise whether claim is accepted or rejected).

There is also possible breach of 5.2 (a) as there is a question about whether the assessor acted in a 'professional manner'.

2 The failure to provide a timely decision to the Internal Dispute Resolution raised non-compliance with section 6.1 of the Code. The insurer undertook the required remedy by counselling the assessor and staff concerned.

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Section 6

Privacy

Introduction

In this section, we look at issues surrounding the handling of your customers' personal information. Most of us value our privacy and we don't like our personal information being passed around without our knowledge. So guidelines are important to ensure information is used correctly.

After completing this section, you should be able to understand how and why you should maintain the privacy of your customers' information.

Gathering information

We live in the 'information age'. Businesses exist on the buying and selling of information, but there is sometimes a thin line between the legitimate use of personal information and the 'invasion' of privacy.



Case study 6.1

In late 1999, there was a lot of media coverage of the possibility of Kerry Packer's Publishing and Broadcasting entering a joint venture with an American company to create a 'data warehouse'. Some people feared that the database would contain the personal and financial details of nearly every Australian.

The information was apparently to come from, among other things, credit companies, the electoral roll, house and car sale records. Mr Packer's own network of information sources—Ticketek, Crown Casino, Channel Nine and its Internet site ninemsn—were also allegedly to provide information.

There was an explosion of media debate and calls for the introduction of laws to protect personal information.

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Activity 6.1

Take some time to think about what sorts of personal information a company could get about you from your credit-card files.

Would it worry you if your credit-card company sold your financial details to another company so that company could identify your spending patterns and then send you targeted advertising material?

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Of course, to assess risk, your insurance company needs to collect a lot of personal information from its customers. While this information is necessary, you have to balance the need for collection with a respect for individuals' privacy.

Privacy legislation

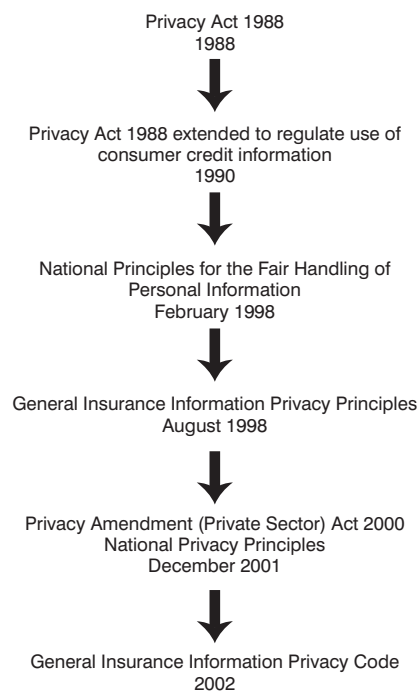
Under the Australian *Privacy Act 1988*, it's illegal for government departments to give out personal information (given certain exceptions of course). The principles outlining how consumers' personal information should be handled under the Privacy Act are found in the *National Principles for the Fair Handling of Personal Information* of 1998.

The *Privacy Amendment (Private Sector) Act 2000* (Cth), which came into force in December 2001, has extended compulsory privacy standards to the private sector.

When the new Private Sector Act came into force, many insurers were already voluntarily working under the Insurance Council of Australia's (ICA) *General Insurance Information Privacy Principles* (the Insurance Privacy Principles) which were based on the National Principles.

There was a good deal of similarity between the pre-existing Insurance Privacy Principles and the new principles laid out in the Private Sector Act—and those insurers that adopted the voluntary Insurance Privacy Principles were well prepared for the new compulsory regime.

We'll move on to look in detail at your obligations under the privacy legislation, but before we do, the following diagram provides a quick review of how the latest Principles have 'evolved':



It's important that you understand your obligations under the new legislation and we'll look at these in some detail. Consider the following activity as you study your privacy obligations.



Activity 6.2

Select one category of insurance your company offers customers (e.g. home and contents or motor insurance) and consider it in the light of these questions.

What personal information do you require from customers applying for this type of insurance?

How is this information stored?

Who has access to this personal information?

What do you tell customers about why you ask for this information and how it will be used?

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Compulsory Privacy Principles

As we mentioned before, until the passing of the Private Sector Act, it was voluntary for insurers to adopt the then Insurance Privacy Principles. However, the Act now makes it compulsory for insurers to belong to a privacy scheme. Insurers must adopt either an approved industry privacy code or the National Privacy Principles (NPP) as set out in the Act. (There are some exemptions from the privacy requirements—e.g. small businesses that don't deal with personal information; employee records—but the large part of insurers' customer information will come under the Act.)

It is possible that some insurers will choose to follow other codes—e.g. insurers that provide other financial services such as banking and/or superannuation might adopt codes from one of those sectors. Whatever choice is made, privacy issues have to be addressed. We imagine that most insurers will adopt the ICA's General Insurance Information Privacy Code (the Privacy Code) and so we'll concentrate our discussion around those principles.

The principles in the Privacy Code and the NPP are essentially the same. However, a key difference is that the Privacy Code is monitored by the IEC's Privacy Compliance Committee (PCC) whereas the NPP will be monitored by the Federal Privacy Commissioner.

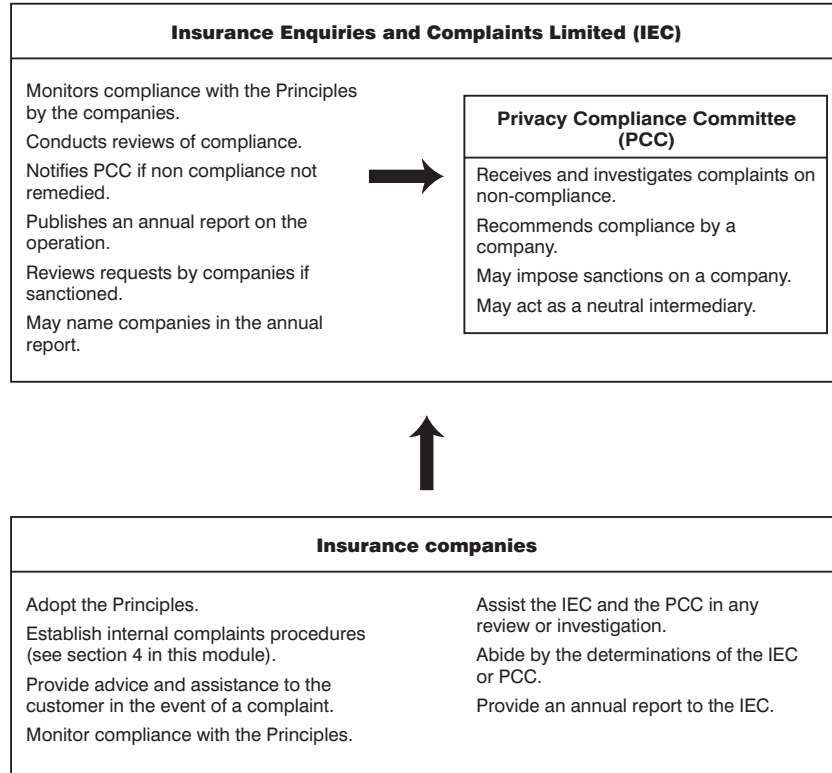
Monitoring

Under the Privacy Code, an insurer will be monitored by the Privacy Compliance Committee (PCC) of the Insurance Enquiries and Complaints Limited (IEC).

The Privacy Compliance Committee will:

- hear complaints from individuals that cannot be resolved by the insurance company's internal dispute scheme and
- monitor the overall implementation of the scheme.

An overview of the different parties' obligations is set out below.



If you work in a country that does not have privacy laws, your company may still have guidelines for handling your clients' personal information.



Activity 6.3

Find the guidelines in your office that set out the requirements for handling clients' personal information. Find out what the guidelines say about:

- what sorts of personal information you can/cannot collect
- how you should store the information
- who has access to the information
- what information you must give customers about how you will use their information.

• • • • •

Benefits

The Privacy Code helps you by:

- establishing a process for efficiently settling privacy disputes
- increasing customer trust and confidence
- improving the quality of data you collect
- providing clear consent to use data for secondary purposes such as marketing.

This will also save your company from wasting money by approaching people who do not want to hear from you.

When does the Privacy Code apply?

You have to follow the Privacy Code whether you are:

- selling policies
- investigating claims
- loss adjusting
- providing any other service.

The Code relates to the collection of all personal information about an identifiable individual—whether for prescribed insurance policies or for commercial policies.

The Code doesn't apply to information collected and used by companies for workers' compensation and compulsory third party (bodily injury) motor vehicle insurance.

Just before we look at the Privacy Code in more detail, work through the following questions to check your understanding of points covered so far.



Self help question 6.1

Answer the questions by circling the correct answers.

- 1 The Privacy Code applies to:
 - A those classes of insurance covered by the General Insurance Code of Practice
 - B any classes of insurance where an identifiable individual's information is collected
 - C any classes of insurance where the insured is a corporation
 - D any class of insurance where the insured is a natural person including workers compensation and Compulsory Third Party insurance.

- 2 On adoption of the Privacy Code, an insurance company must:
 - A complete a Deed of Adoption
 - B implement an internal complaints process to deal with customers' complaints
 - C agree to be monitored by the PCC
 - D all of the above.

- 3 To ensure compliance with the Privacy Code, an insurance company must:
 - A monitor its compliance with the Privacy Code
 - B refer all customer complaints to the IEC
 - C annually report its compliance to customers
 - D all of the above.

- 4 Where there is a complaint, an insurance company:
 - A must provide advice and assistance to the customer
 - B should respond within fourteen to thirty days
 - C can apply a fee
 - D should refer the customer to the IEC

Answers are provided at the end of this section.

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The Privacy Code principles in practice

Personal information

The sort of personal information you need to be careful with includes a client's:

- financial circumstances
- medical history
- previous insurance experience
- identification information such as name, address and telephone number.

These details can be very sensitive for some people. The Privacy Principles will help you ensure that your customers feel confident that you respect their privacy.

The ten Principles

The Privacy Code contains ten Principles. Here are brief summaries of how they should be applied.

Principle 1—Collection

There are five parts to Principle 1. It addresses *how* you should collect personal information and *what* personal information you should ask customers for.

1.1 Only collect information that is necessary for what you do.

1.2 Be fair in the way you collect information.

1.3 Tell the customer who you are and what you intend to do with the information.

1.4, 1.5 Where practicable, collect personal information directly from the customer. If you collect information about the customer from someone else, make sure he or she knows you have done this.

Principle 2—Use and disclosure

Only use or disclose information about customers in ways they expect or in the public interest. This is particularly important when dealing with 'sensitive' information.

Principle 3—Data quality

Make sure that information about customers is accurate.

Principle 4—Data security

Keep customers' information secure:

- keep any of your computer passwords private
- ensure that you store customer information away from public view.

Principle 5—Openness

Be open with customers about the kinds of personal information you hold and what you do with it.

Principle 6—Access and correction

Wherever possible, let customers see the information you hold about them and correct it if it's wrong.

(See the resource for exceptions to the access Principle)

Principle 7—Identifiers

Limit your use of identifiers (e.g. tax file number) that government agencies have assigned to customers.

Principle 8—Anonymity

Don't ask for a customer's personal details unless absolutely necessary. (In practice this is difficult in an insurance context, but it shouldn't be necessary to ask for someone's details if they are only making enquiries about types of cover available.)

Principle 9—Transborder data flows

Protect customer privacy if you send their personal information outside the country.

Principle 10—Sensitive information

Limit the collection of highly sensitive information—if possible get the customer's consent. Handle the information with even greater care than more routine data.

The definition of ‘sensitive’ information includes information or an opinion about an individual’s:

- racial or ethnic origin
- political opinions
- membership of a political association
- religious beliefs or affiliations
- philosophical beliefs
- membership of a professional or trade association
- membership of a trade union
- sexual preferences or practices
- criminal record
- or health information.

Note that financial information is not included as ‘sensitive’, even though many customers think it is.



Activity 6.4

Read ‘Appendix E’ of *Learning Resource, Volume 2* for the full version of the Insurance Privacy Principles and an accompanying commentary. After reading the Principles, answer the following multiple-choice self help questions to check your understanding.

• • • • •



Self help question 6.2

- 1 Where an insurance company inadvertently receives personal information about one of its customers, the company should:
 - A return the information to its source and refrain from making any use of the information
 - B return the information to its source but record details for the company's future use
 - C file the information for future marketing purposes
 - D none of the above.

- 2 Some office layouts do not allow for private conversation and personal information may be overheard by third parties. When discussing personal information in public areas, employees should:
 - A refrain from any action which may result in third parties overhearing personal information about another customer
 - B discuss a customer without mentioning his/her name
 - C ensure customers do not overhear the conversation
 - D whisper.

- 3 Compliance with Principle 1, regarding use of customer's personal information can be achieved when a company:
 - A displays a notice at the counter where information is collected
 - B includes information in brochures or proposal forms
 - C publishes this information on their company Website
 - D all of the above.

- 4 To obtain information about a customer, an insurer can approach:
 - A the Australian Taxation Office
 - B banks
 - C building societies
 - D Insurance Reference Service (IRS) and Credit Reference Ltd (CR).

- 5 Personal information can be collected with a customer's consent from:
 - A insurance companies
 - B an insurance agent
 - C the Insurance Reference Service (IRS)
 - D all of the above.

6 Under the Principles, insurance companies can use private information for unrelated purposes provided:

- A the customers or ex-customers concerned cannot be identified in any way
- B this is done exclusively for staff training
- C the Privacy Compliance Committee (PCC) has authorised its usage
- D approval has been obtained from the customers concerned.

Answers are provided at the end of this section.

• • • • •

Now that you have read the Privacy Principles in full and considered the key facts relevant to your work, here are a series of case studies to demonstrate the Principles. After each one, answer the self help questions to test your understanding.



Case study 6.2

Margaret works in the call centre of a large company and is attending a training course on basic underwriting.

Sample application forms have been photocopied as training aids for the participants.

As she looks through the sample forms, she stops at the motor application form, which contains details of a rejected applicant’s criminal record. The information is in a form that clearly identifies the applicant as an acquaintance from her hockey club.

• • • • •



Self help question 6.3

- 1 Identify the relevant Principle(s).
- 2 Has there been a breach of this Principle(s)? Give reasons for your answer.

Suggested answers are provided at the end of this section.

• • • • •



Case study 6.3

An insurance investigator rings one of his mates from the football club who works for Queens Insurance.

George, I need a favour. I'm working on this case for AZA Insurance and there's something not quite right. Can you hop into that system of yours and tell me if you guys insure a Mrs. Gwen Lawford of 42 Lyons Avenue, French Cove?

George does as he is asked and discovers Mrs. Lawford is indeed a customer. The next question is predictable.

George can you tell me what claims the old girl has made over the past few years?

• • • • •



Self help question 6.4

- 1 Identify the relevant Principle(s).
- 2 Has there been a breach of this Principle(s)? Give reasons for your answer.

Suggested answers are provided at the end of this section.

• • • • •



Case study 6.4

A private investigator, working for an insurance company, is investigating a claim from a policy holder with disability cover for payment of his mortgage. The policyholder claims he has a permanent disability. The investigator visits the claimant's premises and notices his house is for sale.

The investigator returns a few days later, accompanied by a man whom he introduces as his father-in-law. This man has a video camera and asks if he can make a video of the interior of the house for his daughter. The claimant agrees. The videotape shows the claimant showing his visitors around the house. It is subsequently used by the insurance company in an attempt to refute his claim for permanent disability.

• • • • •



Self help question 6.5

- 1 Identify the relevant Principle(s).
- 2 Has there been a breach of this Principle(s)? Give reasons for your answer.

Suggested answers are provided at the end of this section.

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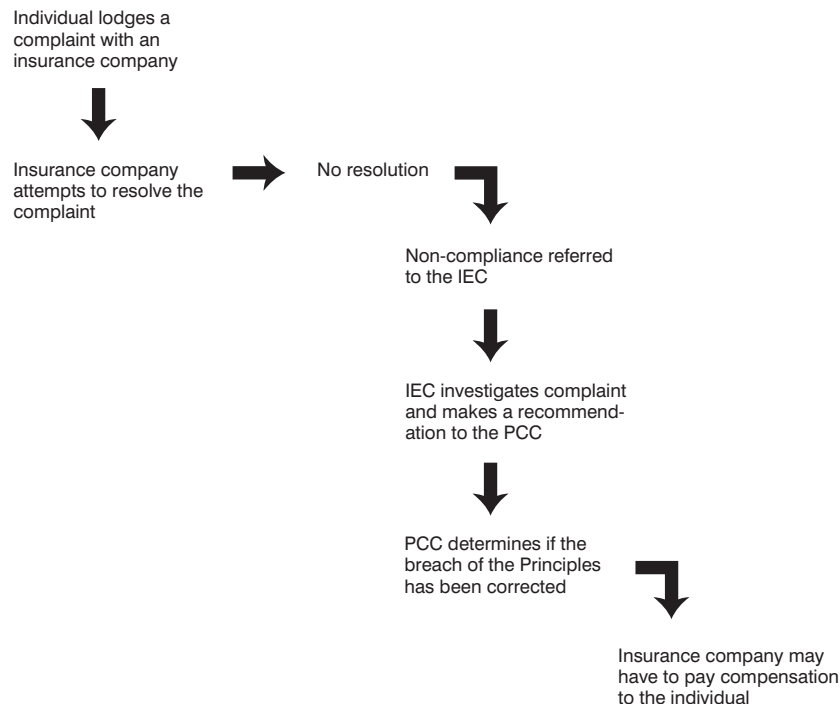
Complaint processes

Insurance companies adopting the Principles must have documented internal dispute resolution procedures in place. As the following flowchart shows, the complaint/dispute resolution procedure for privacy issues is similar to that used for other complaints under the Code of Practice. (See section 5 for details of dispute resolution processes.)

The process differs once it's in the external processes of the IEC. If a complaint can't be resolved by your company's internal processes, you must tell the complainant about the external process involving the IEC's Privacy Complaints Committee (PCC).

IEC staff will investigate the dispute and prepare a report for the PCC, which will determine whether your company has breached the Principles. If so, the PCC can recommend your company fix the problem.

Here is a flowchart of the complaint procedure.



Scheme monitoring and review

The Privacy Compliance Committee (PCC) also has a wider role in monitoring the operation of the Principles. It:

- will receive reports from insurance companies which have adopted the Principles
- can carry out reviews of compliance, even if there have been no complaints.

If a company breaches the Principles, and it has not taken steps to fix the problem, the PCC can:

- require that the company undergo a compliance audit
- recommend that the company be named in the IEC annual report.



Activity 6.5

Let's look at the complaint process you work within.

- 1 Does your company have in place a fully documented internal complaint procedure for dealing with privacy issues? If so, briefly outline the procedure.
- 2 Is this information readily available in writing to customers?
- 3 How quickly are privacy complaints dealt with in your company?
- 4 What happens if the complaint cannot be resolved internally?

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Summary

In this section, we have discussed the sorts of things you need to think about when handling clients' personal information. The existing Insurance Privacy Principles are a very good guide to best practice here, and they will become increasingly important as compliance becomes compulsory in December 2001.

Answers to self help questions

Self help question 6.1

- 1 B. The Principles apply to any classes of insurance where an identifiable individual's information is collected.
- 2 D. On adoption of the Principles, an insurance company must do all of the following: complete a Deed of Adoption; implement an internal complaints process to deal with customers' complaints and agree to be monitored by the PCC.
- 3 A. To ensure compliance with the Principles, an insurance company must continually monitor its own compliance.
- 4 A. Where there is a complaint, an insurance company must provide advice and assistance to the customer.

Self help question 6.2

- 1 A. Where an insurance company inadvertently receives personal information about one of its customers, the company should return the information to its source and refrain from making any use of the information.
- 2 A. When discussing personal information in public areas, employees should refrain from any action which may result in third parties overhearing personal information about another customer.

- 3 D. Compliance with Principle 1, regarding use of customer's personal information can be achieved when a company: displays a notice at the counter where information is collected; includes information in a brochure or proposal forms; publishes this information on their company Website.
- 4 D. To obtain information about a customer, an insurer can approach the Insurance Reference Service (IRS) and Credit Reference Ltd (CR).
- 5 D. Personal information can be collected with a customer's consent from insurance companies, an insurance agent and the Insurance Reference Service (IRS).
- 6 D. Under the Principles, insurance companies can use private information for unrelated purposes only if approval has been obtained from the customers concerned.

Self help questions 6.3

- 1 The relevant Principles are:

Principle 2.1 regarding the use and disclosure of customers' personal information for a purpose other than the primary purpose of collection

Principle 5.1 regarding the responsibilities companies have to communicate what personal information they have and how they will use it

Principle 4 regarding data security may also apply.

- 2 There has been a breach of these Principles if the customer was not informed how his/her personal information was to be used. It is unlikely that he/she would have given permission for this information to be used in a clearly identifiable form.

Self help question 6.4

- 1 The relevant Principles are:

Principle 2 regarding the use and disclosure of customers' personal information for a purpose other than the primary purpose of collection

Principle 4 regarding the security of data.

- 2 There has been a breach of both these Principles because the employee of AZA has gained unauthorised access to a customer's personal information and has disclosed it without the knowledge or consent of the customer.

Self help question 6.5

- 1 The relevant Principle is:

Principle 1 which deals with collecting information by lawful and fair means and not in an unreasonably intrusive way.

- 2 There has been a breach of Principle 1 in this case study based on an actual case that occurred in New Zealand. The private investigator was admitted to the man's house pretending to be interested in purchasing his house. Via these dishonest means, the investigator made a video recording and collected information in an unfair and intrusive manner.

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Section 7

A safe workplace

Introduction

Everyone has the right to a safe workplace. As an office worker you are generally safer than someone working in heavy industry—statistically, you are most at risk from ‘strains, sprains, cuts and bruises’.* Still, these types of injuries could have long-term effects that reduce your quality of life and everybody wants to avoid that. If you are to create a healthy and safe working environment, you need to think carefully about your work practices.

After completing this section you will be able to:

- identify hazards and risks in your workplace
- maintain safe work areas
- understand key Occupational Health and Safety (OH&S) requirements.

* Victorian Workcover Authority, 1997, *Officewise*, Melbourne, p. 53

Why implement OH&S?

There are sound moral, legal and financial reasons why you and your employer should be concerned about occupational health and safety (OH&S).

The moral argument

Businesses need to protect workers and visitors from the pain and suffering of workplace illness and injury. This is the moral obligation to improve workplace safety.

The legal argument

Non-compliance with OH&S Acts can lead to heavy fines, jail terms and possibly being sued. It's better to comply with legislation than to risk such legal penalties

The financial argument

Workers' compensation insurance, lost productivity, damage to equipment, etc. costs billions of dollars a year in Australia. Effective health and safety practices can reduce this cost.

Legislation and guidelines

If you work in Australia, you will be covered by a state or territory Occupational Health and Safety Act which is administered by the state-based WorkCover Authority (or an equivalent). The object of these Acts is to protect you, and others such as visitors, from risks at work. There are also associated Acts, regulations and codes of practice to support the principal Act.

The codes set out practical ways to achieve the health and safety standards required by the relevant Acts. There are both national and state/territory codes. National codes that apply to the office environment deal with such things as manual handling and occupational overuse syndrome.

Unlike the General Insurance Code of Practice we discussed in section 4, these codes lack the legal force of legislation and you can't be prosecuted if you don't comply with them. While you can't be prosecuted for non-compliance, the fact that you don't comply could be used in evidence in a court case.

Both in Australia and overseas, many businesses have developed their own company guidelines and practices for workers to follow.



Activity 7.1

Find the OH&S guidelines that you are expected to follow in your office. These will be useful for future activities.

Before you read on, make some brief notes on what the most common injuries and illnesses are in your workplace. How could they have been prevented?

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Key provisions

There are certain key provisions which you will find in all OH&S Acts.

- duties of employers towards their employees
- duties of employees
- duties of employers and employees towards non-employees (e.g. workplace visitors)

Duties of employers

Employers must:

- provide or maintain safe plant such as machinery and equipment. This includes providing equipment that is designed and set up to support your body against strains.
- provide safe systems of work. This includes planning ahead to avoid heavy workloads that could lead to fatigue and greater chance of accidents.
- ensure the safe use, handling, storage or transport of plant and substances such as harmful chemicals or materials
- provide the information and training necessary to ensure employees' health and safety
- maintain safe workplace facilities by such things as ensuring fire exits are not blocked and emergency equipment is working
- monitor the health and safety conditions of the workplace
- keep accurate records relevant to workers' health.

Employers could be fined or imprisoned if they fail to meet these obligations.

Employers need to take a preventative approach to OH&S so that accidents and/or illnesses don't happen in the first place. The following case study asks you to reflect on this issue. Read the case study and answer the self help questions after it.



Case study 7.1

Yarra Insurance and Octagon Insurance have recently amalgamated and consolidated in Yarra Insurance's head office.

The office is struggling to accommodate the influx of new staff. Staff have to move office furniture around to make room for the new workstations. There are not enough power points for all the new equipment and so there are a number of leads plugged into power boards that were found in the back of a storeroom. Some leads lie across aisles and under workers' chairs.

There are short deadlines for integrating the two companies' systems so that operations can resume as normal. Everyone is expected to put in extra hours until the work is done. Those at the new workstations begin to complain about aching shoulders and wrists.

Tony is the OH&S representative in the head office. He is concerned about what he sees and contacts the office manager to discuss ways of preventing any major injuries.

• • • • •



Self help question 7.1

- 1 What potential health and safety problems might Tony see?
- 2 What preventative steps could be taken to reduce those problems?

Suggested answers are provided at the end of this section.

• • • • •

Duties of employees

As an employee, you are expected to take reasonable care of your own health and safety as well as the health and safety of other people at your workplace.

You must co-operate with the employer and meet any health, safety and welfare requirements.

If you breach an OH&S Act, you could be fined or jailed.

If a work related illness or injury does occur, you should not:

- make it difficult to give or receive aid
- interfere with plant or equipment involved in the accident. (You could of course move or disturb plant to free a trapped worker or to avoid injury or property damage.)

Duties towards non-employees

OH&S legislation also generally requires that employers and employees ensure the health and safety of non-employees (e.g. visitors) at places of work.

As above, failure to meet these obligations can result in fines or imprisonment. An employer can't insert a clause in a contract to try and avoid these obligations.



Activity 7.2

Look again at the workplace guidelines you identified earlier. Find the sections which refer to the obligations of employers and employees and compare them to the common sorts of obligations outlined above.

Are the requirements in your company's guidelines similar? Make notes on any key differences you find.

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How do you comply with the legislation?

All businesses and self-employed persons need to have a basic understanding of what they are required to do under the Acts, regulations and any relevant industry codes of practice. Your employer must:

- a) formulate and implement OH&S policies by establishing:
 - qualified health and safety officer/s to advise on OH&S issues—this includes the appointment of a WorkCover representative and could include the establishment of an OH&S committee.
 - safety-focused procedures
 - employee induction systems
 - safe systems of work, and
 - ongoing relevant safety training.

- b) implement a structured risk management program, including:
 - regular workplace inspections to identify hazards and assess risks
 - risk control measures in response to assessed risks
 - accident/incident recording and investigation, with a strong focus on ongoing monitoring to prevent a recurrence
 - ongoing employee participation through active involvement and consultation
 - regularly reviewing and/or improving policies, procedures and safety strategies
 - conducting regular safety audits to evaluate the effectiveness of the OH&S system.

You must:

- a) take reasonable care for the safety of others in the workplace by following safe work practices—avoiding horseplay, workplace initiation rites, and other dangerous activities.

- b) actively help your employer to comply with his or her responsibilities under the Act by:
 - complying with the firm's OH&S policies and procedures
 - promptly reporting to management all safety or health concerns
 - promptly reporting to management any accidents, or 'near misses'
 - promptly informing the person responsible for WorkCover of any injuries

- actively participating in safety training
 - wearing or using appropriate clothing and equipment
 - using equipment, and substances safely
 - not misusing or interfering with safety equipment or signs.
- c) refraining from deliberately creating a safety or health risk as a means of disrupting work.

To reinforce your understanding of OH&S, read the following case study and answer the self help questions after it.



Case study 7.2

Jenny has been working in the offices of HRB Insurance for three months. She is carrying two boxes of photocopy paper to the photocopier. The boxes she is carrying obscure her view and she trips over one of a number of file boxes on the floor beside the photocopier. The file boxes won't fit in the storage room because it is full of old files, equipment and past publications etc. There have been a number of complaints about the problem over the last three months, but nothing has been done about it.

After tripping, Jenny feels a twinge in her back, but doesn't think too much about it. She doesn't know the OH&S procedures and she doesn't complete an incident report. Three weeks later, her back 'gives out' and her doctor tells her she needs to take two weeks off to recover fully. She has no sick leave left and is afraid she will have to sacrifice some of her annual leave.

• • • • •



Self help question 7.2

Which of the above key elements of compliance might have been breached in the case study by:

- a the employer?
- b the employee/s?

Suggested answers are provided at the end of this section

• • • • •



Activity 7.3

How safe is your workplace?

Following is a generic hazard-inspection checklist for offices.

- 1 Use the checklist to see how well your workplace complies with safety requirements.
- 2 One of the essential strategies for maintaining a safe workplace is to conduct a regular safety inspection to identify hazards and risks. How long has it been since a formal hazard check was done in your workplace?

• • • • •

HAZARD INSPECTION CHECKLIST

Location of workplace: _____ Date of inspection: _____

Inspection carried out by: _____

Subject	Rating			Comments
	Good	OK	Poor	
Staff amenities				
Toilets, lockers, washroom, meal room, are hygienic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubbish bins regularly emptied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
First aid				
First aid kit is available and stocked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emergency contact numbers displayed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fire				
Staff regularly trained in emergency procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Right extinguishers in place, recently serviced, clearly marked for type of use, unobstructed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exit doors easily opened from the inside and routes unobstructed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fire alarm system functioning correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sprinklers unobstructed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floors and stairs				
Even—no holes—floor covering intact—no trip hazards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clean—rubbish picked up—areas around desks tidy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clear—materials stored out of the way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aisles				
Wide enough for human/goods traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clearly lit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unobstructed—clear of electrical cords, rubbish etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Noise and vibration				
Printers hooded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Photocopier separated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indoor climate				
Suitable temperature—no drafts—good ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
No odours, dust or fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Storage				
Enough room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Designed to minimise lifting, twisting, pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appropriate racks or bins for storage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shelves clean—free from dust and rubbish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floors even and free from rubbish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light items on top, heavy towards the bottom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electrical equipment				
Properly stored when not in use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
In good condition—no broken equipment e.g. faulty plugs, sockets, switches and cords	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adequate for the job—no temporary double adaptors or leads in use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Equipment or tools in good condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Security				
Operating properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

OTHER COMMENTS:

(Note other risk factors which may be present at your workplace)

COMPLETED CHECKLIST REFERRED TO: _____

Summary

In this section, we have considered the sorts of occupational health and safety issues and processes that you need to think about in an office environment. Firstly, we looked at common legal requirements for you and your employer and then we discussed what actions you need to take in your workplace to ensure that you follow the law.

If you come from a country without OH&S legislation, you can use this section as a guide for establishing workplace safety. The underlying idea to be taken from this section is that it is in everyone's interest to be alert to OH&S issues in the workplace.

This is the final section in this module. We hope that you have finished the module with a clear idea of the legal environment in which you work.

Good luck with the rest of your studies.

Answers to self help questions

Self help question 7.1

Possible problems

Strains and sprains from lifting.

Shocks from old power boards.
Trips on leads.

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Possible action

Manual handling training. Hire moving staff.

Installing new power points as soon as possible. In the short-term, sticking down leads around walls.

Mental stress.
Strained muscles
from overuse.

There are short deadlines for integrating the two companies' systems so that operations can resume as normal. Everyone is expected to put in extra hours until the work is done. Those at the new workstations begin to complain about aching shoulders and wrists.

Adjusting timelines to reduce short-term stress, or hiring short-term staff to meet deadlines.
Ensuring workstations are adjusted to suit individuals' build.

Self help question 7.2

Possible breaches by employee

Could indicate lack of compliance with company manual handling guidelines.

Jenny should have reported the incident straight away.

Jenny has been working in the offices of HRB Insurance for three months. She is carrying two boxes of photocopy paper to the photocopier. The boxes she is carrying obscure her view and she trips over one of a number of file boxes on the floor beside the photocopier. The boxes won't fit in the storage room because it is full of old files, equipment and past publications etc. There have been a number of complaints about the problem over the last three months, but nothing has been done about it.

After tripping, Jenny feels a twinge in her back, but doesn't think too much about it. She doesn't know the OH&S procedures and she doesn't complete an incident report.

Three weeks later, her back 'gives out' and her doctor tells her she needs to take two weeks off to fully recover. She has no sick leave left and is afraid she will have to sacrifice some of her annual leave.

Possible breaches by employer

Possibly lack of manual handling training.

Lack of regular hazard/risk checks.

This suggests there are problems with the monitoring procedures. OH&S officer might not be doing the job properly. Maybe employees are not being consulted.

Possibly a lack of a proper induction and/or training. Problems with reporting processes as well. Accident not recorded or investigated—this creates the problem in final paragraph.