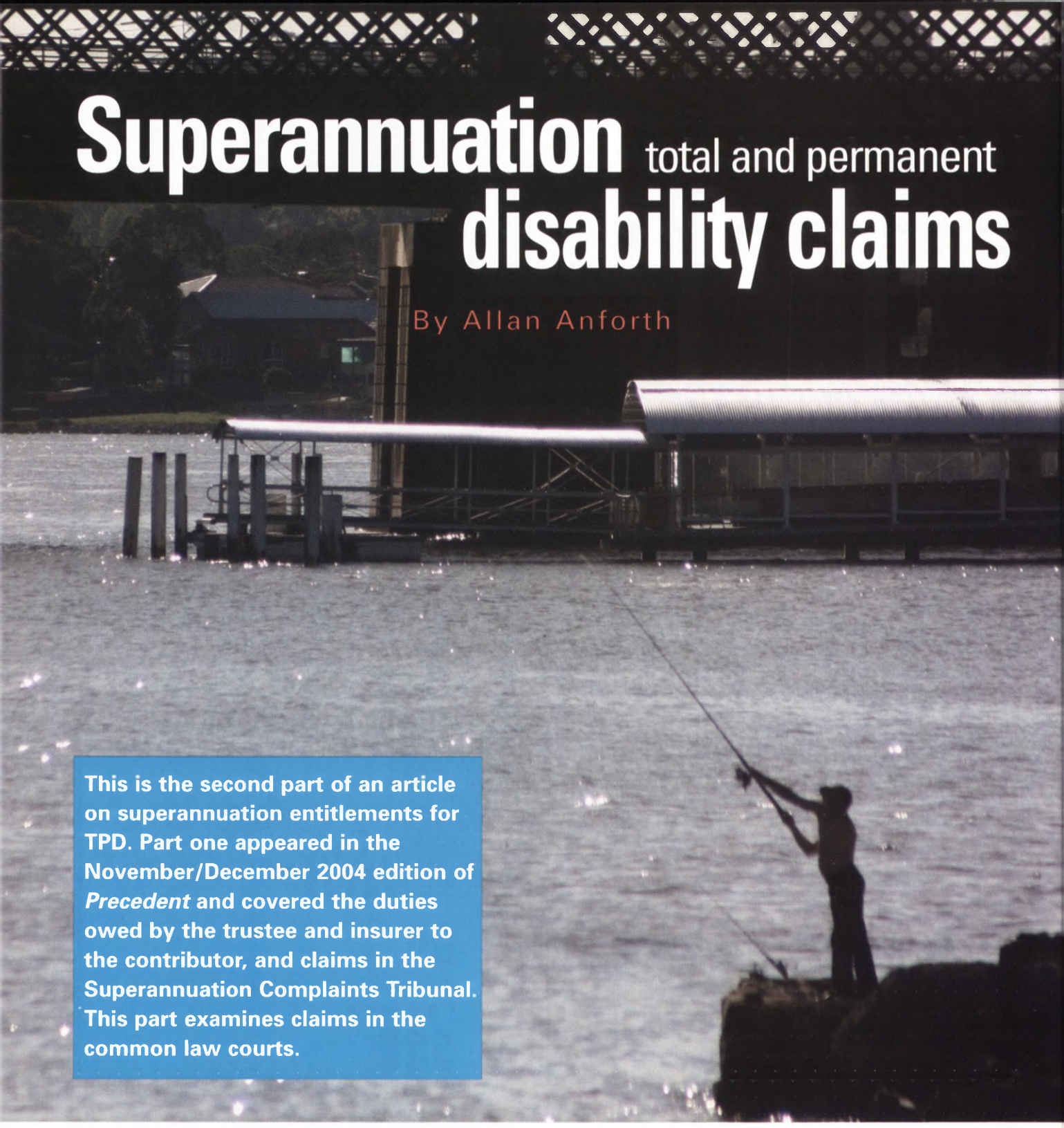
Superannuation total and permanent disability claims

By Allan Anforth



This is the second part of an article on superannuation entitlements for TPD. Part one appeared in the November/December 2004 edition of *Precedent* and covered the duties owed by the trustee and insurer to the contributor, and claims in the Superannuation Complaints Tribunal. This part examines claims in the common law courts.

As a general proposition, contributors are better served in exercising their access to the Superannuation Complaints Tribunal (SCT), rather than pursuing common law actions. This is because the SCT's powers are broader, and the process is quicker and less expensive. Nevertheless, sometimes no choice exists – for example, where the contributor is out of time to lodge in the SCT and there is no option other than to consider a common law action.

REVIEW IN THE COMMON LAW COURTS

An aggrieved contributor does not have to bring their claim in the SCT, but can bring their claim against the trustee and insurer in the supreme court (or district or county court) based on a breach of duty owed to them by the trustee and insurer in the context of their respective contracts. These duties were described in the first part of this article (*Precedent* 65, November 2004).

Proceedings in the courts need to be pleaded in the nature of a breach of contract rather than in debt; both the

trustee and insurer should normally be named as defendants, with separate causes of action pleaded against each. Until such time as the trustee makes a decision finding that the criteria for total and permanent incapacity (TPI) are satisfied, no benefit is payable and hence no debt is owing.[1]

A common law action is an action in contract based on the alleged breach of the fiduciary duty owed by the trustee and breach of contractual and statutory duties by the insurer. In order to succeed, the contributor must show that the trustee/insurer have not assessed the claim reasonably or genuinely. This may arise due to a failure to properly construe the policy, a failure to take account of relevant considerations/evidence, or an unreasonable approach to the weighing of the evidence even if falling short of the 'Wednesbury' sense of unreasonableness. In a practical sense, this is not greatly different to the exercise that would be undertaken by way of judicial review. However, in *Hay v Total Risk Management P/L* Burchett J noted that the trustee is expected to exhibit a higher standard in the discharge of their fiduciary duties.[2]

In *McArthur v Mercantile Mutual Life Insurance Co Ltd*, the Queensland Court of Appeal considered extensively the nature of the cause of action against insurers. The majority was formed by McMurdo P and Muir J, with McPherson J agreeing with the outcome but for different reasons. Muir J (with whom McMurdo P concurred) had the following to say:

> *'There is thus a substantial body of authority in support of the conclusion that where, as in this case, payment is dependent on the formation by a party to a contract of an opinion as to the existence of a state of affairs and the opinion is not duly formed through the fault of that party, the court may proceed to decide, as a question of fact, whether such state of affairs exists. Having made a determination in favour of the insured the court may then order payment of the sum which, would have been payable had the insurer's opinion been duly formed in favour of the insured. That is the course the primary judge took in this case and, not without some misgivings, I accept that it was correct. Some further support for this approach is to be found also in the reasons of the members of the House of Lords in Beaufort Developments. (N I) Ltd v Gilbert-Ash N I Ltd.'*[3]

In proceedings before a court as opposed to the SCT, there is a real issue as to whether medical evidence obtained subsequent to the trustee's and insurer's decision is admissible, in so far as the court is reviewing the fairness or reasonableness of the trustee's decision rather then hearing a de novo review on the merits. In *Caponi v National Mutual Life Association*,[4] *Bannister v National Mutual Life Association and State Fire Commissioner*,[5] and *McArthur*, the court admitted the evidence to the extent that it reflected on the state to TPI at the date of cessation of employment. The full court of WA took a different view in *Tonkin* and declined to allow any new evidence.[6]

The Court of Appeal in Queensland in *McArthur v Mercantile Mutual Life Insurance Co Ltd* took the view that medical evidence from later in time, which has the benefit of hindsight, would be preferred to speculative prognoses from earlier in time.

In the case of TPI claims, the federal court in *CARE v Bishop*[7] made the point that the medical evidence is usually fairly clear as to whether a person is TPI or not, and a failure to find for the employee by the insurer or trustee on clear evidence is a basis for setting aside their decisions.

THE TOTAL AND PERMANENT INCAPACITY/DISABILITY TESTS

There is no one standard test, as each insurance company is entitled to insert its own definition in its own policy. Nevertheless, there is a degree of commonality.

The first point of commonality is that all policies require that the contributor become TPI during the currency of the policy and not afterwards. This is important. When a contributor is injured, it is common for his/her employment to be terminated by reason of his/her inability to carry out the inherent requirement of his/her job. The injury may have happened at work and have given rise to a workers' compensation claim, or it may have happened outside work. It is of no consequence to superannuation policies. But there is an important distinction between suffering an 'injury' and being 'totally and permanently incapacitated/disabled'.

A contributor can have his/her services terminated by reason of an injury without at the time having reached the point of being totally and permanently incapacitated. Superannuation policies lapse on the termination of an employee's services.

However unfair it may be, all policies that the author has read require the contributor to become totally and permanently incapacitated before the termination of employment, or within a defined period (for example, 60 days) after termination of employment if the injury occurred during the employment. For this reason, it is essential that all medical evidence addresses the issue of the contributor's state of health at the time of the termination of his/her employment. This principle is most clearly enunciated in *Bannister v National Mutual Life Association and State Fire Commissioner*.[8]

The test of 'permanency' in a TPI claim is generally couched in terms of being 'unlikely' to ever engage in work for which the contributor is fit, having regard to their previous experience and training. This test requires the contributor to establish only that it is more likely than not that they will never work again in suitable employment (*White v Public Sector Superannuation Scheme, Constantides v Du Pont Superannuation Fund P/L*, and *Davis v Rio Tinto Staff Superannuation Fund*).[9] It is relevant to consider both the degree of impairment of the contributor as well as their capacity to attract an employer (*Munios v Johnson and Johnson Retirement Benefits Ltd and Rio Tinto*).[10] However if, on the evidence, their condition is likely to improve to the point where the contributor no longer satisfied the TPI test, then the condition is not permanent.

The definition of TPI in policies is generally couched in one of two forms; that is, in terms of: >>

1. an incapacity for remunerative employment as a whole; or
2. an incapacity for a specified range of duties of their normal employment.

Policies couched in terms of an incapacity for remunerative employment as a whole entail a consideration of both:

1. the contributor's physical and mental capacity to carry out the work; and
2. the contributor's capacity to attract an interested employer.[11]

In applying clauses of this nature, two divergent views have been taken by the court. One view takes a broad view as to whether the contributor is able to attract an employer in a practical sense, even though they may be fit for some activities.[12]

In other cases, a stricter view has been taken in which the contributor must be unfit for all duties of potentially suitable employment and the capacity to attract an employer in a practical sense is not accorded much weight.[13] For example, in *Cavill*, the Full Supreme Court of South Australia said that a capacity to undertake light duties in the contributor's area of employment was sufficient to defeat a claim.[14]

WORDING OF COMMON DEFINITIONS OF TPD

The use of the word 'any' prior to remunerative employment usually suggests that a capacity for part-time as opposed to full employment may be enough to disqualify the contributor from benefits. Generally, an unqualified reference to the contributor's employment is taken to refer to full-time employment (*Wyllie*[15] and *Chammas*), but ultimately it depends on the wording of the policy clause (*Szuster*).

Where the TPI test is couched in terms of an incapacity for a designated range of duties, the precise wording of the section will be crucially important. One common form of the test requires the contributor to be permanently unable to perform 'each and every normal duty', or words to the same effect. Under this test, if the contributor can perform just one of the duties of his or her occupation, then his or her claim fails, even though s/he may not be able to perform sufficient of the duty to be able to carry out the occupation as a whole.[16]

In *QBE Insurance Ltd v Jande*,[17] the NSW Court of Appeal considered a definition of 'total disablement', which requires that the insured was prevented *from carrying out all the normal duties of his or her usual occupation, profession or business*. The insured ran a café and the evidence was to the effect that he could do some, but not all, of the normal duties of that occupation. The court construed the provision such that if the insured could do just one of the normal duties, then he did not qualify for total disablement. In so doing, the court noted the unfairness and also the presence of a partial disablement clause in the policy that would come to the insured assistance.

In *Ibrahim v Greater Pacific Insurance Co Ltd*,[18] Brownie J in the NSW Supreme Court considered a policy that defined 'total disability' as being 'unable to perform any of the major duties of your regular occupation'. Brownie J took the view that the ability to do a major duty for half an hour a day was not within the contemplation of the parties and did not disentitle the insured.

In *R v Fairclough*,[19] the court considered a policy referring to each and every duty in relation to an incapacitated solicitor. The majority affirmed the decision of the primary judge to apply *Jande*, to the effect that if the insured can do any of the duties beyond an insignificant level, then he or she is not totally disabled.

In *National Australia Bank Ltd v Zollo*,[20] the Full Supreme Court of South Australia. considered a policy which defined total disablement in terms of an inability *from carrying out all the normal duties of his usual occupation*. The court followed *Jande*, and equated the test in *Jande* to the *each and every* test in *Fairclough*. The insured was a master builder whose usual occupation consisted of administrative/investment work and building. The evidence was to the effect that while he could not build, he could do the administrative work. He was found not to be totally disabled.

Policies often distinguish between 'injuries' and 'disease/sickness/illness' and provide for different levels and types of benefits. Policies almost never define these terms in any meaningful way, except that sometimes an 'injury' is defined in terms of 'occurring by accident', or by 'violent and external cause', or words to that effect.

The distinction between 'injuries' and 'disease/illness/sickness' is one that is well known to the law of workers' compensation. The law on this matter was been considered by the High Court in *Zickar v MGH Plastic Industries P/L*;[21] and by the Full Federal Court in *HIC v Van Reesch*[22] and *Australian Postal Commission v Burch*.[23] *Zickar* was determined in relation to the NSW *Workers' Compensation Act* 1987; *Van Reesch* was determined in relation to the *Compensation (Commonwealth Government Employees) Act* 1971; and *Burch* in relation to the *Safety Rehabilitation and Compensation Act* 1988.

In *Zickar*, the High Court held that a condition is the result of an injury as opposed to a disease where the condition, physical or mental, results from the impact or effect of some external stimuli on the body, whereas a disease is characterised as being the progression of an autogenous condition of the body. See also the majority of the High Court in *Australian Casualty Co Ltd v Federico* to the same effect, where it was said:[24]

> *'One would prima facie expect that "injury" would include any physical damage to the human body sustained as the identifiable result of a traumatic occurrence such as the external application of force or the internal application of pressure generated by personal exertion and that "sickness" would include bodily disorder sustained otherwise than as the identifiable result of a traumatic occurrence, such as sickness or disease contracted as the result of a contagion or the operation of natural causes such as old age congenital or insidious disease or the natural progression of some constitutional physical or mental defect.'*

The leading authority on the whether an injury has occurred by 'accident' is the High Court in *Australian Casualty Co Ltd v Federico*.[25] In Federico, the majority said that an injury can occur by accident in one of three ways:

1. It may occur independently of the person by some external impact – for example, a building falling on the person;
2. It may occur as the result of the injured person's own mistake or misjudgement, including involuntary acts by the injured person – for example, slipping on stairs; and
3. It may represent the unintended and unexpected consequence of an intended act, such as the application of unintentionally excessive force or the creation of an unintentionally excessive pressure or strain.

CONCLUSION

Solicitors tend to commence superannuation TPD claims in the >>

common law court, driven by a lack of familiarity with the SCT and the belief that better costs are available to the successful solicitor in the common law action. Solicitors should be aware that many claims fail – with cost implications for the client. Indeed, it is arguable that solicitors who bring claims in the common law courts when the SCT option is still available are acting contrary to the interests of their clients. Accordingly, care needs to be exercised not to allow the tight time lines for lodging claims in the SCT to lapse. ■

Notes: **1** In *McArthur v Mercantile Mutual Life Insurance Co Ltd* 2001 QCA 317 at [59]. **2** *Hay v Total Risk Management P/L* 2004 NSWSC 94. **3** *McArthur v Mercantile Mutual Life Insurance Co Ltd*, at [72]. See also *HCF Life Insurance Co P/L v Kelly* 2002 WASCA 264 to the same effect. **4** Unreported SC WA 12/9/88. **5** Unreported SCTAS 9/10/90. **6** *Tonkin v Western Mining Corporation Ltd* (unreported CA WA 20/4/98). **7** Unreported 12/2/98. **8** Unreported SCTAS 9/10/90. **9** Unreported SC NSW 21/2/97; *Constantides v Du Pont Superannuation Fund P/L* 2002 FCA 534; *Davis v Rio Tinto Staff Superannuation Fund* 2002 FCA 376. **10** Unreported SC NSW 5/12/96 and *Davis v Rio Tinto*. **11** *Munios v Johnson and Johnson Retirement Benefits Ltd* (unreported SC NSW 5/12/96); *Chammas*; *Cavill Power Products P/L v Royle* 1991 42 IR 229; *Szuster v HESTA Aust Ltd* 2000 SADC 2; *Thompson v Armstrong and Royse P/L* 1950 81 CLR 585; *Arnott's Snack Products P/L v Yacoub* 1985 155 CLR 171; *Ruiz v Canberra Rex* 1974 5 ACTR 1; and *Moran Health Care Services v Wood* (NSW CA 96040195 18 April 1997). **12** *Allan v National Mutual Life Association* 1993 9 SR (WA) 68; *Giles v National Mutual Life Association* 1986 4 ANZIC 60-751; *Allessi v National Mutual Life Association* 1982 2 ANZIC 60-481; *Tillotson v ANZ Life Assurance* 1986 17 SR (WA) 34. **13** *Dufty v City Mutual General Insurance* 1977 QD 94; *Riley v National Mutual Life Association* 1986 4 ANZIC 60-584; *Bannister*. **14** *Cavill Power Products P/L v Royle* 1991 42 IR 229. **15** *Wyllie v National Mutual Life Association* unreported SC NSW 18/4/97. **16** *QBE Insurance Ltd v Jande* 1995 ANZIC 61-270; *National Australia Bank Ltd v Zollo* (No.2) (unreported SCSA 21/3/97); *Ibrahim v Greater Pacific Insurance Co Ltd* 1996 ANZIC 61-330; *R v Fairclough FSC of SA* (unreported 12/9/96). **17** 1995 ANZIC 61-270. **18** 1996 ANZIC 61-330. **19** 1996 FSC of SA (unreported 12/9/96). **20** (No. 2) unreported SCSA 21/3/97. **21** (1996) 187 CLR 310. **22** (1996) 24 AAR 81. **23** 1998 944 FCA 5/8/99. **24** 1986 160 CLR 513. **25** 1986 160 CLR 513 (see also the Full Supreme Court of WA in *Tillotson v ANZ Life Assurance Co Ltd*).

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