

8 May 2026

Mr Peter Kell  
Independent Reviewer  
Life Code Independent Review  
Council of Australian Life Insurers

**By online upload**

Dear Mr Kell,

We welcome the opportunity to provide feedback in relation to the Interim Report of the Life Code Independent Review.

Maurice Blackburn Pty Ltd is a plaintiff law firm with 31 permanent offices and 29 visiting offices throughout all mainland States and Territories. The firm specialises in superannuation and insurance claims (particularly total and permanent disability claims), personal injuries, abuse law, medical negligence, employment and industrial law, dust diseases, negligent financial and other advice, and consumer and commercial class actions.

Our Superannuation and Insurance practice has represented and assisted thousands of claimants for over 30 years and currently provides legal assistance to approximately 3,500 to 4,000 clients at any one time.

We witness first-hand the ramifications of poor corporate behaviours by financial service providers which create significant financial hardship in our clients' lives.

We have limited our feedback to:

- Blanket Mental Health Exclusions (part of Section 2)
- Interaction with the law (Section 4)
- Code structure, governance and enforceability (Section 5)

Part A of our submission addresses Section 2. Part B addresses Sections 4 and 5.



Quality  
ISO 9001

**Maurice Blackburn Pty Limited**  
ABN 21 105 657 949  
[mauriceblackburn.com.au](http://mauriceblackburn.com.au)

Level 21, 380 La Trobe Street  
Melbourne VIC 3000  
PO Box 523, Melbourne VIC 3001

DX 466 Melbourne  
T 03 9605 2700  
F 03 9258 9600

### A.1 The Questions in Section 2.1.2 of the Interim Report

Page 14 of the Interim Report outlines three questions through which the Reviewer is seeking further feedback on Clause 2.1(b) of the current Code. Our direct responses to those questions appears on page 11 of this submission. We offer some preliminary observations below, to provide background to those responses.

Clause 2.1(b) requires insurers to design new products that ‘do not incorporate a blanket exclusion specific to mental health in the general terms and conditions of the standard form contract, consistent with our obligations under the Disability Discrimination Act 1992 (the DDA) and equivalent State and/or Territory law.’

The questions in the Interim Report<sup>1</sup> follow the Reviewer’s finding that clause 2.1(b) ‘is appropriately understood as representing a commitment by insurers to go beyond the minimum legal requirement of the DDA and not include blanket exclusions in new standard form policies.’

CALI’s own supplementary submission expressly acknowledges the same position.<sup>2</sup> What is not in dispute, then, is the nature of the current commitment. The industry knows what the Code requires. The question is whether it should be excused from complying with it. For the reasons that follow, Maurice Blackburn believes it should not.

### A.2 What CALI’s Proposal Would Actually Do

CALI’s supplementary submission recommends four changes to the Code.<sup>3</sup> The first – to reinstate a commitment to comply with the DDA – is substantively inert as a Code commitment. That obligation already exists by force of statute, and restating it in the Code adds nothing to what the law already requires of insurers. In substance, reinstating a DDA compliance commitment cannot substitute for the Code’s existing obligation which goes beyond the minimum legal standard.

CALI’s second and third recommendations ask that the Code endorse explicit limitations on mental health cover in standard form group life contracts without individual underwriting. This is not a refinement of the prohibition. It is the removal of the prohibition.

It is also precisely what some insurers are already doing in breach of the current Code. The LCCC’s September 2025 report<sup>4</sup> found that some members are ‘embedding broad exclusions for mental health conditions directly into their standard policy terms.’ AFCA<sup>5</sup> has called for the prohibition to be clarified and strengthened, noting ongoing uncertainty in practice. The Joint Consumer Groups submission noted that insurers ‘flout’ the current prohibition ‘seemingly at will.’<sup>6</sup>

---

<sup>1</sup> Interim Report, p 14 (Questions 1, 2, 3(a)–(d)).

<sup>2</sup> As cited in the Interim Report, p 12.

<sup>3</sup> As cited in the Interim Report, p 13.

<sup>4</sup> Ref: <https://lifecc.org.au/app/uploads/2025/09/FINAL-LCCC-Inquiry-Report-Keeping-the-Promise-Mental-Health-and-Life-Insurance-Commitments-September-2025.pdf>: p 8.

<sup>5</sup> Ref: <https://lifecodereview.org.au/wp-content/uploads/2026/01/AFCA.pdf>: p.14.

<sup>6</sup> Ref: <https://lifecodereview.org.au/wp-content/uploads/2026/01/Joint-consumer.pdf>, p 5.

CALI's proposal is a request to make legitimate what some members have already been doing without permission. The appropriate response is enforcement and accountability, not a reduction in the standard to the level of non-compliant conduct. Recommendation 66, enabling the LCCC to name non-compliant insurers, is the right response and Maurice Blackburn endorses it as overdue.

### **A.3 The Statistical Case Has Not Been Made Out**

CALI asserts that mental health is now the number one driver of TPD claims, generating approximately one in three TPD claims and one in four income protection claims, with claim value doubling over five years to \$2.4 billion. These figures are drawn from CALI's own supplementary submission and from data commissioned by or for CALI. It should be noted that the statistical case for a change of this magnitude has been assembled by the party seeking the change, not an independent body.

The figures also appear to overstate the mental health-specific claims experience. As Zurich's data confirms, almost half of all its TPD claims mention mental health as a secondary issue alongside a primary physical condition.<sup>7</sup> Hence where a claim is classified as a 'mental health claim' even though the primary disabling condition is physical, the statistics likely overcount.<sup>8</sup>

Maurice Blackburn encourages the Reviewer to require CALI to produce disaggregated data – distinguishing claims where mental health is the primary basis of disablement from those where it is a secondary sequela – before any conclusion is reached as to its causative predominance.

The industry's own data does not support a mental health-specific sustainability crisis of the magnitude claimed. For example:

- Acenda data<sup>9</sup> shows musculoskeletal retail TPD claims grew 166% between 2018 and 2023; mental health claims grew 171% – a difference of five percentage points. Nobody is proposing blanket musculoskeletal exclusions.
- APRA's Quarterly Life Insurance Performance Statistics<sup>10</sup> show the industry posted profit after income tax in every quarter of 2025. Group lump sum risk recorded relatively modest losses in three of those four quarters – representing 3–7% of quarterly insurance revenue – but the data attributes those losses to no particular cause of claim. The causal link to mental health is CALI's assertion, not the APRA data's conclusion.
- AustralianSuper's March 2026 member notice<sup>11</sup> confirmed three consecutive years of falling premiums to May 2026. If the industry were experiencing a worsening mental health-specific crisis during that period, premiums would have been rising, not falling. The current repricing

---

<sup>7</sup> Ref: <https://www.smh.com.au/business/companies/mental-health-becomes-a-financial-battleground-as-insurance-premiums-soar-20260423-p5zqln.html>

<sup>8</sup> That gap is not readily filled from trustee-level data: ASIC's 2023 review found that only four of fifteen trustees regularly monitored data on the cause of claims, and none appeared to regularly monitor claim incident rates by member cohort: ASIC, REP 760 (March 2023), p 16.

<sup>9</sup> Ref: <https://www.ifa.com.au/reimagining-tpd-for-modern-australia/>.

<sup>10</sup>APRA, Quarterly Life Insurance Performance Statistics, ref: [//www.apra.gov.au/quarterly-life-insurance-performance-statistics](https://www.apra.gov.au/quarterly-life-insurance-performance-statistics).

<sup>11</sup> Ref: [https://visit.australiansuper.com/rs/389-UGQ-858/images/21502\\_Important\\_changes\\_to\\_insurance\\_costs.pdf](https://visit.australiansuper.com/rs/389-UGQ-858/images/21502_Important_changes_to_insurance_costs.pdf), p.1

cycle, which includes sharp increases in death cover, is more consistent with a correction following competitive underpricing than with any condition-specific crisis.

#### **A.4 The DDA Does Not Provide an Adequate Substitute for the Code Prohibition**

The DDA argument is the load-bearing element of CALI's case. If the DDA provided a robust and practically effective consumer protection against unjustified blanket mental health exclusions, then reverting the Code to a DDA compliance standard would at least be defensible. It does not. There are three distinct reasons for this conclusion, each independently sufficient.

##### ***(a) Jurisdictional structure***

Section 46 of the DDA<sup>12</sup> creates an exemption permitting insurers to discriminate on grounds of disability in offering insurance, provided the discrimination is based upon actuarial or statistical data on which it is reasonable to rely. Equivalent provisions appear in state anti-discrimination legislation.<sup>13</sup> But s 125 of the DDA provides that nothing in the Act renders unlawful discrimination actionable in civil proceedings otherwise than under the Act itself.

So, for example, a consumer denied an insurance benefit cannot rely on a breach of the DDA in State Supreme Court proceedings. Their only avenue is a complaint to the AHRC and, following termination of that complaint, an application to the Federal Court or Federal Circuit Court.<sup>14</sup>

The consumer denied a TPD benefit of, say, \$200,000 therefore faces two entirely separate and non-consolidable sets of proceedings: the contract claim in the State Supreme Court, and the DDA discrimination claim in the Federal Court. The two cannot be heard together. The costs (and risks) of both fall on the claimant.

The claimant must clear the AHRC hurdle before they can even commence the DDA proceedings. Through all of that, the claimant is receiving no employment income, while managing a mental health condition. In practice, the DDA's protection is available only to a claimant who has the financial resources, the legal representation, the cognitive capacity, and the sustained personal resilience to pursue multi-forum litigation over several years. That is not a description of most people with serious mental health conditions who have been denied their insurance benefits.

Nor can AFCA fill the gap. AFCA's jurisdiction derives from the Corporations Act, not the DDA. It cannot make a binding judicial finding of DDA unlawfulness and cannot grant DDA remedies – declarations, directions, or damages under s 46PO of the AHRC Act. AFCA also has no compulsory process powers to obtain the actuarial data that establishing the s 46 exemption requires.

---

<sup>12</sup> Disability Discrimination Act 1992 (Cth), s 46(1)(f) and (g).

<sup>13</sup> Equal Opportunity Act 2010 (Vic), ss 44(1)(b) and 47; Equal Opportunity Act 1984 (WA), s 66P.

<sup>14</sup> Australian Human Rights Commission Act 1986 (Cth), ss 46P and 46PO.

AFCA's own submission to this Review calls for the Code prohibition to be clarified and strengthened – signalling, from its operational experience, that the Code prohibition is the mechanism it relies upon to protect consumers in this space.

***(b) Clause 8.10: simultaneous Code and DDA protection is impossible***

Section 8.10 of the Code provides that none of its provisions can be the subject of proceedings in a court or tribunal. Hence clause 8.10 renders the Code non-justiciable in the Federal Court process discussed above. There is therefore no forum in which a consumer can simultaneously rely on the Code's mental health protections and enforce the DDA's requirements. The Code's protections are available in the pre-litigation dispute resolution process, where the DDA is practically unenforceable.

Clause 8.10 is precisely the reason why the Code prohibition matters: it is the only mechanism that prevents the consumer from ever needing to choose between the two systems.

***(c) The actuarial data: three compounding obstacles***

Even in DDA proceedings, consumers face three compounding evidentiary obstacles.

**First, the statutory threshold:** the exemption requires data that was actually available to the insurer and relied upon at the time of the discriminatory decision<sup>15</sup> – not assembled retrospectively to justify a decision already made.

**Second, the chain-of-provenance problem:** underwriters typically apply reinsurer guidelines rather than actuarial studies directly; the chain from published data to the specific exclusion frequently spans decades and corporate restructurings and is rarely documented. In Maurice Blackburn's experience, compulsory discovery produces materials that post-date the discriminatory conduct with no chain of provenance linking published studies to the underwriting guidelines that resulted in the exclusion.

**Third, commercial confidentiality:** even with compulsory processes – discovery, subpoena, notices to produce – production is resisted on confidentiality or commercial-in-confidence grounds, adding interlocutory proceedings, cost and time the consumer must sustain.

*Ingram v QBE Insurance (Australia) Limited (Human Rights)* [2015] VCAT 1936<sup>16</sup> illustrates all three simultaneously. QBE asserted its mental illness exclusion rested on detailed statistical modelling. When required to produce that data, it could not. The Tribunal found the material was not established to have existed when the policy was created, nor to have been known to those who drafted or approved the policy terms. Some of what QBE produced post-dated the discriminatory conduct. QBE failed to establish the exemption. The proceedings took approximately four years to resolve. Not every consumer has those resources, or that determination, or four years of resilience.

---

<sup>15</sup> *QBE Travel Insurance v Bassanelli* (2004) 13 ANZ Insurance Cases 61-603 at [30].

<sup>16</sup> *Ingram v QBE Insurance (Australia) Limited (Human Rights)* [2015] VCAT 1936 (18 December 2015), Member Dea.

These obstacles are structurally predictable. Neither CALI nor its predecessor the Financial Services Council has published a policy or practice note specifically addressing what actuarial and statistical data life insurers must collect, document and maintain to satisfy the s 46 exemption in the context of mental health exclusions.<sup>17</sup>

The AHRC published comprehensive guidelines on this question in 2016, covering underwriting manuals, local data, international studies, industry experience and actuarial advice.<sup>18</sup> The industry chose not to adopt them into any member standard or guidance document.

AFCA has published no approach document on disability discrimination in insurance or on how it assesses an insurer's reliance on the s 46 exemption.

The Life Code (clause 4.18) refers underwriters to 'CALI standards and guidance' on anti-discrimination law – but no such standard or guidance exists. Without these mechanisms there is no consistent framework to support the DDA as a consumer protection: nothing that operates with any consistency across members, and nothing a consumer experiencing a declined claim can draw upon to understand whether the exclusion was lawfully imposed or how to challenge it.

CALI proposes to make this the consumer's primary protection while having never guided its members on what it requires.

#### **A.5 The Industry Already Possesses the Tools It Needs**

Before considering whether blanket mental health exclusions are necessary, it is worth understanding what already exists in practice.

The industry has characterised group TPD insurance as products designed for physical conditions that have been overwhelmed by mental health claims. This characterisation inverts the historical sequence.

The products were not static and then overwhelmed. **They have been actively redesigned, to embed a comprehensive suite of mechanisms that substantially limit mental health claims exposure without constituting explicit blanket exclusions.** The following table identifies some of the key mechanisms which bear disproportionately on mental health claimants:<sup>19</sup>

---

<sup>17</sup> We note the Productivity Commission's report on its Review of the Disability Discrimination Act 1992 (Report, 2004) vol 1, ch 12 ('Insurance and Superannuation'). The Commission noted that 'the threat of a DDA complaint led to progress in developing a memorandum of understanding (MOU) between the Insurance and Financial Services Association (IFSA) and mental health sector stakeholders' and that '[t]he MOU requires IFSA members to revise their underwriting practices and adopt new guidelines for dealing with people with mental health problems', observing that '[i]t is too early to tell how successful this MOU might be.' That observation was made over two decades ago.

<sup>18</sup> Australian Human Rights Commission, Guidelines for Providers of Insurance and Superannuation (updated 2016), ref: <https://humanrights.gov.au/resource-hub/by-resource-type/publications/guidelines/guidelines-providers-insurance-and-superannuation>.

<sup>19</sup> The cumulative operation of several of these mechanics within a single current product is illustrated by the legalsuper Employer Sponsored Super & Personal Super Additional Information Guide (1 November 2025). Under Part 4 of the legalsuper TPD definition, a member claiming on mental health grounds must satisfy the following requirements, none of which apply to a physical injury claim under Part 1 of the same definition: a 12-month continuous work cessation period

Policy mechanism	Why it bears disproportionately on mental health claimants
Activities of daily living (ADL) and Activities of Daily Work (ADW) tests	Many group policies have applied these restrictive definitions to members who are not in paid employment or work fewer than a threshold number of hours per week. Under the ADL test, a member can only claim if they are unable to perform two or more basic self-care activities such as feeding, bathing, dressing or walking. <sup>20</sup> ADW requires inability to perform basic work activities such as walking 200 metres. The disproportionate effect on mental health claimants persists: a person with severe depression or anxiety may retain those basic capacities while remaining wholly unable to work. <sup>21</sup>
'Solely' causation requirements	Claimants must prove that ceasing work was caused <i>solely</i> by the relevant medical condition. A dismissal recorded as 'misconduct and poor performance' must be traced to the underlying mental illness – a causation burden that does not arise for acute physical injury. In <i>Sharp v Maritime Super Pty Ltd</i> <sup>22</sup> the sole operative cause of termination was a psychotic condition developing for two years before dismissal but diagnosed only six weeks afterwards. <sup>23</sup>
Date of disablement / certification gap	Many group policies define the date of disablement as the later of the date last worked and the date a medical practitioner certifies the insured as disabled. Cover must be on foot at that date – if it has lapsed in the interval, the claim fails at the threshold without merits assessment. For acute physical conditions the gap between ceasing work

(compared to three months for physical conditions); diagnosis by a specialist psychiatrist using DSM criteria; certification by the treating psychiatrist that all reasonable treatment options have been exhausted; and a Psychiatric Impairment Rating Scale assessment of 19% or above conducted by an insurer-approved psychiatrist. The product is publicly available at [legalsuper.com.au](https://legalsuper.com.au).

<sup>20</sup> ASIC's 2019 Report 633 found that mental health claims were approximately five times more likely to be declined (77% for ADL compared to 15% for the general definition) (ref: <https://download.asic.gov.au/media/5311117/rep633-published-17-october-2019.pdf>, table 5, p.36). Pleasingly, the acute harm caused by ADL definitions was substantially cauterised by ASIC's intervention, and ADL definitions are now rarely seen in new products. However, a significant legacy tail persists in policies issued before that change took effect, and continues to affect claimants.

<sup>21</sup> ASIC's 2023 review (REP 760) found nine of fifteen trustees had substituted an activities of daily working (ADW) definition rather than moving to any occupation (ref: [Report REP 760 Insurance in superannuation: Industry progress on delivering better outcomes for members](#)).

<sup>22</sup> *Sharp v Maritime Super Pty Ltd* [2012] NSWSC 1350 (Ward J, NSW Supreme Court Equity Division, 7 November 2012) ('*Sharp*').

<sup>23</sup> *Sharp* [2012] NSWSC 1350, [2], [19]: Mr Sharp was employed as a stevedore from 1997 to June 2006. His employment was terminated on 23 June 2006. He was formally diagnosed with Stimulant Substance Dependence and Chronic Psychotic Disorder (differential diagnosis of schizophrenia) on 2 August 2006, approximately six weeks after termination.

Policy mechanism	Why it bears disproportionately on mental health claimants
	and certification is typically days or weeks. For mental health conditions it is frequently months. <sup>24</sup>
'Any occupation' and retraining definitions	TPD definitions have been progressively widened to require inability to perform any occupation for which the claimant could become reasonably suited through retraining. A claimant with fluctuating severe depression who retains basic physical function faces a contested permanency assessment that simply does not arise for serious physical disabilities.
Maximum medical improvement thresholds	MMI was developed for physical medicine and maps poorly onto mental health conditions characterised by relapse-recovery cycles and treatment-resistant phases, allowing insurers to defer permanency assessment almost indefinitely.
Specialist treatment requirements	Access to specialist psychiatric care is substantially more constrained than orthopaedic or oncological access, particularly in regional areas, creating a structural barrier that falls hardest on those most at risk.
Benefit period limitations and offset provisions	Reductions to two-year benefit periods, extended waiting periods and broad offset provisions against workers' compensation and government disability payments erode product value disproportionately for long-term mental health claimants.
TPD Assist instalment structures <sup>25</sup>	Instalment structures condition each payment tranche on the claimant continuing to satisfy the TPD definition at that date. For conditions characterised by relapse-recovery cycles, each instalment becomes a fresh merits assessment by the insurer.
'First became apparent' / pre-existing condition exclusion	Many group policies exclude conditions that first became apparent before cover commenced. This exclusion is disproportionately triggered by mental health conditions because a report to a treating doctor of a point-in-time psychological issue – depression, anxiety or stress,

<sup>24</sup> Anosognosia – the clinically recognised inability to recognise one's own illness – is a characteristic feature of psychosis, severe depression and bipolar disorder: the person is least capable of seeking diagnosis and certification at precisely the time when they are most acutely ill.

<sup>25</sup> See for example: Australian Retirement Trust, Super Savings Insurance Guide (1 July 2025), available at <https://cdne.australianretirementtrust.com.au/media/project/art/publicweb/pdfs/pds/super-savings-insurance-guide.pdf>.

Policy mechanism	Why it bears disproportionately on mental health claimants
	however mild or momentary – can constitute the condition ‘first becoming apparent’. A brief GP consultation years before cover commenced, for a condition that had fully resolved, can exclude a more serious subsequent episode of disabling mental illness.
Financial affairs supervision exclusion	Some policies exclude TPD where a person’s financial affairs are under third-party supervision due to their medical condition – disproportionately engaging severe mental illness and excluding from cover the claimant most seriously disabled at the moment of greatest need. <sup>26</sup>

The combined effect is that a claimant with a serious mental health condition navigating a modern group life policy is not doing so on a level playing field. The industry does not need blanket exclusions to manage its mental health claims exposure. It has already built the management into the product.

It also bears noting that several of the most significant constraints on mental health claims are recent in origin, and their full effect (along with the effect of any premium increases) has not yet worked through to the reported claims data. The claims experience on which CALI relies reflects policy terms issued under earlier product generations, not under the current architecture.

Maurice Blackburn encourages the Review to require CALI to account for this latency before treating the current claims trajectory as a reliable basis for assessing whether the existing toolkit is insufficient.

Maurice Blackburn believes that the above discussion invites a question which we urge the Reviewer to consider:

Each of the mechanisms described above requires the insurer to engage with the merits of an individual claim – to assess causation, examine medical evidence, evaluate whether MMI has been reached, determine whether the solely test is satisfied etc. A blanket exclusion obviates that process entirely: the claim is declined at the threshold without merits assessment, and the evidentiary and procedural obligations that would otherwise arise do not. In an environment where claims statistics are publicly reported by APRA and ASIC and scrutinised by the media, researchers and prospective customers, there is a structural incentive to reduce the volume and cost of assessed claims rather than improve the quality of assessment.

The Reviewer may wish to consider whether the current proposal reflects, at least in part, a preference for a blunt threshold mechanism over the obligations and costs that a good faith individual assessment process entails.

---

<sup>26</sup> Ibid - Australian Retirement Trust, Super Savings Insurance Guide (1 July 2025), p.15

## A.6 The Practical Consequences: Blanket Exclusions, Disputation, and the Risk of Total Claim Defeat

The most immediate practical consequence of reintroducing blanket mental health exclusions is that it will generate a surge in disputes for claimants with a concurrent mental health condition.

Blanket exclusions drafted in the standard industry language of ‘wholly or in part,’ ‘directly or indirectly,’ or ‘to any extent’ will inevitably generate concurrent cause arguments from insurers against claimants whose primary disabling condition is physical but who also have a mental health component.

The cost of such disputation falls on both sides. Those disputes will involve expert medical evidence on the disentanglement of physical and psychological conditions and will be expensive to resolve.

The concurrent cause principle insurers will invoke derives from *Wayne Tank and Pump Co Ltd v Employers Liability Assurance Corporation Ltd*.<sup>27</sup> Its application to life insurance TPD claims – as opposed to general insurance – is contested: in the TPD context a person can have multiple distinct disabilities each independently sufficient to cause total incapacity, and the jurisprudence develops case by case on its specific facts. The argument will not always succeed.

In *Nathan Rich v TAL Life Ltd*,<sup>28</sup> TAL’s concurrent cause argument failed<sup>29</sup> because the shoulder injury was independently sufficient and clinically separable from the excluded cervical spine condition. But that case illustrates the complexity, cost and expert evidence required to mount that defence.

Similar arguments have been deployed before AFCA<sup>30</sup> and the principle has been applied in the physical versus psychological insurance context since *Lipertis v Australian Casualty Company Pty Ltd*.<sup>31</sup>

The critical distinction between *Rich* and the scenario that would arise under a blanket mental health exclusion is that physical and psychological sequelae cannot be anatomically disentangled. A clinician can examine a shoulder independently of a cervical spine. But the depression that follows and is inseparably connected to chronic pain cannot be assessed in the same way.

Concurrent cause arguments in the mental health exclusion context will not only be raised more readily – they will be harder and more expensive for all parties to resolve.

---

<sup>27</sup> *Wayne Tank and Pump Co Ltd v Employers Liability Assurance Corporation Ltd* [1974] QB 57; AFCA, The AFCA Approach to proximate cause of damage (AFCA Approach paper): ‘AFCA will only apply the Wayne Tank principle if we are satisfied there are multiple proximate causes to a loss and one of the causes of the loss falls within an exclusion in the policy that applies to the insured event.’ Available at [www.afca.org.au/media/1345/download](http://www.afca.org.au/media/1345/download).

<sup>28</sup> *Nathan Rich v TAL Life Ltd* [2024] VCC 1844 (Judge Clayton, County Court of Victoria, 21 November 2024).

<sup>29</sup> *Rich v TAL* [2024] VCC 1844: TAL submitted that the exclusion applied to anything caused ‘directly or indirectly’ from the cervical spine, and that ‘if there is any connection at all between the incapacitation and the cervical spine disorder, the claim will be excluded.’

<sup>30</sup> AFCA Determination 745861. In this matter, a life insurer sought to invoke the *Wayne Tank* principle in the context of a life insurance policy containing a mental health exclusion, arguing that the concurrent mental health cause defeated the TPD claim. Available at <https://service02.afca.org.au/CaseFiles/FOSSIC/745861.pdf>.

<sup>31</sup> *Lipertis v Australian Casualty Company Pty Ltd* [1983] 2 VR 280 (Supreme Court of Victoria, Crockett J).

## A.9 Responses to the Reviewer's Questions

### **Question 1: Whether it would be appropriate to change clause 2.1(b) to allow limitations on cover for mental health in standard form policies.**

No. As detailed above:

- The statistical case for the change has not been made.
- The DDA does not provide an adequate substitute.
- The industry already has extensive structural tools to manage mental health claims exposure, and
- If blanket exclusions are introduced, approaching half of all TPD claimants face the prospect of costly concurrent cause disputes that the industry itself must bear a share of – making the sustainability case considerably less clear than the headline numbers suggest.

Clause 2.1(b) should be retained.

### **Question 2: The impact of the proposed approach on consumers and insurers.**

As detailed above, on consumers, the harm would be substantial.

Approaching half of all TPD claimants mention mental health in some capacity. All of them face the risk that a concurrent mental health exclusion is used to defeat their entire claim, regardless of whether mental health is the primary basis of their disability.

Consumers who seek to challenge exclusions under the DDA would face the three-part problem described in section A.4 of this submission: the jurisdictional structure of the DDA confining relief to the AHRC–Federal Court pathway (with AFCA unable to provide DDA protection), clause 8.10's non-justiciability in those proceedings, and the practical obstacles to compelling actuarial data.

On insurers, the short-term reduction in claims liability would be offset by increased disputation costs and purchased at the cost of the industry's social licence and public trust.

### **Questions 3(a)–(d): Code consistency with the DDA; guardrails and disclosure obligations.**

The Code cannot adequately ensure DDA consistency. The problem is the statutory architecture of the DDA, not the Code's drafting.

Recommendation 2 – requiring a plain English summary of the actuarial and statistical data underlying an adverse underwriting decision – is the mechanism that would most directly address the data transparency problem and Maurice Blackburn supports it.

Guardrails and consumer information measures mitigate harm; they do not prevent it.

The correct approach is to prevent the harm by retaining the prohibition. Recommendations 2 and 3 are valuable free-standing improvements that should be implemented regardless of the outcome on clause 2.1(b), although Maurice Blackburn has reservations as to the enforceability of these rights, based on our extensive experience of insurer resistance discussed above.

### B.1 Section 8.10 and Its Consequences

The Interim Report articulates why enforceability matters:<sup>32</sup>

*Enforceability is critical to the effectiveness of any code. At its heart, an industry code is a promise to consumers about what they can expect when they engage with a subscriber to that code. Consumers should be able to rely on those promises. They cannot be confident in a code if there is not an effective enforcement framework that underpins and incentivises compliance, and there are inadequate consequences for non-compliance.*

The consumer-centred nature of this observation is consistent with the objects of the Review as set out in the Terms of Reference and reiterated on page 6 of the Interim Report:

- *Ensuring the Life Code is fit for the needs of today and the future.*
- *Enhancing the customer experience.*
- *Increasing consumer accessibility and usability of the Life Code.*
- *Ensuring the Life Code is effective, robust, and enforceable.*

As detailed above, section 8.10 of the Code is in direct tension with these objects. It provides that none of its provisions can be the subject of proceedings in a court or tribunal. Its interaction with the DDA's exclusive Federal Court enforcement pathway – creating an impossible position for consumers who need both Code and DDA protection simultaneously – is addressed in section A.4(b) of this submission. The structural case for changing this position was put by Commissioner Hayne in the Royal Commission Final Report:<sup>33</sup>

*If industry codes are to be more than public relations puffs, the promises made must be made seriously. If they are made seriously... the promises... must be kept. This must entail that the promises can be enforced by those to whom the promises are made: the customer.*

Case law in related financial services sectors already establishes that industry code provisions can have contractual effect.<sup>34</sup> The extension of that principle to life insurance contracts through Recommendation 71 is straightforward and overdue.

### B.2 Support for Recommendation 71

Maurice Blackburn supports the Reviewer's Recommendation 71 that the Code should be incorporated into new customer contracts, so that its commitments are contractually enforceable by consumers.

---

<sup>32</sup> Interim Report, p 60.

<sup>33</sup> Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Final Report (2019), p. 12, ref: <https://www.royalcommission.gov.au/system/files/2020-09/fsrc-volume-1-final-report.pdf>.

<sup>34</sup> See for example *National Australia Bank v Rose* [2016] VSCA 169; *Doggett v Commonwealth Bank of Australia* [2015] VSCA 351

A consumer who suffers a breach of an incorporated Code commitment has a cause of action available in the courts – a real remedy that goes to restitution, not merely a complaint to a compliance body with limited powers. Without contractual incorporation, a Code breach produces, at best, a regulatory response that is symbolic from the affected consumer’s perspective.

The Banking Code and Customer Owned Banking Code of Practice are already incorporated into contracts. The Insurance Council of Australia has committed to contractual enforceability for the General Insurance Code. Life insurance is the remaining outlier without principled justification. The Interim Report itself observes:

*Enforceability will also be a focus if CALI seeks ASIC approval for the Code. When approving an industry code ASIC must have regard to whether the obligations in the Code are capable of being enforced. (p.60)*

The Australian Lawyers Alliance (ALA) has expressed a preference for the designation of specific provisions as ASIC Enforceable Code Provisions. Maurice Blackburn acknowledges this as a legitimate approach and a material improvement over the current position.

Our preference is for comprehensive contractual incorporation. Both approaches are substantially superior to the current regime, and we urge the Reviewer to recommend the implementation of at least one of them.

Maurice Blackburn also endorses PJC Recommendations 4.2 and 4.3<sup>35</sup> for ASIC enforcement powers in relation to systematic Code breaches and universal application of the Code. Recommendation 4.2 reads:

*The committee recommends that ASIC be given the power to undertake enforcement action (halting misconduct, remedies and sanctions) in relation to systemic or systematic breaches of codes of practice in the financial services sector, including in the life insurance sector.*

## CONCLUSION

---

The Reviewer has posed a direct question: would it be appropriate to change clause 2.1(b) to allow limitations on mental health cover in standard form policies? In our view, the answer is no.

The statistical case has not been made out. The industry’s own data – from Zurich, from APRA, from AustralianSuper – is inconsistent with a mental health-specific sustainability crisis.

The DDA does not provide an adequate substitute for the Code prohibition. Its jurisdictional architecture, the effect of clause 8.10, and the practical barriers to compelling complete and transparent disclosure of actuarial data combine to make DDA enforcement a theoretical right and a practical impossibility for most consumers.

---

<sup>35</sup>Parliamentary Joint Committee on Corporations and Financial Services, Inquiry into the Life Insurance Industry (Report, 2018), Recommendations 4.2 and 4.3.

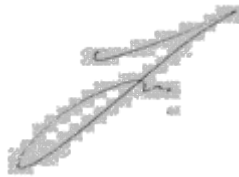
The industry already has the tools it needs – a well-developed and evolving suite of policy mechanics substantially limits mental health claims exposure without any blanket exclusion, and the full constraining effect of the most recent changes has yet to work through the reported data. And if blanket exclusions are introduced, approaching half of all TPD claimants face concurrent cause disputes that are expensive for both sides and may substantially diminish whatever commercial benefit the industry claims to seek.

The industry is not trying and failing to implement the current standard. Some of its members are not implementing it at all. The answer to non-compliance is enforcement and accountability, not a reduction in the standard to the level of non-compliant conduct.

Maurice Blackburn urges the Reviewer to retain clause 2.1(b), to support Recommendation 71 for contractual incorporation of the Code, Recommendation 66 for named non-compliance reporting, and Subject to the above caveat, Recommendations 2 and 3 for proactive actuarial data disclosure and improved disclosure guidance. These measures address the genuine problems in the current system and would go a substantial way toward making the Code's promises meaningful for the people who most need them.

Please do not hesitate to contact the writer and my colleagues on 07 3014 5051 or at [JMennen@mauriceblackburn.com.au](mailto:JMennen@mauriceblackburn.com.au) if we can further assist with the Review's important work.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'Josh Mennen', written over a light grey grid background.

**Josh Mennen**  
Principal Lawyer  
[Maurice Blackburn Lawyers](#)