TOTAL AND PERMANENT DISABILITY IN SUPERANNUATION

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Date: 27 October, 2017

FOLEY'S LIST

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TOTAL AND PERMANENT DISABILITY IN SUPERANNUATION: UNDERSTANDING THE PROCESS, SUBMITTING STRONG CLAIMS AND CHALLENGING REJECTIONS

Presented at the Foley's List and Geelong Law Association Annual CPD day 27 October 2017

1. A Total and Permanent Disability claim is not a claim for personal injury. It is a claim for breach of contract by an insurer and breach of trust by a superannuation trustee. The approach you take to preparing the claim is therefore fundamentally different.

Understanding the process

2. Unlike a personal injury claim, it is not enough simply to present enough medical evidence to convince the court, on the balance of probabilities, that the claimant cannot work or that the claimant is seriously injured. Rather, you need to:

   2.1 Check that the claimant had appropriate cover at the relevant time.

   2.2 Collect and submit evidence that addresses every aspect of the definition of total and permanent disability.

   2.3 When a claim is rejected, consider:

      (a) Whether the trustee and/or the insurer has breached any of their duties in assessing the claim; and

      (b) Whether it is preferable to submit further evidence and seek reconsideration before issuing proceedings.

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A typical definition

3. The definition of total and permanent disability varies from policy to policy. It is essential to consider the words of the particular definition you are dealing with. However, a fairly typical example taken from the recent case of *Hannover Life Re of Australasia Ltd v Jones*: [1]

> **What is Total and Permanent Disablement?**
>
> *Total and Permanent Disablement in respect of an Insured Person who was gainfully employed within the six months prior to the Date of Disablement is where:*
>
> > *the Insured Person is unable to follow their usual occupation by reason of accident or illness for six consecutive months and in our opinion, after consideration of medical evidence satisfactory to us, is unlikely ever to be able to engage in any Regular Remunerative Work for which the Insured Person is reasonably fitted by education, training or experience*
>
> **Date of Disablement**
>
> > *Total and Permanent Disablement is treated as having occurred on the Date of Disablement which is the earlier of:*
> >
> > *(a) the date on which the six (6) months consecutive inability to work that results in Total and Permanent Disablement began; or …*
>
> **Regular Remuneration Work** *[sic]*
>
> > *an Insured Person is engaged in regular remunerative work if they are doing work in any employment, business or occupation. They must be doing it for reward – or the hope of reward – of any type.*

Understanding the process

4. Once you have established that there is cover, there can be pressure from the client to make an application or issue proceedings quickly. However, it is a mistake to apply for benefits or issue proceedings with insufficient material with a view to improving the evidence later.

5. First, putting in a strong claim from the beginning avoids the insurer forming an entrenched view that the client is not entitled to the benefit. Once a denial is made, it can be difficult to shift the insurer's position later even with further evidence.

6. Second, issuing proceedings on insufficient evidence is likely to result in the proceeding having poor prospects of success. This is because, unlike a personal injuries claim, the

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[1] *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [21].

plaintiff cannot succeed simply by establishing on the balance of probabilities that they meet the definition. As demonstrated by the sample definition from *Jones* above, the plaintiff's right to the benefit usually rests not on an objective assessment of the evidence but on the insurer having formed the opinion that the plaintiff is so entitled.

7. The court must therefore engage in a two-step process:[2]

7.1 First, the court must determine whether the insurer or the trustee has breached one of the duties it owes to the plaintiff.

7.2 Second, if and only if a breach is established, the court may then determine for itself whether the plaintiff meets the definition.

What are the duties?

8. The trustee and the insurer have different duties.

9. Equity imposes on a trustee duties to:

9.1 Act in good faith;

9.2 Give real and genuine consideration to the claim, including considering the correct question;

9.3 Exercise powers in accordance with the purposes for which they were conferred;

9.4 Where reasons are disclosed, act upon sound reasons; and

9.5 Act reasonably.[3]

10. Importantly, the duty to give real and genuine consideration to the claim includes a duty to make inquiries for relevant information to seek to resolve conflicting bodies of material.[4]

11. Section 52 of the *Superannuation Industry (Supervision) Act 1993* also relevantly imposes

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2 *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [86].
3 *Telstra Super Pty Ltd v Flegeltaub* (2000) 2 VR 276, [26].
4 *Finch v Telstra Super Pty Ltd* (2010) 242 CLR 254, [66]; *Alcoa of Australia Retirement Plan Pty Ltd v Frost* (2012) 36 VR 618 [47] to [54]; *Telstra Super Pty Ltd v Flegeltaub* (2000) 2 VR 276, [30].

duties to:

11.1 Act honestly in all matters concerning the fund;

11.2 Exercise the same degree of care, skill and diligence as a prudent superannuation trustee would exercise;

11.3 Perform its duties and exercise its powers in the best interests of the beneficiaries;

11.4 Do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success.

12. The insurer's duties have their origin in s 13 of the *Insurance Contracts Act 1984 (Cth)* which imposes on the parties to an insurance contract a duty to act towards each other in utmost good faith. This requires the insurer to have due regard to the interests of the insured as well as its own interests. The most common ways that insurers have been found to have breached this duty in the TPD context is by:

12.1 Failing to consider and determine the correct question;[5]

12.2 Failing to allow the claimant an opportunity to address adverse material upon which it proposes to base its decision (such as surveillance material);[6]

12.3 Adopting an unreasonable decision-making process;[7]

12.4 Forming an opinion that was not open to an insurer acting reasonably and fairly;[8]

12.5 Failing to make a determination within a reasonable time.[9]

How does the two-step nature of the cause of action affect your initial preparation of the claim?

13. When preparing the claim, it is essential to keep the two-step nature of the court's task in mind from the outset. This is because in determining whether any duty has been breached, the court is limited to considering the material that was before the insurer or trustee at the

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5 *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [5] and [65]-[67].
6 *Beverly v Tyndall Life Insurance Co Ltd* (1999) 10 ANZ Insurance Cases 61-453 , [12]-[15] and [88]-[93]; *Hanover Life Re of Australia Limited v Sayseng* [2005] NSWCA 214, [85].
7 *Hellessley v Metlife* [2017] NSWSC 1284, [116].
8 *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [121].
9 *Hellessley v Metlife* [2017] NSWSC 1284, [116], [775].

time the decision was made. Evidence gathered later is relevant only to the second step.[10]

14. If you have issued proceedings on insufficient material, the plaintiff may fail at the first hurdle and the court will never come to consider the new evidence. It will be difficult to establish that an insurer has formed an opinion not open to an insurer acting reasonably and fairly if the material before the insurer is equivocal. You need to ensure that the weight of the evidence is firmly in your client's favour before you issue proceedings. If the evidence is equivocal, it may be wise to collect better evidence addressing the insurer's reasons specifically and seek reconsideration.

15. On the other hand, where there has been a very clear breach of duty by the insurer, it may be tactically better to issue proceedings without seeking reconsideration. This is because once the claimant seeks reconsideration based on new evidence, they may lose the right to complain about the previous decisions.[11] Seeking reconsideration may allow the insurer an opportunity to patch up its decision so as to deny the plaintiff access to the second step in the court's decision making process.

16. Even where there is a clear breach, you need to make sure that there is enough evidence before the court to satisfy the judge that the plaintiff meets the definition. There have been cases where a plaintiff has established a breach of duty based on the procedure the insurer adopted, but failed on the second limb because the substantive evidence did not establish that the plaintiff met the definition.[12]

Checking the claimant's cover

17. Do not assume that a claimant has cover simply because an amount of cover is shown on their superannuation statement. Despite premiums being deducted by the trustee, the claimant may not have cover at all, or may have only limited cover for death but not disability. For example:

    17.1 Many policies limit cover to Australian citizens or permanent residents only. Those on temporary visas may not have cover. It is particularly important to check this where the client is from overseas.

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10 *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [68].
11 *Hellessley v Metlife Insurance Ltd* [2017] NSWSC 1284, [792].
12 *Birdsall v Motor Trades Association of Australia Superannuation Fund Pty Ltd* [2014] NSWSC 632.

17.2 TPD cover is also often dependent on the claimant having been in 'active employment' at the date that they became a member of the fund or at the date the policy commenced (whichever is later). This usually means that they were working or able to work a minimum number of hours per week in their usual occupation without limitation by injury. It is particularly important to be mindful of this if the client has had a long term injury or been on modified duties for many years.

17.3 TPD cover is also usually limited to those working a minimum number of hours per week, or working for particular employers at the date of their disablement. For example, the introductory words of the definition extracted above from *Jones* applies only to a person 'who was gainfully employed within the 6 months prior to the date of disablement'. Some policies (particularly those issued to industry specific or employer specific superannuation funds) will cut off cover within a few weeks of the person ceasing to be employed by a participating employer, even if they are working for a different employer. It is particularly important to check this if the client was injured during a period where they were not working or had recently changed jobs.

18. It is therefore important to ask the fund to provide the full insurance policy before you commence the claim. There is no point spending time and costs gathering evidence only to discover months or years through the process that there was never any cover.

Satisfying the first limb

19. The sample definition from *Jones* above is typical in that it has two 'limbs'. The first limb is usually known as the 'waiting period'. It requires the claimant to have been '*unable to follow their usual occupation by reason of accident or illness'* for a certain period of time. Other more stringent definitions require the person to be 'unable to work' in any occupation.

20. Many people gloss over this part of the definition because in the case of sudden injuries, it is often obvious. However, it is important that there is medical evidence to support this inability to work especially where the injury has occurred outside a Workcover or TAC context and there are not readily available certificates of capacity.

21. Check your client's GP records to ensure that there is evidence that they have been getting medical treatment during this waiting period. A total absence of any medical advice or

treatment makes it difficult to establish that they were unable to work 'by reason of accident or illness'.

22. Also ensure that you get evidence about why the client ceased employment. Most definitions will require a causative link between ceasing work and the illness or injury.

22.1 If the client was terminated because they could no longer perform their duties, then it is easy to establish this causative link.

22.2 However, if the client took a voluntary redundancy, you may need to provide further evidence of the link. For example, a client may have been on modified duties for some time but then took a redundancy because they could no longer cope with those duties. You should submit a statement from the client explaining this.

22.3 Even in the case of an involuntary redundancy or termination for reasons other than illness, it may still be possible (depending on the words of the definition) to fit within the first limb. For example, if a person was on modified duties and then made redundant, it can be argued that they are 'unable to follow their usual occupation by reason of accident or illness' because their illness prevents them from getting another job within their usual occupation that will accommodate their restrictions. However, some definitions are more restrictive and require the person to be 'unable to work'. This means that they must be unable to do any occupation or employment recognised in the community.[13]

Satisfying the second limb

23. Most claims will stand or fall based on the second limb of the definition. In preparing the claim, it is essential to gather evidence that addresses each aspect of the second limb specifically. Unless the injury or illness is clearly catastrophic, it is not sufficient to rely solely on reports prepared for Workcover or TAC purposes because they do not address the correct issues.

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[13] See for example *Hannover Life Re of Australasia Ltd v Colella* [2014] VSCA 205.

23.1 Workcover or TAC reports are often focussed on finding the cause of the injury. This is usually not relevant to TPD.

23.2 Impairment assessments or Medical Panel determinations focus on whether there has been a 'serious injury' but do not really shed any light on the ability to work. A person can, depending on their qualifications and experience, have a serious injury but still be able and likely to work in another role.

23.3 Workcover reports are often concerned with whether a person can do modified duties in a context where the employer is required to provide such duties. If a person is no longer employed, the duties they may be able to do may not amount to a recognised occupation or they may be so restricted that no other employer would hire them. The TPD definition is not concerned with whether a person is physically able to perform certain tasks, but whether they are able to perform an occupation recognised in the community.[14]

'Unlikely ever to be able to engage' in employment

24. First, the more common expression 'unlikely ever' is a lower standard than 'unable ever'.[15] The claimant does not have to establish absolute incapacity.[16] A person is 'unlikely ever to engage in employment' if there is 'no real chance' that they will return to relevant work. A remote or speculative possibility of return to work is insufficient to take them outside the definition.[17]

25. Second, the proposed employment that an insurer suggests a person is likely to perform must be a real job not some special 'light duties' role invented for the injured worker.[18] It must be an occupation recognised in the community.[19]

26. Third, the question is not one of medical capacity to perform certain tasks. The definition requires realistic and common sense consideration of the likelihood that the claimant will

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14 See for example *Hannover Life Re of Australasia Ltd v Colella* [2014] VSCA 205.
15 *TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68, [64].
16 *Wheeler v FSS Trustee Corporation* [2016] NSWSC 534, [75].
17 *TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68, [89]
18 *Baker v Local Government Superannuation Scheme Pty Ltd* [2007] NSWSC 1173, [58].
19 *Hannover Life Re of Australasia Ltd v Colella [2014] VSCA 205, [30].*

actually obtain work in the real world.[20] In preparing the claim, you need to think carefully about what evidence you can gather that establishes why, in the real world, the claimant has no real chance of finding employment.

26.1 Where there is a vocational assessment report that suggests certain occupations would be suitable, consider:

(a) Has the claimant's treating practitioner been given an opportunity to comment upon the physical capacity to perform the suggested occupations?

(b) Does the claimant have capacity to perform all the duties of the suggested occupations to a competitive standard or will they require special accommodations? Will a prospective employer be likely to provide those special accommodations?

(c) Has the assessor considered the combined effect of all the persons restrictions or just focussed on the main injury?

(d) How does the claimant's psychological state affect their ability to engage in those occupations?

(e) How do the claimant's medications affect their ability to engage in those occupations?

(f) Does the claimant have the ability to be punctual and reliable in their attendance at work?

(g) Do those occupations really exist any more? Are there sufficient vacancies to make those occupations more than a theoretical possibility?

26.2 Where an insurer suggests that a person could perform a role with limited hours or with limited responsibilities, consider:

(a) Does that occupation exist as a part-time role or is it realistically only full time?

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[20] See an excellent summary of the principles in *Wheeler v FSS Trustee Corporation* [2016] NSWSC 534, [79]; *Banovic v United Super Pty Ltd* [2014] NSWSC 1470, [78]; *Hellessley v Metlife Insurance Ltd* [2017] NSWSC 1284, [157].

(b) Does that occupation or industry realistically allow for certain limited duties?

26.3 As the question is not purely a medical question, evidence from non-medical sources may be relevant and indeed key. Consider for example:

(a) Evidence from the claimant or their family about their punctuality and levels of everyday activity.

(b) Evidence from a recruiter or employer specialising in that person's industry about the availability of the suggested work or the realistic likelihood of being able to perform the work with the required restrictions.

(c) Evidence from a different vocational assessor who can identify shortcomings in the report the insurer relies upon.

27. Third, in cases where the insurer is not satisfied that there will not be future improvement, remember that the passage of time since the injury is relevant to assessing the probability of future improvement. If medical reports express hope that there will be improvement with certain treatment, consider:

27.1 Was the medical practitioner actually predicting improvement or just expressing an aspirational hope?

27.2 How long has it been since that opinion was expressed?

27.3 Have those treatments now been tried?

27.4 Would those practitioners still express the same opinion now given that the predicted improvement has not eventuated?

28. Fourth, long term continued inability to work or to find work can be a 'key guide' as to the likelihood of finding work in the future.[21]

28.1 Has the claimant been actively looking for work? How many suitable positions have they found and applied for and over what period?

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[21] *Finch v Telstra Super Pty Ltd* (2010) 242 CLR 254, [18]; *Lazarevic v United Super Pty Ltd* [2014] NSWSC 96, [158]; *Birdsall v Motor Trades Association of Australia Superannuation Fund Pty Ltd* [2014] NSWSC 632, [148].

28.2 Has the claimant had vocational assistance to search and apply for work? If so, did the organisation assisting them express any view about their likelihood of finding work?

28.3 Are there any reports (medical or vocational) that comment on the claimant's motivation to find work?

'Reasonably fitted by education, training or experience'

29. A job which a person may be able to perform without further education, training or experience is not necessarily one for which he or she is reasonably fitted by education, training or experience.[22] The definition refers not to *any* work for which the insured might have physical and mental capacity without further training, but to work for which the insured has been prepared and shaped by education, training and/or experience.[23] For the suggested future occupation to take a claimant outside the definition, it must be one for which the claimant has been 'prepared and shaped by his or her past vocational history'.[24]

30. Having some of the requisite individual skills does not equate to being fitted for the employment as a whole: capacity to perform remunerative work is different from capacity to perform a work task. It does not follow that because a person is physically capable of performing one or more work tasks that there is an ability to engage in remunerative work.[25]

31. Further, a person's education, training or experience is assessed at the time of the disablement, not at the time of assessment. This means that occupations which require retraining are not relevant to the assessment of the claim (although some short refresher of existing skills is not considered retraining).[26] It also means that a person who gained new qualifications between the date of disability and the assessment of the claim and is working in some new field can still be considered totally and permanently disabled within the meaning of the policy.[27]

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22 *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [146].
23 *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [147].
24 *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [150].
25 *Hannover Life Re of Australasia Ltd v Colella* [2014] VSCA 205, [30]; *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233, [169].
26 *Hannover Life Re of Australasia Ltd v Dargan* (2013) NSWLR 246.
27 *Chammas v Harwood Nominees Pty Ltd* (1993) 7 ANZ Ins Cas 61-175.

32. Where a vocational assessment has suggested alternative employment, consider:

32.1 Did the claimant have all the qualifications necessary for the role at the time of disablement? This is particularly important where the vocational assessment was obtained during a WorkCover claim where the issue of retraining may not be relevant.

32.2 Do the qualifications and experience the claimant appears to have on paper really reflect their skills? In particular:

(a) Does a certain certificate actually qualify a person to do the job that a vocational assessor asserts that it does?

(b) Has a certificate gained many decades ago actually ever been used or renewed?

(c) Has the assessor made inaccurate assumptions about the skills or experience the claimant has based on their job title?

(d) Was a role they were nominally performing on a return to work program just a 'made up job' that did not involve the real skills required for that role on the open labour market?

32.3 Is the role one for which the claimant has been shaped by their vocational history or has the insurer just relied on entry level jobs that anyone can do without any training such as retail or telemarketing?

32.4 Do the so called 'transferable skills' the vocational assessor has identified really translate into the suggested role? For example, are the administration skills a self-employed tradesperson used in their own business going to be sufficient for them to perform a clerical role in an office environment?

Conclusion

33. Once the TPD definition is properly understood, it becomes clear that it is not sufficient just to pile up medical reports setting out the severity of a claimant's injury. Indeed, in many cases, the dispute is not whether a person is injured or what their restrictions are. The real dispute is whether, given their injury and restrictions, the person is unlikely ever to work in an occupation for which they are reasonably fitted by their education, training or

experience.

34. As far as possible, medical evidence should be directed to the definition. When seeking reports, it is necessary to ask doctors to comment specifically upon the definition and upon issues that affect a person's likelihood of obtaining work such as:

34.1 What physical restrictions does the claimant have?

34.2 What psychological issues affect their ability to work?

34.3 How do their medications affect the ability to work?

34.4 Will the person be able to work at a reasonable pace and how often will they require rest breaks?

34.5 Will the person be able to attend work regularly and punctually?

34.6 How many hours will the person be able to work?

35. Where previous medical evidence expressed hope of improvement and significant time has lapsed without the predicted improvement, it is important to get updated evidence about whether the medical opinions have now changed.

36. It is also essential to consider non-medical sources of evidence such as:

36.1 The claimant and their family or friends.

36.2 Recruiters or industry specialists.

36.3 Former employers or work colleagues (if they remain on good terms).

36.4 Job-seeking assistance agencies.

36.5 Vocational assessors.

37. Evidence should be gathered early so that a strong claim can be submitted from the beginning. Where a claim has previously been submitted and rejected because of poor evidence, it is necessary to strengthen the evidence and seek reconsideration before issuing proceedings. The new evidence should be directed to addressing each point the insurer relies upon. Ideally, this should be done in one go. A slow drip-feed of evidence with multiple requests for reconsideration is counterproductive as it is likely to draw out the

process by many years, frustrate the client and cause the insurer to become further entrenched in its opinion.

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27 October 2017