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The rights of third party beneficiaries under contracts of insurance – A time for change?

18 August 2004

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Introduction

A third party beneficiary under a contract of insurance is a person (which includes a company) who is not a party to a contract of insurance and who is specified or otherwise referred to in the contract as a person to whom the insurance cover provided by the contract extends. Because of the protection afforded by section 48 of the *Insurance Contracts Act* (the ICA) third party beneficiaries are sometimes in general insurance parlance referred to as "section 48 claimants". Most of us are third party beneficiaries. Most of us have effected contracts of insurance as contracting parties which cover third party beneficiaries.

There are many examples of contracts of insurance which cover third party beneficiaries. Consider the following:

- A householder's policy which covers family members and perhaps a credit provider.
- A disability cover or income replacement cover issued for the benefit of a member of a superannuation fund under a group life policy effected by a trustee.
- Public liability cover extended to cover a principal.
- Contract works cover extended to cover a subcontractor.
- Credit card covers effected by a bank for the benefit of cardholders.

The list goes on…

As non-contracting parties, third party beneficiaries have been vulnerable both structurally and legally. Many third party beneficiaries would be unaware of the covers available to them. They may never see a policy schedule and policy wording. They are reliant on the contracting parties in that regard. They are at a legal disadvantage as a non-contracting party. This paper addresses some of the efforts to make third party beneficiaries less vulnerable, the current review which addresses in part the rights of third party beneficiaries, and whether there is a need for change. It is worthwhile first looking at the recent history.

Short history

It is perhaps surprising that traditionally third party beneficiaries under contracts of insurance had suffered through the application of the doctrine of privity of contract. Prior to the advent of the ICA, the indemnity principle (which required an insured making a claim to show a strict proprietary interest in the subject matter of the insurance or some agency or trust relationship to the person who suffered the loss) and the doctrine of privity meant that insurance policies purporting to protect the interests of third parties were ineffective. Demonstrating the necessary relationship could be very difficult, for example, where the policy was taken out before the relationship itself could be regarded as commencing.[1]

A reference was made by the Attorney General in September 1976 for the Australian Law Reform Commission ("ALRC") to review the adequacy of the laws governing contracts of insurance. Six years later the ALRC published Report No. 20 (ALRC 20) and a draft Bill which after much debate and amendment became the ICA. The ICA commenced on 1 January 1986, nearly 10 years after the original reference.

Of its many recommendations, the ALRC recommended that every person who properly falls within a policy description of the persons entitled to indemnity should be entitled to make a claim for loss covered by a contract of insurance. The fact that the person is neither a beneficiary under a trust nor a principal under a contract of agency was said to be irrelevant.[2]

This recommendation by the ALRC led to the enactment of section 48 of the ICA. As if to highlight the enactment of section 48 at around the time of the ICA's commencement, the High Court approved a common law extension of rights to a third party beneficiary in *Trident v McNiece*[3]. It is interesting to contrast the wording of section 48 with the Statement of Justice McHugh (then of the New South Wales Court of Appeal) in *Trident v McNiece*[4]:

> "To be able to sue at common law the beneficiary must be a person who is specified or referred to in the contract, whether by name or otherwise. The insurer is entitled to the same defences as he would have in an action brought by the promisee - party. Moreover, so that the insurer will not be liable at the suit of the promisee - party, the latter will need to be a defendant in the action."

According to section 48 every person who is specified or referred to in a contract of general insurance, whether by name or otherwise, as being entitled to insurance cover can recover loss in accordance with the policy. This is so notwithstanding that the person is not a party to the contract: section 48(1). In relation to the claim, that person will be under the same obligations and may discharge the insured's obligations in relation to the loss: section 48(2). The insurer has the same defences to an action as it would have in an action by the insured: section 48(3).

In 1995, section 48A was inserted into the ICA and replaced the original sections 48(4) and (5). Section 48A relates to policies effected by persons on their own life for the benefit of a third party, and protects the moneys payable under the policy to the third party. Notably because the section applies to a contract of life insurance effected on the life of a person but expressed to be for the benefit of another

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[1] Jovanovic v Broers (1979) 25 ACTR 49

[2] ALRC 20, paras 121-24

[3] Trident v McNiece (1988) 165 CLR 107

[4] Trident v McNiece (1987) 8 NSWLR 270

person, the section has no application to group life insurance effected by a trustee for the benefit of members of a fund.

In 1997, section 48AA was inserted into the ICA. Section 48AA operates where a retirement savings account ("RSA") provider takes out a contract of life insurance for the benefit of RSA holders. Thus, an RSA holder who is specified in the contract can recover a benefit from the insurer in accordance with the contract even though he or she is not a party to that contract.

The review

While there have been major amendments to the ICA, and the various sections of the Act are speckled with amendments, none of the amendments since 1 January 1986 has resulted from a comprehensive review. The recent years have been turbulent ones for the insurance industry. The High Court judgment in *Australian Hospital Care*[5] in 2001 caused professional indemnity underwriters to review their participation in the Australian market given the High Court's interpretation of section 54 as applied to claims made and notified policies. Because of the perceived problems with section 54, other issues with other sections of the Act and the lack of a comprehensive review since the Act commenced, the Commonwealth Government last year commissioned a full review of the Act, to determine the extent to which it is still meeting its original objective of striking a satisfactory legal balance between the interests of insurers, insureds and the community generally. The Panel designated to carry out this review consisted of two eminent persons, Mr Alan Cameron AM, a former chair of the Australian Securities and Investment Commission, and Ms Nancy Milne, one of Australia's leading insurance and reinsurance lawyers.

The Panel reported separately into the operation of section 54. The balance of the Panel's preliminary report and recommendations, entitled Proposals Paper on Second Stage: Provisions other than section 54 (report #2) was delivered in May 2004 following a further Issues Paper in March 2004. Submissions in response were sought. As at the date of this paper the Panel's final report has been provided to the Government but not released to the public.

Therefore, it is important to note that at this point in time we only have available to us the preliminary or draft proposals by the Panel and not final proposals which will be released in due course. Further, even when the final proposals are released it will remain to be seen whether those proposals become law and if so what the effect of the legislation will be. It is envisaged that as with the section 54 issue there will be draft legislation and an opportunity for further submissions on the draft legislation.

Third party beneficiaries

The Panel's discussion and proposals concerning third party beneficiaries are covered in Chapter 10 of the May 2004 Proposals Paper. The Panel covered the issues under five separate headings. The Panel first looked at the question of the general access by third party beneficiaries to the ICA.

General access to the Insurance Contracts Act

The panel received a range of submissions on the current disparity between the access to the ICA enjoyed by insureds and the more restricted access by third party beneficiaries. The Panel contrasted a submission from the Consumers Federation of Australia that third party beneficiaries should have the same access to the ICA as an insured with other submissions that a third party should be able to access some but not all provisions of the ICA. The Panel agreed with the latter submission noting judicial support for extending the ICA to third party beneficiaries.[6] Accordingly, the Panel proposed that third party beneficiaries should have access to the following provisions of the Act:

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[5] *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641.

[6] The High Court in *Trident General Insurance Co Ltd v McNiece Bros Pty Ltd* (1988) 165 CLR 107, Justice Mahoney in *CE Heath Casualty & General Insurance Ltd v Grey* in relation to the obligation of good faith, and Justice Bryson in *Sayseng v Kellogg Superannuation Pty Ltd* [2003] NSWSC 945 (13 November 2003) at paragraph 79 where his Honour held that "a person other than a contracting party to the policy may have standing to challenge the effectiveness of an opinion formed by an insurer".

- recourse to dispute resolution bodies;
- the same rights as an insured for the purposes of subrogation;
- the duty of utmost good faith;
- where the Act allows the insured to give notice, for example, pursuant to sections 40(3) or 74.

While overall the proposals themselves appear uncontroversial there are a few areas likely to create controversy and issues to watch out for.

Dispute resolution

The Insurance Council of Australia opposed recourse by third party beneficiaries to dispute resolution bodies. It argued that recourse to dispute resolution bodies is not provided by the ICA and that arrangements had been developed through the co-operation of the insurance industry. The Insurance Council of Australia also argued that claims involving third party beneficiaries involve complex liability issues more appropriate to be determined on the basis of sworn evidence. Further, that third party beneficiaries do not contribute to the premium pool that funds the cost of the dispute resolution scheme.

Looking at the issues raised, it is true that access by third party beneficiaries to approved dispute resolution bodies would form part of an overall claims handling regime.

To the extent that, for instance, general insurers submit to the Claims Review Panel (IEC), there would be a need for general insurers to agree to submit to the Claims Review Panel in respect of third party beneficiaries. In other words it may not be as simple as a legislative change to the ICA. Further, there may have to be amendments to the codes of practice. One issue would be the awareness of third party beneficiaries to the possibility of access to dispute resolution bodies. Presently the dispute resolution section of the general insurance code of practice specifies requirements as between insurers and consumers. Consumer is defined as "an individual, when that individual, whether alone or jointly with another individual, enters or proposes to enter into an insurance contract which is wholly and exclusively for the consumer's private or domestic use". The General Insurance Code of Practice is currently being redrafted. The Insurance Council of Australia has produced a draft code for the purpose of public consultation. Under the key terms section of the public consultation draft code there is a definition of customer as follows:

> "**Customer** means a person insured under a Contract of Insurance, or who proposes to enter into a Contract of Insurance to which this Code of Practice applies and includes a retail client and a wholesale client within the meaning of Chapter 7C of the Corporations Act 2001."

This definition would have to be expanded if the general insurance code of practice is to apply to third party beneficiaries.

As to the second objection raised by the Insurance Council of Australia, it is true that it would be difficult to hear complex liability issues in the absence of sworn evidence. For the same reason it was always thought to be inappropriate to hear issues as to fraud in the absence of sworn testimony and a transcript. Having said this, it is noted that the public consultation draft code proposes to apply the code and dispute resolution to various insurances issued to small businesses. Small business is defined as one employing up to 100 people if the business is or includes the manufacturer of goods, and otherwise up to 20 people. As with the code of practice it is perhaps a question of finding the right balance.

It is also true that third party beneficiaries do not contribute to the premium pool. There is therefore a question of funding and the pricing of insurances issued to the advantage of third party beneficiaries. The alternative to higher pricing is of course simply not to cover third party beneficiaries. Further, higher pricing and policy terms and conditions are, as always, subject to competition.

Subrogation

Subrogation is a two-way street. Insurers paying claims of third party beneficiaries would wish to be subrogated to the rights of those third party beneficiaries against any other party from whom recovery could be effected. The flip side of this is an extension of those rights given to insureds under Part VIII of the ICA to third party beneficiaries. The detail of this has yet to emerge. An extension of these rights would give third party beneficiaries the advantage of section 65 (which restricts rights of subrogation against family members etc), section 66 (which restricts rights of subrogation against employees[7]), section 67 (which concerns rights with respect to moneys recovered under subrogation) and section 68 (which concerns contracts affecting rights of subrogation).

Utmost good faith

While the extension of the duty of utmost good faith to third party beneficiaries is not in itself controversial the consequences of the extension will have to be watched closely. Proposal 1.2 by the Panel also concerned the duty of utmost good faith and involved a recommendation that the duty should be both a breach of an implied contractual term and a breach of the ICA. A breach of the ICA would not be an offence and would attract no penalty. Therefore, with both proposals linked and accepted, an insurer in breach of its duty of utmost good faith to a third party beneficiary would be both liable in damages and would also be in breach of the ICA.

The ALRC rejected the tort of bad faith for contracts of insurance subject to the ICA.[8] Care needs to be exercised to ensure that the existence of a statutory breach does not open the door to the tort of bad faith. Further, it should also be noted that the duty of utmost good faith is a two-way street. Third party beneficiaries claiming under a contract of insurance should owe a duty of utmost good faith. While supporting the extension of the duty of utmost good faith to third party beneficiaries in principle, the Insurance Council of Australia suggested further consultation with the insurance industry.

Utmost good faith has arguably been the biggest underachiever of the ICA. Just after the inception of the ICA a number of commentators predicted a big future for utmost good faith in providing a remedy. This predicted destiny may be fulfilled if utmost good faith is extended to third party beneficiaries. It is perhaps unnecessary to have recourse to the duty of utmost good faith as a contracting party because of the remedies under contract and elsewhere in the provisions of the ICA. However, third party beneficiaries may well find in the duty of utmost good faith their most potent remedy. For instance, members of a fund seeking access to group life insurance issued by a life insurer to a trustee would currently have to argue a breach of the duty of good faith as opposed to a breach of the duty of utmost good faith by the life insurer. A breach of the duty of good faith would not allow the member to sue for damages.[9]

Access to notification provisions

Finally in this section the Panel recommended that third party beneficiaries have access to the ICA where it allows the insured to give notice, for example, pursuant to sections 40(3) or 74. Section 40(3) allows the insured - and by extension will allow a third party beneficiary - to notify facts which could give rise to

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[7] A third party beneficiary may be a "servant *pro hac vice*". Ashley J held that "employee" where used in section 66 means a person employed under a contract of insurance and not a servant *pro hac vice*: *Deutz Australia Pty Ltd v Skilled Engineering Ltd* (2001) 162 FLR 173.

[8] ALRC 20, para 328.

[9] A member under a superannuation fund has standing to sue a life insurer based on the duty of good faith in the exercise by the life insurer of the rights under the contract including the right of controlling the settlement of the claim: Bryson J in *Sayseng v Kellogg Superannuation Pty Ltd* [2003] NSWSC 945 (13 November 2003). This matter is currently on appeal to the NSW Court of Appeal.

a claim and thereby deem any subsequent claim to have been made at that point of notification. Section 74 provides for policy documents to be supplied on request. Sections 40(3) and 74 are listed as examples. It remains to be seen whether this proposal will extend to other provisions.

The Insurance Council of Australia agreed with this proposal in principle but asked for further clarification. It was noted that the proposal raised privacy considerations with the supply of documentation to third parties. Further, that there may be particular difficulties in relation to some contracts where the insurer may not know the details of the third party beneficiaries to which it would owe a duty. The Master Policy situation was referred to. Under a Master Policy an insurer does not necessarily precisely track the issue of third party covers. This might be done by way of bordereaux.

It is perhaps difficult to argue against further consideration of these issues whether it be at the stage of draft legislation or otherwise.

General insurance and third party beneficiaries

The Panel recommended that section 48(3) of the ICA should be clarified so that it is clear that a third party beneficiary is in no better position than the actual insured, that is, that an insurer should be able to raise the conduct of the insured (whether pre or post contract) in defence of a claim brought by a third party beneficiary.

Section 48 states as follows:

> "48(1) Where a person who is not a party to a contract of general insurance is specified or referred to in the contract, whether by name or otherwise, as a person to whom the insurance cover provided by the contract extends, that person has a right to recover the amount of the person's loss from the insurer in accordance with the contract notwithstanding that the person is not a party to the contract.
>
> (2) Subject to the contract, a person who has such a right:
>
> (a) has, in relation to the person's claim, the same obligations to the insurer as the person would have if her were the insured; and
>
> (b) may discharge the insured's obligations in relation to the loss.
>
> (3) The insurer has the same defences to an action under this section as the insurer would have in an action by the insured."

The Panel noted that the meaning of section 48(3) has resulted in two competing interpretations which have both found judicial support. On the one hand, section 48(3) has been read narrowly to mean that a third party beneficiary must face the same defences as those against the insured but it would be necessary for an insurer to prove facts in support of those defences against the third party beneficiary. In other words, the third party beneficiary would not be tainted with the conduct of the insured. On the other hand, section 48(3) has also been given a wider interpretation. "Same defences" has been interpreted as the insurer's defences against the insured taking into account facts had they been proved against the insured. In other words, the third party beneficiary would be tainted with the conduct of the insured.

The interpretation of section 48(3) has depended, to an extent, on the nature of the conduct alleged against the insured. The latter and wider interpretation found favour in cases concerning alleged non-disclosure by the insured.[10]

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[10] *Commonwealth Bank of Aust v Baltica General Insurance Co Ltd* (1992) 28 NSWLR 579; *CE Heath Casualty & General Insurance Ltd v Grey* (1993) 32 NSWLR 25.

The narrow interpretation has found favour in cases which concerned post-contractual conduct by the insured such as arson,[11] although it was also thought that the treatment of third party beneficiaries would depend upon the relationship with the insured. It appeared that if an insured and a third party beneficiary were covered under a contract of insurance severally (as opposed to jointly) then the insurer would not be able to rely upon the fraud of the insured against the innocent third party beneficiary.

The Panel considered that a third party beneficiary should be in no better position than the insured. It was considered to be odd if a third party beneficiary could be in a better position than the insured when making a claim given that the insurer has contracted on the basis of the insured's disclosure and the terms of the insurance contract entered into with the insured.

Hopefully if the proposal by the Panel is implemented then the great doubts as to the application of section 48(3) can be removed.

A further question raised in the Issues Paper was whether "persons" referred to in section 48 should be limited to existing third party beneficiaries at the time the contract was entered into. It was noted that some contracts of insurance, for instance contract works insurance, can be expressed to include third party beneficiaries such as subcontractors not known at the time that the contract is initially effected. The Panel was of the view that this was a drafting issue which could be avoided if contracts of insurance were drawn sufficiently widely so as not to be limited to existing beneficiaries at the time the contract is entered into.

Life insurance and third party beneficiaries

The Panel proposed that:

- section 48A of the ICA should be amended so it is clear that a third party can bring an action against an insurer without the intervention of the policy owner;
- section 48A of the ICA should be expanded so that the life insured can be nominated as a third party beneficiary;
- section 48A of the ICA should be expanded so that the third party beneficiary can provide a valid discharge to the insurer.

All three of these proposals are uncontroversial and meet needs which were not currently met by the ICA and in particular section 48A. Section 48A is very similar to section 48 except that it applies to contracts of life insurance and therefore is worded slightly differently. Under section 48A the third party beneficiary has the right to any money that "becomes payable". It is a concern under section 48A that, if an insurer decides not to pay a benefit, there is no statutory right available to the life insured to recover the proceeds payable in accordance with the contract of life insurance. The Panel received submissions supporting the view that third parties should have a right to proceed directly against the life insurer and that it should not be the case that due to technicalities in the law the third party must obtain an order that the policy owner enforce the payment on their behalf. The Panel supported this and hence the first proposal above.

Further, the Panel received a submission that section 48A should be expanded so that a life insured can be nominated as a third party beneficiary. Given this it was submitted that it would be preferable for the nominated beneficiary to be able to give a legally binding discharge on the payment of the policy proceeds. The Panel accepted these submissions and therefore made the second and third proposals above.

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[11] *V L Credits Pty Ltd v Switzerland Insurance Co* (1989) 5 ANZ Ins Cas 60-936.

There is perhaps a question as to how cover for third party beneficiaries under life covers such as fund members entitled to cover under group life policies can be addressed in the ICA. If fund members are given access to the duty of utmost good faith as proposed above, this may meet the current lack of rights due to the inapplicability to them of section 48, section 48A and section 48AA of the ICA as presently drafted. There is a question, however, as to whether a further amendment to section 48A is also warranted.

Rights of third party beneficiaries to recover against an insurer

The Panel proposed that section 51 of the ICA should be amended so that:

- it covers the case where the insured is alive and can be found but where the third party cannot recover under execution of a judgment obtained against the insured, that is, when execution is returned with a nulla bona endorsement;
- it applies when a section 48 party is liable and cannot after reasonable inquiry be found; and
- it overrides section 6 of the *Law Reform (Miscellaneous Provisions) Act* 1946 (NSW) (LRMPA) and its State and Territory equivalents.

Under section 51 of the ICA, a third party has the right to recover against an insurer where the insured has died or cannot after reasonable inquiry be found. The State equivalent of section 51 in New South Wales is section 6 of the LRMPA, which allows a third party to access an insurer by creating a charge over the insurance moneys. A similar provision to section 6 is to be found in legislation in the ACT and Northern Territory. Another provision which allows third party access to insurers is section 601AG of the *Corporations Act* 2001 (Cth) which applies to insurers of deregistered companies. Section 6 of the LRMPA has attracted much judicial attention and much has been written about it.[12] No one would therefore disagree with the notion that third parties ought to be able to seek direct recovery from insurers in certain circumstances. This is notwithstanding the forensic difficulty that can be encountered because of a lack of evidence from the insured.

The proposals meet the need for rationalisation in this somewhat fraught area. The first proposal above involves an appropriate expansion of section 51 to enable it to compete with the width of section 6 of the LRMPA and its State and Territory equivalents. This then would allow section 51 to override section 6 without causing hardship. Further, it has been judicially noted that section 51 is limited to a situation where an insured (as opposed to a third party beneficiary) under a contract of insurance is liable in damages to a third party.[13] Again, notwithstanding forensic difficulties, there is a reasonably compelling case that section 51 should also apply where a third party beneficiary of cover as opposed to an insured is liable and cannot after reasonable inquiry be found.

There are arguments against an expansion of section 51. The Insurance Council of Australia argues that it is not reasonable to extend the application of section 51 to circumstances where the insured can be located but has chosen not to lodge a claim under a contract of insurance and has allowed execution of judgment to be entered. The Council argues that the sections' policy objective should be to encourage insureds who can be found to make a claim. If they choose not to make a claim, a third party should not be entitled to claim directly from the insurer. While these are valid concerns, unless s51 provides direct access to match that afforded by section 6 of LRMPA, and its territory equivalents, it would be hard to argue that section 51 should provide an overriding remedy in this area.

The Insurance Council of Australia neither supported nor opposed the other two proposals. On the issue as to section 51 overriding section 6 of the LRMPA, it asked for a more detailed consideration. It expressed the view that it would require consideration of other legislation, including section 117 of the *Bankruptcy Act*, sections 562 and s601AG of the *Corporations Act,* and possibly section 562A of the *Corporations Act* in so far as one was dealing with reinsurance. The Insurance Council of Australia

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[12] See for instance Justice R D Giles, "Reflections on Section 6", Insurance Law Journal, Vol 7 No. 2, 1997, p152; Stanley W Drummond and Peter Mann, "Abolish Section 6", Insurance Law Journal, Vol 8 No. 2, 1997, p79.

[13] *Ripper v Gatenby* (2002) 12 ANZ Ins Cas 61-532; *Aspioti v Leigh /Kortenhorst v Dass* [2003] NSWSC 1224 (19 December 2003).

referred to the experience in the United Kingdom where calls for uniformity have culminated in a draft *Third Parties (Rights Against Insurers) Bill.*

It is certainly a complex area and it is difficult to argue against further consideration of the issues at some stage.

Non-disclosure or misrepresentation by members of group schemes

The Panel proposed:

- Section 32 of the ICA should be amended so that it is made clear that remedies for non-disclosure and misrepresentation remain available in relation to a misrepresentation or non-disclosure that occurs between the time an insured becomes a member of the scheme and applies for cover.

- Section 32 of the ICA should apply to non-superannuation group life schemes.

The provisions of Division 3 of Part IV of the ICA which concern remedies for non-disclosure and misrepresentation apply, by virtue of section 32, to situations where there has been a non-disclosure or misrepresentation to an insurer under a blanket superannuation contract in respect of a proposed member of the relevant superannuation or retirement scheme. Section 32 provides that it is as if the contract were an individual contract in respect of that proposed member entered into at the time the member became a member of the scheme. The rationale of section 32 is that a blanket contract of insurance normally predates any misrepresentation or non-disclosure made by a particular member. As an insurer has remedies only for a misrepresentation or non-disclosure made before the contract was entered into, and not for those made after that time, the insurer would be deprived of any remedy in the case of a blanket superannuation contract. Under section 32 an insurer is entitled to remedies for misrepresentation or non-disclosure by a member as if a single contract between the insurer and trustee (the insured) had been entered into when the member joined the scheme.

A comment was made to the Panel that it is unclear how section 32 applies to non-disclosure and misrepresentation that occurs after the person has joined the superannuation scheme but before cover is effected on their life. It was suggested that the operation of section 32(b), which deems the insurance contract to come into effect when the member joins the scheme, might have the outcome that no disclosure or misrepresentation made after joining the scheme could be relied upon because the remedies under section 29(1) only apply to statements made "before the contract is entered into". The suggestion was that the remedies for non-disclosure and misrepresentation should be available regardless of whether or not a person is a member of the scheme when they apply for the cover. Apparently there was some support and no opposition in relation to the proposal. Given the nature of the proposal it is perhaps beyond objection.

It was also suggested that section 32 should be extended to encompass non-superannuation group scheme arrangements, such as employer and industry schemes. There has been a notable growth in such schemes in Australia. The Panel noted that most stakeholders submitted that there was no logical reason to treat non-superannuation group schemes differently from superannuation group schemes in this respect, again, the proposal to expand section 32 to non-superannuation group life schemes would appear to be beyond objection.

Drafting issues

Finally, given the attention that the review has brought to the rights of third party beneficiaries under contracts of insurance, it is perhaps timely to reiterate a few of the existing drafting issues by way of example. If third party beneficiaries achieve additional rights, some of these drafting issues may become even more acute.

Credit providers

The first example is the notation of the interest of a credit provider under a contract of insurance. On the domestic front this could involve the rights of a credit provider concerning a motor vehicle under finance or the rights of a mortgagee of a mortgaged property. Traditionally banks had what are known as concessions agreements with insurers which protected their rights under contracts of insurance issued to mortgagors. Concessions agreements have largely fallen out of favour, although some may still be in existence.

More commonly banks and other credit providers seek to have their interests noted on contracts of insurance. However, this is an inconsistent practice because it relies first on the conduct of others, secondly on an appropriate notation of interest and thirdly, on the policy wording.

Even when noted the notation may not be an appropriate one. A good example of this can be found in *General Motors Acceptance Corp Aust v RACQ Ins Ltd*[14]. It appears from the recitation of facts of this case by Justice Muir that notwithstanding the agreed fact that General Motors Acceptance Corp Aust ("GMAC") had its interest noted in the policy of insurance, RACQ argued that GMAC was not "a person… specified or referred to in the contract… as a person to whom the insurance cover… extends" within the meaning of section 48(1) of the ICA.

The policy certificate stated:

> "*Motor Comprehensive Insurance* [these words are typed at the top right hand corner of the policy]
>
> *Policyholders* [the insured's name is inserted]
>
> *Vehicle finance: GMAC Finance*
>
> *Drivers:* [the insured's name and the name of another person are inserted]"

RACQ argued that, according to this description on the certificate, the applicant was not shown on the certificate as the insured, or identified as a person covered by the policy, and that the purpose and effect of its name being stated on the certificate was to provide cover to the insured for the mortgagee's insurable interest in the vehicle pursuant to cl.9.5 of the policy. This read as follows:

> ***"Other Interest***
>
> *Your policy does not cover the interest of another person in the insured vehicle unless that interest is shown on your policy certificate."*

Justice Muir noted that RACQ's contentions concerning the inapplicability of section 48 were inconsistent with the agreed facts.

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[14] [2003] QSC 80 (19 February 2003).

He decided that it was possible to determine the matter by reference to various clauses of the policy. Ultimately the fraud of the insured who intentionally destroyed the vehicle defeated the claim by RACQ according to the policy wording. The case therefore demonstrates the confusion and inconsistency in the notation of the interests of finance companies on policies of insurance. Without more, a mere notation of an interest on a policy schedule will not necessarily provide a finance company or for that matter any other third party beneficiary with the cover that is sought. For a bank or finance company to obtain the benefit of section 48, it must be specified or referred to in the policy as the person to whom the insurance cover provided by the policy extends.

Further, even when appropriately noted, the cover provided will be subject to the policy wording. Not all policies contain a credit provider's clause. Therefore, some doubt will attend the notation of a credit provider as an interested party in a policy schedule without a corresponding clause as to the credit provider's rights within the policy wording itself. If and when third party beneficiaries achieve an elevation of rights, and in particular access to the duty of utmost good faith, this could well become a far more pressing matter for all concerned.

Credit card covers

Another issue specifically mentioned by the members of the Panel during the review process is that concerning credit card covers issued by banks. These covers are issued to cardholders as third party beneficiaries under a wholesale contract of insurance between the bank and one or more insurers. Commonly there is a bundle of covers including travel insurance, purchase protection insurance and extended warranty insurance, to name the main covers.

Again, there are a few matters worthy of note. Importantly it is a wholesale contract of insurance between the bank and insurer. If the cardholders were not third party beneficiaries and were instead insureds under the contract of insurance then this would constitute the issue of retail policies subject to the rigours of FSR. Therefore, the language of the policy wordings and other documents forwarded to the cardholders is extremely important. The cardholders should be in no doubt as to the nature of the cover provided to them as third party beneficiaries of a contract entered into between the bank and the insurer. It would be problematic to use any language inconsistent with this which could potentially lead the third party beneficiaries to the incorrect conclusion that they are being issued a contract of insurance as an insured. It may become even more problematic if and when the current proposals find their way into legislation.

Conclusion

Both the review process itself and many of the proposals by the Panel are long overdue. Hopefully a report containing the final proposals will be published shortly, followed by draft legislation and a further opportunity to make submissions. It is in the interests of all of us to monitor this closely. If and when they occur these changes will be very important and the consequences may be far-reaching.

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