Superannuation Complaints Tribunal

Quarterly Bulletin

Issue No. 71

1 Jan – 31 Mar 2013

Chairperson's report

'Claim-staking (28 day letters)' and its importance

Proper claim-staking provides trustees with a degree of protection when paying death benefits. Incorrect claim-staking could result in the Tribunal having jurisdiction to hear a complaint after the benefit has been paid, which could leave a trustee liable for additional payments.

In a current matter before the Tribunal, a complainant disputed the trustee's payment of a death benefit. The complaint to the Tribunal was lodged after the payment was made. When establishing jurisdiction, the Tribunal noted that the complainant (a sibling of the deceased), was not advised by the trustee of its proposed distribution. While this fact in itself does not necessarily mean the trustee has erred, the Tribunal also noted that the complainant, after becoming aware of the trustee's proposed distribution, lodged a submission to the trustee. The Tribunal's view was that the trustee should have issued the complainant a proposal letter at this stage and its failure to do so was unreasonable under section 15(2)(b)of the Complaints Act. Had the trustee notified the complainant of its proposal it would have received the protection afforded under the provision of section 15(2) of the Act.

In another matter, the complainant lodged a complaint with the Tribunal as she had become aware that the trustee had paid the death benefit to the deceased's de facto spouse. When establishing jurisdiction the Tribunal noted that the street name was incorrectly stated in the trustee's proposal letter to the complainant. The Tribunal took the view that this error meant that the complainant was not notified of the trustee's proposal and the trustee's failure to notify the complainant of its proposal was unreasonable under section 15(2)(b)of the Act.

Best practice in claim-staking/28 day letter for the purposes of sections 14(3) and 15(2) of the Complaints Act

While claim-staking affords trustees protection, from the perspective of potential beneficiaries, it sets the clock running on their ability to complain to the Tribunal. The content of claim-staking and final decision letters are critical in the Tribunal's assessment of whether the trustee has notified a person of the proposed payment or has given notice of the trustee's decision in relation to an objection. The written notices that the trustee gives should:

(a) Contain clear information about the approximate value of the benefit with the account balance and any insured amount or anti-detriment amount detailed separately.

(b) Identify each of the persons to whom the trustee proposes to pay the death benefit and the amount to be given to each such person; and if any amount is to be given to a beneficiary in trust, who the trustee is.

(c) Identify the status of the person(s), e.g. spouse, child, interdependent, a financial dependant, legal personal representative, etc.

(d) Contain clear details about the prescribed period within which the recipient of the notice may object to the proposed distribution. The prescribed period is 28 days and commences from the date of receipt of the trustee's claim-staking/28 day letter.

The Tribunal has observed that certain trustees issue death benefit letters by Registered Mail as a safeguard in order to be certain as to the start of the 28 day period.

When should a trustee advise potential beneficiaries that a complaint has been lodged with the Tribunal?

Under s24A(1) of the Complaints Act, in the case of a complaint about the distribution of a death benefit, a trustee must give a written notice about the complaint to all persons (other than the complainant) whom the trustee believes may have an interest in the outcome of the complaint, within 28 days, or such longer period as the Tribunal allows, after the trustee receives notice of the complaint under sub-s 17(1) of the Act.

The content of the notice is described in s24A(3) of the Act.

When a death benefit complaint is received by the Tribunal and there is insufficient information to establish jurisdiction, the Tribunal generally writes to the complainant to obtain this information and also sends a courtesy letter to the trustee advising that a complaint has been received. However, this letter is not a notice under s17(1) and s24A is not invoked. (A s17(1) notice provides a copy of the complaint to the trustee and requests provision of all relevant documents). Therefore, a trustee is not required to inform potential beneficiaries of the complaint with the Tribunal at this stage.

Some trustees are informing potential beneficiaries (other than the complainant) of the complaint to the Tribunal following the Tribunal's courtesy letter. The Tribunal is then contacted by potential beneficiaries. However, due to secrecy provisions under s63 of the Act, the Tribunal is unable to provide any information about the complaint. This only causes frustration and confusion to what might already be an emotional and difficult time for potential beneficiaries.

The Tribunal therefore requests that trustees ensure that they only inform potential beneficiaries on receipt of an s17(1) notice, which is when s 24A of the Complaints Act requires them to do so.

Jocelyn Furlan

Chairperson

Statistical overview

Quarterly statistics – January to March 2013

Telephone inquiries

The Tribunal received 2,754 telephone calls this quarter (last quarter – 2,711), which is an increase of 1.6% compared with the previous quarter.

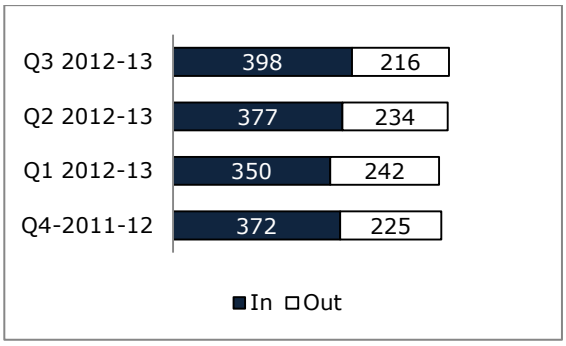
The Tribunal dealt with a wide range of inquiries, the most popular were queries about the Tribunal itself (38.3%), followed by complaint related inquiries (18.1%).

Written complaints

This quarter, the Tribunal received 614 written complaints (last quarter - 611), which is an increase of 0.5% compared with the previous quarter.

Jurisdiction

Of the 614 written complaints received this quarter, 398 (64.8%) complaints were within jurisdiction (previous quarter – 61.7%). Of the 216 (35.2%) complaints closed as outside jurisdiction, 133 (61.6%) were closed pursuant to s.19 of the Complaints Act because the complainant had failed to lodge a complaint with the trustee or the 90 day time limit had not passed from the date of complaint to the trustee, (last quarter 66.6%).

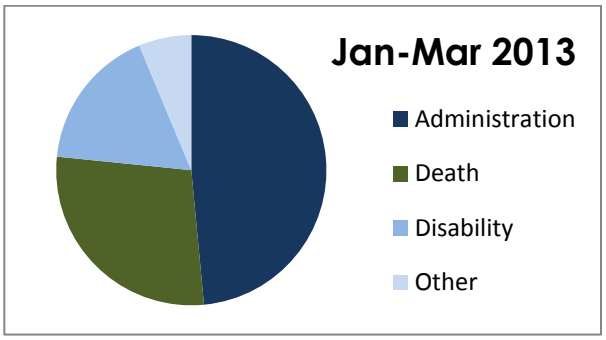


Complaints within jurisdiction

Nature of written complaints within jurisdiction

Complaints fall into four major categories – 'death', 'disability', 'administration' and the catch-all category of 'other'.

Administration complaints comprised the largest category of all written complaints received within jurisdiction – 48.5% (last quarter – 48.8%). Death complaints made up the second-largest category at 28.1% (last quarter – 27.9%), followed by disability at 17.1% (last quarter – 18.8%). Other complaints made up 6.3% (last quarter – 4.5%).



Nature of written complaints within jurisdiction

Performance

Complaints finalised

The Tribunal finalised 537 written complaints this quarter, a decrease of 3.2% compared to the previous quarter.

Of the 537 finalised complaints, 6.6% were finalised at review (last quarter 5.2%), 46.7% were finalised at the inquiry and conciliation stage (i.e., prior to a review hearing) (last quarter – 51.4%) and 46.7% were outside jurisdiction (last quarter 43.4%).

Conciliation conferences

The Tribunal conciliated 63 cases in the quarter, a decrease of 43.2% on last quarter's 111.

Of the 58 cases concluded, settlement was achieved in 26, resulting in a settlement rate of 44.8% (last quarter – 52.9%). 5 cases were adjourned in the quarter.

Nature of conciliation cases

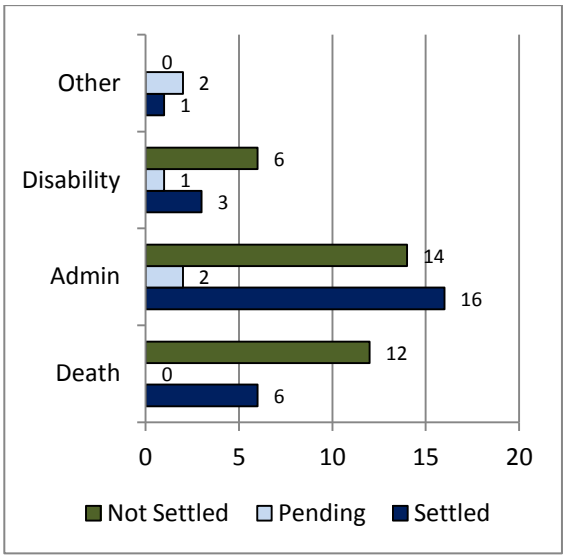
The categories of note in the quarter are as follows:

Death benefits – Of the 18 concluded cases, 6 (33.3%) were settled.

Administration – Of the 30 concluded cases, 16 (53.3%) were settled.

Disability – Of the 9 concluded cases, 3 (33.3%) were settled.

Other – 1 concluded cases, which was settled (100%).



Settlement by conciliation

Review determination outcomes for the quarter

The Tribunal determined 35 cases this quarter (last quarter – 29 cases).

The largest category of complaints determined at review was administration complaints: 23 (65.7%)

Admin	Qtr	YTD
Affirmed	20	42
Remitted	0	0
Varied	0	0
Set aside	3	5
Total	23	47

Disability complaints made up the second largest category: 10 (28.6%)

Disability	Qtr	YTD
Affirmed	9	21
Remitted	0	0
Varied	0	0
Set aside	1	4
Total	10	25

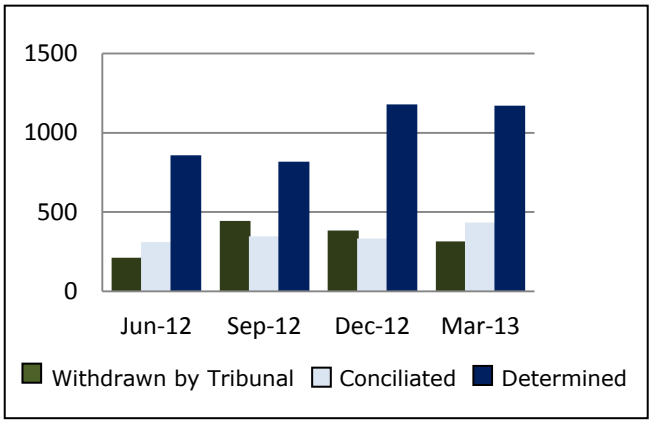
Followed by death benefit complaints: 2 (5.7%)

Death	Qtr	YTD
Affirmed	2	7
Remitted	0	1
Varied	0	0
Set aside	0	5
Total	2	13

88.6% of trustee decisions were affirmed during the quarter, compared with 75.8% last quarter.

Efficiency

Median number of days from receipt of complaint to date closed.



Note: The Tribunal recently adopted a 'first in first out' methodology in relation to complaints received as part of its strategy for reducing backlogs. This has impacted the median number of days taken to resolve complaints in this quarter.

Recent determinations of interest

D12-13\052. Temporary and Permanent Disability

The complainant complained to the Tribunal that the insurer's decision to reduce her TPD benefit as a result of non-disclosure about her smoking was not fair and reasonable because although she had smoked in the past, she had quit thirty years ago. On examination of the medical reports, the Tribunal determined that the complainant was most likely still a smoker at the time of her application for insurance and affirmed the insurer's decision.

On 21 January 2009 the complainant applied for death and TPD cover and on 4 February 2009 she was accepted at non-smoker rates upon completion of a personal statement. In response to the question 'Do you smoke or have you ever been a smoker?' the complainant ticked 'No'. On 27 May 2010 the complainant was diagnosed with metastatic brain cancer from a primary adenocarcinoma of the lung. Medical reports recording the complainant's smoking history resulted in the insurer determining that the complainant was a smoker at the commencement of her cover. The insurer advised that, had the complainant disclosed that she had smoked, she would have been offered insurance at smokers' rates. The insurer determined that the complainant was TPD, but reduced the level of the complainant's TPD benefit from $290,468.85 to $141,971.28 in accordance with section 29(4) of the *Insurance Contracts Act 1984* (the ICA). The trustee considered the insurer's decision and agreed with it.

The complainant's TPD status was not in dispute. The only medical issue related to the complainant's smoking history. The complainant's representative said that the clinical notes which indicated that the complainant was a smoker, who smoked 1-2 cigarettes per day, were wrong and a result of the complainant's poor English and should have reflected that she had smoked 1 – 2 cigarettes per day but had ceased 30 years ago. In relation to the complainant's failure to advise on her insurance application that she smoked 25 years ago, it was submitted that this was an immaterial non-disclosure and had the underwriter known that she had smoked 25 years ago 'the normal underwriting assessment in the industry today is to issue a policy at non-smoker rates'.

Section 21 of the ICA states that an insured has a duty to disclose to the insurer every matter that the insured knows, or that a reasonable person in the circumstances could be expected to know, and this is relevant to the decision of the insurer whether to accept the risk, and if so, on what terms. The Tribunal opined that it was reasonable to assume that if an insurer asks questions about smoking, a person's smoking history is relevant to the insurer in determining whether to offer death and TPD cover, and, if so, on what terms. The complainant's smoking history was a relevant matter and the failure to disclose it was, in the Tribunal's view, a breach of the duty of disclosure.

The complainant argued that it was not fair and reasonable for the insurer to reduce the benefit because although the she had smoked in the past, she was not a smoker in proximity to the time of the insurance application. The difficulty for the complainant, however, was that clinical notes indicated that she may have smoked at around the time she applied for the insurance. The Tribunal carefully considered each of the notes made in 2006, 2009 and 2010 by Dr AK, her treating general practitioner and Dr RM, general practitioner, at the clinic she attended. These notes indicated her smoking status was reviewed and she was noted as a smoker at a rate of 1 to 2 cigarettes per day. Dr AK's entry of January 2009 said 'To stop smoking'.

The Tribunal also had before it notes from her hospital admission in 2010 relating to the complainant's smoking. The complainant's representative submitted that the notes were incorrect because of the complainant's poor English language skills and should be interpreted as indicating that the complainant was a former smoker who had ceased smoking 30 years ago.

While the Tribunal agreed with the complainant's representative that the hospital notes could be read in that light, such an interpretation of the treating doctors' notes was not as easily discernible. Dr AK provided an explanation as follows:

... our file some one has noted that she is a casual smoker and smokes one cigarette per day but [the complainant] stopped smoking at the age of 24 years which is 26 years ago.

The Tribunal was not convinced by this explanation from Dr AK. He himself had made the notes and his explanation did not address that he made the notes, the circumstances in which he made them or why they were wrong.

The Tribunal formed the view that it was more likely than not that the complainant was smoking, albeit a very small amount each day, at the time she applied for the insurance. From the evidence submitted, the Tribunal considered that the decisions of the insurer and the trustee to reduce the complainant's TPD benefit were fair and reasonable in their operation in relation to the complainant in the circumstances.

D12-13\063. Income Protection

The complainant complained that the 90 day waiting period for income protection payments should not apply in his case as he had a terminal illness which, according to the fund information booklet, was exempt from waiting periods. While the Tribunal found the complainant's interpretation of the booklet understandable, as he had not relied on this belief to his detriment, it reaffirmed the trustee's decision.

The complainant was diagnosed with a terminal illness in July 2010 and immediately ceased work. He applied for and received an income protection (IP) benefit of $850 per month. The trustee and insurer applied a 90 day waiting period to the benefit in accordance with the insurance policy. The complainant lodged a complaint with the Tribunal that the decisions of the trustee and the insurer to refuse to waive the 90 day

waiting period for payment of his IP benefit were unfair or unreasonable. He stated that he was told by staff of the fund that his IP benefit would start either from the date he was diagnosed with a terminal illness or when he first left full time employment. He also referred to a statement in a fund booklet entitled 'How to claim your Income Protection Benefit' ('the booklet'), which stated:

IS THERE A WAITING PERIOD?

In most cases (other than for terminal illness), satisfactory proof must be provided to show that you have been absent from work for 90 consecutive days as a result of your disability…

He claimed that this statement meant that the 90 day waiting period did not apply to him as he had a terminal illness. He submitted that fund staff had agreed with his interpretation in telephone conversations.

In its correspondence to the complainant, the trustee stated that it had listened to the telephone conversations between him and the fund, and noted that at no time did the consultants advise that the waiting period applicable to his IP claim would be waived due to a terminal illness. The trustee submitted that the waiting period statement did not state that the 90 day waiting period will be waived and that there was no provision to waive the waiting period under the policy.

The trustee explained its understanding of the waiting period statement as follows:

The information…under the heading "IS THERE A WAITING PERIOD" is to inform the member they do not have to be absent from work for 90 consecutive days. It does not state we will waive there *[sic]* waiting period. This means a member can send their IP claim form in ASAP and we can advise the Insurer the member is terminal as we would like the Insurer to pay them on time or earlier if they can see the member has at least three months to live after the waiting period is finished.

In its submission to the Tribunal, the trustee reiterated that the meaning of the phrase '(other than terminal illness)' in the booklet was in relation to a member being absent from work for a period of time due to disability or illness. At no stage was there a mention of waiving the waiting period.

All documentation received by the complainant from the fund referred to a 90 waiting period. The booklet was the only documentation that referred to the impact (if any) of a terminal illness on the waiting period. The Tribunal's interpretation of the booklet was that although it was not particularly well worded, the most likely meaning was that there was no need for proof of 90 days' absence from work where a person was suffering terminal illness. However, in the Tribunal's view, the complainant's interpretation - that the phrase '(other than for terminal illness)' under a heading referring to waiting periods meant that the 90 day waiting period did not apply in such cases - was understandable.

Having determined that the complainant's interpretation was understandable, the Tribunal also considered whether the complainant relied on this belief to his detriment. There was no evidence before the Tribunal that the complainant suffered any loss as a result of the wording in the booklet, or that the complainant would have, or could have, done anything differently had he been aware that the 90 day waiting period applied.

The complainant was diagnosed with motor neurone disease on 27 July 2010 and immediately finished work and applied for his IP benefit. The trustee and the insurer expedited his claim and he received the first payment on 2 September 2010 (albeit covering the period 25 October 2010 to 24 November 2010). He was therefore in receipt of funds within 37 days of ceasing work.

Accordingly, although the Tribunal was of the view that the complainant's interpretation of the wording in the booklet was understandable, there was no evidence that the complainant acted in reliance of the interpretation to his detriment. The outcome was the same for him as it would have been if he had known that the waiting period would not be waived. The Tribunal, therefore, affirmed the trustee's decision.

In respect of the insurer, the insurer paid the IP benefit to the complainant in accordance with the terms of the policy. There was no evidence before the Tribunal that the insurer made any representations to the complainant in relation to the waiting period and, therefore, the Tribunal determined that it was fair and reasonable for the insurer to decline the complainant's request for payment of IP benefits during the 90 day waiting period.

D12-13\064. Administration

The complainant complained to the Tribunal that the decision of the new insurer to alter the terms of his annuity policy with the old insurer without proper notification, resulting in the cancellation of the policy, was not fair and reasonable. The Tribunal agreed and determined to set aside the insurer's decision and substitute its own that the policy be reinstated.

On 17 June 1994, the complainant applied to the former insurer for an annuity to be issued to him and annuity instalments were, subsequently, paid to him by the former insurer. On 11 December 2000, the Federal Court approved a scheme to amalgamate the insurance business of the former insurer with that of the insurer. Under the scheme, the insurer became liable to pay the annuity instalments payable under the policy issued by the former insurer to the complainant. On 20 October 2009, the insurer sent a letter to the complainant advising him that his annuity policy had been terminated because the account balance had fallen below $2000.

In his submission to the Tribunal, the complainant said that the insurer terminated his annuity policy without his knowledge and that the policy made no provision for the insurer to terminate the policy for the reasons that it stated. He said that the insurer had not produced written evidence to substantiate its claim

that it varied the policy or that it sent him relevant information to vary the policy. He, therefore, submitted that the policy continued to be governed by the terms and conditions of the policy that he purchased from the former insurer in 1994. The complainant said that the insurer had offered him $1,000 to settle his complaint but he refused that offer. He said that he had incurred substantial financial expense in dealing with the issues that arose as a result of the insurer wrongfully terminating his policy.

The Tribunal was not provided with a copy of the annuity policy. It was, however, provided by the complainant with a copy of the customer information brochure that applied from 1 January 1994 to 31 December 1994 in relation to annuities issued by the former insurer. The customer information brochure did not contain any statement that it was a term of the annuity policy that it would be terminated if the account balance fell below $2,000. Based on the evidence available to it, therefore, the Tribunal found that it was not a term of the annuity policy that it was able to be terminated by the insurer if the account balance fell below $2,000.

It was apparent from the evidence that when the insurer took over the insurance business of the former insurer, the insurer had a policy that annuity policies under which it had a liability would be terminated if the account balance fell below $2,000. However, the fact that the insurer had such a policy does not mean that the terms and conditions of the annuity policy that had been issued by the former insurer to the complainant were automatically altered to accord with the policy of the insurer. In order for the insurer to alter the terms of the contract with the complainant (the annuity policy) the insurer would have had to amend the policy terms and provided written advice to the complainant that the policy terms had been so amended.

The insurer in its submission said that, in January 2001, the complainant's plan with the former insurer was transferred into a plan with the insurer and that a letter was sent to the complainant which contained a recommendation that the complainant should contact the insurer's associated financial planner if the complainant required expanded information about the features and opportunities offered under the insurer's plan. The submission went on to say that the information supplied in this letter was a summary of benefits only and did not go into explicit detail about the features of the plan but that there was, however, adequate information available that would have allowed the complainant to contact the insurer to obtain further information on the features of the product. It appeared, therefore, to be the view of the insurer that it could alter a contract with the complainant by sending him a letter which did not provide any details of how the contract had been altered and that if he wanted to find out how his contract had been altered he could telephone the insurer.

It was the view of the Tribunal that the insurer's actions did not have the effect of altering the terms and conditions of the annuity policy that the complainant had entered into with the former insurer and it was the finding of the Tribunal that the original policy did not contain any provision that the policy could be terminated if the account balance fell

below $2,000. The decision of the insurer to terminate the complainant's policy, without it having any authority to do so under the contract that had been entered into with him, was not, in the Tribunal's opinion, fair and reasonable. The Tribunal determined to set aside the insurer's decision and substitute its own that the policy be reinstated.

D12-13\065. Administration

The complainant complained that the trustee's decision to refuse to refund his insurance premiums was not fair and reasonable. He argued that he had not applied for insurance and was not advised that insurance premiums were being deducted. The Tribunal found that the complainant had been adequately informed of the trustee's insurance policy and affirmed the trustee's decision.

The complainant joined the Fund on 23 June 2008. On 30 June 2008 the fund sent a letter to the complainant welcoming him to the fund and providing information about his membership ('welcome letter'). In September 2009 the complainant received his benefit statement as at 30 June 2009 and became aware that premiums for death and disability and income protection insurance were being deducted from his superannuation account. The complainant immediately cancelled all his insurance cover in the fund and requested a refund of all premiums deducted since he joined the fund. The trustee declined to refund the premiums.

In correspondence to the Tribunal, the complainant argued that the fund had not acted ethically or in a fair and reasonable manner as he did not apply for or sign any application to obtain insurance with the fund and that the fund did not advise him during the period that monies were being redirected to insurance policies. He said that as soon as he became aware that he had been paying insurance premiums for 14 months, he cancelled his insurance.

While the Tribunal did not have jurisdiction to review the decision of the trustee to provide insurance cover to the fund's members on an opt-out basis, the Tribunal determined it did have jurisdiction to consider the complainant's complaint about the trustee's decision to refuse to refund his insurance premiums. This involved a consideration of the disclosures made to the complainant by the trustee about the insurance cover and the options for varying or cancelling cover.

After the complainant joined the fund on 23 June 2008 a welcome letter dated 30 June 2008 was sent to him. The complainant did not dispute receiving the letter. The letter included the following:

> New members who are under age 65 with the exception of casuals will be issued with death and disability insurance coverage and income protection upon joining…Details of your cover can be found in the enclosed Product Disclosure Statement and the supplement within…Your employer has classified you as being a non-casual employee. If this is not correct, please confirm with your employer.

> Should you wish to alter or cancel the default level of insurance cover, please complete and return the enclosed 'Insurance Variation Form'.

In the Tribunal's view, this section of the letter clearly explained to the complainant that he would receive death, disability and income protection cover. It was personalised to the extent that it noted that he was recorded as a non-casual employee and requested that he contact his employer if that was not correct. The letter also provided information to the complainant about the opportunity to cancel the cover and referred the complainant to the enclosed Product Disclosure Statement ('PDS') and Supplementary PDS.

The Supplementary PDS dated 4 June 2008 stated on page 5 that if a member qualifies for automatic cover they will receive 3 units of death and disability cover at $3 per week. Page 13 stated that if a member qualifies for automatic cover they will receive sufficient income protection units to insure 75% of their annual salary. It included a table on calculating the cost of the cover.

The complainant stated that he only briefly looked at the letter, however, he did sign and return the proof of identity form attached to the letter.

The Tribunal was therefore of the view that the complainant was adequately informed that he had death and disability and income protection insurance at around the time he joined the fund. In the Tribunal's view, he was also adequately informed at that time that he could cancel the cover. Accordingly, the Tribunal affirmed the trustee's decision to refuse to refund the insurance premiums to the complainant.

D12-13\080. Administration

The complainant complained to the Tribunal that the trustee's decision not to include his bonuses and allowances in the calculation of his superannuation salary was not fair and reasonable. While the trustee agreed that bonuses and allowances may be included, it affirmed that the governing rules of the fund state that a member's salary is determined by the employer and cannot be altered by the trustee, and the salary provided by the employer did not include the bonuses and allowances. The Tribunal agreed with the trustee's understanding and affirmed the trustee's decision.

On 4 August 2010 the complainant lodged a complaint with the Tribunal that the decision of the trustee to reject his request to include bonuses and allowances in his superannuation salary for the calculation of his defined benefit was unfair or unreasonable. The resolution sought by the complainant was payment of $109,891.87 being his calculation of additional defined benefit payable if bonuses and allowances were included in his superannuation salary.

The complainant's complaint centred on the belief that his car allowance, first aid allowance and bonuses should have been included in the salary used to calculate his fund retrenchment benefit. To support his case, the complainant submitted to the Tribunal a plan handbook which was given to him when he joined the fund. The handbook

provided a definition of 'salary' which stated that allowances and bonuses would generally be included.

The Tribunal, however, noted the trustee's submission that the handbook also stated that the fund's governing rules were the final authority. The Tribunal was satisfied that under the governing rules of the fund, the setting of a member's salary for superannuation purposes is done by the employer and the trustee has no power or discretion to alter the information provided by the employer. The Tribunal noted that the employer had advised the trustee that the complainant's base salary excluding bonuses and allowances was the salary to be used for superannuation purposes. The Tribunal therefore considered it fair and reasonable of the trustee to use the complainant's base salary in the calculation of his defined benefit.

The Tribunal considered that the definition of 'salary' in the plan handbook had been unfortunate and potentially misleading for the complainant. It therefore considered whether the complainant had placed any reliance on this information and whether he would have taken any different actions had he known that his bonuses and salary would not have been included in his superannuation salary.

The Tribunal noted the complainant's submission that he would have made voluntary contributions to make up the shortfall between what he was paid and what he thought would be his entitlement had he known that bonuses and allowances were to be excluded. However, the Tribunal was satisfied that all the complainant's annual benefit statements and quotes throughout his fund membership used the salary information as provided by the employer. It appeared to the Tribunal that at no stage did the complainant receive any advice that a salary above his base salary would be used. The Tribunal was therefore not satisfied that the complainant had a realistic expectation throughout his membership that he would receive a much higher benefit than that of which he was continually advised. The Tribunal, therefore, affirmed the trustee's decision.

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