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Unenforceable Exclusions in Travel Insurance

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Abstract

The duty of disclosure that applies to the vast majority of travel insurance contracts entered in Australia requires a matter to be disclosed to an insurer only if the insurer has asked a specific question that calls for that matter to be disclosed. Many exclusion clauses in standard forms of travel insurance mass-marketed in Australia are unenforceable. Some exclusion clauses purport to result in there being different consequences of the insured not informing the insurer, at the time of entering the contract, about some matter, to the consequences that are provided by section 28 Insurance Contracts Act 1984 (Cth) ("IC Act"). To the extent that they purport to result in those different consequences, those exclusion clauses are unenforceable by virtue of section 33 IC Act. Other exclusion clauses have wide definitions of "pre-existing medical condition" and purport to exclude cover concerning all such pre-existing medical conditions. Insofar as these exclusion clauses include in the definition of "pre-existing medical condition" matters other than the sickness or disability that is a cause of a claim, and that the insured was aware of at the time of entering the contract, the clauses are an unenforceable by virtue of section 47 IC Act. Including unenforceable clauses in standard forms of policy is misleading market behaviour. ASIC has ample powers to curb unenforceable clauses like these being included in mass-marketed contracts.

Australians are great travellers, and great consumers of travel insurance. In 2016 41% of adult Australians had travelled overseas in the previous 12 months, and 92% of those travellers had travel insurance[1]. When the numbers are so large, how that insurance operates in practice is of significant public interest. There has been some

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[1] Insurance Council of Australia/Department of Foreign Affairs and Trade *Survey of Australians' Travel Insurance Behaviour* August 2016 http://smartraveller.gov.au/guide/all-travellers/insurance/Documents/survey-travel-insurance-behaviour-web.pdf page 12, 15. The proportion that had purchased travel insurance had dropped marginally to 91% in 2017: *Survey of Australians' Travel Insurance Behaviour 2017* http://smartraveller.gov.au/guide/all-travellers/insurance/Documents/2017-survey-of-Australian-travel-insurance-behaviour.PDF page 9, which the report said was not a significant difference.

publicity about consumers having unhappy experiences when a travel insurance claim was rejected[2].

The contracts of travel insurance available in the market cover loss arising from many types of risk, and are subject to many different types of exclusions. This paper will focus on just one aspect of travel insurance, namely how the policies available in the market operate concerning losses arising from pre-existing medical conditions. However, there will be aspects of the arguments in this paper that will be applicable, at least by analogy, concerning other types of loss, and other types of exclusion clause in contracts of travel insurance. Some aspects of the arguments will also be applicable, with appropriate alterations, to types of general insurance other than travel insurance.

Sometimes travel insurance is acquired not by the traveller entering a contract with an insurer, but as a complimentary extra benefit of the traveller holding a particular type of credit card[3]. Concerning that type of travel insurance the contract of insurance is one between the credit card provider and an insurer, with the credit card holder being a third party beneficiary of that contract. Section 48 *Insurance Contracts Act 1984 (Cth)* ("*IC Act*") entitles a third party beneficiary of an insurance contract to claim under the contract, on certain conditions. However, special problems are raised by the application to a complimentary insurance policy of the sections of the *IC Act* that this paper discusses. Thus this paper concerns itself only with the operation of travel insurance that is purchased under a contract to which at least one of the insured travellers is a party.

The forms of travel insurance contract underwritten in Australia differ from insurer to insurer, but each insurer has its own standard form of contract, that it nearly always uses to write this form of business. It is a very common practice for an insurer's standard form of travel insurance contract to provide coverage for losses arising from cancellation of travel bookings that arise from an unforeseen event, for medical expenses incurred outside Australia, and for additional costs incurred by reason of becoming ill or injured while travelling.

It is also common for such contracts to contain exclusion clauses[4] that purport to deny cover if a loss of the type insured against arises from a pre-existing medical

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[2] "Travel Insurance Horror Stories", *Sydney Morning Herald* August 16 2017 Money section page 1-2. 10% of the 8,094 domestic insurance disputes received by the Financial Ombudsman's Service in 2016-17 related to travel insurance: https://www.fos.org.au/custom/files/docs/fos-annual-review-20162017.pdf page 76

[3] The 2016 survey referred to in footnote 1 found that 20% of Australian travelling overseas in 2016 obtained travel insurance through a credit card – page 22

[4] Some examples drawn from the standard terms of contracts marketed online in Australia in 2017 are set out in Appendix 1 to this paper, at page 67- 72 .

condition of the insured or of a travelling companion of the insured[5]. The contracts available in the market differ, sometimes significantly, in the wording of the exclusion clauses. Sometimes the exclusion clauses specifically state that they exclude coverage for a pre-existing medical condition except where it has been disclosed. Sometimes they simply state that the pre-existing medical condition is excluded, with no mention of whether the condition has been disclosed.

It is elementary that any exclusion clause in an insurance contract is construed *contra proferentem*, ie against the interest of the insurer in the case of a standard form policy issued by the insurer, if the clause is ambiguous[6]. This paper is concerned with two different bases, separate to the *contra proferentem* principle, upon which an exclusion clause in a travel insurance contract might not be enforceable in accordance with its terms.

Many of the exclusion clauses are drafted in words that, if read literally, would entitle the insurer to deny liability if it eventuated that a loss insured against arose from a pre-existing medical condition that the insured had not told the insurer about, even if the duty of disclosure under the *IC Act* had not required the proponent for insurance to inform the insurer about that medical condition before the inception of the contract. This paper argues that, to the extent that the exclusion clauses purport to entitle the insurer to deny liability concerning a pre-existing medical condition that the insured knew about before the contract was entered, the exclusion clause cannot be enforced according to its terms. Instead, if the medical condition is one in relation to which the insured had a duty of disclosure, the insurer has the remedies provided by section 28 *IC Act*, and no others. If the medical condition is one in relation to which the insured had no duty of disclosure neither the exclusion clause nor section 28 *IC Act* gives the insurer any right to deny or limit its liability.

In addition to this, many of the contracts contain extremely wide definitions of "pre-existing medical condition", and purport to exclude liability for claims connected

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[5] It is also common for the contracts to contain a list of particular medical conditions, of a type that are usually not serious or likely to interfere with anyone's travel plans, that the contract states are exempted from any requirement for disclosure. This paper is not concerned with medical conditions that fall within such a list.

[6] *Maye v Colonial Mutual Life Assurance Society Ltd* (1924) 35 CLR 14 at 26-27; *Australian Casualty Co Ltd v Federico* (1986) 160 CLR 513 at 520-1 per Gibbs CJ; *Hammer Waste Pty Limited v QBE Mercantile Mutual Ltd* [2002] NSWSC 1006; (2003) 12 ANZ Ins Cas ¶ 61-553 at [25]-[27] and cases there cited. It is a principle of construction of contracts generally, not just of insurance contracts, that one should construe an exclusion clause *contra proferentem* in the case of ambiguity: *Darlington Futures Limited v. Delco Australia Pty Limited* (1986) 161 CLR 500 at 510; *Nissho Iwai Australia Limited v. Malaysian International Shipping Corporation, Berhad* (1989) 167 CLR 219, at 227. However the *contra proferentem* principle is a rule of last resort, in the sense that it is the way of resolving an ambiguity when other aids to construction are not adequate to resolve the ambiguity: *North v Marina* [2003] NSWSC 64; (2003) 11 BPR 21,359 at [56] –[78].

with any pre-existing medical condition as so defined. While it would depend on the circumstances of an individual claim, in relation to a significant number of claims arising from the sickness or disability of one of the insureds those exclusion clauses are unenforceable by virtue of section 47 *IC Act*.

1. The two different duties of disclosure

The precise extent of the statutory duty of disclosure for a travel insurance contract has varied over the life of the *IC Act*[7]. In the form of the legislation current at the time of writing[8] there are two different formulations of the duty of disclosure that could be relevant to what could, as a matter of ordinary English, be called a "contract of travel insurance".

1.1 The general duty of disclosure

Section 21 of the *IC Act* defines the extent of a general duty of disclosure that applies, subject to any other provision of the Act, to all contracts of insurance that fall within the ambit of the *IC Act*. The core provision in s 21 is:

> (1) Subject to this Act, an insured has a duty to disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known to the insured, being a matter that:
>
> (a) the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms; or
>
> (b) a reasonable person in the circumstances could be expected to know to be a matter so relevant, having regard to factors including, but not limited to:
>
> (i) the nature and extent of the insurance cover to be provided under the relevant contract of insurance; and
>
> (ii) the class of persons who would ordinarily be expected to apply for insurance cover of that kind.

The "Subject to this Act" at the start of section 21 is important for present purposes, because since 1998[9] what I shall call a particular duty of disclosure applies, under section 21A *IC Act*, concerning the original entering of an "eligible contract of

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[7] The formulation of the general duty of disclosure under section 21 has changed as a result of amendments made by the *Financial Laws Amendment Act 1997* (but only to make the language gender-neutral) and the *Insurance Contracts Amendment Act 2013* ("*the 2013 Amending Act*") (adding to the end of section 21(1) (b) the words that commence with "having regard to factors including …", which is probably not a change of substance). The insertion into the Act of the particular duty of disclosure has made a change of substance.

[8] Contained in Compilation No 24 of the *Insurance Contracts Act 1984* (15 July 2017), and Compilation No 15 of the *Insurance Contracts Regulations 1985*, (13 January 2016).

[9] The particular duty of disclosure under section 21A was first introduced by the *Insurance Laws Amendment Act 1998*, and stated in different terms by a replacement version of s 21A introduced by the 2013 Amending Act, which took effect on 28 December 2015.

insurance". In accordance with the principle of statutory construction that a specific provision prevails over a general one[10], it is the particular duty of disclosure, not the general duty, which applies whenever there is an original entering into of an "eligible contract of insurance".

As will be discussed later, most (but not all) contracts that would ordinarily be called "travel insurance" are" eligible contracts of insurance". In particular, practically all of the standard form contracts that are mass-marketed to consumers are "eligible contracts of insurance". Thus most mass-marketed contracts of travel insurance are subject to the particular duty of disclosure, not the general duty.

1.2 The particular duty of disclosure

Section 21A *IC Act*[11] provides:

> *Scope*
>
> (1) This section applies in relation to the original entering into of an eligible contract of insurance.
>
> Note: This section does not apply in relation to the renewal, extension, reinstatement or variation of an eligible contract of insurance. Section 21B applies in relation to the renewal of an eligible contract of insurance.
>
> *Position of the insurer*
>
> (2) Before the contract is originally entered into, the insurer may request the insured to answer one or more specific questions that are relevant to the decision of the insurer whether to accept the risk and, if so, on what terms.
>
> (3) If the insurer does not make a request in accordance with subsection (2), the insurer is taken to have waived compliance with the duty of disclosure in relation to the contract.
>
> (4) If the insurer:
>
> (a) makes a request in accordance with subsection (2); and

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[10] Pearce & Geddes *Statutory Interpretation in Australia* (8th ed LexisNexis Butterworths Australia 2014) ("*Pearce & Geddes*") [4.40]-[4.41] and cases there cited

[11] Section 21A applies only to the original entering into of an eligible contract of insurance, not to when such a contract is renewed, extended, reinstated or varied. Slightly different provisions, arising under section 21B *IC Act*, apply to the duty of disclosure for eligible contracts of insurance when such a contract is renewed. Section 21B was added to the Act by the 2013 Amending Act. Before section 21B was added the general duty of disclosure under s 21 applied concerning renewals of eligible contracts of insurance. As the Explanatory Memorandum for the 2013 Amending Act noted (at [1.56]) this could be "onerous for insureds in comparison with, for example, the framework for eligible contracts under section 21A". There are still no special provisions concerning the extent of the duty of disclosure when an eligible contract of insurance is extended, reinstated or varied. For ease of exposition, and because consumers tend to take out travel insurance to cover a particular trip and do not renew or extend the contract, this paper will deal only with the duty of disclosure that applies upon the original entering of the contract of insurance.

(b) requests the insured to disclose to the insurer any other matter that would be covered by the duty of disclosure in relation to the contract;

then the insurer is taken to have waived compliance with the duty of disclosure in relation to that other matter.

Position of the insured

(5) If:

(a) the insurer makes a request in accordance with subsection (2); and

(b) in answer to each specific question included in the request, the insured discloses each matter that:

(i) is known to the insured; and

(ii) a reasonable person in the circumstances could be expected to have disclosed in answer to that question;

then the insured is taken to have complied with the duty of disclosure in relation to the contract.

Definition

(6) In this section:

eligible contract of insurance means a contract of insurance that is specified in the regulations for the purposes of this section.

There are several ways in which it is easier for an insured to comply with the particular duty of disclosure than with the general duty of disclosure. First, the general duty of disclosure places on the insured the onus of deciding what matters he or she knows, that satisfy either para (a) or para (b) of section 21(1), and requires the insured to disclose those matters. The particular duty of disclosure places no such onus on the insured. Instead all that the insured is required to do is to provide answers to specific questions that the insurer has asked. Under the general duty of disclosure, an insured could fail to comply with the duty of disclosure by failing to volunteer information that the insurer had not asked about. That cannot happen concerning the particular duty of disclosure.

Second, the general duty of disclosure requires the insured to consider what matters the insured knows are relevant to the decision of the insurer whether to accept the risk and if so on what terms. The particular duty of disclosure does not depend on the insured knowing anything about what matters are relevant to the decision of the insurer whether to accept the risk and if so on what terms – it just requires the insured to answer questions.

Third, the questions that the insurer can ask, for the purposes of the particular duty of disclosure, are limited in scope. They must be specific questions, not general

ones. As well, they must be relevant to the decision of the insurer whether to accept the risk and if so on what terms[12].

Fourth, what the insured is required to disclose, in answer to a question, is limited in scope. It is only matter that is known to the insured, AND that a reasonable person in the circumstances could be expected to have disclosed in answer to that question.

2. What is an "eligible contract of insurance"

As contemplated by section 21A (6) *IC Act*, what counts as an "eligible contract of insurance" is prescribed by a regulation. Under Regulation 2B of the *Insurance Contract Regulations 1985* ("*IC Regulations*") there are two different ways in which an insurance contract can be an "eligible contract of insurance". The first arises under Regulation 2B (1):

> (1) A contract of insurance is an ***eligible contract of insurance*** if it:
>
> (a) is for new business; and
>
> (b) is wholly in a class of contracts that is declared to be a class of contracts in relation to which Division 1 of Part V of the Act applies.

A note to Regulation 2B (1) states:

> Note: The following regulations declare certain classes of insurance contracts for Division 1 of Part V of the Act:
>
> ☐ regulation 5 (motor vehicle insurance)
>
> ☐ regulation 9 (home buildings insurance)
>
> ☐ regulation 13 (home contents insurance)
>
> ☐ regulation 17 (sickness and accident insurance)
>
> ☐ regulation 21 (consumer credit insurance)
>
> ☐ regulation 25 (travel insurance)

This note is part of the Regulation[13], and so is to be taken into account in construing it. The note creates the impression in the reader that, either always or usually, travel insurance is an eligible contract of insurance.

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[12] That is, the words "relevant to the decision of the insurer whether to accept the risk and if so on what terms" in section 21A(2) provide a limit on the questions the insurer can ask, not something to which the insured must turn his or her mind.

[13] Section 13 *Acts Interpretation Act 1901 (Cth)*, as replaced by Act No 46 of 2011. The previous version of section 13 had required that notes not be taken to be part of an Act. Clause 1 of Schedule 3 of the 2011 amending Act made clear that its amendments applied to Acts that had been earlier enacted. Section 46 *Acts Interpretation Act 1901 (Cth)* and section 13 *Legislation Act 2003 (Cth)* make the provisions of the *Acts Interpretation Act* applicable to regulations. Thus the new section 13 applies to the construction of Regulation 2B (1).

Many mass-marketed travel insurance contracts are eligible contracts of insurance by virtue of Regulation 2B(1) operating in conjunction with Regulation 25 *IC Regulations*, which provides:

> The following class of contracts of insurance is declared to be a class of contracts in relation to which Division 1 of Part V of the Act applies, namely, contracts that provide insurance cover (whether or not the cover is limited or restricted in any way) in respect of one or more of the following:
>
> (a) financial loss in respect of:
>
> (i) fares for any form of transport to be used; or
>
> (ii) accommodation to be used;
>
> in the course of the specified journey in the event that the insured person does not commence or complete the specified journey;
>
> (b) loss of or damage to personal belongings that occurs while the insured person is on the specified journey;
>
> (c) a sickness or disease contracted or an injury sustained by the insured person while on the specified journey;
>
> where the insured or one of the insureds is a natural person.

2.1 Interpreting Regulation 2B (1) – "wholly in"

By Regulation 2B(1), an insurance contract is only an eligible contract of insurance if it is "wholly in a class of contracts" declared to be ones to which Division 1 of Part V of the Act applies. This wording is less than pellucid, and in consequence there is a difficulty in its interpretation. It arises as follows.

Many of the risks that common forms of travel insurance contracts insure against are merely specific subcategories of one of the three types of risk identified in Regulation 25. For example, insurance against the cost of having a companion travel home with an insured person who has become ill, or against the cost of returning home the body of an insured who dies while travelling, are specific examples of "cover in respect of … a sickness or disease or an injury sustained by the insured person while on the specified journey". [14] Similarly, insurance against the cost of purchase of emergency clothing or toiletries when a transport provider has mislaid baggage, or against unauthorised use of credit cards that are stolen, are specific

[14] *IC Regulations* cl 25(c). Depending on the context it is in, the phrase "in respect of" is capable of indicating a wide range of different types of connection between two subject matters (*Wonall Pty Ltd v Clarence Property Corporation Ltd* [2003] NSWSC 497, (2003) 58 NSWLR 23, at [41]-[43]), and in the insuring clause of an insurance contract, which is construed *contra proferentem*, would be given a wide range of operation

examples of "cover in respect of … loss of or damage to personal belongings that occurs while the insured person is on the specified journey."[15]

The difficulty with the interpretation of Regulation 25 arises because it is fairly common for a mass-marketed form of travel insurance contract to provide cover against losses that extend *beyond* the three types of risk identified in Regulation 25. For example, some contracts provide cover against extra costs that are incurred if a transport provider fails to provide transport that it had agreed to provide[16], against the extra costs that the insured incurs in returning home if the insured's home is destroyed by a natural disaster or if the insured's business partner dies or becomes ill during the voyage, and against any legal liability of the insured to pay compensation to someone else for an event that occurs during the voyage.

To fall within Regulation 25 a contract must provide cover against one or more of the three stipulated types of risk, and the insured or one of the insureds must be a natural person. Regulation 2B (1) says that a contract of insurance that is new business and is "wholly in" the class of contracts identified by Regulation 25 is an eligible contract of insurance. Some might argue that an insurance contract that provides insurance against *more* types of risk than the three types listed in Regulation 25 is not "wholly in the class of contracts" identified by Regulation 25, and thus was not an "eligible contract of insurance". However, such an argument ought not to prevail. The reasons why that is so are a little lengthy, and would be a distraction from the main argument of this paper if set out here, so they appear in Appendix 2[17].

2.2 Travel insurance contracts that are not an "eligible contract of insurance" under Reg 2B(1)

The sorts of contract of travel insurance that would not count as an "eligible contract of insurance" under Regulation 2B(1) would include ones where no natural person was an insured, or where none of the risks covered included a risk of the type identified in Regulation 25. An example of the former would be where the only insured was a corporation that insured against its own loss arising as a consequence of an officer or employee travelling. An example of the latter would be insurance against nothing but legal liability that the insured incurred while travelling. Such contracts are not like the types of contracts that are mass-marketed as travel

[15] *IC Regulations* cl 25 (b)
[16] Whether such a provision was outside the three risks in Regulation 25 would depend upon whether, if the insured paid for and used replacement transportation, the insured would be completing "the specified journey".
[17] at pages 72 to 78 below

insurance, and so it is understandable that the general duty of disclosure that arises under s 21 would apply concerning them.

2.3 What is an "eligible contract of insurance" - Regulation 2B(2)

The second way in which a contract can be an "eligible contract of insurance" arises under Regulation 2B (2)[18]:

> (2) A contract of insurance is an eligible contract of insurance if:
>
> (a) it is not mentioned in subregulation (1); and
>
> (b) it is for new business; and
>
> (c) the insurer, before the contract is entered into, gives to the insured:
>
> (i) a written notice in accordance with the form set out in Part 3 of Schedule 1; or
>
> (ii) an oral notice in accordance with the words set out in Schedule 2; or
>
> (iii) a notice otherwise complying with subsection 22(1) of the Act clearly informing the insured of the general nature and effect of the duty of disclosure and the general nature and effect of section 21A of the Act.

Any contract of insurance whatever that is for new business, regardless of the types of risks it covers, will necessarily fall within either Regulation 2B(1) or Reg 2B(2) (a) and (b). Thus a contract that is for new business and that covers risks far removed from consumer insurance, like a directors and officers liability contract, or a contract of professional indemnity insurance, is capable of being an eligible contract of insurance under Regulation 2B (2). Whether a contract for new business is an "eligible contract of insurance" under Regulation2B (2) will depend on a decision of the insurer, about whether to give one of the three types of notice that are identified in Regulation 2B(2) (c)[19]. What is relevant for present purposes is that, to

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[18] This route to being an "eligible contract of insurance" is subject to an exception in the nature of a transitional provision, identified in Reg 2B (3), that will not be of lasting importance.

[19] Regulation 2B (2) (c) (iii) is not happily drafted. This is because section 22(1) of the Act provides, so far as presently relevant:

> (1) The insurer must, before a contract of insurance is entered into, clearly inform the insured in writing:
>
> (a) of the general nature and effect of the duty of disclosure; and
>
> (b) if section 21A or 21B applies to the contract—of the general nature and effect of that section; and
>
> …
>
> (d) that the duty of disclosure applies until the proposed contract is entered into.

Section 21A applies to a contract only if the contract is *already* an eligible contract of insurance. Regulation 2B (2) (c) (iii) is intended to provide a means whereby a contract can be identified as being an "eligible contract of insurance". Yet one of the criteria under that Regulation depends on whether section 21A applies to the contract. This is circular. The argument of this paper can be advanced without considering Regulation 2B (2) (c) (iii) any further.

at least some extent, Regulation 2B (2) may provide a route by which some contracts of travel insurance will be "eligible contracts of insurance", quite independently of Regulation 2B (1).

3 Ways in which a proponent for an eligible contract of insurance could comply with the duty of disclosure, while still not informing the insurer about what turned out to be a medical condition he or she in fact had

There are several ways in which a proponent for travel insurance under an eligible contract of insurance might have complied with the statutory duty of disclosure even though he or she had not informed an insurer of what turned out to be a medical condition he or she in fact had, and that caused a loss to the insured of a type within the scope of the risks against which the travel insurance insured.

3.1 The matter must be "known to the insured"

The only matters that the duty of disclosure requires the insured to disclose to the insurer are matters that are "known to the insured"[20]. The word "knows":

> "is a strong word. It means considerably more than "believes" or "suspects" or even "strongly suspects""[21].

A somewhat fuller statement is that:

> "what is required is that the matter should be the subject of a true belief, held with sufficient assurance to justify the term "known""[22]

Thus if at the time of entering an eligible contract of insurance an insured in fact has a medical condition, but does not know that he or she has it, there will be a duty of disclosure concerning anything connected with that condition only if the insurer has asked questions that are calculated to elicit whatever it is that the insured knows, short of knowing about the condition itself, that relates to that medical condition.

3.2 Ambiguous questions generally

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[20] Section 21(1) *IC Act*, section 21A (5) (i) *IC Act*

[21] *Permanent Trustee Australia Ltd v FAI General Insurance Company Ltd (in liquidation)* [2003] HCA 25, (2003) 214 CLR 514 at [30]

[22] *Permanent Trustee Australia v FAI General Insurance Co Ltd* (1998) 44 NSWLR 186 at 247 per Hodgson CJ in Eq, cited with approval on appeal in *Permanent Trustee Australia Co Ltd v FAI General Insurance Co Ltd* [2001] NSWCA 20; 50 NSWLR 679 at [41], by the Queensland Court of Appeal in *Australian Casualty & Life Ltd v Hall* [1999] QCA 240; (1999) 151 FLR 360, at 371 at [43]-[44] per Shepherdson J and in *Hammer Waste Pty Ltd v QBE Mercantile Mutual Limited* [2002] NSWSC 1006; (2003) 12 ANZ Insurance Cases ¶ 61-553 at [58]

Because the duty of disclosure for an eligible contract of insurance turns on questions that the insurer asks and that the proponent answers, the terms of the questions that the insurer actually asks are critical for whether the duty of disclosure has been performed.

Section 23 of the Act provides:

> Where:
>
> (a) a statement is made in answer to a question asked in relation to a proposed contract of insurance … and
>
> (b) a reasonable person in the circumstances would have understood the question to have the meaning that the person answering the question apparently understood it to have;
>
> that meaning shall, in relation to the person who made the statement, be deemed to be the meaning of the question.

The effect of section 23 is that ambiguous questions that an insurer asks in relation to a proposed contract of insurance are construed *contra proferentem,* at least if two or more possible meanings of the questions would be reasonably open to a reasonable person, and the proponent apparently understood the question as having one of those meanings.

Section 23 implements a sensible legislative policy. It would be unduly onerous on insurers to treat a question as ambiguous if it had two possible meanings, but a reasonable person in the circumstances would not understand one of those meanings as being what the question intended to ask. As well, it is understandable that if the insured apparently understood an ambiguous question as having one meaning, the insured should not be able to gain any advantage from a question actually having a possible meaning that was different to the one that the insured apparently understood it as having. However, if a question is ambiguous, and a reasonable person would have understood it as having a particular meaning, and the insured apparently understood it as having that meaning, it is reasonable that there be no failure to comply with the duty of disclosure if the insured answers the question accurately in accordance with the meaning he or she apparently understood it to have.

In applying section 23 the words “apparently understood” have the effect that it is not the actual, subjective understanding that the insured had that matters, but rather what someone other than the insured would conclude or deduce the insured understood. However there are questions of construction about as at what time, and on the basis of what data, one is to decide what the insured “apparently

understood". In *Fruehauf Finance Corp Pty Ltd v Zurich Australian Insurance Ltd*[23] Brownie J said[24]:

> "One way of approaching sec. 23 would be to look at the completed proposal form from the point of view of the insurer at the time, and ask whether it would be reasonable for a person answering the questions to have understood them to have the meaning that that person apparently understood them to have. Another way would be to examine the same question now from the point of view of an observer at the trial, i.e. someone who also knows of matters such as, in this case, the thought processes of Messrs Kelly, Virgo and Forrester, who collectively completed the [proposal] form.
>
> This question was not debated, but on balance the former approach seems preferable: this approach looks to the position of the insurer at the time of making the decision whether to accept the proposed risk and, if so, upon what terms. The assumption is that the insurer devised the form of the questions so that if the answers suggest that the person giving the answers attributed a particular meaning to the questions, then in the circumstances set out in sec. 23, the insurer is bound by that meaning. But it does not mean that the insurer ought to know other facts, such as the thought processes involved in answering the question, perhaps first known to the insurer on a trial, years later …"

Very commonly, the answer that a proponent for insurance gives to a question in a proposal for insurance will not enable one to conclude what meaning the proponent gives to the question: often an answer will be a simple "yes" or "no", or similarly terse. An effect of Brownie J's approach to section 23 is that if, from the answer to the question one cannot tell what meaning the person answering the question apparently gave to it, section 23 has no work to do.

There is a long-standing principle of the common law that if a question in a proposal for insurance is ambiguous the question is read in a way that resolves the ambiguity *contra proferentem*, ie by adopting the meaning that is less favourable to the insurer[25]. That principle is capable of operating even if, from the answer to a

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[23] (1990) 6 ANZ Ins Cas ¶ 61-014

[24] At 76,785. These remarks are not part of the ratio of the decision – Brownie J acknowledged that the question was not debated, the reasons for judgment do not record any evidence having been given about the subjective understanding that the men who completed the proposal form had about the meaning of the questions, and thus the question does not appear to have been a live one in the litigation.His Honour also found, at 76,785 column 2, that from the answers it was possible to conclude how the person answering the question understood its meaning. Even so, his Honour's approach seems to be a sensible one.

[25] *Thomson* v *Weems* (1884) 9 App Cas 671 at 687 (approved and applied in *Huddleston v RACV Insurance Pty Ltd* (1975) VR 683 at 687 and *Stone v Tower Australia Ltd* [2003] NSWSC 683 at [82]) and 697; *Condogianis* v *Guardian Assurance Co* (1921) 2 AC 125, (PC) at 130; *Australian Casualty and Life Ltd v Hall* [1999] QCA 240; (1999) 151 FLR 360 at [59] per Shepherdson J (McMurdo P and Thomas J agreeing). This is a separate principle to the principle that the contract of insurance itself should be construed *contra proferentem*.

question, one could not tell how the insured had apparently understood the question. Section 23 should not be construed as preventing this common law principle from continuing to operate.

The *IC Act* adopts, to a very large extent, the recommendations of a report on insurance contracts that the Australian Law Reform Commission published in 1982[26] ("*the ALRC Report*"). In recommending the parent version of s 23 the ALRC Report said[27]:

> "in determining whether there has been a misrepresentation, any ambiguity in a question should continue to be resolved in favour of the insured."

Further, Brownie J himself did not regard his construction of section 23 as ousting the applicability of the *contra proferentem* principle to questions in a proposal form. He said[28]:

> "Finally, the plaintiff argued that question 7 should be construed *contra proferentem*. I agree, but for the reasons given concerning the answer to question 7(G), I do not think that this argument advances the plaintiff's case."

For these reasons, if the insured answers an ambiguous question accurately, in accordance with either the meaning the insured apparently understood it to have, or in accordance with one of the available meanings of the question, the insured does not fail to comply with the duty of disclosure.

3.3 Questions About a "Medical Condition" Can Be Ambiguous

The expression "medical condition" is one whose meaning is clear enough for many practical purposes. However it is far from precise in meaning. It is imprecise to such an extent that if an insurer asks a question in terms of whether an insured suffers from a "medical condition", with no further explanation, that can be an ambiguous question.

As a matter of ordinary English a "condition" can be simply the state in which something is[29]. A "medical condition" could be any state of health or bodily condition for which medical practitioners have a name. Many such "medical conditions" are quite benign. However, another meaning that is well open, as a matter of ordinary English, is that a "medical condition" is "any form of illness or

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[26] *Insurance Contracts* Report No 20 Law Reform Commission, Australian Government Publishing Service Canberra 1982

[27] at [185]

[28] at 76,785-76,786

[29] " the state of something with regard to its appearance, quality, or working order": Oxford Dictionary of English (3rd ed) OUP 2010) online version; "the state that something is in, especially how good or bad its physical state is": Longman Dictionary of Contemporary English online, at http://www.ldoceonline.com/dictionary/condition

abnormality in the body that interferes with a person's usual activities or feeling of wellbeing."[30]. A similar meaning is that it is "an illness or health problem that lasts a long time and affects the way you live"[31], or "an illness or health problem that affects you permanently or for a very long time"[32]. A person could have a bodily condition for which medical practitioners have a name, but in circumstances where there is no reason to believe it will interfere with that person's ordinary activities or sense of well-being. If a person has a bodily condition of that type, he or she could reasonably understand that a question asked by an insurer about whether the insured has a "medical condition" did not seek to find out whether the insured had a bodily condition of that type. What would be the point, after all, of the insurer knowing that the insured had a condition for which doctors had a name, but that was unlikely to interfere with the insured's ordinary activities? If an insured understood in that way the question that asked whether he or she had a "pre-existing medical condition", and gave an honest answer to the question as so understood, that would not be a failure to comply with the duty of disclosure[33].

It has been held that, in response to a question about whether a proponent has "any other condition or injury", a symptom is not a condition[34]. Thus even if an insured knows that he or she has something that is in fact a symptom of a medical condition, that is not the same as knowing that he or she has the condition. Even under the unreformed common law there was no obligation to disclose a symptom that a reasonable person would not regard as material or of a character to influence insurers[35].

3.4 Insurer Asking Questions Not Permitted

The only questions that section 21A(2) permits an insurer to ask, that trigger any consequences so far as performance of the insured's duty of disclosure is concerned, are ones that are relevant to the decision of the insurer whether to accept the risk and, if so, on what terms. If the insurer asks questions concerning any other matter,

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[30] http://www.nps.org.au/glossary/medical-condition as accessed in 2017
[31] http://www.macmillandictionary.com/dictionary/british/condition_1
[32] Longman Dictionary of Contemporary English online, at http://www.ldoceonline.com/dictionary/condition
[33] See *Darwen v Southern Cross Assurance Co Ltd* [1936] QSR 105 at 113, 118 for the analogous position under the common law
[34] *Australian Casualty and Life Ltd v Hall* (1999) 151 FLR 360 at [73], and see [8] per McMurdo P
[35] *Joel v Law Union and Crown Insurance Company* [1908] 2KB 863 at 884 per Fletcher Moulton LJ: "The duty is a duty to disclose, and you cannot disclose what you do not know … Let me take an example. I will suppose that a man has … occasionally had a headache. It may be that a particular one of those headaches would have told brain specialist of hidden mischief. But to the man it was an ordinary headache undistinguishable from the rest. Now no reasonable man would deem it material to tell an insurance company of all the casual headaches he had had in his life, and, if he knew no more as to this particular headache than that it was an ordinary casual headache, there would be no breach of his duty towards the insurance company in not disclosing it."

the effect of s 21A (4) is that the insurer waives compliance with the duty of disclosure concerning that other matter. One effect of this is that if the proponent gives an answer that is wrong or incomplete concerning that question, it does not give rise to any failure to comply with the duty of disclosure[36].

3.5 Incomplete questioning

If a specific question should elicit certain information from the proponent, but the insurer fails to ask that question (or any other specific question that should elicit the same information), it is an effect of section 21A (5) that the failure of the proponent to reveal that information is not a failure to comply with the duty of disclosure.

3.6 Proposals that define "pre-existing medical condition"

It is fairly common, but not universal, for the websites on which insurers give quotations for travel insurance to include a question about whether any of the travellers suffer from a pre-existing medical condition, and to include a reference, often by a hyperlink, to the text of the definition that the contract will use for "pre-existing medical condition".

The definitions of "pre-existing medical condition" vary from contract to contract, but for many of them the definition is extraordinarily wide. For example, under the Westpac contract[37] a person would have a pre-existing medical condition if that

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[36] Oddly though, if a proponent gave a wrong or incomplete answer to a question that was not relevant to the decision of the insurer whether to accept the risk or on what terms, that answer could still be a misrepresentation. The circumstances in which it was taken to be a misrepresentation would be limited, but not completely annihilated, by sections 26 and 27 *IC Act*, which provide:

> **26 Certain statements not misrepresentations**
>
> (1) Where a statement that was made by a person in connection with a proposed contract of insurance was in fact untrue but was made on the basis of a belief that the person held, being a belief that a reasonable person in the circumstances would have held, the statement shall not be taken to be a misrepresentation.
>
> (2) A statement that was made by a person in connection with a proposed contract of insurance shall not be taken to be a misrepresentation unless the person who made the statement knew, or a reasonable person in the circumstances could be expected to have known, that the statement would have been relevant to the decision of the insurer whether to accept the risk and, if so, on what terms.
>
> **27 Failure to answer questions**
>
> A person shall not be taken to have made a misrepresentation by reason only that the person failed to answer a question included in a proposal form or gave an obviously incomplete or irrelevant answer to such a question

However, concerning those misrepresentations that survived section 26 and 27, it is hard to see how section 28 (3) would provide any remedy to the insurer, for the reasons given at footnote 45 below. Thus it is not an anomaly that it remains possible for the answer to a question that offends section 21A (2) to be a misrepresentation.

[37] relevant parts of which are quoted in Appendix 1 at footnote 182

person had had, at any time, an appendectomy (which is "surgery involving … the abdomen") that involved an overnight stay in hospital. They would have a "pre-existing medical condition" regardless of the operation having occurred decades previously, and appendectomies usually being recovered from fully and quickly. The definition in the Westpac contract is triggered if there is "a medical condition of which you *were* aware prior to the time of the contract being issued that involves … surgery involving … the abdomen". [38] At the time the appendectomy occurred the proponent would have had a "medical condition" even on the more demanding meaning of that expression – the proponent had an abnormal condition of the appendix sufficiently serious to justify its removal and the interruption of the proponent's ordinary activities by a stay in hospital. Thus, even though at the time of making application for the contract the proponent would not say that he or she then had a "medical condition" in the ordinary sense of the words, that would not be enough to stop the definition from applying, because he or she *had once had* the medical condition of appendicitis. As well, under the Westpac contract a person would have a "pre-existing medical condition" if at any time in the two years before the contract was issued they had been prescribed a new medication: an extremely high proportion of the population has a "pre-existing medical condition" on that test even though many of the people who have been prescribed such medication are well able to carry out all their usual activities.

The definition in the Australian Seniors contract is even wider[39]: a person has a "pre-existing medical condition", under that contract if the person has "[a]ny physical defect, condition, illness or disease for which treatment, medication or advice (including investigation) has been received or prescribed by a medical or dental advisor" within the previous 90 days. That can extend to any condition at all concerning which the person had seen a doctor or dentist or taken prescription drugs, no matter how insignificant it was in the overall state of health of that person.

Under the Travel Insurance Direct contract[40] a pre-existing medical condition includes a medical condition that had been investigated or treated by a health professional at any time in the past, any condition for which prescribed medicine was (currently being) taken, and any condition for which the proponent had (ever) had surgery. Under that definition the majority of the adult population would have a pre-existing medical condition. The legally knowledgeable would realise that that definition that has been thus incorporated into the proposal would be read down, *contra proferentem*[41], to limit the meaning of "medical condition" and "condition" in

[38] The emphasis on the past tense verb is added
[39] Relevant parts of which are quoted in Appendix 1 at footnote 184
[40] Relevant parts of which are quoted in Appendix 1 at footnote 185
[41] See footnote 25 above

the *definiens*[42], but an ordinary consumer could take "pre-existing medical condition" or "condition" as extending to any condition at all concerning which he or she had seen a doctor or taken prescription drugs, no matter how insignificant it was in the overall state of health of that person.

However, the duty of disclosure under section 21A applies only to matters that are called for by a specific question, AND that are known to the insured, AND that a reasonable person in the circumstances could be expected to have disclosed in answer to the question. If the proposal form enquires whether any of the travellers have a pre-existing medical condition, by reference to an extended definition of "pre-existing medical condition", the wider that definition is the greater will be the prospect that a court will hold that a reasonable person could not be expected to disclose absolutely everything that fell within the definition. For example, if the question would require the proponent to say that he or she had a pre-existing medical condition by reason of having had a tonsillectomy when a very young child there is a realistic prospect that a court would hold that a reasonable person in the circumstances could not be expected to have disclosed it. There will be some circumstances in which a reasonable person could not be expected to disclose a matter that they had no reason to believe had any realistic prospect of interfering with their proposed travel.

4. Onus of proof of failure to comply with the duty of disclosure

The onus of proving the matters to show that there has been a failure to comply with the duty of disclosure is on the insurer[43]. In practice, in relation to an eligible contract of insurance, this will require the insurer to prove what specific questions were asked, what answers were given, and that one or more of the answers was inaccurate or incomplete in a way that amounted to a failure to comply with the duty of disclosure.

Before the advent of the internet there was usually no difficulty in proving what an insured had disclosed, because the insured would have filled out and signed a proposal form, and that form would be available to tender in evidence. If, as will often happen these days, the contract was entered after the proponent answered a series of questions on the internet, an insurer whose computer system has been carefully designed will be able to produce an electronic analogue of a proposal form on paper, filled out and signed by the proponent. If the computer system does not enable that, proof of breach of the duty of disclosure is likely to require evidence of

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[42] In a definition the term being defined is the *definiendum*, the words that do the defining are the *definiens*.

[43] *Dew v Corp Life and Superannuation Ltd* [2001] QCA 459 at [12], *Australian Casualty and Life Ltd v Hall* [1999] QCA 240; (1999) 151 FLR 360 at [72] per Shepherdson J.

the structure of the decision paths that were in operation on the insurer's website on the day that the proposal was submitted – of the content of the various internet screens on the insurer's website, of what choices each internet screen gave to someone navigating through the website, what further requests for information were generated by each possible choice, and the still further requests for information that arose from the answers to each of those requests for information. Depending on the structure of the decision path in a particular insurer's website, it may be possible to identify the answers that a proponent must have given to particular questions, when the outcome of navigating through the website was that a contract in particular terms was generated and issued. If insurers are to discharge their onus of proof of a failure to comply with the duty of disclosure, concerning a contract entered on the internet, they will need to keep records of the precise manner in which their website operated from time to time before it generated a contract of insurance.

5. Sections Limiting the Consequences of an Insured's Failure to Inform an Insurer about a Matter

The consequences of a failure of an insured to inform an insurer about a matter are limited by several provision of the *IC Act*. I set them out here before going on to consider how each operates, and how they interact.

Section 28 provides:

> (1) This section applies where the person who became the insured under a contract of general insurance upon the contract being entered into:
>
> (a) failed to comply with the duty of disclosure; or
>
> (b) made a misrepresentation to the insurer before the contract was entered into;
>
> but does not apply where the insurer would have entered into the contract, for the same premium and on the same terms and conditions, even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into.
>
> (2) If the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.
>
> (3) If the insurer is not entitled to avoid the contract or, being entitled to avoid the contract (whether under subsection (2) or otherwise) has not done so, the liability of the insurer in respect of a claim is reduced to the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred or the misrepresentation had not been made.

Section 33 provides:

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

In Section 33, "this Division" is Division 3 of Part IV of the *IC Act* that extends from section 27A to section 33.

Section 47 provides:

(1) This section applies where a claim under a contract of insurance is made in respect of a loss that occurred as a result, in whole or in part, of a sickness or disability to which a person was subject or had at any time been subject.

(2) Where, at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability, the insurer may not rely on a provision included in the contract that has the effect of limiting or excluding the insurer's liability under the contract by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into.

Section 52 provides:

(1) Where a provision of a contract of insurance (including a provision that is not set out in the contract but is incorporated in the contract by another provision of the contract) purports to exclude, restrict or modify, or would, but for this subsection, have the effect of excluding, restricting or modifying, to the prejudice of a person other than the insurer, the operation of this Act, the provision is void.

(2) Subsection (1) does not apply to or in relation to a provision the inclusion of which in the contract is expressly authorized by this Act.

6. Construction and application of sections 28, 33 and 52

There is clear authority that the provisions of Division 3 of Part IV *IC Act* constitute a statutory code that replaces the common law regulating nondisclosure, misrepresentation and incorrect statements by insured persons in relation to those insurance contracts that fall within the *IC Act*, and that it is to the words of that Act, not the common law, that one must look to ascertain the working of that code[44]. However, the case law does not give anything like a complete exposition or explanation of how that code operates. As well, the operation of the "code" in Division 3 of Part IV is affected by other provisions of the *IC Act*, in particular by sections 47 and 52. Thus I will first consider the construction and effect of sections

[44] *Advance (NSW) Insurance Agencies Pty Ltd v Matthews* (1989) 166 CLR 606 at 615; *CE Heath Casualty & General Insurance Ltd v Grey* (1993) 7 ANZ Ins Cas ¶ 61-199 at 78,283 per Clarke JA (Meagher JA agreeing)

28(3), 33 and 52 from first principles, and only then give an account of the case law concerning those sections.

6.1 Section 28

The only rights that Division 3 of Part IV confers on an insurer arise if the insured has failed to comply with the statutorily imposed duty of disclosure. As discussed earlier, precisely what is required, to comply with the duty of disclosure, depends on whether the insurance in question is an eligible contract of insurance, whether it is an eligible contract of insurance by virtue of Regulation 2B(1), if it is an eligible contract by virtue of Regulation 2B(1) whether the insurer has chosen to ask the insured specific questions, what specific questions the insurer has asked, what the insured knows, and whether the answers given to any such questions comply with section 21A(5)(b). Alternatively, it might be an eligible contract of insurance by virtue of Regulation 2B(2), in which case compliance with the duty of disclosure depends on whatever specific questions the insurer has asked, and whether the insured has answered those questions in a way that complies with section 21A (5) (b).

Section 28 has the effect that, if there is a failure to comply with the duty of disclosure, but the insurer would have still entered the contract on the same terms if the disclosure had been made, the insurer has no remedy on the ground that there has been a failure to comply with the duty of disclosure[45]. If the insurer would not have entered the contract on the same terms if the failure had not occurred, the insurer's remedies are:

- Under section 28(2), if the failure to comply was fraudulent, to avoid the contract.
- Under section 28(3), if the failure to comply was not fraudulent, or the insurer does not elect to avoid the contract, the liability of the insurer is reduced to an amount that would place the insurer in a position in which it would have been placed if the failure had not occurred.

The remedy for fraudulent failure to comply with the duty is quite clear, and presents no legal complications. Discussing misrepresentation as well as failure to

[45] A related principle is that even though if a proponent gives an incorrect or incomplete answer a question that is not relevant to the decision of the insurer whether to accept the risk and if so on what terms, and that incorrect answer is a misrepresentation – see footnote 36 above - the effect of s 28 and 33 together are that the insurer has no remedy concerning that misrepresentation. Because the question was not relevant to the insurer's decision whether to accept the risk and if so on what terms, it necessarily follows that the insurer would still have entered the policy on the same terms if the misrepresentation had not been made, so section 28 does not entitle the insurer to deny liability or reduce the extent of its liability by reason of the misrepresentation, and (for reasons analogous to those appearing later in this paper concerning failure to comply with the duty of disclosure) section 33 makes ineffective any contractual provision that purports to entitle the insurer to deny liability or reduce the extent of its liability by reason of that misrepresentation.

comply with the duty of disclosure would significantly lengthen this paper. Thus, the paper will henceforth confine its attention to the rights of an insurer concerning a non-fraudulent failure to comply with the duty of disclosure.

One particular consequence of section 28 (3) is that if there is a failure to comply with the duty of disclosure, but the insurer would have accepted the risk on the same contractual terms, though subject to a premium loading, the insurer's remedy is limited to obtaining the amount of that loading[46]. Thus if an insured had a pre-existing medical condition, that as things eventuated caused a loss within the risks of the contract to arise, but that was such that the insurer would have accepted the risk with a premium loading, the insurer's only remedy is to reduce its liability by the amount of that loading[47].

Section 28(3) has the effect of reducing "the liability of the insurer in respect of a claim". A "claim" in this context would be a claim, in the sense of a request or demand that a particular insured made to his or her insurer that the insurer pay an amount to indemnify the insured against a particular loss[48]. The reduction of the insurer's liability, pursuant to section 28(3), is to "the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred". After some initial vacillation on the part of the courts, it is now established that one of the courses available to an insurer under section 28 (3) is to reduce its liability to nil[49].

If an insurer is to avail itself of section 28 (3) it bears the onus of establishing not only that there has been a failure to comply with the duty of disclosure, but also that

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[46] Perhaps plus interest on the amount of the loading, from the time that the premium was payable, and at the rate that the insurer earns on circulating capital employed in its business.

[47] Perhaps plus interest, as just mentioned.

[48] "a demand for something as due, an assertion of a right to something"*: Walton v National Employers Mutual General Insurance Association Ltd* [1973] 2 NSWLR 73 at 82 per Bowen JA

[49] *Advance (NSW) Insurance Agencies Pty Ltd v Matthews* (1987) 4 ANZ Ins Cas 60-813; *Advance (NSW) Insurance Agencies Pty Ltd v Matthews* (1989) 166 CLR 606 per Deane J; *Delphin v Lumley General Insurance Ltd* (1989) 5 ANZ Ins Cas 60-941; cf *Ferrcom Pty Ltd v Commercial Union Insurance Co of Australia Ltd* (1989) 5 ANZ Ins Cas 60-907; *Lindsay v CIC Insurance Ltd* (1989) 5 ANZ Ins Cas 60-913; *Ayoub v Lombard Insurance Co (Aust) Pty Ltd* (1989) 5 ANZ INS Cas 60-933; *Twenty- First Maylux Pty Ltd v Mercantile Mutual Insurance (Aust) Ltd* [1990] VR 919; *Zurich Australian Insurance Ltd v Contour Mobel Pty Ltd* [1991] 2 VR 146; *Fruehauf Finance Corp Pty Ltd v Zurich Australian Insurance Ltd* (1990) 6 ANZ Ins Cas 60-014 at 76,789--76,791; *Dwyer v Long* (1992) 7 ANZ Ins Cas 61-120; *Alexander Stenhouse Ltd v Austcan Investments Pty Ltd* (1993) 112 ALR 353 at 357-358; *FAI General Insurance Co. Ltd v. Hendry Rae and Court* (1993) 10 WAR 322 at 337-8 (1993) 7 A.N.Z. Insurance Cases 61-200; *Orb Holdings Pty Ltd v Lombard Insurance Co (Aust) Ltd* [1995] 2 Qd R 51 at 52, 58; *Unity Insurance Brokers Pty Ltd v Rocco Pezzano Pty Ltd* (1998) 192 CLR 603 at [93] [117] footnote 113. *Midaz Pty Ltd v Peters McCarthy Insurance Brokers* [1999] 1 Qd R 279 at 282; *Macquarie Underwriting Pty Ltd v Permanent Custodians Ltd* [2007] FCAFC 60; 240 ALR 519 at [27]. *Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd* (1993) 176 CLR 332 establishes that it is possible under section 54 *IC Act* for an insurer to reduce its liability to nil, which is strongly analogous to the situation under section 28 (3).

if the duty had been complied with it would not have entered into the contract of insurance for the same premium and on the same terms and conditions as it did. In addition it bears the onus of adducing evidence from which the court can calculate the amount of the reduction in the insurer's liability[50]. That would require the insurer to prove either that it would not have entered the contract at all, or else on what terms and conditions (including as to premium) it would have entered the contract.

Evidence by a witness of what he or she would have done if a hypothetical situation had arisen in the past is often treated by a court with caution, sometimes approaching scepticism[51]. An insurer will have difficulty in discharging its onus of proof under section 28 (3) unless it proves that at the time the contract was entered the underwriting staff who were responsible for approving the issue of the particular contract in question had underwriting practices that were not departed from on a discretionary basis. It would also be necessary for the insurer to establish that, if the failure to comply with the duty of disclosure had not occurred, the application of those practices would have led, concerning the proposal for the particular contract of insurance that is the subject of the litigation, either to cover being refused, or to cover being granted on certain precisely identified terms and conditions.

When there has been a failure to comply with the duty of disclosure, a "position in which the insurer would have been if the failure had not occurred" depends in part on what the position of the insurer would have been if the terms of the contract of insurance actually entered were notionally altered to the terms of a contract of insurance that the insured would have entered if there had been no failure to comply with the duty of disclosure. It is the underwriting practice of the particular underwriting staff who were responsible for approving the issue of the particular contract in question - however unusual or idiosyncratic that practice might be - that decides what are the terms and conditions of a contract that the insurer would have entered if there had been no failure to comply with the duty of disclosure. Thus if there had been no failure to comply with the duty of disclosure, and the insurer would have issued a contract that contained an exclusion clause that denied the claim of the insured, a "position in which the insurer would have been in if the

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[50] *Orb Holdings Pty Ltd v Lombard Insurance Co (Aust) Ltd* [1995] 2 Qd R 51 at 54; *Midaz Pty Ltd v Peters McCarthy Insurance Brokers* [1999] 1 Qd R 279 at 284; *Schaffer v Royal & Sun Alliance Life Assurance Australia Ltd* [2003] QCA 182; (2003) 12 ANZ Ins Cas 90-116 at [52]

[51] *Cackett v Keswick* [1902] 2 Ch 456 at 463-464; *Rosenberg v Percival* (2001) 205 CLR 434 at [26], [158]; *Chappel v Hart* (1998) 195 CLR 232 at 246 (fn 64) 272-273; *Seltsam Pty Ltd v McNeill* (2006) 4 DDCR 1 at [115]-[123]; *White v Shortall* (2006) 68 NSWLR 650 at [109]-[114]. The difficulties in finding such evidence credible are such that in litigation governed by the *Civil Liability Act 2002 (NSW)*, such statements are completely inadmissible: s 5D (3) (b) *Civil Liability Act 2002 (NSW*).

failure had not occurred" is that, prima facie, it remains entitled to deny liability under that exclusion clause.

However that prima facie entitlement can be cut down. A "position in which the insured would have been if the failure had not occurred" can be affected by the operation of other provisions of the Act, not contained in Division 3 of Part IV *IC Act*, which remove or restrict the ability of the insurer to rely on a provision of a contract of insurance. One such provision that is presently relevant is section 47, considered later in this paper. If a contract that the insurer would have entered if there had been no failure to comply with the duty of disclosure includes a provision that section 47 prohibits the insurer from relying on in relation to a particular claim, the "position in which the insurer would have been if the failure had not occurred" must take account of the operation of section 47 on the contract that the insurer would have entered. In other words, a provision that section 47 makes inoperative in an actual contract of insurance is also inoperative for the purpose of the notional contract of insurance that determines the extent of any liability of the insurer under section 28 (3).

The indefinite article in the phrase "*a* position in which the insurer would have been if the failure had not occurred" leaves open the possibility that the insurer might have taken one of two or more different courses of action if the failure had not occurred. If the proper conclusion on the evidence in a particular case is that it is more likely than not that, if the failure had not occurred, the insurer would have been in one of two different positions, but it is not possible to conclude that being in a particular one of those positions is more likely than not[52], section 28 (3) as a remedial provision[53] would probably be construed in a way favourable to the insured, and would entitle the insurer to reduce its liability to whichever was the larger of the amounts that its liability would be in each of those two positions.

6.2 Section 33

6.2.1 Different Scope of Operation of Section 28 and Section 33

The scope of operation of section 33 is wider than the scope of operation of section 28. Section 28 operates only when there has been a failure to comply with the duty of disclosure. By contrast, section 33 operates whenever in fact there has been a failure by the insured to disclose a matter to the insurer before the contract was entered. Section 33 operates regardless of whether that failure to disclose a matter is, or is not, a failure to comply with the duty of disclosure. It is a fundamental error

[52] Which seems a fairly unlikely state for the evidence to be in
[53] See *Pearce & Geddes* [9.2]-[9.4]

to read both sections as dealing with "non-disclosure": one must give effect to the difference between the language of the two sections.

There will be situations where this difference between the scope of operation of sections 28 and 33 will matter. If the insurer is taken to have waived compliance with the duty of disclosure, pursuant to section 21A (3), there has been no failure to comply with the duty of disclosure, and so section 28 cannot perform any work of entitling the insurer to decline liability or reduce its liability. However, section 33 can still perform work, if in fact there has been a failure to disclose a matter before the contract was entered. The work that section 33 does is to say that the insurer has no rights in respect of the failure to disclose the matter. I shall argue that if an exclusion clause purports to give the insurer a right, in respect of the failure to disclose the matter, to deny liability or to reduce its liability, section 33 makes that exclusion clause inoperative.

Similarly, if an insurer has asked a specific question that falls within s 21A(2), and the insured answers it in a way that satisfies section 21A (5), there has been no failure to comply with the duty of disclosure. In that situation also section 28 has no work to do, but section 33 has the effect that the insurer has no rights in respect of any failure that there might have been on the part of the insured to disclose any matter to the insurer before the contract was entered into. Likewise if the insurer failed to ask a question that would have required the matter to be disclosed. Other examples of circumstances where there had been no failure to comply with the duty of disclosure, but there had in fact been a failure to disclose a matter, could be given.

6.2.2 Section 33 Affects Rights

Even though section 33 appears in a Division entitled "*Remedies* for non-disclosure and misrepresentation by insured", and under the individual section heading "No other *remedies*"[54], its meaning is not restricted to remedies of the insurer. Rather, its wording explicitly obliterates "any *right*" that an insurer might have, deriving from any source other than the *IC Act*, in respect of a failure by the insured to disclose a matter to the insurer before the contract was entered. It declares that instead of any such right the insurer has the statutory entitlements created by Division 3 of Part IV of the *IC Act*.

A right of the insurer "in respect of" such a failure could arise, as a matter of ordinary English, from any of a variety of sources - it might be a right that arises under the contract of insurance, or under the law of torts (perhaps the tort of deceit, or of negligent misrepresentation), or perhaps under a statute. Wherever outside Division 3 of Part IV of the *IC Act* a right of the insurer "in respect of" a failure by the

[54] Emphasis added

insured to disclose a matter might come from, section 33 removes that right, and requires that the only rights that the insurer has in respect of that failure are the rights that arise under Division 3 of Part IV of the *IC Act*[55]. However, as this paper is concerned with the operation of the *IC Act* on contracts of insurance, I will confine discussion of the effect of section 33 to its effect on contractual rights.

6.2.3 What is a "right", under the contract of insurance, within section 33?

Before s 33 can operate to the advantage of an insured, there must be a *right* of the insurer, arising other than under Division 3 of Part IV of the *IC Act*, that would entitle the insured to not pay or to limit its liability to an amount less than would arise from applying section 28(3). If a contract of insurance contains an exclusion clause that removes from what would otherwise be the scope of the cover a particular type of loss, or defines the scope of the cover in terms such that the insurer has no liability concerning a particular loss, does that clause give the insurer a *right* of a type that can be affected by s 33? I suggest that, on the proper construction of section 33, it does.

A Hohfeldian analysis[56] would say that such a provision in the contract conferred on the insurer an *immunity*, entitling it to not pay, rather than a right. However Hohfeldian analysis does not necessarily dictate what is the correct construction of the *IC Act*. What the words of the statute would be taken to mean, in accordance with ordinary language usage, is far more important for that purpose. The current principles of statutory construction are:

> "The starting point for the ascertainment of the meaning of a statutory provision is the text of the statute whilst, at the same time, regard is had to its context and purpose. Context should be regarded at this first stage and not at some later stage and it should be regarded in its widest sense. This is not to deny the importance of the natural and ordinary meaning of a word, namely how it is ordinarily understood in discourse, to the process of construction. Considerations of context and purpose

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[55] This view of section 33 is consistent with section 15 *IC Act*, which provides:

(1) A contract of insurance is not capable of being made the subject of relief under:
  (a) any other Act; or
  (b) a State Act; or
  (c) an Act or Ordinance of a Territory.

(2) Relief to which subsection (1) applies means relief in the form of:
  (a) the judicial review of a contract on the ground that it is harsh, oppressive, unconscionable, unjust, unfair or inequitable; or
  (b) relief for insureds from the consequences in law of making a misrepresentation;

but does not include relief in the form of compensatory damages.

However section 33 goes even further than section 15, so far as an insured's failure to disclose a matter is concerned, by also removing rights of an insurer which arise from sources other than statute, and rights to receive compensatory damages.

[56] Wesley Newcomb Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning* (1917) 26 Yale Law Journal 710

> simply recognise that, understood in its statutory, historical or other context, some other meaning of a word may be suggested, and so too, if its ordinary meaning is not consistent with the statutory purpose, that meaning must be rejected.[57]"

6.2.3.1 Ordinary language

It is well within ordinary language usage to talk about an insurer having a right to rely on an exclusion clause. In so far as a contract puts certain risks outside the scope of cover when some matter has not been disclosed, it should be remembered that the only circumstance in which section 28 (3) comes to be applied is one in which the insured is making a claim. When section 33 says that the insurer does not have rights apart from those under section 28, the circumstance in which section 33 comes to be applied is likewise one in which the insured is making a claim. When one is considering a situation in which an insured has actually made a claim, it is well within ordinary language usage to say that an insurer has a right to deny liability concerning the claim because the claim falls under an exclusion clause.

6.2.3.2 Language use within the IC Act

Internal consistency of language use within the statute[58] supports the "right" in section 33 extending to a contractual provision that entitles the insurer to not pay. Section 55 *IC Act* says:

> "The provisions of this Division with respect to an act or omission are exclusive of *any right* that the insurer has otherwise than under this Act in respect of the act or omission."[59]

The Division that section 55 talks of is Division 3 of Part V, headed "Remedies". That Division has a similar structure of the Division within which section 33 occurs. The only significant provision in Division 3 of Part V is section 54. Section 54 postulates a situation "where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person". When that act has certain characteristics, s 54(1) says that "the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act." That language contemplates that a "right that the insurer has otherwise than under this Act in respect of the act or omission",

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[57] *SZTAL v Minister for Immigration and Border Protection* [2017] HCA 34, 347 ALR 405 at [14] per Kiefel CJ, Nettle and Gordon JJ. Similarly, *Momcilovic v the Queen* (2011) 245 CLR 1 at 44, [37]

[58] There is a presumption of statutory construction that words are used in a consistent manner throughout a statute: *Pearce & Geddes* [4.6].

[59] Emphasis added

referred to in section 55, could include a contractual provision under which the insurer could refuse to pay the claim either in whole or part.

6.2.3.3 Purpose

As well a purposive approach to construction[60] favours section 33 extending to a contractual provision that entitles an insurer to not pay. It is not difficult to draft an exclusion clause that denies coverage to an insured for losses if the insured in fact did not disclose some matter to the insurer. Consider a clause in a householder's contract that said:

> "The insurer has no liability under this contract concerning loss arising from fire if the insured did not disclose to the insurer, prior to the contract coming into effect, every matter that the insured knew, or that a reasonable person in the insured's position would know, and that would affect the mind of a prudent insurer about whether to accept the risk and if so on what terms."

The practical effect of such a clause would be to deny coverage to the insured unless he or she gave disclosure of a much more extensive kind than is required by the statutory duty of disclosure. Its effect would be the same as reinstating the common law test for nondisclosure, which the *IC Act* expressly set out to alter[61]. Yet such an exclusion clause would be permissible unless section 33 is construed so that a "right" of an insurer includes an entitlement to not pay, pursuant to an exclusion clause.

Before the *IC Act* was introduced there was a variety of different drafting techniques that the drafter of an insurance contract could use to achieve the result that the insurer was not liable to pay for loss arising from a particular type of cause. One was to define the scope of cover in such a way that that type of loss was not within it. A second was to have a wide scope of cover, but to have an exclusion clause that excluded coverage for that type of loss. A third was to require the insured to give a warranty of the truth of certain facts, and to make that warranty the basis of the contract, with the effect that if the warranty proved untrue the insurer had no liability[62]. A fourth was to include in the proposal form a wide question, which if answered accurately would disclose whether there was a chance of that type of loss being suffered, and then to rely on the breach of the duty of disclosure if that

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[60] Section 15AA *Acts Interpretation Act 1901 (Cth)* requires: "In interpreting a provision of an Act, the interpretation that would best achieve the purpose or object of the Act (whether or not that purpose or object is expressly stated in the Act) is to be preferred to each other interpretation."

[61] The ALRC Report at [183] said categorically: "the existing duty of disclosure is not justified by the principle of *uberrima fides*. ..the existing members … recommend that the duty of disclosure should be retained in a modified form."

[62] In the late 19th century it was common practice in England to include in a life policy a warranty that the proponent had no disease, whether latent or not: *Thomson v Weems* (1884) 9 AC 671 at 682. The ALRC Report at [184] describe such warranties, and exclusions to similar effect, as "objectionable" and recommended the introduction of the ancestor of section 47 to overcome them.

question was not accurately answered. The evident purpose of section 33 is that, regardless of which of these drafting techniques was adopted in an insurance contract, any provision of a contract that led to a result that was different to the result that would arise under section 28, in respect of a failure by the insured to disclose a matter to the insurer before the contract was entered, was ineffective.

The effect of s 33 is that any provision in a contract, that purports to give to an insurer greater rights in respect of a failure to disclose a matter than s 28 gives, is ineffective in so far as it purports to give those greater rights. Section 33 operates when there has been a breach of the statutory duty of disclosure, but it also operates whenever in fact there has been "a failure by the insured to disclose a matter to the insurer before the contract was entered". In other words, in circumstances where some matter has not been disclosed, but there was no statutory duty to disclose that matter, if there is a provision in the contract that purports to give the insurer a right to refuse the claim or to not pay it in full, and that right exists or arises in respect of the failure to disclose, the right is ineffective. As well, in circumstances where some matter has not been disclosed, and there was a statutory duty to disclose the matter, if there is a provision in the contract that purports to give the insurer a right, in respect of the failure to disclose, that is different to the rights conferred by section 28, that clause is ineffective.

6.2.4 "In respect of a failure … to disclose…"

In deciding what is a right "in respect of" a failure by the insured to disclose a matter, close attention must be paid to the propositional phrase "in respect of". As a matter of ordinary English, an expression in the form "an x in respect of a y" is broad, and capable of referring to any sort of link or connection between an x and a y. In particular legislative contexts, it has been held that "in respect of" has a wider meaning than "for"[63], and that the closely similar phrase "in relation to" has a wider meaning than "on account of"[64]. Concerning the closely analogous expression "in relation to", the High Court has said that the generality of the expression should be read down only if there is a "compelling reason" to do so[65]. As a general rule, whenever an expression such as "in respect of" occurs in a statute it must be decided, taking into account the context and purpose of the statute, whether there

[63] *Unsworth v Commissioner for Railways* (1958) 101 CLR 73 at 87 per Fullagar J (holding that damages "in respect of" personal injury" includes cases where the cause of action arises out of someone suffering personal injury but the plaintiff is someone other than the person injured), approved by Taylor J in *State Government Insurance Office (Queensland) v Crittenden* (1966) 117 CLR 412 at 416

[64] *Airservices Australia v Canadian Airlines International Ltd* [1999] HCA 62, 202 CLR 133 at [243]

[65] *Fountain v Alexander* (1982) 150 CLR 615 at 629

is a reason for recognising a limitation on the sort of link or connection that comes within the words of the particular statute, and if so what that limitation is[66].

6.2.4.1 The rights that section 33 eliminates

What type of connection does section 33 require between the rights that s 33 says do not exist, and the fact that there has been a failure to make disclosure? When the particular problem that this paper is dealing with is whether the *IC Act* has an effect on the enforceability of exclusions in the standard terms of contracts of insurance, that question can take a more focussed form. It is: what type of connection must there be between an exclusion clause that is unenforceable because of section 33, and the fact that there has been a failure to make a disclosure?

6.2.4.2 Connection in the terms of the exclusion clause?

One possible type of connection is a connection articulated by the terms of the exclusion clause that is under consideration.

An exclusion clause expressed in terms that showed that the insurer's entitlement to not pay was *based on* a failure by the insured to disclose a matter, or that it *arose by reason of* the failure of the insured to disclose a matter, would fairly clearly be a right "in respect of" a failure by the insured to disclose a matter. Thus, fairly clearly, section 33 would make inapplicable any exclusion clause that purported to exclude liability for a pre-existing medical condition except where it has been disclosed[67]. Such an exclusion clause purports to exclude liability for *all* pre-existing medical conditions that have not been disclosed, regardless of whether disclosure of them would be required by the duty of disclosure. Even if the duty of disclosure required the insured to disclose that pre-existing condition, the exclusion clause purports to permit the insurer to deny liability totally concerning a claim that arises from such a pre-existing condition rather than to establish that it is entitled to reduce its liability to some particular extent (which might or might not be totally) in accordance with section 28(3). The exclusion clause has the effect of giving the insurer a wider right to deny liability than s 28 gives, and to that extent section 33 makes the provision inoperative.

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[66] *Commissioner of Taxation v Scully* [2000] HCA 6, 201 CLR 148 at [39] *Wonall Pty Ltd v Clarence Property Corporation Ltd* [2003] NSWSC 497, 58 NSWLR 23, at [41]-[43] and cases there cited; *Sood v Regina* [2006] NSWCCA 114, 165 A Crim R 453 at [37] – [43; *CSR Ltd v Chief Commissioner of State Revenue* [2006] NSWSC 1380, 68 NSWLR 440 at [30] – [31]; *J Blackwood & Son v Skilled Engineering* [2008] NSWCA 142 at [130]; *Kostas v HIA Insurance Services Pty Ltd* [2010] HCA 32, 241 CLR 398 at [24], [25] (concerning the closely analogous phrase "with respect to"); *Travelex Ltd v Commissioner of Taxation* [2010] HCA 33, 241 CLR 510 at [25], [90] (concerning the closely analogous expression "in relation to"). Many other authorities are cited in *Pearce & Geddes* at [12.6]-[12.7]

[67] Such as appears in the Vero policy extracted in Appendix 1

Once section 33 has made such an exclusion clause inoperative the insured would have whatever rights (if any) he or she has under section 28(3). As discussed earlier, those rights depend on what are the terms and conditions of a contract that the (particular) insurer would have issued if there had been no failure to comply with the duty of disclosure. If the insurer would have issued a contract that contained a provision that conferred wider rights, in respect of a failure by the insured to disclose a matter to the insurer before the contract was entered into, than are conferred by section 28 (3), that provision would in turn be struck down by section 33. There could be an endless cycle of notional contracts arising under section 28(3), and an exclusion clause in that notional contract then being struck down by section 33. The only sensible way of giving effect to the legislative policy expressed in section 33 is for an exclusion clause that offends section 33 not ultimately to prevail.

If the connection between the failure to disclose and the right of the insurer to not pay must be found in the terms of the exclusion clause itself, and the contract contains a provision that says that there is no cover for pre-existing medical conditions unless the insurer has expressly agreed to cover them[68] it seems likely that section 33 would not affect the clause. This is because there are two alternative situations:

- If the insured had disclosed the condition to the insurer and the insurer had refused to cover it there would have been no failure to comply with the duty of disclosure, and thus s 28 would have had no scope for operation. Nor would there be a factual failure to disclose a matter to the insurer, and thus s 33 would have no scope for operation.
- Alternatively, if the insured had not disclosed the condition to the insurer the effect of the provision in the contract would be that the insurer could sometimes have a wider right to deny liability than the right it would have, in accordance with s 28, if disclosure had been made. However that wider right is not, under the terms of the exclusion clause in question, a right "in respect of the failure of the insured to disclose a matter", because the insurer has the same right regardless of whether there has been a failure of the insured to disclose the matter. Failure to disclose does not enter into the wording of the clause.

If the connection between the failure to disclose and the right of the insurer to not pay must be found in the terms of the clause itself, and the contract says simply that there is no cover for any pre-existing medical condition[69] it is difficult to see how

[68] Such as appears in the Westpac policy and the QBE policy each extracted in Appendix 1
[69] Such as appears in the Australian Seniors travel policy and the Travel Insurance Direct policy each extracted in Appendix 1

there is any connection in the wording of the exclusion between a failure to give disclosure of any fact, and the entering of the contract.

Thus, on this view of where the connection must be found, section 33 has an effect on an exclusion clause only where the failure to disclose a matter is the basis or reason, appearing from the wording of the clause, why the insurer has no liability, or a limited liability. On that construction of section 33, some exclusion clauses relating to pre-existing medical conditions in mass-marketed contracts will be struck down, but many will not.

6.2.4.3 Connection in the facts?

I suggest that a preferable place to look for the connection between the exclusion clause that is alleged to be unenforceable, and the fact that there has been a failure to make a disclosure, is in how the clause purports to operate in the facts concerning a particular claim. Section 28 is a provision that comes into operation concerning a particular claim. Similarly, a question about whether section 33 has any effect on an exclusion clause arises concerning a particular claim. When section 33 talks of "a failure by the insured to disclose a matter to the insurer before *the contract* was entered into" it is referring to the particular contract pursuant to which the particular claim in question was made.

It is well within ordinary language used to read section 33 as saying that if, concerning a particular claim made under a particular contract, there was in fact a failure by the insured to disclose a matter before the contract was entered into, the insurer has no rights other than those under section 28 concerning the facts that were not disclosed.

A fact that the insured has not disclosed is one that the insured knows, and has not informed the insurer about. As a matter of ordinary English before A "fails to disclose" a matter, it is necessary that A know the matter in question. As Owen J said:

> A "failure to disclose" does not seem to me to mean precisely the same thing as a "non-disclosure", and it might well be thought that there was no "failure to disclose" if the undisclosed fact was unknown to the person upon whom the duty of disclosure lay."[70]

[70] *Federal Commissioner of Taxation v Levy* (1961) 106 CLR 448 at 469 (Dixon CJ and Taylor J agreeing). As a matter of ordinary English, it is also necessary that the matter in question not be already known to the person to whom the disclosure is made: *Foster v Federal Commissioner of Taxation* (1951) 82 CLR 606 at 615; *R v White* (1989) 18 NSWLR 332 at 340; *Nasr v State of New South Wales* [2007] NSWCA 101; (2007) 170 A Crim R 78 at [127] and cases there cited.

At a time when the duty of disclosure in insurance was one expressed in ordinary language rather than using statutory definitions, it was accepted that it is only possible to disclose something that one knows[71]. Thus, every matter that an insured fails to disclose must be a matter that the insured knows.

It is quite possible for an exclusion clause to purport to give an insurer rights, that arise in a situation where a matter was not disclosed, and where the terms of that exclusion clause did not themselves contain any words that state in terms that the right to exclude liability exists because of, or arises from, any failure to disclose. If an exclusion clause operates to deny cover by words referring to a matter that the insured knows before the contract is entered, and in fact that matter has not been disclosed to the insurer, the clause gives the insurer a right in respect of a failure by the insured to disclose a matter. Section 33 makes such a clause inoperative.

Some of the mass-marketed contracts of insurance contain exclusion clauses that state expressly that they exclude cover for pre-existing medical conditions of which the insured was aware[72]. If an insured had not disclosed such a medical condition, such an exclusion clause would confer on the insurer a "right in respect of a failure by the insured to disclose a matter to the insured before the contract was entered into." To the extent that the rights of the insurer under such a clause are wider than its rights under section 28, the exclusion clause is made inoperative by section 33.

Some of the mass-marketed contracts of insurance contain exclusion clauses that state that they exclude cover concerning certain conditions using words that do not in terms talk of medical conditions of which the insurer knows, or is aware, but instead using words that refer to situations where there is a factual inevitability that the insured was aware of the condition in question. Examples of such exclusion clauses are ones that define "existing medical condition" as including a condition for which investigation, medical advice or treatment has been obtained, or for which prescribed drugs have been taken, within 90 days before the contract was issued[73], or as including chronic or ongoing conditions. If in fact such conditions existed, and had not been disclosed, section 33 could make these exclusion clauses inapplicable. The effect of them being made inapplicable would be to restrict the rights of the insurer to not pay or to limit its liability concerning a claim to whatever rights it has under section 28.

Another type of clause that commonly appears is one that that says that there is no cover for a pre-existing condition unless the insurer has expressly agreed to cover it.

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[71] *Joel v Law Union and Crown Insurance Company* [1908] 2KB 863 at 880, 884-5

[72] Eg the Westpac policy, the Travellers Insurance Direct policy and the QBE policy. As discussed later, if the insured does not know that he or she has the condition in question the exclusion is made inoperative by section 47.

[73] The Vero policy.

In the situation where the insured knows that he or she has a pre-existing condition[74] such a clause achieves much the same practical effect as a clause saying that there is no cover for a pre-existing condition that has not been disclosed. It would be a very odd outcome if section 33 were to be construed in a way that allows differences in drafting like this, that do not reflect differences in substance, to have different consequences.

It is consistent with the policy of the alterations that the *IC Act* has made to the common law duty of disclosure that this construction is adopted. The point of the statutory duty of disclosure is to stipulate the extent of matters that are known to the insured that must be disclosed to the insurer before an enforceable insurance contract is entered. It would undermine that policy if a clause in the contract could effectively deny cover on the basis that some matter, besides the matters that are required to be disclosed under the duty of disclosure, was known to the insured. If an exclusion clause could give an insurer rights not found in Division 3 of Part IV, that Division would not be a code that regulates nondisclosure in insurance contracts – yet the High Court says that it is such a code.

This point applies with special force concerning eligible contracts of insurance such as most travel insurance. The point of limiting the duty of disclosure, under section 21A, to a requirement that the insured answer specific questions is to require the insurer to frame questions that will elicit all the information that the insured knows and that is relevant to the insurer's decision about whether to issue the contract and if so on what terms. It cuts across this policy if liability can be denied because the insurer knows something that the insurer did not ask about.

Another policy of the *IC Act* is that the remedies available to an insurer when there has been a failure to comply with the duty of disclosure are limited to those that arise under section 28. When there has been a failure to comply with the duty of disclosure, a clause the substance of which is that an insurer has no liability at all concerning a type of matter that the insured knows before the contract is entered could in some circumstances give an insurer wider rights than the rights that arise under section 28. In having that effect it would operate contrary to the policy of the Act.

On this construction a clause that excludes liability for medical conditions that had not been disclosed would be unenforceable, but in addition clauses that exclude liability for conditions of which the insurer is aware, or on the basis of circumstances

[74]As discussed later, if the insured does not know that he or she has the condition in question the exclusion is made inoperative by section 47.

that are such that there is a practical inevitability that insured is aware of a condition, would be unenforceable.

On this construction of section 33 a wide variety of exclusion clauses would not be struck down by section 33. For example it would be possible, without infringing section 33, for an insurer to exclude cover concerning liabilities arising from:

- Injuries suffered while skiing, or while riding a motor bike
- Certain specified types of medical condition, like mental illness

Such exclusions do not offend section 33 because they operate regardless of what the insured knows at the time the contract is entered.

It is a common practice of insurers who mass-market travel insurance contracts on the internet to include in the internet pages that a proponent must complete before a contract is issued questions about whether the proponent or any other insured has a pre-existing medical condition, and to define "pre-existing medical condition" for the purpose of those questions in the same language that is used in exclusion clauses in the contract of insurance. Even when an insurer adopts this practice, the argument put forward in this paper about the proper scope and effect of section 33 remains of practical importance. It is because an enforceable exclusion clause entitles the insurer to deny cover completely concerning a claim that falls within the clause. In contrast, if an insurer contends that a claim arises from a pre-existing condition, within its definition, that has not been disclosed the insurer must rely on section 28 to reduce its liability. When the insurer relies on section 28 it is the insurer who bears the onus of proving the failure to comply with the duty of disclosure, and the onus of proving the extent to which it is entitled to reduce its liability by reason of the failure to comply with the duty of disclosure,

6.3 Section 52

Section 52 of the *IC Act* achieves the same effect as section 33 by operating to deny to the insurer the right to rely on any provision of the contract of insurance that was actually entered and that is different to the terms and conditions of the notional contract that would have been entered, if there had been no failure to comply with the duty of disclosure[75]. One part of section 52 makes void any provision of a contract of insurance that *purports to* exclude, restrict or modify, to the prejudice of anyone other than the insurer, the operation of the *IC Act*. The Macquarie Dictionary gives the meaning of "purport", when used as a verb, as:

> " **1.** to profess or claim …

[75] As mentioned earlier, that notional policy would also need to operate consistently with section 47 concerning the particular claim.

2. to convey to the mind as the meaning or thing intended; express; imply."

Thus, s 52 makes void a provision in a contract of insurance that *professes or claims* to exclude restrict or modify the operation of the *IC Act*, or the *meaning* of which is that the operation of the *IC Act* is excluded restricted or modified, to the prejudice of anyone other than the insurer.

As well, however, section 52 makes void any provision of the contract of insurance the *effect of which* is to exclude, restrict or modify, to the prejudice of anyone other than the insurer, the operation of the *IC Act*. It is one of a very large number of provisions in the *IC Act* that operate by reference to the *effect* of a contract of insurance[76].

The effect of a provision depends upon how that provision actually operates in practice. How a provision in a contract operates in practice depends on more than the meaning of the words in that provision – it also depends on the factual circumstances in which those words are applied. As McHugh, Gummow and Hayne JJ said in *FA I Insurance Co Ltd v Australian Hospital Care Pty Ltd*[77]:

> "no question about the effect of a contract of insurance can ever be asked in isolation from external facts and circumstances. The question is inevitably about the application of the contract in the light of certain real or hypothesised facts and circumstances."

That section 52 operates concerning both what a clause purports to do, and what effect it has, makes clear that it is not concerned only with matters of form or drafting in insurance contracts, but with how they actually operate in practice. If there is a provision in an insurance contract the effect of which is that, when there has been a failure to comply with the duty of disclosure, the insurer has any right in respect of any failure by the insured to disclose a matter to the insurer before the contract was entered into, more extensive than that conferred by section 28 (3), that provision is void. It is void regardless of whether it takes the form of a limitation on the scope of cover, of an exclusion clause, or whatever other form the ingenuity of the drafter might devise.

A consequence of section 33 is that if there has been a failure to disclose a matter, but that failure is not a failure to comply with the duty of disclosure the insurer has no contractual rights in respect of the failure to disclose. Section 52 goes what might be a step further by making express that any clause that purports to give, or has the effect of giving, any such rights is void.

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[76] Eg s 35(1), s 35(2) (a), s 35(2) (b), s 37, s 37E(6), 39, 40 (1), 43, 44(1), 44(3), 45, 46, 47, 54 (1), 60(2) (b), 62(2) (b), 68

[77] [2001] HCA 38, 204 CLR 641 at [37].

I say "what might be a step further" because there is room for argument about the meaning of "is void" in section 52. Is it to be taken literally, so that a provision that is attacked by section 52 is of no effect for all purposes, or is "void" to be read in an ambulatory way, as being void, in the sense of inoperative, concerning the particular claim? There is a clear difference in language between section 47, which says that in certain circumstances "the insurer may not rely on a provision included in the contract", and section 52, which says concerning a provision that "the provision is void".

The argument about the meaning of "void" in section 52 might need to be resolved for purposes other than the present ones. However, concerning the application of section 52 to a situation where section 33 applies because in fact there has been a failure to disclose a matter it makes no difference whether the correct construction of section 52 is that the provision that it attacks is void for all purposes, or just inoperative concerning a particular claim. One can see this by considering how a court must proceed in deciding whether a provision of a contract of insurance purports to give, or has the effect of giving, the insurer wider rights than would be available under section 28(3) in relation to a failure to disclose a matter. The only way the court can proceed is by comparing what rights the insurer actually has concerning a particular claim once s 28(3) has been applied, and what rights the contract purports to give the insurer concerning that particular claim. When that is the way the court must proceed, it makes no difference which of the possible meanings of "void" is adopted, for the purpose of applying s 52 to a failure to disclose a matter.

6.4 The case law concerning section 33 and 52

The case law concerning the operation of sections 28, 33 and 52 is sparse and far from satisfactory. Two first instance decisions are not consistent with the analysis that I have given so far, but their reasoning is unsatisfactory. A dictum of Hodgson CJ in Eq, and more recent decisions in the Federal Court, are consistent with the analysis I have given.

6.4.1 *Pech v Tilgals*

In *Pech v Tilgals*[78] the principal issues concerned whether an accountant had been professionally negligent and in consequence had a liability to his client. The negligence in question concerned the preparation of tax returns in a way that resulted, some years later, in the issue of amended assessments under which the client became liable to pay penalty tax and additional tax for late payment. There was a cross-claim, in which the accountant sought indemnity under a contract of

[78] (1994) 28 Australian Tax Reports 197 (Supreme Court of New South Wales)

professional indemnity insurance if he were found to have been negligent. Dunford J held that the accountant had been negligent.

The insurance contract covered several different types of risk. The section of the contract that related to professional negligence was known as "policy 1". Clause 3.2 was an exclusion concerning claims

> "arising from any circumstance or circumstances of which You shall become aware, prior to the commencement of insurance cover under this policy 1 and which a reasonable Accountant in Your Position would at any time prior to the commencement of cover have considered may give rise to a Claim or Claims."

Dunford J held that the defendant was aware of the facts that led to the imposition of the penalty tax and additional tax, was aware that the penalty tax and additional tax had been imposed and paid, and was aware that the client was dissatisfied. He held that a reasonable accountant in the position of this particular accountant should have considered that a claim against him may be made.

The accountant argued that the exclusion was "void pursuant to s 52 of [the *IC Act*] in that it would have the effect of excluding, restricting or modifying the operation of the Act by excluding claims that would not be excluded under the principles of nondisclosure.[79] Dunford J rejected that argument[80] , saying:

> "But Special Exclusion Clause 3.2 is not concerned with nondisclosure; the claims specified are excluded from the cover whether the circumstances are disclosed or not, and accordingly the provisions of s 28 are not excluded or modified by the clause. A clause excluding claims notified to the insurer before the commencement of the policy or arising out of anything done or omitted before such commencement would not have anything to do with nondisclosure, and similar considerations, in my view, apply to the clause here under consideration."

That reasoning is inadequate. It treats section 28 as being concerned with "nondisclosure", rather than failure to comply with the duty of disclosure. As well it looks solely at the actual wording of the exclusion, and considers only whether the provisions of section 28 *are* excluded or modified by it. The reasoning fails to consider whether the clause *has the effect* of excluding or modifying the provisions of section 28. It is possible to decide whether the clause has the effect of excluding or modifying the provisions of section 28 only by ascertaining what result would follow from applying section 28, and comparing that result with the result that would arise from applying the exclusion clause.

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[79] at 211
[80] at 211-212

Dunford J did not consider whether the accountant had breached his obligations of disclosure when entering the insurance contract, nor what the consequences of any failure to comply with the duty of disclosure would have been under section 28 (3). Thus His Honour would not have had a basis for deciding that the clause did not have the effect of excluding or modifying the provisions of s 28[81].

Another difficulty with the decision as an authority is that no argument was put concerning the effect of section 33. There was a failure by the insured to disclose certain facts before the insurance contract was entered into, and the exclusion clause was triggered by the insured knowing those facts before the contract was entered into. Thus this was a situation in which section 33 operated to ensure that the insurer had no greater rights, concerning the facts that were not disclosed, than it would have under section 28.

As well the analogy that Dunford J used is unconvincing. A clause excluding claims *notified to* the insurer before the commencement of the contract might not say anything in its words about non-disclosure, but it would in fact relate to a situation where there had been a failure to disclose a matter to the insurer, namely the fact that the claim had been made to the insured. A clause excluding claims *arising out of anything done or omitted* before the commencement of the contract could indeed be one that had nothing to do with nondisclosure, but only if at the time the contract commenced the insured did not know about the thing that had been done or omitted - and in that event there is no analogy to the clause that was in dispute in *Pech v Tilgals*.

The aspect of the decision in *Pech v Tilgals* relating to whether the exclusion clause was void has never been followed[82]. I suggest that it should not be followed in any future case.

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[81] Had his Honour considered that question it is likely that he would have come to the conclusion that there had been non-disclosure. The policy in question took effect in January 1989. The duty of disclosure that applied concerning it was the general duty under section 21, which required an insured to disclose, inter alia, every matter that is known to the insured, being a matter that a reasonable person in the circumstances could be expected to know to be relevant to the decision of the insurer whether to accept the risk and if so on what terms. The finding that a reasonable accountant in the position of this particular accountant should have considered that a claim against him may be made makes it likely that that duty would not have been complied with. However, the findings do not enable one to conclude what the remedy, under section 28, for the failure to comply with the duty of disclosure would have been. In particular, they do not enable one to know whether the insurer would have been entitled to avoid the policy on the grounds of fraud, or to reduce its liability to nil under section 28 (3).

[82] *Pech v Tilgals* was followed in *Murphy & Allen v Swinbank* [1999] NSWSC 934, , *Divune Pty Ltd v Gould Ralph Services Pty Ltd* [2004] NSWSC 8, *Carmody v Priestley & Morris Perth Pty Ltd* [2005] WASC 120, *Leda Pty v Weerden (No 2)* [2006] NSWSC 125, *Christie v Purves* (2006) 3 DCLR (NSW) 85 and *Thalia Corp Pty Ltd v Bentleys (SA) Pty Ltd* [2013] SASC 172, but in each case on a different point to the one concerning whether the exclusion was void under s 52 *IC Act* .

6.4.2 *Porter v GIO*

Similar to *Pech* is the decision in *Porter v GIO Australia Ltd*[83]. *Porter* was a claim by a company director on a directors' and officers' liability contract. Exclusion 10(v) excluded liability for loss arising out of claims

> "arising from circumstances of which any Insured had become aware prior to the Period of Insurance and which the Insured knew (or ought reasonably to have known) to be circumstances which may give rise to a Claim".

McClellan J accepted that the plaintiff was aware of certain factual matters, and was aware that these may give rise to a claim against him. His Honour held that the exclusion clause operated to exclude the insurer's liability to indemnify. He continued[84]:

> Porter submitted that the only remedy for non-disclosure is provided by s 33, Part 4 Division 3 of the Act. However, Exclusion 10(v) operates to exclude the nominated matters from the risk insured. Accordingly, s 33, which only relates to remedies in relation to matters within the policy, is not relevant to the present circumstances.

In light of his Honour's finding that the Insured was aware that the circumstances may give rise to a claim against him it is difficult to see how the duty of disclosure would not have been breached. However His Honour did not make any express decision to that effect. If the duty of disclosure had been breached, that should have lead his Honour to consider what amount, if any, was payable by the insurer in accordance with section 28. If the effect of the exclusion clause was to give the insurer a more extensive right to deny liability than would arise under section 28, then to that extent the exclusion clause was ineffective pursuant to section 33, and void pursuant to section 52. In considering just the wording of the clause, and not its effect, his Honour's reasoning suffers from similar difficulties as the reasoning in *Pech*. It has never been followed[85], and I suggest it should not be followed in future.

6.4.3 *Permanent Trustee v FAI*

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[83] [2003] NSWSC 668; (2003) 12 ANZ Ins Cas ¶ 61-573

[84] At [854], without reference to either *Pech* or the decision of Hodgson J in *Permanent Trustee v FAI*

[85] The only cases in which *Porter* has been referred to are *ACN 074 971 109 (as trustee for the Argot Unit Trust) and Pegela Pty Ltd v National Mutual Life Association of Australasia Ltd* [2006] VSC 507,(2007) 14 ANZ Ins Cas 90-131; at [863]; *Alpha Wealth Financial Services Pty Ltd v Frankland River Olive Co Ltd* [2008] WASCA 119, (2008) 66 ACSR 594 at [24] *Trustees of Roman Catholic Church for the Diocese of Parramatta operating as Bede Polding College v Limit (No 3) Ltd* [2008] NSWSC 887 at [8]; *Fraser v Irish Restaurant & Bar Co Pty Ltd* [2008] QCA 270 at [64] and *Fay v Moramba Services Pty Ltd* [2010] NSWSC 725 at [14]. In none of these cases was it referred to concerning the effect of section 33 or the enforceability of the exclusion clause.

In *Permanent Trustee Australia v FAI*[86] Hodgson CJ in Eq considered a professional indemnity contract that contained a retroactive liability clause, which stated that the liability of the insurer was:

> "unlimited (excluding claims or circumstances which may give rise to a claim which are known to the insured prior to the inception of this insurance)"[87].

His Honour's decision about the construction of the exclusion contained in the retroactive liability clause was:

> "The policy gives insurance against liability for breach of duty, and is a claims-made policy. If any breach of duty by the insured had occurred and damage resulted, and if the claim is subsequently brought, then ipso facto there must at the time of the occurrence have been circumstances which might give rise to a claim; and it is likely that the insured would have known of those circumstances at the time, although not have known that they might give rise to a claim. In my opinion, the retroactive clause should be interpreted as applying only if the insured knows the circumstances *as circumstances which might give rise to a claim*, because otherwise the clause would have the unreasonable effect of excluding many or even most circumstances that were purportedly insured against."[88].

His Honour decided that the insured did not know the circumstances as circumstances which might give rise to a claim, and thus decided that the exclusion clause did not apply, as a matter of construction of the clause.

Much later in the judgment, he also considered the effect of section 33 on the retroactive clause. He said:

> "If the retroactive clause had the effect of excluding liability for something which was in substance a nondisclosure, then I think s 33 would in any event prevent the retroactive clause excluding liability."[89]

This dictum is brief, but an essential consequence of it is that a clause that excludes cover concerning "claims or circumstances which may give rise to a claim which are known to the insured prior to the inception of this insurance" is a clause that confers a "right in respect of a failure by the insured to disclose a matter", and thus is capable of being made ineffective by section 33.

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[86] (1998) 44 NSWLR 186

[87] at 193

[88] at 229-230 (the emphasis is his Honour's). Though there was a subsequent appeal to the NSW Court of Appeal (*Permanent Trustee Australia Co Ltd v FA I General Insurance Co Ltd* [2001] NSWCA 20, (2001) 50 NSWLR 679), and a further appeal to the High Court (*Permanent Trustee Australia Ltd v FA I General Insurance Co Ltd* [2003] HCA 25, 214 CLR 514, neither of those appeals made any presently relevant remarks concerning section 33.

[89] at 254

6.4.4 *Permanent Custodians v ARMA* and related cases

In *Permanent Custodians Ltd v ARMA Pty Ltd*[90] a "claims made" contract indemnified a valuer against liability for professional negligence. A financier had brought proceedings against the valuer alleging that it had suffered loss arising from a negligent valuation. The question for decision was whether the valuer's insurer should be joined to the proceedings to enforce an alleged charge over insurance money, said to arise pursuant to section 6 *Law Reform (Miscellaneous Provisions Act 1946 (NSW).*

The insurer contended that it should not be joined because any claim brought against it was not reasonably arguable[91]. The insurer contended that Conti J should be satisfied that it was entitled to disclaim liability by reason of an exclusion concerning claims "arising from circumstances of which You were aware prior to the Insurance and which You, or a person in Your position, ought reasonably to have realised to be circumstances which might result in a Claim or claim." It contended that the valuer was aware, before the period of cover commenced, that there had been defaults concerning loans that the financier had made on the security of property that the valuer had valued, that the financier was contending that it appeared the valuer's valuations had significantly overvalued the property, and that it appeared likely that the financier would suffer a shortfall.

Conti J granted the leave. He noted[92] both aspects of the reasoning of Hodgson CJ in Eq in *Permanent Trustee Australia v FAI* quoted above (though he mistakenly thought that the decision of Hodgson CJ in Eq predated *Pech*), and apparently accepted a submission that the only way the underwriters could prevent being joined to the proceedings was if he was persuaded that Hodgson CJ in Eq was wrong. It appears that Conti J was unpersuaded that Hodgson CJ in Eq was wrong. However Conti J gave no account of any argument about why Hodgson CJ in Eq might have been wrong, or of what led Conti J to be unpersuaded that Hodgson CJ in Eq was wrong[93]. Nor did his Honour make clear whether he accepted the decision of Hodgson CJ in Eq concerning the construction of the exclusion clause, concerning the

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[90] [2006] FCA 640

[91] the test laid down by *Andjelkovic v AFG Insurances Ltd* (1980) 47 FLR 348 at 356 for granting leave under section 6 to join an insurer

[92] At [28]

[93] It well may be that arguments on these matters were not put to him – when the matter ultimately went on appeal to the Full Court Allsop and Buchanan JJ declined to make a final decision about whether section 33 was engaged "in light of the extent of argument (or lack of it) undertaken on the appeal on the issue": *Macquarie Underwriting Pty Ltd v Permanent Custodians Ltd* [2007] FCAFC 60, 240 ALR 519 at [28]. There is some improbability about the argument presented on the appeal having been less well developed than it was at first instance, particularly as both of the counsel for the financier and the junior counsel for the insurer on the appeal had all appeared at the hearing before Conti J.

effect of section 33, or concerning both matters. His Honour then distinguished *Pech* on the facts[94] without commenting on the manner in which it had applied section 52. Nor did he consider whether the reason that Dunford J gave in *Pech* for the inapplicability of section 52 (that "the claims specified are excluded from the cover whether the circumstances are disclosed or not") might also lead to the conclusion that section 33 was inapplicable[95]. In all these circumstances, the decision is not a strong authority.

Bennett J granted leave to appeal against Conti J's granting of leave to join the insurer[96], without herself expressing any views on section 33.

The appeal to the Full Court of the Federal Court was called *Macquarie Underwriting Pty Ltd v Permanent Custodians Ltd*[97]. The insurer disclaimed any reliance on nondisclosure[98], and argued that the terms of the contract were such that "the cover did not extend to the circumstances which generated the claim for indemnity"[99]. Allsop and Buchanan JJ stated the effect of s 33[100]:

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

Their Honours summarised the plaintiff's argument as being that "the attempt at the definition of coverage cannot withstand the effect of s 33". They held that that contention was arguable[101]. Their Honours said:

> "In another context, s 54 of the *Insurance Contracts Act,* the fitting into the scheme of that Act of claims-made policies caused significant difficulty for a number of years: see *East End Real Estate v C E Heath Casualty & General Insurance Ltd* (1991) 25 NSWLR 400; *FAI Insurance Co v Perry* (1993) 30 NSWLR 89; *Antico v Heath Fielding Australia Pty Ltd* [1997] HCA 35; (1997) 188 CLR 652; and *FAI General*

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[94] at [30]
[95] Conti J later delivered a supplementary judgement, which dealt with two additional grounds, unrelated to either s 33 or s 52, on which the insurer contended it was bound to succeed, and confirmed the granting of the leave: *Permanent Custodians Ltd v ARMA Pty Ltd (No 2)* [2006] FCA 847
[96] *Macquarie Underwriting Pty Ltd v Permanent Custodians Ltd* [2006] FCA 1291
[97] [2007] FCAFC 60, 240 ALR 519
[98] [18]
[99] [19]
[100] At [27], Graham J agreeing at [105]
[101] At [28], Graham J agreeing at [105]

> *Insurance Co Ltd v Australian Hospital Care Pty Ltd* [2001] HCA 38; (2001) 204 CLR 641. These difficulties arose from a desire of insurers to identify the notification of a claim within a policy period as an essential attribute of insurance cover, and not as a contractual condition of the policy regulating required conduct of the insured. The debate about cl 4.1 of the second policy and s 33 is not entirely dissimilar. In cl 4.1 the insurers are attempting to exclude from cover matters which would otherwise be disclosable. The aim may be readily seen to be definitional, but it is arguable that s 33 is engaged."

Their Honours also said[102]:

> "Neither first instance decision referred to (*Permanent Trustee of Australia Ltd v FAI General Insurance Co Ltd* (1998) 153 ALR 529 at 589 or *Pech v Tilgals* (1994) 94 ATC 4206) is determinative. The primary judge did not err in failing to give the latter case overwhelming preference as the appellants submitted he should have done."

153 ALJ 529 at 589 is the place where the passage from *Permanent Trustee v FAI* that I have quoted at footnote 89 above appears.

Because the issue in this line of cases concerned whether the insured's contention was reasonably arguable, rather than whether it was right, the Full Court decision does not provide a clear binding precedent on the correct construction of section 33. Even so, as a considered statement of an intermediate appellate court, their Honours' remarks are entitled to careful consideration.

I suggest that their Honours' explanation of the effect of section 33 is consistent with the explanation that I have given earlier. The result arrived at in the case – that it was arguable that section 33 made inoperative a clause excluding liability for claims arising from circumstances of which the insured was aware before the contract was issued – could not have been arrived at if the clauses struck down by section 33 were confined to clauses that spoke in express terms about a failure to disclose.

6.4.5 *Genworth v Kcram*

Genworth Financial Mortgage Insurance Pty Ltd v Kcram Pty Ltd (in liq) (No 2)[103] was another application for leave to join an insurer under s 6 *Law Reform (Miscellaneous Provisions) Act 1946 (NSW).* The insurance in question was professional indemnity insurance of a valuer. The insurer opposed joinder, on the ground that the claim against the insurer was bound to fail because the contract contained an exclusion of

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[102] [28]

[103] [2011] FCA 1124, 284 ALR 72 at [17]-[18]. In both *Macquarie Underwriting* and *Genworth* it was not necessary for the court to decide anything more than whether the contention was arguable, because the issue in each case was whether an insurer should be joined to litigation to enforce a charge over insurance money that was alleged to have arisen pursuant to s 6 *Law Reform (Miscellaneous Provisions) Act 1946 (NSW)*.

liability concerning "any valuation exceeding $1 million that: (a) was not reviewed by a second appropriately qualified valuer prior to such valuation being issued; and (b) where such review is not clearly recorded on the [valuer's] file for such valuation". The valuation alleged to have been conducted negligently was clearly for more than $1 million, and the insurer alleged it had not been reviewed and recorded in the manner required. Perram J held that it was arguable that the exclusion did not apply because there was an issue of fact about whether the valuation had been reviewed and recorded.

Relevantly for present purposes, the insurer argued that the exclusion was in substance a warranty that all its contracts exceeding $1 million had been checked by two valuers. Perram J held that if the exclusion was a warranty it would not be inevitable that the insurer would escape liability. His reasoning depended upon section 24 *IC Act*, which required any warranty about the existence of a statement of affairs to be treated as a statement made during negotiations preceding the contracts inception. If such a statement was incorrect, it was a misrepresentation, and consequently section 28 limited the remedies concerning it. His Honour accepted that it was arguable that the exclusion was void pursuant to section 33, because it was "an attempt to contract out of Pt IV of the Insurance Contracts Act"[104]. He said that section 33 "operates to make the provisions of Pt IV a code in relation to misrepresentations and non-disclosures"[105]. His Honour continued:

> "A similar argument was accepted by the Full Court to be arguable for s 6(4) purposes in *Macquarie Underwriting Pty Ltd v Permanent Custodians Ltd* [2007] FCAFC 60; (2007) 240 ALR 519. In that case the policy contained an exclusion in respect of circumstances of which the insured was aware prior to entry into the policy and which it ought reasonably to have known might give rise to a claim. It was argued that an exclusion in those terms would directly undermine the operation of s 28 and its specific regime relating to non-disclosure. Allsop and Buchanan JJ concluded (at 524-525 [28]) that that argument was 'arguable' so that the exclusion did not stand in the way of a s 6(4) claim. I would be inclined, in terms of arguability, to reach the same conclusion. Thus, even if Exhibit 2 had been shown to be the whole of the valuer's file, I would nevertheless have concluded that for present purposes it was arguable that the exclusion did not apply."[106]

Again, this is a decision about whether an insured's contention about the construction of section 33 is arguable, rather than whether it is right. The decision advances the argument beyond the position reached by the Full Court in *Macquarie Underwriting* by providing an example of how a "right in respect of … a

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[104] [17]
[105] [17]
[106] No argument was put in *Genworth* that a separate basis for inapplicability of the exclusion clause arose under s 46 *IC Act*.

misrepresentation or incorrect statement", within the meaning of section 33, could be a right that said nothing in terms about any misrepresentation or incorrect statement, but rather was a right that arose in circumstances where there had in fact been a misrepresentation or incorrect statement. I suggest that it is consistent with the account of section 33 that I am advancing.

7. Section 47

The wording of section 47 has stood unchanged in the *IC Act* since the Act's inception. The section arose from a recommendation in the ALRC Report[107]. The ALRC saw the section as an integral part of its reform of the law concerning non-disclosure and misrepresentation. In the course of the chapter in the Report entitled "Non-Disclosure and Misrepresentation" the Commission gave the justification for enacting the provision:

> "A representation on [sic] the existence of a fact should be read as a representation that that fact exists to the best of the insured's knowledge and reasonable belief[108]. Otherwise an insurer might require from an insured a guarantee of accuracy which it was not within his ability to give. As a representation may be converted into a warranty, warranties of truth should be interpreted in the same manner. Some absolute warranties of existing fact might be rephrased as exclusions from cover. An example is the common exclusion of pre-existing illness contained in a personal accident policy. This applies to any pre-existing illness, even if the insured was not, and could not reasonably have been aware of it. Exclusions of that type are as objectionable as analogous warranties. Where an exclusion is based on the state or condition of the subject matter of the insurance, the insurer should not be able to rely on that exclusion if the insured proves that, at the time the contract was entered into, he did not know, and a reasonable man in his circumstances would not have known, of the existence of the relevant state or condition."[109]

7.1 The Construction of Section 47

Section 47 does not prohibit an insurer from including in a contract a provision that has the effect of excluding the insurer's liability by reference to a pre-existing sickness or disability, nor does it make any such provision void. Rather, it makes such a provision unable to be relied on in certain circumstances.

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[107] The ALRC Report p 264 – 265 recommended a single section that covered the matters now dealt with by s 46 (dealing with pre-existing defects or imperfections in things) and s 47 (dealing with pre-existing sickness or disability of people). The legislation as enacted split the ALRC's recommended section into two, and allowed regulations to make an exception from the operation of s 46 concerning certain classes of contracts, but made no provision for exceptions from s 47.

[108] Achieved, for general insurance, in the *IC Act* as enacted by the combined operation of sections 24 and 26.

[109] ALRC Report para 184

The section operates concerning a *particular loss* that is the subject of the *particular claim*. As in section 28(3), a "claim" in the context of section 47 would be a request or demand, that an insured made to the insurer, that the insurer pay an amount to indemnify the insured against a loss[110].

7.1.1 The scope of "sickness or disability"

As a matter of ordinary English a person is "sick" if they are 'affected with a disorder of health, ill or unwell'[111], and can suffer a "sickness" if they are sick, or suffer a 'particular disease or malady or illness'[112]. Manning J has held that "illness" includes a "bad or unhealthy condition of the body", and that a bodily condition that predisposed a person to developing duodenal ulcers was itself an "illness"[113]. A High Court plurality, in construing an insurance policy that provided different benefits for disability sustained "as a result of sickness" to those available for disability sustained "as the result of injury", has said that sickness:

> "would include bodily disorder sustained otherwise than as the identifiable result of a traumatic occurrence, such as sickness or disease contracted as the result of contagion or "the operation of natural causes such as old-age, congenital or insidious disease or the natural progression of some constitutional physical or mental defect": *Halsbury's Laws of England*, 4th ed vol 25 p 311".[114]

Brennan J has said, in the same context:

> "if the pathological condition is occasioned by no more than the buffeting encountered in ordinary living acting on a body that is infirm, a resulting disability should be attributed to the body's infirmity – that is, to sickness – rather than to injury."[115]

Thus as a matter of ordinary English a "sickness" can be any bodily or mental condition that is a departure from a good state of health[116].

"Disability" is an inherently relational word – it means not having the ability to do something, but the word by itself does not communicate what that "something" is.

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[110] "a demand for something as due, an assertion of a right to something"*: Walton v National Employers Mutual General Insurance Association Ltd* [1973] 2 NSWLR 73 at 82 per Bowen JA
[111] Macquarie Dictionary definition of 'sick"
[112] Macquarie Dictionary definition of "sickness"
[113] *Burgess v Brownlow* [1964] NSWR 1275 at 1279
[114] *Australian Casualty Co Ltd v Federico* (1986) 160 CLR 513 at 527 per Wilson and Deane and Dawson JJ. By including "disease" within the scope of "sickness" there is included "a morbid condition of the body. It may be initiated by some external cause or be idiopathic or autogenous": *Favelle Mort Ltd v Murray* (1976) 133 CLR 580 at 587 per Barwick CJ.
[115] *Federico* at 533
[116] Dental plaque and gingivitis have been help to be sufficiently in the nature of "sickness or disease" to be proper subjects of prevention or treatment: *Parke Davis Pty Ltd v Commissioner of Taxation* (1996) 69 FCR 235 at 241 (entitlement of Listerine to sales tax exemption)

That must be gathered from the context in which it appears[117]. In the context of section 47(1), a "sickness or disability" is a condition of body or mind that a person has, and is the type of thing that is capable of causing a loss under an insurance contract. As section 47 applies to all types of insurance contract that fall within the scope of the *IC Act*, there is no occasion to restrict the meaning of the "sickness or disability" by reference to the terms of any particular contract, or by reference to the terms of any type of contract. Nor is there any occasion to restrict those words to something that causes any particular type of loss. There is nothing in section 47 to suggest that a "sickness or disability" must be the type of thing that *actually* causes a loss under a contract of insurance – just that it is the sort of thing that *might* cause a loss under such a contract. Further, section 47(2) makes clear that a "sickness or disability" might be something that an insured actually had, but was not aware of having. In all these circumstances, there is no reason to restrict the meaning of "sickness" in section 47 to anything narrower than any bodily or mental condition that is a departure from a good state of health, and no reason to restrict "disability" to anything narrower than an inability of a person to carry out some task or function. Construing "sickness or disability" that way gives effect to the principle that because section 47 is a remedial provision[118], it should be construed "so as to give the most complete remedy which is consistent with the actual language employed and to which its words are fairly open."[119].

7.1.2 The first precondition for the operation of section 47

There are two preconditions for section 47 making a provision of an insurance contract inoperative. One of them is stated in section 47 (1), the other in the words in section 47 (2) that precede "the insurer may not rely …".

Concerning the first precondition:

- If the particular loss that is the subject of the particular claim occurred as a result, in whole or part, of a sickness or disability that a person had at any time

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[117] In the context of a workers' compensation statute "disability" has been held to refer to the inability of a worker to earn income (*Boucher v Motors Pty Ltd* [1976] Tas SR 130 – though before that statute was amended in 1947 "disability" in it had meant that the worker had any physical interference with a bodily function (*Boucher* at 136)). In the context of a mortgage insurance policy 'disability" has been held to refer to the inability to earn a sum sufficient to reasonably afford the mortgage repayments (*Allan v National Mutual* (1993) 9 SR (WA) 68). In the context of a warranty that a horse was "free from any … disability whatsoever" it meant that the horse did not have anything that destroyed or impaired its ability to do some physical thing (*Cox v Trade Indemnity Insurance Co Ltd* [1986] VR 343 at 346).

[118] *Pearce & Geddes* [9.2] – [9.4], a principle that has been applied to the *IC Act*: *East End Real Estate Pty Ltd v C E Heath Casualty & General Insurance Ltd* (1991) 25 NSWLR 400 at 404, 409, 410; *Antico v Fielding Australia Pty Ltd* ("*Antico*")(1997) 188 CLR 652 at 659 – 660, 669, 675

[119] *Antico* at 675

whatsoever then the precondition that section 47(1) lays down for the operation of the section is satisfied.

- The sickness or disability that triggers section 47 (1) need not be the only cause of the loss that is the subject of the claim: it suffices that the loss is one that "occurred as a result, in whole *or part*, of a sickness or disability…"
- The sickness or disability that triggers section 47 (1) is one of "a person". Thus the precondition is satisfied whether the person who had the sickness or disability is the insured, or someone else[120].
- The sickness or disability is one to which a person "*was* subject or had at any time been subject". Section 47 (1) is speaking as at the time that the claim in question is made – thus the past tense, in the phrase "sickness or disability to which the insured was subject" requires only that the sickness or disability in question have occurred at some time before the claim was made.
- Because the sickness or disability is one to which a person "was subject *or had at any time been* subject" the precondition is satisfied regardless of whether the person in question had the sickness or disability before the contract was entered, or after it was entered. It is satisfied regardless of whether that person had the sickness or disability at the time the contract was entered, or had had the sickness or disability at some time before the contract was entered but no longer had the sickness or disability at the time the contract was entered.

7.1.3 the second precondition – which sickness or disability?

The opening words of section 47(2) create a second precondition for the operation of section 47. It is that, at the time the contract was entered the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability.

Section 47 sometimes uses the indefinite article "*a* sickness or disability", and sometimes uses the definite article, "*the* sickness or disability". The places where the different articles are used are important for the construction of the section. Subsection (1) deals with a loss that is a result in whole or part of *a* sickness or disability to which a person was subject or had at any time been subject. Because of the indefinite article, no particular sickness or disability is being talked about.

When the first part of subsection (2) refers to "*the* sickness or disability" it is referring back to *the same* sickness or disability that is, wholly or partially, the cause of the loss in respect of which the claim is made[121]. The effect of s 47(2) is that if a

[120] But the practical effect of this is limited – see footnote 122

[121] The Full Court of South Australia reached this conclusion in *Galaxy Homes Pty Ltd v The National Mutual Life Association of Australasia Ltd (No 2)* [2013] SASCFC 66 at [88]

loss arises as a result, in whole or part, of a particular sickness or disability, and at the time the contract was entered into the insured was not aware of (and a reasonable person in the circumstances could not be expected to have been aware of) *that particular* sickness or disability, the insurer cannot rely on a provision in the contract that has the effect of limiting the insurer's liability by reference to *any* sickness or disability to which the insured was subject before the contract was entered[122].

This construction of section 47(2) has the consequence that it is critical to decide whether the sickness or disability that is a cause of the loss is the same as a sickness or disability that the insured has previously suffered. In *Galaxy Homes Pty Ltd v The National Mutual Life Association of Australasia Ltd (No 2)* [2013] SASCFC 66 a life insurance contract contained an exclusion:

> We will not pay a benefit for a medical condition, injury or sickness that occurred before the commencement date unless you or the person insured told us in writing about the medical condition, injury or sickness, and we agreed to accept it, when you or he or she applied for the plan ...
>
> For the purposes of this clause, the person insured had a medical condition, injury or sickness if:
>
> A medical practitioner or other health professional gave the person insured, or recommended that he or she receive advice, care or treatment ...

The insured had been diagnosed as suffering from a malignant melanoma in 1994. It was surgically removed, and at the time he was told he had a 40% chance of dying within 5 years. Some 17 years later, and at a time when he had suffered no further symptoms of which he was aware, he took out the contract. He did not disclose his 1994 diagnosis or treatment. During the contract term he was diagnosed as suffering once more from malignant melanoma, of a significantly more advanced stage than that which he had suffered in 1994. The Court held that the exclusion clause was effective. An important part of the reasoning was that the sickness he had encountered in 1994 was the *same sickness* as gave rise to the claim, namely

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[122] For the sake of completeness, another matter should be mentioned concerning the use of different articles in section 47. Because of the indefinite article in "a person" in s 47(1), the two preconditions for the operation of s 47 could be satisfied if a claim is made in respect of a loss that occurred as a result of a sickness or disability to which someone other than the insured was subject. If, for example, an insured traveller incurred loss in cutting short a trip to return home because of an illness of the traveller's parent or business partner, such a loss would be within the scope of some travel insurance contracts. That claim would satisfy the requirements of s 47 (1). If (as could easily happen concerning such a claim) the insured was not aware at the time of entering the policy of insurance that the parent or partner had that sickness or disability, the second precondition for the operation of s 47 would also be satisfied. However no consequence would arise under s 47(2), because it is only contractual provisions that affect the insurer's liability by reference to a sickness or disability *of the insured* that are made inoperative by section 47.

malignant melanoma, and at the time the contract was entered the insured knew that he had once suffered from malignant melanoma.

7.1.4 The second precondition - "aware of the sickness or disability"

The second precondition for the operation of section 47 turns on whether at the time the contract was entered into the insured was "aware of the sickness or disability" from which the loss that is the subject of the claim has resulted. The Oxford English Dictionary[123] gives as meanings of "aware" "Informed, cognizant, conscious, sensible." The Macquarie Dictionary[124] defines it as "cognisant or conscious". In contexts well away from that of insurance, the High Court has sometimes spoken as though to "be aware of" something and to know that thing are not materially different[125].

There are some contexts in which to "be aware of" x has a shade of meaning whereby x is not only known, but is consciously present to someone's mind, in the sense of being part of the focus of the person's attention – eg "She became aware of a slight movement in the bushes, and of an acrid smell." However it is hard to see that that narrower shade of meaning is appropriate to section 47. The words "the sickness or disability" in section 47(2) refer to the "sickness or disability to which a person was subject *or had at any time been* subject", that was referred to in section 47(1). It makes sense to talk about a person "being aware of" a sickness or disability from which they now suffer if it, or its symptoms or discomforts, is consciously present to their attention and known to arise from a sickness or disability. However it is odd to talk about a sickness or disability to which they had at some past time been subject being (now) consciously present to their attention, in any sense other than being known and remembered.

Another reason for treating "aware" in section 47 as being no different in meaning to "knows" is that the ALRC Report explained the purpose of the section that became section 47 in language that speaks as though "aware" and "know" were synonymous[126]. As well the South Australian Full Court has treated "aware of" as being synonymous with "known", though in a context where there was no issue about the precise shade of meaning of the phrase[127].

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[123] Online version accessed 10 October 2017

[124] Online version accessed 10 October 2017

[125] *Deming No 456 Pty Ltd v Brisbane Unit Development Corp Pty Ltd* (1983) 155 CLR 129 at 150-151, 165; *Joslyn v Berryman* (2003) 214 CLR 502 at [44], [75]

[126] The LRC Report contained a draft Bill which included, at page 264- 265 of the Report, a s 47 in which the opening words of section 47 (2) are identical with the opening words of section 47 (2) as enacted. The LRC explained its recommendation in terms that treated "aware" as being synonymous with "knows" – see the extract from [184] of the Report quoted at footnote 109 above.

[127] See text at footnote 132 below.

However, just as something that has been forgotten is not something that is known[128], so a past sickness or disability that a proponent for insurance had forgotten at the time the contract was entered into would not be one of which the insured was aware, within the meaning of section 47(2). Similarly, a past sickness or disability that a reasonable person in the circumstances could not be expected to have remembered would not be one of which a reasonable person in the circumstances would have been aware, within the meaning of section 47(2).

As the ALRC Report recognised[129], the onus of proving the insured's lack of awareness would be on the insured. This accords with the principle that a person who seeks to avail himself or herself of some ground for exception or excuse in a statute bears the onus of proving the facts that bring his or her case within it[130]. In this respect there is a difference between how section 47 works and how the law concerning the duty of disclosure works: the onus of proving the matters to show that there has been a failure to comply with the duty of disclosure is on the insurer[131].

7.1.5 The operative part of section 47

If the two preconditions are satisfied, section 47 (2) requires a certain consequence to arise. It is that "the insurer may not rely on a provision included in the contract that has the effect of limiting or excluding the insurer's liability under the contract by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into".

As the Full Court of South Australia has held[132], in this phrase:

> " … the words "at a time before the contract was entered into" must be understood to refer to an unlimited temporal period prior to the contract being made. It is not confined to the time immediately preceding entry into the contract. Accordingly, the operation of s 47 precludes an insurer from relying on a provision in the contract limiting or excluding the insurer's liability in respect of a claim for a sickness or disability to which the insured was subject at any time before the contract was entered into, where the insured did not know or could not reasonably have known of the condition."

Section 47(2) precludes an insurer from relying on a *provision* in a contract of insurance. "Provision" is "a word of diverse meanings which slide easily into each

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[128] *Re Montagu's Settlement Trusts* [1987] Ch 264 at 284
[129] At [184]
[130] *Dowling v Bowie* (1952) 86 CLR 137 at 139-140
[131] *Dew v Corp Life and Superannuation Ltd* [2001] QCA 459 at [12]; *Australian Casualty and Life Ltd v Hall* [1999] QCA 240; (1999) 151 FLR 360 at [72] per Shepherdson.
[132] *Galaxy Homes Pty Ltd v The National Mutual Life Association of Australasia Ltd (No 2)* [2013] SASCFC 66 at [88]

other"[133]. One of the meanings is that a "provision" in a contract of insurance is a clause or proviso or some other defined part of the written document. A second meaning is that a "provision" of the contract can be the result that ensues from, that which is provided by, such a clause or proviso or other defined part of the contract[134]. In construing section 47 it is probably not necessary to choose between these possible meanings, because section 47 identifies the "provision" that it precludes the insurer from relying on by its *effect*. The "provision" that section 47 neuters might take the form of an exclusion clause, it might take the form of a limitation in the definition of the scope of the cover, or any other form that the ingenuity of a drafter can devise. If the insured was not aware of the sickness or disability that is the cause (in whole or part) of a loss in respect of which a claim is made, and the effect of a provision of the contract of insurance is to limit or exclude the insurer's liability by reference to any sickness or disability to which the insured was subject before the contract was entered, the insurer cannot rely on that provision to limit or exclude its liability concerning that claim.

When a statute makes a "provision" of a contract void or inoperative problems can sometimes arise concerning severance of the contractual provision. They are to do with whether the whole of a clause in the contract is made void or inoperative, whether only some part of it is to be notionally struck out using a "blue pencil" test, or whether it is just a matter of the clause being "read down" so that it is treated as not being construed in some particular way. Because section 47(2) comes into operation only when a specific claim has been made, under a specific contract, and concerning a specific loss, the preferable construction of the operative part of section 47(2) is that the "effect of limiting or excluding the insurer's liability under the contract" is an effect that arises concerning the liability of the insurer concerning that particular claim. On that construction, no problems of severance arise.

7.1.6 "by reference to"

A provision of a contract of insurance "has the effect of limiting or excluding the insurer's liability under the contract *by reference to* a sickness or disability to which the insured was subject at a time before the contract was entered into" when the provision has the effect of the insurer's liability being limited or excluded, and the provision points out or identifies a sickness or disability to which the insured was subject at a time before the contract was entered into as being the circumstance

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[133] Per Lord Simonds, *Berkeley v Berkeley* [1946] AC 555 at 580, cited with approval in *Zurich Australian Insurance Ltd v Metals & Minerals Insurance Pte Ltd* [2009] HCA 50; 240 CLR 391 at [31]

[134] These alternative meanings are recognised in *Berkeley v Berkeley* [1946] AC 555 at 565-6 per Viscount Simon, 570 per Lord Thankerton, 575 per Lord Porter, 580 per Lord Simonds, and 586 per Lord Uthwatt, and accepted in *Clyne v Cardiff* [1965] NSWR 469 at 474-5 and in *Zurich Australian Insurance Ltd v Metals & Minerals Insurance Pte Ltd* [2009] HCA 50 ; 240 CLR 391 at [31].

that brings about that effect, or as being one of the circumstances that bring about that effect.

The Macquarie Dictionary defines *"reference"* as being:

> "1. the act or fact of referring.
>
> 2. direction of the attention.
>
> 3. a mention; allusion..."

It defines "refer" as meaning:

> "1. to direct the attention or thoughts of.
>
> 2. direct for information or for anything required..."

Something can be "referred to" by a word or phrase even if it is not expressly mentioned in the word or phrase. For example, trader A can trade "by reference to" the name of trader B even if the actual name of trader B is not used, but trader A trades under a name that is similar to that of trader B, that is used in a get-up that closely resembles that of trader B, and is calculated to create the impression that the name is that of trader B[135]. A covenant in a lease has "reference to the subject matter" of the lease when it touches and concerns the leased land[136]. There can be a reference to some state of affairs of type A by words that say nothing about a state of affairs of type A, provided that the words in fact point out or identify a state of affairs of type A – for example a clause that says that a particular consequence follows from liquidation of a company is a clause that contains a reference to winding up[137].

A provision of a contract can operate by reference to a sickness or disability if it in fact points out a sickness or disability as the thing that causes that provision to operate, even though it does not use the words "sickness or disability". For example, if a clause defines an "existing medical condition" as including a "medical condition … for which you have been in a hospital or emergency department or day surgery", or as including "a condition for which medication has been prescribed by a medical or dental advisor", and there is an exclusion of liability for loss arising from such a condition, the clause operates by reference to a sickness or disability, even though the words "sickness or disability" do not occur in it.

Consistently with section 47 an insurer is free to exclude from the contract it offers certain specified types of sickness or disability. So far as section 47 is concerned an insurer is free to adopt an underwriting policy whereby it does not cover losses

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[135] *Taylor Bros Ltd v Taylors Group Ltd* [1990] 1 NZLR 19 at 23

[136] *Caerns Motor Services Ltd v Texaco Ltd* [1995] 1 All ER 247 at 257

[137] *Atkinson v Australian Rural Group Ltd* [2002] NSWSC 1232 (2002) 44 ACSR 152 at [38] – [42].

arising from, say, mental illness, or pneumonia[138]. The only restriction that section 47 imposes is when the insurer seeks to exclude or limit its liability concerning a claim by reference to a sickness or disability that the insured has previously suffered.

7.1.6.1 Asteron Life Ltd v Zeiderman – "by reference to"

In *Asteron Life Ltd v Zeiderman*[139] the New South Wales Court of Appeal considered a situation where the insured took out a contract at a time when he was not aware of having ever had cancer, but within three months of the contract being issued was diagnosed as suffering from cancer. The contract contained an exclusion clause stating "we will not pay for cancer if first diagnosed within 3 months after the issue date". The undisputed medical evidence was that the insured would have had the cancer at the time the contract was taken out, even though it was then undetected. The majority in the Court of Appeal, Meagher JA and Bergin J, held that the exclusion clause was effective. Spigelman CJ dissented.

Meagher JA spoke of the exclusion clause as being a "waiting period exclusion". He recognised that section 47 depended upon the insured having "precontract pathology" of which the insured was unaware at the time of entering the contract. He said: "precontract pathology has no logical connection with, and cannot be the cause of, the operation of the waiting period exclusion."[140] . He upheld the submission that "the trial judge was wrong to hold that the waiting period exclusion took effect 'by reference to' precontract pathology."[141]

Meagher JA gave no further explanation of what was meant by "by reference to" in section 47. However Bergin J said:

> "The core purpose of s 47 (2) is to mitigate the effects of certain contractual provisions where liability is sought to be avoided "by reference to" a sickness or disability to which the insured was subject at a time before the contract was entered into. The contract of insurance in this case has the effect of limiting the relevant liability not by reference to (or *because of or on the basis of*[142]) pre-contractual pathology but by reference to post contractual diagnosis irrespective of pre-contractual pathology, that is, irrespective of whether the insured was subject to the

[138] There might be restrictions arising from statutory requirements other than section 47 on the inclusion of such an exclusion. For example a blanket exclusion of losses arising from mental illness might contravene an anti-discrimination statute: *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 1936. If an insurer refuses to grant cover for losses arising from risks unconnected with health, like luggage loss or theft, on the basis of the proponent having previously suffered cancer that refusal might contravene an anti-discrimination statute: *Bassanelli v QBE Insurance* [2003] FMCA 412, affirmed *QBE Travel Insurance v Bassanelli* [2004] FCA 396, 137 FCR 88

[139] [2004] NSWCA 47, 59 NSWLR 585

[140] [45]

[141] [46].

[142] Emphasis added

> particular sickness or disability at a time before the parties entered into the contract."

Spigelman CJ rejected an argument that the word "reference" requires an express reference, saying "the absence of an express reference is not, in my opinion, determinative if, as a matter of substance, the exclusionary clause is appropriately characterised as falling within the statutory formulation."[143] After drawing attention[144] to authorities that had recognised the importance of applying the *IC Act* so that its policy was given effect to regardless of the differing drafting techniques that might be adopted to achieve the result that an insurer had no liability[145], he said that the construction of the words "by reference to" should depend on matters of substance, not form[146]. Like Bergin J, he held that the words "by reference to" in section 47 should be construed as meaning "on the basis of" or "because of"[147]. He also held that section 46 and 47 should be construed consistently with the rest of the Act, and in particular with the provisions of the Act relating to the consequences of nondisclosure. He pointed out that "there is no non-disclosure, of a character entitling the insurer to avoid meeting his obligations under the contract, in the case of a failure to disclose a sickness or disability of which the insured was not, and could not reasonably have been, aware."[148].

Because the construction of "by reference to" as meaning "on the basis of" or "because of" is derived from the reasons of two judges who came to different conclusions about the outcome of the case, it is not part of the ratio of the case. However it is still significantly persuasive. I suggest that that is consistent with the account of "by reference to" that I have given above.

7.1.6.2 The application of "by reference to" to the facts in Asteron

Though in *Asteron* there was this measure of agreement about the meaning of "by reference to" in section 47, I suggest that the application of that meaning to the facts in *Asteron* remains debatable. The particular type of cancer involved in the case was such that a diagnosis within 3 months after the contract being issued could occur only if the cancer had actually been present at the time of entry of the

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[143] [6]
[144] at [7]-[10]
[145] *East End Real Estate Pty Limited v C E Heath Casualty & General Insurance Limited* (1991) 25 NSWLR 400 at 403, 404 per Gleeson CJ, *Antico v Heath Fielding Australia Pty Ltd* (1997) 188 CLR 652 at 668-669; *FAI Insurance Co Limited v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641 at [32]
[146] [11]
[147] [12]. He said: "The use of the word "reference" would, ordinarily, mean 'express mention of'. However, that is not the only meaning of the word in the phrase "with reference to". It can also mean "on the basis of" or "because of". In my opinion, the words in s47 should be construed in the latter sense."
[148] [13]

contract. Spigelman CJ, in dissent, held that the exclusion clause was ineffective because of section 47. He said:

> "Where a person has chosen a criterion of operation which is inevitably associated with another criterion, the choice of the former satisfies a statutory formulation that that criterion takes effect "with reference to" the latter… The limitation or exclusion effected by the 3 month provision is a limitation or exclusion which operates by reference to – in the sense of is based on – a sickness or disability that existed at the time of the contract."[149]

It is a deficiency in the reasoning of Meagher JA and Bergin J that their analysis of the exclusion clause was limited to whether its *wording* depended upon there being a connection between the pre-existing condition and the eventual sickness or disease. As Meagher JA said[150]:

> "A precontract pathology excludes all related claims irrespective of when diagnosis occurs. A "waiting period" exclusion only excludes claims arising out of a diagnosis within the period, and the date of the onset of the underlying pathology is completely irrelevant. The two exclusions are very different."

Meagher JA gave an example that he regarded as showing the strength of the construction he placed upon section 47[151]:

> "Assume an insured is not suffering from cancer at the time he takes out his policy, but the cancer arises within the 3 month period (a situation which all parties agreed was possible), and was diagnosed as soon as it arose, it is obvious that the policy would exclude the claim, and on any view the statute could not affect that result."

That remark is, with respect, perfectly correct – but it is correct because in this example there is neither a verbal connection in the words of the exclusion, nor a logical connection between the concept of there being pre-contract pathology and the concept of whether cancer is diagnosed within three months of the policy inception, nor a factual connection in the manner of progress of the disease, between the insured having a pre-contract pathology and the eventual diagnosis of the cancer. Such an example cannot assist in deciding whether an exclusion clause operates "by reference to" a pre-existing pathology when there is no verbal connection in the words of the exclusion between the pre-existing pathology, and no logical connection between the concept of there being pre-contract pathology and the concept of whether the cancer is diagnosed within three months of the policy inception, but there *is* a factual connection between the pre-contractual existence of the pathology and the eventual manifestation of the cancer.

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[149] [22]-[23]
[150] [43]
[151] [47]

To consider only whether the *wording* of the exclusion clause requires there to be a connection between a pre-existing pathology and the eventual sickness or disease, or whether there is a logical connection between the concept of there being pre-contract pathology and the concept of whether the cancer is diagnosed within three months, is to fail to carry out the task that the operative part of section 47 requires. The statute requires that one consider whether the provision in the contract has the *effect* of limiting or excluding the insurer's liability by reference to some pre-contact pathology. The effect of a contractual provision does not depend on verbal or logical connections – it depends on matters of fact, about how the provision applies to events or circumstances in the real world. Though Bergin J said that she was considering the effect of the exclusion clause, the only type of effect that her Honour took into account was one demonstrated by the words of the clause.[152] Spigelman CJ considered the effect of the clause at a factual level, not merely a verbal or logical level – the words of the clause referred to a situation that, concerning this insured, in fact could arise only if there had been pre-contract pathology. For these reasons I suggest that the result at which the majority arrived in *Asteron* it is mistaken.

However it would be wrong to make too much, for the purposes of this paper, of the difference of opinion between the judges in *Asteron*, or of whether the majority came to the wrong conclusion. The area concerning which there was a difference of judicial opinion in *Asteron* does not arise concerning the vast majority of "pre-existing condition" exclusions in mass-marketed travel insurance contracts. Nearly all of those clauses say explicitly that the exclusion arises if the insured suffers a condition of some type at the time of entering of the contract, so that the wording of the clause itself makes a connection between a pre-existing pathology and an eventual sickness or disease.

7.2 The application of section 47 to mass-marketed contracts

Section 47 limits the circumstances in which an insurer can rely on a provision that has the effect of limiting or excluding the insurer's liability by reference to a sickness or disability to which the insured was subject at a time before the contract was

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[152] In *Farkas v Northcity Financial Services Pty Ltd* [2004] NSWSC 206 Bergin J, sitting as a judge of first instance, considered another policy that provided cover for cancer on the basis that the "life insured first suffered the insured event at least 90 days after the benefit start date". Applying the same reasoning as her Honour had applied in *Asteron*, she held, at [93], that section 47 was inapplicable because the policy "has the effect of limiting the insurer's liability not by reference to pre-contract sickness or disability but to post contractual occurrence or suffering and, in the case of cancer, diagnosis, irrespective of whether the insured was subject to the cancer prior to the contract." As her Honour acknowledged at [93] that expression of view was not necessary for the conclusion at which she arrived. As well, the facts in *Farkas* differed from those in *Asteron* in that the cancer had occurred within the 90 day waiting period. An appeal from the decision was dismissed, but her Honour's dictum about section 47 was not mentioned in the reasons of the Court of Appeal: *Tower Australia Ltd v Farkas* [2005] NSWCA 363, 64 NSWLR 253.

entered. It is very important that it is only if the insured was aware (or a reasonable person in the circumstances could be expected to be aware) at the time the contract was entered of *the* sickness or disability from which the loss that is the subject of the claim has resulted that the insurer can rely on such a provision. For the insured to be aware of anything that falls short of the sickness or disability that is the cause of the loss will not entitle the insurer to rely on that type of provision.

Commonly available contracts of travel insurance contain multiple examples of exclusions that deny cover by reference to a sickness or disability to which the insured was subject at a time before the contract was entered. Many of those exclusions are unenforceable by reason of section 47. There are several identifiable ways in which the exclusion clauses purport to deny cover on a basis that section 47 does not permit.

7.2.1 Symptoms

Some contracts define an "existing medical condition" as arising if the insured is aware of *manifestations* or *symptoms* of the condition, and exclude cover concerning any such condition. If an insured was aware at the time of entering the contract of the symptoms or manifestations of a sickness or disability that eventually resulted in a claim, but was not aware of the sickness or disability itself (and a reasonable person in the circumstances would not have been aware of the sickness or disability itself) section 47 would prevent the insurer from relying on the exclusion.

As has been seen earlier concerning the duty of disclosure, a symptom of a condition is not the same as the condition itself[153].

7.2.2 Investigations and Specialists' Opinions

Some contracts state that a condition that is the subject of investigation, or concerning which the insured is awaiting a specialist's opinion, is an "existing medical condition", even if no diagnosis has been made. The exclusion purports to deny cover for any such "existing medical condition".

If at the time of entering the contract the insured was aware that he or she had some sickness or disability, but did not know what it was, and it eventuated that that sickness or disability was the cause of a loss, the second precondition for the operation of section 47 would not apply, and thus an exclusion of this type would be enforceable. However if the situation was that at the time the contract was entered the insured suspected that he or she might have a sickness or disability, and was

[153] See text at footnote 34 above.

having some investigations carried out, or was seeking a medical opinion, to find out whether indeed there was a sickness or disability, those investigations or the fact that that opinion was being sought could arguably trigger an exclusion clause, as being investigations or advice "for" the sickness or disability to which it later became known the insured was subject[154]. However if the insured did not know (and a reasonable person would not have known) that he or she actually had a sickness or disability, the second precondition would be met, and section 47 would prevent the insurer from relying on the exclusion.

This result is consistent with the provisions of the *IC Act* relating to the duty of disclosure. The general duty of disclosure in section 21(1) *IC Act* requires the insured to disclose certain matters that "the insured knows". As mentioned earlier, knowledge requires more than belief or suspicion.

When section 47 was included in the legislation as an integral part of the law concerning disclosure, one would expect that the word "aware" in section 47 would be construed consistently with the word "knows" in the sections relating to the duty of disclosure.

7.2.3 Developments, Consequences and Complications

The point of many definitions of "pre-existing medical condition" in many mass-marketed contracts of travel insurance seems to be to include as wide a scope of sicknesses and disabilities as possible. For example, by including any condition for which prescribed medication is taken, or medical advice has been sought a very wide ambit of sicknesses and disabilities would be caught. The exclusions in a contract of travel insurance often purport to exclude not only losses arising from such a "pre-existing medical condition" (as defined by the contract), but also developments, consequences or complications that are directly or indirectly attributable to such a medical condition or treatment for such a medical condition[155].

One particular operation of section 47 concerns what happens if, before the insurance was entered, the insured had a sickness or disability that turns out to have been a precursor of a more significant sickness or disability. If the more significant sickness or disability is a cause of the loss, the precondition in section 47(1) is

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[154] In a particular case the need to read the exclusion clause *contra proferentem* might have the effect, depending on the drafting of the particular exclusion clause, and the degree of specificity (or lack of it) with which any sickness or disease that might be found out by the investigations was identified at the time the contract was entered, that an investigation did not count as being "for" the sickness or disability that eventually came to cause the loss.

[155] Wording expressing the same idea that is found in the contracts includes that the exclusion applies if a loss is "caused or exacerbated by, or consequential upon, an existing medical condition", is one "arising from, related to or associated with that condition", or is one "directly or indirectly arising from, or exacerbated by, any Existing Medical Condition"

satisfied. If at the time the contract was entered the insured was not aware (and a reasonable person in the circumstances could not be expected to be aware) of *the significant* sickness or disability the effect of the section is that the insurer may not rely on a provision that excludes the insurer's liability by reference to *any* sickness or disability to which the insured was subject before the contract was entered. That is so even though the loss could accurately be said to be a result, in whole or part, not only of the significant sickness or disability, but also of the precursor, and the insured was aware that he or she had the precursor.

7.3 Interrelationship of disclosure provisions and section 47

Consistently with the way the Law Reform Commission first saw section 47[156], the Full Court of the Supreme Court of South Australia has held[157] that the "purpose of s 47 is to prevent avoidance of the Act's regulation of misrepresentation and non-disclosure." The Full Court approved[158] the following statement that the trial judge had made:

> "The intention behind s 47 … is that an insurer should not be able to side-step or get around the carefully crafted statutory regime in Pt IV of the IC Act which serves to identify material misrepresentations and material non-disclosures and the full extent of remedies available to the insurer, by taking advantage of matters of form so as to recharacterise such conduct as either warranties by an insured or as falling within exclusions from cover."[159]

Even though the Full Court has accepted that the purpose of section 47 is to prevent avoidance of the Act's provisions concerning non-disclosure and misrepresentation some explanation is called for about how that effect is achieved. After all, the wording of section 47 does not mention anything about non-disclosure or misrepresentation.

Section 33 and section 47 operate in complementary circumstances. As a necessary consequence of the meaning of "disclose", section 33 concerns exclusion clauses that operate concerning medical conditions of which the insured was aware at the time of entering the contract. Section 47 concerns clauses that operate concerning medical conditions of which the insured was not aware at the time of entering the contract.

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[156] See text at footnotes 107 to 109

[157] *Galaxy Homes Pty Ltd v The National Mutual Life Association of Australasia Ltd (No 2)* [2013] SASCFC 66 at [79]. An application for special leave to appeal was dismissed: *Galaxy Homes Pty Ltd as Trustee of the Galaxy Homes Unit Trust v The National Mutual Life Association of Australasia Ltd* [2013] HCA Trans 327

[158] At [79]

[159] Though these remarks were made in the course of construing section 47, they are consistent with the account of section 33 I have given earlier.

The manner in which section 33 operates to complement section 47 has changed a little since the *IC Act* first came into effect. Section 21 *IC Act*, as it was originally enacted, imposed a general duty of disclosure:

> (1) Subject to this Act, an insured has a duty to disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known to the insured, being a matter that-
>
> (a) the insured knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms; or
>
> (b) a reasonable person in the circumstances could be expected to know to be a matter so relevant.

In the original version of the *IC Act* the wording of section 47 fitted very neatly with the wording of this duty of disclosure. Section 21 required the disclosure of relevant matters known to the insured or that a reasonable person in the circumstances would know to be so relevant; section 47 prevented a provision of the contract being relied on to deny liability for a pre-existing sickness or disability if the sickness or disability was not of a type that fell within that exact duty of disclosure.

The current version of s 21 imposes a general duty of disclosure in the same terms as the original s 21, save only that s 21 (1) (b) has had added to it a non-exhaustive list of factors that are to be taken into account in deciding whether a reasonable person would know that a matter was relevant to the insurer's decision. Professor Tarr has argued persuasively that the addition of that list of factors makes no difference of substance to section 21[160].

When the duty of disclosure was altered, by making the particular duty of disclosure the one that is applicable concerning eligible contracts of insurance, no alteration was made to s 47 to keep its wording precisely in harmony with the wording of the particular duty of disclosure. In theory, one consequence is that if at the time of entering the contract an insured knows that he or she has the actual sickness or disability that is later the cause of a loss, section 47 does not stop an exclusion clause from operating concerning that loss. That is so regardless of whether the insurer had asked questions that, answered accurately, would have disclosed the sickness or disability. However, given the actual practice of insurers of asking questions about pre-existing medical conditions, this lack of exact match between the wording of the particular duty of disclosure and the wording of section 47 is unlikely to be of

[160] Julie-Ann Tarr "Insurance contract disclosure – an uncertain balance" (2015) 26 Insurance Law Journal 109 at 120

practical importance concerning contract of insurance where the traveller is a party to the contract of insurance[161].

The effect of many of the exclusion clauses, even when read down pursuant to section 47, is that if an insured knows at the time of entering the contract that he or she has the particular sickness or disability that is a cause of a loss, the insurer can totally deny liability for a claim that arises from that sickness or disability. The insurer can deny liability even if, had the condition been disclosed, the insurer would have accepted the risk at a higher premium. In that situation, section 47 enables the insurer to be in a better position than it would have been in if it had invoked the remedy under section 28(3) for a failure to comply with the duty of disclosure.

However, to the extent to which an exclusion clause seeks to remove liability on the basis that the insured had symptoms, or a precursor condition, or was undergoing treatment that the insured did not know was for the same sickness or disability that was a cause of the loss, it is consistent with the disclosure provisions of the Act for section 47 to prevent the insurer from relying on the exclusion. This result is not unfair to insurers, because the effect of the operation of s 47 is confined to making provisions of the contract inapplicable.

Many of the exclusion clauses in mass-marketed contracts exclude cover by reference to a sickness or disability that the insured has previously had regardless of whether the insured had a duty to disclose that sickness or disability. It is not unfair to insurers to make such exclusions inapplicable, to the extent that section 47 does, because even if the clause is inapplicable the insured still owes a duty of disclosure. If the symptoms, precursor state or treatment is the sort of thing that the insured should have disclosed, to comply with the duty of disclosure, and the insured did not disclose it, the insurer will have remedies under s 28 concerning that failure to disclose. Consistently with the policy of the Act, the insurer will bear the onus of proving whatever it must prove to limit its liability pursuant to section 28. If the symptoms, precursor condition or treatment are not the sort of thing that the insured should have had or her attention drawn to by a specific question, and should have disclosed in answer to the question, it is not consistent with the policy of the *IC Act* for an insurer to be able to use a sickness or disability connected with those symptoms, that precursor condition, or that treatment, as a basis for denying liability.

[161] As mentioned earlier, insurance obtained as a complimentary benefit of a credit card, concerning which the insured traveller is not a party to the contract and is asked no questions, is outside the scope of this paper.

8. Regulatory Control of Mass market insurance

This paper has argued that many of the exclusion clauses to be found in mass marketed travel insurance contracts are unenforceable. Many commonly occurring types of exclusion clause, which purport to operate in practice to exclude liability concerning matters that the insured knows at the time the contract is taken out, are unenforceable pursuant to section 33.

Even though section 47 operates to make an exclusion clause unenforceable in relation to a particular claim, the structure of the exclusion clauses in many contracts is such that they will inevitably be unenforceable, to their full extent of their wording, in relation to many claims. It cannot be said that an exclusion that denies cover on the basis that the insured had symptoms, or had some condition that turned out to be the precursor of a more serious condition, or was undergoing investigations will always be unenforceable – such clauses will be enforceable if, *as well as* having the symptoms, or the condition, or undergoing the investigations, the insured is aware that he or she has *the* sickness or disability that is ultimately a cause of the loss. However, in those situations it is the fact that the insured was aware that he or she had the sickness or disability that causes the loss that is crucial to the enforceability of the clause. The mention in the clause of symptoms, or pre-existing conditions, or investigations misleads the insured about the true basis on which such a clause can be enforceable. Indeed, by failing to mention that the insured was aware that he or she had the sickness or disability that is the cause of the loss the clause disguises the only basis on which the clause can survive section 47.

For insurers to include in their standard terms and conditions provisions which will inevitably be to some extent unenforceable if challenged, and that fail to identify the only circumstance in which such a clause can be enforceable, is deceptive market behaviour. It is a particularly undesirable form of market behaviour when the vast majority of the consumers who are the potential purchasers of the contracts are ordinary consumers with no knowledge of insurance law. They would have no reason for believing that the exclusion clause did not mean what it said, and would not have the legal knowledge to enable them to challenge the enforceability of the exclusion clauses according to their literal wording. Indeed it well may be that claims clerks in insurance companies can deny claims with a clear conscience, if they likewise have no reason to believe that the exclusions do not mean what they say. The position of more senior management, responsible for the insurer carrying on its business in a legal manner, might be otherwise.

The practice of including unenforceable clauses in the contracts is one that is particularly likely to be beneficial to the insurers when their unenforceability is unlikely to be spotted. Even if the unenforceability of a clause were to be spotted,

most of the claims on travel insurance contracts are likely to be comparatively small ones concerning which it would not be financially viable for the vast majority of consumers to go to court. While the Financial Ombudsman Service ("*FOS*") can provide free assistance in resolving some disputes about travel insurance, a consumer would need to realise that there was a basis for an exclusion clause not being enforceable in accordance with its terms before the consumer would understand that there might be some point in taking a dispute about such an exclusion clause to FOS. As well a theme of the advice on travel insurance on the FOS website[162] is that a traveller's rights depend on the terms of the insurance contract, without suggesting that those terms might be unenforceable.

In this situation, the way that seems most likely to persuade the insurers to issue contracts with wording that operates within the confines of the *IC Act* is through the action of the industry regulator. Sections 11A – 11F *IC Act* gives ASIC responsibility for general administration of the Act, and powers to require that it be given information to enable it to carry out those responsibilities. In particular it has the power to intervene in any litigation relating to a matter arising under the *IC Act*. That would include intervening in any litigation brought by an insured who sought to challenge the enforceability of an exclusion clause. It would include intervening in any litigation brought on behalf of an insured by a consumer protection organisation that wished to bring a test case.

As well, insurers who provide travel insurance to retail clients are required to hold an Australian Financial Services Licence[163]. It is a condition of such a licence[164] that the licensee must do all things necessary to ensure that the services provided under the licence are provided "efficiently, honestly and fairly". In construing that requirement:

> The "efficiently, honestly and fairly" standard is applied as a single, composite concept, rather than three discrete behavioural norms. The following principles are not in doubt (see *Australian Securities and Investments Commission v Camelot Derivatives Pty Ltd (in liq)* (2012) 88 ACSR 206; [2012] FCA 414 at [69] and [70] per Foster J). First, the words "efficiently, honestly and fairly" entail that a person must go about their duties efficiently having regard to the dictates of honesty and

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[162] http://www.fos.org.au/consumers/frequently-asked-questions/#id=travel-insurance

[163] Though the legislation is extraordinarily complicated a summary is that section 911A *Corporations Act 2001* requires that a person who carries on a financial services business hold a licence. Section 761A defines "financial services business" as a business of providing financial services. Section 766A provides that a person provides a financial service if they deal in a financial product. Section 764A(1)(d) provides that a "financial product" includes a contract of general insurance. Section 766C (1) defines "dealing in a financial product" as including issuing a financial product. Section 761 G (5) provides that issuing travel insurance to an individual is providing a financial product to a person as a retail client. "Travel insurance" is specifically defined by regulation 7.1.16 *Corporations Regulations* in a way that covers all the ground of Regulation 25 *IC Regulation*, but is somewhat wider in scope.

[164] Section 912 A (1) *Corporations Act 2001*.

> fairness, honestly having regard to the dictates of efficiency and fairness, and fairly having regard to the dictates of efficiency and honesty. Second, the phrase connotes a requirement of competency in providing advice *and in complying with relevant statutory obligations*. Third, the word "efficient" entails that the person is adequate in performance and is competent. Fourth, the concept of honesty is looked at *through the lens of commercial morality* rather than through the lens of the criminal law[165].

It is seriously arguable that, at least once an insurer was aware of the arguments put forward in this paper, it would be a breach of that condition for an insurer regularly to include an unenforceable term in a travel insurance contract that was aimed at the mass market, when the consumers in that mass market were likely to be in no position to detect the unenforceability**.**

Further, the issuers of insurance contracts are subject to obligations under the *Australian Securities and Investments Commission Act 2001* ("*ASIC Act*"). An insurance contract is a "financial product" for the purposes of the *ASIC Act*[166]. A person provides a financial service if they issue a financial product[167].

The *ASIC Act* section 12 DF(1) prohibits a person from, in trade or commerce, engaging in conduct that is liable to mislead the public as to (inter alia) the nature or the characteristics of any financial service. Making a practice of issuing standard form contracts that contain unenforceable terms seems likely to contravene that provision. Contravention of the provision is a criminal offence[168]. Contravention can also give rise to a pecuniary penalty[169], an injunction[170], an action for damages[171], the issue by ASIC of a public warning notice[172], an order disqualifying a person from managing corporations[173] , or orders compensating loss or damage caused by the contravention[174]. ASIC has power to seek compensation on behalf of affected

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[165] *Australian Securities and Investments Commission (ASIC) v Avestra Asset Management Ltd (In Liq)* [2017] FCA 497; 120 ACSR 247 at [191] per Beach J (emphasis added). The passage from *ASIC v Camelot* at [69] and [70], summarised by Beach J in *ASIC v Avestra*, has also been approved in *Australian Securities and Investments Commission v Cassimatis (No 8)* [2016] FCA 1023, 336 ALR 209 at [674] per Edelman J.
[166] *ASIC Act* section 12BAA (7) (d)
[167] *ASIC Act* section 12 AB(1)(b) read in conjunction with *ASIC Act* section 12AB(7)(b)
[168] *ASIC Act* section 12GB (Section 12DA and section 12 DF both appear in Subdivision D of Division 2 of Part 2 of the ASIC Act.)
[169] Section 12GBA (1) *ASIC Act*
[170] Section 12 GD *ASIC Act*
[171] Section 12 GF *ASIC Act*
[172] Section 12 GLC *ASIC Act*
[173] Section 12 GLD *ASIC Act*
[174] Section 12 GM *ASIC Act*

people[175]. For a corporate officer to be knowingly concerned in, or to aid and abet, any contravention by the corporation of this standard would itself be an offence[176].

The *ASIC Act* section 12DA (1) also prohibits a person, in trade or commerce, from engaging in conduct in relation to financial services that is misleading or deceptive or is likely to mislead or deceive[177]. Issuing in the mass market standard form insurance contracts containing exclusion clauses that are unenforceable seems likely to contravene that provision. Contravention of section 12DA (1) can bring the same remedies as are available for section 12DF (1), except that there is no criminal penalty or pecuniary penalty or order disqualifying a person from managing corporations.

ASIC has power to accept a written undertaking given by a person concerning any matter concerning which ASIC has a function or power under the *ASIC Act*. That would include the issuing of insurance contracts on terms that contravened section 12DA or section 12 DF, and denying liability pursuant to such clauses. If such an undertaking is breached ASIC can seek a court order directing the person to comply with the undertaking, to disgorge any financial benefit the person has obtained by breaching the undertaking, and to compensate any person who has suffered loss by breach of the undertaking[178].

ASIC has ample powers to control the practice of insurers inserting unenforceable exclusions in mass-marketed travel insurance contracts. If insurers continue to include such clauses in these contracts it would be appropriate for ASIC to consider using its powers.

Appendix 1 - Sample provisions in insurance contracts

The Vero Secure Holiday Travel Insurance contract[179] (underwritten by Vero Insurance Limited) states:

> We will not pay claims arising from:
>
> 1. any pre-existing medical condition suffered by you or a travelling companion, except when it has been disclosed to us and we have endorsed your policy to cover the condition and you have paid the required additional premium for that cover

[175] Section 12GM *ASIC Act*
[176] Section 12GB (1) (b) (c) and (d) *ASIC Act.*
[177] *ASIC Act* section 12 DA(1)
[178] *ASIC Act* section 93AA
[179] http://www.vero.com.au/vero/sites/default/files/fm/pdf/commercial-motor/vero-secholtravel.pdf accessed 5 January 2017 p 48

before the event that gave rise to the claim, or the pre-existing medical condition meets the criteria under the Tier 1 category on page 9 or 10[180],

It defines "pre-existing medical condition"[181] as:

"pre-existing medical condition" means:

- any medical condition for which investigation, medical advice or treatment has been obtained, or for which prescribed drugs have been taken, within the 90 days on or before the issue date shown on **your** schedule, and complications that are directly or indirectly attributable to this medical condition, or treatment for this medical condition, or
- any medical condition that has been diagnosed as chronic or ongoing in nature, regardless of whether **you** have undergone investigation or received medical advice or treatment or taken prescribed drugs within the 90 days on or before the issue date shown on **your** schedule, and complications that are directly or indirectly attributable to this medical condition or treatment for this medical condition.

It contains no special definition of "medical condition".

The Westpac travel insurance contract[182] (underwritten by Allianz Australia Insurance Limited) states:

Pre-existing medical condition means a medical condition of which you were aware of:

1. prior to the time of the policy being issued that involves:
   a] your heart, brain, circulatory system/blood vessels; or
   b] your lung or chronic airways disease; or
   c] cancer; or
   d] back pain requiring prescribed pain relief medication; or
   e] surgery involving any joints, the back, spine, brain or abdomen requiring at least an overnight stay in hospital; or
   f] Diabetes Mellitus (Type 1 or Type 2); OR
2. in the 2 years prior to the time of the policy being issued:
   a] for which you have been in hospital or emergency department or day surgery; or
   b] for which you have been prescribed a new medication or had a change to your medication regime; or
   c] requiring prescription pain relief medication.

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[180] These "pre-existing medical conditions that meet the criteria under the Tier 1 category" were conditions that fell within a list of the type described at footnote 5
[181] The contract identified in footnote 179 at p 58
[182] https://www.westpac.com.au/content/dam/public/wbc/documents/pdf/pb/insurance/travel-insurance-pds.pdf accessed 2 October 2017 at pp 7-8, 27

1. prior to the time of the policy being issued that is:
   a] pregnancy; or
   b] connected with your current pregnancy or participation in an IVF program; OR
2. for which, prior to the time of the policy being issued:
   a] you have not yet sought a medical opinion regarding the cause; or
   b] you are currently under investigation to define a diagnosis; or
   c] you are awaiting specialist opinion.

For the purposes of this clause, "medical condition" includes a dental condition. This definition applies to you, your travelling companion, a relative or any other person.

Unless otherwise agreed, the policy only provides medical and hospital expenses cover for unforeseen emergency medical events which occurred overseas. Cover is not provided for pre-existing medical conditions, unless they are a condition that we expressly agree to cover.

If you have a pre-existing medical condition that is not covered, we will not pay any claims arising from, related to or associated with that condition. This means that you may have to pay for an overseas medical emergency which can be very expensive in some countries.

The Medibank travel insurance contract[183] (underwritten by Zurich Australia Insurance Limited) states:

Existing Medical Condition means a disease, illness, medical or dental condition or physical defect that at the Relevant Time meets any one of the following:

a. has required an emergency department visit, hospitalisation or day surgery procedure within the last two years;
b. requires
   (i) prescription medication from a qualified medical practitioner or dentist;
   (ii) regular review or check-ups;
   (iii) ongoing medication for treatment or risk factor control;
   (iv) consultation with a specialist;

[183] http://policy.travelinsurancepartners.com.au/partners/medibank/files/documents/PDS_MBC.pdf accessed 2 October 2017 p 15, 60. The NRMA travel insurance contract and the Australia Post travel insurance contract are both underwritten by the same insurer as the Medibank contract, and contain relevantly identical terms: http://policy.poweredbycovermore.com/partners/IAL/nrma/files/documents/pds/IAL_NRMA_PDS.pdf# accessed 2 October 2017; https://auspost.com.au/content/dam/auspost_corp/media/documents/AP-Travel-Insurance-FSG-and-PDS.pdf accessed 2 October 2017

c. has

(i) been medically documented involving the brain, circulatory system, heart, kidneys, liver, respiratory system or cancer;

(ii) required surgery involving the abdomen, back, joints or spine;

(iii) shown symptoms or signs however, a medical opinion or investigation has not been sought to confirm or provide a diagnosis; or

d. is

(i) chronic or ongoing (whether chronic or otherwise) and medically documented;

(ii) under investigation;

(iii) pending diagnosis; or

(iv) pending test results.

Relevant Time in respect of:

a. Single Trip policies means the time of issue of the policy

b. Annual Multi-Trip policies means the first time at which any part of the relevant trip is paid for or the time at which the policy is issued, whichever occurs last.

We Will Not Pay For:

13. claims directly or indirectly arising from, or exacerbated by, any Existing Medical Condition You or Your travelling companion has.

14. claims directly or indirectly arising from or exacerbated by Your Existing Medical Condition of Cardiovascular Disease, chronic lung condition or other heart/cardiovascular/ respiratory system problem and any subsequent condition including an acute respiratory condition, Heart Attack, new infection or Stroke.

15. claims directly or indirectly arising from or exacerbated by Your Existing Medical Condition of reduced immunity.

The Australian Seniors travel contract[184] (underwritten by Chubb Insurance Australia Limited) states:

We will not … pay for claims arising directly or indirectly from:

13. any Pre-Existing Medical condition You or Your Travelling Companion have

Pre-Existing Medical Condition means:

(a) any physical defect, condition, illness or disease for which treatment, medication or advice (including investigation) has been received or prescribed by a Doctor or dentist in the ninety (90) days prior to the Issue Date of the Policy; or

[184] http://www.seniors.com.au/seniors/media/documents/seniors-travel-one-trip-pds.pdf?ext=.pdf accessed 2 October 2017 p 20, 32.

(b) any condition, the manifestation or symptoms of which a reasonable person in the circumstances would be expected to be aware at the Issue Date of Your Policy …

The Travel Insurance Direct contract[185] (underwritten by a syndicate of Lloyds underwriters) states:

We will not pay for any claim arising from or relating to the following:

25. Your claim arises from pre-existing medical conditions except as specified

under Pre-existing Medical Conditions

If you have a pre-existing medical condition that is not covered, we will not pay any claims arising from, related to or associated with that condition.

A pre-existing medical conditions means:

a) An ongoing medical or dental condition of which you are aware, or related complication you have, or the symptoms of which you are aware; OR

b) A medical or dental condition that is currently being, or has been, investigated or treated by a health professional (including dentist or chiropractor) at any time in the past, prior to policy purchase; OR

c) Any condition for which you take prescribed medicine; OR

d) Any condition for which you have had surgery; OR

e) Any condition for which you see a medical specialist; OR

f) Pregnancy.

The QBE travel insurance contract[186] (underwritten by QBE Insurance (Australia) Limited) defines Existing medical condition as:

(a) any chronic or ongoing (whether chronic or otherwise) medical or dental condition, illness or disease of which you were aware or should reasonably have been aware, or which is medically documented within the last 12 months or under investigation in the 12 months prior to the issue of the Certificate of Insurance; Or

(b) any physical, Mental Illness or medical condition, pregnancy including a pregnancy complication or illness of the mother up to and including 26 weeks gestation, defect, illness or disease of which you were aware or should reasonably have been aware, or for which treatment, medication, preventative medication, advice, preventative advice or investigation have been received or prescribed by a medical or dental adviser in the 60 days prior to the issue of the Certificate of Insurance and in the case of the Annual Multi Trip Travel Plan also within 30 days prior to booking any trip.

Note: with respect to both parts A and B of this definition

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[185] https://www.travelinsurancedirect.com.au/pds accessed 2 October 2017 p 24-26, 29

[186] https://www.qbe.com.au/personal/quote/travel/international on 2 October 2017, at p 35 - 36, 89

- Where any condition, illness or disease is the subject of an investigation, that condition, illness or disease falls within this definition, regardless of whether or not a diagnosis of the condition, illness or disease has been made.
- This definition applies regardless of whether or not the condition, illness or disease displays symptoms.
- This definition applies to you, your travelling party, your relatives, your business colleague, or any other person you have a relationship with whose state of health could impact on your travel plans.
- An illness or injury the signs and symptoms of which you first become aware of after your Certificate of Insurance was issued and before you went on your trip is not considered an existing medical condition and you do not have to tell us about it.

The QBE contract provides:

There is no cover under any section of this Policy for any claim arising directly or indirectly because of any of the following:

3. The illness, injury or death, is caused or exacerbated by, or consequential upon, an existing medical condition of you, a member of the travelling party, a non-travelling relative or business partner. This exclusion will not apply if you have applied to cover your existing medical condition, cover has been granted by us in writing and you have paid us any additional amount we asked for or the medical condition is one that is automatically covered.
4. The death, illness or injury of you, a member of the travelling party, a non-travelling relative or business partner is caused or exacerbated by or consequential upon, any condition which has been the subject of a medical investigation within the period of 12 months prior to the issue of the Certificate of Insurance, in respect of which no diagnosis has been made. This exclusion will not apply if you have applied to cover your existing medical condition, cover

has been granted by us in writing and you have paid us any additional amount we asked for or the medical condition is one that is automatically covered.

Appendix 2 – "wholly in a class of contracts"

This Appendix explains why a contract of travel insurance that provides cover against more types of risk than the three identified in Regulation 25 *IC Regulations* is an "eligible contract of insurance".

A2.1 "Wholly in a class of contracts" – aid from ordinary language use and grammar

Consider a contract that provided cover against risks of the type that fell within the three types of risk identified in Regulation 25, and also against one or more extra risks. It would be a more natural use of language to say that, though the contract was not *merely,* or *solely,* within the class of contracts identified in Regulation 25, it

was none the less "*wholly* in the class of contracts" identified in Regulation 25, precisely because it insures a natural person and provides cover for one of the three identified risks. A contract of insurance is within the class of contracts identified in Regulation 25 as soon as it provides cover against one of the types of risk listed in Regulation 25. Thus the better grammatical reading is that a contract is "wholly in the class of contracts" that are identified by Regulation 25 if one of the insureds is a natural person and it provides cover for any of the three risks, regardless of whether it also provides cover for other risks.

An example of a contract that would not be "wholly in the class of contracts" identified in Regulation 25 is a contract that provided cover for nothing other than "financial loss in respect of fares for any form of transport to be used, or accommodation to be used, in the course of the specified journey if the insured commences and completes the journey but by reason of from the insolvency of a travel agent or provider of travel or accommodation services pays money to acquire services for which it has already paid the travel agent or provider."[187] Such a contract would never cover a loss that fell within Regulation 25. Thus it is not one that is "wholly in the class of contracts" identified in Regulation 25.

A 2.2 "Wholly in a class of contracts" – aid from statutory purpose

That construction also accords with the apparent purpose of s 21A. The Explanatory Memorandum to the 2013 Amending Act [188] said:

> 'Eligible contracts of insurance' … include contracts that provide cover commonly sought by individual consumers, such as motor vehicle, home contents and travel insurance.[189]

That language is consistent with an intention that "eligible contracts of insurance" should cover all travel insurance of a type that provides cover commonly sought by individual consumers.

The statutory purpose in designating some contracts as being "eligible contracts of insurance" is to enable the particular duty of disclosure arising under s 21A to apply to those contracts. The purpose in creating the particular duty of disclosure is to

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[187] It is unlikely that there would be a market for insurance contracts that were so limited in coverage, but that does not detract from the grammatical point I am presently making.

[188] The Explanatory Memorandum is a legitimate aid to construction of an Act under s 15AB *Acts Interpretation Act 1901 (Cth),* whether it is used to confirm that the meaning of the provision is the ordinary meaning conveyed by the text of the provision taking into account its context in the Act and the purpose or object underlying the Act, or to determine the meaning of the provision when the provision is ambiguous or obscure. That principle of interpretation applies to regulations made under an Act, as if those regulations were themselves an Act: s 46(1) *Acts Interpretation Act 1901*, s 13 *Legislation Act 2003 (Cth).*

[189] Explanatory Memorandum para [1.54]

make compliance with the pre-contractual duty of disclosure something that is capable of being achieved by an ordinary member of the market at which the contract is aimed. Before s 21A was introduced, the general duty of disclosure under s 21 required a proponent to disclose matters that the proponent knows, or a reasonable person in the circumstances, could be expected to know, was relevant to a decision of the insurer about whether to accept the risk and if so on what terms. Most mass-market consumers of insurance contracts will know nothing about what is relevant to the insurer in making that decision[190]. When mass-market consumers are usually in that state of ignorance, there will often be great difficulties in drawing a line between what is a matter that a reasonable person in the circumstances would have known was so relevant, and what is not. The enactment of s 21A was the result of a policy judgment that mass-market consumers of the types of insurance to which s 21A applied could not fairly be expected to comply with the general duty of disclosure under s 21.

The purpose of designating some types of mass market insurance as 'eligible contracts of insurance", and requiring the duty of disclosure to depend solely on the insured answering questions posed by the insurer, was explained in the Explanatory Memorandum to the 2013 Amending Act [191]:

> Insurers should be in a position to decide what matters are material to their decision to provide eligible contracts of insurance and formulate specific questions accordingly. In the event that an insurer is unable to foresee a matter that is relevant to their decision whether to accept the risk of a particular contract, then it is difficult to justify expecting an unsophisticated insured to realise its relevance.

The unreasonableness of expecting a mass-market consumer to identify what might be relevant to the insurer's decision led to the 2013 Amending Act amending the previous version of s 21A so that the insurer was no longer able to ask general questions of a catch-all kind. The Explanatory Memorandum to the 2013 Amending Act[192] explained that it was:

" … currently permissible for the insurer to ask the insured a 'catch all' question, which requires an insured to disclose 'exceptional circumstances':

- that a reasonable person could be expected to know would be relevant to the insurer's decision whether to accept the risk;

and

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[190] particularly when "the insurer" in s 21 is the particular insurer, not any notional reasonable or ordinary insurer: *Permanent Trustee Australia v FAI General Insurance Co Ltd* (1998) 44 NSWLR 186 at 249 per Hodgson CJ in Eq, *Permanent Trustee Australia Co Ltd v FAI General Insurance Co Ltd* (2001) 50 NSWLR 679 at 686 – 687, [31] – [37].

[191] at para [1.56]

[192] at para [1.55], [1.56]

- which would be unreasonable for the insurer to ask a specific question about (subparagraph 21A(4)(b)(iii)).

The current ability to ask 'catch all' questions tends to undermine the benefits for insureds of the framework for eligible contracts of insurance. Insurers should be in a position to decide what matters are material to their decision to provide eligible contracts of insurance and formulate specific questions accordingly."

Those considerations led to s 21A being redrafted so that the only questions that the insurer could ask, that would be relevant to whether the duty of disclosure had been complied with, were specific questions.

The statutory objective of making compliance with a duty of disclosure an achievable task for the ordinary mass consumer would be frustrated if "eligible contract of insurance" did not cover all of the types of contract that are mass-marketed. As mentioned earlier[193], many of the travel insurance contracts that are mass-marketed cover risks beyond the basic ones identified in Regulation 25.

A 2.3 "Wholly in a class of contracts" – aid from legislative history

A feature of the *IC Act* since its inception has been that Part V Division 1 (sections 34 – 37) implements a system of "standard cover" for certain classes of insurance, of a kind commonly bought by consumers rather than businesses, which are classified as "prescribed contracts". The *IC Regulations*, from the first time they were made in 1985, have identified the precise classes of insurance that are "prescribed contracts". Those classes have always been motor vehicle insurance, home buildings insurance, home contents insurance, sickness and accident insurance, consumer credit insurance, and travel insurance. The Regulations that identified each such class have always been Regulations 5, 9, 13, 17, 21 and 25, respectively

The pattern that the *IC Regulations* have followed in defining the "prescribed contracts" is to list types of risks that are usually covered by a contract that would be commonly regarded as being in one of the named classes, and to say that a contract of insurance is a prescribed contract if it provides *any* of the types of cover that appear on that list. The present Regulation 25, quoted at page 8 above, provides an example.

For each prescribed class of contracts the Regulations identify a list of "prescribed events" - events of a kind that could give rise to a claim under an insurance contract in that class. For each prescribed class of contracts the Regulations also identify a list of exclusions, and a minimum amount of cover for each of several particular types of

[193] See text at page 9 above

loss. Together these lists of prescribed events, exclusions and minimum amounts of cover identify the basic elements of an insurance cover.

The system of "standard cover" imposed by the *IC Act* does not require insurers who write insurance that is a "prescribed contract" to write that contract in accordance with the prescribed events, the exclusions, or the minimum amounts. Rather, if an insurer has written a prescribed contract that provides less cover than that which would arise from the prescribed events and exclusions, or a smaller amount of indemnity than the minimum amount, and the insured makes a claim concerning a prescribed event, section 35 *IC Act* limits what the insurer may do concerning that claim. It prevents the insurer from denying the claim, or paying less than the minimum amount, *unless* the insurer proves either (1) that it has clearly informed the insurer, before the contract was entered, of the departures from the prescribed events and exclusions and the minimum amount[194] or (2) that the insured knew, or a reasonable person in the circumstances could be expected to know, of those departures.

The first time regulations were made to identify *eligible* contracts of insurance was by the *IC Regulations* as consolidated on 17 September 1999. Those Regulations introduced a new cl 2B to the *IC Regulations***:**

> A contract of general insurance is an ***eligible contract of insurance***:
>
> (a) if that contract:
>
> (i) is for new business; and
>
> (ii) is wholly in a class of contracts declared in regulation 5, 9, 13, 17, 21 or 25; and
>
> (b) as if each regulation mentioned in subparagraph (a) (ii) applied to the contract, whether or not the insured, or one of the insureds, is a natural person.
>
> *Note* Motor vehicle, home buildings and contents, sickness and accident, consumer credit and travel insurance are mentioned in r 5, 9, 13, 17, 21 and 25.

Thus, the same regulations that had previously been used to identify a "prescribed contract", for the purpose of the standard cover provisions, were pressed into service for the new purpose of identifying an "eligible contract of insurance".

Originally Clause 2B defined "eligible contract of insurance" to include contracts where none of the insureds was a natural person. The later narrowing of the definition, so that under the current Clause 2B only a contract under which one of

[194] Providing the insured with a copy of the insurer's standard form of contract will not necessarily be enough to "clearly inform" the insured of the departures in that contract from the standard cover: *Lockwood v Insurance Australia Ltd* [2010] SASC 140; 16 ANZ Ins Cas ¶ 61-843 at [33]-[36]

the insureds is a natural person, is consistent with the provisions relating to "eligible contracts of insurance" being aimed at ordinary consumers.

Further, Clause 2B from its outset included the expression "wholly in a class of contracts".

At the time that this new clause 2B was added to the Regulations, Regulation 25, identifying the type of travel insurance that counted as a prescribed contract, was:

> The following class of contracts of insurance is declared to be a class of contracts in relation to which Division 1 of Part V of the Act applies, namely, contracts that provide insurance cover (whether or not the cover is limited or restricted in any way) in respect of one or more of the following:
>
> (a) financial loss in respect of:
>
> (i) fares for any form of transport to be used; or
>
> (ii) accommodation to be used;
>
> in the course of the specified journey in the event that the insured person does not commence or complete the specified journey;
>
> (b) loss of or damage to personal belongings that occurs while the insured person is on the specified journey;
>
> (c) a sickness or disease contracted or an injury sustained by the insured person while on the specified journey;
>
> where the insured or one of the insureds is a natural person.

At that time Regulation 26, identifying the prescribed events under a contract of travel insurance that was a prescribed contract, was:

> The following, except in so far as they are excluded by regulation 27, are declared to be prescribed events in relation to a contract referred to in regulation 25:
>
> (a) financial loss on account of:
>
> (i) fares for any form of transport to be used; or
>
> (ii) accommodation to be used;
>
> in the course of the specified journey in the event that the insured person or a member of the insured person's travelling party, through unforeseen circumstances beyond the control of the insured person or member, respectively, cannot reasonably be expected to commence or complete the journey;
>
> (b) loss of or damage occurring to personal belongings of the insured person during the course of the specified journey;
>
> (c) the death of the insured person or a member of the insured's travelling party while on the specified journey;

(d) the insured person or a member of the insured's travelling party contracting a sickness or disease or sustaining an injury while on the specified journey.

There are several types of loss that were listed in Regulation 26 (as at September 1999) that did not fall within Regulation 25 (as at September 1999). They are fares or accommodation if a member of the insured's travelling party "through unforeseen circumstances beyond the control of the insured person or member, respectively, cannot reasonably be expected to commence or complete the journey", " death of … a member of the insured's travelling party while on the specified journey", and "a member of the insured's travelling party contracting a sickness or disease or sustaining an injury while on the specified journey".

Thus, at that time Regulation 25 was pressed into service to define what sort of travel insurance was an "eligible contract of insurance", the Regulations already envisaged that the type of cover that a consumer was entitled to expect would be in a travel insurance contract, unless the consumer had clearly been told otherwise, would include cover for risks that did not fall within Regulation 25. This increases the unlikelihood of any intention that the easier method of performing the duty of disclosure arising under s 21A would not be available to a travel insurance contract that covered risks additional to those listed in Regulation 25.

The effect of the construction of Regulation 2B(1) for which I contend is that if the word "wholly" did not appear in Regulation 2B(1) the meaning of the provision would be the same as when "wholly" does appear in it. There is a prima facie rule of construction that all words in legislation should be given some meaning and effect[195]. However it is:

> "a weak principle, if it is to be applied to reach a conclusion that every provision must have some kind of operative effect. The principle is, as Mason CJ put it, "of limited application". (*Chu Kheng Lim v Minister for Immigration Local Government and Ethnic Affairs* (1992) 176 CLR 1 at 13)"[196]

Further, it is a principle which is "more compelling if the word (or phrase) in question has been added by amendment"[197]. The word "wholly" was in Regulation 2B(1) from the first time that there was a Regulation 2B (1), not added by amendment. Adopting a construction of regulation 2B that gives the word "wholly" no independent work to do is, I suggest, preferable to going against the grammatical reading of the Regulation, the purpose of designating some types of insurance contract as being "eligible contracts of insurance", and the legislative history of the Regulation.

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[195] *Pearce & Geddes* at [2.26] and cases there cited
[196] per Spigelman CJ, *Asteron Life Ltd v Zeiderman* [2004] NSWCA 47, 59 NSWLR 585 at [27]
[197] *Pearce & Geddes* at [2.26] and cases there cited