QFCI

Date: 11/11/11 JM

Exhibit Number: 1027

STATEMENT OF ROBERT SAMUEL HAZELL IN RESPONSE TO REQUIREMENT TO PROVIDE INFORMATION ISSUED TO SUNCORP INSURANCE DATED 2 NOVEMBER 2011

ROBERT SAMUEL HAZELL, c/- Suncorp, Level 31, 266 George Street, Brisbane, states on oath:

1. I am an Internal Dispute Resolution Team Leader in the Internal Dispute Resolution team for the general insurance brands of the Suncorp Group.

2. I have authority on behalf of AAMI to respond to the Requirement to Provide Information issued by the Commission of Inquiry dated 2 November 2011 and addressed to the Suncorp Group.

3. This response relates to information received by the Queensland Flood Commission of Inquiry in respect of the following matters.

Question 1: Please set out whether you disagree with any of paragraph 1(a) to (f) above and, if so, in what way?

4. I agree with the content of the paragraphs 1(a) to (f).

Question 2: What are your formal qualifications?

5. Bachelor of Economics from Monash University (1997).

Question 3: Do you have any training/qualifications with respect to hydrology? If so, what?

6. No.

Question 4: How long have you been employed as a dispute resolution officer (DRO) at AAMI?

7. I was a DRO between February 2010 and August 2011 and since August 2011, I have been an internal dispute resolution team leader.

Question 5: What are the key responsibilities and tasks of a DRO at AAMI? Please provide a copy of AAMI's job description of a DRO.

8. The Consumer Appeals Service is part of the internal dispute resolution department for the general insurance brands of the Suncorp Group and conducts the internal dispute resolution process for AAMI and a number of other Suncorp Group brands. The key responsibilities of a DRO are to conduct dispute resolution in accordance with the Consumer Appeals Service Terms of Reference ('CAS TOR'). A copy of the CAS TOR is attached to the statement of the Executive Manager Internal Dispute Resolution, Mark Richards. A copy of the job description for a DRO is attached as **Annexure 1**.

Question 6: Has AAMI provided you with training in relation to your role as a DRO? If so, please provide details of the training you received and provide a copy of all training material.

9. Yes. Training consisted of one on one training with a team leader using the CAS TOR as the framework and referring to documents set out in the CAS TOR such as the General Insurance Code of Practice, the Insurance Contracts Act, ASIC Regulatory Guide 165 etc., as necessary. The AAMI Decision Maker Toolkit was also used and referred to. A copy of this is attached as **Annexure 2**. Training also consisted of "buddying" with other dispute resolution officers on customer telephone calls and whilst conducting reviews until competency levels were achieved. In addition to the specific training provided in relation to the DRO role, there are other general training courses and mandatory competency training requirements for example product training, OH&S, Privacy, trade practices, diversity and Code of Conduct. The materials for these courses have not been included as they do not specifically relate to the DRO role.

10. Following the Queensland and Victorian floods, CAS created a team of staff members to review flood related disputes, consisting of myself, another dispute resolution officer, a senior dispute resolution officer and a team leader. We undertook additional training using the following materials:

    a. CAS Guide to managing flood claims attached as **Annexure 3**.

    b. FOS Circular – Flood claims attached as **Annexure 4**.

    c. Previous FOS determinations dealing with flood related claims.

Question 7: What were your reasons for deciding not to provide Mr Laszlo's submission to WRM for their expert consideration? In your response, please give details of the criteria upon which you based your decision.

11. When reviewing the decision to reject Mr Laszlo's claim I adopted the following process:

    a. I noted Mr Laszlo's argument that the WRM hydrology report did not offer any evidence to support its conclusion that Burpengary Creek overflowed and that this was the cause of the inundation.

    b. I reviewed the Moorina rainfall data provided by Mr Laszlo and noted that WRM had considered the Moorina Alert data, but had noted that the Browns Creek Alert was closer to the property. I accepted, on the balance of probabilities, that the Browns Creek Alert data was the relevant data for calculation of stormwater runoff. I formed the view that WRM would not change its view on this aspect.

    c. From my training and experience I am aware that calculation of the maximum stormwater flow depth is based on an accepted formula and I was satisfied that the calculation preformed by WRM was reasonable and I did not believe the flow rate of 0.3 metres per second, as suggested by Mr Laszlo, could be justified on the

available information or that WRM would accept this. I believed that WRM, as qualified experts, were better placed to calculate maximum stormwater flow depth than a lay person without relevant qualifications.

d. I also considered the issue of the drain. I took into account that Mr Laszlo was not in a position to confirm this, which I took to being not in a position to confirm water escaping from the drain caused the inundation. I also noted that WRM was aware of the observation that water was surging up through the gully inlets and had considered the drainage features of the vicinity of the subject property, but had still reached the clear conclusion that the subject property was inundated by a combination of floodwater from the Burpengary Creek flowing back up an open channel located in a park to the north of the property and floodwater overflowing from Burpengary Creek upstream of the property. I noted that the aerial photograph in figure 1 in the WRM report showed the floodwater overflow path from the U bend in the Burpengary Creek (which is to the south west and upstream of the property) to the open channel referred to. I also noted that Mr Laszlo stated that the storm water drain was located in the vicinity of the U bend. I considered all of this and the other material in the report and in particular the photograph in the WRM report showing the level of inundation and I believed, on the balance of probabilities, that the level of inundation was unlikely to have occurred as a result of the escape of water from the drain.

12. I was aware that seeking a further report from WRM would delay the review by approximately six to eight weeks and I considered that this was not justified given that in all of the circumstances set out above I had formed the view that:

    a. the information in Mr Laszlo's submission either had already been considered by WRM, was directly contradicted by information in WRM's report, or was not of a kind likely to result in WRM changing its view; and

    b. the evidence was of sufficient strength to make a decision on the available material without seeking a further report from WRM.

Question 8: If not already answered in paragraph 7 above, were timeframe pressures a consideration in making the decision not to provide Mr Laszlo's submission to WRM? If so, in what way were timeframes taken into account?

13. I believe this has been answered in my response to question 7.

14. Timeframe pressures were a consideration in making a decision not to provide Mr Laszlo's submission to WRM only in the sense that I did not believe the delay involved in obtaining further comment from WRM was justified given that my analysis of the material provided by Mr Laszlo was that it was unlikely to change WRM's view, and I believed the information I had to hand was sufficient to make a determination of the review application without any such further comment.

15. Had the material submitted by Mr Laszlo raised issues that I believed had the potential

to change WRM's view or which raised material doubt about whether a review decision could be made on the otherwise available material, the fact that delay would be experienced in obtaining further comment from WRM would not have resulted in a decision not to do so.

Question 9: What other matters beyond facts going to whether the claims fell inside or outside of the policy, if any, were taken into account in determining the outcome of Mr Laszlo's claim? If such other factors were taken into account, please provide a copy of all directions outlining these other factors.

16. The CAS TOR provide that in making a final decision a DRO must have regard to only the following:

    a. All material contained on the file including claim and policy messages, investigation reports, assessment reports, correspondence and information supplied by the consumer.

    b. The terms of the relevant policy of insurance.

    c. The Code.

    d. The FOS Terms of Reference.

    e. Relevant legislation including the Insurance Contracts Act, the Privacy Act, case law and legal principles.

    f. What is fair and reasonable in all the circumstances and good insurance practice.

    g. Previous FOS determinations.

    h. Whether it is appropriate to convene a conciliation meeting to resolve the dispute, giving the consumer the opportunity to be heard by management.

17. No other matters were taken into account in determining the outcome of Mr Laszlo's claim during the internal review.

Question 10: What is your relevant expertise and/or experience that you consider enables you to competently make a decision not to refer to a hydrologist for comment, when the hydrologist's findings are challenged by a customer (as in the case of Mr Laszlo) or where customers engage their own expert?

18. As a result of my training as set out above and my experience in dealing with numerous flood related claims, reviewing hydrology reports and previous FOS determination, I have knowledge of what is required to prove, on the balance of probabilities, that the flood exclusion applies and experience in assessing the strength of the available evidence, including competing evidence.

19. In any particular case, my decision as to whether or not to refer a matter to a hydrologist

for opinion is based on:

a. Whether the evidence already available to me enables me to determine, on the balance of probabilities, whether the conditions for policy cover are met, or alternatively whether the flood exclusion applies; and

b. If not, whether the uncertainty relates to a matter which may be clarified by a hydrologist's opinion.

Question 11: Please provide a copy of the criteria used to determine:

a. When a customer's submission is given to the hydrologist engaged by AAMI (if different to paragraph 7); and

b. When an expert reports is given to the hydrologist engaged by AAMI for their consideration, for example, from an engineer or builder or hydrologist commissioned by the customer that contradicts and/or differs from the facts and/or conclusions made by the hydrologist engaged by AAMI.

20. There are no written criteria.

21. Where a decision is made during an internal dispute resolution process to commission a hydrologist's opinion, what material is given to the hydrologist is determined on a case by case basis, having reference to:

a. The relevance of other available material to hydrology issues, ie any other material available at IDR which may be of utility to the hydrologist in forming an opinion would be provided; and

b. Any advice or direction from the hydrologist as to what information he or she may require in order to undertake their assessment.

Sworn by the Deponent)
)
At Melbourne)
)
This 8th day of)
November 2011)

[redacted]
Robert Samuel Hazell

Before me

[redacted]

Solicitor

MARTIN IMOSA
15 William Street Melbourne Vic 3000
An Australian Legal Practitioner
(within the meaning of the Legal
Profession Act 2004).

POSITION DESCRIPTION

Part A - Role Specification

Role Title:	**Dispute Resolution Officer**		
Business Unit:	GI CRO	**Location:**	Melbourne (601)
Division:	Personal Insurance		
Department:	Internal Dispute Resolution		
Section:	Suncorp GI IDR		
Role Reports to (role title):	Team Leader – Suncorp GI IDR		
Direct Reports (role titles):	Nil		

Purpose (Succinct statement of why the role exists)

To manage the investigation and response to customer's verbal and written complaints and compliments aligned to both business and customer requirements, ensuring that all communication meets General Insurance Code of Practice compliance and legal requirements.

Key Result Areas (Outcomes of the role and the desired behaviours to be exhibited in the role)

Key Result Area: Business Results

- Facilitate responses to all verbal and written customer complaints and compliments made direct to IDR.
- Ensure accurate recording and maintenance of customer and dispute information relevant to resolution of disputes.
- Seek ways to exceed stakeholders' expectations and display flexibility in meeting needs through consideration of a range of alternative solutions.
- Retain existing business through overcoming objections, timely resolution of customer concerns and the building and maintaining of strong relationships' with customers.
- Meet quality audit requirements/benchmarks on consistent basis.
- Communicate with customers in writing or verbally in resolution of disputes using privacy principles, code compliance, legal and company standards.

Key Result Area: Team Performance

- Achieve team performance benchmarks and targets including the tracking, resolution and reporting of disputes.
- Execute delegated levels of authority in order to effectively resolve a dispute by evaluating policies and applying discretion while balancing the needs of the business and the customer.
- Identify and make recommendations ultimately delivering final IDR decisions to relevant areas, any opportunities identified for system, process, product, sales or service improvements.

Key Result Area: Values – Team and Personal Performance

- Supports managers and leaders to define objectives/deliverables and required resources to achieve targets.
- To role model the Suncorp values in all dealings with customers, staff and stakeholders.
- Contribute to team goals and performance standards through active participation in teamwork and proactive support for peers.
- Be a passionate role model and a proactive team member. Be involved and initiate mutually beneficial relationships with team members in accordance with Suncorp values.

Working Relationships (Nature and purpose of internal and external relationships)
The role will require the ability to build and maintain strong working relationships with internal and external stakeholders including: Internal Departments Include: • All teams in all GI IDR Teams, GI EDR Team, GI Claims Operational Units and Support Teams • PI and Brand Leaders and Management Team • Various Business Areas- Marketing, Investigations, Product, Operations, Administration, Branches, • Group Legal PI Department • Group Risk and Compliance Department • Group GI Call Centres External Departments Include: • Financial Ombudsman Service • Other external service providers & business partners and Corporate Partners

Part B - Person Specification

Qualifications (Indicate whether mandatory or desired)
• Dispute resolution, negotiation or mediation studies highly regarded. • General insurance experience desirable. • Customer complaints experience desirable.

Skills and Abilities (Individuals capabilities, include level of proficiency)
• Proven problem solving skills – ability to investigate information provided and break down problems and situations into simple lists of components and tasks. • Proven decision making – ability to make effective decisions in a timely manner relevant to set timeframes and deadlines. • Proven negotiation skills - taking ownership of customer disputes and producing win-win solutions for the customer and the business. • Excellent communication skills – proven ability to address all customer issues and convey dispute outcomes in a confident and concise manner both orally and written. • Time management - demonstrated ability to prioritise tasks and organise workload in an effective manner. • Workload management – proven ability to manage variations in workload through identification of priorities. • Analytical skills - ability to operate in a complex dynamic environment and make decisions and recommend courses of action using data and customer information relevant to disputes. • Customer service - proven ability to deliver service that is committed to customer experience by delivering quality outcomes in required timeframes. • Attention to detail - accurately recording customer details and disputes and displaying accuracy in all aspects of the role. • Managing change - ability to recognise, understand and support the need for change and anticipate the impact on the team and the individual.

Annexure 1

Knowledge (Factual or procedural information needed to perform in the role)
• Advanced knowledge of products, systems and processes
• Comprehensive knowledge of relevant compliance standards, legislative requirements and industry codes.
• Comprehensive knowledge of Internal Dispute Resolution processes and procedures.
• Working knowledge of team standards and metrics, centre benchmarks and company standards.
• Sound understanding of business, market and external environments.
• Comprehensive understanding of FOS terms of reference

Experience (The minimum amount of experience required to perform in the role)
• Minimum 12-18 months in a general insurance claim or product role.
• Negotiation or mediation studies highly regarded.

Additional Requirements

- Occasionally required to work extra hours to meet deadlines.

Prepared by: **Name:** [redacted] **Role Title: Team Leader, Suncorp GI IDR**	***Date: 17 June 2010***
Approved by: **Name: Mark Richards** **Role Title: Executive Manager Suncorp GI IDR**	***Date:***

Annexure 2

AAMI Decision Maker Toolkit

Learner Materials

Revised 2010

Table of Contents

1 History Of Dispute Resolution And Insurance

Introduction

Due to their size and the resources available to them, insurance companies have traditionally dominated their relationships with individual customers. Insurers could rely on the archaic duty of disclosure to deny claims. Essentially this meant that a customer had to tell the insurance company everything that the insurance company wanted to know about underwriting a risk. Almost **any** failure to disclose a relevant matter, no matter how small or non-prejudicial to the insurer, would allow the insurer to deny the claim and avoid the policy.

Insurers felt that they were making the right decisions because so few customers challenged them. The reality was that the complexities and high costs of going to court prevented all but the wealthy from taking on a large insurance company.

The main changes

Two changes redressed this imbalance of power. The *Insurance Contracts Act 1984* codified the bases on which insurers could deny claims or reduce their liability. In particular, insurers can only reduce their liability in proportion to the actual prejudice suffered (e.g. s28(3) innocent misrepresentations and s54 breach of a policy condition).

The second change was the development of the Insurance Enquiries and Complaints Ltd (now the Financial Ombudsman Service and known as the FOS), which provides a forum for resolving disputes that is independent and free to customers.

As part of the reforms introduced into the Corporations Act by the Financial Services Reform Act, terms of reference of the FOS have been extended to disputes regarding underwriting and risk review.

See: Simon Smith's chapter: *General Insurance: The Unfurling of the Umbrella of Protection*, 'In the Consumer Interest: A Select History of Consumer Affairs in Australia 1945-2000', for a comprehensive summary of the history of consumer affairs in relation to the general insurance industry. S. Smith

2 Policy Interpretation

Contra Proferentum

This Latin term essentially means that if wording in a policy can be interpreted in more than one way, it will be interpreted by a court or FOS in the way that most favours the customer. The reason for this rule is that AAMI has drafted the policy. Having said that, the rule is one of last resort and should only be used when it is not clear what was intended. It is widely accepted that it is preferable that courts should work with the words actually used and apply them to the individual circumstances of each case rather than by using a mechanical formula.

Read the policy as a whole

This rule is really based on common sense. When you are attempting to work out what a particular phrase means, you should consider it in the context of the rest of the policy.

Ejusdem Generis

Law lecturers have tormented students for many years by explaining this rule by saying 'Birds of a feather, flock together'. More usefully – where a list of specific words is followed by a more general term, the general term will be limited to the same kind as the particular words.

Example: *Cars, trucks, motorbikes and other forms of transport.*

In that case the general words 'other forms of transport' would probably not be interpreted as including bicycles, because the particular words before it are all motorised.

Words should be given their natural and ordinary meaning

If words are not defined in the policy itself, have a look in a dictionary. Judges do!

Have regard to the type of insurance and its purpose

As an example, AAMI specifically limits the cover it provides to tools of trade and home office equipment under its contents policy. This is because it is domestic insurance rather than business insurance. It's not hard to see that the risks associated with a home can be quite different to those involved with running a business.

Evidence – Useful terms

The following table provides a list of useful terms used in the policy.

Term	Definition
Adversarial system	Our legal system is based on two parties confronting each other in a contest over facts, or the interpretation of facts. Disputed facts are the **facts in issue**.
Law of evidence	Rules and principles that govern proof of the **facts in issue** in a case. The rules of evidence govern the proof that may be lead in a trial.
Rules of evidence are exclusionary	To be admissible in a trial, the evidence must first be **relevant** to a fact in issue. The evidence must render the existence of the fact more or less probable.
Admissible evidence	Only admissible evidence may be introduced into a trial. To be admissible, the evidence must first be **relevant** to a fact in issue i.e. the evidence must render the existence of the fact more or less probable. Second, it must be admissible. Admissible evidence may be excluded if it was obtained **illegally** or by **improper means.**
Admissibility	Admissibility of evidence is for the judge to decide. The jury decides the facts by assessing the **weight of evidence** after issues of admissibility have been ruled upon.
Judicial notice	Certain facts so generally well known that the court 'notices' it without formal proof e.g. that 'grass' is a term frequently applied to cannabis *[Ringstaad v. Butler (1978) 1 N.S.W.L.R. 754 at 757]*
Real evidence	Refers to all evidence other than oral testimony. ***Example:*** *Tape recordings, charts, plans, photographs, fingerprints, a view or a demonstration.* Real evidence is treated as an exhibit at a trial.

Evidence – Useful terms, continued

Term	Definition
Documentary evidence	Also known as the 'Best Evidence Rule'. If an original document is at hand, it must be produced. A copy would be inadmissible however there are exceptions e.g. it has been lost, destroyed or cannot be brought to court due to public inconvenience, or if it would be damaged by moving it. It must be properly executed or otherwise connected with a relevant person.
Formal admissions	Where both parties agree to 'admit' a fact, no further proof of the fact is required e.g. that a person in the proceedings was born on a certain date. Admissible evidence may be excluded if it was obtained **illegally or by improper means**.
Circumstantial evidence	Evidence of a fact from which a judge or jury may **infer** the existence of a fact in issue.
Direct or oral evidence	Evidence of what a witness recounts through his or her own sensations i.e. what was seen heard, touched, smelt or tasted.
Opinion evidence	Is not admissible. That is, a witness may give evidence of things that he or she saw, heard, touched, smelt or tasted (all physical perceptions) but not of a belief, interpretation or evaluation or opinion.
Expert witnesses	Are permitted to give evidence of their **expert opinion**. The subject matter of the evidence must be one concerning a peculiar skill or area of expertise and the witness must be properly qualified in that area to be permitted to express their **expert opinion**. Increasingly, Courts, Tribunals and the FOS are critical of the 'gun for hire' aspect of expert witnesses. Experts are expected to provide an independent and objective opinion for the benefit of the decision maker and not the person who has engaged them.

Burden of proof	The legal **burden of proof** lies upon the party asserting the matter. In civil cases, the plaintiff carries the legal burden of proof and therefore the evidential burden also.

Evidence – Useful terms, continued

Term	Definition
Standard of proof	The **standard of proof** in civil cases is on the **balance of probabilities**. The jury after weighing the evidence in a civil case, decides whether the plaintiff has proven its case on the balance of probabilities. If so, it succeeds. If not, it fails.
Hearsay evidence	Generally is inadmissible. **Hearsay evidence** is testimony in court of a statement made to or heard by the witness out of court where the statement is offered as an assertion of the truth of the matters asserted. Another definition may be that **hearsay** is a statement other than one made by the declarant while testifying at the trial, offered in evidence to prove the truth of the matter stated. **Exceptions - hearsay evidence that is admissible**. Admissions, or declarations against interest, are admissible. Admissions may be by words, in writing or by conduct.
Corroboration	Is independent evidence that is relied upon in support of a fact. ***Example:*** *A lie may be corroborative, or it may not, it depends upon the lie told and whether it is material to the fact in issue, and not told for some other reason such as panic, accidental error, shame, attempts to terminate the inquiry earlier, resentment at officious questioning, or the desire to avoid the discovery of other misconduct.*
Cross examination	Occurs when the lawyer for the other party questions a witness. The cross-examiner may seek to: • establish facts favourable to his or her own case, and/or • destroy or weaken the accuracy or credibility of the opponent's witness.

3 Duty of Utmost Good Faith (Section 13)

Background

The duty of good faith requires AAMI to act with due regard to the insured's interests in situations where the insurer has a conflict of interest (such as paying out a claim). It also requires the insured to act honestly when dealing with the insurer.

The duty essentially involves notions of honesty and fairness.

The duty of good faith originally arose to explain another duty – the duty of disclosure: 'Good faith forbids either party, by concealing what he privately knows, to draw the other into a [contract of insurance] from his ignorance of the fact.' *Carter v Boehm* (1766) 3 Burr 1905.

The duty of good faith has since been extended to all dealings between the insured and the insurer related to the policy and claims made under it. Surprisingly, it has even been suggested that the duty continues if the parties commence litigation against each other.

s13 now makes the duty of good faith a term of every contract of general insurance. The Act goes on to provide for damages for any breach of the duty. The Act also permits an insurer to cancel a contract for a breach.

The remedy for breach of s13 is found in s54. It will be rare for AAMI to rely solely on a breach of s13 to deny a claim. One possible example is where a claimant fails to cooperate with a reasonable request for information during an investigation. AAMI would need to demonstrate prejudice under s54(1). In most cases, a breach of s13 will also amount to misrepresentation or fraud.

AAMI's duty of utmost good faith

Like the insured AAMI must not misrepresent facts about the policy or that are material to the insured's decision whether to take out the policy. AAMI must also point out facts that could affect the insured's ability to make a successful claim. This is why we tell customers about the importance of providing honest and complete answers to our questions.

AAMI's duty of utmost good faith, continued

When handling claims, the duty requires AAMI to:

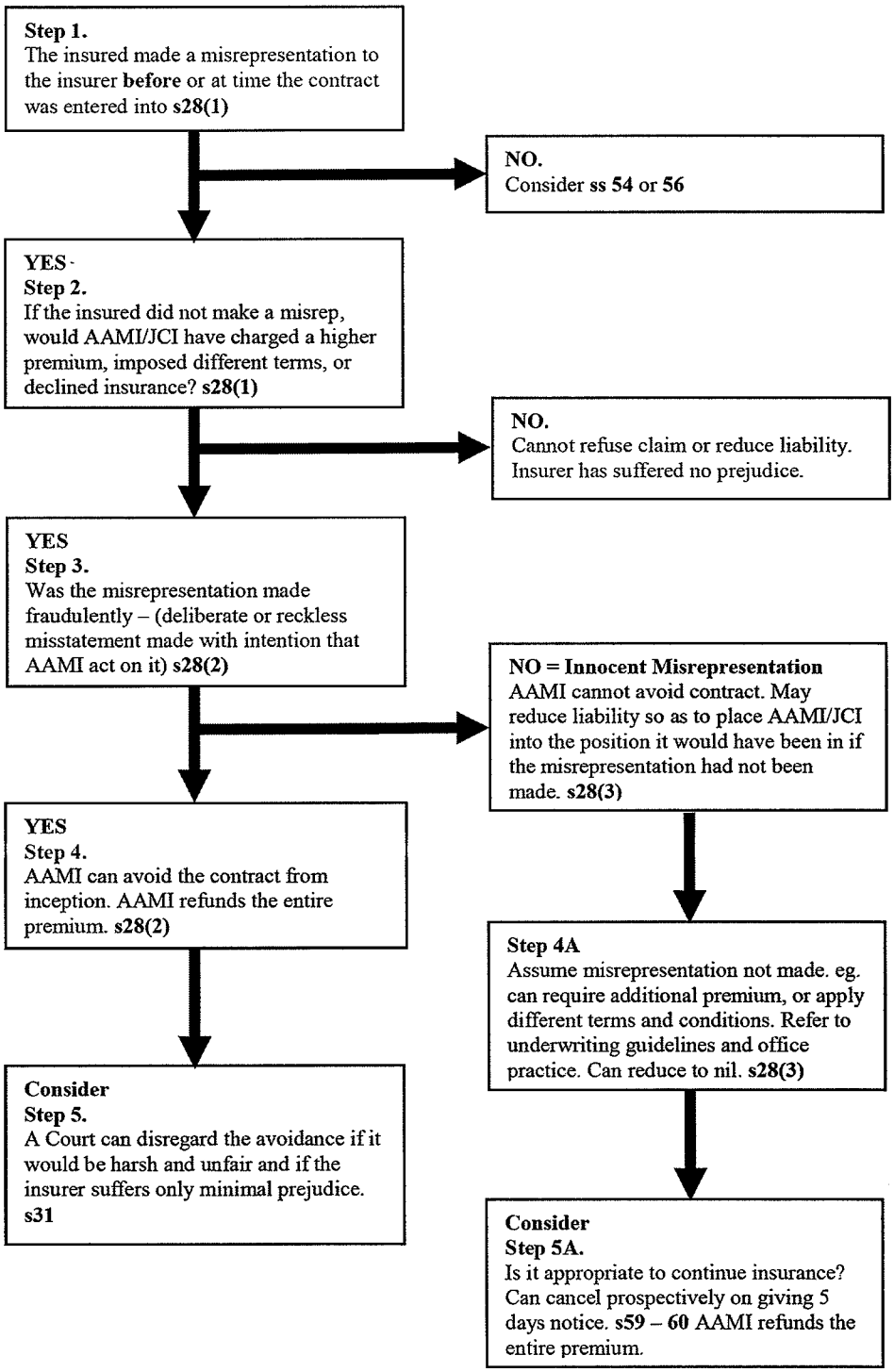
- manage, administer and process claims efficiently and without undue delay
- decline claims only with reasonable evidence or belief that the claim should be declined
- investigate the claim before declining a claim
- investigate claims in a reasonable manner, and
- use only appropriate reasons to decline a claim.

This does not mean that AAMI must act to the insured's benefit and to the detriment of its own interests.

'A duty, the essence of which is to act honestly [should not be] elevated to an obligation in an insurer to coddle its insured and to allow idiosyncratic judicial solicitude to replace principle.'
[Re Zurich Australian Insurance Ltd (1998) QSC 209]

In summary, the duty requires a fair consideration of the insured's interests and an honest interpretation of the policy wording and relevant legislation.

4 Misrepresentation (Section 28)



What is misrepresentation?

Misrepresentation is a false statement of fact in answer to a specific question asked by AAMI made before or at the time of entering into a contract of insurance.

Therefore, if AAMI doesn't ask the right question the insured is under no obligation to tell us other information (that is the duty of disclosure, which AAMI **does not** rely on). You should not use the words such as 'disclose' or 'disclosure' when speaking or writing to a customer about misrepresentation.

A false statement will **not** be a misrepresentation:

- if it was based on the person's belief, and the belief was one that a reasonable person in the circumstances would hold. s26(1)
- unless the person knew, or a reasonable person in the circumstances would have known that the statement was relevant to the insurer's decision whether to accept the risk and on what terms. s26(2)

A failure to answer a question or an obviously incomplete or irrelevant answer will **not** be a misrepresentation. s27

The onus is on AAMI to get the answer.

If a customer has a belief as to the meaning of a question, and that belief is reasonable, the question has that meaning. In other words, ambiguous questions will be construed against AAMI. s23

A false answer to a question can be a misrepresentation, even if it could also amount to a non-disclosure e.g. Have you been convicted or charged with theft, burglary or breaking and entering? Answer 'No'. If that answer is false it will be a misrepresentation. If the customer knew it was false or answered recklessly (not caring if it was true or false) it will be a fraudulent misrepresentation.
[Tyndall Life Insurance v Chisholm (2000) 11 ANZ Ins Cas 90-104]

Only remedy for misrepresentation is that contained in s28

s33 provides that the only remedies an insurer has in the case of misrepresentation before entry into the contract, are those found in s28.

The gateway to misrepresentation - s28(1)

s28(2) deals with fraudulent misrepresentation and s28(3) deals with innocent misrepresentation. These sections only apply if the 'gateway' in s28(1) is passed through. s28(1) says that ss28(2) and (3) do not apply if AAMI would have entered the same insurance contract for the same premium and on the same terms and conditions. In summary, the misrepresentation must have had an impact on AAMI's underwriting decision.

Fraudulent misrepresentation – s28(2)

A statement is made fraudulently if it is made:

- with knowledge of its falsity or without belief in its truth, or
- recklessly, not caring if it is true or false, and
- with the intention that it should be acted upon by the insurer.

Note: Recklessness is not the same as carelessness. AAMI must show that the insured lacked an honest belief in the truth of the answers. 'If he was consciously indifferent to the truth of his answers, he was reckless.'
[Lamb v Johnston (1914) 15 SR (NSW) 65]

The burden of proving that a misrepresentation was made fraudulently falls on AAMI. It will usually be very difficult to prove a person's intention without their cooperation, because:

- it requires proof that the insured knew the representation was false or made it recklessly without caring whether it was true or false
- strong evidence is required due to the gravity of the allegation, &
- insureds will rarely have documentation that can be used to evidence their state of mind at the time of making the representation.

Usually, AAMI will need to rely on circumstantial evidence. The Courts and FOS expect satisfactory proof of what is a serious allegation. **In the majority of cases, AAMI will not be able to prove fraud and so will need to rely on s28(3).**

The form of the misrepresentation will provide some assistance in determining if it was made fraudulently or not. For example, if the insured has a recent criminal conviction, the misrepresentation is more likely to be fraudulent. However, a person might innocently think that they had a burglary claim more than 3 years ago. Other circumstances will be more difficult to decide. An insured recently said that she didn't think she had to mention hail damage when asked if her car was damaged.

Innocent Misrepresentation – s28(3)

In the case of an innocent misrepresentation, AAMI cannot avoid the contract. The only remedy is to reduce its liability so as to place AAMI in the position it would have been in if the person had answered the questions honestly and accurately. What would we have done differently?

This requires a hypothetical enquiry. If the customer had told the truth, what premium, conditions and excess would AAMI have applied? This hypothetical will usually arise at the time of making a claim and so it is important to appreciate the following:

- We have obtained legal advice that AAMI can only rely on a misrepresentation at inception in the **first year of the policy**. This is because at renewal a new contract of insurance is created. It may

be possible to argue that a misrepresentation has been repeated in subsequent years if the wrong information on renewal documentation remains uncorrected.

- If AAMI is able to rely on a repeated misrepresentation, it can only recover an additional premium for the current contract year. It is not possible to recover the extra premium for previous years.
- It is possible to reduce the liability to nil, if AAMI (including JCI) would not have offered insurance.
- When carrying out this hypothetical enquiry, it is important to remember that JCI is an agent of AAMI. This means that we need to have regard to JCI's underwriting guidelines as well as AAMI's. If AAMI would not have offered insurance but JCI would, we need to process the claim applying the JCI premium, excess and policy terms and conditions.

Avoiding or cancelling the contract – s28 and s60

When AAMI **avoids** the contract, it means that the customer was never insured. AAMI can only avoid a contract from inception in the case of a fraudulent misrepresentation. s28(2)

In the case of innocent misrepresentation, AAMI can only cancel the contract **in the future** by giving notice. s28(3), s60 and s59

Fraud is the most serious allegation we can make against a customer. Avoiding a policy in the case of innocent misrepresentation is an illegal act by AAMI. It is a breach of s28 and the utmost good faith provisions. s13 If AAMI makes the same mistake a number of times, it would amount to a breach of the Code of Practice.

Court may overturn the avoidance of a contract in case of fraud – s31

A court or the Referee can disregard the insurer's power to avoid the contract if it forms the view that this would be harsh or unfair to the insured. The court can only do this if the prejudice to the insurer is minimal or insignificant. The aim is to prevent an insurer relying on a harsh remedy where the nature of the fraud does not warrant it. The court must also keep in mind the overriding need to deter fraud. There is no power to excuse in the case of **innocent** misrepresentation.

Example: *An insured misrepresented the purchase price of a car as being $70,000 whereas in fact it was $56,000. The court found that this was a fraudulent misrepresentation by the insured. The court heard evidence that if the misrepresentation had not been made, AAMI would probably have insured the car for an agreed value of $60,000. In all the circumstances, the court decided that AAMI should not avoid the contract but that its liability should be restricted to $56,000. $56,000 was chosen rather than $60,000 so as to recognise the need to deter fraud. [Von Braun v AAMI (1999) 10 ANZ Ins Cas 61-419]*

Example letter: Fraudulent misrepresentation

Important Note: This letter is to be used as an example only. All letters need to be drafted with specific regard to the individual facts of the particular claim.

Introduction
Recite date of incident and where appropriate, most recent contact with customer.

Dear Mr Berlin

RE: Claim Number 135978600

We refer to the claim for theft of contents reported on 5 March 2002.

Body
Factual investigation
Direct evidence in support of rejection (e.g. witness statements, claim forms, photographs).

At the time of purchasing your policy you were asked, 'In the past 3 years have you had any criminal convictions?' to which our records indicate, you replied 'No'. Our enquiries have revealed that at the time of purchasing the policy you had a number of criminal convictions dating from 1990. In particular we refer to the convictions in 2000 and 2001 for obtaining property by deception and for obtaining financial advantage by deception.

Expert Evidence in support of rejection. Copies of expert reports should be provided to the claimant unless the material is privileged or unless special circumstances exist (see FOS Terms of Reference).

We enclose a copy of the police record issued by Queensland Police dated 9 May 2002 for your information.

Despite being given the opportunity to comment, you have been unable to satisfactorily explain why you answered 'No' to this question.

Reason(s) for claim denial.
Reference(s) to page numbers and section of policy in support of rejection decision.
Section(s) of Insurance Contracts Act 1984 in support of rejection decision.
If the evidence supports more than one basis for denial, they should all be set out in the letter.

Page 6 of your Home Building Insurance Policy states: *Our decision to insure you relies on the accuracy of the information you give us. If that information is not accurate, we can reduce or deny any claim you make or cancel your policy.*

We believe the representation you made to AAMI that you did not have any convictions amounts to a fraudulent misrepresentation in response to our specific questions. Accordingly, AAMI is entitled to avoid your Home Building and Home Contents Insurance policies from the date of inception and refuse your claim: Section 28(2) of the Insurance Contracts Act 1984. AAMI will forward you a refund of your premium shortly.

Conclusion
Consumer Appeals paragraph.
A Consumer Appeals brochure should be sent out with the letter.
Offer an opportunity to the claimant to provide more information if appropriate.

If you are not satisfied with our response, you are entitled to have it reviewed at no cost to you by the AAMI Consumer Appeal Service, who will respond to you within 5 working days of receiving your telephone call, letter or e-mail. Your participation in this review process does not affect or compromise your entitlement to seek remedies elsewhere or to issue legal proceedings. Should you wish to exercise this right, please write to: The AAMI Consumer Appeal Service, PO Box 14180, Melbourne City Mail Centre, VIC, 8062 or facsimile (03) 9529 1214 or telephone 1300 130 794 **(9am – 5pm EST Monday – Friday)** or e-mail consumerappeals@aami.com.au.

Sign off
'Yours faithfully' should be used in all letters. 'Yours sincerely' is only appropriate in less formal correspondence.
A nominated manager must sign all denial letters.

Yours faithfully,

Lesley Garside
Home Claims Manager (S Qld)

Example letter: Innocent misrepresentation

Important Note: This letter is to be used as an example only. All letters need to be drafted with specific regard to the individual facts of the particular claim.

Introduction
Recite date of incident and where appropriate, most recent contact with customer.

Dear Mr Paris

RE: Claim Number 1234567890

We refer to the claim for theft of contents reported on 5 March 2002 and our telephone conversation on 25 April 2002.

Body
Factual investigation
Direct evidence in support of rejection (e.g. witness statements, claim forms, photographs).

Expert Evidence in support of rejection. Copies of expert reports should be provided to the claimant unless the material is privileged or unless special circumstances exist (see FOS Terms of Reference).

Reason(s) for claim denial. Reference(s) to page numbers and section of policy in support of rejection decision. Section(s) of Insurance Contracts Act 1984 in support of rejection decision. If the evidence supports more than one basis for denial, they should all be set out in the letter.

At the time of taking out your policy you were asked to provide the purchase price of your car. AAMI's records show that you answered '$19,000'. Our enquiries have found that in fact you paid $13,000 for the car at auction. You agree that $13,000 was the actual purchase price. You explained that you believed the car was worth $19,000 and that was why you gave the answer you did.

Page 6 of your Comprehensive Car Insurance Policy states: *Our decision to insure you relies on the accuracy of the information you give us. If that information is not accurate, we can reduce or deny any claim you make or cancel your policy.*

We believe that you misrepresented the true purchase price when you took out the policy. Accordingly, AAMI is entitled to reduce its liability so as to place it in the position it would have been in if the misrepresentation had not been made: Section 28(3) of the Insurance Contracts Act 1984. If you had answered AAMI accurately, we would have required you to provide your car for assessment. AAMI's subsequent assessment of your car confirms that the most we would have agreed to insure your car for would have been $14,000. Accordingly, I enclose a cheque for $13,500 representing the value of your loss less the excess of $500.

Conclusion
Consumer Appeals paragraph. A Consumer Appeals brochure should be sent out with the letter.
Offer an opportunity to the claimant to provide more information if appropriate.

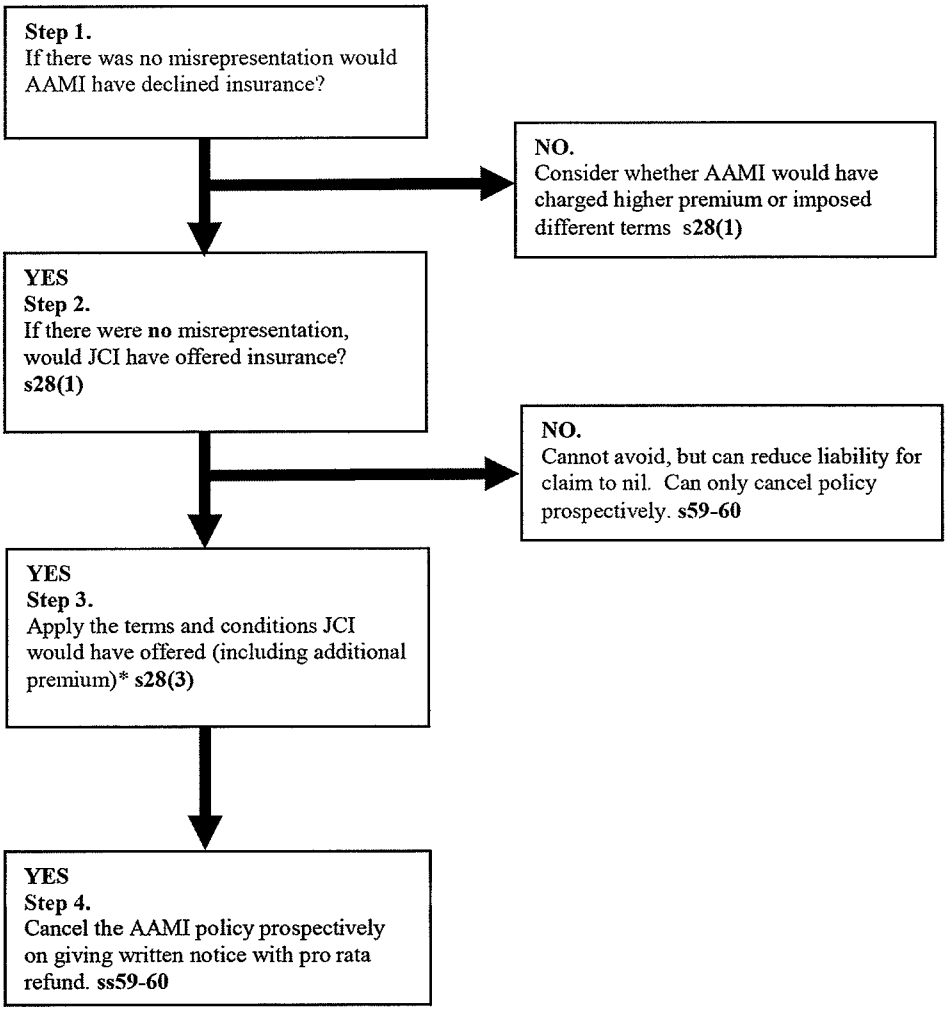
If you are not satisfied with our response, you are entitled to have it reviewed at no cost to you by the AAMI Consumer Appeal Service, who will respond to you within 5 working days of receiving your telephone call, letter or e-mail. Your participation in this review process does not affect or compromise your entitlement to seek remedies elsewhere or to issue legal proceedings. Should you wish to exercise this right, please write to: The AAMI Consumer Appeal Service, PO Box 14180, Melbourne City Mail Centre, VIC, 8062 or facsimile (03) 9529 1214 or telephone 1300 130 794 **(9am – 5pm EST Monday – Friday)** or e-mail consumerappeals@aami.com.au.

Sign off
'Yours faithfully' should be used in all letters. 'Yours sincerely' is only appropriate in less formal correspondence.
A nominated manager must sign all denial letters.

Yours faithfully,

Peter Perfect
Motor Claims Manager (WA)

5 Misrepresentation AAMI and JCI



* Unless the facts of the claim show that the only terms that would have been offered would not have been accepted by the insured.

Misrepresentation - The AAMI and JCI relationship

The customer makes an innocent misrepresentation. AAMI would not have offered cover if the true answers had been provided. JCI would have offered cover with different terms e.g. a higher premium.

In that case the:

- terms and conditions (including premium and excess) of the relevant JCI policy apply to determine AAMI's liability for the claim, and
- customer is still insured with AAMI, under the AAMI policy.

When the claim has been finalised, the status of the person as an AAMI customer must be adjusted:

- AAMI is aware of the misrepresentation and the customer falls outside AAMI's underwriting guidelines.
- The AAMI policy should be cancelled on giving notice under s60(1). The effect of s59 is that AAMI's letter to the customer should advise that the policy will be cancelled 5 business days after the date of the letter.
- AAMI should provide a pro-rata refund of premium for the un-expired part of the policy.
- In some cases, the resulting JCI premium (as compared to the value of the car) will mean that the customer would not have taken up the offer of insurance. If a customer refuses to pay an additional premium, AAMI will be entitled to refuse to meet the claim.

FOS has accepted AAMI's handling of the JCI relationship. In determination 13918, FOS considered a situation where the insured had misrepresented who would drive the car and modifications. FOS determined that misrepresentation was innocent. FOS determined that AAMI was liable for the cost of repairing the car and any claims by third parties pursuant to the terms and conditions of JCI's policy, subject to the insured paying the extra JCI premium and JCI excess. In this case the cost of repairs were $5,000. The extra premium and excess was $6,081. FOS determined that the IO was not entitled to any payment from the insurer. He was entitled to be indemnified in respect of claims by the third party subject to the payment of $1,081.

Example letter: Misrepresentation AAMI and JCI

Dear Mr Smith

Re: Claim No: 123 456 7800

Introduction

Recite date of incident and

Circumstances

I refer to your claim for damage to your car lodged on 1 April 2002 and our telephone discussions today.

Whilst assessing your car, we discovered a number of modifications that were not noted on your policy, including a Sports Steering Wheel, Extractors and Mag Wheels. In addition, during our investigation of the claim you confirmed that your son who is aged 18 regularly drives the car.

Your policy commenced with AAMI on 28 June 2001, at that time you were asked to accurately answer a number of questions related to your car and who would drive it. At the time of taking out the policy, in answer to a question asking if the car had any modifications, you answered that 'the exhaust was new but completely standard'. You were also asked who would drive the car. You answered that you were the sole driver.

AAMI sent you a policy schedule and asked you to check the information you had given. That schedule noted that the car had no modifications and that you were the only driver. You did not contact AAMI to correct this information.

Basis for decision

- *Include reference to policy pages.*
- *Include reference to Act section.*

Section 28 of the *Insurance Contracts Act 1984* deals with the situation where a person makes a misrepresentation before or at the time of entering into a contract of insurance. In such a case, AAMI is entitled to reduce its liability so as to place it in the position it would have been in, if the person had answered the questions honestly and accurately.

In this case, AAMI would not have offered you insurance on the same terms or for the same premium. In fact, AAMI would have referred you to Just Car Insurance (JCI), who is our authorised representative for this type of car. We have obtained a premium quote from JCI of $4,000. Under the terms of the JCI policy, an excess of $1,500 applies in this case. A copy of the JCI policy is enclosed for your information.

Accurately summarise what IO must do.

In order for you to proceed with this claim, you need to pay the additional premium of $3,000 (i.e. $4,000 less premium already paid $860), and the excess of $1,500. That is a total of $4,500.

Outline consequences of IO's decision and invite response within reasonable period.

If you are not prepared to pay the extra premium, AAMI will be entitled to refuse to pay your claim. Further because you have made a misrepresentation, AAMI are also be entitled to cancel your contract of insurance (*Section 60*) on giving notice.

Please advise how you wish to proceed and if appropriate, pay the extra premium and excess of $4,500. Please provide your response by 1 May 2002.

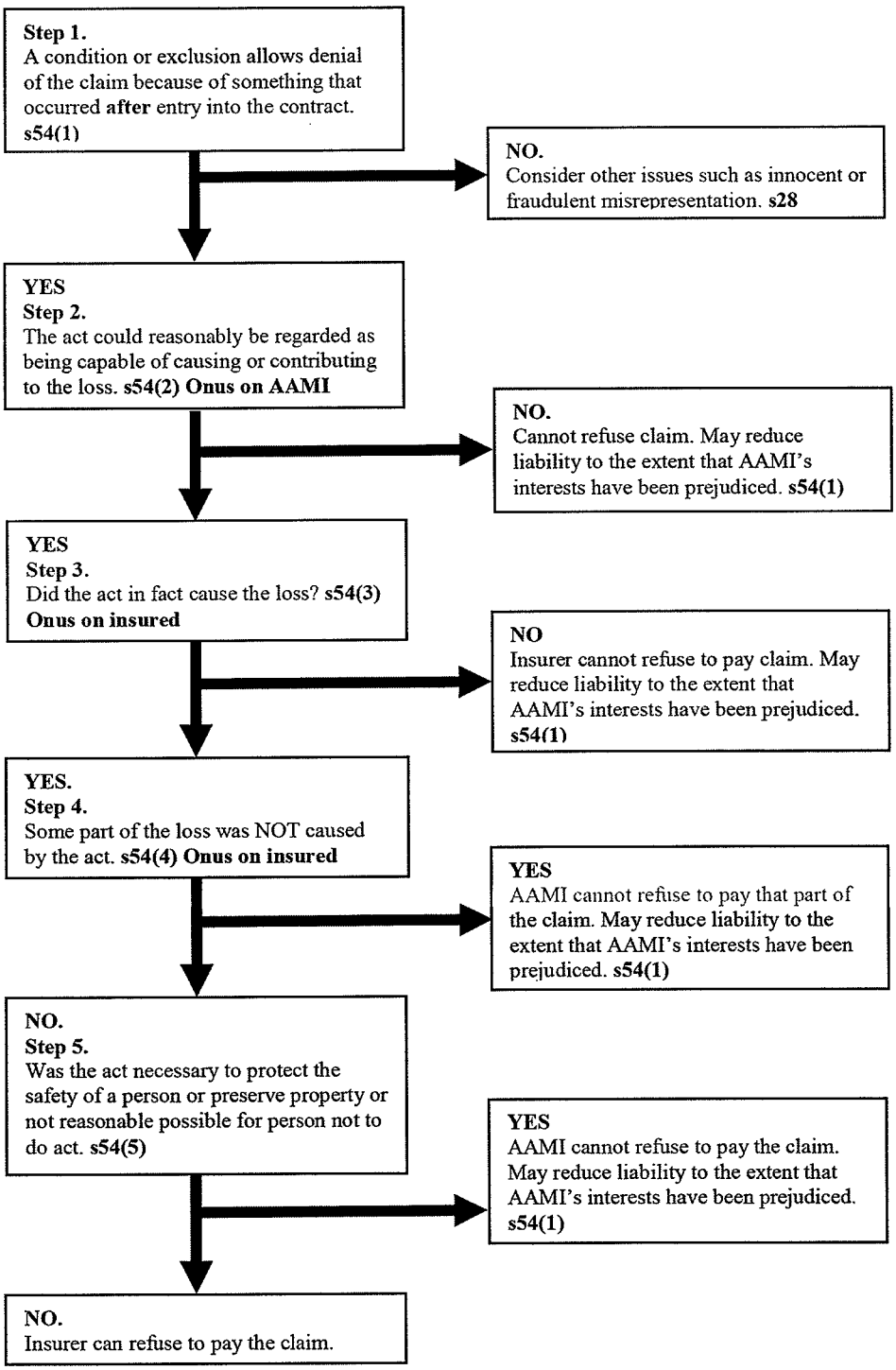
Alternative paragraph where IO has already expressed decision not to proceed with the claim.

You have advised our Claims Officer that this premium is not acceptable to you. As you are not prepared to pay the extra premium and excess, AAMI is entitled to refuse to meet your claim. **I advise that AAMI will cancel your policy in 5 business days from the date of this letter and will refund your premium.**

Offer an opportunity to the claimant to provide more information if appropriate.

[Insert CAS paragraph

6 Breach by Insured During Contract (Section 54)



Commentary on s54

s54(2) permits an insurer to refuse to pay where the act of the insured could reasonably be regarded as being capable of causing or contributing to the loss. Where this requirement is not satisfied, AAMI may only reduce its liability in proportion to the prejudice it has suffered. s54(1)

Examples where s54(2) is not satisfied

A person drives without a ***licence****. The fact that they did not hold a licence at the time of the accident is a breach of the policy entitling AAMI to disallow the claim. s54(2) says you can only do that if the fact that the person was unlicensed 'could reasonably be regarded as being capable of causing or contributing to the loss'. Where the person has simply overlooked renewing their licence, it is unlikely that AAMI will be able to show that this caused or contributed to the accident happening. Therefore despite the policy wording, AAMI cannot refuse to pay the claim. s54(1) then requires an assessment of the prejudice the insurer suffered as a result of the insured's act. In this case, AAMI will not have suffered any prejudice through the person being unlicensed either, and so s54(1) would not allow reduction of the liability. The outcome may be different if AAMI can suggest that an unlicensed driver's inexperience contributed to the accident.*

A person modifies their car but does not notify AAMI. At claim time the modifications are noted. The modifications did not contribute to the cause of the loss so s54(2) does not apply. s54(1) allows AAMI to reduce its liability having regard to its prejudice. Prejudice is decided by what AAMI would in fact have done if the customer had notified it. For example, AAMI may have imposed an additional premium (through JCI). In that case, AAMI could reduce its claim liability by the amount of the premium increase.

In relation to the policy clause relating to the **roadworthy condition of a car** the following alternatives are possible:

- Condition of vehicle contributed to accident. The other driver was 50% responsible. As per s54(3) AAMI may reduce its liability to 50%.
- The car is damaged while parked. AAMI must pay 100%. s54(2)

Cases of breach by insured during contract

De Vito v CUA

Courts have commented that the insurer 'need only show a fairly tenuous link ... In particular, the insurer is not required to prove that the act was, in fact, the cause, or a substantial (or other) cause of the loss.'
[De Vito v CUA (2000) 11 ANZ Insurance Cases 61-470]

In the *De Vito* case, a vehicle overturned and the driver had 'a few' months driving experience. The court looked at the circumstances of the accident and noted that the state of the light, weather, condition of the road, and mechanical condition of the vehicle played no part. The court had little difficulty in finding that the driver's act in driving while so inexperienced could reasonably be regarded as capable of having at least contributed to the occurrence of the loss. Accordingly the insurer was entitled to refuse the claim under s54(2). The obligation then shifted to the insured to prove the link was not there or only partially there.

AAMI v Ellis

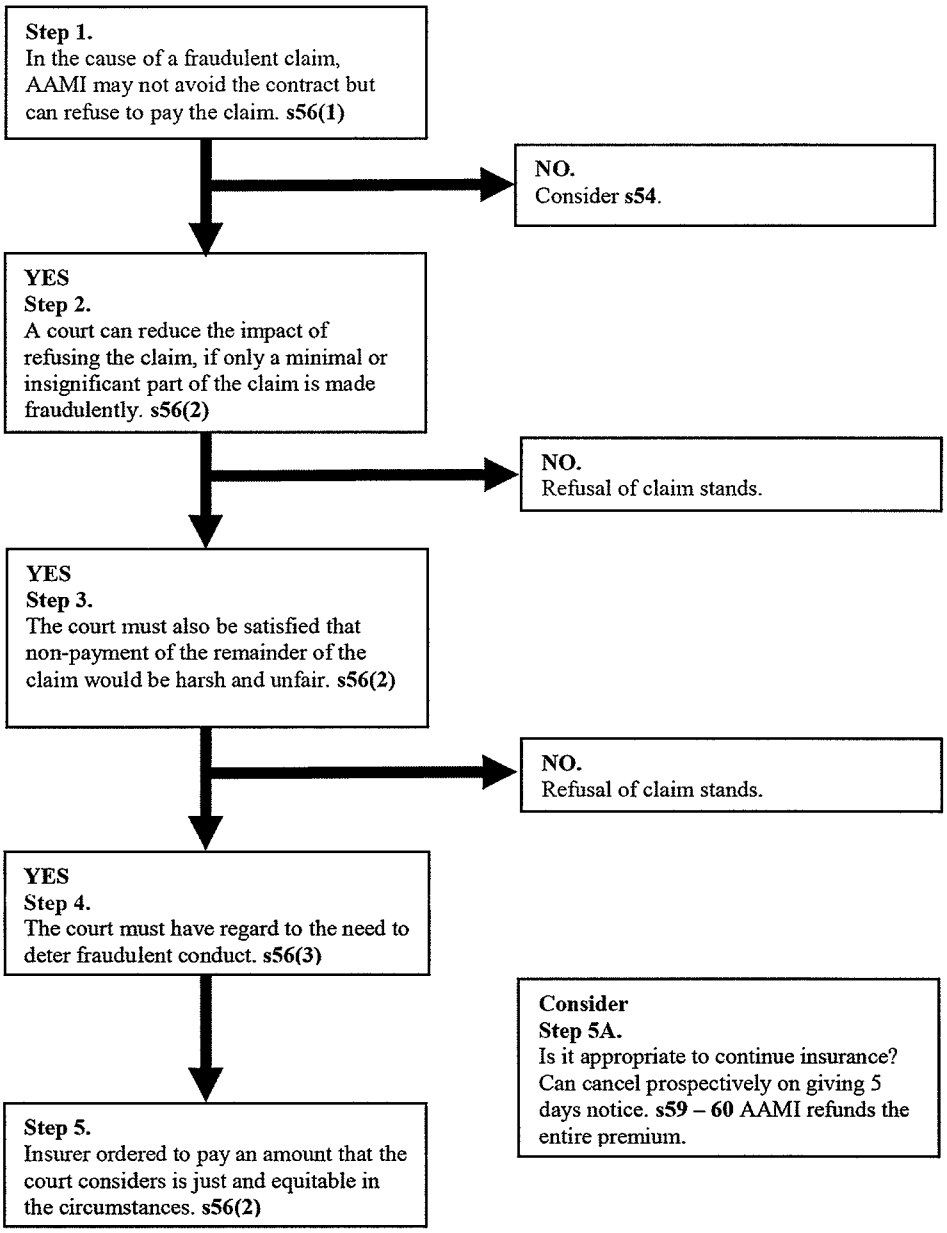
Mag wheels put on car but AAMI not notified. AAMI would have continued the policy subject to a condition that car not be driven by anyone under 25. The car was damaged in an accident whilst driven by 23 year old daughter. The mag wheels played no part in causing the accident. As per s54(3) AAMI could not refuse the claim. However, under s54(1) AAMI's liability was reduced to the extent that their interests were prejudiced by the non-disclosure. AAMI proved that it had lost the chance to specify that the car could not be driven by someone under 25 years of age. Accordingly, the liability was reduced to nil.
[AAMI v Ellis 1990 6 ANZ Ins Cas 60,957]

Moltoni Corp v QBE

s54(1) – **Prejudice**. The High Court has stated that prejudice is to be measured by reference to what **would** have happened if the act had not occurred (as distinct from what **could** or **might** have happened). The two stage proof is:

1. on balance of probabilities AAMI would have acted differently, and
2. had AAMI acted differently, its liability would have been reduced.
   [Moltoni Corp v QBE (2001) HCA]

7 Fraudulent Claims (Section 56)



What is a fraudulent claim?

The Act provides little guidance. The following cases provide some assistance:

- Arson/fraud. In most cases of fraud, AAMI will have to rely on circumstantial rather than direct evidence – e.g. motive, opportunity, the fact that the fire was deliberately lit, and perhaps the credibility of the claimant.
  [Preseed P/L v Colonial Mutual (unreported NSW Sup Ct 5.3.92)]
- Fraudulent exaggeration of claim. Clear evidence that the insured intended to deceive the insurer as compared to an honest estimate.
  [Entwells v National and General Insurance (1991) 6 ANZ Ins Cas 61-059]
- False Statement – eg. a false answer in a claim form related to the results of a blood alcohol test.
  [Gugliotti v Commercial Union Assurance (1992) 7 ANZ Ins Cas 61-104]
    - 'If a person knowingly makes false statements believing that they have an invalid claim in order to mislead the insurer into believing that they have a valid claim, it seems to me not to matter whether in fact the claim is valid or invalid. The claim is made dishonestly and hence fraudulently within the meaning of the Act.' The mental element required to establish fraud is an **intention to deceive** (i.e. an intention to create a false belief in the insurer for the purpose of obtaining a benefit). In that case the insured's 15-year-old son had driven her car without permission and had an accident. The insured believed (mistakenly) that she would not be covered for this under her policy. She moved the car and reported to the police and AAMI that it had been stolen.
      [AAMI v Tiep Thi To (2001) 11 ANZ Ins Cas 61-490]
    - FOS has cautioned that AAMI needs to do more than just point to a false statement. AAMI must prove fraud on the part of the insured in making that false statement. For example, a customer denied having anything to drink when lodging the claim on the telephone. When an investigator interviewed the claimant two days later and asked him to sign a claim form, he admitted that he had consumed some alcohol and blamed stress about the accident. The FOS determined that the insured had corrected the incorrect statement early and AAMI had not suffered any prejudice. Contrast this with the Tiep Thi To scenario where the claimant did not correct the false statement until late in the claim and only after having been challenged with conflicting evidence.

What is a minimal or insignificant part of the claim? S56(2)

A court or the Referee has a discretion to require an insurer to pay part of a fraudulent claim if two preconditions exist:

- that the fraud related to only a minimal or insignificant part of the claim, and
- the non-payment of the remainder would be harsh and unfair.

Note: s56(2) seems to apply only where there is a distinct component of a claim that, although fraudulent, was minimal.
[Riccardi v Suncorp Metway (2001) QCA 190]

- A false answer in a claim form related to the results of a blood alcohol test, tainted the whole claim and was therefore, not minimal or insignificant.
[Gugliotti v Commercial Union Assurance (1992) 7 ANZ Ins Cas 61-104]
- A court found that a substantial amount of contents alleged by the claimant to have been stolen, were in fact not in the house at the time. The discrepancy was large and not consistent with a mere inflation of the claim.
[Tsorotes v RACV (unreported Vic Sup Ct, 30.11.93)]
- A house was destroyed by fire. The insured showed the valuer another house that he said was similar and said his house was in better quality. In fact the destroyed house was in an extremely poor state of repair. The proper value was at best two-thirds and perhaps only one-half of the amount claimed. The insured argued that it was only a minimal or insignificant part of the claim and that he should be given relief. The court found that where the fraud was deliberate such that it tainted the whole of the claim, the insured was not able to establish that only a minimal or insignificant part of the claim was tainted by the fraud.
[Riccardi v Suncorp (2001) QCA 190]
- Examples where relief might be granted as suggested by Michael Arnold, Fraud Referee FOS – A person who has a legitimate claim for contents lost in a house fire but who includes a claim for a new watch that he did not own.

Example letter: Motor fraudulent claim

Important Note: This letter is to be used as an example only. All letters need to be drafted with specific regard to the individual facts of the particular claim.

Dear Mrs Smith

Introduction
Recite date of incident and where appropriate, most recent contact with customer.

RE: Claim Number 12345678900

We refer to the claim for theft of your car reported on 27 September 2002.

Body
Factual investigation
Direct evidence in support of rejection (e.g. witness statements, claim forms, photographs).

Expert Evidence in support of rejection. Copies of expert reports should be provided to the claimant unless the material is privileged or unless special circumstances exist (see FOS Terms of Reference).

We have completed our enquiry and found numerous discrepancies and anomalies with the circumstances of your claim. These concerns include:

- You have not substantiated the purchase and service history of your car. You state that the car was purchased for $14,900 but cannot provide details of the source of those funds.
- You have refused to assist in clarifying these concerns and have not responded to three written requests for information, in particular, proof that the car had been repaired prior to the transfer to you.
- Statements from your mechanic that you did not have sufficient funds to meet repair costs and that you would seek 'to have an insurance company meet the bill for you'. We attach a copy of the statutory declaration we have received from Mr Andrew Mechanic, which outlined the statements allegedly made by you.

Reason(s) for claim denial. Reference(s) to page numbers and section of policy in support of rejection decision. Section(s) of Insurance Contracts Act 1984 in support of rejection decision. If the evidence supports more than one basis for denial, they should all be set out in the letter.

Accordingly, from the information available, AAMI has decided to refuse this claim on the basis that it is fraudulent: s56(1) of the *Insurance Contracts Act 1984*.

Your failure to cooperate with AAMI's investigation of the claim also means that you are in breach of your contractual undertaking set out in page 29 of the policy and your duty of utmost good faith as set out in Section 13 of the Act.

Your Comprehensive Car Insurance policy will be cancelled five (5) business days from the date of this letter and a refund of your premium will be sent to you shortly in accordance with ss 60 and 59 *Insurance Contracts Act 1984*.

Conclusion
Consumer Appeals paragraph. A Consumer Appeals brochure should be sent out with the letter. Offer an opportunity to the claimant to provide more information if appropriate.

If you are not satisfied with our response, you are entitled to have it reviewed at no cost to you by the AAMI Consumer Appeal Service, who will respond to you within 5 working days of receiving your telephone call, letter or e-mail. Your participation in this review process does not affect or compromise your entitlement to seek remedies elsewhere or to issue legal proceedings. Should you wish to exercise this right, please write to: The AAMI Consumer Appeal Service, PO Box 14180, Melbourne City Mail Centre, VIC, 8062 or facsimile (03) 9529 1214 or telephone 1300 130 794 **(9am – 5pm EST Monday – Friday)** or e-mail consumerappeals@aami.com.au.

Sign off
'Yours faithfully' should be used in all letters. 'Yours sincerely' is only appropriate in less formal correspondence. A nominated manager must sign all denial letters.

Yours faithfully,

Richard Motor
Motor Claims Manager (VIC)

Example letter: Home fraudulent claim

Important Note: This letter is to be used as an example only. All letters need to be drafted with specific regard to the individual facts of the particular claim.

Dear Ms Thomas

RE: Claim Number 134258690

Introduction
Recite date of incident and where appropriate, most recent contact with customer.

We refer to the claim for theft of your home contents reported on 1 October 2000.

Body
Factual investigation
Direct evidence in support of rejection (e.g. witness statements, claim forms, photographs).

Expert Evidence in support of rejection. Copies of expert reports should be provided to the claimant unless the material is privileged or unless special circumstances exist (see FOS Terms of Reference).

During the investigation of your claim you made a number of statements in support of your claim that we believe are fraudulent. We have the following concerns:

- When questioned about your employer you were reluctant to provide any details and we now understand your employer was, until recently, your de facto.
- You have failed to provide any documentary or other evidence of the existence of the contents that were allegedly stolen e.g. receipts, operating manuals etc.
- There is independent evidence suggesting that the goods may never have existed. We attach a statutory declaration of a witness whose identity has been deleted for their privacy, however we will rely on this information should this be necessary at a later date.

Reason(s) for claim denial. Reference(s) to page numbers and section of policy in support of rejection decision. Section(s) of Insurance Contracts Act 1984 in support of rejection decision. If the evidence supports more than one basis for denial, they should all be set out in the letter.

AAMI has decided to refuse this claim on the basis that it is fraudulent pursuant to Section 56(1) of the *Insurance Contracts Act 1984.* In addition our interpretation of the facts as outlined above indicate that you are also in breach of your duty of utmost good faith under s13 *Insurance Contracts Act 1984.*

Accordingly your Home Contents Insurance policy will be cancelled within five (5) business days of the date of this letter and a refund of your premium will be sent to you shortly in accordance with ss 60 and 59 *Insurance Contracts Act 1984.*

Conclusion
Consumer Appeals paragraph. A Consumer Appeals brochure should be sent out with the letter. Offer an opportunity to the claimant to provide more information if appropriate.

If you are not satisfied with our response, you are entitled to have it reviewed at no cost to you by the AAMI Consumer Appeal Service, who will respond to you within 5 working days of receiving your telephone call, letter or e-mail. Your participation in this review process does not affect or compromise your entitlement to seek remedies elsewhere or to issue legal proceedings. Should you wish to exercise this right, please write to: The AAMI Consumer Appeal Service, PO Box 14180, Melbourne City Mail Centre, VIC, 8062 or facsimile (03) 9529 1214 or telephone 1300 130 794 **(9am – 5pm EST Monday – Friday)** or e-mail consumerappeals@aami.com.au.

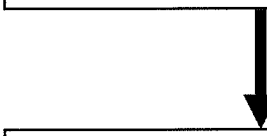
Sign off
'Yours faithfully' should be used in all letters. 'Yours sincerely' is only appropriate in less formal correspondence. A nominated manager must sign all denial letters.

Yours faithfully,

Annie Bolden
NSW Home Claims Manager

8 Cancellation and Refunds (Sections 59-60)

- **ONLY power to cancel comes from s60.**
- **Cancellation ONLY operates prospectively (ie in the future)**
- **Can ONLY avoid from inception if fraudulent misrepresentation s28(2)**



Step 1 – When?
AAMI can cancel a contract **prospectively** in the following cases:

- Breach of duty of utmost good faith. **s60 (1) a**
- Misrepresentation prior to entry into contract. **s60 (1) c**
- Failure to comply with term of contract. **s60 (1) d**
- Fraudulent claims. **s60 (1) e**
- Failure to notify of act/omission required by contract. **s60 (2) a**
- Contract allows AAMI to refuse claim because of act/omission of insured. **s60 (2) b**
- A cover note. **s60 (4) b**

Step 2 – How?
AAMI must give insured notice in writing s59 (1):

- By post to last known address. **s77 (1) b**
- Will be deemed to have been given at the time at which it would have been delivered in ordinary course of post. **s77 (2)**
- Notice needs to give at least 3 business days **after** the day the notice is received, for cancellation to take effect. **Ss59 (2) b and 2A (a) ii**

Step 3 – Reasons
s75 (1) b requires AAMI to provide a statement in writing setting out the reasons for the cancellation, if the insured requests it. It should be usual AAMI practice to provide that statement of reasons automatically in a notice of cancellation.

Cancellation and avoidance

- AAMI can **only** avoid a contract from inception (i.e. retrospectively) if it can establish fraudulent misrepresentation. s28(2)
- **All** other cancellations must be prospective – ie in the future. ss 59 & 60
- The **only** situations in which AAMI can cancel a contract are set out in s60.

Notice

The notice period should be reasonable. The notice is deemed to have been received by the insured in the normal course of the post (unless the insured can prove otherwise). s75(1)(b) In addition, we are required to give at least 3 business days from the day the notice is received before the cancellation takes effect. s59(2A)(a)(ii) This will usually mean AAMI should allow at least 5 business days from the date of sending the notice, before the cancellation will take effect.

Refund of premium

AAMI's usual practice is to refund the insured's entire premium even where we cancel the contract prospectively. This approach is consistent with our duty of utmost good faith and notions of good insurance practice.

It is a general principle of insurance law that once the risk has commenced, there can be no return of premiums paid; as soon as the insurer is on risk under a valid contract of insurance the premium has been earned.
[Booth v Police Benefit Fund (1931) 34 WAR 48]

Whether a refund is payable will depend on the terms of the contract. If the contract does not expressly provide for a refund, an insured would need to convince a court that there is an implied term based on industry practice. Fraud or wrongful act by the insurer would also give the insured the opportunity to get a refund of premiums.

AAMI's policies state that an insured can cancel the policy and we will refund the unexpired portion of the premium less processing costs. The *Financial Services Reform Act 2001* provides that a customer has a 14 day cooling off period during which time AAMI must refund the proportionate time left on risk less a processing charge (s1019B and Reg 7.9.67). As per the policy AAMI will continue to accept a customer cancellation outside the 14 day cooling off period on the same terms.

There is a difference between a cancellation and total loss payout. By making the total loss payment we have indemnified the policyholder to the maximum extent possible under the policy and our obligation is at an end. Therefore, there is no pro-rata premium to refund.

9 Risk Review (Sections 58-60)

Step 1 – When?
If AAMI decides that it will not offer renewal, it must:

- Provide a written notice to the customer [s58(2)];
- No later than 14 days **before** the day on which the policy will lapse [s58(2)];
- By post to last known address [s77];
- Ordinary course of post – add 2/3 days [s77];

If AAMI decides it will offer renewal it must send a renewal notice as above.

Step 2 – Format

- Should include full reasons [s75] - **s75 (1) b** requires AAMI to provide a statement in writing setting out the reasons why renewal is not offered, if the insured requests it. It should be usual AAMI practice to provide that statement of reasons automatically in a notice that renewal is not being offered;
- Signed by nominated manager;

Step 3 – Record Keeping
To prove compliance with Act requirements at FOS:

- Keep copy of each notice;
- Messaging of policy;

Risk Review

- These decisions will now be subject to CAS and, (from 1 January 2004) FOS review.
- List of non claim disputes in paragraph 4.3 FOS Terms of Reference.
- Still unclear how FOS will review these decisions although non-claims disputes will not be referable to FOS, if they relate to:
    - commercial judgment or policy;
    - assessment of risk;
    - the level of premium; or
    - rejection of an insurance policy, except where the dispute is that the proposal was rejected indiscriminately, maliciously or on the basis of incorrect information not provided by the insured. [FOS 4.4]
- FOS can order that insurance be offered; that premium rates be recalculated, that cancellation be reversed, that the insurer issue an apology or any other appropriate remedy. [FOS 10.2]
- FOS will have a 'fast track' system where appropriate – eg. customer not offered renewal. This will involve an FOS Case Manager attempting to conciliate a settlement between the insurer and insured. A resolution at this stage (and within 15 days) will cost $400. If it cannot be settled, it will be dealt with a standard dispute. Assuming it is less than $3000 in value, the cost to AAMI will be $800.
- CAS experience is that there is a large opportunity to reduce the number of appeals to CAS through better communication of the reasons for a decision.
- Will require process changes, including:
    - Sign off of letters by nominated managers;
    - Full explanation of basis for decision;
    - Alignment with Risk Review Guidelines;
    - Inclusion of CAS paragraph (see example letter);
    - Record keeping:
        - Will need to produce copy of letter sent to customer
        - May need to sign statutory declaration as to date the letter was posted
        - Will need to point to evidence supporting decision where relevant (guard against basing decision on incorrect, incomplete or out of date information).
        - Will need to message policy, including other contact with customer (eg. telephone advice).

Notice Requirements

- CAS experience is that we do not always comply with these requirements;
    - Must give 14 days written notice before policy due to lapse [s58(2)]. Telephone notice is **not** sufficient.
    - Must allow for normal post delivery of 2/3 days in addition to 14 days [s77].
    - Should include reasons [s75].
- If fail to comply (or fail to **prove** compliance):
    - New policy automatically comes into effect [s58(3)]
    - Customer pays **no** premium unless claim made [s58(4)]
    - AAMI can cancel at any time, without reasons but on notice [s60(4)(a) and s 59]

Common Issues

- Letters state we are not offering renewal due to 'driving history', when what we actually mean is that due to the number of claims IO has had, they fall outside our underwriting guidelines. Insureds think we are referring to traffic offences.
- General communication issues where we have not spoken to the insured prior to sending out the letter, to clarify whether these circumstances fall outside the guidelines;
- Inadequate explanation of reasons why renewal is not being offered.
- Not taking into account insured's history with AAMI – eg. long standing, number of policies.
- Relying on messages placed on policy or claim some time earlier, without checking current circumstances with customer.
- Not correctly applying guidelines – eg. number of claims over last 3 years, or driving offences.

Example letter: Risk Review

Important Note: This letter is to be used as an example only. All letters need to be drafted with specific regard to the individual facts of the particular matter.

Dispute Resolution and Dealing with CAS

Who's who at CAS

The table below lists contacts at the Consumer Appeals Service (CAS).

Contact Name	Contact Details
General	**Fax:** (03) 9529 1214 **Local call number**1300130794 **Customer e-mail:** [redacted]
Mark Richards – Executive Manager	**Phone:** [redacted] **Email:** [redacted]
[redacted] – Senior Dispute Resolution Officer	**Phone:** [redacted] **Email:** [redacted]
[redacted] – Senior Dispute Resolution Officer	**Phone:** [redacted] **Email:** [redacted]
[redacted] – Senior Dispute Resolution Officer	**Phone:** [redacted] **Email:** [redacted]
[redacted] – Dispute Resolution Officer (Wed & Thu)	**Phone:** [redacted] **Email:** [redacted]
[redacted] – Dispute Resolution Officer	**Phone:** [redacted] **Email:** [redacted]
[redacted] – Dispute Resolution Officer	**Phone:** [redacted] **Email:** [redacted]
Rob Hazell – Dispute Resolution Officer	**Phone:** [redacted] **Email:** [redacted]
[redacted] – Dispute Resolution Officer	**Phone:** [redacted] **Email:** [redacted]
[redacted] - Dispute Resolution Officer	**Phone:** [redacted] **Email:** [redacted]
[redacted] – Consumer Appeals Administrator	**Phone:** [redacted] **Email:** [redacted]

CAS Referral Paragraph

The wording below is to be inserted in all final decision letters.

If you are not satisfied with our response, you are entitled to have it reviewed at no cost to you by the AAMI Consumer Appeals Service, who will respond to you within 5 working days of receiving your telephone call, letter or e-mail. The AAMI Consumer Appeals Service is independent of this department and has the appropriate experience, knowledge and authority to carry out a review. Your participation in this review process does not affect or compromise your entitlement to seek remedies elsewhere or to issue legal proceedings. Should you wish to exercise this right, please write to: The AAMI Consumer Appeals Service, PO Box 14180, Melbourne City Mail Centre, Victoria, 8001, fax on (03) 9529 1214, telephone on 1300 130 794 (9 am – 5 pm EST Monday to Friday) or e-mail to consumerappeals@aami.com.au.

Rules for working with CAS

Decision making

1. A final decision in relation to a customer's claim is to be made by a nominated decision maker and detailed reasons for the decision provided.
2. Customers must be advised of their right to appeal to the CAS. The 'CAS Referral Paragraph' must be inserted in all final decision letters. CAS is also available to **third party motor claimants and third parties from whom AAMI is seeking recovery**.
3. If a customer requests that CAS review the matter and a final decision has not been made by the nominated decision maker, a final decision should be made within 2 business days and the customer and CAS advised of the decision. If a final decision cannot be made within that time, an explanation must be provided outlining why a decision cannot be made (for example, further information is required) and a clear timetable set for a decision, bearing in mind any other applicable timeframes (e.g. those set out in the Charter and the General Insurance Code of Practice).

File management

4. The file is to be forwarded to the CAS on the same day it is requested (CAS is subject to the 5 day response requirement for written enquiries as set out in the Charter and endeavours to review all disputes within a 5 day period).
5. The complete file must be forwarded and material on files should be kept in date order and include all correspondence, statements, reports, photographs and any other relevant material.
6. All telephone or personal contact in relation to a claim is to be detailed on CMS/PROTECT. Be aware that customers are in most cases entitled to printouts of messages, if requested. If the customer refers the matter to the FOS or takes court action, messages will usually have to be provided. Messages should report what was said rather than personal opinions or views of the operator.

See: Protect Messages Training.

7. CAS will seek any additional information/investigation required from the relevant State department. Any request should be acknowledged and action taken on the day of the request. Please keep CAS informed of any delays in obtaining the information.

CAS Determinations

8. CAS will consult with operations prior to making a determination to overturn or vary a decision.
9. If a determination overturns a decision made by operations, CAS will provide the relevant nominated decision maker with reasons. Monthly reports will summarise all overturned or varied decisions. Determinations are to be implemented within 5 working days.
10. Recommendations for ex gratia payments will be made by CAS in accordance with paragraphs 14.20 and 14.21 of the CAS Terms of Reference and Operating Guidelines

FOS Referrals

The External Dispute Resolution (EDR) section of Group Customer Relations (GCRU) prepares all 'Notices of Response' to FOS Referral Notices, rather than this being carried out by the relevant State department. The aim of this to ensure consistency and to capture learning from FOS determinations.

The following guidelines apply to FOS referrals:

- GCRU is the contact point for the FOS and has overall responsibility for preparation of submissions and ensuring compliance with FOS requirements.
- On receipt of a Referral Notice from the FOS, the EDR section will request the file from the relevant State department and it must be forwarded on the day it is requested. The file should be complete (see paragraph 5 above). It should be kept in mind that AAMI's Notice of Response must usually be filed with the FOS within 15 business days of receipt of the Referral Notice.
- An EDR dispute resolution officer will discuss any matters of concern that arise during the preparation of a Notice of Response with the manager of the relevant State department.
- An EDR dispute resolution officer may seek additional information from the relevant State department or request that further investigations be undertaken or reports obtained. Any request should be acknowledged and action taken on the day of the request. The EDR dispute resolution officer is to be kept informed of any delays in obtaining the information.
- The EDR section may, if necessary, seek additional information or obtain reports from other persons, such as expert witnesses. This will be done in consultation with the relevant State department.
- In appropriate cases the EDR section may recommend that

attempts be made to settle the dispute prior to determination by the FOS. In cases where settlement is recommended due to new information or material being provided by the customer in submissions to the FOS the matter will be referred to the dispute resolution officer who made the original IDR decision and he or she will decide, after consulting the relevant State department, whether to attempt to settle the matter. In cases where new information or material has not been provided, but settlement is recommended, the decision whether or not to settle the matter will be made by the relevant State department.

- Specialist Claims Managers or other staff will attend oral hearings in matters where an allegation of fraud is made.
- External solicitors will be used in complex or unusual cases, if this is considered necessary. An EDR dispute resolution officer will consult with the relevant State department before adopting this course.
- The EDR section will provide the relevant State department with a copy of the FOS determination.
- With FOS determinations in favour of the customer, the customer has 1 month to accept the determination and the FOS advises CAS once the determination is accepted. CAS will advise the relevant State department of the acceptance and the determination must implemented within 5 working days.
- A summary of all determinations will be provided in the CAS monthly report.

Procedural fairness and exchange of information

Documentation required

If a customer appeals an AAMI decision to FOS, the Terms of Reference of the FOS require the insurer to provide the customer with a copy of all documents the insurer wants FOS to take into account – clause 7.2.

In order to help a customer understand the basis of our decision and to avoid unnecessary appeals to FOS, it is important that relevant documents are provided to the customer at an early stage. Generally, when a final denial letter is sent, it should be accompanied by relevant expert or assessing reports that have been relied on. In some cases, copies of other material such as photographs or the customer's record of interview should be provided. If appropriate, identifying material can be deleted or extracts provided.

Underwriting guidelines

The FOS has made the point that these are 'guidelines'. When supporting a decision at FOS where guidelines are in issue, AAMI needs to do more than just point to the guidelines. In a number of areas, the guidelines give AAMI staff a discretion. AAMI must provide evidence as to how that discretion is applied. This would usually be through a statutory declaration from an underwriting manager that refers to

previous examples where the same decision had been reached in similar circumstances.

Special circumstances

The FOS will not rely on any material that has not been made available to the other party, unless it decides that special circumstances apply. There are limited examples of special circumstances.

- The first of these is legal professional privilege. This privilege will only arise where the document was predominantly prepared for the purpose of litigation and the only persons who should be privy to such information are the party's lawyers.
- Other circumstances include where the release of information might endanger a third party or it would compromise the insurer's investigation processes. Insurers have also been successful in arguing that certain material should not be available to customers where there is a fraud allegation and making the information available would enable the customer to tailor his or her evidence if he or she was in fact fraudulent.

The FOS has made a number of rulings about special circumstances and advises that:

- when providing examples supporting the application of underwriting guidelines, AAMI does not need to disclose the identity of those persons to the claimant and does not need to seek a preliminary ruling from FOS to delete names.
- AAMI need not provide its complete underwriting guidelines when only a portion is relevant to the decision.
- As a general rule, AAMI will not be required to disclose the names of, or particulars likely to identify, persons/third parties who are not directly involved in the issues for determination, in documents, reports or statements.

Ombudsman

The FOS Ombudsman will weigh the disadvantage done to the claimant in not having access to all the material, against the disadvantage to the insurer in not being able to take the claimant by surprise in cross examination in potential legal proceedings. AAMI pays a fee of $1,100 to have a FOS Ombudsman make a preliminary ruling about restricting access to a customer. Understandably, FOS will require a strong case to be made out before allowing AAMI to rely on material that is not disclosed to the customer.

ANNEXURE 3

AAMI National Catastrophe Response Plan

CAS Guide to managing Flood Claims

Home and Motor

Version number	Date	Amendment description	Approved by
1.0	October 2009	First issue	Mark Richards

In this document

Overview

This document has been prepared by the AAMI Consumer Appeals service and is based on decided court cases and FOS determinations. The legal and factual elements involved in a flood claim are complex and will require careful attention. This document provides an overview of:

- AAMI's Policy Wording concerning flood,
- General Insurance Principles,
- Initial action
- Evidence required, and
- The instructions we need to provide external assessors, hydrologists and investigators

AAMI's policy wording

Introduction

Take careful note of AAMI's policy wording and don't forget that the wording is not contained in the Landlord policies, which specifically cover flood as an insured event.

Wording in the AAMI home insurance policies

The wording contained in the AAMI home insurance policies is:

Yes *– the insured events you* ***are*** *covered for,*

No *– the conditions and exclusions that specifically apply to particular insured events.*

Yes	*No*
Storm *and* ***rainwater*** *including stormwater runoff from areas surrounding the site, or water escaping from any water main, drain, pipe, street gutter, guttering or surface.* ***Storm*** *means violent wind (including a cyclone or tornado), thunderstorm or a heavy fall of rain, snow or hail.*	*Damage or loss caused by* ***flood****.* ***Flood*** *means the inundation or covering of normally dry land by water which:* *escapes or overflows from, or* *cannot enter, because it is full or has overflowed, or* *is prevented from entering, because other water has already escaped or been released from it,* *the normal confines of any watercourse or lake, including any that may have been modified by human intervention, or reservoir, canal, dam or stormwater channel.* ***Flood does not*** *mean stormwater runoff from areas surrounding the site, or water escaping from any water main, drain, pipe, street gutter, guttering or surface.*

General Insurance Principles

Introduction

One of the general insurance principles to be aware of is the onus of proof.

Onus of proof

In accordance with reported case law and determinations from the Financial Ombudsman Service (the FOS) the onus is the insurer to prove that the flood exclusion applies and to obtain the necessary proofs.

The leading reported case is *Hams v CGU Insurance Ltd* 12 ANZ Insurance Cases 61-525 where the court found that the inundation resulted from storm water runoff as opposed to water escaping from a watercourse. A full report of the case can be accessed at http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/nsw/NSWSC/2002/273.html

The *Hams* case and numerous determinations and practice notes on the FOS website indicate the type and extent of evidence required. Staff members dealing with these type of claims should familiarise themselves with these. Given the serious consequences for the insured of a claim denial, the evidence relied upon needs to be of a high quality.

AAMI is required to prove with the use of factual and opinion evidence that the cause of the inundation of the insured property was the escape etc. of water from a watercourse in accordance with the policy wording and that the inundation was not storm water runoff from areas surrounding the site or water escaping from any water main etc.

Further considerations

If there is a possibility that there was an initial inundation resulting from stormwater runoff and a later inundation caused by flood waters, the level of water inside the property from both events needs to be established as AAMI is responsible for damage caused by the initial inundation, but not any additional damage caused by the subsequent inundation.

If there is a possibility that the water resulting in the inundation was a mixture of stormwater and flood water, the *Wayne Tank* principle should apply i.e. where the damage has two proximate causes, one of which is covered by the policy and other is subject to a policy exclusion, the exclusion applies to the whole of the damage and the insurer is not liable. Appropriate investigations should be undertaken to determine whether this has any application.

Initial action

Introduction

It is important to act as quickly as possible in storm/inundation claims. The customer is usually suffering considerable stress and in need of a decision on the claim as soon as possible. From AAMI's viewpoint it is important to obtain as much information regarding the inundation as possible, at an early date and whilst recollection of witnesses is fresh and the evidence on the ground is still there.

Instructing assessors, hydrologists and investigators

The usual course would be to instruct assessors initially and request that they report back as a matter of priority as to whether they believe the inundation may have been caused as a result of flood as defined in the policy. The assessors should be provided with the policy wording at the outset and templates for instructing hydrologists and investigators.

If the assessors believe the inundation may have been caused as a result of flood, they should be instructed to:

- Engage an hydrologist to commence investigations immediately.
- Instruct an investigator to work in conjunction with the hydrologist and conduct interviews with insureds and other witnesses,

with a view to obtaining the evidence set out in the next topic.

Evidence required

Introduction

There is variety of evidence that can be gathered by assessors, hydrologists and investigators.

Topographical information

Detailed evidence is required setting out the height above sea level of the insured property to prove the likelihood of water flowing from where it is likely to have escaped from the watercourse to the insured property. The relevant topographical maps relied upon need to be properly identified.

Maps & Diagrams

Showing the exact location of the insured property, the points where it is likely the water escaped from the watercourse, the distances and the likely path of the water.

Reports of previous flood events or flood studies

If reliance is placed on these they need to be properly identified and an indication given as to where a full copy of the report may be obtained. If the reports are not readily accessible, copies of relevant pages or extracts are to be provided.

Eyewitness accounts

As much eyewitness evidence as possible should be obtained. The FOS has indicated that statements from witnesses should be taken by experienced investigators, rather than hydrologists. Statements should be obtained from the insureds, owners of neighboring properties, local council officials, emergency organisations, police and others. Principally this should be factual in nature and include time of peak of inundation, direction of flow of water, colour of water, presence of debris and any other relevant observations.

Sometimes it will not be practical for an investigator to obtain a statement. In such cases, the assessor or hydrologist should make detailed contemporaneous notes of the conversation and obtain the name and address of the witness.

Consideration should be given to engaging an investigator at a later date to obtain a statement from a witness.

Observations of assessors, hydrologists & investigators

Obviously by the time they are able to attend, this may be limited, but if reliance is placed on any observations (i.e. nature of property damage) full details of the observations should be recorded in the report and photographs with identifying marks provided.

Continued on next page

Evidence required, Continued

Photographs & amateur videos	Where possible copies of these should be obtained. If this is not possible these should be viewed and notes taken of what they contain. The name and contact details of the person holding the material should also be obtained. Assessors, investigators and hydrologists should be required to provide as many photographs as possible to support their observations and these must be clearly identified.
Media reports	Consideration should also be given to utilizing media reports.

Letter templates for external assessors

Introduction

When instructing external assessors to deal with storm/inundation claims there is a template letter for staff to use that provides the assessor with:

- General Information
- General Insurance Principles
- Requirements for their preliminary report

In addition, if an external assessor needs to instruct either a hydrologist or investigator there is a template letter for them to use that provides the hydrologist and investigator with details of the information that AAMI require.

Continued on next page

ANNEXURE 4

THE FINANCIAL OMBUDSMAN SERVICE

circular

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Flood claims

Home and contents insurance policies: storm and flood claims

Not all home and contents type insurance policies cover damage caused by the flooding that may be created as a result of a significant storm. This is primarily because some policies cover 'rain' water but not 'flood' water. Rain water damage and flood water damage are not the same.

Disputes about whether a home and contents insurance policy covers the insured for loss or damage caused by water entering a home after a storm raise some common issues which the Financial Ombudsman Service (FOS) must assess.

Policy wording

The first question we consider is: What words are used to create any exclusion for flood or storm damage in the policy?

We look at:

- the certificate of insurance, and
- the policy document/product disclosure statement.

If an exclusion for flood or storm water damage exists, it should be set out in these documents.

Storm damage

Although there is no standard definition of 'storm', we generally take the view that a home flooded by rain water would normally be regarded as storm damaged.

If the policy covers 'storm' damage and the dispute is clearly about damage caused to a home flooded by rain water, we will then consider the extent of the cover for storm damage.

Flood damage

There is no standard definition of 'flood' damage in home and contents insurance policies.

Sometimes flood damage caused by rain water is included in the policy definition but other forms of flood water are excluded. The source of the water which flooded the home and caused the damage may become a critical factor as to whether or not the damage is covered under the policy.

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Did the insurer (FSP) 'clearly inform' the insured that the policy does not provide flood cover?

Where a policy does not provide cover for flood damage, we will assess whether the FSP clearly informed the applicant that the policy did not extend to flood cover. This is because a general insurer is under a legal obligation to 'clearly inform' their customers of an exclusion in the insurance policy relating to flood damage.

When an FSP fails to comply with this requirement, the insurance contract (ie policy) becomes a legislatively 'prescribed contract'. That means certain terms become a part of the policy cover even though they were not in the policy itself. Flood damage is covered under a 'prescribed contract', therefore an FSP may be come liable for flood damage suffered notwithstanding the policy was not intended to cover flood damage.

In most cases an FSP will fulfil its responsibility to clearly inform the insured of the exclusion if it:

- provided the policy outlining the exclusion to the insured prior to the insured suffering the loss as a result of flood damage, and
- the policy exclusion for flood damage is clear and unambiguous.

What caused the damage?

If 'flood' water damage is excluded under the policy, then FOS will assess information about the cause of the damage.

We will ask was the water that entered the home and caused all of the damage:

- 'rain' water and therefore the damage may be covered by storm damage provisions of the policy, or
- 'flood' water and therefore the damage may not be covered by the policy because of the flood damage exclusion,

or did a mixture of both 'rain' and 'flood' water cause the damage? In this situation, we would assess:

- was it 'rain' water that *first* entered the home and caused all of the damage in which case all of the damage may be covered by the policy, or,
- was it 'rain' water that *first* entered the home and caused part of the damage followed by 'flood' water which caused further damage, in which case part of the damage may be covered by the policy and part may not.

When the damage is effectively caused by two concurrent causes, and one cause is covered under the policy (eg rain water damage) and the other cause is excluded (eg flood water damage), the courts have held that the FSP is entitled to deny liability.

However, where rain water first floods a home, followed by flood water at some later stage, the damage caused by the initial rain water will be covered provided this damage can be separated from the subsequent flood water damage. It is a question of what is the dominant or proximate cause of the damage.

Example:
The storm damage to the home was caused by a mixture of flood water and rain water. The information available established that the flood water formed about 5% of the water in the house. This was partly because the flood water was too low to enter the home and could not have caused damage on its own.

Result:
We found that rain water was the proximate or dominant cause of the damage because the flood water had a minimal or insignificant contribution to the loss.

Who has to prove how the damage was caused?

The insured has the onus of establishing, on the balance of probabilities, that they suffered damage caused by an event which was within the policy. This could be that the damage was caused by a storm (rather than a flood).

If the insured establishes that, on the face of the facts, the damage was caused by an event which was within the policy, the onus shifts to the FSP to prove, on the balance of probabilities, the claim falls within a policy exclusion. This could be that the damage was caused by a flood (rather than a storm).

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Hydrologist's report

In some cases, the cause of the damage is clear, such as when water from a fast flowing river breaks its banks and enters a home built on the bank. The subsequent damage is most likely flood damage, not storm or rain water damage.

However, where the cause is less clear because of a combination of events, an expert report, normally provided by a hydrologist, may assist to establish whether the origin of the water is flood water or rain water, and therefore whether or not the damage is covered by the policy.

FOS takes into account a hydrologist's report to assess issues such as:

- the amount of rainfall that fell prior to the time when a creek or river broke its banks,
- where the creek/river broke its banks, and
- the path the flood water took from the time it broke its banks until it reached the home.

In some cases FOS, with the agreement of the parties, will appoint an independent hydrologist to report on the damage.

Often it is necessary for FOS to attend the location with the parties and hydrologists to gain a complete picture of the events leading to the claim.

Other information

Other information FOS would consider in assessing the source of the water depends on the facts of a case but could include:

- photo or video footage establishing that rain water entered the home, or
- eye witness accounts.

It is up to both parties to provide information about the source of the flooding so an assessment can be made by FOS based on all of the available information.

FOS may make additional inquiries of both the FSP and the insured in order to satisfy itself as to whether the events fall within the policy or within one of the exclusions of the policy.

Only when FOS is satisfied it is in a position to make a determination will a written determination be made.

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