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Lessons from the Courtroom: Navigating Trustee Duties and Insurance Complexities

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Abstract

Since the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry in 2018 (the Royal Commission), litigation in the superannuation sector, including insurance in superannuation, has intensified. Recent and ongoing class actions and regulator enforcement now target practices that may breach core trustee obligations.

This paper explores the landscape:

- What were the issues facing recent legal proceedings?
- Did governance, systems, or behaviour fail?
- What lessons emerge from these failures?
- What duties do trustees (and insurers) owe to members in offering group insurance, especially in areas where consent or disclosure is ambiguous?
- Beyond the headline cases, are there latent risks still under the radar?
- What role do actuaries have in reducing legal, operational, and reputational risks?
- Looking forward, what might 'good practice' look like?

Keywords: *Trustee duties, insurance in superannuation, superannuation governance, class actions, regulatory enforcement, member outcomes, fiduciary responsibilities, group insurance, litigation risk, regulatory compliance, risk management, best financial interests duty, trustee covenants (SIS Act), insurance administration, actuarial advice*

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Executive Summary

The Royal Commission provided the industry with an independent review of how the industry was performing. This is to be welcomed. It has made a difference, steering the superannuation industry onto a more robust and sustainable path and enlivening the regulators.

The Royal Commission had some strong criticism of parts of the industry and its regulators. This has resulted in:

- A change (1 July 2021) to the member best interest covenant. Most significantly the onus of proof has shifted from the regulator to the trustee (evidential burden) in civil liability actions commenced by the regulators, with the trustee assumed to have breached the new best financial interests duty in these types of actions unless they have evidence to demonstrate otherwise.
- A much-improved SPS250.
- Litigation by class action law firms.
- Better guidance and direction from regulators.
- Enforcement by regulators where there was previously little or none.

Recent class actions, most of which came out of the Royal Commission's work, together with regulator enforcement (in total, we discovered 34 superannuation trustee cases – see Appendix 3) provide some learnings on:

- Poor trustee decisions including in the areas of insurer review, conflict management, prioritising other parties over members, disclosure and communication, default insurance design, efficiency, reporting to the regulator and remediation.
- What a successful defence looks like.

Latent risks still exist – particularly for the provision of insured benefits. We have provided examples of these in Section 7.

The insured benefits provided through superannuation are of great value to Australians. Superannuation members paid $6.5 billion[1] in group premiums to the life insurance industry in 2025 and will receive through their superannuation fund a similar amount in claim payments (currently estimated as $5.9 billion[1]) for the cover provided by those premiums. These are very large cashflows, primarily moving between members via the pooling of members' risk provided by the life insurance and superannuation industries. In our opinion, the design and delivery of this approximately $12.4 billion in annual cashflows warrants greater focus from the superannuation industry if it is to avoid these latent risks.

The evidential burden on the trustee arising from members' best financial duties means greater rigour and documentation of decisions are required if the trustee and trustee directors are to avoid costly litigation, penalties and remediation.

From the members' point of view, prevention of errors and omissions is always better than cure; cure involves one or more of complaints, remediation, enforcement, litigation and cost (most likely ultimately borne by the members).

For the members the order of merit for detecting and rectifying an error or omission is:

1. Early detection by the trustee and immediate remediation.
2. Detection by the trustee and remediation.
3. Detection by a third party and remediation.

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[1] https://www.apra.gov.au/quarterly-life-insurance-performance-statistics - direct premiums group superannuation, ignoring reinsurance cashflows

4. Regulator enforcement, including remediation and most likely penalties, which may ultimately be paid for in part or full by members.
5. Class actions, which are not optimal for members and may also ultimately be paid for by members. Class actions do provide some remediation for members, if they are successful, and do hold trustees more fully to account than the alternative which is, no disclosure of poor decisions and no remediation.
6. Doing nothing.

Superannuation is complex, especially insurance in superannuation, which is often provided on a default basis to large, diverse memberships. Trustees are accountable for decisions affecting members and must act in their best financial interests and with honesty, care, skill and diligence.

Actuaries can play an important role in supporting trustees to meet these obligations by providing an integrated, evidence-based perspective across the full insurance cycle. Actuarial advice can help trustees clearly articulate trade-offs, test and monitor outcomes over time, and document the analysis and reasoning underpinning key decisions in a way that aligns with relevant SIS and corporate law requirements.

An industry characterised by strong governance and minimal litigation is achievable. With a cultural shift in some areas, the right skills, and a heightened focus on members' best financial interests, trustees can make decisions that reduce risk and avoid costly disputes. Legislators and regulators play a crucial role in fostering this culture by enacting prudent laws and regulations and holding trustees accountable, ultimately supporting a sustainable and efficient superannuation system, including insurance, that benefits all members.

1. Introduction

The Actuaries Institute's Group Insurance in Superannuation Public Policy Statement[2] (PPS) published in August 2025, neatly summarises the important role insurance plays in the retirement income system:

> "During their working life, around 30% of Australians will be financially impacted by disablement or the death of their partner. In many cases, this will have a severe impact on their future working income and their retirement income.
>
> Financial support through group insured death and disability benefits provided by superannuation funds can be a very efficient and effective means of mitigating the financial loss impacting these individuals. As a proportion of the insurance cover provided, individual members pay a relatively small premium to help cover the risk of this severe financial stress.
>
> Insured benefits provided under group policies within superannuation (referred to as death and disability benefits in this Statement) are one of the cornerstones for meeting the objective of superannuation, particularly the dignified retirement objective of superannuation."

APRA emphasises the importance of insurance in protecting households in its recent publication *'Mind the Gap - An Insurance Climate Vulnerability Assessment*[3]'. This applies equally to death and disability insurance. To paraphrase APRA's statement[4], *affordable and widely held death and disability insurance supports a resilient and productive economy by protecting households against large and unexpected financial losses*.

Insurance in superannuation is a defining feature of Australia's retirement income system. By embedding death and disability insurance within superannuation, policymakers sought to deliver affordable, broadly accessible protection against financial shocks during a member's working life in the event of death or disability. Superannuation is not only a financial asset, for most working Australians, it is also their primary source of insurance to help protect their greatest asset – their ability to earn future personal exertion income.

This integration places insurance at the intersection of retirement savings, consumer financial protection, and RSE licensee (trustee) fiduciary duty, creating a complex governance environment.

Since the Royal Commission, insurance in superannuation has become the subject of litigation, regulatory intervention and public scrutiny. Class actions and regulatory enforcement proceedings test whether trustee decision-making, governance, and operational execution meet fiduciary and statutory duties[5], in particular *'acting in members' best financial interest'*. They are a powerful forum for evaluating the adequacy of trustee actions.

This paper examines what recent legal proceedings reveal about possible weaknesses in trustee governance with a focus on insurance in superannuation, the extent to which trustee duties have been breached, how trustees can navigate the complexities of insurance in superannuation to reduce legal, operational, and reputational risk going forward, and the roles actuaries can play to support this.

In the context of this paper, 'best financial interest' (s 52(2)(c) of the Superannuation Industry (Supervision) Act 1993 (SIS Act)) also refers to its pre-1 July 2021 predecessor 'best interest'.

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2 https://content.actuaries.asn.au/resources/resource-ce6yyqn64sx3-2093352434-60254

3 https://www.apra.gov.au/mind-gap-an-insurance-climate-vulnerability-assessment

4 APRA's statement, "Affordable and widely held *home* insurance supports a resilient and productive economy by protecting households against large and unexpected financial losses" and substituting 'home' with 'death and disability'.

5 Fiduciary duty is a high-level duty of loyalty and trust arising from a specific relationship (for example, trustee-beneficiary), whereas a statutory duty is an obligation explicitly imposed by a government-enacted law or statute

The 1 July 2021 change also changed the onus of proof in civil liability actions commenced by the regulators.

In this paper, TPD refers to the Total and Permanent Disablement benefit and IP refers to the Income Protection benefit.

2. The Legal and Regulatory Context for Insurance in Superannuation

2.1 Regulatory Framework and Trustee Obligations

Insurance in superannuation operates across intersecting trustee, prudential and conduct regimes. Together, these frameworks are designed to protect members, support members' best financial interests and promote the sustainability of the superannuation system.

APRA supervises prudential soundness, including the financial strength, operational resilience, and governance of trustees and life insurers. APRA's remit also includes consideration of members' best financial interests, with some level of regulatory overlap with ASIC.

ASIC supervises conduct regulation, including disclosure, product governance and distribution, complaints handling and breach reporting, where trustees hold an Australian Financial Services Licence (AFSL) and engage in conduct regulated under the Corporations Act.

At the core of trustee obligations are the trustee covenants under section 52(2) of the SIS Act and the insurance covenant under section 52(7) and related obligations under the Corporations Act 2001 and APRA prudential standards. Collectively, these require trustees to:

- Act honestly and with the care, skill and diligence of a prudent superannuation trustee[6].
- Act in the best financial interests of the beneficiaries[7].
- Act fairly between and within classes of beneficiaries[8].
- Not to do anything that would prevent the trustee from, properly performing their functions and powers[9].
- Ensure insurance arrangements are appropriate for members, having regard to the membership profile of the fund[10].
- Avoid inappropriate reduction of retirement incomes through the cost of insurance premiums[11].
- Manage conflicts of interest and give priority to duties owed to members, including maintaining adequate risk management and governance frameworks[12].
- Select, appoint, and maintain appropriate insurers, and perform regular monitoring and due diligence on those arrangements[13].
- Do everything that is reasonable to pursue an insurance claim for the benefit of a member where the claim has a reasonable prospect of success[14].
- Assess, monitor, and report annually on member outcomes, including outcomes relating to insurance benefits, costs, and value[15].

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6 SIS Act s 52(2)(a), (b)

7 SIS Act s 52(2)(c)

8 SIS Act s 52(2)(e), (f)

9 SIS Act s 52(2)(h)

10 SIS Act s 52(7)(a)

11 SIS Act s 52(7)(c)

12 SIS Act s 52(2)(d), Corporations Act 2001 (Cth) s 912A(1)(aa)

13 SIS Act s 52(2)(b), SIS Act s 52(7)(a), (b), (c), SPS 250, para 19

14 SIS Act s 52(7)(d)

15 SIS Act s 52(10), s 29VN, SPS 515, Corporations Act 2001 (Cth) s 1017D

APRA gives practical force to these duties through Prudential Standard SPS 250 (Insurance in Superannuation) and related prudential standards as well as guidance through SPG 250. See Appendix 1 for further details.

The Life Insurance Code of Practice (LICOP) (currently being reviewed) is a compulsory code for life insurers. It has practical implications for trustee decision-making, particularly in relation to claims oversight, service standards, and member outcomes. See Appendix 2 for further details.

2.2 Post-Royal Commission expectations and why these matters for trustees

The Royal Commission has materially strengthened the practical standard by which trustee conduct is judged. For trustees, this means insurance in superannuation requires ongoing care, diligence, and active oversight rather than a passive reliance on process, documentation or service-provider reporting.

The Commission emphasised that trustee decision-making must be genuinely informed, requiring trustees to identify the relevant considerations, obtain and test the necessary information and advice, and apply proper care, skill and diligence in doing so:

> "A trustee has a duty to identify relevant considerations before making a decision and to use all proper care and diligence in obtaining the relevant information and advice relating to those considerations. It has been said that if the consideration of the trustee is not properly informed, it is not genuine. The duty to take these steps flows both from the best interests obligation and also from the duty of care, skill and diligence."
>
> *The Royal Commission Final Report, Vol 2, p. 58*

In this context, trustees are expected to be able to demonstrate that insurance design, insurer selection, claims oversight, communications and remediation are:

- *Member-first and outcome-directed*, prioritising member financial outcomes over institutional or commercial considerations. The Royal Commission criticised conduct where entities compromised member interests, leading to 'good enough' outcomes rather than best interests outcomes:

  > "Those persons and entities obliged to pursue the best interests of clients or members too often sought to strike some compromise between the interests of clients or members and their own interests or the interests of a related third party (such as the person's employer, or the entity's owner). A 'good enough' outcome was pursued instead of the best interests of the relevant clients or members."
  >
  > *The Royal Commission Final Report, Vol 1, p. 3*

- *Conflict-controlled (and not reduced to procedural compliance)*, reflecting the Commission's finding that conflicts are inherently difficult to manage and cannot be addressed through checklists alone:

  > "Conflicts between duty and interest can seldom be managed; self-interest will almost always trump duty"
  >
  > *The Royal Commission Final Report, Vol 1, p. 3*
  >
  > "Conflicts of interest cannot be managed through box-ticking processes."
  >
  > *The Royal Commission Final Report, Vol 1, p. 231*

- *Substance over form (outcomes tested, not merely procedurally compliant),* recognising that member harm can persist even where formal frameworks exist. Trustees should test whether controls are effective in practice, identify root causes, and implement corrective actions that prevent recurrence.

  As the Commission stated:

  > "What the Recommendation requires is much more than an exercise in 'box ticking'. Its proper application demands intellectual drive, honesty and rigour. It demands thought, work and action informed by what has happened in the past, why it happened and what steps are now proposed to prevent its recurrence. Above all, it demands recognition that the primary responsibility for misconduct in the financial services industry lies with the entities concerned and with those who manage and control them: their boards and senior management."
  >
  > *The Royal Commission Final Report, Vol 1, p. 391*

- *Auditable and defensible*, supported by clear evidence can withstand regulatory scrutiny and litigation, including evidence that trustees actively test, challenge and validate information received from insurers, administrators and related parties, rather than passively relying on reporting:

  > "...requires ongoing care and diligence… it must test the information it receives and seek further information where necessary… [and] satisfy itself that the trust is being run in the best interests of the members."
  >
  > *The Royal Commission Final Report, Vol 1, p. 230*

The Commission also reinforced a markedly stronger enforcement posture, crystallised in its expectation that regulators should default to litigation when contraventions are identified:

> "In the end, the critical question whenever ASIC is considering any contravention of the law must be the question ASIC now accepts must be asked: 'Why not litigate?'"
>
> *The Royal Commission Final Report, Vol 1, p. 424*

In practical terms, this shift materially increases the importance for trustees of high-quality evidence, clear escalation discipline, and timely, comprehensive remediation where insurance arrangements, administration or claims handling fail to deliver appropriate member outcomes. The Commission's commentary on remediation governance underscores the expected urgency:

> "Enough is enough. Fix this, and fix it now."
>
> *The Royal Commission Final Report, Vol 1, p. 398*

2.3 Regulatory Impact

The Royal Commission led to:

a) A change (1 July 2021) to the member best interest covenant. Most significantly the onus of proof has shifted from the regulator to the trustee (evidential burden) in civil liability actions commenced by the regulators, with the trustee assumed to have breached the new best financial interests duty in these types of actions unless they have evidence to demonstrate otherwise.

b) APRA making significant changes to SPS 250. The initial draft, released in November 2019, included a cut and paste of many of the Commission's recommendations. This was subsequently enhanced following submissions and SPS 250 was released 1 July 2022.

The key changes to SPS250 from the Commission's recommendations were:

- Independent Certification of Related Party Arrangements (Recommendation 4.14)
  - Mandatory Certification: Trustees must now obtain an independent certification before entering into or materially altering an insurance arrangement with a related party insurer.
  - Ongoing Review: This certification must be updated on a triennial basis to ensure the arrangement remains appropriate.
  - Best Interests Test: The independent certifier must state that it is reasonable for the trustee to form the view that the arrangement is in the best financial interests of beneficiaries and satisfies all legal requirements.
  - APRA Reporting: Trustees are required to provide this certification to APRA within five business days of receiving it.
- Fair and Reasonable Status Attribution (Recommendation 4.15)
  - Status Rules: Trustees must ensure that any rules used to attribute a particular "status" to a member, such as occupational (for example, "blue-collar") or lifestyle categories (for example, "smoker status") are fair and reasonable.
  - Member Impact: This change aims to prevent members from being unfairly charged higher premiums or having their retirement income eroded due to inappropriate status classifications.

3. Structural Complexities of Insurance in Superannuation

Insurance in superannuation for members is life insurance delivered through a trust-based retirement savings vehicle primarily on a default basis.

For trustees, insurance in superannuation involves the management of the design and delivery of benefits for very large, diverse memberships involving very large cashflows[16], primarily moving between members via the pooling of members' risk provided by the life insurance and superannuation industries.

The result is an arrangement that can look simple to members – 'insurance through my superannuation' – but is structurally complex for trustees. This section outlines the inherent structural complexities of insurance in superannuation.

3.1 Default and passive member consent – why defaults exist, and why they attract scrutiny

Default cover is a defining feature of group insurance. It is used by all superannuation funds and is supported by legislation.

Default cover expands access (including for members who would not actively buy cover or who may be declined or provided with restricted cover) and typically reduces costs through risk pooling. Most members do not actively choose cover.

3.2 Inherent conflicts – cover, cost, and commercial incentives

Insurance in superannuation embeds structural conflicts that trustees must actively manage, for example:

- Premiums versus retirement outcomes – Premiums reduce retirement balances for those members who are fortunate enough not to have a claim event over their working life, though they also provide financial security and peace of mind during members' working lives given the random nature of death and disability. Around 70%[17] of members are in this position.
- Price versus terms and claims outcomes – Lower premiums can be achieved through stricter definitions, exclusions, eligibility rules, or claims processes that reduce claimability. On the other hand, stricter terms may mean that benefits are not provided in circumstances where the trustee determined that benefits are appropriate. Balancing these competing objectives (cover when appropriate versus cost) is a key part of the insurance design process.
- Commercial relationships – Insurer, administrator, claims manager and adviser arrangements can create incentives that are not naturally aligned to member outcomes, especially if not governed with strong oversight and assurance.

3.3 Group insurance embedded within trust structures – scale, automation, and data integrity risk

Insurance in superannuation is typically provided through group policies held by the trustee for members. This structure is cost-efficient and expands access, but it also creates a governance challenge: members often experience insurance as a 'personal entitlement' while it is administered through trustee-controlled fund rules, policy terms, and discretions. The trustee sits between the member and the insurer, in both product design and claims pathways, which means

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16 For example; in 2025, APRA statistics (footnote 1) show that Superannuation members paid $7,800 million in group premiums to the life insurance industry in 2025 and will receive an estimated $7,900 million in claim payments related to the cover provided by those premiums.

17 https://www.actuaries.asn.au/research-analysis/the-value-of-group-insurance-in-superannuation-utilisation

design and operational defects, ambiguity in definitions or weak oversight can translate into member detriment at the individual level or at scale.

In addition, insurance in superannuation is administered at scale and relies heavily on automated rules and system workflows to determine eligibility, cover commencements/cessations, and premium rates (including plan variations).

This scale and automation create a structural vulnerability: a single defect in business rules, configuration, data mapping, an interface/data feeds or system, test coverage can be replicated across thousands of members before detection – potentially leading to systemic overcharging, underinsurance, unintended cover lapses, or members paying for cover they do not hold.

This structure can also create data challenges, include inconsistent employer data, missing occupation/salary details, incomplete contribution histories and weak traceability of member elections and underwriting outcomes (loadings/exclusions). Reconciliation breaks between member deductions, insurer billing, cover-in-force records and claims eligibility frequently drive remediation programs, especially during insurer transitions, product consolidations, cover changes and administrator migrations.

3.4 Legacy design created by trustees and insurers or by legislative change – accumulation of rules and exceptions

Legacy designs are maintained generally for ease of transition or perceived equity. These designs create an ongoing cost inefficiency issue for trustees.

Insurance arrangements often accumulate legacy features – closed cohorts, grandfathered eligibility rules, multiple unit structures, historical ‘at work’ tests, and inconsistent underwriting records. Each redesign (for example, insurer change, benefit redesign, opt-in migration) can create new transitional cases: members may be moved between cover types, underwriting status may not transfer cleanly, and opt-in/opt-out settings may change – unintentionally resulting in erosion of member benefits. These legacy layers create latent risk that may only emerge at claim time or with audits, often requiring remediation, potentially leading to litigation.

Insurance arrangements often have long-standing design (eligibility rules, definitions, unit structures, premium smoothing, continuation terms) that persist even as legislation changes. Regulatory reforms such as Protecting Your Super (PYS) and Putting Members’ Interests First (PMIF) alter default settings, inactivity and balance rules and opt-in requirements; yet system logic, product disclosures and operational processes may lag behind reforms.

3.5 Interdependencies between trustees, insurers, administrators, and advisers

Insurance in superannuation often relies on interlocking roles:

- Administrators maintain member records and run eligibility and premium deduction logic.
- Insurers price, underwrite and assess claims[18].
- Administrators and claims managers (insurer or trustee) administer claim intake, evidence and claims workflows.
- Trustee claims review staff.
- Advisers (where present) influence member decisions, including insurance opt-in/out or additional cover.

Because these parties and systems operate as a single, joined-up service from a member’s perspective, the end-to-end operating model can be difficult to assess and manage, particularly

[18] Occasionally, claims assessment is outsourced to the trustee, the administrator or a third party.

across handoffs, shared data, and split accountability. As a result, small data defects or process gaps can cascade across systems and counterparties, and when a dependency fails, members experience it as a breakdown in the cover and service they receive. Disputes often test not only what went wrong, but whether trustee oversight, monitoring and assurance over the end-to-end model was reasonable.

3.6 Low member understanding and engagement – cover terms and costs

Super Consumers Australia's Pulse survey[19] dated March 2025 has found that some members do not understand the insured benefits provided through their superannuation fund.

The survey found that:

- 27% of people are either unsure if they have insurance (19%), or don't know what their policies are (9%).
- Over half of 25–29 year olds don't know that default insurance normally starts at age 25, even though they have recently passed this age threshold.

Multiple reviews and complaints trends indicate members often do not understand the insurance they hold within superannuation, particularly exclusions, waiting periods, eligibility triggers, and the cost/benefit trade-off.

The range of understanding within the membership makes it more difficult for trustee communication to inform the membership about their insured benefits.

3.7 Default and voluntary cover co-existing – cohort risk profile drift

Default cover and voluntary top-ups often sit side-by-side. Default cover typically reduces from the middle ages, reflecting member needs. On the other hand, voluntary cover is fixed in dollar terms until typically age 60. For voluntary cover, members that have a higher expectation that they may claim are more likely to retain or increase cover, while other more healthy members may see large increases in premium with age and opt out of cover, shifting the insured pool's risk profile.

This can increase premiums for remaining members including default members, complicate sustainability of default pricing and heighten disputes about fairness and value, particularly where design assumptions no longer match the member mix.

3.8 Default cover and corporate Cover

Large corporate plans have particular attraction to trustees looking to gain the large asset base that comes with them. There may be direct or indirect pressure to provide premium rates on a more favourable basis to members of these plans, cross-subsidised directly or indirectly by the default cohort.

[19] https://superconsumers.com.au/research/pulse-spotlight/

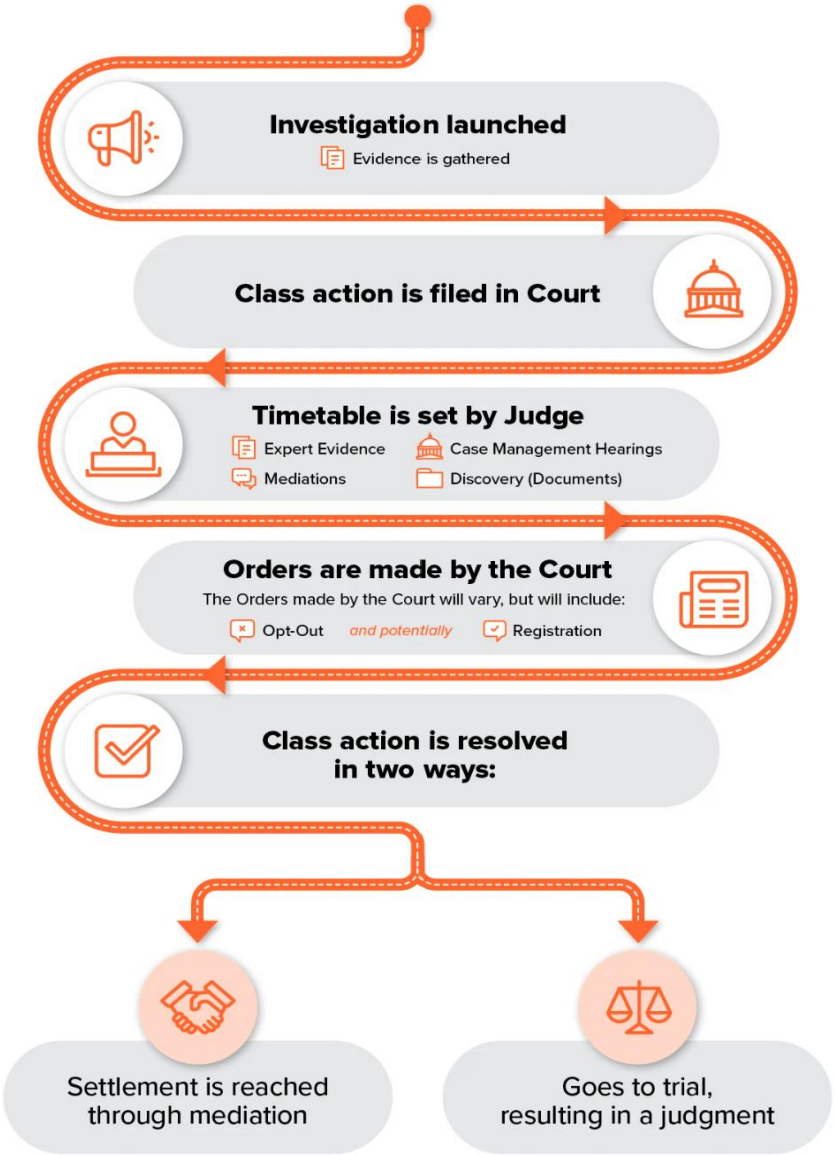
4. Recent Litigation and Regulatory Intervention

Since the 2018 Royal Commission, insurance in superannuation has been a heightened focus for both plaintiff firms (often supported by litigation funders) and regulators. Matters typically examine whether outcomes delivered to members matched what was promised and what was required under trustee duties and regulatory expectations.

4.1 Class Actions

4.1.1 What does a Class Action Look Like?

Shine Lawyers' website sets out a summarised explanation of a class action, including a diagram describing the process:



This process matters because it shows how a class action can turn what may start as a discrete insurance or administration issue into a prolonged, highly scrutinised governance event for a trustee. Once filed, the proceeding quickly becomes evidence-driven and deadline-driven: documents, data, expert analysis, and board records are tested against trustee duty standards, often years after the underlying conduct occurred. The practical impacts can be significant. These include management distraction, reputational harm and substantial costs (legal fees, expert fees, funder commission, insurance and administration costs).

4.1.2 Parties to a Class Action (Superannuation)

Superannuation class actions in Australia are typically run as 'representative proceedings' (most commonly in the Federal Court). The parties to a class action include:

- Applicant / Representative Plaintiff – a member who brings the claim on behalf of themselves and the group.
- Group Members – members included in the class, usually on an opt-out basis and bound by the outcome.
- Respondents / Defendants – usually the trustee, and may include third party providers to the trustee, for example, insurer.
- Legal Representatives – Plaintiff and Respondent lawyers.
- Experts – assist the Court.
- The Court – oversees case management, settlement approval, and distribution. Once a class action is commenced, it cannot be discontinued without the approval of the Court.

Some class actions also include:

- A Litigation Funder providing the funding for the Applicant's case in exchange for a commission from any recovery.
- Litigation Funder's insurer. The Funder may want to insure part or all of their risk.

4.1.3 Funding a Class Action

Class actions have to be funded as the costs are incurred before any settlement or judgement. The costs are large – covering legal work, experts, data analysis, notices and administration. Whilst the awarding of costs is ultimately at the discretion of the court, in principle, the unsuccessful party usually pays the successful party's costs.

Funding is commonly provided through a mix of conditional fee arrangements ('no win, no fee') and third-party litigation funding, with the funder typically covering a proportion of costs as they accrue and often providing adverse costs protection and/or funding security for costs if ordered. The funder may also insure part of their risk.

If the case is settled with a payment by the trustee, the funder and Plaintiff lawyers are usually paid from the settlement amount', subject to Court approval. Settlement proceeds are therefore typically reduced by Court-approved deductions (legal costs, expert costs, funder commission, insurance/security costs and settlement administration) before the net amount is distributed to eligible group members as partial remediation under the approved distribution scheme.

4.2 Common Themes

Common themes in the insurance in superannuation class actions include:

- Default insurance design and delivery – whether default cover was appropriately provided, designed, and administered (including eligibility, continuity of cover, premiums and exclusions).
- Insurer review including tenders and renewal decisions – whether insurer selection and premium/benefit settings were made in members' best interest / best financial interests and supported by a robust decision-making process.
- Disclosure and member communications – whether communications were clear and accurate in substance (not just technically compliant), including around premiums, cover changes, opt-out, and the impact on balances.

- Trustee oversight and governance – whether trustees exercised appropriate oversight, challenge, monitoring, and judgement across the end-to-end operating model and service provider arrangements.
- Conflict of interest – favouring parties other than the members.

Common themes in regulatory enforcement include:

- Claims handling and complaints – timeliness, fairness, and oversight of claims processes (including delays, denials, and poor complaint handling), and the trustee's role in supervising claims arrangements.
- Suitability, value, and balance erosion – default insurance settings and premium impacts on member outcomes, including unnecessary or poor-value cover.
- Disclosure and communication – misleading, incomplete, or inadequately targeted notices; incorrect member information and representations about cover.
- Operational integrity and remediation – data/process failures (for example, premium errors, cover misapplication), incident reporting failures, and the adequacy and timeliness of remediation.
- Governance, conflicts, and conflicted remuneration – structures and incentives affecting premiums, fees, commissions or decision-making that may not align with member outcomes.

4.3 Insurance Related Litigation and Enforcement Examples

Appendix 3 sets out a list of the class actions and regulatory enforcement involving superannuation funds since the Royal Commission.

The discussion in this section is a summary of the cases that are directly insurance related. It also includes five that are not directly insurance related but are still relevant to trustees.

4.3.1 Default insurance: design and delivery

QSuper Class Action (settled, set for approval hearing 16 April 2026)

Allegations of members being charged higher life insurance premiums than they should have been (including issues connected to occupational rating or premium settings and notification); The settlement amount is $67 million without admission of liability.

Rest Superannuation Class Action (ongoing)

Allegations that members were provided with default Income Protection insurance (and so charged premiums) in circumstances where cover became of little or no value (for example, inactivity rules; multiple policies), causing financial loss through a lower account balance and loss of investment returns.

4.3.2 Insurer Review

Colonial First State (CFS) Class Action (settled)

Allegations against the trustee that members were overcharged for group insurance (Death/TPD/IP) through CFS products.

Allegation against the insurer that it knew or ought to have known of the trustee's duties to members and it knowingly took profits from the excess premiums.

The settlement amount is $140 million without admission of liability.

AMP Group Superannuation Class Action (separate class action to AMP Superannuation Class Action – ongoing)

Allegations against the trustee that members were overcharged for group insurance (Life/TPD/IP) through AMP products.

Allegation against the insurer that it was knowingly involved in these breaches of trustee duties.

BT/Asgard Funds Class Action (discontinued)

Allegations of breaches of trustee duties in relation to group insurance provided to members following an insurance tender process with governance/conflict/selection issues.

4.3.3 Disclosure and member communications – substance and accuracy

QSuper Class Action (same class action as above, different allegation – settled)

Allegations QSuper failed to properly notify members of insurance premium changes and/or failed to implement systems to apply lower occupational rates to eligible members, resulting in overcharging and associated losses.

Rest Superannuation Class Action (same class action as above, different allegation – ongoing)

Allegations include an information or communication dimension (members allegedly defaulted and continued paying in circumstances where cover was effectively unavailable), though the core allegation is premium deductions or poor-value cover.

4.3.4 Trustee oversight, governance, and operational accountability

AMP Superannuation Class Action (ongoing)

Allegations that, following the introduction of MySuper (which required members to be defaulted into a MySuper product unless they made an active choice), the trustee continued to grandfather members into commissioned insurance arrangements rather than defaulting them into commission-free MySuper arrangements, resulting in members paying higher insurance premiums and suffering premium erosion and reduced retirement savings.

Telstra Superannuation ASIC civil penalty proceedings (ongoing)

ASIC action for breaches of internal dispute resolution requirements (complaints handling), relevant to insurance or disputes handling in superannuation.

Mercer Superannuation ASIC civil penalty proceedings (ongoing)

Allegations of trustee's failures to comply with the reportable situations regime (late or non-reporting of investigations into significant breaches), including insurance administration issues such as incorrect insurance premium refunds after members had died and alleged misleading information to ASIC understating impacted member numbers.

CBUS ASIC civil penalty proceedings (not directly insurance related but relevant – settled)

ASIC proceedings alleging systemic delays in processing death benefits and TPD insurance claims and associated governance or reporting failures. A penalty of $23.5 million was paid.

AustralianSuper ASIC civil penalty proceedings (not directly insurance related but relevant)

ASIC proceedings following investigation into merging of duplicate accounts. A penalty of $27m was paid.

ASIC proceedings (separate case) following investigation into delayed death benefit payouts AustralianSuper reportedly paid remediation to beneficiaries whose processing exceeded its internal target timeframes. This case is ongoing.

NULIS / MLC Class Action (not directly insurance related but relevant – judgement)

Allegations that trustees delayed moving members to cheaper MySuper options, leaving members paying higher fees or commissions; primarily a fees or Accrued Default Amounts (ADAs)[20] governance case, but relevant to conflicted remuneration and trustee governance themes that often coexist with insurance issues in superannuation litigation. The judgement was in favour of the trustee and the litigants must pay costs.

OnePath Masterfund Class action (not directly insurance but relevant – settled)

Allegations included that members' fees funded commissions to advisers (and other trustee duty issues), raising conflict or best-interest concerns. While not directly insurance in superannuation, it is relevant to conflicted charges and governance failures impacting member outcomes.

Star Entertainment ASIC civil penalty proceedings (not directly insurance but relevant – judgement, penalties imposed, further penalties pending)

Allegations that Star's board and senior executives breached their duty of care and diligence under s 180 of the Corporations Act by failing to adequately identify, manage and escalate serious money-laundering and criminal association risks and by permitting misleading communications to the company's banker about transactions occurring at Star's casino.

4.3.5 Conflict of interest, preferring the interests of parties other than the members

AMP Superannuation Class Action (same class action as above, different allegation – ongoing)

Allegations that, following the introduction of MySuper (which required members to be defaulted into a MySuper product unless they made an active choice), the trustee continued to 'grandfather' members into commissioned insurance arrangements rather than defaulting them into commission-free MySuper arrangements, resulting in members paying higher insurance premiums and suffering premium erosion and reduced retirement savings.

Colonial First State Class Action (same class action as above, different allegation – settled)

Allegations against the trustee that members were overcharged for group insurance (Death/TPD/IP) through CFS products.

Allegation against the insurer that it knew or ought to have known of the trustee's duties to members and it knowingly took profits from the excess premiums.

The settlement amount is $140m without admission of liability.

AMP Group Superannuation Class Action (same class action as above, different allegation – ongoing)

Allegations against the trustee that members were overcharged for group insurance (Life/TPD/IP) through AMP products.

Allegation against the insurer that it was knowingly involved in these breaches of trustee duties.

BT/Asgard Funds Class Action (same class action as above, different allegation – discontinued)

Allegations of breaches of trustee duties in relation to group insurance provided to members following an insurance tender process with governance/conflict/selection issues.

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[20] See, for example, SPG 410 "MySuper Transition" (February 2013) - https://www.apra.gov.au/sites/default/files/spg-410-february-2013.pdf

5. Deep Dive Case Studies – What the Class Actions and ASIC Litigations Tell Us

The following sections use publicly available records (lawyer websites and publicly available court documents) to provide a deep dive into some of the individual cases. Appendices 4 to 8 provide further detail of these cases.

The deep dives are useful as they set out each of the allegations and defence for each of the cases we have selected. Very few class actions end up with a court judgement, being either discontinued or settled, Without the learned judge's opinion it is important to understand what the parties' perspectives are on each case, so an opinion can be formed on the reasons for the outcome.

5.1 QSuper Class Action

5.1.1 Summary

The QSuper Class Action is a representative proceeding filed in the Federal Court of Australia (VID691/2021) by Jessica Amy Challenor on behalf of herself and approximately 15,000 other Group Members. The case involves legal representation by Shine Lawyers and litigation funding by Woodsford.

The action alleges that QSuper Board improperly implemented an occupational rating system for life insurance premiums on an opt-in basis without adequately informing members, resulting in many paying higher premiums and suffering financial loss.

The class action concerns insurance changes effective from 1 July 2016. The claim framed the issues primarily through the Trustee's covenant duties – acting in members' best financial interests, exercising care, skill, diligence, and ensuring costs or fees were appropriate and properly governed, alongside disclosure and conflicts themes.

Relief sought includes compensation for premium overpayments and associated lost investment earnings.

5.1.2 Claims, Defences and Responses to Defences

This section summarises only the key claims and defences most relevant to the issues and outcomes. For a complete list of all claims, defences, and any responses to defences, refer to Appendix 4.

Opt-in occupational rating (members had to elect to access lower premium rates)

Claim	Despite knowing occupational rating would affect premiums, the Board implemented it on an opt-in (written election) basis rather than automatically applying the correct rate.
Defence	An automatic approach was not feasible or required because QSuper lacked enough personalised occupational information without a member declaration/application. QSuper says it acted prudently by keeping default cover and allowing members to personalise cover via election.
Response to Defence	None.

Inadequate / misleading member communications about the election requirement

Claim	Communications to members • did not adequately disclose the need to elect in writing to access occupational rates/lower premiums • advised members "*you don't need to do anything*" which was misleading, and resulted in eligible members staying on higher default premiums.
Defence	Taken together (Notice / May Letter / May Email / Insurance Guide), communications were sufficient to convey that members needed to take action to personalise cover (including being occupationally rated). "*You don't need to do anything*" referred only to default cover continuing automatically, not to personalisation options. QSuper disputes distribution/access issues and denies misleading conduct.
Response to Defence	Materials still omitted the 'elect in writing' requirement; hyperlinks/attachments and distribution were inadequate; Many communications were not valid/sufficient notice (s1017B); 'Know Your Insurance' wording still omitted the election requirement.

Breaches of SIS covenants / general law duties (care, best interests, conflicts):

Claim	QSuper breached SIS covenants and related general law duties, including conflict management, alleging a preference for QSuper/QInsure financial interests.
Defence	Denies contraventions and says it acted as a prudent trustee: changes preserved cover and improved flexibility; the 'automatic system' standard is rejected because occupational rating required member-provided information; denies any conflict/personal benefit (QInsure profits are fund assets), and disputes the pleaded formulation of 'best interests' as a prescriptive duty.
Response to Defence	None.

5.1.3 Outcomes

The proposed resolution is a $67 million settlement, made without any admission of liability by QSuper and subject to Federal Court approval (approval hearing listed for 16 April 2026). Eligible Group Members had to register by 27 February 2026 to have their eligibility assessed and be considered for a payment.

As disclosed on the ART's website[21];

> "The QSuper Board reached an agreement to settle the class action relating to the introduction of occupational ratings for insurance purposes for QSuper members on 1 July 2016.
>
> The QSuper Board hasn't admitted any wrongdoing and chose to settle the matter to avoid the risk of costs from ongoing litigation."

[21] https://www.australianretirementtrust.com.au/governance-and-reporting/prescribed-information/qsuper-class-action

5.1.4 Funding

The proceeding was funded through a litigation funding arrangement with Woodsford and a 'no win, no fee' costs agreement with Shine Lawyers.

The funding of the settlement of $67 million will be through QSuper's general reserve. ART's website[22] discloses the following relating to the funding of the $67 million settlement amount;

> "The settlement amount will come out of money that had already been set aside by QSuper to provide for the potential liability from the class action, which was put into a reserve at the time of the merger to form Australian Retirement Trust. The general reserve was built up over the period that QSuper existed from, for example, the administration fee and the investment revenue earned on the general reserve.
>
> The settlement amount is $67m which includes legal costs and disbursements, and other fees and costs associated with the class action."

5.1.5 Distribution

Proposed Court-approved deductions from the $67 million include (among other items):

- 27.5% funding commission to Woodsford ($18.425 million);
- legal costs and disbursements (including $7.23 million incurred to date and $0.95 million estimated to settlement approval);
- adverse costs insurance/security for costs ($2.705 million);
- settlement administration costs ($1.1 million); and
- other approved funder/management costs and modest reimbursement payments to the Applicant and a Sample Group Member.

After Court approved deductions, it is estimated that approximately $36.01 million (about 54%) will be available for distribution to participating Group Members, calculated using an assessment methodology reflecting occupational rating categories and individual circumstances.

5.2 BT/Asgard Superannuation Class Action

5.2.1 Summary

The BT/Asgard Superannuation Insurance Class Action is a representative proceeding filed in the Federal Court of Australia (VID826/2023) by Dannyalan Raymond Fisher, Jonathan Fedson, and Roy Ferguson on behalf of themselves and other group members. The case is being run by Shine Lawyers.

The action relates to insurance held through certain BT/Asgard superannuation products (including Retirement Wrap, BT Superannuation For Life, BT Superannuation, and Asgard Independence Plan Division Two) and concerns the conduct of the relevant trustees, BT Funds Management Ltd (BTFM) and Westpac Securities Administration Limited (WSAL), and the group insurance arrangements issued by the insurer, Westpac Life Insurance Services Ltd (WLISL)[23].

The claim alleges breaches of trustee duties and related obligations under superannuation and general law in relation to the tendering for, and/or implementation and management of, group

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[22] https://www.australianretirementtrust.com.au/governance-and-reporting/prescribed-information/qsuper-class-action

[23] TAL acquired WLISL from Westpac in 2022 as part of Westpac's exit from life insurance underwriting. Following completion, WLISL was renamed TAL Life Insurance Services Limited.

insurance provided to members. The insurer is alleged to have been knowingly involved in certain alleged contraventions. Based on the publicly available description, the pleaded issues are framed principally through trustees' duties/covenant-style themes (including acting in members' best financial interests, exercising care, skill and diligence, and proper governance of insurance related costs and arrangements),

The relevant period was (approximately) 6 October 2017 to1 April 2023. Relief sought included compensation for loss said to have been suffered by affected members in connection with the alleged misconduct (including insurance-related financial loss and associated consequential loss).

5.2.2 Claims, Defences and Responses to Defences

This section summarises only the key claims and primary defences most relevant to the issues and outcomes. For a complete list of all claims, defences, and any responses to defences, refer to Appendix 5.

Tender/insurer selection process was improper (related-party insurer preferred)

Claim	In the 2016 tender, AIA scored higher on weighted criteria, but the trustees selected WLISL – a related party, by letting non-weighted criteria become determinative, contrary to prudent trustee process and duties.
Defence	• BTFM/WSAL deny impropriety and say the tender was properly governed and independently supported: a broader panel of insurers was invited to tender but only WLISL and AIA bid for full scope. • Governance committees and Non-Executive Director oversight operated; weighted criteria were product and pricing/service model/commercial and contractual. • Non-weighted criteria included transition risk, financial strength, 'revenue uplift,' and alignment to future state. • Boards were informed WLISL had product and pricing benefits (including scoring higher for relevant cohorts). • Rice Warner supported the recommendation and confirmed the review was comprehensive and like-for-like.
Response to Defence	None.

Members paid higher premiums and/or excessive insurance-related add-ons ('Overcharge' / markups)

Claim	Because WLISL was selected and retained (including renewals), members allegedly paid materially higher premiums than they otherwise would have obtained from third-party insurers ('Overcharge'), and also paid additional insurance-related charges such as administration loadings, adviser commissions (some cohorts), and an 'Asgard Enhanced Premium' above master policy rates (collectively framed as an 'Asgard Markup').
Defence	• BTFM/WSAL accept some premium rate increases occurred from mid-2019 for certain products, but dispute the 'overcharge' characterisation. • BTFM/WSAL also argue parts of the pleading are defective ('embarrassing') and deny on that basis, and note a rate guarantee applied to 30 June 2019 for certain products.

	• On additional insurance-related charges, BTFM/WSAL admit some premium fees applied to certain cohorts (with historical rates), adviser commission only applied to limited/historical negotiated cohorts (often predating WLISL's appointment), deny the 'enhanced premium' allegation as inadequately pleaded, and plead limitation/time-bar issues for some commission/ premium claims prior to 6 Oct 2017.
Response to Defence	None.

Breach of SIS covenants in making/implementing the group insurance decisions

Claim	By selecting WLISL and implementing/maintaining the insurance arrangements (including alleged overcharge/markups), the trustees breached SIS covenants**:** • care/skill/diligence, best interests, conflict prioritisation/management, and insurance strategy/cost/erosion requirements.
Defence	BTFM/WSAL deny contraventions, contend parts are inadequately pleaded, and say they acted within an established insurance governance framework/IMF with reference to SPS 250. They also deny the underlying conflict and overcharge premises said to underly the SIS breaches.
Response to Defence	None.

5.2.3 Outcomes

The class action was discontinued following approval by the Federal Court of Australia on 20 November 2024.

The Applicants and the lawyers and their funder (Woodsford), agreed with the Respondents to discontinue the proceeding after the Respondents filed applications to strike out (remove) parts of the Applicants' statement of claim because it is legally defective (having served various additional materials). In view of these applications and materials, the Applicants, Shine Lawyers, and Woodsford agreed to discontinue the proceeding.

Under the approved discontinuance:

- The proceeding was discontinued without any admission of liability by the Respondents.
- The Respondents paid an amount towards the Applicants' costs of bringing the proceeding.
- Woodsford ceased funding the proceeding and did not fund any further proceedings against the Respondents arising from the same or similar facts.
- Shine Lawyers ceased to act in the proceeding.
- From 60 days after the discontinuance approval, any limitation periods applicable to Group Members began to run again, allowing them to pursue claims in other proceedings if they chose.

Group Members who had registered their interest were notified of the discontinuance proposal and their rights. Those who opposed the discontinuance had the opportunity to submit a Notice of Objection before the Court's approval but no objections prevented the discontinuance.

No common fund or compensation pool was established for distribution to Group Members, and no payments were made to them as part of the discontinuance, only a small contribution by the Respondents towards the Applicants' costs.

5.3 Colonial First State (CFS) Class Action

5.3.1 Summary

The CFS Class Action is a representative proceeding filed in the Federal Court of Australia (VID 28/2020) by Simon Mallia on behalf of himself and group members. The case involved legal representation by Shine Lawyers and litigation funding by Woodsford.

The action alleges that the Trustee breached its duties by selecting and maintaining a related-party insurer, resulting in members paying higher insurance premiums than they would have under a competitive process. The claims include allegations of excessive insurance related fees and markups, conflicts of interest due to financial incentives linked to premium arrangements, and breaches of statutory covenants under the Superannuation Industry (Supervision) Act 1993 (SIS Act) and fiduciary duties.

The class action challenges the Trustee's decisions made in relation to group insurance policies.

Relief sought includes compensation for overcharged premiums, restoration of lost retirement balances due to premium overpayments, and equitable remedies related to breaches of trustee duties and conflicts of interest.

The proceeding addresses issues of trustee governance, proper exercise of discretion, transparency, and fairness in insurance arrangements affecting superannuation fund members, with claims framed primarily around statutory trustee covenants, fiduciary duties, and equitable principles.

5.3.2 Claims, Defences and Responses to Defences

This section summarises only the key claims and primary defences most relevant to the issues and outcomes. For a complete list of all claims, defences, and any responses to defences, refer to Appendix 6.

Statutory contraventions by Colonial First State Investment Limited (Australia) (CFSIL) (trustee covenants under the SIS Act)

Claim	CFSIL contravened the SIS Act trustee covenants in connection with the IMF approval decision and the subsequent group insurance decisions, by: • failing to exercise prudent trustee care, skill and diligence (s 52(2)(b)); • failing to act in members' best interests (s 52(2)(c)); • failing to properly manage conflicts and prioritise members' interests (s 52(2)(d)); and • failing to have and implement an appropriate insurance strategy and properly consider insurance cost/erosion of retirement income (s 52(7)(a)–(c)).
Defence	CFSIL denies any contraventions and says: • the covenants should be applied according to their statutory terms (and not expanded by the applicants' characterisations); • the 'best interests' covenant was 'best interest' until 1 July 2021 and 'best financial interest' from 1 July 2021;

	• the content/scope of the covenant obligations must be read together with, and is informed/qualified by, the Commonwealth Essential Superannuation Trust Deed and the FirstChoice Trust Deed; and • it denies the factual foundations relied on to establish breach (including the conflict/benefit foundations).
Response to Defence	None.

Related statutory contraventions by CFSIL (enforcement provisions)

Claim	The same covenant contraventions also constitute contraventions of: • s 55(1) (for conduct prior to 6 April 2019); and • s 54B(1) (for conduct after 6 April 2019).
Defence	CFSIL denies these contraventions and says they are derivative of the s 52 covenant contraventions; therefore, if there is no breach of the s 52 covenants, there is no contravention of s 55(1) or s 54B(1).
Response to Defence	None.

Fiduciary / trust law claims against CFSIL

Claim	• CFSIL owed fiduciary duties (including avoiding conflicts and not improperly using its position to gain an advantage for itself and/or the insurer, CommInsure) and breached those duties by failing to avoid the conflict and/or using its position to obtain benefits for itself and/or CommInsure. • The SIS covenant contraventions are also pleaded as breaches of trust, and CFSIL acting recklessly. Relief sought includes equitable compensation and/or an account of profits/benefits/gains (including amounts connected with 'Excess Premiums').
Defence	CFSIL denies breach and says: • it admits limited fiduciary duties, but their scope is limited by the Trust Deeds and the statutory framework; • it denies the factual premises said to establish conflict and improper benefit, and therefore denies breach of fiduciary duty and breach of trust; • Trust Deed provisions (to the extent lawful) permit related-party dealings and allow CFSIL/associates to retain profits/benefits/fees, answering the improper profit/conflict case; • a FirstChoice Trust Deed limitation of liability applies (subject to the SIS Act), so CFSIL is only liable for dishonest acts/omissions or intentional/reckless failure to exercise required care and diligence, and it denies the pleaded recklessness/culpability threshold is met; and • if wrongful depletion of fund assets were established, the proper relief is restoration of fund assets (not gain-based relief).

Response to Defence	None.

5.3.3 Outcomes

The Federal Court approved the settlement of this class action for $140 million, without any admission of liability by the trustee. The settlement sum is inclusive of costs and interest and is intended to resolve the claims of approximately 850,000 group members who held cover through Colonial First State superannuation products during the period from 22 January 2014 to 15 February 2022.

Following approval, payments will be made to eligible group members under the Court approved settlement distribution scheme.

5.3.4 Funding

The proceeding was funded by:

- Woodsford Group Limited (Woodsford) as litigation funder; and
- Shine Lawyers acting with a portion of fees deferred (and uplift sought on deferred fees),

The $140 million class action settlement is funded primarily through an arrangement with the Commonwealth Bank of Australia (CBA).

CFSIL stated that it will not use assets of the FirstChoice Fund or Essential Superannuation Fund (including any operational risk financial reserve) to pay the settlement sum or distribution costs.

5.3.5 Distribution

Subject to Court approval, the Applicant proposes that the following be deducted from the $140 million settlement sum:

- Legal costs, fees and expenses: approximately $14,260,701.48.
- Litigation funding commission (Woodsford): $38,500,000 (stated as 27.5% of the settlement sum).
- Adverse costs insurance / security for costs (premiums + insurer deeds of indemnity): $4,488,400.
- Shine Lawyers uplift (25% on unpaid/deferred fees not paid by the funder): approx. $1,255,366.85.
- Payments to the Applicant and sample group members (time/expenses): approx. $24,000.
- Contradictor costs: to be paid (amount not specified in the notice extract).
- Settlement administration costs: payable, subject to Court approval (amount not specified in the notice extract).

Based on the above items excluding administration costs, the notice estimates about $81,472,531.67 (about 58.2%) would be distributed to group members.

The opt-out notice (issued to members to allow them to opt out of the class action) also describes Woodsford's success fee framework in the funding agreement as the greater of 27.5% of gross proceeds or 3.5 times cash outlay, and that adverse costs / ATE insurance premiums and related costs may also be payable from proceeds (subject to Court approval).

5.4 AMP Commission and Insurance Class Action

5.4.1 Summary

The AMP Commissions and Insurance Class Action is a representative proceeding brought in the Federal Court of Australia (VID489/2020) by Nigel Peter Stack and others on behalf of themselves and other Group Members. Their lawyers are Shine Lawyers.

The Respondents are AMP Financial Planning Pty Limited, Charter Financial Planning Limited, Hillross Financial Services Limited (together, the AMP Licensees), AMP Limited, and Resolution Life Australasia Limited (formerly AMP Life Limited) (AMP Life).

The proceeding concerns financial advice given by AMP-authorised advisers in circumstances where commissions and other incentives were payable on 'Commissioned Products' (including life/risk insurance and platform/investment products). The claims frame the issues through modern advice and superannuation and insurance governance themes, including:

- advisers and licensees being financially incentivised by commissions, incentives, and 'buy-back' register arrangements;
- conflicts of interest and alleged failures to act in clients' best interests and give priority to clients' interests (FOFA duties);
- 'fees for no service'/ongoing service fee issues for clients who paid ongoing service fees but did not receive the promised services; and
- for insurance sub-group members, the allegation that AMP Life insurance premiums were inflated relative to substantially equivalent or better third-party products ('Excess Premiums'), and that those cheaper alternatives were not disclosed or recommended.

The pleaded Relevant Period is 23 July 2014 to 15 February 2021 (inclusive). Relief sought includes compensation/damages, and in some cases equitable relief such as an account of profits.

5.4.2 Claims, Defences and Responses to Defences (non-exhaustive list)

This section summarises only the key claims and primary defences most relevant to the issues and outcomes. For a complete list of all claims, defences, and any responses to defences, refer to Appendix 7.

Commissioned Products Advice Model (Commissioned Products sold/maintained through AMP advice networks):

Claim	• AMP Authorised Representatives provided personal advice for Group Members to acquire, renew, or continue to hold Commissioned Products on which commissions were payable. • Commissions were paid by product issuers to AMP Licensees under distribution arrangements (and/or via AMP Licensees to advisers/practices). • Members bore the cost because commissions were embedded in insurance premiums and/or incorporated into product fees/unit pricing. • Members received no additional benefit merely because commissions were paid (including no requirement for ongoing services in exchange for trail). • AMP entities/licensees benefited from continuation of commission flows.

Defence	• During the Relevant Period, AMP Licensees had distribution/facilitation/licensee agreements with product issuers under which commissions could be payable. • Commission terms and incidence varied by product/provider and were governed by the relevant agreements and product terms. • AMP Authorised Representatives were generally not parties to the distribution agreements and those agreements did not provide for authorised representatives to receive trailing commissions (remuneration flowed via licensee/practice arrangements). • Commissions were not always funded by member-borne fees/premiums/unit prices as pleaded. • Unparticularised allegations concerning unidentified Group Members are not admitted. • The mere payment of commissions does not establish wrongdoing, loss, or entitlement to an account of profits.
Response to Defence	None filed to date.

Commission Control (Commissions could be dialled down/switched off/rebated, reducing cost):

Claim	• Commissions on Commissioned Products were capable of being switched off or dialled down at the product-provider level by the adviser, switched off or dialled down at the licensee level, and/or rebated to the client by the adviser. • For AMP Life insurance products, commissions were embedded into and increased premiums, and reducing/switching off commissions would make the product cheaper; disclosure materials contemplated alternative commission arrangements could reduce insurance cost. • Group Members paid more than they needed to pay because commissions were maintained rather than reduced/turned off/rebated.
Defence	• Commissions could not necessarily be switched off, dialled down, or rebated. • Whether any adjustment was possible depended on the product and circumstances (including any adviser–client agreement). • Commissions did not necessarily increase product costs and were not always funded through fees/premiums/unit prices. • Unparticularised group-wide allegations about unidentified Group Members (including ‘substantially higher’ costs and ‘substantially cheaper’ alternatives) are not admitted and are said to be liable to be struck out absent proper particulars. • Reliance is placed on the statutory and contractual framework (including that certain commissions were lawful/grandfathered). • Loss and damage are denied.
Response to Defence	None filed to date.

Conflicted Advice Incentives (Conflicted remuneration structure created systemic conflicts of interest):

Claim	• Commissions and remuneration structures created conflicts between advisers/licensees (and, in some contexts, AMP Life/AMP) who benefited from commissions/incentives and maintaining commission flows, and clients who would benefit from commissions being reduced/switched off/rebated or from using lower-cost alternatives. • Commissions were a material component of remuneration and could reasonably be expected to influence advice about acquiring/renewing/ retaining products and levels of cover/investment. • Commissions incentivised retention of commission-bearing products even when unsuitable or more expensive than alternatives, and incentivised recommending AMP products (including AMP Life insurance) over substantially equivalent or better and cheaper third-party products.
Defence	• Commissions and related arrangements did not reasonably influence personal advice as pleaded and the question depends on the specific client, adviser, and available alternatives. • Receipt of commissions (including grandfathered commissions) was lawful and did not breach Future of Financial Advice (FOFA) duties; AMP Licensees had policies, training, and monitoring to ensure compliance and systemic failure is denied. • Adviser remuneration was managed between adviser and practice and was not always monitored by AMP Licensees. • Commissions were not always funded as pleaded and the 'pass-through' claim is denied. • Claims about 'better' alternatives or 'higher' costs are denied as lacking proper detail.
Response to Defence	None filed to date.

5.4.3 Outcomes

The class action remains ongoing with no final determination publicly reported. The proceedings continue through the Federal Court process, with AMP and related entities defending the claims. There have been no public announcements of settlement or resolution, and the parties remain engaged in litigation and related compliance and remediation activities where applicable.

5.5 AustralianSuper ASIC Litigation

5.5.1 Summary

In early 2025, shortly after the Federal Court ordered the fund to pay a $27 million pecuniary penalty for failures relating to merging duplicate member accounts, ASIC commenced a new court civil penalty proceeding against AustralianSuper Pty Ltd (AustralianSuper), in its capacity as trustee of the AustralianSuper fund. This proceeding concerns alleged delays in processing and paying death benefit claims, and associated systems, resourcing, oversight and governance failures, during the period 1 July 2019 to 18 October 2024 (Relevant Period). The matter sits

within ASIC's stated enforcement priority[24,25] on superannuation member services, amid growing service-related complaints (including to AFCA).

The proceeding is an ASIC regulator enforcement action (not a member class action).

ASIC's case is framed through:

- AustralianSuper's obligation as an AFS licensee to provide financial services efficiently, honestly and fairly under s 912A(1)(a) of the Corporations Act 2001 (Cth); and
- AustralianSuper's obligation to comply with financial services laws under s 912A(1)(c) of the Corporations Act, including the requirement under s 34(1) of the SIS Act and reg 6.21(1) of the *SIS Regulations* to cash (pay) a member's death benefits 'as soon as practicable' after the member dies.

ASIC alleges large-scale delay outcomes, including that AustralianSuper took between four months and four years (from return of claim forms) to pay or decline at least 6,699 –6,897 'No Objection' death benefit claims, and that approximately 7,000 claimants suffered financial loss and distress/inconvenience.

ASIC also pleads that AustralianSuper outsourced parts of death claims processing to Australian Administration Services Pty Limited (Link) under an administration and custody agreement dated around 14 June 2019, while remaining legally responsible for claims administration and provision of the relevant financial services.

While AustralianSuper has not filed a formal Defence document publicly, its unofficial position emphasises ongoing remediation efforts, cooperation with ASIC, and steps taken to address the issues. The trustee disputes the characterisation of its conduct as deliberate or negligent and highlights the unprecedented operational pressures faced during the Relevant Period.

Relief sought by ASIC includes declarations of contraventions, pecuniary penalties, adverse publicity orders, and orders requiring AustralianSuper to implement improved systems and provide independent compliance reports.

5.5.2 Claims, Defences and Responses to Defences

This section summarises only the key claims and primary defences most relevant to the issues and outcomes. For a complete list of all claims, defences, and any responses to defences, refer to Appendix 8.

No Objection death benefit claims took months to years to pay or decline:

Claim	AustralianSuper took between four months and four years from the date a claim form was returned to pay or decline at least 6,699–6,897 death benefit claims where no objection was received (No Objection Claims), including at least 941 claims where AustralianSuper held a valid binding death benefit nomination (BDBN) at the time of death.
Defence	No formal defence filed to date.
Response to Defence	Not applicable.

[24] https://www.asic.gov.au/about-asic/asic-investigations-and-enforcement/asic-enforcement-priorities/

[25] https://www.asic.gov.au/about-asic/news-centre/speeches/customers-are-key-super-trustees-need-to-listen-and-act-now/

Failure to pay benefits 'as soon as practicable' (SIS Act / reg 6.21) and corresponding financial services law non-compliance:

Claim	AustralianSuper failed to pay members' benefits as soon as practicable after death as required by s 34(1) SIS Act and reg 6.21(1) of the SIS Regulations, and thereby contravened s 912A(1)(c) of the Corporations Act. ASIC pleads this in relation to at least 752 members, and alternatively pleads contraventions on at least 6,699 occasions (based on No Objection Claims) or at least 700 occasions (based on the pleaded sample delay categories and schedules).
Defence	No formal defence filed to date.
Response to Defence	Not applicable.

Failure to provide services efficiently, honestly and fairly (EHF) due to systemic backlog, poor oversight, and inadequate remediation:

Claim	• AustralianSuper failed to do all things necessary to ensure relevant financial services were provided efficiently, honestly and fairly, contrary to s 912A(1)(a) of the Corporations Act. • Due to systemic delays and SIS law non-compliance, at least 3,857 complaints were made about delayed death benefit claims. • Sustained failure to meet service levels/metrics, knowledge of and inadequate response to a sustained backlog (including Board committee reporting). • Insufficient resourcing and performance management of Link. • Continued charging of monthly administration fees during the period of unreasonable delay. • Inadequate systems/records for identifying and remediating affected claimants. ASIC also pleads a resulting contravention of s 912A(5A).
Defence	No formal defence filed to date.
Response to Defence	Not applicable.

5.5.3 Outcomes

The proceeding is ongoing with no final determination publicly reported. ASIC continues to pursue its claims through the Federal Court process, and AustralianSuper continues to engage with the regulator and implement remediation and operational improvements and defend the case.

Looking at the trustee's 30 June 2025 Annual Financial Report[26] (for the trustee company):

- It has not established a provision for the current case. Note 21 explains why this is the case.

> "During the financial year, ASIC brought enforcement proceedings against the Trustee, alleging contraventions of the Corporations Act in relation to AustralianSuper's processing payment of death benefit claims between 1 July 2019 and 18 October 2024.Those proceedings are ongoing.
>
> At the date of this report no penalties have been imposed and there is uncertainty whether there will be an obligation to pay any penalty as the Company is defending the proceedings against it."

- The trustee has provided the following update to members on its website[27]:

> "Paying out members' retirement savings after they die is the final service we provide them. During COVID, a sharp increase in member deaths and a significant impact of the pandemic on staffing numbers saw a backlog relating to the processing of death claims emerge.
>
> We recognised this and developed a strategy with our service provider to clear the backlog of claims. Despite some improvement, we were not satisfied the backlog was reducing fast enough so we made the significant decision to bring the processing of death claims in house. Bringing this function in house strengthens our ability to deliver this important service efficiently and empathetically.
>
> AustralianSuper is fundamentally transforming how we deliver member services. We are part way through a $120 million investment in service improvements, including bringing operations in house that require high care and empathy.
>
> Since our in-house Bereavement Centre was launched in April 2024 with 75 dedicated case managers handling death claims from start to finish, we have seen a significant reduction in claim processing times.
>
> We welcome the regulator's industry-wide attention on this matter."

5.6 NULIS Class Action

5.6.1 Summary

In Brady v NULIS Nominees (Australia) Ltd (as trustee of the MLC Super Fund) (No 4) [2024] FCA 1374, a representative (class) proceeding was brought against NULIS in relation to alleged 'fees for no service' conduct following a successor fund transfer (SFT). The claim focused on whether NULIS continued to deduct certain advice/service-related fees from members' superannuation accounts in circumstances where the relevant services were alleged not to have been provided after the transfer.

The case was framed through:

- Trust law and deed construction issues – whether the fund's governing rules conferred power to levy the fees in the circumstances and whether charging them involved a breach of trust.

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[26] https://www.australiansuper.com/-/media/australian-super/files/about-us/financial-statements/2025-trustee-financial-statements.pdf

[27] https://www.australiansuper.com/about-us/newsroom/2025/03/statement-regarding-commencement-of-civil-proceedings

- Statutory trustee covenants under s 52 of the SIS Act – Including the covenants relating to care, skill and diligence, best interests, conflicts, fairness, and acting within functions and powers.
- A Corporations Act issue – whether the arrangements involved conflicted remuneration (including in connection with the payment of commissions) and the implications for the characterisation of the fees.

This case is of interest even though it does not relate directly to insurance in superannuation because:

- it is one of few that make it to a judgement by the Court; and
- the judge made detailed determinations on the interpretation of some of the key SIS Covenants which formed part of the case:
    - the care, skill and diligence covenant: s 52(2)(b) SIS Act;
    - the best interests covenant: s 52(2)(c) SIS Act;
    - the conflicts covenant: s 52(2)(d) SIS Act;
    - the fairness covenants: s 52(2)(e) and (f) SIS Act; and
    - the functions and powers covenant: s 52(2)(h) SIS Act.

5.6.2 Outcomes

The Federal Court of Australia dismissed the class action against NULIS for breaching its duties as a trustee under the SIS Act, including allegations about the payment of grandfathered commissions after the 1 July 2016 successor fund transfer. The court determined that NULIS had the power under the trust deed to charge the fees, and the payments of 'grandfathered commissions' to financial services licensees after the successor fund transfer on 1 July 2016, were not considered 'conflicted remuneration' under the relevant legislation. The court rejected the allegations that NULIS acted improperly in charging these fees or paying commissions, leading to the dismissal of all claims against the trustee.

After that dismissal, the Court ordered the Applicant to pay NULIS's costs (party/party), with those costs to be determined through a lump-sum assessment process. The applicant appealed and asked the Court to pause (stay) the costs orders until the appeal was resolved. The judge refused that request. While the Court accepted there were arguable issues on appeal, the applicant did not persuade the Court that the practical 'balance of convenience' justified stopping the costs process.

The stay application was dismissed, and the applicant was also ordered to pay NULIS's costs of the stay application.

5.7 Star Entertainment ASIC Civil Penalty Enforcement Proceeding

5.7.1 Summary

In ASIC v The Star Entertainment Group Ltd (Star)[28], ASIC initiated civil penalty proceedings in December 2022 against 11 former Star directors and officers, alleging failures in managing money laundering risks and escalating issues to the board.

[28] https://www.asic.gov.au/about-asic/news-centre/find-a-media-release/2026-releases/26-040mr-federal-court-finds-two-star-entertainment-senior-executives-breached-duties-non-executive-directors-did-not-breach-duties/

ASIC's case was framed through:

- Corporations Act directors' and officers' duties s 180 (1)[29] – whether the individuals exercised the required care and diligence in identifying, managing and responding to serious risk issues, including escalation to the board; and
- governance and escalation failures – including allegations that key risk matters were not adequately addressed and/or not appropriately escalated to the board, and that misleading information was provided to a major bank about certain transactions occurring on Star's premises.

This proceeding is of interest (despite not being a superannuation case) because:

- ASIC pursued alleged governance failures against individuals (senior executives and non-executive directors), not just the entity;
- the senior executives were found at fault and personal penalties were applied, both dollar and employment related. This has implications for management staff at superannuation funds;
- the judgement sets out the responsibilities of non-executive directors generally (including presumably superannuation fund trustee directors); and
- it provides a recent, high-profile example of how courts assess risk governance, escalation discipline, and executive accountability under the Corporations Act.

5.7.2 Outcomes to date

Penalties following admissions (decision after hearing on 24 February 2025)

The Federal Court penalised two former executives after they admitted breaches of Corporations Act directors' and officers' duties s 180 (1) on agreed facts:

- Former Chief Casino Officer
  - Outcome: contravention of s 180(1) found (admitted).
  - Conduct (as found): approving an arrangement granting exclusive access to a private gaming room despite known risk to Star's legal/regulatory position; failing to inform the Board of relevant information and risks; and failing to recommend the relationship be reviewed or terminated.
  - Orders / consequence: $180,000 pecuniary penalty and 18 months' disqualification from managing corporations.

- Former Chief Financial Officer
  - Outcome: contravention of s 180(1) found (admitted).
  - Conduct (as found): failing to prevent Star from sending correspondence to NAB on 7 November 2019 containing inaccurate, incomplete and misleading representations about CUP card use for gambling at NAB terminals within Star's casino.
  - Orders / consequence: $60,000 pecuniary penalty and 9 months' disqualification from managing corporations.

[29] s 180 (1): A director or other officer of a corporation must exercise their powers and discharge their duties with the degree of care and diligence that a reasonable person would exercise if they: (a) were a director or officer of a corporation in the corporation's circumstances; and (b) occupied the office held by, and had the same responsibilities within the corporation as, the director or officer.

Liability judgment (5 March 2026)

In a later judgment (ASIC media release 26-040MR), the Federal Court found:

- Former CEO and Managing Director and former Chief Legal & Risk Officer breached s 180(1) of the Corporations Act.
- ASIC's case against seven former non-executive directors was dismissed, with the Court finding they did not breach their duties (and ASIC stated it will not appeal that dismissal).
- The matter will proceed to a penalty phase for the two officers, where ASIC will seek financial penalties and disqualification orders; as at the media release, penalties/disqualification periods had not yet been determined.

As sourced from the ABC News[30], the two officers had seven breaches of director's duties admitted between them. Each breach carries a maximum penalty of up to $1,050,000.

Justice Lee made a number of notable remarks in his judgement as recorded in the court document[31]:

"Toleration of the languid, listless indifference of gentleman directors of the Victorian and Edwardian ages is a thing of the past. The law now expects significantly more of officers of a corporation in discharging their duties and when delegating to others."

Introduction Ref 3

"Directors are remunerated, sometimes handsomely, to do their job, which requires real engagement with information provided to them. A director, whether executive or non-executive, is required to take reasonable steps to place themselves in a position to guide and monitor the management of the company and is expected to take a diligent and intelligent interest in the information available to them, understand that information, and apply an enquiring mind to their responsibilities."

Conclusion and Orders Ref 1945

"The 'culture' that prevailed was so dysfunctional and unethical that senior management was tardy in preventing junket operators from behaving inappropriately and lied to its bankers to secure an ongoing commercial advantage."

Conclusion and Orders Ref 1953

30 https://www.abc.net.au/news/2026-03-05/star-asic-judgement-china-money-casino/106418064

31 https://www.judgments.fedcourt.gov.au/judgments/Judgments/fca/single/2026/2026fca0196

6. What are the Learnings?

Litigation is a lag indicator of unresolved governance, operational, and/or cultural weaknesses.

These proceedings shift the focus from what trustees did to whether what they did was reasonable, defensible, and member-focused in substance. Across the details of the court proceedings outlined in this paper, several patterns recur: reliance on frameworks that were not effective in practice, weak evidence of trustee challenge and trade-off thinking, and member harm that was foreseeable (or became foreseeable) but was not prevented quickly enough.

They also reinforce that insurance in superannuation is often where what may appear as small design or administration decisions can create large-scale detriment once amplified through automation, outsourcing, and member inertia.

Considering the matters discussed in this paper, the most consistent learning is that trustees are expected to evidence three things:

- outcome-based reasoning;
- active oversight; and
- timely remediation.

Having frameworks, policies and minutes is no longer a sufficient, unless the trustee can demonstrate those frameworks and policies worked in practice. The shift from 1 July 2021 in onus of proof onto the trustee in relation to members best financial interests is very significant for decision making.

6.1 No Admission, Big Pay-Out: What It Really Means

Many class actions end in a settlement with a ‘no admission of liability’ clause. This clause means the respondent does not legally concede it breached duties or laws. It is not the same as a finding of ‘no fault,’ and it does not mean the underlying concerns were unfounded. It preserves the respondent’s position that liability is not admitted and avoids creating a formal precedent or confession that could be used in other proceedings.

A settlement (or court-approved discontinuance with cost payments) means, effectively, that the parties have agreed to end the proceeding on negotiated terms because that outcome is commercially preferable, for the Applicant lawyers, the funder and the trustee, to continuing the case to a court hearing. In deciding to settle, the parties will take into account, for example:

- Litigation risk (uncertainty of court outcome even with a strong case) – every party involved in the class action has a risk/reward profile, including the trustee, the Applicant’s lawyers and the funder (if there is one).
- The cost, time, and for the trustee disruption of ongoing litigation.
- Evidentiary burden and expert complexity.
- For the trustee reputational and member-confidence considerations.
- The desire of the trustee to keep the details confidential.
- The desire to remove contingent liabilities from the balance sheet/governance agenda.

The practical implications of a settlement for the trustee are:

- ‘No admission’ reduces legal consequences, not scrutiny. Even without admissions, stakeholders may reasonably infer that the issues raised were serious enough to justify paying to resolve them, and regulators/boards should still treat the matter as a signal of poor or questionable governance.
- Payment reflects risk management, not culpability. A trustee may pay to avoid the downside risk and expense of litigation, rather than because it accepts wrongdoing.

- Member-outcomes impact still exists regardless of admissions. Costs (settlement amounts, cost contributions, and defence costs) can still be material, and the allegations usually map to trustee governance themes (conflicts, best financial interests, process integrity, oversight).

6.2 Market Practice and the 'regulator tick' – the trustee may not be immune

The litigation highlighted that regulatory engagement, prudential compliance, or the absence of prior regulator intervention does not equate to 'regulatory approval' or litigation immunity.

Trustees may make decisions within a broadly accepted market practice, safe in the herd, 'competitive,' 'reasonable,' 'consistent with industry', and still face claims that the decision did not reflect members' best financial interests or resulted in inappropriate erosion of retirement income, or that conflicts were not substantively managed, or that the trustee did not turn its mind to foreseeable member detriment.

This learning is evidenced for example in the:

- QSuper Class Action (Section 5.1), where despite apparent compliance with regulatory frameworks and no regulatory intervention, the trustee faced claims regarding the reasonableness of premium settings and member communications.
- CFS Class Action (Section 5.3) where despite apparent compliance with regulatory frameworks and no regulatory intervention, the trustee faced claims regarding the reasonableness of premium rates.

The concept of being safe in the herd is perpetuated in some APRA guidance, for example in SPG 250 (inappropriate erosion and tender period). This does not reflect the requirements APRA sets out in relation to members' best financial interests in SPS250.

The litigation indicates the trustees should be prepared to defend decisions on the basis of what the trustee knew and what they might reasonably be expected to foresee, what it tested, what options were considered, and why the chosen path best served members, not merely that the approach was common, or competitive (on some measure) or had not previously been challenged by the regulator. All of these considerations need to be documented at the time the trustee decisions are made or actions taken, so that there is a complete 'audit trail' to support that decision/action.

6.3 'Lawful' is not the same as 'defensible'

Legal permissibility is the starting point, not necessarily the finish line. A trustee decision can be technically within its power (under regulation, the trust deed, and disclosure requirements) yet still be challenged if the trustee cannot demonstrate that, in substance, the decision delivered the best financial interests outcome for members (and see Section 6.4 for a broad description of the legal hierarchy).

Obtaining legal advice that an approach is permissible does not, on its own, establish that the trustee has discharged its member-first duties. Legal advice typically answers:

> "*Can we legally do this?*" and "*What are the legal risks?*"

rather than:

> "*Should we do this for members?*" or *"Is this the right thing to do?"*

Trustees may be judged on whether they:

- identified foreseeable detriment and trade-off;
- tested realistic alternatives;
- assessed outcomes holistically (price, terms/claimability, sustainability, service, and transition impacts); and
- can evidence why the adopted approach produced the best net outcome for members.

The QSuper proceedings illustrates this. QSuper defended its premium differences as permissible risk-based product design, while the claim challenges whether the outcome was member-first, especially the opt-in (written election) requirement for lower rates and whether members were clearly told. It shows that 'lawful' can still be challenged if the decision isn't outcomes-defensible for members.

NULIS provides a useful contrast on the role of power. It shows that where conduct is clearly authorised and documented and legally permissible, it may be defensible if challenged.

6.4 The legal hierarchy matters: Deed or IMF versus the law

A possible misunderstanding is the *hierarchy* of legal obligations that governs trustee duties relating to insurance in superannuation. Trustee decisions may be defended (internally and sometimes in litigation posture) primarily on the basis that they were 'allowed' by the trust deed or were 'managed' because the trustee followed its IMF. But deeds and IMFs sit towards the bottom of the hierarchy. They are governance tools and enabling documents; they cannot dilute or displace higher-order statutory duties.

A practical 'hierarchy' we suggest is:

1. Legislation – for example in the context of this paper, the SIS Act including:
    - Covenants (act honestly; care, skill and diligence; best financial interests, conflicts; insurance); and
    - APRA's power to set prudential standards for funds and trustees.
2. Regulations and APRA Prudential Standards.
3. Trustee agreements – such as the trust deed, insurance policies, insurance administration policies, all properly constructed.
4. Trustee policies – such as the Insurance Management Framework, policies, procedures, properly constructed.
5. APRA's prudential practice guides, circulars, guidance notes – which support APRA's prudential standards. While these are very important, they are not enforceable.

In the CFS Class Action, the defence (Section 5.3 and Appendix 6 – Claim 1 – Defence) illustrates a common framing: that the content and scope of covenant obligations 'must be read together with, and is informed/qualified by' the relevant trust deeds.

Whatever the ultimate legal merit of that position, it may be a risk, treating deed permissions and IMF compliance as if they are determinative of legality and defensibility.

This may play out for example as follows:

- Board/management papers correctly identify a conflict (for example, a related-party insurer), but conclude it is 'managed' because the trustee complied with the IMF steps and/or because the deed permits related-party dealing.
- Control testing and internal assurance then focuses on whether the IMF process was followed (box-ticking), rather than whether the outcome satisfies the covenants and best financial interests obligation in substance.
- Over time, a defective IMF or an IMF that is too process-driven and insufficiently outcome-driven becomes embedded as 'the standard', and large amounts of governance effort are spent proving compliance with rules that are themselves inadequate.

This 'IMF compliance = compliant with the law' logic is particularly dangerous if the IMF itself is flawed, generating a false sense of legal safety, including for external reviewers. Even auditors and third-line assurance can fall into the same trap if they test adherence to the IMF without also testing the adequacy of the IMF against the statutory duties it is addressing.

Trustee documents and internal frameworks may guide implementation, but they do not override the governing law. We suggest a core learning for trustees is to consider the legal hierarchy and test decisions against all the obligations, particularly the highest-order obligations.

6.5 'Lowest premiums' is not always 'best' – tendering should assess the full offer

The BT/Asgard Class Action demonstrates that:

- trustees can select a related-party insurer over a higher-scoring competitor if they can robustly justify the decision based on a comprehensive assessment of the full offer; and
- where non-price or non-scorecard factors influence the outcome, trustees need to justify those factors in member-outcome terms and retain full evidence of their assessment.

This learning indicates that trustees should go beyond weighted scores and demonstrate outcome-focused, evidence-based decision-making to meet their best financial interests and other obligations.

6.6 Care, skill and diligence is a good defence

Even where trustees and insurers act with the stated goal of providing broad insurance protection, litigants and regulators may look for evidence of care, skill and diligence in:

- selecting and renewing insurers;
- assessing pricing;
- ensuring administration correctly implements eligibility and premium rules; and
- overseeing claims handling and member communications.

Care, skill and diligence will most likely be scrutinised in hindsight. In this case, the trustee should be able to demonstrate that it did not simply receive information, but tested it, challenged assumptions, and validated the operational reality (especially where outsourced providers execute key functions). This is illustrated in the QSuper Class Action, CFS Class Action and AustralianSuper ASIC enforcement.

In addition, the Star Entertainment ASIC civil penalty enforcement (Section 5.7) outcome is an important cross-sector reminder that 'personal accountability can attach to governance failures'. It highlights expectations that boards and senior executives act honestly, exercise care, skill and diligence, and ensure serious risks are properly managed and escalated to the board.

Specifically, lessons for Directors and Officers are:

- Active oversight requirement: The judgment highlights that 'passive oversight is not enough'. While Non-Executive Directors were cleared in this case, the ruling emphasises that they must 'interrogate, probe and, if necessary, challenge' information.
- Escalation is critical: Executives are responsible for bringing serious risks to the board's attention; withholding or downplaying information is a breach of duty.
- Board pack management: Directors cannot blame an inability to manage the volume of information ('oppressive board packs') for missing red flags.
- For high-risk companies, the standard of care is higher, requiring increased diligence and independent inquiry.

6.7 Member outcomes are assessed end-to-end, not in silos

Insurance governance fails when trustees treat issues as disconnected 'streams' – product design in one place, administration controls in another, claims handling elsewhere, and communications *as* a compliance matter. From a member perspective, these form a single promise: premiums deducted should correspond to real, claimable cover, administered correctly, and supported by timely claims and informative communications.

Regulatory actions focused on claims delays and complaints trends reinforce that 'service delivery' can be treated as a core legal and governance issue rather than an operational matter. Trustees should expect scrutiny of:

- Claims timeliness and backlog control.
- Complaint volumes and root-cause analysis.
- Whether members were charged fees during periods of unreasonable delay.
- Whether remediation was timely and complete.

Governance therefore must integrate product, administration, insurer oversight, complaints, and remediation, rather than treating them as separate workstreams. The AustralianSuper ASIC Litigation (Section 5.5 and Appendix 8) underscores this, with claims focusing on systemic delays in death benefit claims processing and inadequate remediation, highlighting the need for end-to-end oversight.

6.8 Conflicts – actively managed and evidenced

Insurance in superannuation contains inherent conflicts such as the interests between and within classes of members, commercial relationships with insurers and administrators, fee structures linked to premiums, and indirect incentives in distribution models (where advice is involved). The post–Royal Commission environment has increased intolerance for conflict management that is purely procedural.

Trustees should expect that conflicts will be assessed based on their substance:

- Were conflicts identified early and clearly?
- Were mitigations real (governance separation, independent advice, tender discipline, documented rationale)?
- Were decisions demonstrably member-first despite the conflict?

The CFS Class Action (Section 5.3 and Appendix 6) illustrates how related-party insurer arrangements can escalate into significant litigation, leading to reputation and financial exposure. Although liability was not determined in this case, the $140 million settlement (no admission of liability) indicates the scale of risk when plaintiffs allege that conflicts were not sufficiently controlled or evidenced and that members paid more than they should have in premiums.

By contrast, the BT/Asgard Class Action (Section 5.2 and Appendix 5) was discontinued with Court approval after strike-out applications, reinforcing that trustees need strong, contemporaneous evidence (including independent advice and a defensible tender rationale) to withstand scrutiny when a related-party insurer is selected or retained.

The AMP Commission and Insurance Class Action (Section 0 and Appendix 7) similarly highlights the governance risk where conflicted remuneration is alleged to have influenced advice and product recommendations.

6.9 Trustee accountability – effective oversight of outsourced administrators

Outsourced operating models are often established, but they do not transfer accountability.

Recent regulatory and litigation activity reinforces that trustees are expected to independently assure critical controls and end-to-end performance, rather than rely solely on administrator attestations, insurer reporting, or consultant advice. CPS 230 Operational Risk Management[32] clearly sets out APRA's expectation in relation to board approval and oversight, monitoring of processes and legal obligations in relation to outsourced business processes and activities.

Where deficiencies persist over extended periods, courts and regulators may treat this as a failure of oversight, not merely a provider issue.

Another key learning is that if oversight is anchored only to Service Level Agreements (SLAs), trustees can miss problems that members actually experience. Better practice may be framed around member outcome measures, such as end-to-end timeliness, rework rates, complaints, error frequency and recurrence of remediation as well as cohort analysis on a full range of cohorts.

The ASIC proceeding against AustralianSuper illustrates this accountability lens: ASIC's claims are framed around systemic outcomes and trustee responsibility for ensuring outsourced administration delivers acceptable member outcomes. Importantly, this learning reflects the expectation that trustees remain accountable for results in delegated operating models.

6.10 Remediation governance is part of the standard of care

Remediation is evidence of governance quality. ASIC focuses on whether trustees:

- responded quickly once the issue is known;
- identified the full impacted population;
- applied fair and explainable methodologies;
- implemented controls to prevent recurrence; and
- maintained an auditable record of decisions, testing, and assurance.

This learning is central to the AustralianSuper ASIC Litigation (Section 5.5 and Appendix 8), where inadequate and delayed remediation of death benefit claims was a key issue.

[32] https://www.legislation.gov.au/F2023L01242/2025-07-01/2025-07-01/text/original/word

6.11 Service providers – not immune

Recent proceedings reinforce that liability risk is not confined to the trustee. Insurers, administrators and other service providers may be exposed where they are alleged to have been knowingly involved in, assisted with or benefited from conduct that constitutes a trustee breach, particularly where the provider understands the superannuation context and the trustee's statutory and fiduciary duties but still participates in (or profits from) the impugned arrangements.

In the CFS Class Action (Section 4.3.2 and Appendix 6 – Claim 5), the Applicant alleged that the insurer knew or ought to have known of the trustee duties owed to members and knowingly took profits from 'excess premiums' said to flow from conflicted or improper insurance arrangements. The learning is that plaintiff strategies increasingly seek to follow the economics of the alleged member detriment and attach liability to the party that allegedly received or retained the financial upside, not only the party that made the decision.

This theme also appears in the BT/Asgard Superannuation Class Action (Section 5.2 and Appendix 5), where the insurer was alleged to have been knowingly involved in certain contraventions connected with the tendering for, and/or implementation and management of, the group insurance arrangements. Although that proceeding was ultimately discontinued, it illustrates that insurers can be drawn into trustee governance disputes where they are alleged to have participated in or benefited from the outcome, pricing or ongoing arrangements said to disadvantage members.

Similarly, the AMP Commission and Insurance Class Action (Section 0 and Appendix 7), and the AMP Group Superannuation Class Action overcharging themes described at Section 4.3.2 highlight how plaintiffs may frame claims so that insurers and advice-related entities are not treated as bystanders. Where an insurer (or other provider) is alleged to have designed, enabled, maintained or profited from structures that create member detriment, such as premium inflation, commission-loaded pricing, or conflicted distribution incentives, plaintiffs may allege the provider was involved in facilitating the trustee's breach or participated in conflicted remuneration outcomes.

Trustees and insurers should assume that, in high-impact member detriment scenarios (especially those involving pricing margins, commissions, or related-party arrangements), litigation risk can extend across the operating model. Contracting, governance and assurance should therefore be built on an end-to-end view of accountability, with clear evidence that providers' actions, incentives, and financial outcomes are consistent with member-first decision-making and do not depend on arrangements that could be characterised as conflicted or improperly profitable.

In the contractual relationship between trustee and insurer there is an imbalance of legal expertise: the trustee is likely to be more experienced in superannuation law, regulation and governance (for example, the SIS Act) and the insurer is likely to be more experiences in life insurance law, regulation and governance. The trustee should apply extra scrutiny to any aspects of the insurance policy and/or underwriting and claims management processes that may contravene superannuation law/regulations (albeit inadvertently from the insurer's point of view). For example, the insurer may suggest that a particular exclusion be included in the policy to help reduce claims costs. However, the trustee may need to undertake a member cohort analysis to identify any cohort adversely affected and whether that is defensible from a members' best financial interests perspective.

6.12 Class Actions – in most scenarios they are sub-optimal for members

Those class actions that are settled are a relatively low-cost outcome for the trustee as they may not require full remediation (remediation sought by the Applicant or possibly awarded by the Court) to members. The settlement amount is a negotiated settlement between the Applicant's lawyers, funder and trustee, based on how they see their risk/reward profile in the action, and considering the possible outcomes of a full court case and judgement.

There is no direct consideration of members' best financial interest, as there would be if the trustee recognised an error and remediated members. although the Court must approve the settlement amount and distribution. The remediation for members is what is left over from the negotiated settlement after the costs of the Plaintiff's lawyers, experts and the funder are met.

The cost of losing the class action for the Applicant law firm and funder is high and this risk is built into the high commissions received from successful cases.

It may be concluded therefore that class actions that result in a settlement payment to members affected by a poor trustee decision(s) are good for members but only to the extent that:

- It is better to receive something than nothing, noting that with few exceptions, an individual member is unlikely to have the time or money to litigate a trustee. The settlement amount will be well below the full remediation cost. The member payout ratio after settlement costs are taken from the settlement amount will be less than 100% and likely to be well under 50%.
- Trustee behaviour and decision making may improve including in the industry generally.
- The costs of the defence and settlement are not met by member money.

For the reasons above, most settlements are sub-optimal for members, albeit better than the 'no action' alternative.

The table below summarises an example of the various risk/return profiles of the parties to a class action considering only the direct financial outcomes:

Scenario		Ultimate Risk/Reward Rating for Each Party to the Class Action ^					
Court Judgement	Outcome for the Applicant	Group Members *	Other Members **	Applicant Lawyers	Funder	Trustee ^^	Trustee Lawyers
No	Discontinuance	2	2	1	1	3	5
	Settlement	4	2	5	5	3	5
Yes	Loss with costs to defence	2	2	1	1	3	5
	Win	5	2	5	5	3	5

^ 1 is a large loss, 2 is a loss, 3 is neutral, 4 is a gain and 5 is large gain

* Members that are part of the class action

** Other members who are not part of the class action, assuming members fund directly or indirectly the settlement/remediation

^^ Assuming the trustee funds the case using trustee company's reserves built up from member transfers

7. Latent Risks – Litigation and Enforcement

Recent proceedings show how routine insurance decisions can be re-cast as trustee duty issues once three things coincide:

- member financial harm;
- visibility (data, complaints, media, regulator attention, Royal Commission attention); and
- poor reasoning or reasons for the decision and/or poor documentation of decisions and decision processes.

This section discusses latent risks, what hasn't been tested in litigation or enforcement, but could be. It highlights under-the-radar areas that are plausible candidates for litigation or enforcement, particularly where the trustee has treated them as operational irritants or pricing realities, but litigants and regulators assess them through the lens of member-first trustee obligations.

A latent risk may emerge as litigation or enforcement if there is:

- member financial detriment at scale;
- the issue is discoverable (through data, trustee minutes, complaints, audits, or a regulator's review); and
- the governance record does not withstand scrutiny.

The absence of litigation to date is not evidence the risk is low. It may simply mean that it has not been examined or discovered yet by the legal profession or a regulator. The class actions and ASIC action discussed in earlier sections of this paper were commenced some years after the issues arose. For example, the Relevant Period for the CFS class action commenced in 2014, while the class action was finally settled in 2025 and approved by the Court in 2026.

Latent risks often sit in the intersection between default design, outsourcing, member communication and system rules, where predictable misunderstanding or 'silent' detriment can persist unnoticed for years, perpetuated if it becomes 'normal practice' over time.

Whether or not a trustee ends up paying for remediation or fines, a public litigation (class action or ASIC enforcement) is costly for trustees, and in many cases members (who generally end up paying the costs of the action including any remediation). See Section 7.1 for further details.

The cost of putting together a defence is high made up of:

a) direct costs, for example, professional fees to lawyers and experts, and for ASIC civil cases the burden of proof sits with the trustee in relation to members' best financial interest;

b) opportunity costs through the divergence of trustee and management focus from other more productive activities; and

c) reputational damage.

Class actions

If the trustee loses a class action by settling, a large proportion of the settlement will include fees for the Applicant's costs for lawyers, experts and the funder, as well as the remediation costs. These costs are on top of the costs a) to c), listed above. However, the settlement cost will likely be less than a loss in court as the settlement cost will not fully compensate members for their loss, as it is a negotiation reflecting the risk profile of the three institutions involved (trustee, Applicant's lawyers and the Funder).

Regulatory enforcement action

If the trustee loses an ASIC proceeding (or resolves it on agreed terms), the cost profile is different to a class action. There is no applicant 'settlement pool' negotiated with a funder, but outcomes may include:

- pecuniary penalties;
- declarations of contravention;
- injunctions;
- adverse publicity orders;
- court-ordered compliance and remediation programs (often with independent expert reviews and ongoing reporting);
- operational uplift (systems, resourcing, controls, governance), which can be materially costly;
- trustee civil penalties;
- director or management civil penalties;
- extended regulatory engagement; and
- negative reputational impacts amplified by the regulator's public statements relating to the proceeding.

Unlike class actions, ASIC proceedings can also create broader flow-on consequences, including heightened APRA scrutiny, enforceable undertaking-style commitments, additional reporting obligations, and increased future litigation risk because pleadings, evidence and findings (if made) provide a roadmap for follow-on claims even where members are not parties to the regulator action.

7.1 Who pays? Liability allocation and ethical tension

It is counter intuitive that members pay for the costs of their own remediation plus, indirectly, the costs on both sides of a litigation.

A material latent risk is how remediation, settlements and penalties are funded, and whether the funding approach aligns with member-first obligations and community expectations.

This creates a governance and accountability challenge: trustees should be able to clearly explain 'who pays' and 'why', and demonstrate that funding choices promote fairness and appropriate behavioural incentives. This includes active consideration of the appropriate mix of the various sources of funding the outcome of a poor decision:

a) fund reserves – held within the fund, for example the Insurance Reserve (if one is held) or Operational Risk Financial Requirement (ORFR) or Administration Reserve;

b) trustee risk reserve – held within the trustee company (which may be funded by members' assets rather than shareholders) and is used to fund financial risks of the trustee or its directors that are incurred in connection with their trustee roles;

c) trustee liability insurance – particularly useful in spreading the costs evenly for what might be considered random infrequent and large events;

d) insurer contributions – where appropriate;

e) administrator/service provider contributions – where appropriate; and

f) shareholders of the trustee company.

The CFS Class Action settlement is an example of f) above, at least for the settlement amount of $140 million. As set out in Section 5.3.4, the settlement is being funded by the parent shareholder (Commonwealth Bank of Australia). This appears appropriate as it was arguably the shareholders who benefited from the excess premium alleged in the case (ignoring staff bonus structures). It avoided the ethical questions associated with members funding the financial consequences of alleged trustee governance or decision-making issues. In addition, it aligns incentives by placing the cost on the party with economic control and (arguably) governance influence.

The AustralianSuper ASIC Litigation referred to in Section 5.5, resulted in pecuniary penalties of $27 million. This was funded using a mix of b) $17 million and c) $10 million[33].

Overall, trustees should treat 'who pays?' as a deliberate design choice within governance, and develop funding policies and the reasons for these, including fairness and appropriate behavioural incentives as discussed above.

7.2 Board skill and priority – insured benefits

Insurance in superannuation is a relatively complex benefit feature of superannuation funds, involving design and pricing through to servicing and claims and delivered through multiple parties (trustee, insurer, administrator and advisers) as discussed in Section 3.5.

For most funds, the group insurance premium is one of the largest outsourcing expenditures (alongside investment management fees and administration fees), often involving hundreds of millions of dollars per annum in premiums which heightens the governance stakes and the need for robust, outcomes-based oversight. In addition, the inflow of claim payments back to the fund, and then to members is of a similar magnitude.

A latent risk is lack of insurance experience on trustee boards (collectively) and the technical capability in group life insurance: the technical ability to understand how the components of the overall insurance process (for example, design, pricing, sustainability) interact, where risks typically arise, and how decisions translate into measurable member outcomes. That experience shows up in practical ways: having the confidence and knowing 'what questions to ask', 'what evidence to require', 'what to challenge and interrogate', and 'how to define, measure and monitor outcomes' that matter to members' best financial interests.

A compounding risk arises where boards who perhaps don't have depth of experience (collectively), rely heavily on management, insurers, administrators or consultant summaries. External advice may be used as a 'rubber stamp' rather than to challenge and provide independent judgement. This weakens the trustee's ability to test decisions and demonstrate member-first governance.

Some high-level indicators of the priority a trustee board places on insurance in superannuation (alongside its broader responsibilities) are:

- Board skills matrix – showing which skills the Board sees as a priority and the level of skill for each, that the Board collectively has.
- Board committee structure – again showing the priority the Board places on its major activities.
- Directors' insurance experience – as an indication of the type of experience the Board sees as necessary for good governance.

[33] AustralianSuper Pty Ltd 2025 accounts

Based on current publicly disclosed information, an analysis of these indicators for 9 of the largest funds is set out in the table below.

Trustee	Fund Assets 30 June 2025 (APRA Statistics) $bn	Insurance Skill mentioned in Board Competency Matrix?	Board Insurance Committee?	Number of Directors	Number Listing Insurance Experience in Their Profile
Australian Retirement Trust Pty Ltd	364	Yes	No	12	1
AustralianSuper Pty Ltd	412	Yes*	No	12	0
Aware Super Pty Ltd	208	No	No	11	1
H.E.S.T. Australia Ltd.	101	No	No	14	0
Host-Plus Pty. Limited	140	Competency matrix not found	Yes**	9	0
Mercer Superannuation (Australia) Limited	81	No	No	6	2
N. M. Superannuation Proprietary Limited	128	No	No	7	1
Retail Employees Superannuation Pty. Limited	102	No	No	9	1
United Super Pty Ltd	107	No	No	13	1

* The Board skills matrix is shown as 'Yes' if insurance is mentioned in the matrix. However, for AustralianSuper, insurance is included within a diverse group of other skills and it is unclear if the rating is for all the skills required or only some of the skills.

** Insurance claims review committee only.

Key observations are:

- apart from ART, the skills matrix is silent on insurance as a required skill or one that needs to be rated from a knowledge point of view;
- at the board committee level, there is very little priority with insurance often being a subset of a board committee, such as operational or member outcome type committees;
- most boards have a director who has included insurance of some sort in their profile; and
- the analysis shows that while insurance in superannuation has some priority – it is not a high priority, nor a commensurate priority.

Building on the priority gap outlined above, a related risk is, whether insurance receives sustained board-level attention once governance structures and annual calendars are set. Even where trustees have access to capable management and external advisers, insurance decisions can be crowded out by other priorities unless there is clear ownership, regular agenda time, and a forum that drives ongoing oversight of pricing, design sustainability, claims outcomes, service performance, and emerging risks.

7.3 Spirit of the legal and regulatory settings versus legal interpretation – TPD/IP policy silos

A key latent risk in insurance in superannuation sits in the gap between the member-protective intent of the legal and regulatory settings and how those settings may be applied narrowly or defensively in operational practice. One example is the TPD/IP policy silos.

On a strict interpretation, the claims covenant (SIS Act s 52(2)(g)) "*to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success*', is reactive as it is triggered by a claim that exists.

However, the spirit of the covenant may suggest the trustee should also do everything to inform a member if the trustee has information available to it that, if a member made a claim, the claim would have a reasonable prospect of success. It may also be reasonable to expect this under the care, skill and diligence covenant and the best financial interests covenant. The 'information' available to the trustee may include cover type and medical information.

Examples where this may arise are:

- if a member has made and received a TPD claim and has IP cover, but has not submitted an IP claim; and
- if a member has been receiving IP benefits for a long time and the medical and other information supporting the IP claim indicates that the member may meet the TPD definition but has not submitted a TPD claim.

In both these examples the member's claim may have a reasonable prospect of success. The second example may require a regular check by the trustee, rather than a once off assessment.

Unfortunately, the LICOP reinforces the silo treatment of IP and TPD claims as these are typically insured under separate policies. Clause 5.5 requires that, within 10 business days of receiving a claim, an insurer tells the claimant (among other things) about all the relevant benefits under the Life Insurance Policy they are claiming on. This obligation is policy-specific: it informs members about benefits available within the policy that is the subject of the claim, but it does not extend to identifying potential entitlements under other policies issued by the insurer (for example, where the trustee's IP and TPD benefits are insured by the one insurer under separate group policies).

7.4 Communication that meets legal requirements but fails to inform

A latent risk may be the gap between complying communication and member comprehension.

Trustees may satisfy the legal requirements for the PDS and notifications, yet members may not understand, for example:

- when cover starts or started;
- what exclusions or pre-existing condition exclusions apply and how these cease;
- that cover has ceased or is about to cease;
- how offsets, and waiting periods operate; or
- how the default cover levels may relate to the member's circumstance.

This risk is structurally 'baked in' to the insurance in superannuation model because default cover is commonly delivered through passive member consent (Section 3.1) and is compounded if members have low understanding and engagement with cover terms and costs (Section 3.6). Where insurance relies on member inertia, communications are not merely a compliance exercise: they are effectively the primary mechanism by which 'consent' becomes 'informed'.

Helping members understand their insurance well enough to make an informed decision requires a particular communication skill – especially when explaining:

- opt-in options where a member has an option to commence cover or increase cover on favourable underwriting terms;
- continuation of cover options (PYS); and
- that 'easy opt-out' pathways have real trade-offs.

General descriptions of insured benefits, that imply the member is fully covered when this is not the case, may also be problematic.

Where predictable misunderstanding exists at scale, the litigation risk may rise particularly if the trustee knew (or should have known) that members were unlikely to understand without improved communications.

Examples of risks associated with communication are:

- An annual statement or welcome letter that confirms a member has default insurance, shows the premium deducted from their account, and then provides a simple instruction to cancel cover, along the lines of, "*You can cancel your insurance at any time in Member Online or by calling us*", sometimes with a brief line such as *"you may wish to seek financial advice*". While this may be technically compliant and common across the industry, it can fail to convey the real trade-off: what protection the member is giving up, that cancelling may leave them (and their beneficiaries) financially exposed if an insurance event occurs, and that reinstating cover later may not be possible on the same terms (underwriting, exclusions, loadings, or declines). Where members are nudged toward a frictionless cancellation pathway without meaningful information of the associated risks, beyond a generic 'seek advice' disclaimer, predictable misunderstandings can occur at scale and lead to member detriment.
- Trustee cancellation of cover (PMIF transition rules) and PYS, noting that AFCA[34] has received a large volume of complaints in this area and has had to issue advice to trustees to assist with the efficient processing of these complaints.

7.5 Default design trade-offs

Another latent risk is design changes, particularly for default cover.

Many funds have left their default cover unchanged for long periods, despite increases in salaries (for those funds that provide dollar benefits, rather than salary-based design, effectively reducing cover in real terms) and despite the increases in the Superannuation Guarantee. Some funds have also reduced cover in nominal terms. Of itself, this may not be an issue provided the trustee has comprehensive evidence that the design trade-offs (needs and premium impact on retirement income) deliver appropriate member outcomes and are in members' best financial interests.

Some design changes may require particularly strong evidence and additional rigour that members' best financial interests are served. For example:

- Design changes that run contrary to a trustee's previous design philosophy. These changes are effectively a criticism of the trustee's previous approach.
- Design changes that reduce cover often come with options for members to retain their current levels of cover so that, on average, these members pay more in premiums than members who accept the cover reduction. Where this change is associated with price (per dollar of cover) increases, members who opt to retain their current levels of cover will incur higher overall premium costs. It is important for the trustee to conduct a cost/benefit trade-off analysis for each of these cohorts of members.

[34] EDR Response Guide, Insurance in Superannuation – Insurance Cancellation

- Design changes that create legacy closed pools, particularly where the closed pool's experience is expected to be poor and/or deteriorating, resulting in continually higher premium rates.

The risk is that a design change may be framed as a failure to act in members' best financial interests. This risk is higher where the trustee cannot evidence a rigorous trade-off assessment (insurance needs and premium impact on retirement income) and where communications (and see Section 7.12.5) do not clearly explain the change in the level of protection, its consequences, and why the trade-off was considered by the trustee to be justified. Pointing to the similar approach of other funds may not provide trustees with immunity.

7.6 Competition, benchmarking and tenders – the limits of 'market standard'

Competitiveness as it relates to member premium rates is a nebulous concept.

- In Australia, no two funds have the same membership demographic profile (occupation, sex, age, salary) and the same design (benefits, key definitions, cover levels, rating structure). In these circumstances it is not possible to compare the premium rates of Fund A directly with Fund B.
- Further, rating factors (age, occupation) vary between funds, some funds include a trustee margin in the premium rates directly or through retention of the tax deduction on premiums. Some funds will be in a position to subsidise their rates through releases of their insurance reserve.

Fund management may respond to this by comparing the dollar member premiums (with or without adjustment for the sum insured) and absolute default cover levels with a selection of funds they consider are competitor funds.

Unfortunately, the results typically reflect the mix of insurance risks for the multitude of cohorts within each fund and therefore provide no useful guide regarding members' best financial interest. Dollar premium analysis is trustee focused (and seeks to answer the question 'will members shift funds because of the premiums?) rather than member focused ('are the rates in members' best financial interest?'). It is further complicated when one of the competitor funds has a large increase or decrease in rates, reflecting the recent experience of that fund.

With a member focus, funds may instead look at a comparison of the expected insurer margins[35], this being the amount in excess of the underlying expected claims cost. This is the real cost to the members as the claims cost is independent of the insurer, all things being equal (the claims cost being a member benefit).

Consistent with this, the Actuaries Institute's Group Insurance in Superannuation Public Policy Statement[2] Footnote 6 cautions that benchmarking is not a substitute for member-outcomes analysis and robust price/service validation:

> "Competitive comparisons with other funds are used by some trustees for premium (absolute or age rates), cover levels and cover types. These are focused on positioning the superannuation fund against other funds rather than seeking the best outcomes for the members of the fund."

A latent risk may therefore arise where trustees rely heavily on premium benchmarking to justify the premium they pay the insurer. This is especially relevant given structural differences between funds (demographics and design) and the persistent trade-off/conflict structure between cover,

[35] For example, using ASIC report on the loss ratios of large funds over the 5 years to 2018.

cost, and claimability (Section 3.2), as well as risk pool drift where default and voluntary cover co-exist (Section 3.7) and corporate/default dynamics can distort cross-subsidies (Section 3.8).

It is also important for trustees, when procuring independent benchmarking reports to consider the questions posed. For example, the following briefs are clearly very different:

- provide your opinion on whether the fund's premium rates are competitive based on benchmarking against those of other funds; and
- provide your opinion on whether the fund's premium rates are in the best financial interests of beneficiaries.

Even if widely adopted, a practice may still be challenged where it foreseeably causes detriment to a member cohort(s) and the trustee cannot demonstrate a clear, member-outcomes rationale for adopting it.

7.7 Provision and reinstatement of cover – PMIF/PYS reforms

Reforms such as PMIF and PYS changed how default cover is provided, ceases, and is reinstated. Specifically, these reforms introduced rules that between them, prevent the commencement of cover for younger members and members with low balances and inactive accounts, unless the member makes an election to maintain or take up cover.

A latent risk may arise with PMIF where default cover was turned off under the PMIF transition rules (for example, because a member had a balance under $6,000), but is not switched back on when the member later becomes eligible for opt out cover ($6,000 account and 25 or older). Some funds have switched cover on again, others have not. Presumably both groups have determined that their approach is in members' best financial interests and have communicated that effectively with their members.

A latent risk may also arise with PYS trustee cover cancellation where communication follows only the letter of the law (in timing and content) but turns out to be inadequate at informing members of the benefits they are forgoing and the options they have. This is another example where compliance with legislation or regulations is 'necessary' but is 'not necessarily sufficient' to ensure that the trustee, overall, has acted in the members' best financial interests.

These issues are high-risk because they create large cohorts of 'silent underinsurance': members believing they have insurance through superannuation (or reasonably assume default cover will restart once they meet published criteria), but discover at the worst possible time (claim time) that cover was turned off or never reinstated and they are uninsured.

7.8 Best interests intent with insufficient diligence – 'good faith, poor evidence'

A latent risk may arise where governance practice becomes overly passive and reporting led.

In these scenarios, boards are provided with management papers that recommend a preferred option, but the board does not test whether the paper presents the full picture, whether the pros and cons have been fairly set out, or whether all viable alternatives have been identified and assessed.

The risk increases where boards:

- Rely on management reporting and recommendations without independent challenge and judgement.
- Accept a limited set of 'presented options' without asking whether other viable options exist, including options that management has not brought forward (and see Section 7.2).
- Receive papers that are incomplete or biased – for example, emphasising costs and downplaying trade-offs, implementation risks, or downside member impacts.

- Treat ‘due diligence’ as having a Members’ Best Financial Interests Duty compliance statement or pack and minutes, rather than evidence of inquiry, testing and challenge. A possible pitfall is ‘due diligence’ reviews that demonstrate compliance with the fund’s risk management statement and risk mitigation strategies and/or compliance with the fund trust deed and/or policies (such as the IMF), rather than directly demonstrating compliance with the trustee’s duty to act in members’ best financial interests. These demonstrations of ‘indirect compliance’ may not be complete if the fund policies, trust deed or IMF, themselves, do not comply (fully) with the best financial interests duty.
- Do not seek (or retain) the right specialist expertise to independently validate and challenge assumptions, outcomes and trade-offs.

In litigation, the question is rarely whether the Members’ Best Financial Interest Duty pack was completed and approved. It is whether trustees exercised the required care, skill and diligence, controlled conflicts, and can evidence that they actively tested, challenged, and made an independent judgement that the decision was in members’ best financial interests. Where the evidence trail is thin, good faith may be acknowledged, but it is unlikely to be a defence.

7.9 Insurance tenders as an indication of good governance

The Actuaries Institute’s Public Policy Statement[2] Footnote 14, Paragraph 4 summarises why tendering the insurance arrangements is good practice:

> “The process best informs price and service levels (particularly claims management and underwriting processes) and generates innovation from insurers and trustees in relation to benefit design, structures and processes. The period between reviews will vary by fund depending on amongst other things the structures they have in place for independently reviewing the premium rates.”

With tenders resulting in a high rate of change of insurer (52% as set out in Appendix 9), it is reasonable to conclude that tenders do create value for members and improve member outcomes.

APRA, in its guidance, identifies infrequent tendering as an “*indication that the best financial interests of beneficiaries may not have been prioritised*[36]”. ‘Infrequent’ according to APRA is defined as “*market tender has not been conducted for a period of time longer than the industry average*”. APRA does not define what is meant by the ‘industry average’. Nevertheless, SPG250 suggests that APRA sees tender frequency as part of a range of indicators reflecting good governance.

There is a wide range of approaches by trustees to the frequency of tendering the insurance policies. The table in Appendix 9 sets out the last year in which each of the larger funds (27 considered) commenced the tender of their policies based on the period to 30 June 2025. The graph below summarises the distribution.

[36] SPG250 paragraph 68

Key observations from Appendix 9:

- The analysis shows that assuming all funds were to commence a tender in 2026, the average period between tenders would be 6 years. Of course, only a handful of funds will commence a tender this year and the average period between tenders is well in excess of 6 years.
- On an insured-lives weighted basis, the average period would be 8 years. The higher average period possibly reflects that many larger funds undertake frequent independent rate reviews between tenders and have arrangements that return a large proportion of excess insurer premium back to insured lives.
- 52% of the tenders resulted in a change of insurer.

The risk for trustees who do not tender is being able to establish (with regulators and litigants) that the alternative (to a tender) processes and reviews put in place by the trustee – deliver outcomes that are commensurate with, or better than, those of running a tender and that decisions not to tender are made in members' best financial interests.

7.10 Regulatory reforms implementation risk – partial implementation

Reforms often require rapid updates across legal documents, administration systems, rules engines, payroll/employer feeds, member portals, communications, fund policies, and insurer interfaces.

A latent risk is not only implementation error but partial implementation. For example:

- one system reflects the new rule(s) while another does not;
- communications align to legislation but processes do not; or
- policy schedules, Product Disclosure Statements (PDSs), fund rules, and administration systems conflict.

Litigation may frame system errors as governance and oversight failures rather than 'IT defects', because trustees are expected to manage end-to-end change risk and member outcomes. This is particularly true when administration is outsourced to a third party, as the trustee retains overall responsibility, but it is more challenging to monitor compliance with fund rules and service standards than if the trustee had direct control over the administration.

The IT industry appears in general to have moved system testing to a 'best endeavour' testing level, without comprehensive and independent testing prior to release. This effectively puts system testing in part on the user and accepts remediation costs may be incurred. This approach is high risk for trustees.

7.11 TPD design and definition

The TPD benefit has been problematic for many years and for several reasons. More recently, the difficulty in determining permanency has increased for a large proportion of claims. At the same time, there is increased pressure through the compulsory LICOP to make a decision within set timeframes. The rapid increase in the take-up of voluntary high sum insured TPD cover makes the claims decision particularly confrontational and often involves a lawyer at claim time.

By offering a benefit that for some significant claim causes is not accurately assessable in a reasonable timeframe, trustees may be exposed to a latent risk:

- claims accepted when they should not have been accepted create unstable pricing and price increases; and
- claims declined when they should be accepted create rework and complaints.

7.12 Other latent risks

7.12.1 Trustee reliance on insurer for experience analysis

A latent risk may arise if the trustee relies heavily on their insurer's advice in relation to experience, premium rate changes, and terms and conditions, even where that advice is offered in good faith:

- The advice is conflicted and cannot be independent.
- It is unlikely (though not impossible) the actuaries, or other employees of the life office offering the advice to the trustee, understand the framework in which the trustee works.
- It may be unclear which actuary within the life office is taking responsibility for the advice.

Receiving the advice is not an issue but being able to either internally or externally review and challenge the advice in these circumstances is important.

7.12.2 Conflicted relationships – external financial advisers

Personal advice provided by the financial planning industry may provide a source of growth for the trustee's fund(s), particularly asset growth. A latent risk may arise if the trustee prioritises the interests of the trustee (asset growth) over the interest of insured members, for example by providing high voluntary cover levels, concessional underwriting and/or rates that do not reflect the underlying risk in order to encourage advisers to put their clients' assets in the fund.

7.12.3 Inadequate IMF

A latent risk may arise if the trustee establishes governance structures, processes and check lists in the IMF and then establishes oversight and risk management processes that simply test compliance with the IMF.

If the IMF itself is inadequate or defective, then the trustee and its management may devote time and cost in ensuring compliance with defective rules and processes.

7.12.4 Insurance reserve management and fairness between cohorts

Use of an insurance reserve to reduce premium rates over the long term, smooth premiums, meet the fund's insurance expenditure, fund remediation, or pay settlements raises equity and purpose questions. Latent risks may arise with insurance reserves where, for example:

- the reserve policy is vague or ambiguous and able to be circumvented;
- the insurance reserve is underfunded and requiring additional premiums from members to build it back up;

- the insurance reserve is overfunded and results in distributions back to insured members being delayed;
- the insurance reserve is used to fund activities or costs that are not insurance related; and
- disclosure does not explain to members why there is an insurance reserve and how it is used including in the annual report reasons for the movements in the insurance reserve over the year.

7.12.5 Communication of cover options to members on a change of design

Changing design is a high-risk activity for trustees, particularly when members are given a choice (option) to retain the current level of cover or move to the new default cover. Typically, before and after comparisons are provided to members of cover level and premium to help them make an informed decision.

There may be a latent risk where a trustee does not provide, for example:

- a-like-for-like comparison on a common date so that differences caused by other factors do not distort the comparison, for example, the impact of an age difference on the premium rate or cover level; and
- an explanation of how the cover and premiums under each of the option(s) will change in future years, perhaps with a projection.

7.12.6 Risk frameworks that respond to incidents rather than anticipate them

Insurance risks lend themselves to predictive monitoring. For example, reconciliation of transactions between administration systems and the ledger and between the trustee and the insurer, premium anomalies by cohort, claims duration creep, complaint spikes and exception backlogs. Trustees that rely only on incident reporting, rather than leading indicators, may be exposed to hindsight criticism when systemic issues emerge and the ultimate cost of remediation may be higher.

7.12.7 Governance of insurance tools – calculators, modelling, and digital journeys)

As trustees provide guidance through insurance calculators and digital journeys[37], model risk becomes a governance issue, even if the model is provided by a third party. Latent risks may include:

- assumptions that materially bias member decisions;
- assumptions or methodologies that are inappropriate;
- insufficient explanation of limitations (for example, exclusions, eligibility, continuation);
- inadequate testing for vulnerable cohorts;
- failure to present the trade-offs of member decisions (for example, reducing cover may increase members' financial risk at the point of death and disability); and
- weak version control and review governance.

If tools drive member decisions, it is prudent for trustees to justify (with documentation) tool design and oversight as part of member outcomes governance.

[37] The end-to-end digital experience trustees provide to members through tools like insurance calculators, encompassing data inputs, models, user interfaces and decision aids that guide member choices.

8. Reducing Trustee Risk – How Can Actuaries Help

Actuarial advice does not stop at analytics. Actuaries may bring a holistic perspective both quantitatively and qualitatively, across pricing, design, member outcomes, equity, fairness, sustainability, sound financial management and ethics, all in compliance with the SIS laws and corporations law. Actuaries are well placed to assist trustees make decisions in members' best financial interest and evidence those decisions. Some examples of actuarial advice in this area are discussed below:

Insurance design and default settings

Actuarial analysis can assist trustees when setting the default insurance design, helping to ensure it is appropriate for the fund's membership profile and remains appropriate over time, quantifying the trade-offs between protection and premium impact on retirement savings and helping to ensure the design is sustainable.

Claims experience

Actuarial monitoring of the claims experience may assist trustees detect leading indicators of foreseeable member detriment (before issues become problematic), enabling earlier governance action and supporting the expectation that trustees actively oversee insurance outcomes.

Insurer selection, tenders, renewals, and premium rate reviews

Actuarial capability can assist trustees to demonstrate insurer selection and pricing decisions were optimal for members, by forming an independent view of reasonable pricing and terms, normalising comparisons for benefit differences, quantifying cohort impacts of trade-offs, and supporting disciplined documentation. This is particularly important where conflicts (including related-party considerations) are present.

System design

Actuarial capability can help trustees translate insurance design and fund rules into clear, testable specifications for administrator and insurer systems (including eligibility, default cover, premium rate tables, opt-in/opt-out pathways, and events-based changes).

Actuaries also provide independent testing and implementation assurance, using member-level recalculation, scenario testing, and reasonableness checks to validate that configuration changes operate as intended, remain aligned to member communications, and do not introduce unintended cross-subsidies or member detriment. This is particularly valuable where change programs are complex, data quality varies, or multiple parties share responsibility for build and release.

System changes and implementation risk

When administration and insurer systems implement changes to eligibility, cover, and premium rules at scale, actuarial testing and assurance can help trustees reduce the risk that system changes diverge from fund rules and member communications. This also reduces the reliance on complaints and remediation, to detect errors and omissions.

Monitoring and assurance frameworks – operational controls and reconciliations

Actuarial input can support trustee oversight by designing quantitative monitoring, dashboards, and member-level reconciliations that detect premium and cover mismatches, eligibility errors, and systemic configuration defects earlier, aligned to prudential expectations for oversight, outcomes monitoring, and control effectiveness (including SPS 250 and SPS 515).

Transparency, member outcomes reporting, and equity assessment

Actuarial reporting can translate insurance complexity into board-usable member outcome measures and cohort impacts, helping trustees identify and explain material cross-subsidies, low-

value or low-claimability cohorts, and retirement outcome erosion, and to evidence that any inequities are deliberate, justifiable, and appropriately governed and disclosed.

Member communication

Assist trustees in ensuring member communications are accurate from both a product and numerical perspective, particularly where assumptions must be set, calculations performed or comparisons made.

Strengthen ‘litigation readiness’

Assist trustees in developing remediation methodologies that are efficient, fair and reasonable for members, and in apportioning remediation costs to the responsible parties.

Insurance reserve governance – sustainability, fairness, and disclosure

Actuarial analysis can support trustees to govern insurance reserves in a way that is sustainable and equitable across cohorts by clarifying reserve purpose and beneficiaries, modelling adequacy under stress, assessing intergenerational impacts and supporting clear decision rules and disclosure narratives that can withstand external scrutiny.

9. Looking Ahead – What 'Good' May Look Like

Court cases and regulatory actions rarely turn on whether a trustee had a policy, a committee, or a process on paper. They turn on something more practical, evidence that the legislation was followed with intent, that the 'spirit of the legislation' was considered and that the trustee actively assessed whether minimum legislative steps were sufficient to achieve member-first outcomes.

In that sense, litigation is not just a backwards-looking accountability mechanism; it is also a preview of the operating standard trustees are being measured against. The trajectory is clear: expectations are shifting from 'did you follow a process?' to 'did you deliver an outcome?' – and 'can you prove it?'

This section steps out of the courtroom and into the boardroom. It describes what 'good' may look like in practice:

- Communication designed to educate, inform, and empower member decisions, not merely to 'disclose' – layered, timely and targeted.
- Governance that makes trade-off decisions explicit (cover, cost, sustainability, equity) and can be defended in member-outcome terms.
- Conflicts stripped out where possible and appropriately managed when not.
- Third-party arrangements (including the insurer) that are demonstrably member-first – clear standards, enforceable levers and strong assurance rights.
- Operating models where accountability is clear and considered on an end-to-end basis across the trustee, its staff, insurers and administrators.
- Controls that detect and contain problems early, before automation and member inertia risk turning small defects into systemic detriment.

The aim is not to set an unrealistic standard of perfection. It is to describe a trustee posture that is resilient and demonstrably member-first.

9.1 What may 'good' trustee governance look like

Trustee standards – outcomes as well as process

Trustees are able to show that they monitored member outcomes, anticipated foreseeable detriment (for example, premiums for no cover, opt-in or opt-out designs that predictably fail significant cohorts of members, claims delays), actively oversee administrators/insurers and manage conflicts in substance.

Boards and executives with collective insurance skills

Trustee boards and executives with technical insurance skills, operating-model literacy and independence to interrogate insurance decisions including design, pricing, claims operations, data/rules and remediation. It shows up as deep and insightful challenge and evidence standards that don't depend primarily on provider assurances and/or the existence of committees and minutes.

Technical rigour becomes a core feature of insurance governance

Strong technical capability embedded in insurance governance of superannuation funds; used to translate design, pricing and experience into member-outcome impacts, and to make key trade-offs explicit and testable.

Trustees being able to demonstrate that they had input from suitably qualified and experienced people to test insurer and administrator assertions, quantify member impacts, and evidence best

financial interests decisions, particularly where complexity, outsourcing and data limitations make outcomes difficult to validate by process alone.

Actuaries are well placed to provide this technical support.

Operating model accountability (end-to-end ownership)

Trustees hardwire end-to-end accountability through a clear Responsible, Accountable, Consulted and Informed (RACI) framework, contractual levers/audit rights and a trustee-owned map of critical controls (eligibility logic, premium deductions, claims triage and timeframes, and member communications).

9.2 Appointed Actuary

Superannuation funds are now very large financial organisations. The cost/benefit trade-off of having an Appointed Actuary role reporting to the Board has become more compelling. Some funds already see actuarial expertise as a core skill to have on their Boards.

Unlike other large financial organisations such as life insurers, general insurers and health funds, superannuation funds are not required to have an Appointed Actuary to provide independent actuarial advice to the Board, although defined benefit superannuation funds have an RSE Actuary appointed by the Board to provide advice to the trustee on its financial position.

Accumulation funds have significant reserves (for example, ORFR and other operational, administration reserves) and some have insurance reserves. These reserves need to be actively managed to ensure they are not too small (creating solvency/operational fragility and an inability to remediate issues) and not too large (creating inequity between cohorts and inappropriate cross-subsidy). An Appointed Actuary within the fund would be ideally placed to provide independent advice on reserve adequacy, target ranges, release and replenishment triggers and equitable allocation across member cohorts.

Similarly, benefit design sustainability, including the sustainability of default insurance settings, premium trajectories, eligibility and continuation rules, and the long-term balance between adequacy of cover and the impact of premiums on retirement income requires rigorous forward-looking analysis and projections. That analysis may best be delivered through an Appointed Actuary model.

Importantly, the comments above apply across the entire range of fund activities (including, for example, superannuation investment products and investment management), as well as the insured benefits.

10. Conclusion

We have set out the key findings of the Royal Commission in Section 2.2 and discussed recent litigation and enforcement in Section 4 and Section 5.

Class actions and regulatory enforcement actions since the Royal Commission provide some important learnings (Section 0) for the industry.

Latent risks still exist (Section 7). We have set out a range of areas where trustees may become exposed if these risks are not appropriately managed, and managed in the light of the '2021 evidential burden' under the members' best financial interests covenant.

The Royal Commission has resulted in a dramatic increase in class actions. Will this trajectory continue, or will it fizzle and burn out? Have trustees (collectively) created a new branch for the class action industry – one that surveys trustee decisions and member complaints and becomes increasingly effective at sniffing out potential class actions; an environment where litigation becomes routine, at significant cost to members who ultimately pay the price through diverted time, attention and costs borne by funds?

For regulatory enforcement actions, members also ultimately bear much of the cost.

Will regulators continue to step up and keep poor trustee decisions in the spotlight?

Looking forward, governance success for trustees collectively will be, amongst other things:

- The demise of class actions as they become economically unviable, indicating that the role of trustee has developed and matured to the stage where there are few trustee errors and omissions or poor decisions that lead to member detriments.
- A corresponding reduction in the need for regulatory enforcement, because strong governance, oversight, and decision-making are embedded as standard practice.

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Court Proceedings and Legal Documents

This *section includes pleadings, court orders, judgments, and settlement notices related to class actions and ASIC litigations.*

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- Federal Court of Australia, Victoria Registry. (2024, December 19). *Further amended statement of claim* (Form 17, r 8.06(1)(a)) [Pleading]. *Jessica Amy Challenor v QSuper Board*.
- Federal Court of Australia, Victoria Registry. (2025, February 17). *Defence to further amended statement of claim* (Form 33, r 16.32) [Pleading]. *Jessica Amy Challenor v QSuper Board*.
- Federal Court of Australia, Victoria Registry. (2025, February 25). *Reply to defence to further amended statement of claim* (Form 34, r 16.33) [Pleading]. *Jessica Amy Challenor v QSuper Board*.
- Federal Court of Australia, Victoria Registry. (2025, November 19). *Orders* [Court order]. *Jessica Amy Challenor v QSuper Board* (Button J).
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- Federal Court of Australia. (n.d.). Notice of proposed settlement: QSuper class action for $67 million [Settlement notice].

BT/Asgard Class Action (VID826/2023):

- Federal Court of Australia, Victoria Registry. (2024, January 19). *Statement of claim* (Form 17, r 8.06(1)(a)) [Pleading]. *Fisher & Ors v BT Funds Management Ltd & Ors*.
- Federal Court of Australia, Victoria Registry. (2024, May 10). *Defence* (Form 33, r 16.32) [Pleading]. *Fisher & Ors v BT Funds Management Ltd & Ors*.
- Federal Court of Australia, Victoria Registry. (2024, May 31). *Second respondent's defence* (Form 33, r 16.32) [Pleading]. *Fisher & Ors v BT Funds Management Ltd & Ors*.
- Federal Court of Australia. (n.d.). Notice of proposed discontinuance of class action [Court-ordered notice]. Fisher & Ors v BT Funds Management Ltd & Ors.
- Federal Court of Australia. (n.d.). Notice of objection to proposed discontinuance [Form]. Fisher & Ors v BT Funds Management Ltd & Ors.

Colonial First State Class Action (VID28/2020):

- Federal Court of Australia, Victoria Registry. (2025, July 21). *Orders* [Court order]. *Simon Mallia v Colonial First State Investments Ltd & Ors* (Bennett J).
- Federal Court of Australia, Victoria Registry. (2025, July 24). *Second further amended statement of claim* (Form 17, r 8.06(1)(a)) [Pleading]. *Simon Mallia v Colonial First State Investments Ltd & Ors*.
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- Federal Court of Australia, Victoria Registry. (2025, September 9). *Second further amended originating application* (Form 19, r 9.32) [Originating application]. *Simon Mallia v Colonial First State Investments Ltd & Ors*.

- Federal Court of Australia. (n.d.). *Notice of proposed settlement for $140 million* [Settlement notice].

AMP Class Action (VID489/2020):

- Federal Court of Australia, Victoria Registry. (2021, June 11). *Reply* (Form 34, r 16.33) [Pleading]. *Nigel Peter Stack & Ors v AMP Financial Planning Pty Limited & Ors*.
- Federal Court of Australia, Victoria Registry. (2023, December 15). *Originating application* (Form 19, r 9.32) [Originating application]. *Nigel Peter Stack & Ors v AMP Financial Planning Pty Limited & Ors*.
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AustralianSuper ASIC Litigation (VID289/2025):

- Federal Court of Australia, Victoria Registry. (2025, March 11). *Concise statement* (Form NCF1) [Pleading]. *Australian Securities and Investments Commission v AustralianSuper Pty Ltd*.
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NULIS Class Action:

- *Brady v NULIS Nominees (Australia) Limited (as trustee of the MLC Super Fund) (No 4)* [2024] FCA 1374 (Markovic J, December 2, 2024) (Federal Court of Australia, New South Wales Registry) (NSD 1736 of 2019).

Start Entertainment ASIC Civil Penalty Proceedings:

- *Australian Securities and Investments Commission v Bekier* (Liability Judgment) [2026] FCA 196 (Federal Court of Australia, Lee J, March 5, 2026).

Appendix 1: Major Legislation and Regulations relating to Insurance in Superannuation

1) Superannuation trustee law (core duties and operating rules)

- SIS Act 1993 – trustee covenants (including section 52(2), S52(7)), best financial interests and outcomes duties.
- SIS Regulations 1994 – operating rules relevant to insurance in superannuation (benefit or payment settings, operational requirements).

2) Prudential / governance standards (APRA)

- APRA Prudential Standard SPS 250 (Insurance in Superannuation)
  Plus supporting APRA standards that typically underpin insurance governance and oversight:
- SPS 220 – Risk Management
- SPS 510 and SPS 521 – Governance and Conflicts
- SPS 515 – Strategic Planning and Member Outcomes
- SPS 231 / CPS 230, SPS 234, SPS 114 (as applicable) – Outsourcing / operational resilience / information security

3) Financial services conduct, disclosure, and complaints (ASIC)

- Corporations Act 2001 – disclosure and conduct obligations (PDS/ongoing disclosure, DDO, reportable situations, etc.)
- ASIC Act 2001 – general consumer protection (misleading/deceptive conduct, unconscionable conduct)
- ASIC RG 271 – Internal Dispute Resolution (IDR) expectations (guidance under the Corporations Act/ASIC Act framework)

4) External dispute resolution

- AFCA Rules – External Dispute Resolution (EDR) requirements and processes.

5) Data/privacy (claims and health information handling)

- Privacy Act 1988 and Notifiable Data Breaches scheme – handling of sensitive/health information, breach notification.

6) Insurance contract law (trustee–insurer policy context)

- Insurance Contracts Act 1984 – policy terms and insurance law concepts influencing trustee–insurer contracting and claims oversight (even where the trustee is not the ‘insured’).

Appendix 2: Life Insurance Code of Practice

While trustees are not signatories to the Life Insurance Code of Practice (LICOP), they have indirect obligations to ensure that members receive the practical protections provided by the LICOP where the trustee's insurance arrangements involve an insurer bound by the LICOP. In practice, this requires trustees to appropriately select, contract with, oversee, and monitor insurers and any outsourced claims administrators to ensure delivery of the LICOP protections, including:

- ensuring member communications are clear, accurate, and easy to understand;
- supporting timely, fair, and respectful claims handling;
- overseeing outsourced claims administrators to maintain service quality;
- providing accessible complaints and dispute resolution pathways;
- protecting members during underwriting and evidence-of-insurability processes;
- managing policy changes and premium adjustments transparently;
- identifying and supporting vulnerable members with appropriate care;
- ensuring timely and accurate data sharing to prevent unnecessary delays; and
- maintaining ongoing monitoring, incident management, and continuous improvement to safeguard member interests.

Although contractual responsibility for claims management typically rests with the insurer, trustees retain oversight responsibilities for the insurance arrangements, including agreeing the insurer's claims management policies as part of the insurer appointment process, pursuing insurance claims for the benefit of members and overall monitoring of insurance processes. Claims should be progressed and determined within reasonable timeframes, consistent with the LICOP. While the LICOP generally contemplates decisions within six months, not all claims are complex, and the 'complex claim' provisions should only be applied where justified.

The LICOP is currently under review.

Guiding Principles and Service Promise of LICOP

Our guiding principles

Life insurers provide critical support by giving you the protection and certainty you need on your best and worst days.

We play an integral role in the Australian community as part of the health, disability and social safety net, supporting millions of people at an individual level and adding value nationally through significant economic and social contributions.

We are committed to engaging with you, the broader community and government to build an inclusive, supportive and thriving Australia.

Our guiding principles are shared by all life insurers and reinsurers subscribed to the Life Code.

They provide an important ethical framework to guide our customer service to you and our overall decision making. We will continually build and promote an ethical culture, supported by sound corporate governance practices and effective staff training.

1. We will support you to make informed financial decisions by communicating with you in a clear, timely and transparent way and openly sharing information about life insurance products with other professionals and organisations.
2. We will act in good faith in selling life insurance products that give you protection and certainty and in providing services to you.
3. We will meet the needs of the community by designing and selling life insurance products that provide value and sustainably meet the wide range of needs in the community, and keeping our promise to deliver good customer and community outcomes.
4. We will act fairly and honestly in all our dealings with you, actively listen to your needs and concerns, and provide ways for you to seek a review of our decisions or make a complaint.
5. We will make life insurance accessible, by providing additional support to access our products and services and help if you are experiencing vulnerability or facing financial hardship.

Our service promise

The life insurance industry has voluntarily developed the Life Code to protect you, the customer. The Council of Australian Life Insurers (CALI) promotes the Life Code to customers through its members. The 10 promises made by subscribers to the Life Code are:

1. We will be honest, fair, respectful, transparent and timely when we communicate with you, and we will use Plain Language unless medical or other technical terminology is needed.
2. We will ensure our staff and Authorised representatives use appropriate sales and retention practices.
3. We will offer extra support if you have trouble with the process of buying insurance or claiming.
4. If we find that a sale was made using unacceptable sales practices, we will fix it, for example by issuing a refund or replacement policy.
5. When you make a claim, we will explain the process and keep you informed about our progress assessing it.
6. We will decide on your claim within the Life Code's timeframes. But if we cannot, we will explain why and tell you how to make a Complaint.
7. If we decline your claim, we will explain why in writing and let you know what to do if you disagree.
8. We will restrict the use of investigators and Surveillance to preserve your right to privacy.
9. The independent Life Code Compliance Committee (Life CCC) will monitor our compliance with the Life Code.
10. We will be accountable for Life Code requirements, and the Life CCC can sanction us.

Appendix 3: Court Proceedings against Superannuation Funds since the Royal Commission

The summary list below sets out court proceedings against superannuation funds since the Royal Commission. It is prepared on a best-efforts basis using publicly available information available at the time of preparation. It may not capture all cases, or the current status of each case.

Class Actions

Case / proceeding	What it's about	Litigation lodge year	Type	Settled / outcome / date	Settlement
Suncorp Superannuation Class Action (Quirk v Suncorp Portfolio Services Ltd (trustee))	'Fees for no service' allegations involving a superannuation trustee.	2019	Class action	Settled (approved 2022)	$33m
Colonial First State Fees Class Action (Krieger v Colonial First State Investments Ltd)	'Fees for no service' allegations involving a superannuation fund/trustee.	2019	Class action	Settled (approved 2024)	$100m
NULIS Nominees Class Action (Brady v NULIS Nominees (Australia) Ltd)	'Fees for no service'/commission funding allegations against the trustee (incl. SIS covenant issues).	2019	Class action	Dismissed at trail with costs (2024)	—
AMP Superannuation Class Action (Alford v AMP Superannuation Ltd and others)	Post–Royal Commission superannuation issue class action around overcharged administration fees	2019	Class action	Settled subject to court approval (2026)	$120m
BT Superannuation Class Action (Ghee v BT Funds Management Ltd)	Superannuation class action (post–Royal Commission context).	2019	Class action	Settled (approved 2023)	$29.95m
Colonial First State Class Action (Mallia v Colonial First State Investments Ltd & Anor)	Insurance product-related class action concerning member insurance outcomes.	2020	Class action	Settled 2026	$140m
MLC MySuper Class Action (Shimshon v MLC Nominees Pty Ltd & NULIS Nominees (Australia) Ltd)	Post–Royal Commission superannuation issue (MySuper-related) class action.	2020	Class action	Settled; awaiting approval	$64.25m
ANZ and OnePath Superannuation Class Action (Janssen v OnePath Custodians Pty Ltd)	'Fees for no service' allegations involving superannuation members.	2021	Class action	Settled; awaiting approval	$50m
QSuper Class Action (Challenor v QSuper Board)	Insurance product-related class action concerning member insurance outcomes.	2021	Class action	Settled 2026	$67m
REST Superannuation Class Action (Kusmanoff v Rest Employees Superannuation Pty Ltd)	Insurance product-related class action concerning member insurance outcomes.	2023	Class action	Ongoing (2023)	—

ASIC / APRA enforcement actions

Case / proceeding	What it's about	Litigation lodge year	Type	Settled / outcome / date	Settlement / penalty
APRA action – IOOF (additional licence conditions)	Additional licence conditions imposed to address governance/conflicts concerns.	2018	APRA licence conditions	Conditions imposed (2018)	—
APRA v IOOF (disqualification proceedings)	APRA disqualification proceedings against IOOF executives alleging failures to act in members' best interests (governance / oversight).	2018	APRA litigation	Dismissed by the Federal Court (2019); APRA ordered to pay costs[38]	—
APRA Court-Enforceable Undertaking (CEU) – Allianz Australia Insurance Ltd	Court-enforceable undertaking addressing governance and risk control weaknesses.	2019	APRA CEU	Accepted (2019)	—
ASIC v MLC Nominees / NULIS (fees for no service)	ASIC enforcement over 'fees for no service' misconduct (misleading conduct / EHF).	2020	ASIC litigation	Penalties ordered (2020)	$57.5m
APRA CEU – AMP Superannuation Ltd	Court-enforceable undertaking addressing compliance deficiencies, risk management, and governance frameworks.	2021	APRA CEU	Accepted (2021)	—
ASIC v REST Super	ASIC enforcement over misleading representations about limitations on members' rights to transfer/roll over out of the fund (portability/rollover processing requirements).	2021	ASIC litigation	Dismissed by the Federal Court (2024)[39,40]	—
ASIC v Statewide Superannuation (insurance representations)	ASIC enforcement alleging Statewide misrepresented to members that they had insurance cover when they did not.	2021	ASIC litigation	Commenced; outcome not stated in your inputs	—
ASIC v Future Super (greenwashing infringement notice)	ASIC infringement notice regarding alleged greenwashing by a superannuation fund promoter.	2023	ASIC enforcement	Infringement notice issued (2023)	—

[38] Dismissed by the Federal Court (20 September 2019) in its entirety, finding APRA had not proven the alleged contraventions on the pleaded case. Because APRA did not establish the underlying contraventions/misconduct, there was no foundation for the disqualification orders APRA sought against the individuals.

[39] Dismissed by the Federal Court (18 Sep 2024), ruling that even if allegations were true, they did not amount to misleading conduct under the law. In 2025, ASIC issued two infringement notices totalling $37,560 to Rest alleging that Rest sent annual statements and emails to members who had previously cancelled, chosen not to receive, lost or not held insurance cover via the fund suggesting that they continued to hold active death, TPD or IP insurance. Rest paid the penalties without an admission of liability.

[40] https://www.asic.gov.au/about-asic/news-centre/find-a-media-release/2025-releases/25-218mr-rest-pays-two-infringement-notices-in-relation-to-insurance-failures/

ASIC action – Telstra Super complaints handling	ASIC launched its first-ever civil penalty proceeding for alleged breaches of internal dispute resolution (IDR) requirements under Regulatory Guide 271.	2023	ASIC civil penalty proceeding	Ongoing	—
ASIC v AustralianSuper (duplicate accounts)	ASIC enforcement for failures to merge duplicate accounts (unnecessary fees and insurance premiums).	2024	ASIC litigation	Penalty ordered (2024)	$27m
APRA v Mercer Superannuation (Australia) Limited (additional licence conditions)	APRA imposed additional licence conditions on Mercer Superannuation to address APRA-identified risk management and compliance management deficiencies requiring a remediation plan with an independent expert, an independent operational effectiveness review, and a further remediation plan with Trustee Chair attestation.	2024	APRA licence conditions	Conditions announced 28 May 2024; in force from 27 May 2024	—
ASIC v Mercer Superannuation (greenwashing)	ASIC enforcement alleging misleading statements about 'Sustainable Plus' options and exclusions.	2024	ASIC litigation	Penalty ordered (2024)	$11.3m
ASIC v LGSS Pty Ltd (Active Super) (greenwashing)	ASIC enforcement where the Court found misleading ESG/exclusion statements.	2024	ASIC litigation	Liability found; penalty pending (2024)	—
ASIC v United Super Pty Ltd (Cbus) (insurance claims / death benefits delays)	ASIC enforcement relating to serious failures in handling insurance claims and death benefits, with unreasonable delays affecting thousands of members.	2024	ASIC litigation	Penalty ordered (2024/2025)	$23.5m
APRA CEU – OnePath Custodians Pty Ltd	Court-enforceable undertaking relating to MySuper/member outcomes compliance (plus APRA infringement notice).	2024	APRA CEU / infringement notice	CEU accepted (2024); infringement notice issued (2024)	—
APRA action – Equity Trustees Superannuation Ltd (data reporting)	Formal action for failures to meet data reporting obligations.	2024	APRA infringement notice / fine	Fine imposed (2024)	—
APRA action – HESTA (licence conditions)	Additional licence conditions imposed following issues during an administration provider transition.	2024	APRA licence conditions	Conditions imposed (2024)	—
APRA v First Super (disqualification proceeding)	APRA proceeding seeking disqualification of a senior responsible person for alleged SIS	2024	APRA litigation	Commenced; ongoing (as of 2024)	—

	Act governance breaches (conflicts, care and diligence, best financial interests) linked to contracting.				
ASIC v AustralianSuper (delayed death benefit payments)	ASIC sued the trustee alleging delayed processing of nearly 7,000 death benefit claims between 2019 and 2024 (incl. 'as soon as practicable' and EHF).	2025	ASIC litigation	Commenced; ongoing (2025)	—
ASIC v Mercer Superannuation (reportable situations / member services)	ASIC sued Mercer alleging systemic failures to report investigations into serious member services issues (incl. incorrect insurance refunds for deceased members).	2025	ASIC litigation	Commenced; ongoing (as of 2025)	—
ASIC v Diversa Trustees (First Guardian Master Fund)	ASIC civil penalty proceedings alleging due diligence and monitoring failures in connection with Diversa's trustee role for the First Guardian Master Fund.	2025	ASIC litigation	Commenced; ongoing (as of 2025)	—
APRA CEU – United Super Pty Ltd (Cbus)	Court-enforceable undertaking requiring a risk transformation program following findings of deficiencies in expenditure and risk management processes (plus APRA investigation).	2025	APRA CEU	Accepted (2025)	—
APRA CEU – Netwealth Superannuation Services Pty Ltd	Court-enforceable undertaking to address weaknesses in investment governance (onboarding, due diligence, monitoring).	2025	APRA CEU	Accepted (2025)	—
ASIC v Macquarie Investment Management (Shield Master Fund)	Federal Court declarations reported for contraventions involving failures to properly monitor the Shield Master Fund (part of a matter involving significant payments to affected investors).	2026	ASIC litigation	Declarations of contravention reported (2026)	—

Appendix 4: QSuper Class Action

Claims, Defences and Responses to Defences

Claim 1: Queensland Police members paid higher insurance premiums than other members

Claim

Queensland Police members paid higher insurance premiums than other members, approximately double standard accumulation rates.

Defence

QSuper accepts police were treated differently, but says this reflected the product design and risk rating for police:

- Pre–1 July 2016, police had 4 units of death and TPD and no IP.
- From 1 July 2016, QSuper applied a separate 'Default Police Rate' for QPS members.

QPS members were subject to the 'high risk rate' under the occupational rating framework, and the policy set high-risk relativities (for example, TPD 350% of Standard).

Response to Defence

No specific response.

Claim 2: Board awareness of occupational risk classifications and fair premium allocation

Claim

The QSuper Board was aware of occupational risk classifications (including police and other high-risk roles) and the need for fair allocation to premium categories.

Defence

QSuper accepts police were treated differently, but says this reflected the product design and risk rating for police:

- Pre–1 July 2016, police had 4 units of death+TPD and no IP.
- From 1 July 2016, QSuper applied a separate 'Default Police Rate' for QPS members.

QPS members were subject to the 'high risk rate' under the occupational rating framework, and the policy set high-risk relativities (for example, TPD 350% of Standard).

Response to Defence

No specific response.

Claim 3: Occupational rating implemented on an opt-in (election) basis rather than automatically

Claim

Despite the awareness, the Board implemented occupational rating on an opt in basis rather than applying it automatically, requiring eligible members to make a written election to access lower rates.

Defence

QSuper denies an automatic system was feasible or required:

- It says it did not have sufficient personalised information to determine which occupational rate an individual qualified for without a member declaration/application.

It says it acted prudently by maintaining default cover and giving members the ability to personalise cover (including occupational rating via election).

Response to Defence

No specific response.

Claim 4: Member communications about election requirement (occupational rating)

Claim

Member communications inadequately disclosed the election requirement, resulting in many eligible members remaining on higher default premiums. Statements ("*you don't need to do anything*") were misleading.

Defence

QSuper denies this and says communications, taken together, conveyed the need to take action to personalise cover:

- It relies on the Notice / May Letter / May Email / Insurance Guide and says these provided sufficient information to understand the changes and what members needed to do.
- QSuper pleads the Notice referred to changing cover via Member Online or forms and that 'choosing to be occupationally rated' was part of personalising cover, which an ordinary member would understand required an election.
- It also disputes the claim that communications were not sent/made accessible, pleading distribution methods (post or electronic) and processes for bounced emails, and says it was not aware at the time of any spam-filter issues.

QSuper denies misleading conduct and explains the meaning:

- It says "*you don't need to do anything*" referred to default cover and premiums automatically rolling over on 1 July 2016, while members could choose to take steps to personalise cover.
- It denies the pleaded misleading representations and denies conduct was misleading or deceptive.

Response to Defence

Applicant maintains the communications did not disclose the need to elect in writing for occupational rates / lower premiums, and disputes that hyperlinks amounted to proper distribution/access:

- Post recipients: Notice Pack still omitted the 'election in writing' statements.
- Electronic recipients: Notice/May Letter not attached; hyperlinks to Notice/Member Online did not constitute distribution/making accessible; and materials still omitted 'election in writing' statements.
- May Letter / May Email did not constitute valid or sufficient s1017B notice.
- 'Know Your Insurance' wording about varying premiums by being occupationally rated still omitted the 'election in writing' statements.

Claim 5: Board-approved rating design involved cross-subsidisation (fairness / competitiveness concerns)

Claim

The Board approved a rating design that involved cross subsidisation between lower risk and higher risk cohorts and was aware of related fairness and competitiveness concerns.

Defence

The QSuper Board acknowledges that occupational rating inherently involves some level of cross-subsidisation as part of balancing risk and premium allocation:

- The rating design was developed based on actuarial analysis and market considerations to ensure fairness, sustainability, and competitiveness.
- The Board was aware of the trade-offs between competitive positioning and equitable premium allocation and sought to improve member equity and product sustainability over time.
- The Board acted prudently and within its discretion, considering the interests of all members collectively.
- Any cross-subsidisation was a recognized and managed aspect of the product design consistent with trustee obligations.
- The Board denies any conflict of interest, stating premiums were applied to ensure financial sustainability rather than personal gain.

Response to Defence

No specific response.

Claim 6: Breaches of SIS Act covenants and general law duties (including preference for QSuper/QInsure financial interests)

Claim

There were breaches of SIS Act covenants (care and skill, best interests, and conflict management) and corresponding general law duties, including a preference for the Board's and its subsidiary insurer's (QInsure) financial interests.

Defence

QSuper denies contraventions and says it acted as a prudent trustee:

- It denies breach of the care and skill and best interests covenants and says it implemented changes prudently to preserve cover and improve flexibility for members.
- It disputes the 'automatic system' standard of prudence because occupational classification required member-provided information and declarations.
- On conflicts, it denies a conflict and says it had no personal interest; any profits/allocations from QInsure were fund assets (not personal benefit), and premiums supported the sustainability of the insurance policy for insured persons.
- It denies the pleaded general law 'best interests' formulation as a positive prescriptive duty, while acknowledging core fiduciary conflict/profits principles.

Response to Defence

No specific response.

Claim 7: Members' loss and entitlement to compensation / restoration

Claim

Members suffered loss (overpaid premiums and lost investment earnings) and are entitled to compensation/restoration

Defence

QSuper denies causation and loss, and pleads limits on any remedy:

- It denies that members suffered loss/damage as alleged.
- It pleads that for members still in the fund, any loss (if any) would be loss to the fund, not a vested personal entitlement.
- It says any compensation for premium deductions must be credited to super balances (no 'de facto release' to third parties).
- It pleads any loss period should be limited to 1 July 2016–June 2017 because of the later 'Know Your Insurance' campaign that explicitly highlighted occupational rating options.

Response to Defence

Applicant disputes any reduction for contributory negligence and says it is just and equitable that QSuper bears responsibility, and says Group Member claims are to be pleaded after the common questions trial.

Appendix 5: BT/Asgard Class Action

Claims, Defences and Responses to Defences

Claim 1: Tender / insurer selection process by BT Funds Management Ltd (BTFM) and Westpac Securities Administration Limited (WSAL) was improper with related-party insurer preferred.

Claim

The Trustees (BTFM and WSAL) conducted a tender process for group insurance in 2016, and despite a third-party insurer (AIA Australia Limited (AIA)) scoring higher on weighted criteria, selected Westpac Life Insurance Services Limited (WLISL), a related party, with non-weighted criteria ultimately determinative, contrary to trustee duties and prudent process expectations.

Defence

BTFM/WSAL deny impropriety and plead the tender was properly run and supported by expert/actuarial input:

- A broader insurer panel was invited; only WLISL and AIA bid for the full scope.
- Governance structures existed (steering committee, working groups, Non-Executive Director oversight).
- Weighted criteria were ‘product and pricing / service model / commercial and contractual’; non-weighted criteria included transition risk, financial strength, ‘revenue uplift’, and alignment to future state.
- Boards were informed WLISL had product and pricing benefits; WLISL scored higher than AIA on ‘product and pricing’ for relevant cohorts (though AIA’s total weighted score was slightly higher overall).
- Rice Warner supported the recommendation and confirmed review was comprehensive and like-for-like.
- Deny pleaded allegation that ‘non-weighted criteria were determinative’ in an improper sense.

Response to Defence

None.

Claim 2: Premiums increased / ‘overcharge’ due to Group Insurance Decisions by BTFM and WSAL

Claim

As a consequence of selecting and maintaining WLISL as insurer (including later renewals/maintenance decisions), members allegedly paid materially higher premium rates than would otherwise have been obtained (the ‘Overcharge’), compared to what could have been obtained from third-party insurers / best rates.

Defence

BTFM/WSAL:

- Plead certain premium rate increases occurred for some products from 1 July 2019 (for example, BT Super for Life and BT Super) and from 1 September 2019 (Asgard Employee Super), but do not accept the pleaded ‘overcharge’ framing.

- Deny the pleaded allegations about paying higher-than-best or higher-than-third-party premiums are properly pleaded (some parts 'embarrassing' and liable to be struck out) and deny them under that objection.
- Plead a rate guarantee period applied until 30 June 2019 for certain products.

Response to Defence

None.

Claim 3: BTFM and WSAL charged or allowed excessive insurance-related fees or markups (admin fees, adviser commission, enhanced premium).

Claim

The Trustees charged (or allowed to be charged to members) insurance-related add-ons including:

- Trustee administration fees (percentage loadings on premium);
- Adviser commissions (up to 25%) in some Asgard arrangements; and
- 'Asgard Enhanced Premium' (premium charged above master policy rates);
  and it was not in members' interests to pay these (collectively framed as 'Asgard Markup' / overcharge).

Defence

BTFM/WSAL:

- Admit certain administration fee structures applied to 'certain, but not all' members (and plead different historical rates, for example, BT Super standard cover admin fee was 22% prior to 2019).
- As to adviser commission: plead it applied only for limited cohorts / historical arrangements (pre-dates WLISL appointment) and only where negotiated (for example, certain pre-22 Oct 2013 employer sub-plans; certain pre-1 July 2014 retail members with negotiated commission).
- Deny Asgard 'enhanced premium' allegation as pleaded (plead paragraph is 'embarrassing'/liable to be struck out and deny under cover of that objection).
- Plead limitation defence: any cause of action under general law or SIS s 55(3) in respect of adviser commissions/premiums is time-barred to the extent it arose prior to 6 Oct 2017.

Response to Defence

None.

Claim 4: Conflict of interest: BTFM and WSAL had incentive to select/retain related insurer and higher premiums

Claim

There was a conflict between the Trustees' duties to members and the Trustees'/WLISL's financial interests because:

- Trustees benefited financially from higher premium arrangements (including fees as % of premiums), and
- WLISL benefited by maximising profit; and

- Trustees knew or ought to have known of the conflict at the time of the Group Insurance Decisions.

Defence

BTFM/WSAL deny:

- That it was in their financial interest to obtain group insurance at a higher premium rate.
- That a conflict (as pleaded) existed, and deny knowledge or ought-to-have-known allegations (tied also to their denials about overcharge or markup).
- Also plead WLISL was not insurer for all products for the entire Relevant Period.

Response to Defence

None.

Claim 5 - Breach of SIS covenants (s 52(2) and s 52(7)) in making/implementing Group Insurance Decisions by BTFM and WSAL

Claim

By making/implementing the Group Insurance Decisions (including selecting WLISL, paying/charging the overcharge, commissions/markups), the Trustees contravened:

- s 52(2)(b) (care, skill, diligence),
- s 52(2)(c) (best interests),
- s 52(2)(d) (conflict priority/management), and
- s 52(7)(a)-(c) (insurance strategy, cost consideration, inappropriate erosion).

Defence

BTFM/WSAL deny contraventions and plead (in substance):

- The pleaded parts of the claim are defective/'embarrassing' in places and denied under objection.
- They relied on insurance governance frameworks (BT Financial Group Insurance Management Framework) and prudential standard SPS 250 (Prudential Standard SPS 250 Insurance in Superannuation), and plead an IMF (Insurance Management Framework) existed and was used/approved.
- They deny the conflict and overcharge foundations said to give rise to the SIS breaches.

Response to Defence

No specific response.

Claim 6: Breach of fiduciary duties (conflicts/profits) by BTFM and WSAL

As trustees, BTFM/WSAL owed fiduciary duties to avoid conflicts and not improperly gain an advantage for themselves/WLISL; they breached those fiduciary duties by failing to avoid the conflict and/or using position to obtain benefits.

Defence

BTFM/WSAL:

- Admit they owed fiduciary duties as trustees, but plead the scope depends on the governing rules and statutory framework (including SIS covenants).
  Deny breach, largely by denying the underlying pleaded conflict/benefit/overcharge premises.

Response to Defence

None.

Claim 7: WLISL (insurer) knowingly involved in trustees' contraventions (SIS s 55(3)) / equitable accessorial liability

Claim

WLISL was 'involved in' the Group Insurance Decisions and trustees' contraventions because it set premium rates, obtained actuarial advice on expected costs/profits, and knew corporate structure/related-party context; therefore liable under SIS s 55(3), and/or for equitable compensation/account of profits (including 'knowing receipt').

Defence

WLISL:

- Generally denies involvement/knowledge-based allegations (including denial of pleaded 'involvement' and 'knowing receipt').
- Pleads limited admissions on background facts (participated in tender; novations; policy terms about adviser commission mechanics; insurer for certain periods only).
- Does not admit many trustee-process, premium, conflict, and loss allegations (often 'does not know and cannot admit').
- Denies liability to pay compensation/account as pleaded.

Response to Defence

None.

Claim 8: Loss / damage and entitlement to compensation or restoration (including 'Overcharge' and erosion of retirement balances) against BTFM and WSAL

Claim

Applicants and Group Members suffered loss/damage, including:

- amounts deducted from super accounts in excess of what would have been deducted absent contraventions ('Overcharge'), and
- consequential erosion of retirement balances / investment earnings;
  and seek statutory compensation (SIS) and/or equitable compensation and/or account of profits.

Defence

BTFM/WSAL deny loss/causation and plead constraints on remedies:

- If there was any misapplication of fund assets, appropriate relief may be an order for the trustee to 'make good' fund assets; if made good, members remaining in the fund may have suffered no recoverable loss under SIS s 55.
- If compensation is ordered, it may properly be applied into the person's superannuation balance.
  Plead additional causation points: AIA may have offered more restrictive terms

(including on consequential injuries), and selection of a different insurer might have reduced ability to claim for some members (pleaded by reference to First

- Applicant's TPD (Total and Permanent Disablement) claim context).
- Plead that some group members' premiums were paid by employers (Insured Employee Group Members), and deny those members suffered loss in relation to premiums paid by employers.

Response to Defence

None.

Claim 9: BTFM and WSAL 'exclusion/indemnity' style clauses in trust deeds do not defeat relief (implicit in relief claim)

Claim

The Trustees (BTFM and WSAL) were required by the governing rules/trust deeds of the relevant super funds to comply with the statutory trustee covenants in sections 52(2) and 52(7) of the SIS Act.

Defence

BTFM/WSAL plead a further defence that, under clauses in relevant trust deeds, they are excluded from liability to members for the relief sought (relying on specified clauses across the Retirement Wrap, BT Lifetime Super, Asgard and Westpac trust deeds).

Response to Defence

None.

Claim 10: 'Honest and ought fairly be excused' relief (SIS Act s 221) not available (implicit dispute) against BTFM and WSAL

Claim

BTFM and WSAL made a set of legally binding promises (covenants) that they would:

- act with the care, skill and diligence of a prudent super trustee (s 52(2)(b));
- act in the best interests of members (s 52(2)(c));
- where there is a conflict, give priority to members' interests and ensure members are not adversely affected (s 52(2)(d)); and
- have and follow an insurance strategy and properly consider insurance cost, including ensuring insurance does not inappropriately erode members' retirement income (s 52(7)(a)–(c)).

Defence

BTFM/WSAL plead that, if (which is denied) they contravened a civil penalty provision as alleged, then:

- the proceeding is an 'eligible proceeding' under s 221(1) of the SIS Act;
- BTFM/WSAL acted honestly at all material times; and
- having regard to all the circumstances, they ought fairly to be excused;

and therefore the Court should relieve them wholly, or alternatively partly, from any such liability under s 221(2) of the SIS Act.

Response to Defence

None.

Appendix 6: Colonial First State Class Action

Claims, Defences and Responses to Defences

Claim 1: Statutory contraventions by Colonial First State Investment Limited (Australia) (CFSIL) (trustee covenants under the SIS Act)

Claim

CFSIL contravened (and in some places 'continues to contravene') the following SIS Act covenants in connection with (i) the IMF approval decision and (ii) the subsequent group insurance decisions:

- s 52(2)(b) – failure to exercise the degree of care, skill and diligence of a prudent superannuation trustee.
- s 52(2)(c) – failure to act in the best interests of members (best interests duty).
- s 52(2)(d) – failure to appropriately manage conflicts (including giving priority to members' interests, ensuring duties are met despite conflict, and ensuring members' interests are not adversely affected).
- s 52(7)(a) – failure to formulate, review regularly, and give effect to an insurance strategy for beneficiaries.
- s 52(7)(b) – failure to consider the cost to beneficiaries of offering/acquiring insurance.
- s 52(7)(c) – failure to ensure insurance cost does not inappropriately erode retirement income.

Defence

CFSIL deny contraventions and plead (in substance):

- CFSIL rely upon the terms of ss 52(2)(b), 52(2)(c), 52(2)(d), 52(7)(a), 52(7)(b), 52(7)(c) for their full force and effect, and do not accept any pleaded characterisation of those covenants beyond their statutory terms.
- As to s 52(2)(c), CFSIL plead the covenant was to act in the 'best interest' of beneficiaries until 1 July 2021, and in the 'best financial interest' of beneficiaries from 1 July 2021 and otherwise deny the applicants' pleaded formulation.
- CFSIL plead the scope of the covenant obligations must be read together with, and is informed/qualified by, the Commonwealth Essential Super Trust Deed and FirstChoice Trust Deed pleaded by CFSIL (and CFSIL rely on those deeds for their full force and effect).
- CFSIL otherwise deny the factual allegations said to establish breach (including the pleaded conflict/benefit foundations).

Response to Defence

None.

Claim 2: Related statutory contraventions by CFSIL (enforcement provisions)

Claim

The above covenant contraventions also constituted:

- s 55(1) contraventions (for conduct prior to 6 April 2019), and
- s 54B(1) contraventions (for conduct after 6 April 2019).

Defence

CFSIL:

- CFSIL deny contraventions and plead (in substance):
- Any alleged contravention of s 55(1) and/or s 54B(1) is derivative of the pleaded covenant contraventions.
- Accordingly, to the extent CFSIL deny any contravention of the s 52 covenants, CFSIL also deny any corresponding contravention of s 55(1) or s 54B(1).

Response to Defence

None.

Claim 3: Fiduciary / trust law claims against CFSIL

Claim

CFSIL:

- owed fiduciary duties to avoid conflicts and not improperly use its position to gain an advantage for itself and/or CommInsure;
- breached fiduciary duties, including by:
- failing to avoid the conflict, and/or
- improperly using its position to gain a benefit for itself and/or CommInsure;
- committed breaches of trust, because the SIS covenant contraventions are also pleaded as breaches of trust;
- acted recklessly, constituting a reckless failure to exercise required care and diligence;

and is therefore liable to:

- pay equitable compensation, and/or
- account for and pay benefits/profits/gains (including connected to the pleaded 'Excess Premiums').

Defence

CFSIL deny breach and plead (in substance):

- CFSIL admit limited fiduciary duties as trustee (avoid conflicts without fully informed consent; not improperly use position to gain advantage), but plead that the scope of any such duties is limited by the Trust Deeds and the statutory framework.
- CFSIL deny any breach of fiduciary duty and/or breach of trust (including denying the premises said to establish conflict and improper benefit).
- *CFSIL rely on pleaded Trust Deed provisions* (to the extent not prohibited by Superannuation Law) *which permit related-party dealings and permit CFSIL/associates to retain profits/benefits/fees* (including in relation to related-party insurance arrangements and remuneration mechanics), and plead those provisions answer the 'improper profit/conflict' foundations.
- CFSIL rely on a pleaded Trust Deed limitation of liability (FirstChoice) to the effect that (subject to the SIS Act) CFSIL is only liable for dishonest acts/omissions or intentional/reckless failure to exercise required care and diligence, and thereby deny any pleaded recklessness/culpability threshold is met.

- As to relief, CFSIL plead that if (which is denied) any wrongful depletion of fund assets were established, the appropriate relief is an order requiring restoration of fund assets to the extent of any wrongful depletion, rather than the gain-based relief pleaded.

Response to Defence

None.

Claim 4: Loss / damage claim (causation and compensation) against CFSIL

Claim

The contraventions caused loss and damage to the Applicant and Group Members, including:

- payment of 'Excess Premiums' (premiums higher than would have been paid absent the pleaded contraventions) through at least 15 February 2022,
- reduction in amounts received / expected to be received from the funds,

and compensation is sought from CFSIL (pleaded with reference to SIS Act compensation provisions).

Defence

CFSIL deny loss/causation and plead (in substance):

- CFSIL deny the alleged contraventions and, by reason of those denials, deny the pleaded causal chain to any 'Excess Premiums' or other loss/damage.
- CFSIL otherwise deny the pleaded loss/damage allegations.
- In the alternative, if (which is denied) the assets of the relevant funds were wrongfully depleted, the appropriate remedy is an order that CFSIL restore the assets of the relevant fund(s) to the extent of any wrongful depletion (as applicable), rather than the compensation case as pleaded.

Response to Defence

None.

Claim 5: Claims against CommInsure – 'involvement' in SIS Act contraventions

Claim

CommInsure (CMLA):

- knew relevant matters (including the conflict, lack of competitiveness, profitability, lack of tender, and pleaded inadequacy of data);
- was involved (within the meaning of s 55(3) of the SIS Act) in the contraventions;

and is therefore liable to:

- compensate the Applicant and Group Members for loss/damage (pleaded under s 55(3)), and/or
- pay equitable compensation, and/or
- account for and pay the Excess Premiums and all benefits/profits/gains made or derived from the group insurance contracts.

Defence

CFSIL plead (in substance):

- CFSIL deny the underlying contraventions said to found any 'involvement' claim.
- CFSIL deny the pleaded matters alleged to establish CMLA's knowledge and plead, by reason of those denials, that CMLA could not have known the matters alleged.
- CFSIL plead limited admissions only (including that CMLA was not required to tender for certain contracts), and otherwise do not admit/deny as pleaded.
- In the alternative, if (which is denied) there was wrongful depletion and/or CMLA was involved, the appropriate remedy is restoration of fund assets by CFSIL or CMLA/AIAA (as applicable) to the extent of any wrongful depletion.

CMLA deny liability and plead (in substance):

- deny 'involvement' and knowledge-based allegations (deny the pleaded knowledge matters and deny being knowingly concerned/involved in any trustee contraventions);
- admit limited background matters only (including non-tender position as pleaded and other limited factual matters where admitted), and otherwise do not admit many trustee-process / conflict / premium / loss allegations (often 'does not know and cannot admit');
- deny any liability to compensate or account as pleaded.

Response to Defence

None.

Claim 6: Claims against CommInsure – knowing receipt

CommInsure:

- received the 'Excess Premiums' (pleaded as occurring from 22 January 2014 to 1 April 2021); and
- did so with knowledge of material facts giving rise to the pleaded breaches of trust/fiduciary duty (or alternatively knowledge of circumstances that would indicate those facts to an honest and reasonable person);

and is therefore liable to:

- pay equitable compensation, and/or
- account for and pay the Excess Premiums and all benefits/profits/gains made or derived from the group insurance contracts.

Defence

CFSIL deny and plead (in substance):

- CFSIL deny the underlying contraventions/breaches said to give rise to misapplied trust property and therefore deny the premise that CMLA could have the requisite knowledge of such matters.
- CFSIL rely on pleaded Trust Deed provisions (to the extent lawful) permitting related-party dealing and retention of profits/benefits/fees, which are inconsistent with the applicants' pleaded premise that receipt of premiums/profits was 'improper' or necessarily reflective of a breach.

CMLA deny knowing receipt and plead (in substance):

- deny the underlying contraventions/breaches said to make the premium receipts 'misapplied trust property';

- deny knowledge of the material facts said to constitute the alleged breaches (and/or deny the pleaded circumstances giving rise to the required knowledge);
- plead limited admissions only and otherwise do not admit many allegations concerning trustee decision-making, alleged conflict, and loss.

Response to Defence

None.

Claim 7: Claims against AIA Australia Limited (AIAA) – transfer/assumption of liability

Claim

If any liability of CommInsure has been transferred to and assumed by AIAA under the court-confirmed scheme effective 1 April 2021, then:

- AIAA is liable for the relief claimed against CommInsure in the (further amended) originating application.

Defence

AIAA plead (in substance):

- generally adopts CMLA's Defence (by 'refers to and repeats' corresponding paragraphs) across the main issues (including contraventions, loss/causation, and the CMLA involvement/knowing receipt allegations);
- admits the existence/effect of the court-approved Scheme effective 1 April 2021 and relies on the Scheme for its full force and effect;
- pleads that the liabilities alleged against CMLA are of a kind to which the Scheme applies and, consequently, any such liability is transferred to and assumed by AIAA;
- pleads that if liability for CMLA conduct is established (denied), CMLA is not liable and AIAA is liable instead (by operation of the Scheme);
- pleads (as background) that from 1 April 2021 AIAA was party to relevant insurance policies with CFSIL (and otherwise does not know/cannot admit other implementation allegations).

Response to Defence

None.

Claim 8: Compensation claim against CFSIL under s 55(3) of the SIS Act

Claim

By reason of the alleged contraventions by CFSIL of the

- SIS Act trustee covenants (including the covenants in ss 52(2)(b), 52(2)(c), 52(2)(d), and
- 52(7)(a)–(c)) in connection with the pleaded insurance decisions and conduct,

CFSIL is liable under s 55(3) of the SIS Act to compensate the Applicant and each Group Member for loss or damage suffered because of those contraventions.

The loss/damage for which compensation is sought includes, without limitation:

- amounts deducted from members' superannuation accounts by way of premiums allegedly higher than would have been paid absent the contraventions (i.e., alleged 'Excess Premiums' / overcharging); and
- consequential erosion of members' superannuation balances (including reduced retirement savings and associated impacts on investment earnings/returns).

Defence

CFSIL deny liability and plead (in substance):

- CFSIL deny the alleged covenant contraventions and, by reason of those denials, deny any entitlement to compensation under s 55(3).
- CFSIL deny the pleaded loss/damage and deny that any loss/damage was caused by any conduct of CFSIL.
- In the alternative, if (which is denied) fund assets were wrongfully depleted, the appropriate remedy is an order that CFSIL restore the assets of the relevant fund(s) to the extent of any wrongful depletion (as applicable), rather than compensation as pleaded.

Response to Defence

None.

Appendix 7: AMP Class Action

Claims, Defences and Responses to Defences

Claim 1: Commissioned Products sold/maintained through AMP advice networks (the 'Commissioned Products Advice Model')

Claim

AMP Authorised Representatives provided personal advice to Group Members to acquire, renew, or continue to hold 'Commissioned Products' (including insurance and non-insurance products) on which commissions were payable.

The claim pleads that:

- product issuers (including AMP Life and other issuers) made commission payments under distribution arrangements to the AMP Licensees (and/or via the AMP Licensees to advisers/practices);
- although commission payments were paid by issuers or through licensee arrangements, the cost was borne by members because commissions were:
- embedded in insurance premiums (for insured products), and/or
- incorporated into product fees and/or unit pricing (for investment/platform products);
- members received no additional benefit merely because commissions were paid (including no requirement that ongoing services be provided in exchange for trail commissions); and
- AMP entities/licensees benefited from the continuation of commission flows through their distribution and advice model.

Defence

The Respondents plead (in substance):

- Admit in part that, during the Relevant Period, AMP Licensees had distribution/facilitation/licensee agreements with product issuers (including AMP Life) under which commissions could be payable to AMP Licensees in respect of certain financial products, including insurance products.
- Say the terms and incidence of commissions (including whether upfront and/or trailing, and how calculated) varied by product and provider, and were governed by the relevant agreements and product terms.
- Say that AMP Authorised Representatives were generally not parties to the Distribution Agreements and those agreements did not provide for authorised representatives to receive trailing commissions (rather, remuneration flowed via the licensee/practice arrangements).
- Deny that commissions were always funded by member-borne administration/ investment/management fees, insurance fees, or declared unit prices, and deny the pleaded 'always funded' characterisation.
- Say they are unable to plead to unparticularised allegations concerning unidentified Group Members and, to that extent, do not admit the allegations.
- Otherwise deny any pleaded implication that the mere payment of commissions establishes wrongdoing, loss, or entitlement to an account of profits.

Response to Defence

No formal defence filed to date.

Claim 2: Commissions increased the cost of products and could be 'dialled down', switched off, or rebated (the 'Commission Control' claim)

Claim

Commissions on Commissioned Products (including AMP Life Products) were capable of being:

- switched off or dialled down at the product-provider level by the adviser;
- switched off or dialled down at the licensee level; and/or
- rebated to the client by the adviser.

For AMP Life insurance products in particular, commissions were embedded into and increased the premiums payable, and that:

- if the adviser elected to dial down or switch off commissions, the product would be cheaper; and
- product disclosure materials contemplated that alternative commission arrangements could reduce the cost of insurance.

Group Members paid more than they needed to pay for products (particularly insurance) because commissions were maintained rather than reduced/turned off/rebated.

Defence

The Respondents deny liability and plead (in substance):

- Commissions could not necessarily be 'switched off,' 'dialled down,' or 'rebated' as alleged; whether any adjustment was possible depended on the product and the circumstances (including any adviser–client agreement).
- Commissions did not necessarily increase product costs as alleged, and were not always funded through administration/investment/management fees, insurance fees/premiums, or declared unit prices.
- The Respondents cannot plead to unparticularised allegations about unidentified Group Members (including claims of 'substantially higher' costs/premiums and 'substantially cheaper' alternatives) and contend those allegations are liable to be struck out absent proper particulars.
- In any event, the Respondents rely on the statutory and contractual framework (including that certain commissions were lawful/grandfathered) and deny any loss or damage as pleaded.

Response to Defence

No formal defence filed to date.

Claim 3: Conflicted remuneration structure created systemic conflicts of interest (the 'Conflicted Advice Incentives' claim)

Claim

The commissions and remuneration structures created conflicts between:

- advisers/licensees (and, in some contexts, AMP Life/AMP) who benefited from commissions, incentives, and maintaining commission flows; and

- clients who would benefit financially from commissions being reduced, switched off, or rebated, or from using lower-cost alternatives.

Commissions:

- were a material component of adviser remuneration;
- could reasonably be expected to influence advice about whether to acquire/renew/retain products (and levels of cover/investment);
- incentivised retention of commission-bearing products even when unsuitable, more expensive than alternatives, or no longer aligned to client needs; and
- incentivised recommending AMP products (including AMP Life insurance) over third-party products, even where third-party products were substantially equivalent or better and cheaper.

Defence

The Respondents deny and plead (in substance):

- Commissions and related arrangements did not reasonably influence personal advice; this depends on the specific client, adviser, and available alternatives.
- Receipt of commissions, including grandfathered ones, did not breach FOFA duties and was lawful.
- AMP Licensees had policies, training, and monitoring to ensure compliance and deny systemic failure.
- Adviser remuneration was managed between adviser and practice, not always monitored by AMP Licensees; the pleaded characterisation is denied.
- Commissions were not always funded as alleged; the 'pass-through' claim is denied.
- Claims about 'better' alternatives or 'higher' costs lack proper detail and are denied

Response to Defence

No formal defence filed to date.

Claim 4: Incentive payments beyond commissions distorted advice (the 'Incentives Programs' claim)

Claim

Beyond commissions, AMP product issuers (including AMP Life) and/or AMP Licensees provided other monetary benefits (Incentives) tied to volume and growth of sales and revenue, further incentivising advisers/practices to recommend AMP and other commissioned products.

Programs and arrangements said to operate during the Relevant Period, including (by licensee/practice cohort):

- Hillross: Short Term Rewards (STR) Program; Development Management and Advice (DMA Advice) Program; and Buy-Back Benefit linkage.
- Charter: Value Participation Scheme (VPS) and DMA Advice Program; and Buy-Back Benefit linkage.
- AMPFP: Business Growth Allowance (BGA); DMA Advice Program; Bonus DMA; and Buy-Back Benefit linkage.

These incentives:

- could reasonably be expected to influence advice;

- increased conflicts; and
- supported a system where advice and product retention/recommendations were shaped by revenue maximisation rather than client best interests.

Defence

The Respondents deny and plead (in substance):

- Incentives were not likely to influence personal advice; any influence depends on the client/adviser circumstances and whether the Incentive would actually be earned from the advice.
- Incentives were generally paid to Practices, not advisers; adviser pay was set by the Practice.
- Programs were not purely sales-driven and included compliance/education criteria.
- AMP Licensees had conflicts/FOFA compliance systems and deny any breach from Incentives alone.
- Other allegations about unidentified group members and alleged loss/causation are denied or not admitted.

Response to Defence

No formal defence filed to date.

Claim 5: Register 'buy-back' options incentivised maintaining commissions and AMP products (the 'Buy-Back Conflict' claim)

Claim

Each AMP Licensee offered advisers/practices a 'buy-back' option under which the licensee (or AMP, in some circumstances) could purchase the adviser's client register, with the buy-back price calculated in part by reference to commission streams and/or incentive entitlements.

Key features include:

- valuation methodologies that weighted AMP Life commissions and certain AMP-linked revenue more heavily than third-party product earnings;
- large aggregate exposure (pleaded to exceed $1 billion during the Relevant Period);
- financing of register purchases via loans (including via AMP Bank), secured by register rights/buy-back benefits; and
- the economic effect that switching off/dialling down/rebating commissions would reduce register values and adversely affect parties with exposure to register valuations and financing.

Advisers were structurally incentivised to keep clients in commission-bearing products (including AMP Life products) to preserve register value and service debt, deepening conflicts and impacting advice quality.

Defence

The Respondents deny and plead (in substance):

- They admit client register rights and buy-back arrangements existed, but deny they created the alleged conflicts or could reasonably be expected to influence advice.
- Any alleged influence depends on the particular client and adviser/practice, including whether the adviser would actually gain remuneration, whether a comparable

alternative with a different commission outcome was reasonably available, and whether a buy-back was realistically likely at the time.

- The buy-back was a structured 'buyer-of-last-resort' process (notice and transfer attempts first); the licensee only acquired register rights if no transfer occurred.
- Register rights could include client contact/records access and sometimes ongoing service fees, but only valued where services were actually provided.
- Commissions could not always be switched off/reduced/rebated; it depended on the product and the circumstances (including any adviser–client agreement).
- They rely on FOFA obligations and plead AMP Licensees had compliance systems, and they deny or cannot admit unparticularised allegations about 'better/equivalent' alternatives and unidentified group members.

Response to Defence

No formal defence filed to date.

Claim 6: Insurance sub-group – AMP Life premiums included 'Excess Premiums' vs substantially equivalent or better products (the 'Excess Premiums' claim)

Claim

For the 'Stack Sub-Group Members' (defined as those advised to acquire/renew/continue AMP Life Products on or after 23 July 2014), AMP Life premiums were higher than premiums payable on substantially equivalent or better third-party insurance products available in the market. The difference is pleaded as 'Excess Premiums'.

- Advisers undertook to provide advice regarding insurance needs including premiums;
- Members were advised to acquire/renew/continue AMP Life Products and paid AMP Life premiums;
- Members were not told (and did not know) that (a) cheaper substantially equivalent or better policies were available, (b) the nature/amount of any Excess Premiums, or (c) that AMP Life premiums incorporated the Excess Premiums; and
- Advisers failed to properly investigate, consider, and recommend lower premium alternatives (and/or failed to obtain one-off approval to recommend products outside AMP's approved lists).

Members paid inflated premiums and suffered loss, and that AMP Life received those premiums (including Excess Premiums) and profited.

Defence

The Respondents deny and plead (in substance):

- AMP Life premiums were not 'excessive'; any 'equivalent or better' and 'cheaper' comparison is member-specific (personal factors, product features, underwriting, exclusions and eligibility) and cannot be determined generically.
- The 'equivalent/better,' 'higher', and 'cheaper' allegations are insufficiently particularised (embarrassing), liable to be struck out, and are denied.
- They cannot plead to allegations concerning unidentified group members and therefore do not know/do not admit them.
- FOFA best interests and conflicts priority duties do not prohibit commissions; no breach is established merely because commissions were paid.

- Claims are denied to the extent the conduct predates the Chapter 7 regime, and are time-barred to the extent accrued more than six years before commencement.
- Where premiums were paid from super, members did not suffer recoverable personal loss; any compensation (denied) would need to be paid back into the relevant super interest.
- Where cover was through super, it was provided under group policies issued to the trustee, with premiums charged under those arrangements (not separate retail policies to members).

Response to Defence

No formal defence filed to date.

Claim 7: Approved Product Lists, one-off approvals, and 'in-super' constraints steered insurance recommendations (the 'APL Steering' claim)

Claim

AMP Licensees' Approved Product Lists (APLs) and related policies steered advisers toward AMP products (including AMP Life insurance), making it harder to recommend cheaper third-party products.

Key elements include:

- AMP Life products were included on Insurance APLs;
- Insurance APLs/benchmarking guidelines allegedly did not provide sufficient information to identify whether cheaper substantially equivalent or better products existed outside the APL;
- advisers required one-off approval to recommend off-APL insurance, with criteria (for example, minimum price savings evidence) making it difficult in practice;
- platform APLs were primarily AMP platforms and (until late 2019) AMP platforms could only host AMP Life insurance; and
- for insurance held through certain AMP super funds, 'Third Party Insurance in Super Requirements' imposed extra administrative steps for holding third-party insurance through super (separate trust account + sweeps), further discouraging third-party insurance.

These structures increased conflicts and reduced the practical ability of advisers to recommend cheaper third-party products, contributing to members paying higher premiums (including Excess Premiums).

Defence

The Respondents deny and plead (in substance):

- AMP's APLs offered a range of life/risk products (including third-party), and advisers were not restricted to AMP Life products.
- Non-APL recommendations were subject to a workable approval process limited to new non-APL product recommendations, with exemptions (including for retained/adjusted cover) and scope for one-off or blanket approvals.
- There was no improper 'steering'; whether to recommend a cheaper/alternative product depends on the individual client's circumstances and cannot be assessed generically.

- Allegations that the APL/approval process was an improper barrier (for example, 'substantially equivalent/better/best value') are inadequately particularised, embarrassing, and liable to be struck out.
- The Respondents cannot plead to unparticularised group-wide allegations about unidentified members and deny the APL/approval arrangements caused loss.

Response to Defence

No formal defence filed to date.

Claim 8: Approved Product Lists, one-off approvals, and in-super constraints steered insurance recommendations

Claim

AMP Licensees' Approved Product Lists (APLs) and related policies steered advisers toward AMP products (including AMP Life insurance), making it harder to recommend cheaper third-party products.

Key elements include:

- AMP Life products were included on Insurance APLs;
- Insurance APLs/benchmarking guidelines allegedly did not provide sufficient information to identify whether cheaper substantially equivalent or better products existed outside the APL;
- advisers required one-off approval to recommend off-APL insurance, with criteria (for example, minimum price savings evidence) making it difficult in practice;
- platform APLs were primarily AMP platforms and (until late 2019) AMP platforms could only host AMP Life insurance; and
- for insurance held through certain AMP super funds, 'Third Party Insurance in Super Requirements' imposed extra administrative steps for holding third-party insurance through super (separate trust account + sweeps), further discouraging third-party insurance.

These structures increased conflicts and reduced the practical ability of advisers to recommend cheaper third-party products, contributing to members paying higher premiums (including Excess Premiums).

Defence

The Respondents deny and plead (in substance):

- They cannot admit unparticularised allegations concerning unidentified OSF sub-group members and otherwise deny them.
- Ongoing service fees were agreed directly with clients and disclosed in the relevant advice/service documents (including OFAs/OSAs/AAAs/SOAs and, post-FOFA, FDSs) and in at least annual client statements.
- Any 'ongoing service package' was client- and adviser-specific; the pleaded services are examples only.
- For the named applicants alleged to have paid OSFs: they agreed to the disclosed fees and were provided services during the relevant period (including reviews, advice preparation, and admin/transaction support), as particularised in the Defence.
- If any 'fee for no service' occurred, it was due to individual adviser failure, not systemic misconduct as alleged.

- AMP licensees conducted a large-scale review/remediation program and introduced annual confirmation arrangements for services/fees.
- Loss and causation are denied; any compensation for fees paid from super must be paid back into the relevant superannuation interest.
- Claims are time-barred to the extent accrued more than six years before commencement (and, for equitable claims, by laches/analogous limitation principles).

Response to Defence

No formal defence filed to date.

Claim 8: Ongoing service fees charged where ongoing services were not provided (the 'OSF / Fees for No Service' claim)

Claim

For the 'OSF Sub-Group Members' (those who paid ongoing service fees but did not receive the promised ongoing service package):

- Advisers offered an ongoing service package including reviews, access, portfolio review activities, and communications/education;
- Members paid ongoing service fees (OSFs), often in addition to commissions;
- In many instances, advisers did not provide annual ongoing personal advice/services as agreed;
- System/process weaknesses (including client allocation issues, BOLR pool transfers, manual processes, unclear guidance, and inadequate controls) contributed to fees remaining on despite no services being delivered; and
- In some cases, members transferred into a BOLR pool continued paying OSFs while not allocated a servicing adviser.

Members paid fees without receiving the contracted service, and that AMP entities/licensees benefited from those fee arrangements.

Defence

The Respondents deny and plead (in substance):

- They cannot admit unparticularised allegations concerning unidentified OSF sub-group members and otherwise deny them.
- Ongoing service fees were agreed directly with clients and disclosed in the relevant documents (OFAs/OSAs/AAAs/SOAs and, post-FOFA, FDSs) and in at least annual client statements.
- Any 'ongoing service package' was client- and adviser-specific; the pleaded services are examples only.
- For the named applicants: they agreed to pay the disclosed ongoing fees and were provided services during the Relevant Period (including advice preparation, reviews, and administrative/transaction support), as particularised in the Defence.
- Any 'fee for no service,' if it occurred, arose from individual adviser failure, not systemic misconduct as alleged.
- AMP licensees conducted a large-scale review/remediation program and introduced annual confirmation arrangements for services/fees.
- Loss and causation are denied; any compensation for fees paid from super must be paid back into the relevant superannuation interest.

- Claims are time-barred to the extent accrued more than six years before commencement (and, for equitable claims, by laches/analogous limitation principles).

Response to Defence

No formal defence filed to date.

Appendix 8: AustralianSuper ASIC Litigation

Claims, Defences and Responses to Defences

Claim 1: No Objection death benefit claims took months to years to pay or decline

Claim

During the Relevant Period, AustralianSuper took between four months and four years from the date a claim form was returned to pay or decline at least 6,699–6,897 death benefit claims where no objection was received (No Objection Claims). This included at least 941 claims where AustralianSuper held a valid binding death benefit nomination (BDBN) at the time of death.

Defence

No formal defence filed to date.

Response to Defence

Not applicable.

Claim 2: Failure to pay benefits 'as soon as practicable' (SIS Act / reg 6.21) and corresponding financial services law non-compliance

Claim

AustralianSuper failed to pay members' benefits as soon as practicable after death as required by s 34(1) SIS Act and reg 6.21(1) of the SIS Regulations, and thereby contravened s 912A(1)(c) of the Corporations Act (failure to comply with financial services laws).

ASIC's concise statement pleads this in relation to at least 752 members (and in the concise statement's pleading of contraventions, refers to 752 occasions). In the Statement of Claim, ASIC pleads alternative quantifications, including:

- contraventions on at least 6,699 occasions (based on No Objection Claims not paid as soon as reasonably practicable), or alternatively
- contraventions on at least 700 occasions (based on the sample delay categories pleaded and schedules).

Defence

No formal defence filed to date.

Response to Defence

Not applicable.

Claim 3: Delay in sending claims packs (initial documentation)

Claim

AustralianSuper took 15 to 213 days after first notification of a claim to send a claims pack to the first claimant, in respect of at least 254 death benefit claims (as enumerated in Schedule 1).

ASIC pleads that failing to dispatch a standard claims pack within 14 days of notification was unreasonable in the context of the 'as soon as practicable' obligation.

Defence

No formal defence filed to date.

Response to Defence

Not applicable.

Claim 4: Delay in reviewing Link's recommendation and making a determination

Claim

After Link made a recommendation on a claim, AustralianSuper took 15 to 92 days to review the recommendation and make a determination (or request further information), on at least 207 occasions (Schedule 2).

ASIC pleads that failing to review and decide within 14 days was unreasonable in the context of the 'as soon as practicable' obligation.

Defence

No formal defence filed to date.

Response to Defence

Not applicable.

Claim 5: Delay in notifying claimants of determination/decision

Claim

AustralianSuper took 15 to 368 days to notify claimants of a determination after the determination was made, on at least 228 occasions (Schedule 3 in the Statement of Claim).

ASIC pleads that failing to notify within 14 days was unreasonable in the context of the obligation to cash benefits as soon as practicable.

Defence

No formal defence filed to date.

Response to Defence

Not applicable.

Claim 6: Delay in making payment after having all required information

Claim

AustralianSuper took 15 to 1,140 days to make payment after it had all information required to pay the benefit, on at least 256 occasions (Schedule 4).

ASIC pleads that failing to pay within 14 days of having all required information was unreasonable (and in a large proportion of the sampled cases, exceeded 30 days).

Defence

No formal defence filed to date.

Response to Defence

Not applicable.

Claim 7: Delay in requesting or acting on necessary information; poor claimant communications

Claim

AustralianSuper took 15 to 529 days to request information or additional information required to progress claims, and/or failed to respond appropriately to claimant enquiries, on at least 88 occasions (Schedule 5 includes worked examples such as long periods without follow-up, requests to wrong recipients, failure to acknowledge receipt, and delays tied to locating BDBNs).

Defence

No formal defence filed to date.

Response to Defence

Not applicable.

Claim 8: Failure to provide services efficiently, honestly and fairly (EHF) due to systemic backlog, poor oversight, and inadequate remediation

Claim

In the Relevant Period, AustralianSuper failed to do all things necessary to ensure that the relevant financial services were provided efficiently, honestly and fairly, contrary to s 912A(1)(a) of the Corporations Act, by reason of:

- the frequency, nature and extent of the delay and SIS law non-compliance;
- at least 3,857 complaints about delayed death benefit claims (March 2020 to 15 September 2023);
- sustained failure by AustralianSuper and Link to meet agreed service levels (including correspondence and work-item timeliness targets, and a '62% within 4 months' claim timeliness metric);
- knowledge of, and inadequate action to address, a death claims backlog over a sustained period (including reporting to a Board committee from November 2020);
- failure to ensure sufficient resourcing and effective performance management of Link (including delayed formal escalation and failure to terminate/replace arrangements sooner);
- continued charging of monthly administration fees during periods of unreasonable delay; and
- inadequate records/systems enabling efficient identification and remediation of affected claimants, and lack of timely remediation.

ASIC pleads that as a consequence of the s 912A(1)(a) contravention, AustralianSuper also contravened s 912A(5A) (civil penalty provision).

Defence

No formal defence filed to date.

Response to Defence

Not applicable.

Appendix 9: Period Since Last Tender

This analysis draws on fund documents publicly available online up to 30 June 2025 and APRA MySuper statistics dated 30 June 2025[41]. It covers 92% of insured lives under MySuper products. MLC Super (201,206 insured members) is excluded from the analysis because it has never tendered its insurance policies.

Key observations:

- The analysis shows that assuming all funds were to commence a tender in 2026, the average period between tenders would be 6 years.
- On an insured-lives weighted basis, the average period would be 8 years.
- The higher weighting reflects that many larger funds undertake frequent independent rate reviews and have arrangements that return a large proportion of excess insurer premium back to insured lives.
- 52% of the tenders resulted in a change of insurer.

MySuper Product Name	Fund Name	Year Last Full Tender Commenced	Years Since Last Tender	Change of Insurer	Number of Insured Lives
AMP MySuper No.3 *	AMP Super Fund	2023	3	Y	134,802
QSuper Lifetime *	Australian Retirement Trust	2015	11	Y	408,594
Super Savings Lifecycle Investment Strategy	Australian Retirement Trust	2024	2	Y	628,268
AustralianSuper MySuper	AustralianSuper	2012	14	N	1,383,302
MySuper Lifecycle	Aware Super	2022	4	Y	472,783
LGIASuper MySuper	Brighter Super Fund	2023	3	Y	64,762
Balanced (MySuper)	CareSuper	2016	10	Y	285,988
FirstChoice Employer Super	Colonial First State FirstChoice Superannuation Trust	2021	5	N	98,341
Growth (Cbus MySuper)	Construction and Building Unions Superannuation Fund	2015	11	Y	557,400
Equipsuper MySuper	Equipsuper	2021	5	Y	55,522
Essential Super	Essential Super	2021	5	N	53,815
First Super MySuper	First Super	2026	0	Y	58,917
HESTA MySuper	HESTA	2024	2	N	576,541
Balanced option	HOSTPLUS Superannuation Fund	2013	13	N	703,741
MySuper Balanced	Legal Super	2025	1	N	17,538
Vision MySuper	Local Authorities Superannuation Fund	2017	9	Y	37,286
Mercer SmartPath	Mercer Super Trust	2016	10	Y	215,015
NESS MySuper	NESS Super	2025	1	N	6,057
Diversified (MySuper)	NGS Super	2024	2	N	41,247

[41] https://www.apra.gov.au/annual-mysuper-statistics

MySuper	Prime Super	2022	4	Y	42,842
PSSap MySuper Balanced	Public Sector Superannuation Accumulation Plan	2015	11	Y	91,384
Balanced	Rei Super	2021	5	N	9,953
REST Super	Retail Employees Superannuation Trust	2018	8	Y	611,675
SmartMonday Lifecycle	Smart Future Trust	2025	1	N	20,861
Bendigo MySuper	The Bendigo Superannuation Plan	2020	6	N	6,908
UniSuper Balanced	Unisuper	2023	3	N	224,108
Vanguard MySuper*	Vanguard Super	2022	4	N	6,249

* First tender