SUPPLEMENTARY DETERMINATION

REFERRAL NO: 205 02 20675

Consumer Credit– Insurance Contracts Act 1984 S's 13, 59 & 60
– pre-existing medical condition – utmost good faith

SUMMARY OF FACTS

The background to this case is somewhat unusual. On 24 December 2002 the applicant received a Local Court Statement of Liquidated Claim initiated by the member for restitution of claim payments made by it. These proceedings have since been adjourned at the court's request, to enable the IOS to review and determine the dispute. The member has not objected to the Panel adjudicating on this matter, and the Panel notes the proceedings are next listed before the court on 20 May 2005.

The applicant arranged consumer credit insurance in February 2000 in respect of a loan for a motor vehicle purchase, which he was paying off by instalments over a period of 61 months. The applicant stated he first became disabled for work from 1 November 2000 due to reactive anxiety, stress and depression and subsequently submitted a claim under the policy in January 2001, which was received by the member on 29 or 30 January 2001. The member, without seeking advice from the applicant's medical practitioner, or any further information from the applicant, on 2 February 2001 denied the claim on the basis the applicant was suffering from a pre-existing condition which was excluded under the terms and conditions of the contract of insurance.

As a result of the applicant failing to make payments on the motor vehicle loan, the finance company repossessed the vehicle in question on 13 February 2001 and sold the vehicle at auction for the amount of $6,800.00.

In the meantime, the applicant whilst an in-patient at a psychiatric hospital or institution, had a conversation with a representative of the member on 7 February 2001 asking that he submit a new claim for this illness. The applicant refused to do so, noting that this was the same illness that was the subject of this dispute. The applicant subsequently submitted a further medical report from his treating doctor which diagnosed the applicant as suffering from a Post Traumatic Stress Disorder.

On 17 December 2001 the member finally accepted the claim and made payments for the period from 1 November 2000 to 23 June 2001, 24 June 2001 to 19 February 2002, 20 February 2002 to 20 May 2002. The Panel notes from the member's file a note from one of its claims officers which included the following:

> "Have spoken to doctor. He states that some people suffer reactive depression for years without it becoming PTSD. He states that whilst [applicant] has suffered from many forms of depression for years, he did not start to suffer or he did not know that he had the symptoms of PTSD until November 2000. I have reviewed this claim with [another Claims Officer] and we feel that there is no way that we can avoid paying this claim any longer."

On 9 August 2002 the member informed the applicant that it had elected to pay out the remainder of the loan in the amount of $2,561.82.

On 20 October 2002 the applicant was informed by the member the policy had been cancelled on 28 March 2001 and no further payments would be made and as a result, the applicant has submitted this application to IOS to have the decision reviewed.

In summary, the applicant submits the member wrongly refused to indemnify him at the first instance, based on a belief he was suffering from a pre-existing condition. Furthermore, he contends, had the member accepted the claim as it subsequently did, on 17 December 2001, the vehicle would not have been repossessed and sold at auction. In this way, he says, the member has failed in its obligations under the contract of insurance. The applicant also submits the policy has been wrongfully cancelled and he did not give written permission for the policy to be cancelled. In any event, the finance company had no right to cancel the policy.

The member's submission, briefly stated, is that it refused to indemnify the applicant at the first instance on the grounds he was suffering from a pre-existing condition. The member submits it mistakenly paid monies to the financial institution on behalf of the applicant after the policy had been cancelled by it and restitution should be paid for all monies paid to the applicant after cancellation by the financier.

ISSUES IN DISPUTE

The Applicant's View

The member was not entitled to refuse indemnity to him at the first instance as he was not suffering from a pre-existing condition and the condition disclosed on the claim form was a new and separate condition. As a result of this refusal, his motor vehicle was repossessed and the member is obligated to reimburse him $6,800, being the amount for which the vehicle was sold. He also claims other amounts which will be set out and analysed hereunder.

There was no entitlement to cancel his policy without his written permission. The member has failed its obligations under the contract of insurance and failed to act with utmost good faith towards him.

The Member's View

It was entitled to refuse to indemnify the applicant at first instance based on evidence provided to it by the applicant at that time.

The policy was cancelled without its knowledge and it has inadvertently made payments on behalf of the applicant post cancellation for which it is entitled to restitution.

RELEVANT POLICY PROVISIONS

"DISABLEMENT COVER – WHEN WE PAY

We pay the following amounts if, during the term of the Policy and because of an accident or sickness, you are totally and continuously unable to perform the duties of any occupation for which you are reasonably qualified by education, training or experience:

- We pay the lesser of one-thirtieth (1/30) of the Monthly Instalment, or $50 for each day you are disabled. The maximum we pay is $1,500 per month.
- We do not pay for the first 14 days of Disablement or for any of the events or circumstances detailed overleaf.

...

WHEN THE POLICY ENDS

The Policy ends as soon as one of the following occurs:

- The Policy is cancelled
- The Loan Contract is paid out
- The term of the Policy expires on the date set out in the Proposal & Schedule

- The time for repayment of the loan has passed – that applies even if you still owe money
- You die

...
WHEN WE WILL NOT PAY
We won't pay a benefit for any claim related to the following events as indicated by a • in the following table.
CAUSE/CONDITION
Any injury or illness for which you had advice or treatment from a medical practitioner within six months before the Policy began, and you had advice or require treatment for the same condition within the six months after the Policy began.

...
Any illness, injury or condition which is a direct or indirect result of any pre-existing illnesses and/or medical conditions."

TERMS OF REFERENCE

"10.2 A Panel, Referee or Adjudicator may determine a dispute by finding in one or more of the following ways:

...
(b) ...
(iv) a member should reinstate a policy of insurance as it had not cancelled a policy of insurance in accordance with the Insurance Contracts Act 1984 and that the cancellation is of no effect; and

...
(vi) interest (but at a rate not exceeding the rate prescribed under S57 of the Insurance Contracts Act 1984 or under a credit contract where appropriate) is payable or not payable by the member; and
(vii) any other remedy that may be appropriate in the circumstances."

"10.3 A Panel, Referee or Adjudicator may not determine that a member is liable to pay any punitive, exemplary, aggravated or unspecified general damages."

LAW INVOLVED

Section 13 of the Insurance Contracts Act 1984 provides that a contract of insurance is a contract based on the utmost good faith, and there is implied in each contract, a provision requiring each party to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

Section 59 of the Act provides that an insurer who wishes to exercise a right to cancel a contract of insurance shall do so by giving notice in writing of the proposed cancellation to the insured. The notice has the effect to cancel the contract at whichever is the earlier of the following times, namely at the time when another contract of insurance is entered into, being a contract intended to replace the first mentioned contract or whichever is the latest of the following times.
(i) 4.00p.m. on the applicable business day (as defined);
(ii) if a time is specified for the purpose in the contract – that time;
(iii) if a time is specified in the notice – that time.

"60(1) Where, in relation to a contract of general insurance:
(a) a person who is or was at any time the insured failed to comply with the duty of the utmost good faith;
(b) the person who was the insured at the time when the contract was entered into failed to comply with the duty of disclosure;

(c) the person who was the insured at the time when the contract was entered into made a misrepresentation to the insurer during the negotiations for the contract but before it was entered into;

(d) a person who is or was at any time the insured failed to comply with a provision of the contract, including a provision with respect to payment of the premium; or

(e) the insured has made a fraudulent claim under the contract or under some other contract of insurance (whether with the insurer concerned or with some other insurer) that provides insurance cover during any part of the period during which the first-mentioned contract provided insurance cover;

the insurer may cancel the contract."

OUTCOME AND REASONS

The applicant lodged a claim on the member as a result of becoming totally incapacitated by way of a medical condition. The form was date-stamped as received in the member's office on 29 or 30 January 2001. At the outset the applicant submitted a claim form and a medical certificate from his general practitioner to confirm his incapacity. The claim form also identified a psychiatrist who had been consulted "on this matter".

When completing the claim form on 15 January 2001, to the questions:

"Explain the nature of your illness", the applicant answered
"Reactive anxiety – stress – depression"
"When was the illness first diagnosed?" he answered:
"(1982) 1 November 2000".
"Have you ever suffered from this or a similar condition before?" he answered: "Yes".
"First diagnosed 1982 all other information is in Navy medical records."
However, in the medical certificate attached to the claim form, his medical practitioner responded to the questions as follows:
"What was the cause of the injury or illness so far as known to you?"
"Anxiety since 1/11/00"
...
If through illness please describe the following:

- Nature of illness "Depression"
- Details of any prior illness: "Reactive anxiety"
- Any connection of prior illness with this particular illness: "Not really – coped well with Discharge from navy"
- How long has this connection been in existence – whether treated for same or not? "1/11/00."

In a letter dated 2 February 2001, the member advised the applicant that

"we are unfortunately unable to pay a claim in this instance".

On 5 February 2001, the applicant was admitted to hospital and while he was an in-patient in the psychiatric ward he had a conversation with a representative of the member. It is not clear who initiated the conversation and the applicant does not deny he spoke to the member's representative on that day. He submits he has no recollection of that period in time due to the fact he was heavily medicated.

The applicant's submission

The applicant has sought the following relief by the IOS:

- As a result of a breach in the contract of insurance by the member in wrongly refusing to indemnify him, payment of $6,800.00 should be made representing the amount that the repossessed vehicle was sold for at auction.

- Interest on the above amount from the conclusion of March 2001 and ongoing until settlement is reached.
- Restitution in the amount of $30 per week from the time of repossession of the vehicle to date and continuing. As a result of the breach of the contract of insurance the applicant lost his benefit of convenience and use of his motor vehicle and has had to resort to alternative means of transport which has impacted on him financially.
- A determination that under the Insurance Contracts Act 1984 the contract of insurance was not cancelled.
- A determination that the member is not entitled to seek recovery from the applicant on the basis the policy and/or his interest in the policy was cancelled.
- A direction that the member discontinue proceedings in the local court.
- The member pay all legal costs he has incurred to date in the amount of at least $14,550.00 on the basis that these costs have been incurred as a result of the member wrongly initiating proceedings against the applicant.
- The member rectify the applicant's credit history as a consequence of its initiating legal proceedings in the local court against the applicant which are still ongoing.

The member's submission

The member, through its solicitor, submits it was entitled under the terms and conditions of the contract of insurance to refuse indemnity to the applicant at first instance, as he provided information by way of claim lodgement that his incapacity was as a result of a pre-existing condition.

The member in its submission to the IOS seeks to have its decision upheld on the grounds that:

- The policy was cancelled, thus terminating its contract with the applicant. By way of mistake, the member has inadvertently continued to pay monies on behalf of the applicant post cancellation and seeks a determination that it is entitled to restitution of these monies.
- The applicant's policy was cancelled by the financial institution on 28 March 2001. Furthermore, it submits that after the vehicle was repossessed the applicant no longer held an insurable interest and effectively this lead to the contract of insurance being null and void.

The unfolding of this dispute has involved several major events; the Panel intends to deal with each one in sequence.

1. *The initial claim*

On 29 or 30 January 2001 the applicant's claim was received by the member. It was made as a result of his becoming totally incapacitated for employment by way of reactive anxiety, stress and depression. The applicant submitted a medical certificate from his general practitioner in conjunction with the claim form. On 2 February 2001, just over two days later, and without requesting more substantial information, the member refused the claim on the basis the applicant was suffering from a pre-existing condition. This is one of the fastest decisions by a member to deny a claim the Panel has encountered. There is no record the member sought advice from the general practitioner or the psychiatrist, who was named on the claim form, nor that it

sought clarification from the applicant with respect to any matter relating to the claim form.

However, it appears a representative of the member spoke to the applicant via telephone on 7 February 2001, suggesting that he submit a new claim for the illness. The applicant apparently refused to do so, noting this was the illness, the subject of the dispute. The member further submits it asked the applicant questions relating to the claim and says the applicant answered he was suffering from a pre-existing condition. The Panel is puzzled by this event, because at the relevant time, the applicant was an in-patient in a psychiatric institution and was apparently heavily sedated. The Panel cannot determine from the material provided, whether it was the member's representative who initiated the call or the applicant. In any event, in all the circumstances, the Panel does not propose to rely on anything that was said between the parties during this conversation, in view of the applicant's circumstances, and the fact that five days before the conversation, the member had unequivocally rejected the claim, and if the member seriously wanted to review its decision, it should have advised the applicant to this effect in writing.

The applicant, via his solicitor, submits the member had an obligation to determine that he was in fact totally disabled and if more information were required to make this decision, the member had a duty to seek such information. From the time the claim was lodged to the time it was denied, the member did not attempt to contact the applicant, nor did it seek additional information from him or his medical practitioner, nor did it seek independent medical advice as to the various medical conditions referred to in the claim form.

The applicant submits the medical certificate that accompanied the claim form did not support a proposition the applicant was suffering from a pre-existing condition. The applicant's solicitor notes that when answering a question with regard to pre-existing condition the medical practitioner wrote

> "not really – coped well with discharge from the Navy".

The applicant submits that, on the basis of the documentation presented to the member at the initial stage, the member did not have evidence to refuse the claim and should have obtained further information. In not obtaining this information the applicant via his solicitor submits the member has breached its obligations under the contract of insurance and its duty to act with utmost good faith towards the applicant.

The applicant submits that as a result of this initial breach, the financial institution repossessed his vehicle as the member refused to make payments on his behalf under the contract of insurance. The applicant submits that he lost the value and use of the vehicle. Had the member not breached its contractual obligations, he would have a continuing benefit of the vehicle to date and ongoing.

The member notes in the medical certificate contained in the claim form, the treating medical practitioner diagnosed the applicant's condition as "reactive depression/ anxiety". Upon this basis the member submits that, at first instance, for all intents and purposes, the applicant was suffering from a pre-existing condition that was disclosed on his proposal form thus it was excluded under the terms and conditions of the contract of insurance.

The member refutes allegations by the applicant's solicitor that it did not seek to obtain further information from the applicant, noting its records show that, on 7 February 2001, a representative of the member spoke to the applicant about the

claim. The member submits that during this conversation the applicant admitted to it his condition was pre-existing. This was, however five days after the date of the letter of denial.

In the Panel's opinion, when the claim form was submitted by the applicant, the member and its staff had the following obligations.

Firstly, they had to deal with the claim with utmost good faith, which has been defined judicially to mean to act "with scrupulous fairness and honesty" (see Sutton *Insurance Law in Australia*, 3rd Ed. p.162).

Secondly, member's staff would have or should have become aware that, as this was a consumer credit policy, if the applicant were incapacitated for work, and if the claim were to be denied, in all probability the applicant would not be able to keep up the loan payments, and the motor vehicle would be repossessed within a short period of time, which of course, is ultimately what happened.

Thirdly, the member and its staff were obliged to consider the contents of the claim form carefully, and if the claims officer were not certain as to the basis of the claim, he or she should have sought more information from the applicant and/or his medical adviser.

In terms of the specific aspects of the claim form, the Panel notes the applicant explained the nature of his illness as "reactive anxiety", "stress" and "depression" which are of course three separate illnesses, although the Panel acknowledges that the term "stress" might include elements of both. The applicant as a lay person, stated that the illness was first diagnosed on 1 November 2000 but in brackets he included the figures "1982", which arguably, might indicate an initial impression that he had an illness in similar form some 18 years previously. He also added the words "First diagnosed 1982 all information in navy records", which arguably might perpetuate the potential ambiguity referred to above. However, in the Panel's opinion any potential ambiguity would be resolved by reference to the medical practitioner's certificate. The Panel notes that, in that document he states the illness was "depression", the prior illness was "reactive anxiety", an entirely different illness with entirely different symptoms, and then the answer appears in relation to a question dealing with the connection with the prior illness "not really" followed by the statement that the illness, the subject of the claim, commenced on 1 November 2000. In the Panel's opinion, this information should have removed any remaining doubt about the matter and persuaded a reasonably objective and diligent claims officer that the illness giving rise to the claim was a new illness. However, if contrary to expectation, the claims officer was unduly and perhaps unreasonably still unconvinced of these matters, at the very least the claims officer should have sought additional information from the doctor, or obtained his own medical counsel.

For these reasons, the Panel concludes the member unreasonably denied the claim, failed in its obligations to act with utmost good faith towards the applicant, because it did not apply the principles of scrupulous fairness to the process referred to above, and by so doing, ought to have known of the distinct likelihood the vehicle may be repossessed.

2. Repossession and disposal of the vehicle.

The applicant's vehicle was repossessed by the credit provider on 13 February 2001 and sold on or about 5 April 2001.

As stated above, the applicant, in good faith, submitted a claim form which informed the member that he was unable to continue to meet his obligations with the financial institution. The member was then required to make a decision as to whether to commence payments to the financial institution once they were in receipt of all required information.

With regard to the repossessing of the vehicle, the member submits that at no stage prior to the repossession taking place was it informed either by way or correspondence or verbally that the applicant was suffering from post traumatic stress disorder which form the later basis of the claim. Consequently, the member submits, it was not liable for the repossession of the vehicle and that the amount the vehicle sold for at auction is essentially the applicant's continued payments.

The member's solicitor asserts that once the applicant provided evidence to suggest that he was in fact suffering from post-traumatic stress disorder, the applicant effectively lodged a new claim with the member, hence why it was suggested that he formally lodge a new claim for a new illness/sickness. The member submits that it is under this claim that the member fulfilled its duties and obligations under the policy and paid out the claim.

The policy requires the member to pay monthly instalments until such time as the applicant can recommence payments or the loan is paid out. The member states that it has not breached its obligation as from the time the claim was accepted payments were made to the financial institution and the loan was paid out. It is irrelevant that prior to acceptance of the claim, the vehicle was repossessed, and the member is not required to reimburse the applicant for the sum obtained at auction as the repossession was not through its fault.

As pointed out earlier in this determination the repossession of the vehicle was a direct consequence of the member's decision to reject the initial claim. Given that the member reversed its decision to refuse indemnity to the applicant under the initial claim, the applicant believes that he is entitled to be reimbursed the amount that the vehicle was sold for at auction. The applicant's argument is that the member was relieved of the requirement to pay the credit provider to the extent of the proceeds of the disposal of the vehicle, i.e. $6,800. The Panel understands and accepts the logic of that argument because, if the vehicle was not repossessed and the claim had been admitted, it would have ultimately had to pay this sum.

The applicant contends that, had the member not breached its obligations under the terms and conditions of the contract of insurance and acted with utmost good faith towards him, it would have requested further information regarding his incapacity at the outset and the claim would have been accepted. Had the claim been accepted at first instance, the applicant submits that not only would he still have the vehicle for his personal use, the member would have had to pay the financial institution the amount that the vehicle had been sold for at auction.

If the process had been pursued the member could have communicated with the financial institution that it was seeking further and better information from the applicant's medical advisers as to the claimed condition and its cause. The Panel is of the view that the initial rejection of the claim precipitated the applicant's inability to meet his repayment obligations and led to the repossession and selling of the vehicle as the obligations of the applicant to make monthly repayments were not being met by the member on his behalf.

Whilst a member has the right to refuse to indemnify an applicant on the basis that the claimed illness falls outside the terms and conditions of the contract of insurance, in this particular instance the member did not have satisfactory evidence to make a final decision in respect of the claim within the two days it took to do so. Furthermore once the necessary information was in the possession of the member it accepted the claim and payments were commenced with the financial institution on behalf of the applicant.

As a direct result of the repossession of the vehicle, the applicant was forced to make alternative transport arrangements and incur costs in doing so. The Panel considers that the costs of alternative transport arrangements flowed from the member's failure properly to deal with the applicant's claim in a timely and professional fashion.

The Panel notes the member's solicitor has maintained that effectively the member has never accepted liability for the initial claim. The member contends that the applicant submitted a new claim based on a new medical condition, being post-traumatic stress disorder, and this is the claim that it has accepted.

In this regard, the member argues that, not only has it met its obligations under the terms and conditions of the policy, being that it pays monthly instalments to the financial institution once a claim is accepted, but it cannot be held liable for the repossession of the vehicle because at the time the vehicle was repossessed, it was of the belief the applicant was not suffering from post traumatic stress disorder, and the amount the vehicle was sold for at auction is essentially the continued required payments of the applicant.

There has only been one claim form submitted by the applicant. Based on this claim form the member communicated to the applicant that it refused him indemnity. During a telephone conversation held with the applicant whilst he was an in-patient in the psychiatric hospital, the member's representative requested the applicant submit a new claim form. The applicant apparently declined to do so which is entirely his decision.

On this basis alone, the Panel is unable to justify the proposition that the member had agreed to indemnify the applicant under a new claim. It is more appropriate to say that the member accepted liability for the original claim once the information that should have been sought before denial of the claim was presented and under the terms and conditions of the policy paid on behalf of the applicant the monthly repayments to the financial institution. This is confirmed by the fact that all payments were made under the original claim number which had initially been refused.

It is the Panel's opinion that the refusal of the member at first instance led to the vehicle being repossessed and subsequently sold at auction on the basis that the applicant was no longer able to meet his obligations to make monthly payments.

3. *Cancellation of the policy*

The member has initiated local court proceedings against the applicant on the grounds that it had paid monies on behalf of the applicant after the policy was cancelled and that as a result the applicant has benefited unjustly from its mistake in continuing to make payments.

In the Statement of Liquidated Claim it is attested that the policy was cancelled on 28 March 2001 by the financial institution and that the member seeks restitution of

$7,682.09 for payments made after the date of cancellation. The member has not specified how that amount is made up. According to correspondence between the member and the applicant it made the following payments:

Date	Amount paid	In respect of period:
17 Dec 2001	2817.44	1 Nov 2000 -23 Jun 2001
3 Jan 2002	3036.14	24Jun -19 Feb 2002
3 May 2002	1170.70	20 Feb – 20 Mar2002
9 Aug 2002	2561.82	Pay out loan
TOTAL	9586.10	

The loan contract between the credit provider and the applicant specifies at clause 4.1

> "You must take out, and then maintain, insurance over the Goods ... in your name and [ours] as co-insureds for our respective interests."

The applicant submits that he has on repeated occasions requested the written documentation in relation to the cancellation of the policy. This has never been forthcoming and the applicant submits that there has never been any authorization or request from him to cancel the policy or to permit anyone else to do so on his behalf.

Furthermore, the applicant submits that even if the financial institution had communicated in relation to cancellation of the policy, as it did on or about 6 April 2002 it had no right to do so. Given that the financial institution was not acting for the applicant at any stage, it did not have authority to cancel his interest, hence the policy with respect to the interests of the applicant, had not been extinguished.

He further states that as the policy had not been lawfully cancelled, the member had no recourse to initiate court proceedings against him on the grounds that it had made payments on his behalf after the policy had been cancelled. The applicant contends that the member has manipulated the policy cancellation scenario as a means to initiate legal proceedings against him for some unknown reason, although the applicant's solicitor somewhat quaintly speculated it was "a pre-emptive strike".

In documents supplied by the applicant's solicitor, requests were made to the member to supply the applicant's then solicitor with documentary evidence that the policy was cancelled. To date there has been no evidence supplied by the member to support its contention that the policy was indeed cancelled.

The member in its responses to IOS and in court proceedings has relied on a statement within the insurance proposal which states that an insurer may in writing cancel a policy for reasons under law. The member has also further argued the policy was issued to the financial institution and not the applicant hence its ability to cancel the policy.

The member has not been willing to provide information that the financial institution either orally or in writing cancelled the policy on 28 March 2001. In an e-mail dated 25 October 2002 staff of the member indicated that they had no idea about the cancellation of the policy. However, the answer was ultimately supplied by the credit provider's solicitors in a letter to the applicant, the policy was cancelled pursuant to the credit provider's right to do so under s138 of the Consumer Credit Code. The Panel acknowledges the right of the credit provider to cancel its interest in the policy but notes that even if the policy was in the name of co-insureds for their respective interests the cancellation is effective only to cancel the credit provider's interest. In any event, any attempt by the credit provider to cancel the applicant's interest in the

policy would be wrong, in accordance with contract law, and would clearly be in breach of sections 59 and 60 of the Insurance Contracts Act.

It should also be noted in terms of the financier's purported cancellation of the policy, that its name appears on the policy in large print and it states "[financer's name] is an agent of [member]". It also states

> "We may cancel this policy by telling you in writing, only for reasons allowed under law."

However, the contract was a contract of insurance between the member and the applicant, although it was arranged by the financier as agent for the member. As far as the Panel is aware, the policy itself does not give the financier the right to cancel the contract, other than the Panel notes that under the Credit Code for the relevant state, it has certain rights. However, it is not necessary to further explain that issue, as the only rights the member has to cancel the contract, vis à vis the applicant, is by virtue of sections 59 and 60 of the Insurance Contracts Act, which it has never suggested it has done. The Panel therefore determines that the policy is still in existence insofar as it determines the rights and obligations of the parties to this determination.

However, the member also states that the policy has come to an end because it has paid out the loan. If it were necessary to do so, the Panel would consider whether the member is entitled to rely on that term in the circumstances, and as to whether section 14 of the Act ought to be considered as being applicable to the issues in dispute. However, the Panel is of the opinion it is not necessary to consider this aspect of the matter prior to considering what relief it should be given to the applicant, because in the circumstances it does not consider that the loan contract was paid out. This will be evidenced by the following determinations.

The first determination the applicant requests in relation to the $6,800 which the financier received from the sale of the vehicle. The basis of that request is that if the member had not wrongfully denied liability in the first instance, the vehicle would not have been sold. For the reasons outlined above, the Panel is of the opinion that the member did wrongfully deny liability for the claim, and that as a direct result of that wrongful denial, the vehicle was repossessed and sold. In these circumstances the Panel is of the opinion that, the member has breached the terms of the contract, it would properly and fairly consider the claim, and secondly, the member failed to act with scrupulous fairness towards the applicant in accordance with its obligations to act with utmost good faith, and is therefore obliged to pay the sum of $6,800 to the applicant. It is also clear that the member has benefited under the insurance contract to that amount, because it would have had to pay that sum to the applicant in any event, by virtue of his unchallenged ongoing severe disablement.

The applicant further requests that the sum of $30 per week be paid to him from the end of March 2001, being a date after repossession of the vehicle to date, as a result of not having the use of the motor vehicle. He calculates that sum on the basis of costs incurred as a result of not having a motor vehicle for his use. In the Panel's opinion it is difficult to assess the cost that would be incurred as a result of the loss of the advantages a motor vehicle provides. However, if the applicant were forced to use public transport on a daily basis, or for even five days per week, this sum would be exceeded. From the Panel's experience the cost of a small taxi fare would exceed $10 - $15. The Panel thus considers the applicant's request in this regard to be of a modest nature and determines the member pay the applicant the sum of $30

per week from 1 April 2001 to date, a total of 214 weeks, which produces a total figure of $6,420.

The applicant also seeks interest on the sum of $6,800 from March 2001 to date on the basis the member has wrongfully withheld payment of that sum from him in the circumstances outlined above.

Section 57 of the Insurance Contracts Act provides that where an insurer is liable to pay a person an amount under a contract of insurance (which is the case in this instance) the insurer is also liable to pay interest on that sum to the person in accordance with the section. Subsection (2) provides the period in respect of interest is payable is the period commencing on the date from which it was unreasonable for the insurer to have withheld repayment of the amount, up until the date when payment is made. Subsection (3) refers to the prescribed rate in accordance with the regulations. In the Panel's opinion, the date upon which it was unreasonable for the insurer not to have paid this sum is a date following the appropriation of the amount away from the applicant. It appears the applicant claims interest on this amount from 1 April 2001 and continuing, which in the Panel's opinion is fair and reasonable. The Panel thus determines the member pay interest on the sum of $6,800 to the applicant, in accordance with the amount prescribed in the regulations made pursuant to the Insurance Contracts Act, from 1 April 2001 until the date when this determination is satisfied. The Panel further determines the member should pay interest at the statutory rate on the sum of $6,420 from the date each payment fell due until the determination is satisfied or alternatively, for ease of calculation at the member's option interest may be calculated from 1 April 2003 on the total figure.

The applicant also seeks a determination that the contract of insurance was not cancelled. The Panel determines for the reasons set out above, that as between the applicant and the member, the insurance contract was not cancelled.

The applicant also seeks a determination that the member is not entitled to seek recovery from the applicant of the sums claimed in the legal proceedings referred to above on the basis that the policy was cancelled. The Panel notes that the member has issued proceedings in the local court for recovery of various sums on the basis that the policy was cancelled. The Panel cannot issue a determination with respect to issues that are currently before the court, notwithstanding the court has agreed to the Panel determining as many of the issues in dispute between the parties as it can, and therefore the Panel is not prepared to make the determination requested by the applicant. However, the Panel makes the observation that it cannot see how the sums claimed by the member against the applicant are payable at law, nor can the Panel understand how it can be alleged that the applicant has been "unjustly enriched" by the payment of the sums referred to in the Statement of Claim. The Panel is also of the opinion that it has no power to determine or direct that the member discontinue proceedings in the local court, as this is a matter for adjudication by the Court.

The applicant also seeks a determination that the member pay the legal costs for which he is liable. The applicant's solicitors have described the details of costs as follows:

Professional Fees	$14,550.00
Disbursements	$ 362.00
GST on professional fees & disbursements	$ 1,491.24
Total:	$16,403.64

Because proceedings were initiated against him by the member, the applicant has had to instruct a solicitor to protect his interests. The applicant's solicitor has submitted a bill of costs to date in the abovestated sums for work undertaken to protect the applicant's interest in the local court proceedings and also to prepare submissions for the dispute lodged to the IOS.

In the early stages of the dispute the applicant tried to resolve this dispute with the member directly and did not wish to involve solicitors or initiate court proceedings. The member, instead of communicating with the applicant in an attempt to resolve issues, instructed its solicitor to initiate proceedings without informing the applicant as to the status of the dispute. Once proceedings were initiated, the applicant submits that he was told by the member, that all future correspondence was to be through its solicitor. On advice from the local court, the applicant then sought to instruct a solicitor to protect his own interests.

The power of the Panel to deal with this issue is in clause 10(2)(vii) of the Terms of Reference, which are set out above, which authorizes the Panel to provide "any other remedy that may be appropriate in the circumstances". In the Panel's opinion this is a very wide power and permits the Panel to make an award of legal costs in favour of a successful applicant.

However, as the Insurance Ombudsman Scheme is an alternate dispute resolution scheme, this is a power, which in the Panel's opinion, should only be exercised in favour of an applicant in limited or exceptional circumstances, such as where the issues in dispute are so complex or unusual, that the policyholder would not be able to present his case adequately without legal representation.

The Panel also observes the applicant has shown he is both articulate in his written submissions and perceptive of his legal rights, notwithstanding he has suffered consistently from a range of psychiatric illnesses which have led him to be severely incapacitated. However, in the Panel's opinion, the member's behaviour towards him in this dispute has been so extraordinarily severe, and the issue of legal proceedings in the circumstances was, in the Panel's opinion, breathtakingly aggressive. The applicant's solicitor described it as possibly "a pre-emptive strike" which although somewhat melodramatic, is nevertheless not without merit. In any event, the issue of legal proceedings changed the whole character of the dispute, and were it not for the decision made by the magistrate to allow the Service to consider the dispute, may have involved the applicant in even more substantial legal costs than he has incurred to date.

In any event, in the Panel's opinion the applicant wisely obtained legal advice from a legal solicitor who has presented his case with great clarity and precision and his intervention in the dispute has been of invaluable assistance to the Panel. The Panel further notes that the member has also been very well represented by a competent firm of solicitors, so therefore, in the Panel's opinion it was necessary for the applicant to also obtain legal assistance of a high standard, which as stated above, he has done. The issues raised in this matter are amongst the most difficult the Panel has had to embrace. In fact, the Panel observes an entry from one of the member's own claims officers who complained that the issues in dispute were beyond her comprehension. In these circumstances the Panel has concluded that it should determine that the applicant's legal costs be met by the member.

However, the Panel finds it difficult to determine the quantum of those costs in view of the unresolved legal proceedings, the complexity and longevity of the dispute and the fact that the hourly rate submitted by the applicant's solicitors may not be consistent with the scale of costs applicable to the local court. The applicant's solicitor has provided the Panel with a detailed calculation of those costs which the Panel accepts as fair and reasonable. However, the Panel is of the opinion that if the member regards the estimate or details of costs as excessive, it should have the opportunity of disputing the figure claimed. In these circumstances the Panel proposes to determine.

The member pay the applicant's reasonable costs, either in the sum of $16,403.64, plus any additional costs incurred since the estimate was provided, or as assessed by an independent cost consultant, either nominated by the Panel or as agreed between the parties.

The final determination requested by the applicant is that the member rectifies the applicant's credit history as a consequence of its initiating legal proceedings in the local court against him. The Panel is uncertain whether its jurisdiction extends to making such a determination, notwithstanding the wide powers referred to above, and it has not been asked to make such a determination before. However, it does not believe it is appropriate to do so in view of the fact that the proceedings in the local court remains extant, but it is prepared to reserve liberty to the parties to seek a further determination from the Panel on this issue, in the event it is necessary to do so, following resolution of the proceedings in the local court which, as stated above, are at least nominally listed for hearing on 20 May next.

The Panel wishes to make a final comment that this has been a difficult dispute which has as its origin in the applicant lodging a claim form four and a half years ago. After having carefully considered all the material provided by parties, it believes it is fair to categorize the member's conduct during the four and a half year period of the claim, as falling well short of the standard of scrupulous fairness which is the judicially determined standard to establish it has acted with utmost good faith towards the applicant. On the other hand, the Panel has not been able to fnd an instance where the applicant's conduct would seem to be less than what the law requires of him.

21/7/05