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and
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CONSUMER INSURANCE LAW: PRE-CONTRACT DISCLOSURE AND MISREPRESENTATION

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THE LAW COMMISSION
THE SCOTTISH LAW COMMISSION

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LIST OF ABBREVIATIONS USED IN THIS REPORT

1906 Act	Marine Insurance Act 1906
ABI	Association of British Insurers
AR	Appointed Representative
BILA	British Insurance Law Association
CII	Chartered Insurance Institute
CP	Consultation paper: Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007), Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134
FOS	Financial Ombudsman Service
FSA	Financial Services Authority
IAR	Introducer Appointed Representative
ICOBS	Insurance Conduct of Business Sourcebook
MIA	Marine Insurance Act 1906
MIB	Motor Insurance Bureau
MS	Multiple Sclerosis
ONS	Office for National Statistics
PwC report	PricewaterhouseCooper LLP, *ABI Research Paper 5: The Financial Impact of the Law Commission's Review of Insurance Contract Law* (November 2007)
TPD	Total permanent disability

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CONSUMER INSURANCE LAW: PRE-CONTRACT DISCLOSURE AND MISREPRESENTATION

To the Right Honourable Jack Straw MP, Lord Chancellor and Secretary of State for Justice, and the Scottish Ministers

PART 1
INTRODUCTION

1.1 This report and draft Bill are published as part of the English and Scottish Law Commissions' joint review of insurance contract law. The report recommends a new consumer statute to address the issue of what a consumer must tell an insurer before taking out insurance.

1.2 The existing law, as set out in the Marine Insurance Act 1906,[1] requires a consumer to volunteer information to insurers. It is clearly important that insurers receive the information they need to assess risks. Information from policyholders is often the basis of underwriting decisions on whether to accept risks at all, and if so, at what price and on what terms. However, it is now generally accepted that insurers should ask consumers for the information they want to know. The law needs to be updated to correspond to the realities of a mass consumer market.

1.3 Our draft Bill replaces the duty to volunteer information with a duty on consumers to take reasonable care to answer the insurer's questions fully and accurately. Where a consumer makes a deliberate or reckless misrepresentation, our draft Bill permits the insurer to treat the contract as if it did not exist, and refuse all claims. Where the consumer answers questions carelessly, it provides the insurer with a proportionate remedy. However the consumer who acts both honestly and carefully is protected.

1.4 These ideas are not new. They reflect the approach already taken by the Financial Ombudsman Service (FOS), and generally accepted good practice within the industry. However, our reforms would make the law simpler and clearer, allowing both insurer and insured to know their rights and obligations.

[1] Although this Act appears to apply only to marine insurance, the courts have held that it codifies the common law, and therefore embodies the principles which apply to all insurance: see para 2.3 below.

PREVIOUS REPORTS

1.5 There have been several previous reports calling for the reform of the law on misrepresentation and non-disclosure in insurance contracts. The Law Reform Committee recommended reform as long ago as 1957.[2]

1.6 In 1980 the English Law Commission undertook a review of the law on non-disclosure and breach of warranty in insurance contracts. It concluded that the law was "undoubtedly in need of reform" and that such reform had been "too long delayed".[3] Reform was also urged in a report by the National Consumer Council in 1997.[4]

1.7 A major factor in our decision to return to this area was a report by the British Insurance Law Association (BILA) in 2002.[5] The report was prepared by a sub-committee with an impressive breadth of membership — academics, brokers, insurers, lawyers, loss adjusters and trade associations. BILA declared itself "satisfied that there is a need for reform".

1.8 Despite the many reports calling for reform, there has been no legislative change. This is not because the insurance industry has sought to justify the 1906 Act: it has long accepted that many of the rules set out in the Act are inappropriate for a modern consumer market. Instead, the Association of British Insurers (ABI) and its predecessor have argued that any changes are best dealt with as a matter of self-regulation or ombudsman discretion, rather than by a change in the law itself. We think this has led to unacceptable confusion. The time has now come for statutory reform, as we explore below.

A HISTORY OF THIS PROJECT

1.9 Our present recommendations and draft Bill follow substantial consultation with the insurance industry and with consumer groups over several years.

Issues papers

1.10 We started the review in 2006, in response to BILA's report. Our initial views were set out in a series of issues papers, of which three covered topics considered in this report.

(1) Issues Paper 1, in September 2006, considered the law of misrepresentation and non-disclosure in both a consumer and a business context.

(2) Issues Paper 2, in November 2006, dealt with warranties, and included a discussion of "basis of the contract" clauses.

[2] Fifth Report of the Law Reform Committee (1957) Cmnd 62.

[3] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 1.21.

[4] National Consumer Council, *Insurance Law Reform: the consumer case for review of insurance law* (May 1997).

[5] British Insurance Law Association, *Insurance Contract Law Reform – Recommendations to the Law Commissions* (2002).

(3) Issues Paper 3, in March 2007, on intermediaries and pre-contractual information, looked at when the policyholder is responsible for mistakes by an intermediary in communicating information to the insurer.

We received substantial feedback from these papers, which led us to modify our views.

The consultation paper and responses

1.11 In July 2007, we published a full consultation paper (CP), setting out detailed proposals for reform.[6] We received 105 written responses and attended over 50 meetings with insurers, policyholders, brokers, lawyers and representative groups.

1.12 In May 2008 we summarised the responses to our consumer proposals.[7] In October 2008 we produced a similar summary of responses on business issues.[8]

1.13 We were greatly encouraged by the strong support for reforming the law on misrepresentation and non-disclosure as it affects consumers. Given the strength of demand for consumer reform, we said we would draft legislation to deal with pre-contract information from consumers as a matter of priority. We are therefore publishing this report now, before our proposals on business reform have been finalised.

Support for reform

1.14 Support for consumer reform came from consumer groups, brokers, lawyers and the FOS. It also came from insurers themselves. Of the 39 insurers and insurance organisations responding to our paper, only four argued against reform. Many actively welcomed reform to make the law simpler and clearer:

> We support the view that the current regime applicable to consumer insureds would benefit from a clear statutory statement of obligations… and we support an update to the current law to align with best practice. [RSA]
>
> The law should be reformed where it currently bears little or no resemblance to market practice. [Zurich Financial Services]
>
> Aviva believes that to codify current best practice would simplify the position and ensure that it was adopted by all. [Aviva]
>
> We would welcome [reform] so that both the insured and the insurer have a clear understanding of the position. [Aegon UK]

1.15 Scottish Re set out the main arguments for reform:

[6] Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Consultation Paper No 134.

[7] Reforming Insurance Contract Law: a summary of responses to consultation on consumer issues (May 2008).

[8] Reforming Insurance Contract Law: a summary of responses to consultation on business issues (October 2008).

> We believe that making the law fairer and more transparent for consumers would improve consumer protection by giving consumers the legal rights they are entitled to. Reform would also enhance the reputation of the industry by reducing the scope for insurers to rely on strict legal rights that are unfairly balanced in their favour. Reform would simplify the rules for the benefit of all stakeholders… Finally, reform should also provide guidance to the FOS on what Parliament considers to be a reasonable balance between the interests of the consumer and the insurance industry. [Scottish Re]

1.16 We were also told that reform would improve confidence in the industry. The Chartered Insurance Institute thought that the current lack of legal clarity had a direct impact on the industry's reputation. Reform would give improved peace of mind that claims would be paid, thereby resulting in improved consumer confidence.

Controversial proposals

1.17 Two proposals proved to be controversial. The first was our proposal on intermediaries, to the effect that an intermediary should be taken to act for an insurer in obtaining pre-contract information, unless it was clearly independent.[9] Brokers and lawyers queried whether the test was workable, and insurers were concerned that it would disrupt the market.[10] We have now substantially re-thought our proposals. In March 2009 we published a policy statement on the status of intermediaries, which set out a less radical approach. The relevant provisions of the draft Bill are along the lines set out in the policy statement.

1.18 Secondly, the consultation paper asked whether in consumer life insurance, insurers should be prevented from relying on a negligent misrepresentation after the policy had been in force for five years.[11] "Non-contestability" periods of this sort are applied in Australia, New Zealand and many US states, and we asked whether there was merit in the idea. Responses were split on the issue. Most insurers opposed the idea, on the grounds that it might encourage consumers to take less care in filling out forms.

1.19 We accept that a five-year cut-off applying only to life insurance was an arbitrary measure, and not essential to the scheme. Although some insurers may decide to offer a five-year cut-off period to reassure consumers, we do not think it should be included within legislation. It is not part of this draft Bill.

A SHORT, TARGETED BILL

1.20 This report and draft Bill are addressed specifically at the area causing the greatest problems, where there is most demand for change. The draft Bill applies only to consumers, not to businesses. Furthermore, it only deals with pre-contract information, not other issues such as the effect of warranties or conditions precedent.

[9] CP, Proposal 12.70 (discussed in para 10.28).

[10] For a summary of responses on this issue, see the Consumer Summary of Responses (May 2008) above, Part 5.

[11] CP, Proposal 12.23 (discussed in para 4.203).

1.21 In April 2009 we published a further issues paper, asking if the smallest businesses, with less than ten staff, should be treated like consumers for the purposes of pre-contractual information and unfair terms. In November 2009, we published a summary of responses to the paper, which showed that a majority of respondents favoured increasing protection to these small businesses. We will publish a separate report on this issue in due course. The issue of providing greater protection for small businesses is not dealt with in this report or draft Bill.

1.22 Our consultation paper discussed the problems of warranties, which are terms in insurance contracts that may have particularly draconian consequences.[12] This draft Bill does not reform the law of warranties, except to abolish "basis of the contract" clauses.[13] The main reason is that the need for reform is less pressing. Warranties in the strict legal sense are used only rarely in consumer insurance.[14] And if they are used unfairly, consumers have remedies not only under the Financial Services Authority (FSA) rules but also under the Unfair Terms in Consumer Contracts Regulations 1999. Furthermore, we think that the law on consumer warranties should be consistent with the law on business warranties. We have therefore decided against separate rules on warranties which would apply only in a consumer context.

GIVING A STATUTORY BASIS TO OMBUDSMAN GUIDANCE

1.23 Essentially, the draft Bill codifies what the FOS already does. We have worked closely with the FOS to understand its approach, and we have been greatly encouraged by the support it has given to this project.

1.24 As part of our study, we carried out two surveys of final ombudsman decisions. In 2006 we read 190 decisions classified as consumer non-disclosure complaints,[15] and a full account of our findings is given in Appendix C to the consultation paper.

1.25 In 2009 we read a further 47 final ombudsman decisions about consumer non-disclosure, to see whether there had been any changes. The results are set out in Appendix C to this report. The main findings are similar, except that there has been a reduction in the number of complaints about critical illness insurance, as discussed below.

[12] For further discussion, see paras 10.2 to 10.19 below.

[13] This is a technical way in which insurers can turn representations on proposal forms into warranties. Such clauses are discussed further in paras 2.23 to 2.28 below.

[14] In our survey of 50 FOS consumer cases concerned with policy terms, we did not find any in which a warranty had been applied in a strict legal sense (see CP, para 7.26). However, warranties were regularly used in small business policies.

[15] This included decisions on misrepresentations.

DIFFICULTIES WITH CRITICAL ILLNESS INSURANCE

1.26 In 2006, as we started this review, newspapers and consumer programmes reported serious concerns about the number of critical illness claims refused because of problems with application forms. London Economics estimated that out of 17,500 critical illness claims made, 11% were refused, through refusal rates varied sharply between insurers, from 3% to 17%.[16]

1.27 The Chartered Insurance Institute (CII) quoted a leading financial journalist, commenting on the high refusal rates for critical illness insurance, which the CII described as "vividly encapsulating the poor public confidence in this market":

> The right of insurers to "trawl" back through a claimant's medical records in this way is the unacceptable side of the insurance industry. Indeed, I think it is wholly counter-productive because by turning down valid claims, the insurance industry merely gives protection insurance a bad name. It puts people off buying it.[17]

1.28 The evidence suggests that this loss of confidence did reduce sales. The FSA data show that while the number of critical illness policies used to protect mortgage payments continued to track mortgage sales, sales of stand-alone critical illness policies fell by 49% from 2006-7 to 2007-08.[18] Swiss Re commented that "concerns around the viability of the product, premium increases and generally negative comment around entitlement to, and payment of claims, were all seen as contributing factors to this decline".[19]

1.29 In January 2008, the ABI responded to public concern by issuing formal written guidance on non-disclosure in protection insurance.[20] It was designed to prevent insurers from "underwriting at claims", by automatically trawling through medical records when they received a claim, looking for discrepancies between the policyholder's medical notes and the information given on the proposal form. The Guidance also embodied the FOS approach by dividing misrepresentations into three categories: "innocent", "negligent" or "deliberate or without any care". The Guidance states that for innocent misrepresentations the insurer should pay the claim in full; for negligent misrepresentations the insurer should apply a proportionate remedy; and for the final category the insurer may refuse all claims.[21]

[16] CP, Appendix B, p 22.

[17] Jeff Prestridge, Personal Finance Editor of the Financial Mail on Sunday, writing in *Financial Adviser* (24 September 2007).

[18] The number of policies sold fell from 86,000 in 2006-07 to 44,000 in 2007-08: Financial Services Authority, *Pure Protection Contracts: Product Sales Data Trends Report* (September 2008).

[19] Swiss Re, *Term and Health Watch* (2008).

[20] ABI Guidance, "Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products" (January 2008).

[21] Above, para 2.1.

1.30 In January 2009 the ABI upgraded the status of the Guidance to that of a Code of Practice.[22] This means that compliance with the Code is now a condition of ABI membership.

1.31 The last figures available from the FOS show that in 2006-07, the FOS closed 1,047 complaints from consumers about issues of non-disclosure and misrepresentation. Since April 2007, the FOS classification system has changed and it is no longer able to provide overall figures for the number of complaints it receives about these issues.

1.32 However, the FOS has been tracking the number of complaints about non-disclosure in critical illness and income protection insurance. These show that since 2007, there has been a welcome reduction in the number of complaints reaching the FOS about these products. In 2006-07, the FOS closed 376 complaints where non-disclosure was the dominant issue in critical illness and income protection disputes. In 2008-09, it closed 130 such cases. Whilst the FOS has explained that its records are indicative only, this does represent a significant fall.

1.33 There are some reasons to predict a rise in complaints in 2009-10. In July 2009 the ABI said that there were clear (but not conclusive) indications that the recession, which began in the third quarter of 2008, was leading to an increase in general insurance fraud. It also suggested that customers may have a heightened sense of "entitlement" during a difficult economic period.[23] This would suggest that complaints are likely to rise for three reasons: consumers may be more likely to conceal information to get cheaper insurance; insurers may be more likely to perceive their customers as dishonest; and consumers may be more likely to complain if a claim is turned down. Similarly, in August 2009, the British Insurance Brokers' Association reported that 58% of its members thought they "had to fight harder on behalf of clients to get claims paid during a recession".[24]

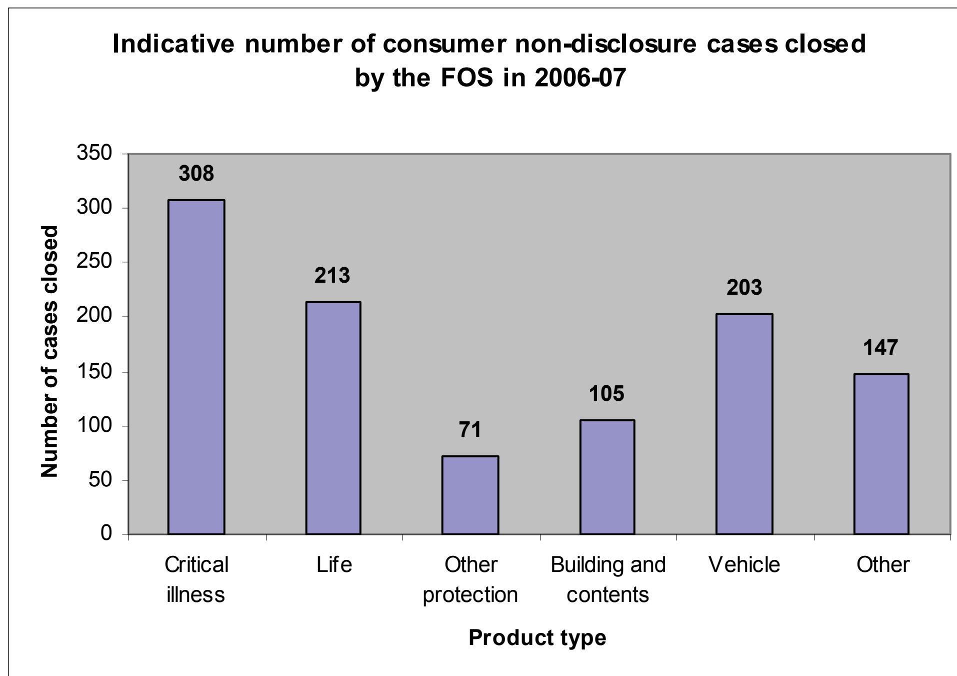
1.34 Although public disquiet about critical illness policies increased interest in the project, our review was not designed to address any one subject area. It is a long term project, designed to meet the concerns first raised in 1957, and to update a law that is more than a hundred years old. The specific problems about critical illness insurance that reached public attention from 2004 to 2007 are an illustration of the difficulties that can arise from confusion over the principles that should be applied to claims where there appears to be a non-disclosure or misrepresentation by the insured.

[22] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009).

[23] ABI, GI Fraud Research Brief (July 2009).

[24] BIBA, "Brokers adding value in the claims process" (6 August 2009).

1.35 The problems dealt with by this report may cover a wide range of types of insurance. The graph below is based on FOS figures for 2006-07, the latest year for which general data is available. It shows that issues of non-disclosure and misrepresentation cause significant problems for life insurance, vehicle insurance and building/contents insurance claims. The issue can also occur across a variety of other products, including pet insurance and private medical or dental insurance. The FOS tells us that it is not aware of any fall in non-disclosure or misrepresentation complaints for insurance generally, other than for critical illness and income protection policies.



HARD LAW OR SOFT LAW?

1.36 We do not consider the content of this draft Bill to be controversial. There is more controversy, however, over the form that reform should take. The ABI has consistently argued against statutory reform. Instead, it argues that the deficiencies within the current law, as set out in the Marine Insurance Act 1906, should be dealt with through “market regulation”. This would involve the FSA, the FOS and industry representatives working together to identify and address perceived problems.

1.37 Although most major insurers thought that statutory reform would be simpler and clearer, the ABI was supported in its view by two insurers, Fortis Insurance Ltd and ACE European Group. The Lloyd’s Market Association commented that it found our consumer proposals “broadly acceptable, in that they largely reflect existing practice”. However, it queried the need for statutory intervention, “when most proposals could be more flexibly introduced via regulation, with the same effect for consumers”.

1.38 There is no power to amend the current law by regulation. Nor does the FSA have any jurisdiction to tell the court how to resolve a dispute. All that self-regulation or FSA rules can do is attempt to prevent insurers from relying on their legal rights, or aid the FOS in deciding what is fair and reasonable. The critical illness problem which arose in 2006-07 demonstrates that the regulatory and market-based approach is not always effective.

1.39 In Part 2, we set out the complexities of the current rules, in which the strict letter of the law has been overlain by successive layers of self-regulation, FSA rules and FOS guidelines. In Part 3, we examine the ABI's arguments, and explain why we think legislative reform is needed. We identify five problems with the current system:

(1) Consumers are only able to obtain justice from the FOS, not from the courts, as the courts are forced to apply unfair rules. But the FOS cannot help all those with disputes. Its compulsory jurisdiction, for example, is limited to awards of £100,000.

(2) The current rules are unacceptably confused. Claims handlers may fail to understand what the FOS requires, leading to claims being rejected unfairly. And many consumers with rejected claims do not realise that they have a right to complain to the FOS. The resulting muddle leads to a loss of confidence in the insurance industry.

(3) The confusion also penalises some vulnerable groups. We have been given examples of the particular problems experienced by those with criminal convictions and those with multiple sclerosis.

(4) The system imposes inappropriate roles on financial regulators. The FOS is forced to act as a policy-maker, and the FSA is distracted from its key purpose.

(5) At a time when the European Union is demanding that national differences in commercial law are justified, it is difficult to justify the present incoherent layers of law to an international audience.

1.40 Parliament codified the law in this area in 1906. We think the time has now come to update the law to meet the needs of a different century.

THE STRUCTURE OF THIS REPORT

1.41 This report is divided into eleven further Parts:

(1) Part 2 outlines the current position. It describes the law, as set out in the Marine Insurance Act 1906, and the problems with the law. It then outlines the various layers of self-regulation, FSA rules and ombudsman discretion which have been used to protect consumers from the harshness of the law.

(2) Part 3 sets out the case for a new consumer statute. We explain why we think the various layers of soft law do not adequately protect consumers and why we think the 1906 Act should be reformed.

(3) Part 4 provides an overview of our recommendations.

(4) Our detailed recommendations are set out in Parts 5 to 10: Parts 5 and 6 discuss the core scheme; Part 7 considers group insurance and insurance on the life of another; Part 8 looks at intermediaries; and Part 9 examines amendments to other Acts. Finally, Part 10 considers proposals which we discussed in the consultation paper but which are not included in the draft Bill.

(5) In Part 11 we summarise the costs and benefits of our recommendations. These are discussed in greater detail in a full impact assessment, available on our websites.[25]

(6) Part 12 lists our recommendations.

1.42 This is followed by four appendices:

(1) Appendix A contains the draft Bill and explanatory notes.

(2) Appendix B gives details about how compensatory remedies will work in the more complex cases. These are where the consumer: has taken out double insurance; recoups part of the loss from a third party; and makes a misrepresentation before varying the contract.

(3) Appendix C updates the survey of FOS cases, analysing 47 recent ombudsman decisions.

(4) Appendix D lists those who responded to our consultation paper.

1.43 An impact assessment relating to our proposals is available separately on our websites.[26]

[25] See www.lawcom.gov.uk/insurance_contract.htm; www.scotlawcom.gov.uk.

[26] As above.

PART 2
THE CURRENT POSITION: LAYERS OF LAW, RULES AND GUIDANCE

2.1 In this Part, we summarise the current obligations on consumers to give information to insurers when they take out insurance policies, and the remedies available to insurers when things go wrong. This is not an easy task. The underlying law is set out in the Marine Insurance Act 1906, but there is general agreement within the insurance industry that these rules are inappropriate to a modern consumer market. The law must now be read subject to layers of self-regulation, Financial Services Authority rules, ombudsman decision-making and industry guidance.

2.2 Below we give a brief description of each of these layers. A more detailed account is available in our 2007 consultation paper.[1]

MARINE INSURANCE ACT 1906

2.3 British insurance law developed during the eighteenth and nineteenth centuries, and was partially codified in the Marine Insurance Act 1906. Although strictly the 1906 Act only applies to marine insurance, the courts have consistently held that it applies to all forms of insurance, on the grounds that it codifies the common law.[2]

2.4 The 1906 Act is an impressive document, written in clear, forthright terms. The problem is that the principles are set out so clearly that the courts have found it difficult to develop them to meet contemporary needs. Here we discuss three legal rules which are inappropriate for modern consumer insurance: the duty to disclose; the duty not to misrepresent; and basis of the contract clauses.

The duty to disclose information

2.5 Unlike most contracts, insurance contracts are said to be based on "utmost good faith". One aspect of this is that the law imposes a duty on prospective policyholders to disclose all material facts. This duty is spelled out in section 18 of the 1906 Act, which states that "the assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured".[3] A "material circumstance" is defined as one:

> which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk.[4]

[1] Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Consultation Paper No 134. See Parts 2 and 3 and Appendix A.

[2] See, for example, Lord Mustill's statement in *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501, at 518. For further discussion, see *MacGillivray on Insurance Law* (11th ed 2008) paras 17-006 and 17-007.

[3] MIA 1906, s 18(1).

[4] MIA 1906, s 18(2).

2.6 Thus the law considers how a hypothetical prudent insurer would have reacted to the information. The test has been held to mean that the circumstance must have an effect on the mind of a hypothetical insurer, but that effect need not be decisive.

2.7 In 1994, the House of Lords added a further test, in the case of *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*.[5] The court held that the insurer must show that it has been "induced" to enter the contract: that is, if the insurer had known the truth, it would not have entered into the policy at all, or not on the same terms.[6] In other words, it would have done something different, either by refusing cover, increasing the premium or changing the policy terms.

2.8 The duty to disclose is subject to some limited exceptions. For example, the policyholder does not need to disclose facts which diminish the risk, or which are matters of "common notoriety or knowledge", or where the insurer waives information about a set of circumstances.[7]

2.9 The 1906 Act states that "if the assured fails to make such disclosure, the insurer may avoid the contract".[8] The insurer may refuse to pay all claims arising under the policy, and may recover any payments already made. Usually, the insurer must return the premium to the policyholder.[9]

Problems with the duty to disclose

2.10 The law applying to insurance contracts differs from most consumer contract law by requiring consumers to volunteer information without being asked for it. Insurers are not required to ask questions. Instead, the law entitles an insurer to sit back and rely on the consumer to tell it everything that it needs to know. The most obvious problem is that most consumers are unaware that they are required to volunteer information. Even if they know that they are under a duty to disclose facts, they may have no idea what is relevant to the insurer.

2.11 The law looks at the question of what is material solely from the insurer's point of view. It does not ask what a reasonable policyholder thinks might be relevant – only at what would influence a hypothetical prudent insurer, and what this particular insurer would have done had it known the full facts. Given that few consumers understand how the underwriting process works, it imposes a duty on consumers that most are unable to fulfil.

[5] [1995] 1 AC 501.

[6] In *St Paul Fire and Marine Insurance Co Ltd v McConnell Dowell Constructors Ltd* [1995] 2 Lloyd's Rep 116, the Court of Appeal applied a presumption that if a misrepresentation is material it induced the contract. However *Assicurazioni Generali v Arab Insurance Group*, [2002] EWCA Civ 1642, [2002] All ER (D) 177 held that the insurer must prove inducement on the balance of probabilities – though it may sometimes be possible to infer inducement from the facts.

[7] MIA 1906, s 18(3).

[8] MIA 1906, s 18(1).

[9] According to MIA 1906, s 84(3)(a), "the premium is returnable, provided that there has been no fraud or illegality on the part of the assured". It is not wholly clear how far this extends to non-marine insurance.

2.12 The case of *Lambert v Co-operative Insurance Society Ltd* illustrates the problems with the duty to disclose.[10] When Mrs Lambert insured her family's jewellery the insurer did not ask about her husband's previous convictions and she did not mention them. Mr Justice Mackenna commented that:

> Mrs Lambert is unlikely to have thought that it was necessary to disclose the distressing fact of her husband's recent conviction when she was renewing the policy on her little store of jewellery. She is not an underwriter and has presumably no experience in these matters.[11]

2.13 When Mrs Lambert claimed £311 for lost jewellery, the insurer avoided the policy. The Court of Appeal held that the insurer was entitled to do so under the rules of law set out in the 1906 Act. The conviction was a material circumstance, which would have influenced a prudent insurer. It did not matter that a person in Mrs Lambert's position would not have realised this. The law was clear, though not necessarily fair. As Mr Justice Mackenna put it:

> The defendant company would act decently if, having established the point of principle, they were to pay her. It might be thought a heartless thing if they did not, but that is their business, not mine.[12]

2.14 A further problem lies in the remedy of avoidance, which may operate in a particularly harsh way. Where the insurer establishes that the policyholder failed to disclose a material fact, it may refuse all claims, even if (had it known the truth) it would have made only a small change to the policy. For example, where an insurer would have doubled the excess had it known about a minor previous conviction, it may refuse the whole claim, not simply apply the higher excess. This means that insurers may be over-compensated for the loss they have suffered.

2.15 Most insurers accept that in a mass, commoditised market, it is no longer practical for them to receive unstructured information from consumers. When we consulted on abolishing the duty to disclose, few insurers attempted to defend it. It was generally agreed that insurers should ask questions about the information they wanted to know.

The duty not to misrepresent

2.16 The law also allows insurers to avoid policies where a policyholder makes a mistake in answering a question. The relevant rule is set out in section 20(1) of the 1906 Act:

> Every material representation made by the assured or his agent to the insurer during the negotiations for the contract, and before the contract is concluded, must be true. If it be untrue the insurer may avoid the contract.

[10] [1975] 2 Lloyd's Rep 485.

[11] Above, at 491.

[12] Above.

2.17 The definition of “material” is the same as in section 18: a representation is material if it would “influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk”.[13] Again, the insurer must show that it has been “induced” to enter the contract: had it known the truth, it would not have entered into the policy at all, or not on the same terms.[14]

2.18 Section 20 distinguishes between matters of fact and matters of “expectation and belief”.[15] Where the representation is one of fact, the consumer’s state of mind is irrelevant. The insurer may avoid the policy even if the consumer had a genuine and reasonable belief that what they said was true.

2.19 However, if the representation is one of expectation or belief, it is said to be true “if made in good faith”.[16] This point is illustrated by the case of *Economides v Commercial Union Assurance Co*.[17] A 21 year old man undervalued the contents of his flat after his parents moved in with him. As his statements on this issue were found to be a matter of opinion rather than fact, it was sufficient that they were held in good faith. It was not necessary that they should be based on reasonable grounds.[18]

Problems with the law on misrepresentations in insurance contracts

2.20 Again, the law as set out in the 1906 Act can operate unfairly. The first problem is that policyholders may be denied claims even when they act honestly and reasonably. Our survey of ombudsman cases shows that some insurers continue to use extremely general questions, where it is not clear what information the insurer is seeking. It is easy for consumers to misunderstand such questions, and therefore give inaccurate answers, even if they are doing their best to answer truthfully. Where the question is considered one of fact rather than opinion the insurer may avoid the policy even if the consumer has acted reasonably. The following example, taken from our recent survey of FOS decisions, illustrates this problem.

> Miss A took out a critical illness policy in March 1999. The insurer asked her a number of health-related questions, including:
>
> *Have you ever suffered from… any muscular, skeletal, joint, bone or back disorder including arthritis, rheumatism or repetitive strain injury (RSD)?*[19]

[13] MIA 1906, s 20(2).

[14] See *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501.

[15] MIA 1906, s 20(3).

[16] MIA 1906, s 20(5).

[17] [1998] QB 587.

[18] Above, by Simon Brown and Peter Gibson LJJ. Sir Iain Glidewell preferred to leave the matter open. See H Bennett, “Statements of Facts and Statements of Belief” (1998) 61 *Modern Law Review* 886; J Cartwright, *Misrepresentation, Mistake and Non Disclosure* (2nd ed 2007), para 2.14.

[19] The insurer uses “RSD” in this question to refer to repetitive stress disorder, an old name for repetitive strain injury.

Miss A answered 'no' to this question. In 2006 Miss A was diagnosed with a degenerative spine condition, and made a claim under the policy. The insurer refused her claim and avoided her policy partly on the basis that she had failed to mention a single episode of lower back pain from March 1996, three years before she completed the insurance application form.

Following a complaint by Miss A, the FOS determined that:

"the question asks about back disorders, which makes reference to arthritis and rheumatism, and therefore, it is unlikely that [Miss A] would have deemed a single episode of low back pain to be a disorder, when the examples are of significant medical conditions."

The FOS ordered that the insurer should reinstate Miss A's policy on its original terms.

2.21 Problems in interpreting questions are not limited to critical illness policies, as the following example demonstrates.

Mr B completed a proposal form for motor insurance with a major insurance company. He was asked a number of questions about his car, including:

Has the car been changed, modified or altered in any way from the manufacturer's standard UK design or specification? Please include any change to the engine or which alters the performance of your car; cosmetic changes to the bodywork or trim (e.g. fitting of spoilers or bodykits); changes to suspension; wheels or brakes (e.g. alloy wheels or lowered suspension).

Mr B ticked the 'no' box. When Mr B's car was later stolen, the insurer refused his theft claim and avoided the policy on the basis that Mr B had not informed them that he had installed a very expensive stereo, entertainment and navigation package. The insurer argued that this was a modification to the car.

Mr B complained to the FOS, saying that he did not think a stereo upgrade was a modification that needed to be disclosed, as it did not affect the performance or appearance of his car. He pointed out that it did not fall within any of the examples given in the question.

The FOS agreed with Mr B, concluding that the question did not make it clear to him that a stereo upgrade was the sort of modification that the insurer wanted to know about.

2.22 Where the consumer has acted carelessly, it is right that the insurer should have some remedy, but as before the remedy of avoidance may operate too harshly. In the consultation paper we gave the following example taken from our survey of ombudsman cases.[20]

> When taking out critical illness insurance, a consumer acted carelessly in failing to disclose a loss of hearing. She later suffered from (unrelated) leukaemia. Had the insurer known about the hearing problem, it would have merely excluded hearing issues from the policy, and would have paid the leukaemia claim. The insurer sought to avoid the whole policy. In strict law, the insurer was entitled to do this. However, the ombudsman found that this would not be fair and reasonable, and ordered the claim to be paid.

"Basis of the contract" clauses

2.23 As we have seen, section 20 only provides insurers with a remedy if the misrepresentation is material and induced the insurer to enter into the contract. However, the law allows insurers to obtain greater rights. All that is necessary is that the insurer adds a declaration to a proposal form or policy stating that the consumer warrants the accuracy of all the answers given, or that such answers "form the basis of the contract". This has the legal effect of turning representations into warranties.

2.24 Warranties are terms in insurance contracts which are accorded a special status. According to the 1906 Act, a warranty "must be exactly complied with, whether it be material to the risk or not".[21] This means that once the insurer can show that the consumer has warranted the truth of the representation, the insurer can avoid the policy for any mistake, however trivial or unimportant.

2.25 The leading case on the issue is *Dawsons Ltd v Bonnin*.[22] A furniture removal firm took out insurance on a lorry. The firm filled out a proposal form, giving its business address in central Glasgow. When asked where the lorry was usually parked, it inadvertently wrote "above address". In fact, the lorry was usually parked in the outskirts. The firm argued that this fact was not material: it did not increase the risk and probably decreased it. However, the form contained a declaration that the proposal "shall be the basis of the contract". The House of Lords held that this had the effect of converting the statements into warranties. Thus it did not matter whether the mistake was material. The insurer could use any mistake on the form to refuse all claims under the policy.

[20] CP, p 4.

[21] MIA 1906, s 33(3).

[22] [1922] 2 AC 413, 1922 SC (HL) 156.

Problems with "basis of the contract" clauses

2.26 For many years, judges have criticised the use of basis of the contract clauses. The Law Commission's 1980 report quoted criticisms dating back to 1853.[23] In 1908, Lord Justice Moulton said he wished he could "adequately warn the public against such practices".[24] In 1927, Lord Wrenbury described their use as "mean and contemptible".[25]

2.27 The problems with such clauses are obvious. Few consumers would understand the significance of signing a statement that their answers were "warranted" or that they formed "the basis of the contract". Nor is it clear why insurers should be permitted to refuse claims because of trivial or immaterial mistakes on application forms.

2.28 As we shall see, modern practice decries the use of basis of the contract clauses. There is a general agreement among insurers not to refuse claims for immaterial errors. We are not aware of any recent consumer case in which a basis of the contract clause was upheld. However, in 1996, the Court of Session upheld such a clause against a small business.[26] As a matter of strict law, a court would be entitled to reach the same result against a consumer.

ALTERNATIVES TO LAW

2.29 During the course of this review, no one argued that the rules incorporated within the 1906 Act were fair or appropriate for consumer insurance. Instead, those who opposed reform said that legislative change was unnecessary. The Association of British Insurers (ABI), in particular, argued that it did not matter what the law said because insurers would not rely on their legal rights. Instead of changing the law it would be better to rely on industry and Financial Services Authority (FSA) initiatives. The ABI put the point as follows:

> More law is unlikely to provide a better deal for customers. The real challenge is for the industry and the FSA to make a success of principles-based regulation.[27]

2.30 Since 1977 there has been a series of initiatives to prevent insurers from exercising their legal rights. The result is overlapping layers of self-regulation, FSA rules and ombudsman rules. These layers are not easy to understand: they are complex and often inconsistent. Here we summarise the most important points.

[23] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 7.2, referring to *Anderson v Fitzgerald* (1853) 4 HL Cases 484, 10 ER 551.

[24] *Joel v Law Union and Crown Insurance Co* [1908] 2 KB 863, at 885.

[25] *Glicksman v Lancashire and General Assurance Co* [1927] AC 139. See also *Mackay v London General Insurance Co* [1935] 51 Lloyd's Law Report 201 and *Provincial Insurance v Morgan* [1933] AC 240, at 250.

[26] *Unipac (Scotland) Ltd v Aegon Insurance* 1996 SLT 1197.

[27] ABI News Release (73/07), "Make a success of regulation – more law unlikely to help consumers" (17 July 2007).

STATEMENTS OF PRACTICE

2.31 The first Statements of Practice were issued by the British Insurance Association and Lloyds in 1977. They were then amended and strengthened in 1986.[28] The main impetus for change was the threat that the Government might implement the Law Commission's 1980 draft Bill. In February 1986, the Secretary of State told Parliament that he had accepted the changes as an alternative to law reform.

> The insurers have informed me that they are willing to strengthen the… statements of insurance practice on certain aspects proposed by the Department… I am well aware of the arguments, advanced amongst others by the representatives of consumers, in favour of legislation on non-disclosure and breach of warranty. But I consider that on balance the case for legislation is out-weighed by the advantages of self-regulation so long as this is effective.[29]

2.32 Although the 1986 Statement of General Insurance Practice was withdrawn in 2005, it is still an influential document, which the Financial Ombudsman Service has used as the basis of its own approach. It is therefore worth outlining its main provisions.

(1) Proposal forms were required to include a prominent warning, explaining that material facts should be disclosed. Applicants had to be warned that if they were in any doubt about whether facts were material, they should disclose them.

(2) The Statement said that "those matters which are generally found to be material should be the subject of clear questions". However the statement did not specify a sanction if this provision was not observed.

(3) Insurers undertook not to repudiate liability on grounds of non-disclosure of a material fact which a policyholder could not reasonably be expected to have disclosed.

(4) Insurers undertook not to repudiate liability on grounds of a misrepresentation unless it was a deliberate or negligent misrepresentation of a material fact.

(5) The use of basis of the contract clauses was prohibited. The Statement said that "neither the proposal form nor the policy shall contain any provision converting the statement as to past or present fact in the proposal form into warranties".

[28] For a history of the Statements of Practice, see CP, Appendix A. The text of both the 1986 Statement of General Insurance Practice and the Statement of Long-Term Insurance Practice can be found in Appendices B and C of our first Issues Paper, available on our websites. See http://www.lawcom.gov.uk/docs/insurance_contact_law_issues_paper_1.pdf and http://www.scotlawcom.gov.uk/downloads/cpinsurance_issue1.pdf.

[29] Written Answer, Hansard (HC), 21 February 1986, vol 92, 356W to 357W.

2.33 In 1980, the Law Commission strongly criticised the use of self-regulation rather than statutory reform.[30] It pointed out that statements were voluntary, and insurers were free to ignore them. Furthermore, they left the insurer as the sole judge of whether a misrepresentation was reasonable or negligent.

FINANCIAL SERVICES AUTHORITY RULES

2.34 The Financial Services and Markets Act 2000 set up the Financial Services Authority (FSA) as the single statutory regulator for the financial services industry. As far as conduct of business regulation is concerned, the FSA took responsibility for investment insurance in 2001 and for general insurance in 2005.

ICOBS rules on non-disclosure and misrepresentation

2.35 The FSA Handbook consists of high-level principles which are supplemented by more detailed rules. For example, Principle 6 states that “a firm must pay due regard to the interests of its customers and treat them fairly”. Rule 8.1.1 of the Insurance Conduct of Business Sourcebook (ICOBS) goes on to say that “an insurer must handle claims promptly and fairly” and “not unreasonably reject a claim (including by terminating or avoiding a policy)”.

2.36 In the case of consumer insurance, ICOBS 8.1.2 incorporates the main provision of the Statement of General Insurance Practice by stating that:

> A rejection of a consumer policyholder’s claim is unreasonable, except where there is evidence of fraud, if it is for:
>
> (1) non-disclosure of a fact material to the risk which the policyholder could not reasonably be expected to have disclosed; or
>
> (2) non-negligent misrepresentation of a fact material to the risk.

2.37 Unlike the earlier rules, since 2008 the FSA has not demanded that insurers warn consumers about the duty to disclose. However it still advises insurers to issue such warnings. Guidance given in ICOBS 5.1.4 states that:

> A firm should bear in mind the restriction on rejecting claims for non-disclosure. Ways of ensuring a customer knows what he must disclose include:
>
> (1) explaining the duty to disclose all circumstances material to a policy, what needs to be disclosed, and the consequences of any failure to make such a disclosure; or
>
> (2) ensuring that the customer is asked clear questions about any matter material to the insurance undertaking.

[30] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, pp 27 to 29.

The effect of ICOBS

2.38 Unlike the Statements of Practice, the FSA rules are binding on insurers. In theory the FSA could take disciplinary action against a firm which routinely relied on its legal rights to avoid policies for non-disclosure. It could, for example, impose a fine. This is unlikely, however, to be of much help to individual policyholders faced with a single harsh decision. In theory, an affected policyholder may also bring a claim against a regulated firm for breach of statutory duty.[31] However, this would be a difficult, unusual and expensive course of action. There have been very few reported cases where it has been applied,[32] and we are not aware of any concerning ICOBS 8.1.2.

2.39 The FSA rules do not modify the law. Where an insurer had acted within its strict legal rights in avoiding a policy, a court may not overturn the decision because the avoidance was unreasonable. This leads to the anomalous result that an insurer could act within its rights, win a court case, and then (in theory) be fined for having fought the case.

Matters omitted from ICOBS

2.40 It is worth noting that several important provisions of the Statement of General Insurance Practice did not make their way into ICOBS. The FSA was keen to keep the Sourcebook as short as possible, and it did not include provisions unless there was a clear need. Thus the FSA rules do not require insurers to ask questions about those matters which are generally found to be material.

Basis of the contract clauses

2.41 Furthermore, the FSA handbook omits the provision in the Statement of General Insurance Practice that insurers should not include basis of the contract clauses on their proposal forms or policies. The ABI has told us that the fact that the FSA Rules do not mention basis of the contract clauses explicitly does not mean that their use would be condoned. If an insurer attempted to rely on a basis of the contract clause in a consumer contract, it would breach Principle 6 that insurers should treat customers fairly.

2.42 That said, some insurers continue to include basis of the contract clauses on their proposal forms or policy terms. A quick search through the internet established several examples. This is a fairly typical clause, taken from a proposal form for consumer property insurance for unoccupied property:

> I/We understand that the signing of this proposal does not bind me/us to complete this insurance but agree that should a contract of insurance be concluded, this proposal and the statements made therein shall form the basis of the contract.

[31] Financial Services and Markets Act 2000, s 150.

[32] In *Spreadex Ltd v Sekhon* [2008] EWHC 1136 (Ch), [2008] All ER (D) 329 a spread-betting company brought a claim against a private individual for money owed. The private individual defending the claim counter-claimed under s 150 of FSMA 2000 for breach of the Conduct of Business Rules r 7.10.5.

2.43 It is not clear why insurers continue to include basis of the contract clauses in this way. Insurers may wish to provide themselves with the maximum legal rights should they suspect fraud, but find themselves unable to prove it. Alternatively, insurers may cling to the old familiar words without necessarily appreciating their legal effect.

FINANCIAL OMBUDSMAN SERVICE

2.44 The first insurance ombudsman scheme was set up in 1981, on a voluntary basis. It was soon followed by other ombudsman schemes in the financial services sector.[33] These voluntary schemes were consolidated and put on a statutory footing in the Financial Services and Markets Act 2000, which establishes the Financial Ombudsman Service (FOS). Under section 228, ombudsmen are directed to determine complaints "by reference to what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case". Ombudsmen may therefore depart from the law where they consider the law to be unjust.

2.45 For most consumers with disputes about insurance, the FOS offers the only realistic method of redress. There are many reasons why a consumer may prefer to use the FOS rather than the courts, including the fact that the FOS is free.[34] Moreover, for some types of dispute, the FOS offers consumers the only opportunity of obtaining a fair result. If the consumer went to court, the court would be forced to apply unfair law.

2.46 The FOS approach to misrepresentation and non-disclosure is explained in a series of case studies and guidance notes in *Ombudsman News*.[35] As part of this review we have supplemented these notes by two studies of ombudsman decisions (in 2006 and 2009) to understand more about how the FOS approaches these issues.[36]

2.47 It is clear from the published material and from our surveys that the FOS goes much further than either the Statement of General Insurance Practice or the FSA Rules in modifying the principles of the 1906 Act. Two particular issues stand out.

[33] The Insurance Ombudsman Bureau was the first private-sector ombudsman scheme in the UK. It was established on a voluntary basis by three insurers, with a remit to make awards which, if accepted by the complainant, were binding on the insurer up to a limit of £100,000.

[34] In our 2007 consultation paper, we listed ten reasons. The FOS is also quicker, more accessible and more inquisitorial, and can be used without legal representation.

[35] See, in particular, *Ombudsman News*, Issue 27 (April 2003); Issue 46 (June 2005); and Issue 61 (May 2007); and the FOS Consumer Factsheet on Medical Non-Disclosure in Insurance (August 2007).

[36] The results of our 2006 survey are set out in the 2007 CP, Part 3 and Appendix C. The 2009 survey is set out in Appendix C of this Joint Final Report.

Abolishing the duty to disclose

2.48 First, the FOS has effectively abolished the duty of disclosure. As we saw, the 1986 Statement required insurers to ask clear questions about matters which are generally found to be material. The FOS has interpreted this to mean that if an insurer fails to ask a question, it cannot complain that information was not disclosed. This is different from the requirement in ICOBS 8.1.2. ICOBS would allow an insurer to reject a claim where no question was asked, if the consumer could reasonably be expected to have volunteered it.

2.49 This leads to the added confusion that insurers routinely warn consumers that they have a duty to disclose, even though the FOS does not recognise it.

Proportionate remedies for negligent misrepresentations

2.50 The FSA rules only prevent insurers from rejecting claims for those misrepresentations which are considered to be "non-negligent". Where the consumer has acted fraudulently or negligently, the FSA rules permit insurers to avoid the policy. Where the consumer has simply been careless, this may lead to harsh results. As discussed above, an insurer may deny a claim for cancer because the consumer has made a careless misrepresentation about unrelated hearing loss. The insurer may do this even if the insurer would merely have excluded hearing from the policy, had it known about the hearing loss.

2.51 The FOS takes a different approach. It effectively divides misrepresentations into three types:

(1) where the consumer acted reasonably (or "innocently"), the FOS requires that the insurer pays the claim;

(2) where the consumer was careless (variously referred to as "negligent" or "inadvertent"), the FOS will provide a proportionate remedy; and

(3) where the consumer acted deliberately or recklessly, the insurer is entitled to avoid the policy.

2.52 In other words, for negligent misrepresentations, the FOS asks what policy terms the insurer would have offered had it been aware of all the information. If the insurer would have charged a higher premium, it will be ordered to pay a proportion of the claim. If the insurer would have inserted an exclusion into the policy, the ombudsman asks if the claim would have been paid had the exclusion been present.

2.53 Most of those we consulted felt that the FOS was right to impose proportionate remedies in this way. The FOS approach was considered workable and just. However, proportionate remedies are a major innovation. Although they are widely used in French insurance disputes, they are not generally used in UK law. There is no statutory or regulatory basis for proportionate remedies. Nor is there any discussion in the insurance law textbooks about how such remedies would work in complex cases. In Appendix B we attempt to give greater guidance about how proportionate remedies should be applied in the more complex cases, such as where a consumer is insured by two different insurers, or where the consumer later receives a partial reimbursement of his or her loss.

THE ABI CODE OF PRACTICE

2.54 In January 2008, the ABI issued formal written guidance on "Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products". The guidance applied to life, critical illness, income protection and total permanent disability policies. It responded to public disquiet at the way in which critical illness claims in particular have been turned down for what are seen as minor or technical misrepresentations. In January 2009, the status of the guidance was changed, to make it a Code of Practice.[37] ABI members are now required to comply with the Code as a condition of membership. At the same time, the content was extended to cover group schemes.

2.55 The Code states that:

> The ABI believes that this code goes beyond the current legal position in many aspects. However, insurers should note that it does not purport in any way to replace the Law. [38]

This suggests that insurers may still be entitled to rely on the 1906 Act in some circumstances, though it is not clear when this might be appropriate. However, the FOS recognises the Code of Practice as representing good practice within the industry and applies it to its case load on that basis.

2.56 The Code recognises the three-part classification of misrepresentations set out above. It accepts the distinction between "innocent", "negligent" and deliberate/reckless misrepresentations (referring to reckless misrepresentations as those made "without any care"). Crucially, the Code accepts that for negligent misrepresentations a proportionate remedy should be applied. It explains that the outcome will depend on:

> what the underwriting decision would have been if the omitted information had been accurately disclosed at the time the customer took out the policy.[39]

2.57 We welcome both the production of this guidance and its subsequent elevation to the status of a Code. The Code has clarified the rules on non-disclosure in protection insurance, and led to a reduction in the number of critical illness disputes reaching the FOS.[40] However, the Code does not clarify the appropriate rules in general insurance disputes (over, for example, home or motor insurance).

2.58 Although the FOS does not require consumers to volunteer information in general insurance disputes, not all insurers necessarily understand or accept this. As we shall see, our study of recent FOS decisions has found cases in which insurers continue to argue for a general duty to disclose material facts, as set out in section 18 of the Marine Insurance Act 1906.

[37] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009).

[38] Above, para 1.5.

[39] Above, para 4.2.

[40] See para 1.32 above.

CONCLUSION

2.59 The rules governing what consumers need to tell insurers when they take out insurance are complex and confusing. There is general recognition that the law is overly harsh, and unsuited to a twenty-first century consumer market. The law has therefore been overlain by a variety of statements of practice, FSA rules, FOS discretion and industry guidance.

2.60 In Part 3 we explain why we consider the current position to be unacceptable and in need of legislative reform.

PART 3
THE CASE FOR A NEW CONSUMER STATUTE

3.1 The process of buying insurance is a common one. Each year, for example, three-quarters of households take out contents insurance.[1] The question of what a consumer must tell an insurer before buying insurance is one that concerns all consumers who take out insurance, and all the insurers who deal with them.

3.2 In our view, the law in this area needs to be clear, straightforward and fair. Here we set out five problems with the current position:

(1) *Consumers are only able to obtain justice from the Financial Ombudsman Service, not from the courts*. Although the FOS decides cases in a fair and reasonable way, it cannot help all those with disputes. Its compulsory jurisdiction is limited to awards of £100,000, and the FOS declines cases which require witnesses to be cross-examined.

(2) *The rules applying to non-disclosure and misrepresentation are unacceptably confusing*. Many of the "warnings" given by insurers on this subject are misleading rather than helpful. Claims handlers sometimes fail to understand what the FOS requires, leading to claims being rejected unfairly. And many consumers with rejected claims do not realise that they have a right to complain to the FOS. The resulting muddle leads to a loss of confidence in the insurance industry.

(3) *Confusion over the law penalises some vulnerable groups*. We have been told that particular problems exist for older consumers, for those with criminal convictions and for those with multiple sclerosis.

(4) *The present system imposes inappropriate roles on the FOS, the FSA and the courts*. The FOS is forced to act as a policy-maker rather than an adjudicator; the FSA is distracted from its key purpose; and the courts are systematically forced to reach unfair decisions.

(5) *Increasingly, differences in law between the UK and its European partners need to be justified*. The rules set out in Part 2 cannot be justified before an international audience.

3.3 Below we discuss each problem in turn. We explain why we think that these problems can only be addressed by a new statute to replace the rules set out in the Marine Insurance Act 1906.

THE FOS CANNOT PROTECT ALL CONSUMERS

3.4 If consumers go to the FOS, their case will be dealt with fairly. However, the FOS cannot handle all consumer cases.

[1] 76% of households take out contents insurance, and 74% take out vehicle insurance. Just over a third (36%) of households have life assurance: see Office for National Statistics, *Family Spending: A Report on the 2007 Expenditure and Food Survey*, table A1.

3.5 The first problem is that the amount of the dispute may exceed £100,000. Recommendations can be made for any sum, but the recommendation is not binding on the insurer for the amount that exceeds £100,000. In relation to life insurance or building insurance, £100,000 is a low limit. In our most recent survey of 47 ombudsman decisions on consumer non-disclosure, three cases exceeded £100,000. The largest claim was for £271,800. We understand that where the FOS makes non-binding recommendations, many insurers pay voluntarily, but we do not know how many refuse to pay awards because they exceed the FOS limit.

3.6 The following example is taken from our recent survey. We do not know if the insurer paid the full claim voluntarily. If the insurer decided to defend the case in court, the court would be required to decide the case under different rules from the ones applied by the FOS. The court would not only have looked at the questions the consumer answered but at whether there were other matters he should have disclosed voluntarily.

> Mr C took out critical illness insurance for £119,000. The form asked:
>
> *Have you at any time suffered from, had or been advised to have, any medical investigation or consultation, advice, operation or treatment for any of the following: Heart attack, chest pain, palpitations, heart murmur, high blood pressure, high cholesterol, stroke, or any disease or abnormality of your heart, arteries or veins.*
>
> The complainant answered no, and later suffered a heart attack. His medical notes indicated that he had had raised blood pressure readings 18 months previously. He had not received any treatment or investigation for these, but the insurer claimed that he had received lifestyle advice. This, together with other alleged misrepresentations, led them to avoid the policy.
>
> The ombudsman found that the misrepresentations were innocent, as Mr C had no reason to think his blood pressure was a cause of concern. She awarded Mr C £100,000. She also recommended that the insurer should pay the balance, commenting:
>
> "*This recommendation is not part of my determination or award. It does not bind the business. If the business does not pay the recommended balance and Mr C decides to sue for the balance in court, the court would need to make its own decision on whether or not to award anything*."

3.7 Secondly, under FSA Rules, the FOS may decline to deal with a case if it "considers that it would be more suitable for the matter to be dealt with by a court, arbitration or another complaints scheme".[2] The FOS told us that the rule has a significant impact. The case may turn on disputed evidence from a third party (such as a broker or departed salesman), who needs to be cross-examined. The FOS commented that "this creates a whole category of cases to which our process is unsuited". In such circumstances, the FOS may be obliged to refer the case to the courts, where the 1906 Act will be applied. The FOS stated that:

> This basis is one that we do not regard as fair or reasonable or as representing good practice in the sector. In other words if the insurer can justifiably demand that they are able to cross-examine a third party then they may win a non-disclosure case that they would otherwise have lost at the FOS.[3]

3.8 Consumers who are unable to use the FOS must either accept the insurer's decision or bring a court action. In court, they must argue their case within the terms of the 1906 Act.

THE RULES ARE CONFUSING

3.9 In Part 2 we described how this area was covered by inconsistent layers of law, self-regulation, FSA rules and FOS discretion. This makes the law difficult to explain. As a result, both claims handlers and consumers may misunderstand what the rules require. Claims handlers may make unfair decisions, and consumers may lose confidence in the insurance industry.

Inadequate explanations

3.10 The difficulty in describing the law can best be illustrated with some examples. This is the explanation of the duty to disclose given by the FSA in its recent guide for consumers about insurance, entitled *No Selling; No Jargon; Just the Facts about Insurance*:

> "Material" facts are facts that you ought reasonably to know are relevant to the insurer's decision whether to offer you insurance cover and at what price, so they must be disclosed. This information will form the basis of the contract between you and the insurer.
>
> If you are asked a specific question, you must respond honestly, and it is no defence to say that you didn't realise that the fact was material. If you don't disclose material facts, your policy may be invalidated and you won't be able to make a claim. So make sure you disclose everything, however irrelevant it may seem at the time.[4]

[2] Dispute Resolution Sourcebook (DISP), para 3.3.1(10) (FSA Handbook).

[3] For the full text of the FOS evidence to us on this issue, see CP, para 3.59.

[4] Available on www.moneymadeclear.fsa.gov.uk, p 23.

3.11 This explanation does not reflect the 1906 Act. As we have seen, under section 18, the insured must disclose everything that would be material to a hypothetical prudent underwriter. It is irrelevant whether the insured ought reasonably to know what is relevant. Nor does this explanation reflect what the FOS does. The FOS has effectively abolished the duty to volunteer information. Under the FOS approach, the consumer's duty is to take reasonable care to answer the questions they are asked honestly and fully. The consumer is not obliged to second guess what the insurer might be interested in but has not asked about.

3.12 Nor do we think that the advice to "disclose everything, however irrelevant" is practical or helpful. Consumers only have limited time to devote to insurance applications: they cannot be expected to write their life histories. If they did, insurers would not have the staff or resources to read them. In our survey of ombudsman cases, we found some extremely general questions, for example:

> Have you within the last 7 years consulted a doctor, psychiatrist, consultant, clinic, osteopath etc concerning your mental or physical health?[5]

In practice, consumers routinely exercise judgment, omitting routine issues and minor illnesses, and limiting their answer to things they think the insurer would want to know.

3.13 Explanations similar to the one given by the FSA, however, are common. A quick search of the internet reveals several hundred warnings along similar lines, given on websites, in policies and on proposal forms. These examples are typical:

> If you don't disclose all material facts, your insurance could be invalid and not give protection in the event of a claim. In particular, you should tell us about any incidents (whether your fault or not, and whether you claimed or not). [Home insurer]

> In applying for insurance all material facts must be disclosed. Failure to do so could invalidate the policy. A material fact is one which is likely to influence an insurer in the assessment and acceptance of the application (e.g. any criminal conviction concerning dishonesty)… If you are in doubt as to whether a fact is material then it should be disclosed. [Motor insurer]

The final example is particularly misleading, as consumers are not obliged to disclose convictions which have become spent under the Rehabilitation of Offenders Act 1974.[6] The 1974 Act also provides that any question about criminal convictions must be treated as if it did not include spent convictions.[7]

5 See Appendix C, paras C.9 to C.15.

6 The Rehabilitation of Offenders Act 1974, s 4(3)(a) states that "any obligation imposed on any person by any rule of law… to disclose any matters to any other person shall not extend to requiring him to disclose a spent conviction or any circumstances ancillary to a spent conviction (whether the conviction is his own or another's)".

7 See s 4(2)(a).

Misunderstandings by claims handlers

3.14 The problem with these explanations is that claims handlers start to believe them. Since 2005, the FOS has published guidance stating that it will not permit an insurer to avoid a policy if it failed to ask a question about the matter under dispute. However, some claims handlers appear not to be aware of the FOS approach to this issue.

3.15 In our recent survey of 47 ombudsman decisions on non-disclosure, we found five in which insurers had purported to avoid policies on the ground that the consumer had failed to volunteer information for which they had not been asked. This is the first example:

> Mr and Mrs D insured their household building and contents with a major insurer. They were sent a policy schedule giving the last renewal date as 15 January 2007. In July 2007, they made a claim for water damage.
>
> The insurer purported to avoid the contract on the ground that Mr D had not disclosed that he had been convicted of common assault on 1 June 2007. The insurer pointed to a provision in the key facts document which described the policy as "a monthly contract". The insurer argued that this put the consumer under a duty to disclose material facts on a monthly basis, even though no questions were asked.
>
> In November 2008 the ombudsman required the insurer to reinstate the policy and deal with the claim. She held that Mr and Mrs D had a duty to disclose the conviction only when the policy was due for renewal on 15 January 2008, and "then only in response to a clear question".

3.16 In the second case, the insurer claimed that on renewal the consumer should have mentioned starting a business from home. In another case, a car insurer had failed to ask about a co-driver's motoring conviction, but claimed that the insured should nevertheless have disclosed it.

3.17 Thus it appears that some insurers continue to turn down claims on the basis of a failure to volunteer information. We are surprised, however, that an insurer would argue the point to a final ombudsman decision. This suggests that some insurers simply fail to understand the FOS guidance on the subject.

3.18 If consumers are aware of their rights to go to the FOS, they will eventually get their claims paid (albeit after some delay and aggravation). The greater problems arise where consumers are unaware of the FOS, or do not realise that the FOS will uphold their claims. The evidence shows that only a minority of people who feel that their claim has been rejected unfairly will contact the ombudsman.[8]

3.19 In its response to us, the FOS commented that clearer rules would lead to fewer unfair refusals:

> It may be that some insurers who do not have regular dealings with us do not fully understand our approach. It may be however that some insurers deliberately apply the legal position and it is only if a complaint is upheld against them that they are forced to act in line with our approach. If the law was reformed, this would greatly increase the chances that consumers would not need to bring a complaint in order to be treated fairly.

Lack of consumer confidence

3.20 The evidence suggests that consumers are generally satisfied with insurers' products and services, until something goes wrong. However, if they have cause for complaint, they can quickly lose trust in the system.

3.21 Each year the ABI carries out a large scale Customer Impact Survey, talking to the customers of 34 providers of life, pensions and investment insurance.[9] The 2008/09 survey shows a good level of overall satisfaction.[10] Only a small minority (3%) of customers made a complaint to the provider during the year. However, among those who did complain, the ABI noted that there is "significant dissatisfaction with complaint handling".[11] Over half (55%) of those who complained felt their complaint had been handled poorly, and only 11% felt that it had been handled in an "excellent" or "very good" way.[12] The ABI is planning qualitative research to look at the reasons behind this.

3.22 We think that the lack of clear rules about when insurers may turn down claims for misrepresentation and non-disclosure contributes to this dissatisfaction. As the Chartered Insurance Institute said in its response to our consultation paper, "failure in the legal clarity of our service to consumers has a direct impact on the industry's reputation".

[8] The FOS 2008/09 Annual Review, p 75, states that "our research with consumers who do *not* use our service shows consistently that around 12% say they have recently complained to a financial services business. Of those who say they remained unhappy after their complaint, usually over half take no further action". Research for the Legal Services Commission reached a similar finding. In 2004, it interviewed over 5,000 people, of whom 45 said they had an insurance claim rejected unfairly. Only three people had contacted the ombudsman. Most people had either done nothing, or had attempted to handle the issue on their own (information provided by the Legal Services Commission).

[9] This includes annuities and other forms of protection insurance.

[10] ABI Industry Report: 2008/09 Customer Impact Survey (March 2009), p 12. It shows that 51% of customers were "extremely" or "very" satisfied and only 8% of customers were "not at all" or "not very" satisfied.

[11] Above, p 29.

[12] Above, p 27.

3.23 Dissatisfied consumers talk to their friends. The Customer Impact Survey found that one in five customers would not recommend the company to friends and family.[13] Some will talk to the press. And the resulting bad publicity can quickly translate into a lack of sales, as the problems in 2007 over critical illness refusal rates showed. In some cases insurers do need to give unwelcome news, and tell consumers that their claims will not be paid. But we think it would be easier to tell the consumer that the law entitles the insurer to refuse the claim (and to justify the decision in the press), than to say that the insurer may refuse the claim under industry guidelines.

3.24 A lack of confidence may also encourage consumers "to get their retaliation in first" by acting less than honestly in their dealings with insurers. In another ABI survey, a fifth of respondents said that they would be willing to make an exaggerated or completely made up insurance claim at some point in the future.[14] This is a worrying finding and one which merits further investigation. However misguided such thinking may be, it becomes easier for people to justify breaking the rules to themselves and to their friends if they feel that the rules themselves are opaque and unfair.

3.25 In July 2009, the Insurance Industry Working Group chaired by the Chancellor of the Exchequer set out a vision for the insurance industry in 2020. The theme of the report was to increase customers' confidence and trust in the insurance industry, while fostering customers' awareness of their own responsibilities.[15] Key watchwords were understanding, awareness, transparency, simplicity and confidence. The report acknowledged that customers need to become more informed purchasers of insurance and need products that they understand. Customers also need confidence that valid claims will be paid. The report recommended several possible initiatives, such as looking at "conditions of payout, including what constitutes a valid claim".[16] We think that a clearer, fairer law on what consumers must tell insurers before taking out insurance will contribute directly to these policy goals.

THE EFFECT ON VULNERABLE GROUPS

3.26 During our consultation we were told that problems over non-disclosure and misrepresentation caused particular difficulties for some vulnerable groups.

Age Concern

3.27 Age Concern cited research it had conducted with older people about their experience of motor and travel insurance. It found that many older consumers "were confused about what they need to tell their insurer, particularly in relation to health problems". Age Concern commented that:

> The effects can be severe for the individual and also weaken trust in the insurance industry.

[13] Above, p 12.

[14] ABI Savings and Protection Survey 2009, p 16.

[15] Insurance Industry Working Group, "Vision for the Insurance Industry in 2020" (July 2009), Executive Summary, p 1.

[16] Above, p 14.

Age Concern mentioned several cases reported in discussions where claims had been refused for non-disclosure, even though the consumer had not realised the need to disclose.

Multiple Sclerosis Society

3.28 The Multiple Sclerosis (MS) Society thought the current law caused particular problems for those diagnosed with multiple sclerosis. It sent us 11 extracts from anonymised case histories where critical illness claims had been refused, usually because early but undiagnosed symptoms had not been reported. The MS Society commented that:

> The unpredictability and complexity of MS, with its wide ranging symptoms, means that insurers are often able to refuse a critical [illness] payout on the grounds of non-disclosure of incidents which occurred many years before the consumer was aware of any potential that they might have the condition.

3.29 When someone is diagnosed with multiple sclerosis it is often clear in retrospect that previous vague symptoms such as pins and needles or numbness were early indications of the disease. However, everyone experiences pins and needles at some stage. Before a diagnosis, few would think that it was an important or relevant issue to tell an insurer.

3.30 Questions about the early symptoms of MS continue to cause problems. In our survey of recent ombudsman decisions, four out of the 17 decisions over critical illness involved an MS diagnosis. This case, taken from our survey, illustrates the issues.

> Mr and Mrs E took out a life and critical illness policy.
>
> Mrs E was asked whether in the last five years she had had "*numbness, loss of feeling or tingling of the limbs or face, loss of balance or co-ordination*". She answered no. She had experienced some tingling in her feet and legs, but was told that these were connected to the recent birth of her child, and the feelings soon went.
>
> In answer to another question, Mrs E said that she had suffered from blurred vision, but was now fully recovered. According to her medical records, the pain had gone, and her vision was improving, but the sight in her left eye remained poor.
>
> When Mrs E later developed MS, she made a claim for critical illness. The insurer considered that Mrs E had acted deliberately or recklessly in giving the answers she did, and avoided the policy. The ombudsman found that Mrs E's answers were not entirely accurate, but "this was no more than an inadvertent mistake".

The ombudsman applied a proportionate remedy, asking what the insurer would have done had it known about the blurred vision. The ombudsman found that it would still have offered life cover, albeit at an increased premium, and held that the insurer should reinstate the life cover. However, as the insurer would have declined the critical illness cover, it was entitled to reject her critical illness claim.

3.31 Not everyone will pursue a complaint to the FOS. The MS Society commented that the cases it dealt with "illustrate the vulnerability many people feel after the diagnosis of MS which can make them less willing to challenge a decision".

Unlock

3.32 Unlock is the National Association of Reformed Offenders. In November 2008 it wrote to us to express concern that some insurers continue to require convictions to be disclosed in the absence of specific questions. Its members were often confused and distressed about the issue, with little idea of what their obligations were.

3.33 Unlock included several case histories, together with correspondence on the issue with a leading motor insurer. The insurer outlined the position in the following terms:

> Whilst we do not ask specifically about non-motoring offences, as per the principle of utmost good faith the proposer has a duty not to conceal anything that is relevant.

3.34 When Unlock queried this, a senior underwriter confirmed that they did expect consumers to volunteer information about convictions:

> Any private car customer who has any unspent non-motoring criminal convictions must volunteer this information to the insurer. We, the insurer, are then in a position to make an informed decision, based on the full facts presented whether to offer or to decline the risk.

3.35 We were surprised by this, as the same insurer had previously written to us to support the abolition of the duty to volunteer information. It felt that any imbalance in the law had largely been rectified by the influence of the Statement of General Insurance Practice and the FOS. Large organisations, however, do not always speak with one voice.

3.36 The issue of criminal convictions is a sensitive one for insurers. In our recent survey, out of the 30 cases not related to critical illness, five concerned criminal convictions, including the example in paragraph 3.15 (from a different insurer). Insurers may be more likely to fall back on the strict letter of the law when faced with "criminality", even for relatively minor offences, such as common assault. It is very much in the interests of clarity and certainty that insurers should ask specific questions about convictions, rather than relying on a duty of disclosure.

INAPPROPRIATE ROLES

3.37 Despite the problems caused by the current confusion, the ABI continues to argue against statutory reform. In July 2009, the ABI confirmed its position in the following terms:

> The protection that is afforded under market regulation is more appealing than that which may arise through statutory reform. There is a danger that statutory reform of insurance contracts might add an unnecessary layer of regulation and bureaucracy. The Financial Ombudsman Service (FOS) policy statements and judgments are based on law, but also on custom and market practices, including industry codes. The approach of the Financial Services Authority (FSA) in providing market-based solutions allows for a greater degree of flexibility than codified reform. Those actually working in the market on a daily basis are able to participate in identifying and addressing perceived problems; this flexibility should not be stifled by reform by way of primary legislation.[17]

3.38 The present reliance on soft law permits the FOS to remedy obvious injustice, but we do not think that it is desirable in the long term. We are concerned that it imposes inappropriate roles on those involved: the FOS is forced to make policy; the FSA is given an on-going responsibility, which could distract it from its key purpose; and the courts are required to apply unfair law.

3.39 Parliament assumed responsibility for insurance law when it codified the law in 1906. Once a law has been codified it needs to be reviewed from time to time.

The FOS is forced to make policy

3.40 In most areas of its work, it is true that FOS decisions are based mainly on law, supplemented by market practice and industry codes. This, however, is not the case with disputes over non-disclosure or misrepresentation in insurance contracts. Here, the FOS has only been able to reach fair and reasonable decisions by disregarding some of the main legal principles set out in the 1906 Act. As we saw in Part 2, the FOS has often been required to go beyond FSA rules and industry codes.

3.41 The two main doctrines which govern this area – the abolition of the duty to disclose and proportionate remedies – are ombudsman inventions. In January 2008 the ABI issued Guidance endorsing the use of proportionate remedies in long-term protection insurance.[18] However, this Guidance followed rather than led the FOS approach, and there is still no official endorsement of proportionate remedies in general insurance. As explored above, the lack of any clear industry statement abolishing the duty to volunteer information continues to cause confusion and distress to consumers.

[17] ABI's Response to the English and Scottish Law Commissions' Issues Paper on Micro-Businesses (July 2009).

[18] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009).

3.42 In its response to us, the FOS indicated its unease with the current position:

> Our preference is for our decisions to be based on law and for our decisions on what is "fair and reasonable" to coincide with the law. It is much easier to defend and justify our decisions when they are consistent with the legal position and it is advantageous to all our potential users if our decisions can be predicted…. We also take the view that it is logically and morally unjustified to hang on to old law if it is widely agreed that the law is bad and no longer serves any useful purpose.

3.43 The ABI is also critical of the idea that the FOS should form policy. In March 2009 it issued a policy statement stating that it wants "the Financial Ombudsman Service to focus on arbitration, not policymaking".[19] We are concerned that the current system forces the FOS to assume a responsibility for which it is not best suited.

Requiring the FSA to update the law would distract it from its key purpose

3.44 The ABI argues that the FSA can provide more flexible rules and is able to work with industry representatives to adapt to an ever changing market place.

3.45 The FSA has done relatively little to establish new legal rules. The rules currently set out in ICOBS 8.1.2[20] are a simplified version of the Statement of Practice.[21] These principles have not been added to since 1986, when the Department of Trade and Industry and insurance representatives agreed to introduce self-regulation as an alternative to the Law Commission's draft Bill. Instead, the FSA has encouraged the industry to treat its customers fairly. Although this is worthwhile, it is a different activity from establishing rules which can be used as a basis of legal decision-making.

3.46 We do not think that it is appropriate to impose an ongoing responsibility on the FSA to deal with the consequences of unfair law. Recent reviews of financial regulation since the banking crisis of 2008 have stressed the need to focus on prudential regulation and the analysis of systemic risk (to prevent insolvencies), rather than on the details of consumer protection. In March 2009, the Turner Review commented on the need for a new balance between conduct of business regulation and prudential regulation. The Review commented that the previous balance, "with the benefit of hindsight, now appears biased towards the former".[22] The Sassoon Tripartite Review, commissioned by the Shadow Chancellor, reached a similar conclusion:

[19] ABI, *Regulation and Markets for the 21st Century* (March 2009), p 2.

[20] See above, para 2.36.

[21] See above, para 2.32.

[22] FSA, *The Turner Review: A Regulatory Response to the Global Banking Crisis* (March 2009), p 87.

> In retrospect, it is easy to see that the focus of the FSA on the development of policies to give the consumer of financial services a better deal... was not matched… by a similar focus on developing the prudential regime.[23]

3.47 In its July 2009 white paper, the Conservative Party proposed to abolish the FSA and create a new Consumer Protection Agency. This would place less emphasis on compliance and take "a much tougher approach". It would "be a far more consumer-orientated, transparent and focused body".[24] We consider that a new agency would be able to focus more directly on its task of protecting consumers if it were to operate against a background of clear law.

The courts are required to apply unfair law

3.48 Where consumers do take their disputes to court, the courts are left to apply unsatisfactory legal rules.

3.49 Senior judges have expressed their concern about this. For example, the influential report from the British Insurance Law Association in 2002 included the text of lectures calling for reform by Lord Justice Longmore and Lord Justice Rix, and a foreword by Lord Mance.[25]

Preserving flexibility

3.50 The final argument put by the ABI is that reforming the 1906 Act might lead to a loss of flexibility. The ABI argued that:

> The danger with prescriptive rules is that they can quickly become out of kilter with the developing needs of an evolving market and are thereby rendered obsolete.[26]

3.51 We can understand that Parliament would be reluctant to reform the law if the new law were to become outdated quickly. We have therefore deliberately drafted the Bill in a way that would enable it to develop with changing circumstances. We have, for example, used open-textured words (such as "reasonable") and provided non-exhaustive lists of factors to show how such words should be interpreted. We think this will give the courts and the FOS a clear steer, without precluding them from taking into account new factors as the market changes.

3.52 The draft Bill should also be seen as providing minimum rights for consumers. It is always open to insurers to write their contracts in such a way as to give consumers greater rights.

[23] Interim report (March 2009), p 8.

[24] Conservative Party, "From Crisis to Confidence: Plan for Sound Banking" (July 2009).

[25] BILA, Insurance Contract Law Reform – Recommendations to the Law Commissions (2002).

[26] ABI's Response to the English and Scottish Law Commissions' Issues Paper on Micro-Businesses (July 2009).

EUROPEAN DEVELOPMENTS

3.53 In a world of global finance, the UK increasingly has to justify differences in commercial law between the UK and its European partners. The European Commission has mentioned insurance contract law as one particular area where common legal rules should be considered.[27] Thus, in June 2009, the European Commission included insurance contract law harmonisation as part of its “Stockholm programme”. This is a new agenda to put “freedom, security and justice” at the heart of the European Union.[28]

> The **regulation of business law** would help oil the wheels of the internal market. A variety of measures could be considered here: common rules determining the law applicable to matters of company law, insurance contracts and the transfer of claims, and the convergence of national rules on insolvency procedures for banks.[29]

3.54 This follows the work conducted by the Restatement of European Insurance Contract Law Project Group (“the Innsbruck Group”).[30] In December 2007 the Group submitted a chapter on insurance contracts as part of the Draft Common Frame of Reference. These rules could perhaps form the basis of a European Directive. Alternatively, they could be used as a “28th regime” optional contract law instrument, which the parties could choose as an alternative to the law of a specific jurisdiction.[31]

3.55 UK insurance law is based on different principles from civil law systems. It is unlikely that the European Union would impose a civil law system on the UK, if our existing traditions can be justified. The problem with the system of law set out in Part 2, however, is that it cannot be justified before an international audience. It makes no sense to say that we should preserve a system in which the law is recognised as being unfair, on the grounds that the FOS is left to apply its own rules. European insurers who have little experience of doing business in the UK might legitimately ask how they are meant to discover what the FOS does.

3.56 In Parts 4 to 9 we set out details of a reformed law, which would be seen to be fair and reasonable both within the UK and abroad.

[27] See the Opinion of the European Economic and Social Committee on “The European Insurance Contract” adopted on 15 December 2004.

[28] Communication from the Commission to the European Parliament and the Council, “An Area of Freedom, Security and Justice serving the Citizen” (10 June 2009) (COM (2009) 262 Final).

[29] Above, para 3.4.2.

[30] See http://www.restatement.info.

[31] See J Basedow, “The Case for a European Insurance Contract Code” [2001] *Journal of Business Law* 569; J Basedow, “Insurance Contract Law as part of an Optional European Contract Act” [2003] *Lloyd’s Maritime and Commercial Law Quarterly* 498; M Clarke and H Heiss, “Towards a European Insurance Contract Law? Recent developments in Brussels 2” [2006] *Journal of Business Law* 600.

PART 4
THE RECOMMENDED SCHEME IN OUTLINE

4.1 Here we provide a broad overview of our recommended scheme. The recommendations are explained in detail in Parts 5 to 9.

THE SCOPE OF THE DRAFT BILL

4.2 The draft Bill is relatively narrow in its scope. It applies only to consumer insurance contracts: that is, to insurance bought by individuals for purposes wholly or mainly unrelated to their trade, business or profession. Furthermore, it only deals with the issue of what a consumer must tell an insurer before entering into or varying an insurance contract.

4.3 The draft Bill abolishes the duty currently imposed on consumers to volunteer material facts. In its place, the draft Bill places a duty on consumers to take reasonable care not to make a misrepresentation.

4.4 Where an insurer has been induced by a misrepresentation to enter into an insurance contract, the insurer's remedy will depend on the consumer's state of mind. Insurers are required to pay claims where the consumer has acted reasonably. Insurers may avoid policies where the consumer has acted deliberately or recklessly. For careless misrepresentations, insurers are entitled to a compensatory remedy.

4.5 In addition, the draft Bill:

(1) abolishes basis of the contract clauses;

(2) gives insurers remedies where misrepresentations are made by group scheme members and those whose lives are insured by others (and who are not party to the insurance contract);

(3) provides a structure to decide for whom an intermediary acts when passing information from a consumer to the insurer; and

(4) prevents insurers from contracting out of this scheme to the detriment of the consumer.

ABOLISHING THE CONSUMER'S DUTY TO VOLUNTEER INFORMATION

4.6 It is now accepted practice that insurers should ask questions about what they want to know. The Financial Ombudsman Service (FOS) refuses to allow insurers to avoid a consumer policy for non-disclosure where no question has been asked. Our draft Bill gives statutory effect to the FOS approach.

THE DUTY TO TAKE REASONABLE CARE NOT TO MISREPRESENT

4.7 The duty to take reasonable care not to misrepresent means that consumers must take reasonable care to answer insurers' questions fully and accurately. It also means that if consumers do volunteer information, they must take reasonable care to ensure that the information is not misleading.

4.8 The concept of a "misrepresentation" has been defined in the case law as a statement which is untrue or misleading. In particular, an answer may be literally accurate but still amount to a misrepresentation because it is incomplete.[1] Our intention is that the concept of a misrepresentation as set out in the draft Bill should be interpreted according to common law principles.

4.9 However, the Bill clarifies one issue about the definition of a misrepresentation: a consumer's failure to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation. This means that a consumer may breach their duty by failing to respond to a renewal letter asking if the previous particulars are correct. One would need consider whether the circumstances are such that a reasonable consumer in the same position would have responded.

4.10 The draft Bill provides remedies to an insurer where the consumer has breached the duty, and the insurer has been induced to enter the contract. Again, the concept of "inducement" has been preserved from the current law. It means that the insurer must show that without the misrepresentation it would not have entered into the contract, or would have done so on different terms.

4.11 The current law provides that a misrepresentation is only actionable if it is "material", in that it would influence the judgment of a hypothetical prudent underwriter.[2] We have not preserved this concept. Under our draft Bill, it is enough for the insurer to show that it was induced by the misrepresentation, and that a reasonable consumer would not have made it. The insurer does not also have to show that the misrepresentation would have influenced other underwriters in the market.

THE THREE-PART CLASSIFICATION

4.12 The draft Bill gives legislative effect to the three-part classification used by the FOS:

(1) Where a misrepresentation is *honest and reasonable*, the insurer has no remedy and must pay the claim.

(2) Where a misrepresentation is *careless*, the insurer has a compensatory remedy. This is based on what the insurer would have done had the question been answered accurately and completely.

(3) Where the misrepresentation is *deliberate or reckless*, the insurer may treat the policy as if it does not exist and decline all claims. The insurer would also be entitled to retain the premium, unless there was a good reason why the premium should be returned.

The terminology applied to these categories has been somewhat inconsistent. Below we refer to representations being "reasonable", "careless" or "deliberate or reckless".

[1] See, for example, *Roberts v Avon Insurance Co Ltd* [1956] 2 Lloyd's Rep 240 and *Winter v Irish Life Assurance plc* [1995] 2 Lloyd's Rep 274.

[2] Marine Insurance Act 1906, s 20(2).

4.13 As part of this project we have consulted widely on definitions of "reasonable" and "deliberate or reckless". We are encouraged that the Association of British Insurers (ABI) has now largely adopted the definitions we proposed in our Consultation Paper.[3] Careless does not need to be defined: a representation may be considered "careless" if it is neither "reasonable" nor "deliberate or reckless".

Acting honestly and reasonably: the policyholder is protected

4.14 Under the Financial Services Authority (FSA) rules, insurers are not permitted to refuse claims for a misrepresentation that was neither fraudulent nor negligent. The draft Bill sets this out in statutory form. Provided that the consumer acted both honestly and reasonably, the insurer would be required to pay claims under the policy.

4.15 The standard of care required is that of a reasonable consumer. The draft Bill provides a non-exhaustive list of factors which may need to be taken into account, including the type of policy, the clarity of the question, any relevant explanatory material from the insurer, and whether the consumer was represented by an agent. It looks at what might be expected from a hypothetical "normal" or "average" consumer in the market.

4.16 The test does not take into account consumers' individual circumstances, unless the insurer knew about them or ought to have known about them. For example, the test does not make allowances for the fact that the consumer did not speak English or was illiterate, unless the insurer was or ought to have been aware of the issue.

4.17 In practice, the level of care expected from consumers will depend on the way that the insurance was sold. For example, greater care would be required if the insurer told consumers to take time to check their records before completing the form, than if the insurer advertised the insurance as "quick to complete". Similarly, a higher level of care would be reasonable if the consumer was helped by an agent. Insurers may use general questions if they wish, but if they do, they run the risk that consumers may act reasonably and still fail to give the requisite information. Thus if the insurer wishes to know whether the consumer has ever consulted a doctor about a mole, it would be better to ask a specific question than to rely on a general question about whether the consumer has sought medical advice about "any ailment".

4.18 In some cases, a consumer may have more than average knowledge or understanding. For example, whereas someone with medical knowledge would be likely to understand what is meant by "paraesthesia", the average consumer might not. It is therefore possible that someone might act "reasonably", applying the standards of an average, reasonable consumer, but may nevertheless act dishonestly given his or her own greater level of understanding. The draft Bill provides that where a misrepresentation is made dishonestly it is always to be taken as showing lack of reasonable care.

[3] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009). This replaced the similarly worded ABI Guidance ("Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products") issued in January 2008.

Acting “deliberately or recklessly”: the policy is avoided

4.19 Where the consumer has made a “*deliberate or reckless*” misrepresentation the insurer would be entitled to avoid the policy. This means that the insurer may treat the policy as if it did not exist, and refuse all claims under it.

4.20 This may go further than is necessary to compensate the insurer for the loss it has suffered. It has a penal element to show society’s disapproval of the behaviour and to deter wrongdoing. On the same principle, we recommend that the insurer should normally be entitled to retain any premiums paid. The draft Bill states that the insurer need not return the premiums paid unless it would be unfair to the consumer to retain them.

4.21 In the 2007 consultation paper, we discussed the definition of “deliberate or reckless” misrepresentations in detail. We argued that rather than relying on existing definitions of fraud or dishonesty, the legislation should set out a specific test to identify behaviour which is morally reprehensible.

4.22 The test set out in the draft Bill reflects the consultation paper proposal. The insurer may avoid the policy and refuse all claims if it can show that, on the balance of probabilities, the consumer:

(1) knew that the statement was untrue or misleading, or did not care whether or not it was untrue or misleading; and

(2) knew that the matter was relevant to the insurer, or did not care whether or not it was relevant to the insurer.

The ABI’s Code of Practice uses a definition of “deliberate or without any care” which is the same in content as the one set out in the draft Bill.[4]

4.23 The insurer’s task of proving that a misrepresentation was made deliberately or recklessly should not be unduly onerous or require an exceptionally high standard of proof. In the consultation paper we suggested that the insurer’s task of proving fraud might be helped by two presumptions, namely that the consumer knew:

(1) what someone in their position would normally be expected to know; and

(2) that where the insurer asked a clear question, the issue was relevant to the insurer.

4.24 These presumptions reverse the burden of proof. The onus would be on the consumer to show that they had less knowledge than that normally expected, or that they did not realise the issue was relevant, despite the clear question. Most respondents agreed that these presumptions would be useful, and they are included within the draft Bill.

[4] ABI Code of Practice, above, para 2.1.

Acting carelessly: a compensatory remedy

4.25 A careless misrepresentation is one made without reasonable care, but which was not deliberate or reckless. Here the insurer is entitled to a remedy which aims to put the insurer in the position it would have been in had the consumer taken reasonable care to answer the question fully and accurately. This involves asking what the insurer would have done had the consumer taken care to tell the truth.

(1) If the insurer would have changed a policy term, the policy is treated as if those terms applied. For example, if the insurer would have excluded a particular type of claim, it should not be obliged to pay claims that would fall within the exclusion. If the insurer would have imposed a warranty or excess, the claim would be treated as if the policy included that term.

(2) If the insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium.

(3) If the insurer would have declined the risk altogether, the policy may be avoided, the premiums returned and the claim refused.

4.26 The use of compensatory remedies is not new. In 1997, the National Consumer Council commented that "the Ombudsman… regularly uses the proportionality principle to settle the amount of a claim to be paid in non-disclosure cases".[5] However, until recently their use was relatively rare. In our original survey of ombudsman cases, the insurer had offered to pay a proportion of the claim in only four cases (2%), and the FOS reduced the claim proportionately in another five (3%). However, it appears that insurers are now more prepared to offer proportionate payments. In our recent survey of ombudsman decisions, insurers offered to pay a proportion of the claim in 5 out of 47 cases (11%).[6]

4.27 Although the numbers are still small, this suggests that the proportionality principle has become more accepted and institutionalised. It is no longer merely a formula used by the ombudsman to come to a fair and reasonable outcome. It is becoming a rule which claims handlers need to understand and apply within their case loads.

4.28 Compensatory remedies are easy to describe and to apply in most cases, but their effect may sometimes be complex. Examples of possible complexity include cases where the consumer makes a misrepresentation when varying the contract; or has insured the same risk twice; or later recoups some (but not all) of their loss from a third party.

4.29 We therefore think it may be helpful to set out how proportionate payments interact with other ways in which a claim may be reduced. In Part 6 and Appendix B, we provide further guidance on this issue. Not all the issues are spelled out in the draft Bill, as often the existing law achieves the correct outcome.

[5] National Consumer Council, *Insurance Law Reform* (1997), p 26.

[6] This included three critical illness cases and two other cases. The FOS awarded a proportionate payment in another three cases. In five cases, the insurer applied changed terms; and in another three cases, the FOS required a change of terms.

"BASIS OF THE CONTRACT" CLAUSES

4.30 "Basis of the contract" clauses have been criticised for many years. Few policyholders understand their effect. In 1986, the Statement of General Insurance Practice barred their use; they are not thought to treat customers fairly; and the FOS would almost certainly reject an attempt by an insurer to rely on them.

4.31 The draft Bill abolishes basis of the contract clauses. This brings the law into line with recognised good practice.

GROUP INSURANCE

4.32 Typically, in a group insurance scheme, an employer arranges insurance in respect of employees and their dependants. The policyholder is the employer, while the employees who are entitled to receive benefits under the policy are not party to the contract. Although the sector is extremely important (providing around 40% of life-cover), the law on group insurance appears under-developed. If, for example, an individual member misrepresents their health, the legal effect is uncertain.

4.33 Our recommendations would bring the law into line with accepted good practice. The draft Bill provides that where a misrepresentation is made by a group member who is receiving an insurance benefit for non-business purposes:

(1) it would have consequences only for the cover of that individual; and

(2) any dispute about the misrepresentation would be determined according to the principles set out in our draft Bill.

4.34 These provisions are limited. They apply only where the individual group member makes a misrepresentation. The policy as a whole remains a business policy. This means that the business policyholder (such as the employer) remains under a duty to disclose material facts.

LIFE INSURANCE ON THE LIFE OF ANOTHER

4.35 Where a consumer insures another person's life, it is common for the insurer to ask the person whose life is insured (L) about their health. If the policyholder acts reasonably, but L is dishonest or negligent, the insurer may seek to refuse the claim. The insurer cannot rely on the law of misrepresentation, because the duty not to misrepresent applies only to the policyholder. Instead, it is common for insurers to ask the policyholder to sign a warranty, stating that L's answers form "the basis of the contract".

4.36 As explained above, the draft Bill abolishes basis of the contract clauses. Instead, we recommend that representations by L should be treated as if they were misrepresentations by the policyholder. If the insurer can show that either the policyholder or L (or both) behaved deliberately, recklessly or carelessly, it should have the remedy appropriate for that kind of conduct.

INTERMEDIARIES

4.37 It is not unusual for consumers to blame intermediaries for the provision of inaccurate or misleading information to insurers.[7] For example, an intermediary might give poor advice about what to include on a proposal form, or write down the consumer's answers incorrectly. In an extreme case, the intermediary might ask the consumer to sign a blank form and then write in incorrect information, so as to maximise their commission.

4.38 In law, if an agent acts for the consumer, the consumer is held responsible for the agent's actions. This means that under our draft Bill, if the consumer's agent acted deliberately or recklessly, then the insurer could avoid the claim. If the agent acted carelessly, a compensatory remedy would be applied. This is the result even if the consumer had acted reasonably throughout the process. The consumer would then face the difficulty of bringing a claim against the intermediary.

4.39 On the other hand, if the intermediary acted as an agent for the insurer, the insurer would be responsible for their poor advice. The insurer would be required to pay the claim, and pursue its own remedy against the intermediary.

4.40 It is therefore important to know for whom an intermediary acts when helping a consumer complete an insurance application. Unfortunately, the law in this area is uncertain, as the courts and the FOS have struggled to apply early twentieth century cases to a rapidly changing market place.

4.41 In our consultation paper, we proposed a single bright line test to determine for whom an intermediary acts in transmitting pre-contract information.[8] We now think that it is not possible to have a single test. The issue must depend on a range of factors. Furthermore, different agencies may arise in respect of different tasks. For example, an intermediary may act for the consumer in obtaining a quote from the insurer, but act for the insurer in receiving premiums.

A new statutory code

4.42 In March 2009, we published a policy statement on the status of intermediaries which proposed a new statutory code, based largely on the existing law.[9] Where the current law does not provide clear answers, we have supplemented it by drawing upon FOS practice and industry understanding.

[7] In our original survey of 190 ombudsman decisions, 25 (13%) involved allegations about what an intermediary said or did. This continues to be an issue. In our recent survey, nine out of the 47 cases (19%) raised this allegation.

[8] Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134, paras 10.26 to 10.32.

[9] Reforming Insurance Contract Law, Policy Statement: The Status of Intermediaries: for whom does an intermediary act in transmitting pre-contract information from consumer to insurer? (March 2009).

4.43 We hope that the draft Bill will provide greater clarity in this difficult area. The ABI Code of Practice states that:

> whether an intermediary was acting as an insurer's agent in a transaction will depend on the facts and circumstances of each case.[10]

While this is clearly right, it provides insurers with little clarity over which facts and circumstances are relevant. The draft Bill aims to provide greater guidance, while retaining sufficient flexibility for the FOS and the courts to adapt to new arrangements.

4.44 The draft Bill states that an intermediary is considered to act for the insurer in three circumstances. Thus an intermediary acts for the insurer if:

(1) the intermediary is the appointed representative of the insurer;

(2) the insurer has given the intermediary express authority to collect the information as its agent (for example, through an express term in a terms of business agreement); or

(3) the insurer has given the intermediary express authority to enter into the contract on the insurer's behalf.

4.45 In other cases, the intermediary is presumed to act for the consumer unless it appears that the agent acts for the insurer. The issue would need to be determined by looking at all the circumstances, weighing the various factors in the case. The draft Bill sets out an indicative and non-exhaustive list of the factors that are relevant to the decision. The courts and the FOS will be able to consider new factors as the market changes.

4.46 These statutory principles would only have a direct effect in cases concerning faults in the transmission of pre-contractual information in consumer insurance. The draft Bill does not apply to other areas of agency (such as whom an intermediary acts for in collecting premiums) or to business insurance.

NO CONTRACTING OUT

4.47 The draft Bill prevents insurers from including terms in insurance contracts which would put the consumer in a worse position in respect of pre-contract disclosure and representations than the draft Bill permits.

[10] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009), para 3.4.2.

LEAD-IN TIME

4.48 For those insurers who are already complying with FOS guidelines and the ABI Code, we do not think this legislation will involve many changes in practice. We understand that insurers regularly review their application forms, processes and policy wording. We hope that our recommendations will be one factor to be borne in mind during these reviews, encouraging firms to ensure that their questions are as clear as possible and that they have removed references to basis of the contract clauses. We do not think that insurers need to wait for the legislation to be passed before doing this.

4.49 However, the draft Bill also provides a one year lead-in time, between being passed and coming into effect. This is to ensure that firms have time to carry out a final review of their processes in the light of the legislation.

PROPOSALS NOT INCLUDED

Warranties

4.50 The draft Bill does not reform the law of warranties, except to abolish "basis of the contract" clauses.[11] As we explained in our summary of responses, we have decided to postpone reform of consumer warranties and deal with them alongside the business reforms.

4.51 We look at this issue in more detail in Part 10. The main reason is that the need for reform is less pressing. Warranties in the strict legal sense are used only rarely in consumer insurance.[12] And if they are used unfairly, consumers have remedies not only under the FSA rules but also under the Unfair Terms in Consumer Contracts Regulations 1999. Furthermore, we think that the law on consumer warranties should be consistent with the law on business warranties. We have therefore decided against separate rules on warranties which would apply only in a consumer context.

A five-year cut-off

4.52 The consultation paper asked whether in consumer life insurance, insurers should be prevented from relying on a negligent misrepresentation after the policy had been in force for five years.[13] "Non-contestability" periods of this sort are applied in Australia, New Zealand and many US states, and we asked whether there was merit in the idea. Responses were split on the issue. Most insurers opposed the idea, on the ground that it might encourage consumers to take less care in filling out forms.

[11] This is a technical way in which insurers can turn representations on proposal forms into warranties. Such clauses are discussed further in paras 6.105 to 6.112 below.

[12] In our survey of 50 FOS consumer cases concerned with policy terms, we did not find any in which a warranty had been applied in a strict legal sense (see CP, para 7.26). However, warranties were regularly used in small business policies.

[13] CP, Proposal 12.23 (discussed in para 4.204).

4.53 Again, we look at this issue in more detail in Part 10. We accept that a five-year cut-off applying only to life insurance was an arbitrary measure, and not essential to the scheme. Although some insurers may decide to offer a five-year cut-off period to reassure consumers, we do not think it should be included within legislation. It is not part of our draft Bill.

Giving effect to industry written guidance

4.54 The FOS has stated that it will not permit an insurer to avoid a policy where to do so would contravene industry guidance or codes. We have therefore considered whether a court should also be able to prevent an insurer from taking advantage of remedies when it would be unreasonable to do so under industry guidance. We discuss the advantages and disadvantages of such a provision in Part 10.

4.55 We have decided, on balance, not to require the courts to take industry guidance into account. We do not wish to give the ABI or other industry bodies the power to bind non-members if this is thought to be inappropriate. Nor would we wish to discourage the industry from agreeing codes to be applied by the FOS. The courts may, however, continue to refer to relevant industry guidance as they would under the present law.

PART 5
CORE RECOMMENDATIONS I: DEFINITIONS AND DUTIES

5.1 In this Part and the next (Part 6) we consider the detailed recommendations which make up the core scheme for dealing with pre-contractual misrepresentations by a consumer to an insurer. Subsequent Parts consider our recommendations on group insurance, insurance on the life of another, intermediaries and amendments to other Acts.

5.2 We begin by looking at the definitions of “consumer” and “insurance”. We then discuss abolishing the consumer’s duty to volunteer information, and replacing it with a new duty. The new duty requires consumers “to take reasonable care not to make a misrepresentation to the insurer”. The duty arises “before a consumer insurance contract is entered into or varied”. We explain, in turn, the concept of a “misrepresentation”; the timing of the misrepresentation; and the nature of “reasonable care”. These recommendations are included in the first three clauses of the draft Bill.

5.3 After summarising the proposals made in our 2007 consultation paper, and the responses received, we explain our subsequent thinking. The background to our proposals is to be found in the consultation paper,[1] and further details of the responses to those proposals are given in the summary of responses to be found on our websites.[2]

5.4 Part 6 then discusses the remedies we think should be available to an insurer if the consumer’s duty not to misrepresent is breached. Part 6 also sets out our policy to prevent the parties from contracting out of the recommended scheme, either through basis of the contract clauses or through other contract terms.

THE DEFINITION OF A CONSUMER

5.5 In the consultation paper, we provisionally proposed that consumer insurance should be defined to cover contracts of insurance entered into by individual policyholders for purposes wholly or mainly unrelated to their businesses.

5.6 This means that in “mixed use” policies, where the insurance covers some private and some business use, one needs to look at the main purpose of the insurance. For example, insurance on a car used mainly as a taxi with only the occasional private trip would be considered commercial insurance. However, an individual who insured their home contents for £30,000 including £3,000 of business equipment would be considered a consumer.

[1] Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134 (referred to below as “CP”).

[2] Reforming Insurance Contract Law: a summary of responses to consultation on consumer issues (May 2008).

5.7 Of the 65 respondents, 27 agreed without comment. However, around 15 insurers urged us to follow the FSA definition, which excludes “mixed use” policies from the consumer regime.

The FSA approach

5.8 The FSA rules introduced in January 2008 define a consumer as a natural person who is acting for purposes that are “outside his trade or profession”.[3] This follows the definition used in the EU Directive on Distance Marketing of Consumer Financial Services.[4] The Distance Marketing Directive, in turn, follows the definitions used in a range of EU consumer directives, including directives on unfair terms and consumer sales.[5] The definition is also similar to that used in the Brussels Convention on Jurisdiction, which also talks about “a purpose which can be regarded as being outside his trade or profession”.[6]

5.9 How far does the FSA definition apply to products which involve some element of business use? In its guidance, the FSA states:

> If a customer is acting in the capacity of both a consumer and a commercial customer in relation to a particular contract of insurance, the customer is a commercial customer.[7]

This would suggest that an individual insuring a home which includes a home office would be classified as a commercial customer. Similarly, car insurance which allows “occasional business use” would be considered commercial insurance.

5.10 The Financial Services Consumer Panel argued that the FSA definition was too narrow, and gave insufficient protection to the self-employed. It fully supported the inclusion of “or mainly” in the definition of consumer insurance:

> We agree that consumers, who, for example, insure their home and set aside a room in their house for use as an office, should not find themselves excluded from the consumer regime.

[3] ICOBS Rule 2.1.1(3). We do not think there is a difference between an “individual” and a “natural person”. They are both intended to exclude companies and corporations.

[4] Directive 2002/65/EC, Art 2(d).

[5] The definition in the Unfair Terms in Consumer Contracts Directive is identical and was considered at length in our Report on Unfair Terms in Contracts (2005) Law Com No 292; Scot Law Com No 199. Three other Directives (Doorstep Selling 85/577; Distance Selling 97/7 and Consumer Sales 99/44) use a similar approach, though there are some minor variations in the words used.

[6] Brussels Convention on Jurisdiction and Enforcement of Judgments in Civil and Commercial Matters 1968, art 13. See also Civil Jurisdiction and Judgments Act 1982, Sch 8, rule 3(1).

[7] ICOBS Guidance 2.1.3.

5.11 Clearly, where possible, we should eliminate unnecessary differences between our definitions and those used by the FSA. We therefore held discussions with the FSA to explore this issue further. The FSA told us that the new ICOBS rules do not draw sharp distinctions between different types of insured. The principles and high-level standards set out apply to all customers. It appears that their definition is not intended to draw a sharp or legalistic distinction between people who do (or do not) insure a home office, for example. Our draft Bill will, however, give consumers considerably more protection than business customers with the result that the definition will be more significant.

Our recommendation

5.12 In most respects, the definition of "consumer" used in the draft Bill is similar to the one used by the FSA. In this context "individual" means the same as "natural person". It means that the insurance must be taken out by a person, rather than by a company or other corporate body. Also, both definitions focus on the policyholder's purpose at the time the insurance was bought.

"Business" or "trade, business or profession"?

5.13 The definition proposed in our consultation paper referred to "an individual's business". The FSA definition follows the EU directive on Distance Marketing of Consumer Financial Services and the Brussels Convention, and uses the phrase "trade or profession". We had originally considered "business", "trade" and "profession" to be synonymous. However, we accept that "trade or profession" may be more likely to include employees.

5.14 This is illustrated by the Scottish case of *Prostar Management Ltd v Twaddle.*[8] Here a professional footballer appointed a company to act on his behalf in contractual negotiations with his employers and in the commercial exploitation of his "identity". The footballer contended that he was the employee of a football club and thus did not have a trade or profession. The Sheriff Principal concluded that the footballer had the trade or profession of "professional footballer" and rejected any suggestion that the terms "trade" and "profession" had narrow or specialised meanings.[9]

5.15 We wish to avoid any unnecessary differences between the definition in our Bill, and the definitions used in the various European Union consumer law directives and the Brussels Convention. The draft Bill therefore uses the phrase "trade, business or profession", which includes employees.

[8] 2003 SLT (Sh Ct) 11.

[9] Above, para 14.

5.16 In interpreting this phrase, we would expect the courts to have regard to other case law on the issue.[10] For example, in *Standard Bank London Ltd v Apostolakis (No 1)* a married couple resident in Greece had entered into a foreign exchange agreement with a UK bank.[11] Considerable sums of money were involved (up to USD 7 million). The bank later closed several of the transactions, allegedly causing loss to the couple. The couple argued that their contracts were consumer contracts for the purposes of the Brussels Convention and the Unfair Terms in Consumer Contracts Regulations 1999. Mr Justice Longmore held that the couple were indeed consumers because they had acted outside of their respective professions (civil engineering and law respectively). The large scale of their transactions was not a determining factor. This illustrates that the issue is often one of fact, which the FOS and the courts will have to determine on a case by case basis.

Mixed-use policies

5.17 The only substantive difference between our definition and the FSA definition lies in the treatment of mixed-use policies. It is very common for vehicle insurance to cover a limited amount of business use, or for home contents insurance to cover a limited amount of business equipment. We think that it is important to protect individuals taking out these forms of insurance: indeed to exclude them would severely reduce the usefulness of our reforms. Furthermore, it is unlikely that the Financial Ombudsman Service (FOS) would be prepared to adopt such a narrow definition, thereby increasing confusion in this area. We therefore recommend taking the approach proposed in the consultation paper, by including within the application of our draft Bill individuals who enter into an insurance policy wholly or mainly for purposes unrelated to the individual's trade, business or profession.

5.18 As we said in the consultation paper, a self-employed window cleaner who uses a van mainly for window-cleaning would be taking out insurance in a business capacity. However, a self-employed contractor who used a car mainly for private use would insure the car as a consumer. We thought that an individual who takes out insurance to protect his or her income in the event of illness or disability would be considered a consumer, whether the income was gained through employment or self employment. However, if an individual were to insure an employee's health this would normally be for business purposes. The ABI has asked us to clarify the position of a private landlord who takes out house or legal expenses insurance. We think that letting a house commercially would be considered a business, even if it was not the landlord's primary business. This means that insurance for the purposes of the business would be business insurance.

5.19 **We recommend that the draft Bill should apply to insurance entered into by an individual for purposes wholly or mainly unrelated to the individual's trade, business or profession**.[12]

[10] See, for example, *Benincasa v Dentalkit Srl,* Case C-269/95 [1997] ECR 1-3767.

[11] [2002] CLC 933.

[12] See draft Bill, cl 1.

No exemption for high value goods

5.20 In the 2007 consultation paper we asked whether there was a need to exempt insurance on specific high value items (such as jets and yachts) from the consumer regime.[13] Most respondents thought that there was no need for special exemptions. It would add complexity and cause definitional problems. It was also pointed out that a house is often worth more than a yacht: the purpose for which an item is used is more important than its value. We agree.

5.21 Thus the draft Bill will apply to all consumer insurance, including insurance that is technically "marine" insurance because it covers yachts and other pleasure craft.

5.22 Some individuals may set up a limited company to own a yacht or jet. It is worth noting that to fall within the definition of consumer insurance, the policyholder must be an individual. Thus if the company takes out the insurance, it will not be considered consumer insurance, whatever its purpose.

5.23 **We recommend that there should be no exemption for high value goods**.

THE DEFINITION OF INSURANCE

5.24 The draft Bill does not define insurance. In 1980, the English Law Commission noted that there was no statutory definition of "a contract of insurance". However, the courts had no problems in determining the matter. The Commission thought that a statutory definition would be "unnecessary and undesirable".[14] We have reached the same conclusion. The matter should be left to the courts, applying common law principles.

5.25 The FSA is bound by the Financial Services and Markets Act 2000 (Regulated Activities) Order 2001, which largely adopts the common law approach to defining insurance, subject to some specific inclusions and exclusions. In practice, we think that the courts will be highly influenced by whether the contract is offered by an authorised insurance company.[15] However, the courts will not be bound by any specific inclusions or exclusions within the Regulated Activities Order in force at the time.

5.26 **We recommend that the definition of insurance should be left to the common law**.

[13] CP, para 12.3.

[14] Insurance Law: Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 2.7.

[15] As the Law Commission said in 1980, in cases of uncertainty the courts will have regard "to whether one of the parties is an authorised insurance company" (para 2.7).

ABOLISHING THE DUTY TO VOLUNTEER INFORMATION

5.27 In the consultation paper we pointed out that it is now generally accepted good practice that insurers should ask consumers questions about any material facts they wish to know. In consumer cases the range of factors relevant to the insurer's decision is well known and predictable. Insurers can be expected to ask specific questions about the great majority of issues, and may use general questions for the rest.[16] The FOS recognises this and will refuse to allow an insurer to avoid a policy for non-disclosure where no question was asked. We provisionally proposed that there should be no duty on a consumer proposer to disclose matters about which no questions were asked.[17]

5.28 Most respondents, including most insurers, agreed on the grounds that this reflects the FOS's existing approach and long established good practice. We therefore recommend abolishing the duty to disclose currently enshrined in sections 17 and 18 of the Marine Insurance Act 1906.

5.29 Section 17 states that an insurance contract:

> is based on utmost good faith, and if utmost good faith is not observed by either party, the contract may be avoided by the other party.

The section has been held to have an effect on both pre-contractual and post-contractual conduct by the insured. Pre-contractually, it has been interpreted to mean that a consumer insured is under a duty to volunteer material information, and that the penalty for failing to do so is avoidance.[18]

5.30 Our draft Bill does not change the law on post-contractual conduct.[19] However it does ensure that section 17 has no effect on a consumer's duty to give pre-contractual information or on insurers' remedies if they do not.

5.31 Section 18 deals specifically with non-disclosure. It places an obligation on the insured to disclose every circumstance which "would influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk". We regard this as no longer appropriate in consumer insurance.

[16] CP, para 4.20.

[17] CP, para 12.4.

[18] See *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469.

[19] We intend to publish further issues papers on this subject in 2010, looking at both the insurer's and the insured's duty of good faith after the contract has been formed.

5.32 As a matter of strict law, sections 17 and 18 apply only to marine insurance, and not to other forms of consumer insurance. However, the 1906 Act has been held to codify the common law. There are many judicial statements that the 1906 Act should be regarded as an authoritative source of common law principles in relation to non-marine insurance.[20] Therefore, under clause 2(5), the draft Bill makes two separate changes. It modifies any common law rule which is to the same effect as section 17, namely that a consumer insurance contract is one of utmost good faith. The clause also modifies section 17 itself, in so far as that section applies to consumer marine policies. Clause 11 then sets out the consequential amendments to sections 18 to 20 of the Marine Insurance Act 1906, and the common law rules to the same effect as those sections. We discuss this further in Part 9.

Insurers may still ask general questions

5.33 In the consultation paper we proposed that insurers should be allowed to ask general questions, but if a consumer acted reasonably in giving an incomplete answer, the insurer would be expected to pay the claim. Most respondents agreed with us. The FOS commented that "this reflects our existing approach, which itself reflects long-established good industry practice".

5.34 To take an example raised by a broker in their response: a buildings policy proposal might ask "are there any other hazards we should know about?" We think that a consumer who makes fireworks at home would be required to mention this fact. This hazard is so obvious and extreme that it is the sort of thing that a reasonable consumer would mention. However, it may not be reasonable to expect consumers to state that they lived near rivers: if insurers want information to assess flood risk, they should ask for it.

5.35 Thus the draft Bill does not require the insurer to ask specific questions. However, as we discuss below, in assessing the reasonableness of the consumer's response to a question, the court or ombudsman will take into account "how clear, and how specific, the insurer's questions were".[21] Furthermore, if an insurer asks a clear and specific question, the consumer is presumed to know that matter was relevant. This means that the onus would be on consumers to show that they did not act deliberately or recklessly in failing to give the information.

5.36 **We recommend that**:

(1) **There should be no duty on a consumer proposer to disclose matters about which no questions were asked**.[22]

[20] See *Pan Atlantic Insurance v Pine Top Insurance Co Ltd* [1995] 1 AC 501 at 518, by Lord Mustill.

[21] Draft Bill, cl 3(2)(c).

[22] See draft Bill, cl 2(4).

(2) **Insurers should be permitted to ask general questions, but in assessing the reasonableness of the consumer's response, the court or ombudsman may take into account the clarity and specificity of the question**.[23]

THE NEW DUTY TO TAKE REASONABLE CARE NOT TO MISREPRESENT

5.37 In the consultation paper we stated that consumers should be under a duty to answer the insurer's questions honestly, and to take reasonable care that their replies are accurate and complete. Equally, if consumers provide the insurer with information which was not asked for, they must do so honestly and carefully.

5.38 There was general agreement that consumers should be under a duty of this sort. The only issue was how to express such a duty in the draft Bill. Below we explain why we have taken the view that this duty is best expressed as a duty on the consumer "to take reasonable care not to make a misrepresentation to the insurer", as set out in clause 2(2).

5.39 If insurers and others wish to explain this duty to consumers we think it would be right to return to the words used in the consultation paper. Effectively, the draft Bill places a duty on consumers to answer insurers' questions honestly, and to take reasonable care that their replies are accurate and complete. And if consumers provide insurers with information which was not asked for, they must do so honestly and carefully.

5.40 **We recommend that consumers should be under a duty to take reasonable care not to make a misrepresentation to the insurer**.[24]

THE CONCEPT OF A "MISREPRESENTATION"

The consultation paper proposal

5.41 Under the current law, a reply which is either inaccurate or misleadingly incomplete is considered to be a misrepresentation. We asked whether we should state expressly what constitutes a misrepresentation, or whether we should leave this to the common law.[25] Most respondents thought we should define misrepresentation, especially if we could do so in a way that was clear, unambiguous and free from jargon. However, a substantial minority thought that the matter should be left to the common law. Lord Justice Rix suggested that any rules should be stated only "in barest outline"; he warned that we should be wary of "instant ossification".

[23] See draft Bill, cl 3(2)(c).

[24] See draft Bill, cl 2(2).

[25] CP, para 12.7.

5.42 In the consultation paper, we discussed the case law which shows that the courts have interpreted the concept of a misrepresentation widely and flexibly. For example, it is possible to make a misrepresentation by failing to correct a statement which becomes untrue after it is made but before the contract is entered into.[26]

5.43 An answer may also amount to a misrepresentation by omission, and we wanted to preserve this approach. For example, in *Roberts v Avon Insurance Co*,[27] the applicant was asked to complete the declaration, "I have suffered no similar loss, except…". The applicant left the space blank. This was held to constitute a representation that there had been no similar losses.

5.44 Similarly*, Winter v Irish Life Assurance plc*[28] shows how a failure to answer a question fully may constitute a misrepresentation. The applicant filled in a proposal form. Question 2 asked "are you at present suffering from any physical defect or illness?", but she left the answer blank. Question 3 asked "have you had any medical or surgical attention? If yes please give full details". The applicant answered "yes" and wrote "MECONIUM ILEUS (3 days old)". She did not mention that she had cystic fibrosis or that she had undergone a liver biopsy. The judge found that the two answers taken together could fairly be taken to mean that she was misrepresenting the facts by claiming that she was suffering from no physical defect or illness, and had had no significant medical attention since she was three days old.

The duty on renewal

5.45 The issue of "misrepresentation by omission" is particularly acute on renewals. In the consultation paper we pointed out that on renewal consumers are often asked whether there has been a change in circumstances. If a consumer has forgotten what questions they were asked the previous year, this may be hard to answer accurately. We noted that if insurers wanted to know whether anything had changed, it was good practice to supply the consumer with a copy of the previous information.[29]

5.46 In the consultation paper we decided, however, that it was not necessary to set out specific proposals on the issue. In law, a renewal is simply a new contract. We thought that the duty to take reasonable care to answer questions should apply equally on renewal.

[26] *English v Dedham Vale Properties Ltd* [1978] 1 WLR 93.

[27] [1956] 2 Lloyd's Rep 240.

[28] [1995] 2 Lloyd's Rep 274.

[29] CP, paras 4.205 to 4.213.

5.47 We have been asked how the draft Bill applies if the insurer writes to the consumer with a clear letter asking about recent changes, but receives no reply. May the insurer assume that nothing has changed? The ABI thought that the renewal process should be made as easy as possible, so as to prevent lapses in cover. It points out that, under the Government's new proposals on uninsured vehicles, a vehicle owner who allows a motor insurance policy to lapse commits a criminal offence.[30] Therefore, an insurer should not have to wait for the consumer's response before renewing a policy: it is better to ensure continuity of cover.

5.48 It was our intention that the duty in clause 2(2) should apply equally on renewal. If an insurer writes to a consumer asking if anything has changed, and the consumer fails to reply, leading the insurer to believe that nothing has changed, this may amount to a misrepresentation. Depending on the clarity of the question and the other circumstances discussed below, the misrepresentation might be made without reasonable care.

5.49 The existing case law, however, is concerned with a failure to answer specific questions on a form, rather than a failure to reply to a form altogether. Although the idea that an omission may amount to a misrepresentation is consistent with legal principles, it was suggested that this is not clearly established in the current law. The ABI expressed concern that a failure to reply to an insurer's letter on renewal might not amount to a misrepresentation. It asked for the issue to be clarified. As we discuss below, we accept that it would be helpful for the draft Bill to clarify this point.

Misrepresentations by omission: our recommendation

5.50 We think it is right to take a wide and flexible approach to the issue of what amounts to a misrepresentation. In particular, it should cover cases where an answer is misleadingly incomplete. However, if the applicant clearly refuses to answer a question, and the insurer nevertheless accepts their proposal, then this would not be a misrepresentation.

5.51 The draft Bill therefore preserves the concept of a misrepresentation as interpreted through the case law. This ties consumer insurance law to the concept of misrepresentation as it applies in general contract law, and ensures some consistency between the two regimes.

[30] See Department for Transport, "Public consultation on proposals to inform Regulations for the introduction and operation of a scheme for Continuous Insurance Enforcement of statutory motor insurance" (January 2009), available at http://www.dft.gov.uk/consultations/closed/motor/annexa.

5.52 For the avoidance of doubt, the draft Bill also includes an additional provision, which states that a consumer's failure to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation for the purposes of the draft Bill (regardless of whether or not it could be under the present law).[31] This would apply where an insurer writes to a consumer on renewal with a statement of the information it holds about the consumer, asking if anything has changed. It would also apply where the insurer takes information from the consumer over the phone, and then sends the consumer a statement of fact, asking the consumer to contact them if the statement is incorrect.

5.53 This provision simply states that a failure to respond to the request to amend particulars may amount to a misrepresentation. It will then be a question of fact, in all the circumstances of the case, whether the consumer's failure to respond is or is not reasonable. A failure to respond may be considered reasonable, for example, if the letter is confused or unclear, or if the insurer has failed to provide an adequate means of response.

5.54 **We recommend that the draft Bill should clarify that a failure to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation for the purposes of the draft Bill (whether or not it could be under the present law)**.[32]

THE TIMING OF THE MISREPRESENTATION: BEFORE THE CONTRACT WAS "ENTERED INTO OR VARIED"

5.55 The current duty to disclose (under section 18 of the 1906 Act) and the duty not to misrepresent (under section 20) only arise before the contract is concluded or varied. We recommend that this aspect of the law should be retained. As discussed below, the draft Bill does not impose duties after the contract has been agreed.

5.56 Clause 2(1) states that the duty not to misrepresent arises "before a consumer insurance contract is entered into or varied". This preserves the substance of the current law, though there is a change in terminology. As discussed, it is not necessary to refer specifically to renewals as in law a renewal is simply treated as a new contract.[33]

"Entered into"

5.57 The Marine Insurance Act 1906 uses slightly different terminology. Sections 18 and 20 refer to a contract being "concluded", which means that the negotiations are concluded and the contract is agreed. We think that the phrase "entered into" is clearer in this context, but the concept is the same.

[31] See draft Bill, cl 2(3).

[32] See draft Bill, cl 2(3).

[33] See, for example, *Lambert v Co-operative Insurance Society Ltd* [1975] 2 Lloyd's Rep 485.

"Or varied"

5.58 Under the current law, when a policyholder seeks to vary a contract of insurance, only information relating to the variation itself must be disclosed. There is no requirement to disclose information relating to the rest of the original policy.[34]

5.59 There appear to be very few cases concerning variations. We are not aware of any court cases which address the issue of variations in a consumer context. Nor did the issue arise in any of the ombudsman cases in our surveys. Despite the relative rarity of disputes over misrepresentations made prior to variations, however, we think that our reforms should deal with them. If the draft Bill failed to mention variations, such disputes could arise in the future, and we would not wish the 1906 Act to apply to them.

5.60 The remedies for misrepresentations made before a variation are discussed in paragraphs 6.101 to 6.104 and in Appendix B.

The draft Bill does not impose duties after the contract has been entered into

5.61 In the consultation paper, we considered what should happen where a consumer made an innocent mistake on an application form and later, after the contract has been entered into, discovered it was wrong. Should there be a duty to inform the insurer?

5.62 Under the current law, if a party has stated a material fact that was true at the time, but ceases to be true before the contract has been made, they must correct the statement. A similar principle would apply if someone says something in good faith, and then discovers the statement is wrong. However, once the contract has been made, the duty to disclose ends. There is no general or statutory obligation on the policyholder to inform the insurer of a change of circumstances. If an insurer wants to be notified about changing circumstances, it must add an express term to the policy. Such a term would be subject to review under the Unfair Terms in Consumer Contracts Regulations 1999.

5.63 In the consultation paper we proposed to retain the current law. If a consumer becomes aware before a contract has been formed that a statement on a proposal is untrue, the consumer should take reasonable care to correct the mistake.[35] However, this duty ceases after the contract has been entered into. At that point any requirement to provide information must be based on a policy term.

[34] *Lishman v Northern Maritime* (1875) LR 10 CP 179.

[35] As discussed above, it is not necessary to make explicit provision for this. The point is implicit within the definition of a misrepresentation.

5.64 Respondents queried how this would apply to clauses within critical illness policies. It is common for critical illness cover to start several months after the policy has been agreed. Where this happens, insurers often include express terms requiring consumers to notify the insurer of any changes in their health between completing the application and the date that cover starts. These terms generate some dispute.[36] Where an insurer rejects a claim on the basis of a failure to notify after the contract has been formed but before cover starts, the FOS will look at the decision critically. Ombudsmen are prepared to overturn a decision if the applicant had not been given a clear warning.

5.65 The answer is that such clauses would not fall within the draft Bill. Under the current law, insurers may include an express term in the contract requiring such disclosure. This would continue. We do not recommend a change to the current law in this regard.

5.66 **We recommend that the draft Bill should apply to misrepresentations made before the contract is entered into or varied**.[37]

THE NATURE OF "REASONABLE CARE"

5.67 In the consultation paper we proposed that if the consumer was acting honestly and reasonably when the misrepresentation was made, the insurer should pay the claim.[38]

5.68 The responses suggested that this is already a well-established principle within current insurance practice. Of the 62 consultees who addressed this issue, the great majority agreed with our proposal, usually without comment. The ABI thought that this was the right policy, although in its view legislation was not required:

> We have no objection to this formulation in relation to the honest consumer proposer. It is in line with current FOS decisions, industry practice and FSA regulation.

[36] In our survey of 190 final ombudsman decisions on non-disclosure, this issue arose in 27 critical illness cases. See CP, p 364.

[37] See draft Bill, cl 4(1).

[38] CP, para 12.12(1).

5.69 A few respondents pointed out that the proposed approach differed from the remedy available for an innocent misrepresentation in general contract law. In England and Wales, the court has a discretion under the Misrepresentation Act 1967 to award damages in lieu of rescission.[39] The appropriate measure of damages is uncertain: we did not find any cases in which the section had been raised in a consumer insurance case, or indeed where a consumer had been ordered to pay damages to any non-insurance business for an innocent misrepresentation. It is likely however that the measure of damages would be low,[40] probably no more than the difference between the premium paid and the premium that should have been paid. There was little enthusiasm for a damages remedy of this type.

5.70 We do not think that insurers should be granted a remedy where the consumer has acted honestly and with reasonable care, either under our draft Bill or the Misrepresentation Act 1967. The draft Bill specifies that the remedies set out in Schedule 1 are the only remedies available.[41]

The different ways in which a misrepresentation can be "reasonable"

5.71 In the consultation paper we discussed many ways in which an untrue or incomplete statement could be made reasonably. We said a misrepresentation might be reasonable where:

(1) the question was general, and a reasonable consumer would not understand that the insurer was asking about the particular information at issue;[42]

(2) the consumer had reasonable grounds for believing that what they said was true;[43]

(3) a reasonable consumer would not have appreciated that the fact was one which the insurer would want to know about;[44]

(4) it was reasonable for the consumer to assume that the insurer would obtain that information for itself;[45] or

(5) in particular, if the insurer indicated that it may obtain information from a third party, the consumer might reasonably think the insurer would obtain the information directly from the third party.[46]

39 Misrepresentation Act 1967, s 2(2). For a discussion of this remedy and the relevant Scots law, see our Issues Paper 1, Misrepresentation and Non Disclosure (2006), Appendix A.

40 See *William Sindall v Cambridge County Council* [1994] 1 WLR 1016.

41 See draft Bill, cl 4(3).

42 CP, para 4.32. This is also discussed above.

43 CP, para 4.120.

44 CP, para 4.121.

45 CP, para 4.143.

46 CP, para 4.144.

5.72 There will be other possibilities. For example, the form may be so badly designed that even consumers taking reasonable care would fail to notice the question.

5.73 We do not think it is necessary to specify the various ways in which a consumer may take reasonable care, but still make a statement which is inaccurate or misleading. Any such list would inevitably be incomplete. Instead the draft Bill sets out a general test of reasonable care.

A "reasonable person" or "a reasonable person in the circumstances of the insured"?

5.74 In the consultation paper we discussed what circumstances the judge or ombudsman should take into account in assessing whether the consumer acted reasonably. We considered whether the test should be subjective, and take into account the consumer's individual circumstances, or whether it should be objective, looking at what one would expect from a reasonable consumer in the market. In particular, should the judge or ombudsman take into account the consumer's age, education and knowledge of English?

5.75 We provisionally proposed that the main test should be objective, looking only at those issues that apply to normal consumers in the market, including the type of policy and the way the policy was advertised and sold. It would only take account of issues such as the consumer's age or knowledge of English in so far as these were known to the insurer.[47]

5.76 This provoked some controversy. The FOS pointed out that this was a harsher test than the one it currently employs. It feared that our proposals did not provide sufficient protection for those without financial capability. Age Concern thought that vulnerable elderly consumers would not be protected.

5.77 By contrast, many industry respondents opposed the idea that the test should take into account consumers' subjective circumstances where these were known to the insurer. The ABI viewed the proposal as placing an obligation on sales staff to assess whether or not the proposer fully understands the nature of the contract. It thought that insurers may refuse to deal with some applicants for fear that they may later argue that they were not in a position to contract. It was also suggested that some consumers might use their poor knowledge of English as an excuse.

5.78 However, the ABI Code of Practice adopts a similar test to our proposal. The Code states that insurers should pay the claim in full where:

> The customer has acted honestly and reasonably in all of the circumstances, including the customer's individual circumstances but only where these were known to the insurer.[48]

[47] CP, para 12.12 (2) and (3).

[48] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009), para 2.1.

5.79 We understand that this test is now accepted within the industry and by the FOS. Despite the fears expressed initially by some insurers, it has proved to be workable. On the other hand, we accept the point made by some consumers that the test is narrow. Consumers should not be expected to go to great lengths to show what the insurer actually knew. It should be enough if the insurer ought to have known about the individual's circumstances.

5.80 The draft Bill therefore takes account of the characteristics and circumstances of the actual consumer if the insurer was or ought to have been aware of them. The ABI has queried how the phrase "ought to have been aware" would be interpreted. We intend it to focus in a practical way on the understanding of the relevant staff at the time the reply is received. We do not intend that the insurer should be deemed to know information held by other departments, which is not available to the staff at the time. For example, the ABI asked about a situation where a customer applies for house insurance with a poor knowledge of English and is helped through the process, and then later applies for car insurance with the same insurer over the internet. We accept that internet sales are an automatic process. We do not think that there should be any obligation on an insurer to check previous records in these circumstances.

The standard depends on the type of insurance and the way in which it was sold

5.81 The level of time, trouble and care a consumer is expected to take in completing a proposal form must depend on the type of insurance and the way in which it was sold. We consider it needs to be assessed in the light of all the relevant circumstances including:

(1) the type of insurance and its target market;

(2) the insurer's explanatory material and publicity;

(3) how clear, and how specific, the insurer's questions were; and

(4) whether the consumer was using an agent.

5.82 For example, greater care would be required if the insurer told consumers to take an hour to check their records before completing the form, than if the insurer advertised the insurance as "quick to complete". Similarly, a higher level of care might be expected if the insurance was only sold through specialist brokers who were able to guide the consumer through the process.

5.83 In our recent survey of ombudsman cases, a consumer was taken through an application for household insurance over the phone. Her answers were recorded. When asked about previous claims, she mentioned a claim for a burst pipe. She was asked when it was and hesitated: she thought that it was about two years ago. She was then asked how much it was for. Again she hesitated, and eventually suggested that it was "about £7,000… £8,000". When it later transpired that the claim was for £12,800 the insurers avoided the policy. In a case like this, the standard of reasonable care should take account of the fact that the insurer did not ask the consumer to check her records. Although her hesitations should have alerted the insurer to the fact that she was uncertain as to the amount, the insurer continued to accept an answer given from memory.

5.84 As discussed above, insurers may use general questions if they wish, but if they do, they run the risk that consumers may act reasonably but still fail to give the requisite information. Thus if the insurer wishes to know whether the consumer has ever consulted a doctor about a mole, it would be better to ask a specific question than to rely on a general question about whether the consumer has sought medical advice about "any ailment".

5.85 Although we think that it would be helpful to provide guidance by setting out these factors in the legislation, we do not think the list should be exhaustive. Instead, the test should be flexible, so that it can develop as the market changes.

Proving lack of reasonable care

5.86 In the consultation paper, we proposed that the burden of showing that a consumer proposer made an unreasonable misrepresentation should be on the insurer. Many insurers expressed concern about this, arguing that it would be unduly onerous for them to show what the consumer knew. These concerns appear to be based on a misunderstanding. Insurers would not be required to show what a consumer knew. They would only be required to show what a reasonable person in the circumstances would have known.

5.87 Under the draft Bill, as at present, the insurer would be required to prove that the consumer made a misrepresentation: that is that the consumer made a statement which was untrue or misleading. In most cases, little additional evidence would be required to show that the misrepresentation was unreasonable. Usually the insurer will provide a copy of the proposal form and argue that the question was clear. Courts and ombudsmen will then use their own understanding and judgment to decide how a reasonable person would have acted. We do not think that issues of reasonableness will turn on the burden of proof.

Can a consumer be "reasonable" but dishonest?

5.88 In some cases, a consumer may have more than average knowledge or understanding. For example, whereas someone with medical knowledge would be likely to understand what is meant by "paraesthesia", the average consumer might not. It is therefore possible, at least in theory, that someone might act "reasonably" if one applies the standards of an average consumer, but may nevertheless act dishonestly given his or her greater level of understanding.

5.89 We would not wish the draft Bill to leave readers in any doubt that dishonest misrepresentations are unacceptable: an insurer has a remedy where it has been induced by a dishonest misrepresentation to enter into an insurance contract. We therefore think that the Bill should specify that a dishonest misrepresentation is always unreasonable. This would prevent a consumer who has lied from arguing that another, less well-informed consumer, might have made a reasonable mistake about the same issue.

5.90 **We recommend that**:

(1) **Where a consumer acts honestly and with reasonable care when making a misrepresentation, the insurer should not be granted a remedy for that misrepresentation**.

(2) **The standard of reasonable care should be that of a reasonable consumer, and should only take into account individual circumstances if the insurer was or ought to have been aware of them**.[49]

(3) **The degree of care a consumer is expected to take in completing a proposal form should be assessed in the light of all the relevant circumstances**.[50]

(4) **The draft Bill should provide guidance on the type of factors that are relevant, such as the type of insurance, the insurer's explanatory material, whether an agent was used and the clarity of the questions**.[51]

(5) **The draft Bill should specify that a dishonest misrepresentation is always to be taken as showing a lack of reasonable care**.[52]

[49] See draft Bill, cl 3(3) and (4).

[50] See draft Bill, cl 3(1).

[51] See draft Bill, cl 3(2).

[52] See draft Bill, cl 3(5).

PART 6
CORE RECOMMENDATIONS II: REMEDIES AND CONTRACTING OUT

6.1 In Part 5 we explained why we think that consumers should be under a duty to take reasonable care not to make a misrepresentation to the insurer. In this Part we set out the remedies which we recommend should be available to an insurer when this duty has been breached.

6.2 Clause 4 of the draft Bill provides that the insurer is entitled to a remedy if the representation breached the duty set out in clause 2, and the insurer can show that the representation made a difference.

6.3 Under clause 5 of the draft Bill, there are two types of remedy. We recommend that if the misrepresentation was "deliberate or reckless" the insurer should be entitled to avoid the contract and refuse all claims. In most cases, the insurer would be entitled to keep the premiums. However, if the representation is a careless one, then the insurer should be entitled to a compensatory remedy, the nature of which depends on what the insurer would have done had it been given an accurate answer. We explain the difference between "deliberate or reckless" misrepresentations and careless ones (as defined in clause 5) and consider the remedies set out in Schedule 1 of the draft Bill.

6.4 In this Part we also recommend controls to prevent the parties from contracting out of the scheme to the detriment of the consumer, either through basis of the contract clauses (clause 6) or other contract terms (clause 10).

6.5 Later Parts consider group insurance, insurance on the life of another, intermediaries and the amendments required to other Acts.

THE INSURER'S REMEDIES FOR MISREPRESENTATION

6.6 Clause 4(1) sets out the circumstances in which an insurer is entitled to a remedy for a misrepresentation. There are two requirements. First, the misrepresentation must breach the duty set out in clause 2, and discussed in Part 5. Second, the insurer must also show that the misrepresentation made a difference. As we discuss below, this means that if the insurer had known the truth, it would not have entered into the contract at all, or would have done so only on different terms.

SHOWING THAT THE MISREPRESENTATION MADE A DIFFERENCE

Inducement

6.7 Under current law, an insurer is entitled to bring a claim for misrepresentation only if it can show that it has been "induced" to enter the contract. This test was first set out in the case of *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*.[1] It means that the insurer must show that without the misrepresentation, it would not have entered into the policy, either at all or on the same terms. In other words, had the insurer known the truth, at least one term of the policy would have been different.

6.8 At one stage, there was some debate about whether inducement could be presumed.[2] Recent case law has confirmed that it cannot be presumed. The insurer must prove inducement on the balance of probabilities - though it may sometimes be possible to infer inducement from the facts in the absence of direct evidence.[3]

6.9 In the consultation paper, we proposed to retain this test, and most consultees agreed with us.[4] The draft Bill should require the insurer to show that without the misrepresentation it would not have entered into the contract at all, or would have done so only on different terms. This preserves the current law, and we would expect the courts to interpret the provision in the light of existing case law. We would expect that in most cases the insurer would provide underwriting guidelines or evidence from an underwriter to show what had been done in similar circumstances.

Materiality

6.10 The current law provides that a misrepresentation is only actionable if it is "material", in that it would influence the judgment of a hypothetical prudent underwriter.[5] We have not preserved this concept. Under the draft Bill, it is enough for the insurer to show that it was induced by the misrepresentation, and that a reasonable consumer would have provided the information. The insurer does not also have to show that the misrepresentation would have influenced other underwriters in the market.[6]

1 [1995] 1 AC 501.

2 See *St Paul Fire and Marine Insurance Co Ltd v McConnell Dowell Constructors Ltd* [1995] 2 Lloyd's Rep 116.

3 See *Assicurazioni Generali v Arab Insurance Group* [2002] EWCA Civ 1642, [2002] All ER (D) 177 and *Laker Vent Engineering Ltd v Templeton Insurance Ltd* [2009] EWCA Civ 62.

4 CP, para 12.6.

5 Marine Insurance Act 1906, s 20(2).

6 See CP, para 12.15 and the discussion at paras 4.125 to 4.129.

6.11 As we explained in the consultation paper, we do not wish to prevent insurers from developing niche markets, by selecting risks on the basis of facts which seem irrelevant to other insurers.[7] The great majority of those responding agreed. As Aegon UK pointed out, what is material to one insurer may not be material to another: therefore, it should be "open to insurers to insure on whatever basis they decide".

6.12 **We recommend that**:

(1) **To receive a remedy for misrepresentation, the insurer must show that without the misrepresentation, it would not have entered into the contract at all, or would have done so only on different terms**.[8]

(2) **The insurer need not show that the matter would have been relevant to another hypothetical prudent insurer in the market**.

DISTINGUISHING BETWEEN "DELIBERATE OR RECKLESS" AND "CARELESS" MISREPRESENTATIONS

6.13 Clause 5 distinguishes between "deliberate or reckless" misrepresentations and "careless" ones. We recommend that where the misrepresentation is deliberate or reckless, the insurer should be entitled to avoid the contract and refuse all claims. In most cases, the insurer would also be entitled to keep the premiums. However, if the representation is careless, then the insurer should be entitled to a compensatory remedy, which depends on what the insurer would have done had it received a careful and accurate answer to the question.

6.14 Below we begin by discussing the definition of "deliberate or reckless", and the remedies available for deliberate or reckless misrepresentations. We then consider careless misrepresentations and compensatory remedies.

DEFINING "DELIBERATE OR RECKLESS"

6.15 In our first Issues Paper we described "deliberate or reckless" misrepresentations as "fraudulent". This drew concern. Many insurers associated the term fraud with criminal standards of proof, and thought they would not be able to prove fraud. It is not our intention that the insurer's task of proving that a misrepresentation was made deliberately or recklessly should be unduly onerous, or require an exceptionally high standard of proof.

6.16 In the consultation paper, we proposed that rather than relying on common law concepts of fraud we should set out a specific test. We looked for a test which would identify cases involving morally reprehensible behaviour.[9] Here it is appropriate to impose the remedy of avoidance, which does more than simply compensate the insurer for the loss. The remedy should also indicate society's disapproval of the behaviour and discourage such behaviour in the future.

[7] See CP, paras 4.125 to 4.129, and proposal 12.15.

[8] See draft Bill, cl 4(1)(b).

[9] See CP, para 4.50.

"Deliberate"

6.17 We said that making a deliberate misrepresentation involves knowing that a misrepresentation is untrue and relevant.

"Reckless"

6.18 Recklessness is a difficult concept. In the case law it is described as making a statement without caring whether it is true or false.[10] In this context, "not caring" is different from acting "carelessly", by not taking sufficient care to check the facts. It requires a lack of interest in whether a statement is true, or whether a statement is relevant.

6.19 In the consultation paper we explained that in practical terms, a misrepresentation would be considered reckless when the consumer *must have known* that what they said was inaccurate and that the inaccuracy mattered. It would not apply simply because they *should have known* it was inaccurate and relevant: that would be careless. We explored ways in which we could explain the concept more precisely, but concluded that it was best left to the common law.[11]

6.20 Most respondents agreed with us, although a few thought that greater clarity was needed. The FOS asked for a more detailed definition, as "there is a very poor understanding of the definition of 'reckless' in law amongst insurance practitioners". In its response, the ABI suggested further guidance could be given by regulatory bodies or by the ABI. The ABI has since published a code to cover this difficult area which explains the concept as acting "without any care".

Knowledge of relevance

6.21 The most controversial aspect of our proposed test was whether a consumer acted deliberately or recklessly if he or she realised that the answer was strictly inaccurate but did not realise that the inaccuracy was relevant. Ten insurers expressed concern that it would be too difficult to prove that a consumer knew that (or was reckless as to whether) the matter was relevant.

6.22 The problem most frequently arises where consumers are asked fairly general questions, such as requests to list all the times they have been to the doctor in the last five years. Often the form provides only limited space for an answer. In such circumstances, it is common for consumers not to list trivial complaints but to confine their answers to what they think is relevant.

6.23 The issue was considered by the Privy Council in *Zeller v British Caymanian Insurance Co Ltd*.[12] Here, a consumer knew that he had consulted a doctor and received a slightly raised cholesterol reading but did not disclose this information to the insurers. The court found that he was still acting in good faith because he did not realise it was relevant. Lord Bingham commented that where an applicant is asked whether he had recently consulted a doctor:

[10] *Derry v Peek* (1889) LR 14 App Cas 337.

[11] CP, para 12.9

[12] [2008] UKPC 4, [2008] All ER (D) 219. The case is decided under Cayman Law, which follows the common law approach.

> he is expected to exercise his judgment on what appears to him to be worth disclosing. He does not lose his cover if he fails to disclose a complaint which he thought to be trivial but which turns out later to be a symptom of some much more serious underlying condition.[13]

6.24 As discussed in Part 3, the Multiple Sclerosis Society told us that it is common for consumers to omit medical details which they thought were trivial at the time, only to find in retrospect that the insurer regarded them as relevant early symptoms of multiple sclerosis.

6.25 In our study of FOS cases we found a more difficult case. The consumer suffered from an eating disorder. One of the symptoms of her condition was that she found it hard to accept the seriousness of her predicament, or to recognise that it was a psychiatric condition. She failed to mention it in response to a question about psychiatric illness, and later developed multiple sclerosis. The ombudsman found that if the insurer had known of the problem it would have excluded mental illness and increased the premium by 50%. She received two thirds of the normal claim.

6.26 At one level, the consumer knew that she suffered from an eating disorder. A reasonable consumer would have realised that such a matter was relevant, but this particular consumer failed to recognise its relevance, given her individual circumstances. The consumer clearly acted unreasonably, but we do not think that she acted dishonestly because she did not realise that her condition was serious and relevant. In a case such as this, we think that the insurer should be given a remedy, but that the remedy should not be avoidance. Avoidance involves a penal element, designed to show society's disapproval of the consumer's conduct and to discourage wrongdoing. In a case like this, we agree with the FOS that the insurer should be given a compensatory remedy, which aims to put the insurer in the position in which it would have been had it known the information.

6.27 After some debate on these issues, in 2008 the ABI decided to adopt a similar definition of "deliberate or without any care" to the one proposed in our consultation paper.[14] Consumers act deliberately if they know a statement is untrue and know that it is relevant. They act recklessly if they know that a statement is untrue, and do not care if it is relevant – or if they know that a statement is relevant, but do not care if it is true. It is also reckless to make a statement not caring if it is true *and* not caring if it is relevant. However, if consumers say something which they genuinely believe to be true, this would at most be careless, whether or not they put their minds to whether it was relevant. It would also be careless if they failed to put their minds to whether something was true, if they genuinely thought that it was irrelevant.

6.28 We agree with the ABI that this is the right approach.

[13] [2008] UKPC 4, [2008] All ER (D) 219, para 20.

[14] ABI Guidance, "Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products" (January 2008), para 2.1.

Our recommended definition

6.29 The definition in the draft Bill is the same in content as the one adopted in the ABI's 2008 Guidance, and now set out in the 2009 ABI Code of Practice.[15] This is the basis of current FOS decision-making and has been accepted by insurers.

6.30 In the draft Bill, clause 5(2) states that the insurer may avoid the policy and refuse all claims if it can show that, on the balance of probabilities, the consumer:

(1) knew that the statement was untrue or misleading, or did not care whether or not it was untrue or misleading, and

(2) knew that the matter was relevant to the insurer, or did not care whether or not it was relevant to the insurer.

6.31 We have followed the common law in describing acting recklessly as "not caring" whether a statement is untrue or misleading, or "not caring" whether the matter was relevant to the insurer. This borrows from the case of *Derry v Peek* and needs to be understood within the existing case law.[16] It denotes a lack of interest in the truth of what one is saying, rather than acting carelessly by not checking the facts.

6.32 We have also followed the consultation paper proposal and accepted industry guidance by stating that consumers only act deliberately or recklessly if they realise that the matter was relevant to the insurer, or did not care whether it was relevant. By knowing that "a matter was relevant", we mean that the consumer thinks it is something the insurer would want to know. The consumer does not need to know that the matter would have a decisive influence on the terms of the policy.

6.33 **We recommend that the insurer may avoid the policy and refuse all claims if the consumer acted deliberately or recklessly. That is, if the consumer**:

(1) **knew that the statement was untrue or misleading, or did not care whether or not it was untrue or misleading, and**

(2) **knew that the matter was relevant to the insurer, or did not care whether or not it was relevant to the insurer**.[17]

Shifting the burden of proof

6.34 We think that it is right that it should be for the insurer to show that the consumer acted deliberately or recklessly. However, it is not our intention that this task should be unduly onerous. In the consultation paper we suggested that the insurer's task of proving fraud might be helped by two presumptions. These presumptions are that the consumer knew:

(1) what someone in their position would normally be expected to know; and

[15] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009), para 2.1.

[16] (1889) LR 14 App Cas 337.

[17] See draft Bill, cl 5(2).

(2) that where the insurer asked a clear question, the issue was relevant to the insurer.

6.35 Thus once the insurer has shown (for example) that a smoker would normally be expected to know that they smoked, and that the question on the subject was clear, the onus of proof would shift to the consumer. The consumer would need to show why they had not acted deliberately or recklessly in making the representation. Most respondents thought that these presumptions would be useful. The ABI described them as "vital presumptions needed to assist insurers".

6.36 We therefore recommend that the legislation should include these presumptions. Clause 5(5) states that it is to be presumed, unless the contrary is shown:

> (a) that the consumer had the knowledge of a reasonable consumer; and
>
> (b) that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer.

6.37 Note that it is always open to the consumer to rebut these presumptions by providing evidence about his or her state of mind. Take an example in which the consumer failed to mention a heart attack, in response to a clear and specific question. Given that most reasonable people would know that they had suffered a heart attack, the insurer does not need to prove that the consumer acted deliberately or recklessly. Instead, it is up to the consumer to show lack of knowledge of the heart attack or lack of understanding of the question. For example, the consumer could explain that the doctor failed to tell them about a minor heart attack, or provide other evidence of lack of understanding.

6.38 If the court or ombudsman believed this evidence, it would mean that the insurer would be given a compensatory remedy. In other words, the insurer would only be entitled to avoid the policy if it would not have taken the risk at all. It could not avoid where it would have charged a higher premium or imposed different terms.

6.39 **We recommend that the insurer should have to show, on the balance of probabilities, that the consumer acted deliberately or recklessly. However, the task should be made easier by two presumptions. These are that the consumer**:

(1) **had the knowledge of a reasonable consumer; and**

(2) **knew that the matter was relevant, if the insurer asked a clear and specific question**.[18]

[18] See draft Bill, cl 5(5).

DELIBERATE OR RECKLESS MISREPRESENTATIONS: MAY THE INSURER RETAIN THE PREMIUM?

6.40 At present, when an insurance policy is avoided the insurer will normally return the premium. The FOS states that, where a consumer acts "fraudulently", the insurer may keep the premium, but the burden of proving "fraud" is extremely high. In our survey, we did not find any cases where premiums had been kept in this way.

6.41 In the consultation paper we argued that where a consumer had acted deliberately or recklessly, it was important to send a strong social message that such behaviour was unacceptable. We therefore asked whether, in cases of deliberate or reckless misrepresentation, the insurer should be entitled to retain the premium.[19]

6.42 Most respondents thought that insurers should be entitled to retain premiums. They felt this was appropriate to show society's disapproval, to deter wrongdoing and to compensate the insurer for the administrative costs it had incurred. That said, it was not an issue which generated strong feelings. Insurers seemed prepared to continue their current practice, under which premiums are generally returned.

6.43 A few respondents thought that allowing insurers to keep premiums would operate harshly in some cases. Jonathan Hirst QC and the Financial Services Consumer Panel argued that there should be discretion for the courts or the FOS to order repayment in appropriate circumstances. It was also pointed out that we failed to explain how the principle would apply to investment policies.

Our recommendation

6.44 Following consultation we have reached the view that, as a general rule, where a consumer has made a deliberate or reckless misrepresentation the insurer need not return the premiums paid. This would demonstrate society's disapproval of such behaviour. However, we accept that the rule might operate harshly in some circumstances. As we discuss below, we are particularly concerned that the rule may be overly harsh where life insurance policies include an investment element. We were also concerned about joint policies, where one policyholder makes a deliberate misrepresentation and the other acts honestly and reasonably.

6.45 Our conclusion, therefore, is that the insurer may keep any premiums paid, except to the extent that this would be unfair to the consumer. If so, the court or ombudsman should have a discretion to order that some or all of the premiums are returned to the consumer.

[19] CP, para 12.10.

6.46 This recommendation differs from the current law, as set out in section 84 of the Marine Insurance Act 1906. This section states that where the policy is avoided by the insurer from the commencement of the risk, the premium is returnable, provided there has been no fraud or illegality by the assured.[20] The draft Bill states that section 84 must be read subject to the new provisions on retaining premiums.[21]

6.47 **We recommend that where the consumer has made a deliberate or reckless misrepresentation, the insurer need not return any of the premiums paid, except to the extent that it would be unfair to the consumer to retain them**.[22]

Examples of when it may be unfair to retain premiums

6.48 Below we give examples of cases in which it might be unfair for the insurer to keep some or all of the premiums paid. However, these examples should not be seen as limiting the power of the courts or the FOS to do justice in the few difficult or hard cases that come before them. If there are large numbers of cases raising similar issues, we think that the FOS is best placed to issue guidance on how it intends to deal with the issue.

Investment-type life insurance

6.49 One example where it appears unfair to keep premiums is where life insurance has an investment element, as in an endowment policy. Take an example where a consumer paid £2,000 a year into a policy, on the basis that each year £1,800 was paid into a savings scheme. After 10 years, if the policy were surrendered it would be worth £25,000, which represents the value of the investment. However, if the insured died, the estate would receive £30,000, representing an additional "insurance" element. In our example, the consumer dies and is found to have lied about health issues. Clearly, the consumer is not entitled to £30,000 but we think it may be appropriate to repay the £25,000 investment.

6.50 The current law on this is not entirely clear. We think the court could only order the return of the £25,000 investment if there were two severable contracts: one for investment and one for insurance. Otherwise the correct valuation under current law would be to return the £20,000 premium paid with interest. In some circumstances, this may be more than the value of the investment. A fall in the stock market, for example, may mean that the policy is only worth, say, £15,000.

6.51 It is difficult to be prescriptive about exactly what should happen in this case, given the variety of possible products on the market. Some contracts may be severable; others may be indivisible. One would not wish the consumer to lose contributions made to a savings product that was not affected by the misrepresentation. On the other hand, it seems wrong that a dishonest consumer should be better off than an honest one, if the investment was worth less than the premiums paid. We think the court should have enough flexibility to do justice in such a case.

[20] MIA 1906, s 84(3)(a).

[21] Sch 1, para 17.

[22] See draft Bill, Sch 1, para 2.

Joint policies

6.52 Another example is where two policyholders take out a joint policy: one makes a deliberate misrepresentation and the other acts honestly and reasonably. Under the current law, if it is a joint policy (as opposed to a composite policy) the insurer may refuse all claims under the policy. We intend to retain this aspect of the law.

6.53 The issue of returning premiums becomes important in joint lives policies, where the premiums may have been made over many years. Take an example where a husband and wife take out a joint policy, to pay out on the first death. The wife has filled in the application form correctly, but the husband lied about his health. The husband dies. Under the current law, the insurer may avoid the policy and refuse to pay any claims under it. However, in practice, the premiums are generally returned in full (with interest), and the FOS will often give the wife the alternative of continuing the policy on her own life. We think that if the wife had contributed to the premiums, and had not colluded in the dishonesty, it would be fair to repay premiums to her (at least to the extent of her own contributions).

CARELESS MISREPRESENTATIONS

6.54 Under the draft Bill, those misrepresentations which are made without reasonable care, but which are not deliberate or reckless, are termed "careless misrepresentations".

6.55 This category has been known by a variety of labels. In 2005, the FOS described such misrepresentations as "inadvertent". However, in the consultation paper we expressed concern that the term "inadvertent" might suggest only mild carelessness.[23] Instead we described the category as "negligent" – a term which was later adopted in the ABI Code of Practice.[24]

6.56 In drafting the Bill, however, we were concerned that the term "negligent misrepresentation" (and with it "negligent misstatement") has become closely associated with a particular branch of tort law[25] – that stemming from the case of *Hedley Byrne & Co Ltd v Heller & Partners Ltd*.[26] We do not intend to import a definition used elsewhere into our draft Bill. Therefore, to avoid confusion, we have used the term "careless" misrepresentation. We do not intend any difference in substance between the words "negligent" and "careless". The only reason for using the term "careless" is to emphasise that this is a new, stand-alone category. It is not intended to draw on any existing concepts or case law within the law of negligence.

6.57 Careless misrepresentations cover a broad swathe of conduct where the policyholder failed to take sufficient care to understand what the insurer wanted to know or to check their facts. Note that there is no need to define careless misrepresentations: a misrepresentation is careless if the consumer has not taken reasonable care but has not acted deliberately or recklessly.

[23] CP, para 4.71.

[24] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009), para 2.1.

[25] Or, in Scots law, delict.

[26] [1964] AC 465.

COMPENSATORY REMEDIES FOR CARELESS MISREPRESENTATIONS

Consultation paper proposals

6.58 In the consultation paper we argued that although an insurer should have a remedy for a careless misrepresentation, the right to avoid the whole policy often went further than was necessary to protect the insurer. As we explained in Part 2, avoidance is a harsh remedy. It would, for example, allow an insurer to refuse a claim for cancer because it was not told about hearing loss - even if, had the insurer known about the hearing loss, it would only have excluded hearing claims from the policy.

6.59 Instead we proposed that the law should provide a compensatory remedy which aims to place the insurer in the position in which it would have been had it known the true facts. In particular:

(1) Where the insurer would have excluded a particular type of claim, the insurer should not be obliged to pay claims that would fall within the exclusion.

(2) Where an insurer would have imposed a warranty or excess, the claim should be treated as if the policy included the warranty or excess.

(3) Where an insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium. For example, if an insurer should have charged £2,000, but only charged £1,000, the consumer would receive half their claim. This is often referred to as a "proportionate" settlement.

(4) Where an insurer would have declined the risk altogether, the policy may be avoided, the premiums returned and the claim refused. This would be equivalent to "avoidance" under the current law.[27]

Respondents' views

6.60 Around three-quarters of those who addressed this issue agreed with the scheme set out above. The FOS commented:

> In our experience, over a number of years, the insurance sector has no problems with applying this remedy (ie re-underwriting policies on altered terms and/or making partial claim settlements) when it has been decided by us. We therefore see no reason why proportionality could not be enacted into law. It is also our experience that consumers also recognise this approach as fairer than outright avoidance in cases of non-dishonest misrepresentation.

[27] CP, para 12.19.

6.61 The Chartered Insurance Institute agreed:

> As a professional body with a remit to protect the public by guiding the profession, we concur with the Commissions' approach regarding this core area of the consultation. We cite the many controversial cases where insurers have denied claims or avoided policies arising from innocent or unintentional misrepresentations, so the logic around the proportionality test and compensatory remedies to align more closely the compensation charged on the consumer with the harm suffered by the insurer is welcomed.

6.62 However, many respondents raised possible practical problems. As the Jardine Lloyd Thompson Group put it, the remedy is "easy to say but difficult to put into practice". A minority disagreed with the proposal on the basis that the problems would be too great.

Our recommendation

6.63 Compensatory remedies are now an accepted part of FOS decisions, and are widely regarded as workable and just. We think they should be included in legislation.

6.64 The basic principle is simple. It involves looking at what the insurer would have done if the consumer had not been careless but had instead taken reasonable care to give an accurate and complete answer to the question. As stated in Schedule 1, paragraph 4, the remedies are based on what the insurer would have done had the consumer complied with the duty set out in clause 2(2). Had this duty been complied with, the insurer would have known the relevant information, and may have reacted in one of three ways: it may not have entered into the contract at all; it may have changed one or more policy terms not related to the premium; or it may have charged a higher premium. We think the insurer should only be entitled to avoid the contract if it would not have entered into the contract at all. If the insurer would have contracted on different terms, the contract should be treated as if it were made on those terms. If the insurer would have charged more, it should pay a proportion of the claim.

6.65 Of course, the insurer might have made several changes. It might have added one or more contract terms (such as an exclusion or higher excess) and also charged more. For example, an insurer might have charged more for life insurance and refused to provide insurance for total permanent disability. If so, both changes would apply. Thus the insurer would not be required to meet any claims for total permanent disability and need pay only a proportion of the life insurance claim.[28]

[28] In some cases, the insurer might have offered a lower ceiling of cover and charged less for the policy as a result. For example, it might have declined to provide total permanent disability cover, and therefore charged a lower overall premium. Under the draft Bill, the insurer is entitled to apply the less favourable terms. If the contract is severable, the insurer should return the additional premium. If the contract is not severable, it may keep the additional premium.

6.66 **We recommend that where the consumer has made a careless misrepresentation, the insurer is entitled to a compensatory remedy as follows**:

(1) **If the insurer would not have entered into the contract on any terms, the insurer may avoid the contract (but must return the premiums);**

(2) **If the insurer would have entered into the contract on different terms (apart from those relating to the premium), the contract is treated as if it were made on those terms;**

(3) **In addition, if the insurer would have charged a higher premium, the insurer may reduce the amount of the claim proportionately**.[29]

6.67 Although compensatory remedies are far from new, until recently they have been applied only occasionally. They have mainly been applied by the FOS, following a complaint. In the last few years, however, compensatory remedies have become an accepted part of consumer insurance practice, and are now more likely to be applied by claims handlers themselves.[30]

6.68 They therefore need to be explained in greater detail. Below we discuss the principles behind compensatory remedies. In Appendix B we explore particularly complex cases: where the consumer makes a misrepresentation when varying the contract; or where the consumer has insured the same loss twice; or where the consumer later recoups part of their loss from a third party.

Explaining compensatory remedies in more detail

6.69 In the draft Bill, the compensatory remedies in relation to a claim are set out in Schedule 1, paragraphs 3 to 8. A "claim" in this context is intended widely, and simply means that the insured has asked for a benefit under the policy. It may, for example, relate to a benefit under an annuity policy. The insurer may have paid the claim and then discovered the misrepresentation, or may have discovered the misrepresentation and then refused to pay the claim. Disputes over claims may be distinguished from disputes over whether the contract should continue in respect of future risks, which we discuss below.

6.70 In most cases, the process of applying compensatory remedies is relatively straightforward. Below we give a standard example, taken from our recent survey of ombudsman decisions.

[29] See draft Bill, Sch 1, paras 4 to 8.

[30] In our original survey of ombudsman cases, the insurer had offered to pay a proportion of the claim in only four cases (2%). In our recent survey of ombudsman decisions, insurers offered to pay a proportion of the claim in five out of 47 cases (11%).

> Mr F took out a protection plan covering life insurance, critical illness insurance and provisions which allowed him to waive the premiums in the event of serious illness. When Mr F was diagnosed with cancer, the insurer reviewed his application and found that he had not fully disclosed an obsessive-compulsive disorder. The ombudsman found this negligent. The insurer was required to reinstate the policy on the same terms it would have offered had it known about the disorder. The underwriting evidence showed that it would have rated the critical illness cover at +25%, the life cover at +75%, and would have declined the waiver of premiums cover altogether.
>
> The insurer was therefore required to pay a proportion of the critical illness claim, deducting any waived premiums from the settlement. The life cover was continued: on death, the consumer would receive a proportionate payment.

6.71 By way of illustration, if a consumer paid £100 in premiums, but should have paid £125, then the appropriate proportion would be 100/125 x 100 = 80%. The consumer would receive 80% of the claim.

6.72 Although compensatory remedies are now a recognised part of consumer insurance practice, misunderstandings about them persist. They are not simply doing whatever is fair and reasonable in the circumstances. As we explore below, they look at the loss to the insurer, not at the degree of fault shown by the consumer. Nor do compensatory remedies consider whether there is a causal connection between the misrepresentation and the claim. And in some cases it is necessary to explore a chain of questions, asking what the results of a test might have been and how the insurer would have reacted to them.

The insurer's loss rather than the consumer's degree of fault

6.73 In its response, Friends Provident argued that proportionate remedies may lead to arbitrary results when seen from a consumer's point of view. For example, insurers often make premium additions for mild cases and exclusions for more serious health problems. This means that if two people make identical misrepresentations, the person with the mild case may receive only a proportionate settlement, while the person with the more serious case may have an unrelated problem and be paid in full.

6.74 The aim of a compensatory remedy is to put the insurer in the position in which it would have been had the consumer fulfilled his or her duty. It does not relate to the degree of carelessness. In some cases a minor degree of fault may lead to a relatively large change in the contract. In personal injury claims it is generally understood that, where a driver's moment of minor inadvertence leads to a large loss, the size of the claim should reflect the loss, not the fault. The same principle applies here.

Not a causal connection test

6.75 In the consultation paper we considered, and rejected, the idea that a consumer who has acted negligently should be entitled to enforce any claim unrelated to the risk.[31] We acknowledged that it may seem unfair that if a householder fails to mention possible subsidence, for example, the insurer may deny a burglary claim. However, we did not think that requiring a causal connection was practical. Many questions are about criminal records or previous claims. Although the fact that someone was involved in a motor accident last year does not cause an accident next year, it is still highly relevant to the risk. Similarly, an insurer may find information about previous depression relevant to the risk of serious illness without being able to prove a causal link between depression and cancer. Almost everyone who addressed the point agreed with us.

6.76 Where an insurer would have added an exclusion, the effect of a compensatory remedy may be similar to a causal connection test. For example, if an insurer would have excluded hearing problems from a critical illness policy had it known about a hearing loss, it will still be obliged to pay other claims, such as in respect of leukaemia. However, if the insurer would simply have charged more, the consumer will receive only a proportion of the claim, even if it is unrelated to the misrepresentation. If the insurer is able to show that it would not have entered into the contract at all, then it may refuse all claims and simply return the premiums. Where, for example, a consumer has been mildly careless in answering a question about flood risk, and the insurer can show that had it known about the flood risk it would not have insured the home at all, then it would be entitled to refuse all claims, including those for fire or theft.

A chain of questions

6.77 Several life and protection insurers asked what would happen if the insurer would have postponed a decision pending further tests. In these circumstances, the court or ombudsman would need to go on to ask what the result of the test would be likely to be. The ABI pointed out that it is not always possible to answer this question with precision. This is true. However, courts and ombudsmen are used to dealing with questions of this sort and to making the best estimate of what would have happened.

6.78 For example, the courts already tackle complex hypothetical questions in the current inducement test. Here the law requires the courts to ask whether the insurer would have entered into the contract on the same terms had it known the truth. In *Drake v Provident*,[32] the Court of Appeal was prepared to follow through a chain of questions to discover the effect in practice. The consumer had taken out motor insurance which also covered his wife as an additional driver. There were two inaccuracies on the form, one which increased the risk and one which decreased it. First, the owner failed to disclose his speeding conviction. However, the form also indicated that the wife was involved in a "fault" accident, though this should have been re-classified as a "no fault" accident.

[31] CP, para 12.22.

[32] *Drake Insurance plc v Provident Insurance plc* [2003] EWCA Civ 1834, [2004] QB 601.

6.79 Lord Justice Rix said "the question for present purposes is not what actually happened, but what would have happened if the speeding conviction had been declared".[33] He said that "when account has to be taken of a non-disclosure, the issue moves from the world of actual fact into the world of hypothesis".[34] The court found that if the insured had mentioned the speeding conviction, then the status of the accident would also have come to light. The insurer operated a points system, under which the two issues would have cancelled each other out. Thus the defendant insurer had not shown that the failure to disclose the speeding conviction had induced the contract.

6.80 Compensatory remedies take the next step. They require insurers to show not only that they would have contracted on different terms, but what those terms would have been. However, the approach is the same. In some cases, courts and ombudsmen may need to ask a chain of questions.

6.81 The first question is what should the consumer have answered, if he or she had taken the degree of care the law requires. If, for example, the consumer should have mentioned high blood pressure readings, what would the insurer have done? If the insurer would have asked for further tests, what would the result of those tests have been, and how would the insurer have reacted to those results?

6.82 As the ABI Code of Practice points out, in some cases the underwriting decision would have been deferred. The Code is right to say that in such a case:

> insurers should try to determine what the ultimate underwriting decision would have been (that is, at the end of the deferred period and when the investigation was complete).[35]

In some cases, where there is nothing to suggest that the insurer's worries would have been overcome, the most realistic outcome would be that the insurer would not have entered into the insurance contract at all.

THE EFFECT OF CARELESS MISREPRESENTATIONS ON FUTURE COVER

6.83 The preceding discussion looks at the effect of a careless misrepresentation on claims that have already arisen. In the consultation paper we briefly considered the effect such a misrepresentation should have on future cover.

6.84 The issue does not arise where the consumer had acted deliberately or recklessly: there the policy is avoided and no longer exists. Nor does it arise for reasonable misrepresentations. The insurer is bound to the contract. However, the effect of careless representations involves policy choices.

[33] Above, by Rix LJ, para 62.

[34] Above, by Rix LJ, para 74.

[35] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009), para 4.2.5.

6.85 In the consultation paper, we thought that where an insurer would have declined cover, the policy should be avoided, and the premium returned (as happens at present). But where the insurer would have offered the policy on different terms, we preferred the current FOS practice to the strict letter of the law. The FOS generally allows the consumer a choice. For an inadvertent misrepresentation, the policy may be avoided and the premium returned. Alternatively, we thought that if the consumer wished it, the insurer should be obliged to continue the cover on amended terms. For example, the consumer may pay an additional premium. Alternatively, the cover may continue for the same premium, but subject to an exclusion. We pointed out, however, that this would not prevent the insurer from relying on a more general contractual right to cancel on notice.[36]

6.86 This proposal drew relatively little comment. Most issues of misrepresentation arise in the context of claims, and disputes about future cover are relatively rare. Only 51 consultees addressed the issue, and of those who did, two thirds simply agreed without comment. However, a minority of insurers opposed the proposal, on the grounds that insurers should not be forced to contract with those who have behaved negligently.

6.87 We have now reconsidered this proposal. We accept that, in most types of policy, either party should be entitled to cancel on reasonable notice. However different considerations apply in life insurance claims. Below we consider each type of policy.

Non-life insurance: either party has a right to cancel

6.88 For non-life insurance, we do not think that the parties should be compelled to continue a contract on terms which are different from those they thought they were agreeing and which differ from those they wished. The insurer, for example, may have lost all trust in the consumer, and may not wish to continue in the relationship. Meanwhile, the consumer might not be able to afford the increased premiums the insurer is now asking for, and may find that a part payment does not meet his or her needs. For example, a consumer may not wish to continue private medical insurance which would pay for only half the cost of an operation. The consumer may prefer to cancel the contract and use NHS treatment.

6.89 The issue arises when the insurer discovers a careless misrepresentation which would not allow it to avoid the policy altogether, but would result in different terms or a proportionate payment. We think that in these circumstances, either side should be entitled to cancel future cover, provided they give reasonable notice. In many cases, the careless misrepresentation will come to light after the consumer makes a claim, but the insurer may find out about it in other circumstances.

6.90 When the matter comes to light, the insurer has a choice. It may give notice to the consumer that it intends to treat the contract as containing different terms (or resulting only in a proportionate settlement). Alternatively, the insurer may terminate the contract for the future, after giving reasonable notice to the consumer.

[36] CP, paras 4.185 and 4.188.

6.91 If the insurer decides to continue the policy, the consumer also has a choice. The consumer may accept the amended terms. Alternatively, the consumer may feel that the insurance no longer meets his or her needs, and decide to terminate the contract (again after giving reasonable notice).

6.92 If either side decides to terminate the contract, the part of the premium which relates to the future should then be returned to the consumer. Thus, if the consumer paid monthly, and cover terminated at the end of the month, the consumer would not be required to make any payment after the cancellation. If, on the other hand, the consumer paid the full year's premium in advance and the insurer cancelled after six months, the consumer would be entitled to the return of half the annual premium. We did consider whether the premium should be proportionate to the degree of risk rather than to the time that has elapsed. For example, storm damage is more likely in the winter. However, this seems an unnecessary complication. It would be simpler, and cause fewer disputes, if the premium were simply allocated pro rata to the time covered by the insurance.

6.93 This policy would be subject to other legal principles. In particular it is subject to the law of waiver, to an agreement between the parties, or to other rights under the contract to cancel the policy. For example:

(1) Under the current law in England and Wales, an insurer would be considered to have waived its rights if it becomes aware of a misrepresentation and continues to accept premiums without reserving its position. In Scotland, this would be dealt with by the law of personal bar. These doctrines should continue to apply.

(2) The parties may agree to carry on with the policy, perhaps subject to an additional premium, or to an exclusion or reduced pay-out.

(3) Any right to cancel which has been written into the contract would still apply (subject to the Unfair Terms in Consumer Contracts Regulations 1999).

6.94 Once the contract had been terminated, the insurer would no longer be liable for any claims which might arise under it. However, any claims which arose before the notice was given, or during the period of reasonable notice, would be treated in the same way as any other claim to which a compensatory remedy applied.

Life insurance: the insurer is obliged to continue the policy on amended terms

6.95 The FOS argued strongly that separate rules should apply to life insurance (that is, insurance that pays a set sum on death). It is common for life insurance to be sold alongside critical illness cover. Take an example where the consumer is diagnosed with a critical illness, such as cancer, and makes a claim under the critical illness element. What should happen to the life insurance if the insurer discovers that the consumer has made a careless misrepresentation? If the insurer were entitled to cancel the life insurance policy at this stage, the consumer would suffer harsh consequences. A consumer who had been diagnosed with cancer would not be able to arrange alternative life insurance. They would lose all benefit under a policy which they may have contributed to for many years.

6.96 For life insurance, we think that the insurer should be required to continue the policy on amended terms. Thus if the insurer would be liable to make a proportionate payment on the consumer's death, the insurer should be required to continue the policy and make a proportionate payment on the consumer's death. If the insurer would have written in an exclusion or warranty, it must continue the policy subject to that exclusion or warranty. This result is already established within the industry and when we discussed it with the ABI it did not appear controversial.

6.97 The reason for singling out life insurance is that it is an important long-term form of insurance, where the premiums in the early years of the policy pay for the increased risk in the later years. It also leads to pre-valued money claims where it is relatively easy to make a proportionate payment. It is not the same as paying for only some of a quantified loss, such as half the cost of an operation or half the cost of rebuilding a home.

6.98 The position would be different if the insurer would not have taken on the risk at all had it known the true facts. Then the insurer would be entitled to avoid the policy altogether, and simply repay the premiums.

6.99 Again, these rights would be subject to the ordinary principles of waiver. If an insurer became aware of a careless misrepresentation and accepted premiums without raising the issue, it may be considered to have waived the point.

6.100 **We recommend that, following the discovery of a careless misrepresentation**:

(1) **in non-life insurance, either side should be entitled to cancel future cover on reasonable notice;**[37] **and**

(2) **for life insurance, the insurer should be required to continue the policy on amended terms.**[38]

REMEDIES FOR MISREPRESENTATIONS BEFORE A VARIATION

6.101 For a long time, the law was not clear about what remedy was available to an insurer if the policyholder made a misrepresentation or non-disclosure in relation to a variation. However, the courts seem to have settled on the view that only the variation, rather than the entire policy, may be treated as if it does not exist.[39]

[37] See draft Bill, Sch 1, para 9.

[38] See draft Bill, Sch 1, para 9(5).

[39] This was the view taken by Leggatt LJ in *The Star Sea* and by Longmore LJ in *The Mercandian Continent* and *Limit No 2 Ltd:* see *Manifest Shipping Co Ltd v Uni-Polaris Co Ltd (The Star Sea)* [1997] 1 Lloyd's Rep 360; *K/s Merc-Scandia XXXXII v Ocean Marine Insurance Co Ltd and Others (The Mercandian Continent)* [2001] EWCA Civ 1275, [2001] 2 Lloyd's Rep 563; and *Limit No 2 Ltd v Axa Versicherung AG* [2008] EWCA Civ 1231, [2008] 2 CLC 673.

6.102 We set out the remedies appropriate to variation cases in Part 2 of Schedule 1 to the draft Bill. We recommend that where there is a qualifying misrepresentation in relation to a variation, and that variation can reasonably be treated separately from the insurance policy, the remedy should only apply to the subject matter of the variation. However, there are some cases where the variation may go to the heart of the insurance policy, and where it cannot be so easily treated separately. To avoid the courts having to rewrite significantly the policy in such a case, we propose that, where a variation cannot reasonably be treated separately from the policy, the remedy should apply to the entire policy. This means that if the consumer made a deliberate or reckless misrepresentation, the insurer may avoid the whole policy.

6.103 This issue is discussed in more detail in Appendix B.[40]

6.104 **We recommend that where a qualifying misrepresentation is made before an insurance contract is varied, the remedy should depend on whether the variation can reasonably be treated separately from the insurance policy**.

(1) **Where the variation can be separated, the remedy should only apply to the subject-matter of the variation**.

(2) **Where it cannot be separated, the remedy should apply to the whole policy**.[41]

ABOLISHING BASIS OF THE CONTRACT CLAUSES

6.105 As we saw in Part 2, basis of the contract clauses are a legal device by which insurers may increase their rights when a consumer makes a mistake on a proposal form.

6.106 In strict law, the insurer is entitled to add a declaration to a proposal form or policy stating that the consumer warrants the accuracy of all the answers given, or that such answers "form the basis of the contract". This has the legal effect of turning representations into warranties. Under section 33(3) of the Marine Insurance Act 1906, any such warranty "must be exactly complied with, whether it be material to the risk or not".[42] This means that once the insurer can show that the consumer has warranted the truth of the representation, the insurer can avoid the policy for any mistake, however trivial or unimportant.[43]

6.107 It is now generally accepted that in the consumer market insurers should not rely on basis of the contract clauses. In 1986 the ABI Statement of General Insurance Practice barred their use, and the FOS would reject any defence based on them. Although the FSA rules do not specifically mention basis of the contract clauses, the ABI has confirmed to us that it would consider the use of such clauses to contravene an insurer's duty to treat its customers fairly. Our intention is to bring the law into line with accepted practice in this area.

[40] See paras B.28 to B.45.

[41] See draft Bill, Sch 1, paras 10 to 12.

[42] MIA 1906, s 33(3).

[43] *Dawsons Ltd v Bonnin* [1922] 2 AC 413, 1922 SC (HL) 156.

6.108 In the consultation paper, we provisionally proposed to follow the Australian approach, which provides that a statement by the insured about past or present fact takes effect as a representation rather than as a warranty.[44] The great majority of respondents agreed with us. Out of 57 responses, 53 simply agreed without comment.

6.109 On further reflection, however, we have decided to take a narrower approach than the one we proposed in our consultation paper. Our original proposal would not only have affected a statement in a policy or on a proposal form which converted answers into warranties. It would also have affected any specific fact warranty within the policy. Thus the proposal would have affected a policy term to the effect "warranted: the car is roadworthy". However, it would not affect a term which excluded claims which arose when the car was unroadworthy. Nor would it apply to a definition of the risk stating that the policy only covered roadworthy cars. As we came to draft the Bill, we found the distinction between these terms to be problematic. It often appeared to be more one of form than of substance. We were also concerned that a wide statutory provision may introduce uncertainty into the way in which contract terms were interpreted. We were not sure, for example, when an average clause would be a simple policy term and when it might be considered to be a warranty of fact about the value of the insured goods.

6.110 As far as we are aware, specific fact warranties are not a major problem within consumer insurance policies. And if they are used in an unfair way, the courts already have a tool to deal with them, namely the Unfair Terms in Consumer Contracts Regulations 1999. The use of warranties is a greater problem in small business contracts.[45] We are currently consulting on the issue in relation to small and micro-businesses,[46] and may return to the issues of warranties generally at a later date.

6.111 In the context of our draft Bill, clause 6 is aimed at the main evil. It prevents representations from being converted into a warranty by provisions either in the insurance contract or on the proposal form. It specifically outlaws provisions to the effect that answers "form the basis of the contract" or that the proposer "warrants the truth" of all answers given. However, the clause does not attempt to reclassify specific terms within the policy.

6.112 **We recommend that basis of the contract clauses should be abolished. Representations should not be capable of being converted into warranties by means of a policy term or statement on the proposal form.**[47]

[44] CP, para 12.25.

[45] We recently compared five consumer policies with 16 micro-business policies. None of the consumer policies we looked at contained references to "warranties". However, four of the micro-business policies contained warranties. Two contained a section on warranties, each with over 10 separate provisions. Similarly, our analysis of final ombudsman decisions concerned with disputes over policy terms found no consumer disputes about warranties, but several small business disputes: see CP, paras 7.25 to 7.37.

[46] Issues Paper 5, Micro-businesses - should micro-businesses be treated like consumers for the purposes of pre-contractual information and unfair terms? (April 2009).

[47] See draft Bill, cl 6.

NO CONTRACTING OUT

6.113 In the consultation paper we argued that insurers should not be entitled to give themselves greater rights to reject claims for non-disclosure and misrepresentation by adding terms to this effect to their contracts. We provisionally proposed that it should not be possible to contract out of the consumer rules governing misrepresentation and non-disclosure in consumer insurance except in favour of the consumer.[48] Almost everyone who responded to this question agreed. The FOS described it as "an essential element of the reform".

6.114 We have therefore included a provision preventing contracting out in the draft Bill. Clause 10(1) renders a contract term of no effect if it would put the consumer in a worse position than under the draft Bill. The clause only applies to terms dealing with disclosures and misrepresentations made before the contract is entered into or varied. It does not affect contract terms which require consumers to give insurers information during the course of the contract. These would need to be fair within the Unfair Terms in Consumer Contracts Regulations 1999, but are unaffected by the draft Bill.

6.115 Clause 10(1) applies not only to terms of the insurance contract itself, but also to terms contained in secondary contracts. However, in clause 10(4), the draft Bill makes an exception for agreements to settle claims. We would not wish to prevent valid settlements, even if the consumer settled on less favourable terms than a court would have awarded.

6.116 **We recommend that it should not be possible to contract out of the draft Bill, except in favour of the consumer**.[49]

Contracting out through a choice of law clause

6.117 Clause 10(2) prevents contracting out through a clause which opts for the law of another country when UK law would otherwise apply to the contract, to the extent that a different law would put the consumer in a worse position than under the draft Bill.

6.118 The law applicable to insurance contracts where the risk is situated within the European Economic Area is governed by the Financial Services and Markets Act 2000 (Law Applicable to Contracts of Insurance) Regulations 2001. The Regulations set out what are essentially default rules which specify which law should govern the contract if the parties do not make a choice. The parties are, however, free to choose another law if they wish.

[48] CP, para 12.24.

[49] See draft Bill, cl 10.

6.119 The simplest case is where the consumer resides in the UK and the risk is situated in the UK. In this case, the 2001 Regulations provide that UK law would apply unless the parties have chosen an alternative law.[50] Clause 10(2) of the draft Bill means that if a consumer living in the UK insures a house in the UK, then a choice of law clause cannot be used to put the consumer in a worse position as regards disclosures or representations than they would be under the draft Bill.

6.120 There are special rules for vehicles and travel insurance. For example, if a consumer living in the UK buys a travel insurance policy in the UK which lasts for less than four months, the default rule is also that UK law applies. Again, the insurer cannot use a choice of law clause to put the consumer in a worse position than under the draft Bill.

6.121 However, if a UK resident insures a house in Spain, then the parties to the contract may choose either UK law or Spanish law.[51] If no choice is made, the applicable law is the law of the country most closely connected with the contract.[52] Regulation 4(9) provides that there is a rebuttable presumption that the contract is most closely connected to the state where the risk is situated. Therefore, in the absence of a term choosing the applicable law, the law applicable to the contract is likely to be Spanish law. In these circumstances, clause 10(2) would not apply. The parties would therefore be free to choose Spanish law, whatever Spanish law provides about disclosures and representations.

6.122 **We recommend that a choice of law clause should not be used to put a consumer in a worse position in respect of pre-contractual disclosures and representations if UK law would otherwise apply**.[53]

[50] Reg 4(2).

[51] Reg 4(3).

[52] Reg 4(8).

[53] See Draft Bill, cl 10(2).

PART 7
GROUP INSURANCE AND INSURANCE ON THE LIFE OF ANOTHER

7.1 In this Part, we consider how our core recommendations should apply in two particular circumstances when a misrepresentation is made by someone who is not the policyholder under the contract. First we consider misrepresentations made by members under group insurance schemes. We then consider misrepresentations made by a person whose life is insured by another consumer.

GROUP INSURANCE

7.2 Group schemes are an increasingly important form of insurance. Typically, such schemes are set up by employers for the benefit of their employees and concentrate on protection insurance: nearly 40% of life cover, for example, is provided through such schemes.[1] Yet the legal principles which apply to such schemes are uncertain and under-developed.

7.3 Under a group scheme, the policyholder is typically the employer, who arranges the scheme directly with the insurer. The group members (typically employees) have no specific status.[2] As they are not policyholders, the duty to disclose set out in the Marine Insurance Act 1906 does not apply to them. This means that if a group member makes a misrepresentation, the insurer's remedies are uncertain. The insurer may be left without any protection at all. Alternatively, the insurer may require the policyholder to warrant the truth of the members' statements. Under strict law, this would mean that if an individual were to make a misrepresentation, the entire policy would fail, and the insurer would not be obliged to pay claims to any of the members. Neither outcome is satisfactory.

7.4 In the consultation paper, we proposed to bring the law into line with the FOS approach and accepted practice in the market. We proposed that where a misrepresentation is made by a group member (such as an employee):

(1) it should have consequences only for the cover of that individual. It should not, for example, invalidate claims by other members of the group; and

(2) if the insurance was of a type which would have been consumer insurance had the group member arranged it directly, any dispute about the misrepresentation should be determined in accordance with our proposals for consumer insurance. Thus if an individual employee had misrepresented his or her health on a declaration form, the court or ombudsman would ask whether the misrepresentation was innocent, negligent or deliberate/reckless.[3]

[1] Figures provided by Swiss Re, as of end 2006.

[2] In Scots law, members might acquire a *jus quaesitum tertio* (a right acquired by a third party in a contract between others) but only if there is an intention to benefit them.

[3] CP, para 12.44.

7.5 On the other hand, where the policyholder was a business, any misrepresentation made by the policyholder would be dealt with under the business regime.

7.6 Most respondents agreed with our proposals. Out of 46 respondents, over half agreed without comment. The FOS said that the proposal reflected current market practice, which it has adopted.

7.7 No one argued that a misrepresentation by an individual member should affect others within the group. However, a handful of insurers expressed unease about treating misrepresentations by group members under the consumer regime. Scottish Widows, for example, were concerned that our proposals treated group insurance as consumer insurance, requiring firms to switch between the retail and business insurance regimes and creating administrative confusion. The Group Risk Development Group (GriD) also thought that the proposals might create confusion and administrative delays. We think these concerns are based on a misunderstanding. Our proposals do not mean that group insurance would be treated as consumer insurance. They simply give a legal basis to current practice, by determining the effect of a misrepresentation by a group member.

7.8 In January 2009, the ABI added material on group schemes to its Code of Practice. The Code states that "any disclosure by an individual scheme member should not affect any other scheme member's entitlement to receive benefits from the scheme".[4] Instead, a non-disclosure by individual members of the group scheme should be considered under the general principles of the Code, which consider whether a misrepresentation was innocent, negligent or "deliberate or without any care". The Code is to the same effect as our proposals, which appear to be generally accepted within the industry.

7.9 Below we consider the details of our proposals on group insurance. We look first at how group insurance should be defined. We then consider the consequences of a misrepresentation, first by the group member and then by the policyholder. Finally, we consider whether a group member who has made a deliberate or reckless misrepresentation should nevertheless be entitled to what the industry refers to as "free cover".

Defining group insurance

7.10 We have considered whether the problems related to group insurance only arise in typical employment-related schemes, or whether similar issues affect other forms of insurance. In the consultation paper, we asked consultees if they were aware of problems in other types of group insurance, which were not linked to the employer/employee relationship.[5]

[4] ABI Code of Practice, para 10.3.

[5] CP, para 12.46.

7.11 We were told that similar issues arise in block building policies taken out by landlords for the benefit of tenants. Management companies and owners may also take out buildings insurance for the benefit of long leaseholders. Sometimes this covers more than just the owner's liability to maintain the property. It may, for example, compensate leaseholders for damage to parts of the building which are their own responsibility, such as plasterwork. The FOS said that it occasionally considers complaints from tenants who benefit from block building policies, where the tenant's interest is noted on the policy. In those circumstances it treats the tenant as though they had arranged the insurance directly with the insurer (that is, as a consumer) even though the actual policyholder tends to be a limited company.

7.12 The problem may occur whenever one party (the policyholder) takes out insurance to provide cover for another, and the person who is not the policyholder provides information to the insurer. If the person covered is effectively a consumer, then we think the principles in our draft Bill should apply. Clearly, our draft Bill should not apply where the group scheme only provides cover in a business context (such as construction policies, protection and indemnity policies, and parent and subsidiary policies).

7.13 Under the definition in our draft Bill, one would need to consider the following questions:

(1) Did a policyholder (A) take out a policy which was intended to provide cover to a third party (C)? As discussed below, the cover must normally do more than cover the policyholder's liability towards C. It must also provide some additional cover (such as life insurance, contents insurance or buildings insurance which covers the third party's own responsibilities).

(2) Is C a party to the contract? Our scheme would only apply if C is not a party to the contract. In many cases where one person takes out insurance on behalf of others, the correct legal analysis is that the beneficiaries are all co-insured, or that the person arranging the insurance acts as agent for the others. Take a case, for example, where a group of friends decides to go on holiday together, and one of them arranges travel insurance on behalf of the others. The correct legal analysis may be either that it is a joint policy, or that the arranger was an agent for each of the others. The group insurance provisions in our draft Bill would only apply where the C could not be characterised as a policyholder.

(3) Was C required to provide the insurer with information before the insurer became liable for the particular element of the cover that benefited C? This would apply where an employee was required to fill out health information in order to receive additional life cover, or where a leaseholder was asked to report to the insurer on the state of their property. This information may be provided directly (as when the employee communicates directly with the insurer) or indirectly (as where the employee hands their employer a form, which is passed on to the insurer).

(4) If so, would C be treated as taking out consumer insurance had C entered into a contract with the insurer directly in respect of that cover? For example, life cover, critical illness cover, household contents or buildings cover for residential flats would all be considered consumer insurance if C had bought them from the insurer directly. However, if a construction policy provided public liability insurance to sub-contractors on a building site, this would not be consumer insurance, and would not fall within the scope of our draft Bill.

7.14 If C is not a party to the contract, but the answers to questions (1), (3) and (4) are yes, then any misstatement made by C to the insurer before inception of the insurer's liability to C would be treated as a consumer misrepresentation under our Bill.

7.15 This clause is not intended to apply to normal liability insurance, such as employers' liability insurance, where the policyholder is obliged to compensate a third party in any event, and the only issue is whether the policyholder can recoup the payment from the insurer. We did consider whether the draft Bill should specifically exclude insurance of A's own liability to C in order to make this point more clearly. However, it was pointed out that some employment contracts include (say) extended sick pay, provided that the employer is able to recoup the payment from the insurer. Although this is written as liability insurance, the brunt of any non-payment is borne by the employee rather than the employer. We think cases such as this, where the group member rather than the policyholder is left without payment, should fall within clause 7.

Consequences

7.16 The consequence of treating a misrepresentation by a group member as a consumer misrepresentation is that:

(1) Any misrepresentation would have consequences only for the cover of that individual (not for the policy as a whole).

(2) Any dispute would be determined in accordance with our proposals for consumer insurance. The court or ombudsman would need to ask:

(a) whether the insurer had been induced to provide that particular element of cover; and if so

(b) whether the misrepresentation was innocent, negligent or deliberate/reckless, and apply the appropriate remedies.

Misrepresentations by the group policyholder

7.17 Under our reforms, if the policyholder is a business and makes a misrepresentation or non-disclosure, it would be regarded as a commercial matter and dealt with under the business regime. In our consultation paper we asked if consultees agreed that a non-disclosure or misrepresentation by a business policyholder should provide the insurer with the same rights to avoid a policy as would apply to other business insurance.[6]

7.18 The majority of the respondents agreed that a non-disclosure or misrepresentation by the employer should be dealt with under the business regime. Several insurers argued that businesses taking out group insurance were sophisticated parties, who should be expected to make full disclosure. It was said that the right to avoid a policy in the event of non-disclosure by an employer group policyholder was "a vital remedy". However, 11 respondents disagreed with this proposal, on the ground that it would have an unduly harsh impact on employees. They feared that employees would be deprived of cover by mistakes which were not of their own making.

7.19 Some group schemes cover thousands of employees. We accept that if an insurer were to avoid such policies the results could be serious, as many employees would find themselves without cover through no fault of their own. They may well have a claim against their employer, but this will not help them if the employer becomes insolvent. However, the same problems arise for third party claimants in many situations. We do not think that this is a problem which can be solved by insurance contract law.

7.20 Thus the draft Bill does not affect the duties placed on a business policyholder under a group scheme.

"Free cover"

7.21 Most group insurers provide a certain level of cover without any individual underwriting – that is without the insurer collecting information about the individual employee's health. This is often referred to as "free cover". We were told that it was not unusual for group insurers to provide up to £1 million in "free cover". However, if any employee wanted additional life cover (say £5 million) the insurers would ask the employee to complete a health declaration form.

7.22 Under current practice, if the employee has made a misrepresentation on the health declaration form, it is common for insurers to refuse the £5 million claim but to pay the £1 million which they would have provided in any event. They may do this even if the employee has been fraudulent. In the consultation paper we asked if this practice should continue under our scheme.[7]

[6] CP, para 12.45(2).

[7] CP, para 12.45(1).

7.23 Consultees were fairly evenly divided on this issue. Nine respondents argued that where the member has made a deliberate or reckless misrepresentation, the insurer should be entitled to refuse all benefits in respect of that member. Eight agreed with the alternative option of providing the free cover subject to satisfying the eligibility criteria for the scheme. The FOS thought that free cover should be given where the free cover had not been induced by the misrepresentation.

7.24 Having considered the matter further, we do not think that is necessary for our scheme to make any special provision in respect of “free cover”. Thus the issue is not specifically mentioned in the draft Bill. Instead, the question should be determined in accordance with the basic principles of our scheme.

(1) The first issue is whether there has been inducement. If the free cover was granted before the misrepresentation was made, then the insurer cannot have been induced to provide the free cover by the misrepresentation. However, if both the “free” and additional covers were provided simultaneously as part of the same package, then (if the insurer would not have provided the additional cover) there has been inducement: at least one term of the contract would have been different.

(2) If the insurer has been induced, the question then turns on the member’s degree of fault. If he or she acted deliberately or recklessly, the insurer would be entitled to refuse all claims to that member. If the misrepresentation is merely careless, then the court or ombudsman would ask what the insurer would have done had they known the information. If the insurer would have provided a £1 million payment in “free cover” in any event, then the £1 million payment should be made.

7.25 Insurers could, of course, continue to be more generous if they wished. We note that the ABI’s 2009 Code of Practice states that:

> Any non-disclosure by an individual group scheme member should not affect that member’s entitlement to benefits up to the amount of any free cover limit applicable to that member at the time of joining the scheme.[8]

7.26 As we understand this paragraph, it means that ABI members have pledged themselves to pay the “free cover” in group protection insurance even if a misrepresentation was deliberate or reckless and made before the “free cover” was granted. It is entirely open to ABI members to make such a pledge, and it is open to the FOS to enforce it.

[8] ABI Code of Practice, “Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products” (January 2009), para 10.2.

7.27 **We recommend that**:

(1) **Group insurance should be defined widely, so as to cover insurance contracts intended to provide cover to a person who is not a party to the contract, but who would be a consumer if he or she had taken out the cover directly with the insurer**.[9]

(2) **Where a group member provides information to the insurer**:

(a) **any misrepresentation should have consequences only for the cover of that individual;**[10] **and**

(b) **any dispute should be determined in accordance with our proposals for consumer insurance**.[11]

(3) **The draft Bill should not**:

(a) **affect the duties of a business group policyholder to provide information;**[12] **or**

(b) **include specific provisions in respect of "free cover"**.

INSURANCE ON THE LIFE OF ANOTHER

7.28 A consumer policyholder may take out insurance on another person's life, as where a husband insures the life of his wife, or a wife insures the life of her husband. The person whose life is being insured is asked questions about their age and state of health and the insurer relies on that information when writing the risk. However, the life insured is not a party to the contract. This means that if the life insured makes a misrepresentation, the insurer would not normally be entitled to a remedy unless the policyholder knows of it.

7.29 Insurers may protect themselves by requiring the policyholder to agree that the life insured's answers form "the basis of the contract". However, this goes further than is necessary to protect the insurer's legitimate interest: it means that even an innocent or reasonable mistake would prevent the policyholder from recovering. As already discussed, there was overwhelming support for abolishing basis of the contract clauses. This means that insurers would need some other form of protection.

[9] See draft Bill, cl 7(1).

[10] See draft Bill, cl 7(4).

[11] See draft Bill, cl 7(2).

[12] See draft Bill, cl 7(5).

The consultation paper proposals

7.30 In the consultation paper, we said that in the absence of an agreement to the contrary, the policyholder should bear the risk that the person whose life is insured has acted negligently or dishonestly. Therefore, we provisionally proposed that in consumer life-of-another policies, representations by the person whose life is insured should be treated as if they were representations by the policyholder. If the insurer can show that either the life insured or the policyholder (or both) behaved deliberately, recklessly or carelessly, it will have the remedy that is appropriate for that kind of conduct.[13] All of the 35 replies we received agreed with the proposal.

7.31 We also asked consultees whether parallel issues arise in other consumer contexts.[14] We wondered, for example, whether similar problems might arise where there are additional drivers named on motor policies. However, after some discussion with the ABI and particular insurers, we have not found any examples of problems in other areas.

Our recommendation

7.32 Under clause 8 of the draft Bill, where information is provided to the insurer by the life insured (L), it is to be treated as though L were a party to the contract. Thus L is under the same duty to take reasonable care not to misrepresent as a policyholder would be. The insurer is granted a remedy if either the policyholder or L fails in this duty.

7.33 This means that in a consumer life insurance policy on another's life, if L makes a misrepresentation, the court or ombudsman must ask:

(1) Was the insurer induced to enter the contract (that is, would it have entered the policy at all, or on the same terms, had it known the truth)?

(2) If so, did L act either deliberately/recklessly or carelessly? For example, if L deliberately failed to mention a cancer diagnosis, the insurer is entitled to avoid the policy, even if the policyholder was unaware of the cancer. If L acted carelessly in failing to mention a mole, the court would apply a compensatory remedy.

7.34 Where L acted deliberately, and the policyholder was innocent, we think this would be a good reason to allow the policyholder the return of the premiums. However, the draft Bill does not need to make special provision for this: it is already covered by the general discretion over the return of premiums.[15]

[13] CP, para 12.48.

[14] CP, para 12.49.

[15] See paras 6.40 to 6.53 above.

7.35 In some cases, L may have acted reasonably, but the policyholder may have been deliberate/reckless or careless. Take an example where a husband is told that his wife is terminally ill, but the wife is not told, and the husband takes out insurance on his wife's life. The wife acts honestly and reasonably in saying there is nothing wrong with her health. However, the husband also fills out a form which asks if he is aware of any problem with his wife's health and he answers no. This would be considered a deliberate or reckless misrepresentation by the policyholder, which would justify the insurer avoiding the policy. However we do not think that any special provisions are needed to reach this result. It follows from the core scheme in the draft Bill.

7.36 **We recommend that where a consumer takes out insurance on the life of another, and information is provided to the insurer by the person whose life is insured, that information should be treated as if it were provided by a party to the contract.**[16]

The effect on a "joint lives" policy

7.37 We have been asked to clarify how this recommendation would affect a joint lives policy, where spouses insure each other's life and each spouse completes a separate part of the proposal form with details of their own health. Let us assume, for example, that the wife was truthful, but the husband lied about his health (without his wife's knowledge).

7.38 The first possibility is that the husband dies, and the wife makes a claim. Under the draft Bill, the insurer may invalidate the policy as a result of the husband's misrepresentation, as he is the life insured. As it is a joint policy, avoidance affects the whole policy (covering both husband and wife). We think, however, this would be a circumstance in which the premiums that the wife had paid should be refunded to her.

7.39 In the consultation paper we asked whether the court or the FOS should also have a discretion to order the insurer to continue the policy as a single life policy on the wife only.[17] Although most consultees considered this would be a fair outcome, several insurers thought it would be difficult to do, as the premium and terms of cover could be quite different. We think that this might be a suitable outcome if agreed between the parties, or as a result of the exercise of the FOS discretion to come to a fair and reasonable outcome. We do not think, however, that this should be compelled as a matter of law.

7.40 The second possibility is that the wife dies. We were told that in practice it would be unusual for the insurer to discover the husband's misrepresentation. If it did come to light, however, the insurer would be entitled to avoid the whole policy and refuse all claims under it. Again the court or ombudsman would need to use its discretion to determine whether it would be fair for the insurer to keep the premiums.

[16] See draft Bill, cl 8.

[17] CP, para 6.71.

PART 8
INTERMEDIARIES

INTRODUCTION

8.1 Rather than dealing directly with each other, the consumer or insurer may use an intermediary to assist them in placing an insurance contract. Intermediaries may operate under a variety of titles, such as broker, agent or insurance consultant. Intermediaries may also act in a variety of ways. They may, for example, see one or both parties in person, or deal with them over the telephone or through a website.

8.2 For the purposes of this report, the issue is what should happen if the intermediary acts either "carelessly" or "deliberately or recklessly" in transmitting pre-contract information from the consumer to the insurer.

8.3 Under normal agency law, a person is responsible for the actions of their own agent. This has the following consequences:

(1) If the intermediary acts for the *consumer*, the consumer is bound by the acts of the intermediary. This means that if the intermediary has acted deliberately or recklessly, the insurer is entitled to avoid the policy, even if the consumer has acted honestly and reasonably. If the intermediary acts carelessly, the insurer has a proportionate remedy against the consumer. The consumer would then need to bring a separate action for professional negligence against the intermediary.

(2) If the intermediary acts for the *insurer*, then any wrongdoing by the intermediary is the responsibility of the insurer. The insurer must pay the claim, and pursue a separate action against the intermediary.

8.4 It is therefore important to know for whom an intermediary acts when helping a consumer complete an insurance application. Unfortunately, the law in this area is uncertain, as the courts and the FOS struggle to apply early twentieth century cases to a rapidly changing market place.

Why it matters

8.5 It could be argued that this is really a question of form rather than substance. Whichever party bears the loss as a result of the agent's negligence or wrongful conduct will be able to claim damages from the agent for the amount of that loss. So why does it matter whether the consumer has to sue the insurer or the intermediary?

8.6 From the consumer's point of view, it is easier to claim under the insurance policy than to sue the intermediary:

(1) It is more straightforward to pursue a complaint against an insurer for non-payment of a claim than to make a separate complaint for negligence or fraud against an intermediary.[1]

(2) Consumers may be required to pursue claims against insurers as far as they can in any event, to avoid the risk of the intermediary arguing that they have not proved any loss.

(3) The consumer may be disadvantaged when seeking insurance in the future by having had an insurance claim denied because of a misrepresentation.

8.7 From the insurer's point of view it is easier to refuse to pay under the policy than to sue the intermediary:

(1) The insurer may have little practical means of proving that it was the intermediary (rather than consumer) who made the misrepresentation.

(2) Insurers are legitimately concerned about taking responsibility for the actions of independent agents over whom they exercise little control.

The problem in practice

8.8 Problems involving intermediaries and the transmission of pre-contract information are fairly common. In our original survey of 190 ombudsman decisions involving disputes about pre-contract information, 25 (13%) involved allegations about what an intermediary did or said during the placing of insurance. The issue continues to be raised. In our recent survey of 47 decisions, nine (19%) involved an allegation about the intermediary's actions.

8.9 It is often difficult to determine for whom the intermediary acts. The case law on this issue stretches back over a hundred years, and ombudsmen frequently struggle to apply these cases to an ever changing and increasingly complex market. Intermediaries now come in a wide variety of forms and their relationship with the consumer and insurer varies greatly. At one extreme they may be very closely linked to the insurer – for example, the intermediary may be recruited by the insurance company to solicit customers. At the other extreme, the intermediary may be an independent agent, chosen and approached by the consumer and able to offer impartial advice on the market. In the middle lies a broad spectrum of diverse arrangements. Since the depolarisation of the insurance market in 2005, intermediaries are no longer required to be either independent or tied to a single insurer. They may be "multi-tied" – which could mean virtually independent or closely linked to only two insurers.

[1] In the consultation paper we discussed a sample of FOS cases. We noted that in some cases the consumer had pursued a complaint against the insurer to a final ombudsman decision only to be told to start again against the intermediary. We thought that more could be done to assist complainants to bring complaints against the correct organisation, if necessary considering complaints in tandem where the status of the agent was disputed (CP, para 9.124). We understand that the FOS is now prepared to consider joint complaints in this way.

8.10 New methods of selling insurance are constantly being introduced. For example, the intermediary may be a retailer which offers a limited range of insurance products (such as extended warranties) as a sideline; or the intermediary may be a large recognised brand (such as a supermarket or a bank) which distributes insurance products under its own logo (known as "white-labelling"). Information technology has prompted considerable change as internet selling and price comparison sites have become increasingly important.[2]

OUR VIEWS

The 2007 consultation paper

8.11 In the consultation paper, we attempted to draft a single bright line test to determine for whom an intermediary acts in transmitting pre-contract information. We said that an intermediary should be taken to act for the insurer unless it is clearly independent. We asked whether only those intermediaries who conducted a fair analysis of the market should be considered to act for the consumer.

8.12 Most consultees disagreed with this test on the ground that it was unworkable. Considerable uncertainty was expressed about what a fair analysis of the market required. It was pointed out that many firms no longer give advice about the whole market. Large composite insurers may have agreements with hundreds of small firms, and no real possibility of monitoring or controlling how these firms conduct their business. The FSA in particular expressed concern that if insurers were held responsible for intermediaries they were unable to control, they may be less prepared to accept business from them. We would not wish to damage the network of small, accessible, independent intermediaries.

The 2009 policy statement

8.13 In March 2009 we published a policy statement which explained that we had changed our view. On reflection, we did not think it was possible to have a single test. Instead, we concluded that the issue of who an intermediary acts for must depend on a range of factors. We proposed a new statutory code, based largely on the existing law. Where the current law failed to provide clear answers, we supplemented it by drawing upon FOS practice and industry understanding.

8.14 Our aim was to find a balance. Insurers should bear responsibility for those intermediaries within their control, and have appropriate incentives to exercise that control in a way that prevents problems from occurring. Insurers should not, however, be liable for the actions of many small intermediaries with whom they do not have a close relationship.

[2] A summary of recent data on the intermediary market is to be found in our March 2009 Policy Statement, paras 1.10 to 1.16, and can be viewed on our websites.

8.15 Several insurers and brokers urged us to require intermediaries to tell the consumer for whom they were acting. It was suggested that this rule should be decisive: whatever the intermediary said should decide the legal position. We considered this proposal carefully and came to the conclusion that it had insuperable problems. Insurers could simply require intermediaries to tell consumers that the intermediary acted for the consumer, irrespective of the reality of the situation. The closer the relationship between intermediary and insurer, the more the insurer could insist on it, and the less accurate the statement would be. Meanwhile consumers would be unlikely to find the declaration helpful. Few consumers would realise that it meant that they would suffer the consequences of any fraud or error of the intermediary. Consumers are already sent considerable information at the point of sale, and much of it remains unread.

8.16 Nor did we think that such a declaration would adequately protect the interests of insurers. If the intermediary forgot to tell the consumer that the intermediary was the consumer's agent, the insurer could find itself unwittingly responsible for an agent over whom it has no control. We were concerned that an undue emphasis on whether a particular declaration was given would put the decision into the hands of the least appropriate person: the fraudulent intermediary. An intermediary who wished the insurer to suffer the consequences of the fraud could tell the consumer that he or she acted for the insurer.

8.17 We agreed with the statement in the ABI Code of Practice that:

> Whether an intermediary was acting as an insurer's agent in a transaction will depend on the facts and circumstances in each case.[3]

However, we thought it would be helpful to provide further guidance on which factors and circumstances were relevant to the decision.

8.18 We said that in three circumstances, an intermediary is always considered to act for the insurer. Thus an intermediary acts for the insurer if:

(1) the intermediary is the appointed representative of the insurer;

(2) the intermediary has actual express authority from the insurer to collect pre-contract information on its behalf (for example, through an express term in a terms of business agreement);

(3) the intermediary has authority to bind the insurer to cover.

8.19 In other cases, the intermediary acts for the consumer unless there is a close relationship between the intermediary and the insurer. The issue would need to be determined by looking at all the circumstances, weighing the various factors in each case.

[3] ABI Code of Practice, para 3.4.2.

8.20 We thought that it would be helpful to provide a list of the factors that were relevant to the decision. However, any such list would need to be indicative and non-exhaustive. Market practice in this area has changed rapidly with the increased use of technology and regulatory developments, and may well change again. The law will need to adapt to such changes.

8.21 We also stressed that different agencies may arise in respect of different tasks. The intermediary may "change hats" during the process. For example, an intermediary may act for the consumer in obtaining a quote from the insurer, but act for the insurer in receiving premiums. The crucial issue is therefore to decide for whom the intermediary is acting *at the time* of any carelessness or wrongdoing. The intermediary may also act in different capacities in respect of different types of cover. For example, the intermediary may act for the insurer in binding the insurer to temporary cover, but for the consumer in respect of the main cover.

8.22 Finally, we said that the statutory principles should only have a direct effect in cases concerning faults in the transmission of pre-contractual information in consumer insurance. The statute would not apply to other areas of agency (such as who an intermediary acts for in collecting premiums) or to business insurance.

8.23 Following further discussions with the ABI and others, these recommendations form the basis of Schedule 2 of the draft Bill.

8.24 **We recommend that intermediaries should be considered to act for the insurer if at the time of the conduct in question**:

(1) **the intermediary was the appointed representative of the insurer**;

(2) **the intermediary had express authority from the insurer to collect pre-contract information as its agent**;

(3) **the intermediary had authority to enter into the insurance contract on behalf of the insurer**.

8.25 **In other cases, the intermediary acts for the consumer, unless it appears that the intermediary acts for the insurer. This would need to be determined in the light of all the circumstances, weighing the factors in each case**.

THE DRAFT BILL

8.26 Below we explain these recommendations in more detail, and consider how they have been implemented in the draft Bill.

The draft Bill must be read subject to general agency principles

8.27 The draft Bill does not attempt to set out the general law of agency. It does not, for example, spell out when a consumer or insurer would be bound by the acts or omissions of their agent. This would be a dangerous thing to attempt.

8.28 As is the case in any legislation, the draft Bill must be read subject to agency principles. This means that a consumer may be held responsible for a deliberate or reckless misrepresentation made by their agent, even if the consumer has behaved reasonably in the circumstances. The insurer may avoid the policy and refuse all claims under it. Similarly, an insurer is entitled to a compensatory remedy where the consumer's agent has made a careless misrepresentation. The consumer's recourse in such circumstances would lie against the intermediary rather than the insurer. Equally, an insurer may be bound by the actions of their agent, in (for example) waiving the effect of a misrepresentation.

8.29 We do not think that it is necessary to specify these general principles in the draft Bill. However, for the avoidance of doubt, clause 12(4) clarifies that nothing in the draft Bill "affects the circumstances in which a person is bound by the acts or omissions of that person's agent".

The new framework applies only for the purposes of the draft Bill

8.30 Clause 9 refers to the test set out in Schedule 2 for determining whether an intermediary acts for the consumer or for the insurer. This test only applies for the limited purposes of the draft Bill. That is, it only applies to consumer insurance, and it will only determine for whom the intermediary acts while collecting and transmitting pre-contract information from the consumer to the insurer. The test does not apply to other agency issues (such as for whom an intermediary acts in collecting premiums).

8.31 In the policy statement, we commented that "if the courts found the framework useful for its primary purpose, they may find the same principles helpful in other areas".[4] However, the court would only do this to the extent that the test codifies existing common law principles.

In three cases the intermediary acts for the insurer

8.32 Under the test set out in our policy statement, there are three cases where the intermediary should be taken as acting for the insurer.

The agent is acting as the insurer's appointed representative

8.33 Under the Financial Services and Markets Act 2000, a person may carry on regulated activities as an appointed representative (AR). Section 39(3) states that:

> The principal of an appointed representative is responsible, to the same extent as if he had expressly permitted it, for anything done or omitted by the representative in carrying on the business for which he has accepted responsibility.

[4] Para 4.19.

8.34 As the FSA fact sheet explains, the effect of this section is that "the AR acts as an agent for the principal". In strict law, this applies only to regulatory matters, and not to contractual matters (where the common law applies). However, insurers work on the basis that their appointed representatives are their agents for all matters. The draft Bill clarifies that for the purposes of the draft Bill, an intermediary acts as an agent for an insurer to whom they introduce or with whom they place business if the intermediary is acting in its capacity as the insurer's appointed representative.

8.35 An intermediary who only introduces customers to a general insurer may become an "Introducer Appointed Representative" (IAR) rather than a full AR. The FSA explains that "fewer rules apply to an IAR, but the relationship between you and your Principal is the same".

8.36 The draft Bill would also apply to IARs. Clearly, IARs have fewer opportunities to introduce misrepresentations into the transmission of information from consumer to insurer, as they do not place business. However, mistakes are still possible. An IAR might, for example, step outside their remit by giving a consumer wrong information about the meaning of a question on the form. Section 39(3) states that the principal is responsible for actions which were not permitted as if the principal had permitted them. This means that if an IAR was not permitted to give advice about how to fill in a form, but did so anyway, the principal would be responsible. The insurer would be required to pay the claim and then pursue a remedy against the IAR.

8.37 That said, it is important to stress that the intermediary must be acting as the insurer's representative *at the time of the action*, and *in connection with the cover* in question. For example, a multi-tied intermediary may act as an IAR for several insurers. Thus an IAR may act as an agent for Insurer A in introducing a consumer to Insurer A, and as an agent for Insurer B in introducing a consumer to Insurer B. The intermediary will only act for Insurer B while introducing the consumer to Insurer B.

The insurer has given the intermediary express authority to collect the information as the insurer's agent

8.38 This would apply where the insurer has specifically told the intermediary that it should collect the information as the insurer's agent. A statement of this type might, for example, be included in the terms of business agreement between the insurer and the intermediary. The existing law is clear that if the insurer gives express authority in this way, the intermediary acts for the insurer. Under the draft Bill, the court or ombudsman would not be required to look at other factors. The statement would be determinative. In theory, it would be possible for both the insurer and the consumer to give express authority in this way. In these circumstances, we think that the insurer's actions should be decisive, as the insurer would normally be better informed about the consequences of the declaration.

8.39 It could be argued that this rule should not be confined to cases in which the insurer has given express authority. Under the existing law, an intermediary acts for the insurer if the insurer has given the intermediary implied actual authority. The court would construe the terms of business agreement as a whole, to see whether actual authority could be implied. However, we do not wish the courts to look for implied authority at this stage. Where the court is considering whether authority can be implied in the circumstances, it should consider the factors set out in our general test below.

The insurer has given the intermediary express authority to enter into the contract as the insurer's agent

8.40 This is the current law. If the insurer has granted the intermediary specific authority "to hold the underwriter's pen" and the intermediary makes the decision to enter into the contract for the insurer, then the intermediary must act for the insurer at that point. When the contract is formed, the intermediary is the underwriter. It cannot misrepresent to itself.

8.41 The intermediary must have authority to act as the underwriter at the time of the action, and in connection with the cover in question. For example, an intermediary might act as the consumer's agent by inputting information into the insurer's computer systems, and only then receive authority to bind the insurer to cover. In this situation, the intermediary would be said to act for the consumer when giving information to the insurer but for the insurer when entering into the contract.

8.42 We have been asked what happens if the intermediary is given specific authority to bind the insurer to cover only if certain criteria are met (for example, if the consumer has no previous criminal convictions). Take a case in which the consumer quite honestly admits to having criminal convictions, but the intermediary acts outside the terms of its authority by binding the insurer to cover and then lying to the insurer to say the consumer has no convictions.

8.43 Under the current law, is the insurer bound to the contract in these circumstances? We think that it would be, unless the consumer had reason to suspect that the intermediary was acting outside the terms of its authority. The insurer has given the intermediary authority to enter into the contract on its behalf – and as far as the consumer is concerned, the intermediary has apparent authority to bind the insurer. Of course, the insurer would not be bound if the consumer had colluded in the fraud in some way, or if the insurer had specifically told the consumer that the intermediary did not have authority to bind the insurer in these circumstances. We intend that this aspect of the law should remain the same following our reforms.

The general test

8.44 In all other cases, the intermediary will be taken to act for the consumer unless in the light of all the relevant circumstances, the intermediary acts for the insurer.

8.45 As we noted in the policy statement, in the absence of any factors indicating a close relationship between insurer and intermediary, the intermediary is deemed to act for the consumer. Even if some factors do indicate such a close relationship, they may nonetheless be outweighed by other factors indicating that the intermediary acts for the consumer.

8.46 The list of factors in the draft Bill is indicative and non-exhaustive. Although the ABI expressed some reservations about the policy statement, it specifically agreed with us on this point, stating that "the main benefit of the indicative approach is flexibility".[5] At present, there is a considerable range of intermediaries, and the range is likely to expand in the future. It is therefore important to have a flexible test.

A presumption in favour of acting for the consumer

8.47 The starting point under the draft Bill, as under the current law, is that the agent acts for the consumer, unless there are circumstances which show that the intermediary acts for the insurer.

Factors tending to show that the intermediary acts for the consumer

8.48 Some factors confirm that the intermediary is acting for the consumer. The draft Bill sets out three examples.

FACTOR (A): THE AGENT UNDERTAKES TO GIVE IMPARTIAL ADVICE TO THE CONSUMER

8.49 Where an intermediary undertakes to give the consumer impartial advice about the choice of insurer, this strongly suggests that the intermediary acts for the consumer. This would be so, even if the intermediary fails to give impartial advice. A failure to give the promised advice indicates that the intermediary has agreed to act for the consumer, but has then failed in its duty to the consumer, rather than that it acts for the insurer.

FACTOR (B): THE AGENT UNDERTAKES TO CONDUCT A FAIR ANALYSIS OF THE MARKET

8.50 A single tie or multi-tie is not necessarily incompatible with being independent. An intermediary may select the insurer or panel of insurers after conducting a full analysis of the market. As the ABI points out, in these circumstances "the intermediary will continue to regard himself as independent and acting on behalf of consumers".

8.51 Take an example where the intermediary undertakes to give a consumer impartial advice, and selects a panel of insurers each year after a fair analysis of the market. If the panel includes (say) five different insurance firms, we think the fact that the panel was selected after a fair analysis of the market would strongly suggest that the intermediary acts for the consumer. The fair analysis is likely to outweigh the limited number of insurers. If the intermediary had a single tie, however, the court may look much more sceptically at the intermediary's claim to give impartial advice.

[5] ABI Response to the English and Scottish Law Commissions' Policy Statement on the Status of Intermediaries (May 2009).

FACTOR (C): THE CONSUMER PAYS THE AGENT A FEE

8.52 We think that consumers will generally associate paying a fee to an intermediary with the idea that the intermediary acts for them. The presence of a fee also reduces the likelihood that the intermediary will deliberately suppress information, which is often done to earn commission.

8.53 Note that the fee does not necessarily have to cover the whole cost. The intermediary may also receive a commission from the insurer. However, the smaller the fee compared to the commission, the less significant it will be.

8.54 In the policy statement, we suggested a further factor, where the intermediary provides full disclosure to the consumer of the commission it has received from the insurer. However, the ABI commented that "it is not clear why the disclosure of a commission means an intermediary acts for the consumer". We agree that this factor is not necessarily helpful and we have omitted it.

Factors tending to show that the intermediary acts for the insurer

8.55 In the policy statement we listed six factors which indicated a close relationship between intermediary and insurer. Following discussions with the ABI and others, we have slightly amended these factors. The draft Bill now lists five factors which may tend to show that the intermediary acts for the insurer.

FACTOR (A): THE AGENT PLACES INSURANCE WITH ONLY A SMALL PROPORTION OF THE INSURERS WHO PROVIDE THIS TYPE OF INSURANCE

8.56 In our policy statement we said that one factor would be where:

> The intermediary only places insurance with a limited number of insurers. (The smaller the number of insurers, the greater the indication that the intermediary acts for the insurer).

8.57 We explained that where an intermediary deals with a single insurer, we think that it should be taken to act for the insurer unless there are specific factors to show that it acts for the consumer. However, where an intermediary deals with five separate insurers, the issue is much more open.

8.58 The ABI pointed out that the number required to establish a close relationship may differ according to different markets. Thus in a large market (such as house insurance), a multi-tie of three may suggest a close relationship – while for niche products (such as caravan insurance) it might not.

8.59 Following the ABI's representations we amended this factor to refer specifically to "a small proportion" of insurers in the market.

FACTOR (B): THE INSURER PROVIDES THE INSURANCE THROUGH ONLY A LIMITED NUMBER OF AGENTS

8.60 When insurers deal through a large network of intermediaries, they may be wary of taking responsibility for small, unknown organisations they have little realistic means of monitoring. We do not wish to hasten the decline of small intermediaries by imposing responsibility on insurers in such circumstances.

8.61 However, where the insurer limits its distribution channels to a small number of intermediaries, this indicates a close relationship. In the absence of countervailing factors, we think it appropriate to make insurers responsible for preventing wrongdoing by such intermediaries.

FACTOR (C): THE INSURER PERMITS THE AGENT TO USE THE INSURER'S NAME IN PROVIDING THE AGENT'S SERVICES

8.62 This reflects the current law. Where a principal permits another party to conduct business using the principal's name, the law would normally regard that party as having ostensible authority to act as the principal's agent. The law recognises that consumers are unlikely to know that the insurer and intermediary are separate entities, and that they are likely to think they are dealing directly with the insurer.

FACTOR (D): THE INSURANCE IN QUESTION IS MARKETED UNDER THE NAME OF THE AGENT

8.63 This relationship is known as "white labelling". Typically, an insurer enters into a relationship with a bank, supermarket or other high street name, whereby the intermediary markets the insurance as its own. FSA rules require that the policy document contains the name of the insurer. However, the consumer would have to be an avid reader of small print to pick up that the bank or supermarket is an intermediary rather than an insurer. The marketing is designed to encourage the consumer to believe that the insurer and intermediary are the same body.

8.64 Where the insurance product is branded with the intermediary's name, the consumer is particularly vulnerable to bad advice from the intermediary, as they are likely to believe that anything said by the intermediary is said by the insurer. Thus if a representative of X Bank, selling X Insurance, states that there is no need to mention a previous shoplifting conviction on the form, the consumer is particularly unlikely to query the advice. A consumer will act quite reasonably in thinking that the direct assurance from an X bank representative takes precedence over any X-branded written material.

8.65 As a general rule, we think that insurers who enter into a "white-label" relationship with an intermediary should take responsibility for the actions of its business partner. If the intermediary makes misrepresentations to the insurer, the insurer is better placed to pursue the matter than the consumer.

FACTOR (E): THE INSURER ASKS THE AGENT TO SOLICIT THE CONSUMER'S CUSTOM

8.66 In the past, it was common for insurers to employ teams of agents to solicit business on their behalf, sending agents to knock on doors. There is authority to suggest that where an insurer asks an intermediary to solicit business in this way, the intermediary acts for the insurer. In *Winter v Irish Life Assurance plc*,[6] Sir Peter Webster observed that intermediaries were commonly held to have been acting as an agent for the insurer where:

[6] [1995] 2 Lloyd's Rep 274. See also *Arif v Excess Insurance Group Ltd* 1986 SC 317; *Whitlam v Andrew Hazel for Lloyds* [2004] EWCA Civ 1600, [2004] All ER (D) 28.

> … the intermediary was employed by or tied to the insurer and that, in that capacity, he had initiated the relationship between the insurer and the assured.[7]

The draft Bill preserves this aspect of the law. Although insurer-inspired soliciting is not perceived to be a current problem, it may return as a sales method.

8.67 Originally, we suggested a sixth factor, namely that "the insurer exerts substantial control over the way the agent conducts its business". However, the ABI and others argued this was confusing. It might be taken to relate to the organisational structure between the insurer and the intermediary, looking for example at whether the insurer owned a certain percentage of voting rights or capital in the intermediary. This was not our intention and we have omitted this factor from the legislation.

EXAMPLES

8.68 To illustrate how we see these tests working, we discuss four examples.

Intermediaries who deal with a range of insurers and do not provide advice

8.69 A recent report on the life insurance market noted "a very significant growth in the number of new, non-advised" sales of term insurance, coming directly from independently authorised firms.[8] These firms may not have close ties with any particular insurers. Neither will they conduct a fair analysis of the market or provide independent advice. In these cases none of the listed factors may be present. Nor will there be any other factors of note.

8.70 The starting point under the draft Bill is that the intermediary acts for the *consumer*. In other words, if there are no relevant circumstances to show that the agent acts for the insurer, then the agent is taken to act for the consumer. This differs from the policy proposed in our consultation paper, which considered an intermediary to act for the insurer, unless clearly independent.

Independently authorised tied agents

8.71 The intermediary may have arrangements to place the policy in question with a single insurer and yet have its own independent authorisation rather than act as the insurer's appointed representative. This is often the case where there is a well-known large intermediary, such as a supermarket or bank. The policy documents are likely to be branded with the intermediary's name, and the consumer may well not be aware of the existence of a separate insurer.

8.72 In each particular case the court will need to consider whether the relationship between the insurer and intermediary is such that it falls within one of the three cases where the agency relationship between them is automatically assumed. In some cases the intermediary will have been given express authority to bind the insurer or to collect or pass on pre-contract information on its behalf.

7 [1995] 2 Lloyd's Rep 274 at 282.

8 Swiss Re, *Term and Health Watch* (2008), p 11.

8.73 However, even where this is not the case, we would expect the factors in this type of arrangement to show that the intermediary acts as the insurer's agent. The intermediary places the insurance with only one insurer (factor (a)) and may market the insurance under its own name (factor (d)). There are no countervailing factors to suggest that the intermediary acts for the consumer.

Independently authorised multi-tied agents

8.74 Frequently an intermediary has links with a limited number of insurers – falling somewhere between the single-tied and the fully independent advisor. The links may be in the form of formal "ties" with the insurer, or some sort of more flexible "panel" arrangement.

8.75 In these cases, it is often difficult to decide for whom the intermediary acts. Simply because an intermediary decides to offer only a limited number of policies, it does not necessarily mean that any one particular insurer will necessarily be in a position to monitor and control the intermediary's behaviour. Instead, it is one factor to take into account.

8.76 If the intermediary undertook to give independent advice, or conducted a fair analysis of the market, then we think that the intermediary is acting for the consumer. If not, then the answer depends on the number of insurers in the market with which it deals, given the size of the market as a whole.

Price comparison websites: "aggregators"

8.77 It is now common for consumers to buy insurance through price comparison websites (known as aggregators).[9] The industry has already identified that consumers face various problems when using these sites[10] and the FSA undertook a review in May 2008.[11] It found two particular areas of concern:

(1) Many insurance comparison websites use "assumptions" to generate quotes. Not all of the websites made it clear to consumers what these assumptions were.

(2) The information provided by the consumer to the comparison site was on some occasions incorrectly passed on to the broker or insurer.

8.78 The role taken by the aggregator varies from case to case. In some cases the aggregator does little more than put the consumer in touch with the insurer, after which the consumer gives information to the insurer directly. For example, the aggregator may provide a link which takes the consumer to the insurer's homepage, where the consumer inputs the information required. Here there is no opportunity for the intermediary to be involved in a misrepresentation.

[9] Research from Datamonitor found that in 2008 three quarters of customers visited such sites at the time of their car insurance renewal.

[10] The British Insurance Broker's Association commissioned FWD to undertake research in January 2008 in relation to the use of aggregators: http://www.biba.org.uk/MediaCenterContentDetails.aspx?ContentID=388.

[11] FSA Review into general insurance comparison websites: www.fsa.gov.uk/pages/Doing/Regulated/Promo/thematic/review_gi_comparison.shtml.

8.79 In other cases, however, the aggregator plays a greater role in placing insurance. The consumer may input the relevant data just once, onto the form appearing on the aggregator's website. Then, once the consumer has selected which insurance to take up, the information on the form is transferred electronically to the insurer. This arrangement is attractive as it avoids the consumer having to input the same information twice. Here the FSA has identified that inaccuracies have arisen in the transmission of the information.

8.80 Another particular problem can occur in the collection of the relevant information. The aggregator's website may pre-populate the question form in order to obtain the lowest possible quote. For example, some proposals relating to car insurance will assume that the consumer has no driving convictions, leaving it to the consumer to alter this default option if necessary. The assumptions are often hidden away in the terms and conditions and the consumer may well not be aware of their existence. Where this form is then used as the basis of the policy, any inaccuracies in the assumptions will be passed from the intermediary to the insurer.

8.81 There is no case law on the present agency relationship of aggregators and we do not know how the FOS regards their position. Several aggregators assert that they do not act as the agent of either party. For example, confused.com explicitly states on its website that it is not a broker. It describes itself as a "search engine". However, it does pass information to the insurer. It seems to us that when it undertakes this task it must be doing so on behalf of one of the parties, and will therefore be acting as that party's agent.

8.82 Where the aggregator transmits the information electronically to the insurer's website we believe that the insurer must have given the aggregator express authority to do this. The aggregator will therefore be acting as the agent of the insurer in relation to the passing on of the pre-contract information. Where an error occurs in the transmission process, we consider that the insurer should take responsibility for it.

8.83 More difficult issues arise in relation to the collection of pre-contract information. The consumer may not input the correct information onto the form because they are not aware of the assumptions that the aggregator has already made. In some cases the insurer may have given the intermediary express authority to collect the information in this way. There would therefore be an automatic agency relationship between them. In other cases the court would need to look at the various factors in order to assess the closeness of the relationship. Unless a close relationship is proved, then, under the test in the draft Bill, the aggregator acts for the consumer in collecting the information.

PART 9
AMENDMENTS TO OTHER ACTS

9.1 In this Part, we start by considering the changes we are recommending to sections 17 to 20 and section 84 of the Marine Insurance Act 1906.

9.2 We then consider the implications of our draft Bill for section 152(2) of the Road Traffic Act 1988. This provision appears to allow an insurer to avoid compulsory motor insurance for non-disclosure or misrepresentation, but it operates only in extremely limited circumstances. Although the amendments we are making to section 152(2) are minor ones, the compulsory motor insurance scheme is complex and it is necessary to explain it in some detail.

AMENDING THE MARINE INSURANCE ACT 1906

9.3 In Part 5 we explained that the draft Bill abolishes the duty to disclose which is currently enshrined in the Marine Insurance Act 1906. In strict law, the 1906 Act applies only to marine insurance, and not to other forms of consumer insurance. However, the 1906 Act has been held to codify the common law.[1] Therefore, the draft Bill makes two separate changes to sections 17 to 20 of the 1906 Act. It amends those provisions in so far as they apply to those forms of marine insurance which are also consumer insurance. The draft Bill also modifies the common law rules to the same effect as those sections.

The insured's duty to disclose: sections 17 and 18

9.4 Section 17 sets out a general principle, namely that insurance contracts "are based upon the utmost good faith". If this is not observed, the other party may avoid the contract. Section 18 is said to be a specific example of this principle. It provides that before the contract is concluded the insured must disclose material circumstances to the insurer.

9.5 The draft Bill redefines utmost good faith in the context of consumer insurance. It replaces the duty on consumers to volunteer information with a duty to take reasonable care not to misrepresent. This modification to section 17 is so central to the reforms that the changes to section 17 are set out in clause 2. The changes to section 18 and other relevant sections of the 1906 Act are contained in clause 11 dealing with consequential provisions.

The agent's duty to disclose: section 19

9.6 Section 19 states that:

> Subject to the provisions of the preceding section as to circumstances which need not be disclosed, where an insurance is effected for the assured by an agent, the agent must disclose to the insurer –

1 See *Pan Atlantic Insurance v Pine Top Insurance Co Ltd* [1995] 1 AC 501 at 518, by Lord Mustill.

(a) Every material circumstance which is known to himself, and an agent to insure is deemed to know every circumstance which in the ordinary course of business ought to be known by, or to have been communicated to, him; and

(b) Every material circumstance which the assured is bound to disclose, unless it comes to his knowledge too late to communicate it to the agent.

9.7 Where the section is breached, the insurer has a right to avoid the policy against the policyholder.

9.8 In the consultation paper, we explained that section 19(b) appears merely to replicate section 18. Where the insured is bound to disclose information, and that information has not been disclosed, the insurer has a right under section 18 to avoid the policy. However, section 19(a) is more problematic. It entitles an insurer to avoid a policy against an insured because the agent failed to mention something known to the agent, but not known to the insured. In the consultation paper we considered the case in which a retailer arranged product insurance on behalf of its customers. In theory, if the retailer was aware that a brand of washing machine was prone to a particular fault, and failed to tell the insurer, the insurer could invalidate the customers' policies. However, we commented that we had not found any case in which the section has been applied in a consumer context.

9.9 We asked whether there was any reason to retain the two sub-sections for consumer insurance.[2] Most respondents confirmed that the section had never been used, and that the issue was "largely academic". If an insurer did attempt to use section 19 against a consumer, the FOS would use its "fair and reasonable" jurisdiction to prevent it. There was general agreement that if there were to be legislation in this area, section 19 should be disapplied in a consumer context.

The insured's duty not to misrepresent: section 20

9.10 Section 20(1) states that:

> Every material representation made by the assured or his agent to the insurer during the negotiations for the contract, and before the contract is concluded, must be true. If it be untrue the insurer may avoid the contract.

9.11 The section goes on to define a "material" representation and to distinguish between matters of fact and matters of "expectation or belief".

[2] CP, paras 12.75 and 12.76.

9.12 As we explained in Part 5, there are some aspects of this duty which we are preserving in the new scheme. In particular:

(1) We are retaining the concept of a misrepresentation as it has been interpreted in the current case law.[3]

(2) We are making no change to the timing of the misrepresentation. Section 20 states that the representation must be made "before the contract is concluded". The draft Bill uses slightly different terminology.[4] However, we do not intend this to be a substantive change from the current law.

(3) Our scheme preserves the "inducement test". This is not specifically mentioned in section 20, but was added to the definition of materiality by *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*.[5] It means that the insurer must show that without the misrepresentation, it would not have entered into the policy, either at all or on the same terms.

9.13 However, there are aspects of section 20 which we are not preserving. As explained in Part 6, an insurer will no longer be obliged to show that the misrepresentation was "material" in the sense that it would have influenced the judgment of a hypothetical prudent underwriter.[6] We do not wish to prevent insurers from developing niche markets, by selecting risks on the basis of facts which seem irrelevant to other insurers.[7]

9.14 Nor are we retaining the current distinction between matters of fact and matters of "expectation or belief". Under section 20, matters of fact must be true. However, matters of "expectation or belief" need only be made in good faith. This is more limited than misrepresentation in contract law generally, where it has been held that a statement of opinion may carry the implication that there are reasonable grounds for the belief.[8]

[3] See *Roberts v Avon Insurance Co* [1956] 2 Lloyd's Rep 240 and *Winter v Irish Life Assurance plc* [1995] 2 Lloyd's Rep 274, and the discussion at paras 5.41 to 5.54 above.

[4] Clause 4(1) states that the insurer has a remedy for a misrepresentation made by the consumer "before a consumer insurance contract was entered into or varied".

[5] [1995] 1 AC 501.

[6] Marine Insurance Act 1906, s 20(2).

[7] CP, paras 4.125 to 4.129, and proposal 12.15. For further discussion, see paras 6.10 to 6.12 above.

[8] *Brown v Raphael* [1958] Ch 636. See *Chitty on Contracts* (30th ed 2008) paras 6-007 to 6-010 and W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007) paras 6-22 to 6-23.

9.15 The courts have used the distinction between fact and belief to protect consumers who make an honest mistake, by designating the statement as one of belief. For example, in *Economides v Commercial Union Assurance Plc*,[9] a 21 year old student undervalued the contents of his flat after his parents moved in with him. The Court of Appeal found that as the value was a matter of opinion rather than fact, it was sufficient that the statement was made in good faith. However, the Court of Appeal was clearly influenced by the fact that the insured behaved reasonably in the circumstances. If the court had thought that the statement was unreasonable, it may well have designated it as a matter of fact.

9.16 We do not think that the distinction between fact and opinion is easy to make in practice. As Chitty comments:

> It is submitted that no simple distinction between statements of fact and statements of opinion or intention will sufficiently take account of the different varieties of possible statements which may be made in pre-contractual negotiations.[10]

Our scheme therefore removes the distinction between fact and opinion. Both statements of fact and statements of opinion must be made with reasonable care.

9.17 Finally, and crucially, under our reforms the remedy for a misrepresentation would no longer be automatic avoidance. The insurer would only be entitled to avoid the contract where the misrepresentation was deliberate or reckless, or where the insurer would not have entered into the contract at all. In other cases, the insurer would be entitled to a compensatory remedy.

9.18 **We recommend that sections 18 to 20 of the Marine Insurance Act 1906 (or any common law rules to the same effect) should not apply to consumer insurance contracts**.[11]

Returning premiums: section 84

9.19 This section sets out an insurer's duties to return premiums. Section 84(3)(a) states that where the policy is avoided by the insurer from the commencement of the risk, the premium is returnable, provided that there has been no fraud or illegality on the part of the assured.

9.20 In Schedule 1, paragraph 17, the draft Bill states that section 84 must be read subject to the new provision in paragraph 2(b). This allows an insurer to retain premiums where the consumer has made a deliberate or reckless misrepresentation, except to the extent that it would be unfair to the consumer. This is such a minor change that we did not consider it necessary to modify any common law rule to the same effect. The normal principle applies, which is that the common law must be read subject to statutory intervention.

[9] [1998] QB 587.

[10] *Chitty on Contracts,* para 6-010.

[11] See draft Bill, cl 11(1) and (2).

SECTION 152(2) OF THE ROAD TRAFFIC ACT 1988

The scheme for compulsory motor insurance

9.21 The Road Traffic Act 1988 sets out a scheme for compulsory motor insurance. Under Part VI of the Act, it is compulsory for motorists to insure against liability for death or bodily injury to third parties and for damage to property belonging to third parties (though property damage is limited to £1 million).

9.22 Once a motor insurer has issued an insurance certificate, it is obliged to pay a third party who has obtained judgment against the insured in respect of a compulsory liability. The Act gives third parties wide-ranging protection. For example, section 148 states that various exclusions are of no effect against the third party. Thus the insurer may not refuse to pay the third party because the insured has broken a policy term relating to the condition of the vehicle or the age of the driver. Under section 151(5), the insurer is required to pay the third party even when it is entitled to avoid or cancel the policy as against the insured, or has already done so.

9.23 However, the insurer's obligation to pay third parties is qualified by section 152. The section sets out various exceptions under which the insurer is not required to satisfy a judgment. Most are procedural in nature. For example, section 152(1)(b) provides that the insurer will not be liable while execution of the judgment is stayed pending an appeal.

9.24 For the purposes of this report, the relevant provision is section 152(2). Under this section no sum is payable by an insurer under section 151 if it obtains a declaration from the court that it is entitled to avoid the policy on the ground that the policy was obtained:

(i) by the non-disclosure of a material fact; or

(ii) by the representation of a fact which was false in some material particular.

9.25 Thus, despite section 151(5), as Professor Clarke has said, "what is taken from the insurer by one hand of Parliament appears to have been given back by another".[12] Although section 152(2) does not mention the Marine Insurance Act 1906, it echoes the language of sections 18 and 20. Thus the reference to avoiding for non-disclosure under section 152(2)(a)(i) above appears to mean the same as avoiding for failing to make a disclosure under section 18 of the Marine Insurance Act 1906.[13]

[12] M Clarke, *The Law of Insurance Contracts* (4th ed 2002) para 5-9C.

[13] See *Zurich General Accident and Liability Insurance Co Ltd v Morrison* [1942] 2 KB 53. At one time it was thought that the two tests were slightly different as under section 152(2) the policy had to be "obtained" by the non-disclosure (that is, the insurer had to be induced to enter the contract). However, since *Pan Atlantic Insurance v Pine Top Insurance Co Ltd* [1995] 1 AC 501 this aspect of the section 152(2) test has been incorporated into the Marine Insurance Act 1906.

The practical significance of section 152(2)

9.26 Section 152(2) has a long history. It was included in the legislation when compulsory motor insurance was first introduced in 1934.[14] At the time, the section meant that third parties would be denied payment in the event of a non-disclosure. Today, however, the practical effect of section 152(2) is much less than first appears. This is because third parties are given a further level of protection through the Motor Insurance Bureau (MIB). The MIB scheme ensures that third parties are paid, even if the driver was uninsured or had misrepresented a relevant fact.

9.27 Under an agreement between the MIB and the Government,[15] the MIB compensates the victims of uninsured drivers where there is no other insurer to meet the claim. However, where a policy has been avoided, the MIB does not meet the claim directly. Instead, under Article 75 of the MIB's Articles of Association,[16] the liability is passed back from the MIB to the insurer who has avoided the policy. In other words, the original insurer is required to step into the shoes of the MIB. It becomes an "Article 75 insurer".

9.28 Thus in most cases there is little point in an insurer using section 152(2) to avoid a policy. Even if the insurer succeeds in avoiding liability under the Road Traffic Act, it will simply have to pay the claim under Article 75. Section 152(2) only becomes useful to an insurer when there is another insurer in the frame to meet the third party's claim. This may happen in three types of case.

(1) Where the accident was caused by two or more people. Take a case, for example, where drivers A and B are both responsible for injuring victim C. If B's insurer avoids under section 152(2), then, under the MIB's rules, A's insurer must satisfy the whole claim. This is true even if B was mainly to blame and A was only, say, 10% liable.

(2) Where the damaged property is covered by other insurance ("subrogated claims"). Take a case in which driver A collides with a wall, causing damage to C's house. If C had insured the house against collision damage, C's property insurer would be required to pay for the damage and recover the amount from A's motor insurer. Under the MIB agreement, C's insurer will not be entitled to recover if A's insurer uses section 152(2) to avoid the policy.

(3) Where the motorist is insured with two insurers for the same loss ("double insurance"). Take a case in which a consumer is covered under his or her own car insurance with Insurer A to drive any car, and as a named driver with Insurer B to drive his or her spouse's car. If A obtains a declaration under section 152(2), B must pay the full amount of the third party claim.

[14] Road Traffic Act 1934, ss 10(1) and 10(3).

[15] A copy of the agreement is available at http://www.dft.gov.uk/pgr/roads/miud/uninsureddriversagreement.

[16] Available at http://www.mib.org.uk/NR/rdonlyres/C8092E35-A79E-4DBB-A8D3-5FA1682941A7/0/MIBArticles030708_5500825_.pdf.

9.29 We are told by the MIB that these scenarios do arise, but infrequently. In each case, the dispute is between two insurers about how the loss will be allocated. The third party is always compensated.

9.30 Under the MIB agreement, there is an exception to the principle that a third party will always be compensated: a passenger will not be compensated for the injuries caused by an uninsured driver if the passenger knew or ought to have known that the driver was uninsured at the time. However, we do not think that this exception would apply where the insurer avoids under section 152(2). By definition, section 152(2) only applies where the driver is insured under a policy which must be avoided.[17] Thus the passenger cannot know that the driver was uninsured.

Our recommendation

9.31 During the course of the review, we considered whether to repeal section 152(2) altogether. This would simplify the Act and remove the potential for insurers to engage in prolonged arguments among themselves about who was responsible for a particular loss. However, the MIB and ABI made a strong plea to us not to change the present delicate arrangements under which uninsured losses are allocated within the industry.

9.32 We have therefore pursued the second option, which is to amend the section to bring it in line with our draft Bill. Our policy is that where the insurance falls within the definition of consumer insurance, insurers should only be able to use section 152(2) in circumstances where avoidance is possible under the draft Bill. This means that the insurer may avoid where the misrepresentation or non-disclosure was deliberate or reckless, or where it was careless and the insurer would not have entered into the policy at all.

9.33 We do not think that section 152(2) should apply where the insurer would be liable, but only for a proportionate sum. The policy behind the compulsory insurance scheme is that an insurer should be liable in full to a third party, even if the insured has made a mistake or breached a policy term. In 1934, a specific exception was made for non-disclosure and misrepresentation, because they were considered so serious. We think that this exception should be confined to serious cases. Allowing section 152(2) to be used when the insurer was liable for a proportion of the claim would lead to complex and unnecessary disputes between insurers. It would not produce outcomes that were fairer to the parties involved, or more efficient in economic terms. The box below gives an example.

[17] In *Adams v Dunne* [1978] RTR 281 it was held that a policy which is voidable but not yet voided is still "in force". Thus until an application under s 152(2) is made, the driver is still insured.

A and B are involved in an accident. C is a passenger in A's car, and sues both A and B. A is found 10% liable, whereas B is found 90% liable. If B's insurer is able to seek a section 152(2) declaration, then under the MIB's rules, A's insurer will have to settle the entirety of C's claim. Where B's insurer would be entitled to avoid under the draft Bill, this outcome would remain.

However, it is our view that if B's insurer would be entitled to a proportionate remedy if paying B – in paying the third party C under the 1988 Act it cannot take advantage of that and should pay its full share of the judgment.

There may be an argument that, if the proportionate remedy amounts to 50%, then B's insurer should pay that proportion of B's share of the claim – that is, 45%. That would leave 55% to be paid by A's insurer under Article 75. However, we think this result is no fairer or more efficient than to leave A's insurer paying 10% of the claim and B's insurer paying 90% of the claim.

The amended section

9.34 Clause 11(3) of the draft Bill adds words to section 152(2). Below we reproduce section 152(2), with the added words shown in italics:

> Subject to subsection (3) below, no sum is payable by an insurer under section 151 of this Act if, in an action commenced before, or within three months after, the commencement of the proceedings in which the judgment was given, he has obtained a declaration –
>
> (a) that, apart from any provision contained in the policy or security, he is entitled to avoid it *either under the Consumer Insurance (Disclosure and Representations) Act 2009 or, if that Act does not apply,* on the ground that it was obtained
>
> (i) by the non-disclosure of a material fact, or
>
> (ii) by a representation of fact which was false in some material particular, or
>
> (b) if he has avoided the policy or security *under that Act or* on that ground, that he was entitled to do so apart from any provision contained in [it] *the policy or security*.

9.35 **We recommend that, for consumer motor insurance, an insurer should only be entitled to a declaration under section 152(2) of the Road Traffic Act 1988 if it would be entitled to avoid the policy under the draft Bill**.[18]

[18] See draft Bill, cl 11(3).

PART 10
PROPOSALS NOT INCLUDED IN THE DRAFT BILL

10.1 In this Part we consider three proposals which we have decided not to include in the draft Bill. The first proposal concerns warranties. The second is for a five-year non-contestability period in life insurance. Finally, we have considered whether to require the courts to take account of industry guidance where it would give the consumer greater rights than would be required under our draft Bill.

WARRANTIES

10.2 Warranties are terms of insurance contracts which are accorded special status under the Marine Insurance Act 1906. The draft Bill does not reform the law of warranties, except to abolish "basis of the contract" clauses.[1] In our summary of responses we explained that we had decided to postpone reform of consumer warranties and deal with them alongside the business reforms.[2]

Sections 33 and 34 of the Marine Insurance Act 1906

10.3 Section 33 of the 1906 Act refers to warranties "by which the assured undertakes that some particular thing shall or shall not be done, or that some condition shall be fulfilled, or whereby he affirms or negatives the existence of a particular state of facts".

10.4 Where the insured gives such a warranty "it must be exactly complied with, whether it be material to the risk or not". If not, the insurer is discharged from all further liability, including liability for claims which have nothing to do with the breach. Section 34(2) confirms that once a warranty is broken the insured "cannot avail himself of the defence that the breach has been remedied" before the loss.

10.5 This has the potential to operate harshly. For example, if a warranty required the insured to maintain a fire alarm, then a strict interpretation of section 33 would mean that a delay in maintaining the alarm would discharge the insurer for liability for all further claims. The insurer may refuse claims for flood and burglary, which had nothing to do with fire. It would even allow the insurer to refuse a claim that arose after the maintenance had been carried out, at a time when the alarm was operating perfectly.

[1] This is a technical way in which insurers can turn representations on proposal forms into warranties. Such clauses are discussed further in paras 2.23 to 2.28 above.

[2] Reforming Insurance Contract Law: a summary of responses to consultation on consumer issues (May 2008), Part 4.

10.6 The courts frequently interpret policy terms in a way that avoids these draconian effects.[3] They may, for example, interpret the warranty narrowly, so that it does not apply to the facts in question,[4] or not to the whole policy,[5] or not to future conduct.[6] The courts may also find that the term, on its proper construction, is not actually a warranty. Instead, it may be some other form of term, such as a definition of the risk or a temporal condition.[7]

10.7 This has left the definition of a warranty somewhat confused. There is no single form of words which confers warranty status on a term. The use of the word "warranty" is indicative but not decisive. Often the decision on whether a term is a warranty depends on the effect the courts think that the term should have. As Lord Justice Rix put it:

> It is a question of construction, and the presence or absence of the word "warranty" or "warranted" is not conclusive. One test is whether it is a term which goes to the root of the transaction; a second, whether it is descriptive or bears materially on the risk of loss; a third, whether damages would be an unsatisfactory or inadequate remedy.[8]

Previous proposals

10.8 In November 2006, we published an Issues Paper which suggested that an insurer should only be permitted to refuse a claim for breach of warranty if there is a causal connection between the breach and the loss. We said that this should not only affect warranties in the strict sense, but should also apply to other terms with a similar effect. However, we accepted that some clauses were fundamental (for example, the geographic area in which the loss took place or the purpose for which a vehicle was used). We said that these should be exempt from the causal connection test. Many respondents considered this unduly complex and arbitrary.

[3] See the discussion in CP, paras 2.54 to 2.66.

[4] *Provincial Insurance v Morgan* [1933] AC 240.

[5] *Printpak v AGF Insurance Ltd* [1999] Lloyd's Rep IR 542.

[6] *Hussain v Brown* [1996] 1 Lloyd's Rep 627.

[7] See *Farr v Motor Trading Mutual Insurance* [1920] 3 KB 669 and *Kler Knitwear v Lombard General Insurance Co* [2000] Lloyd's Rep IR 47.

[8] *HIH Casualty and General Insurance Ltd v New Hampshire Insurance Co* [2001] EWCA Civ 735 [2001], 2 Lloyd's Rep 161, para 101.

10.9 In the 2007 consultation paper we changed our view. We proposed that the causal connection test should apply only to terms which are currently considered to be warranties.[9] We thought that, in consumer contracts, other terms which had a similar effect to warranties should continue to be controlled by the Unfair Terms in Consumer Contracts Regulations 1999. We did, however, identify a need to extend protection against unfair terms to less sophisticated businesses which contracted on the insurer's standard terms. We said that the insurer should not rely on a warranty, exception or definition of the risk in standard terms if it rendered the cover substantially different from what the insured reasonably expected.[10]

10.10 Academics criticised our proposal to apply a causal connection test to warranties in a strict sense on the ground that it is extremely difficult to define a warranty. It was said that terms with a similar effect should be regulated in the same way. Professor Robert Merkin and Professor John Lowry wrote:

> In our view it makes sense for clauses with the same objective to be regulated in the same way, and indeed any attempt to ban a particular form of clause may well lead to insurers adopting another form of clause to the same effect. It makes particular sense for insurers not to use clauses which have consequences far beyond their purpose, a warranty being the obvious example of that possibility. Our starting points are, therefore, that: clauses with the same object and effect should be treated in the same way; and warranties should be removed from English jurisprudence.

10.11 As we explained in the summary of responses, the same obligation can be phrased in different ways. A consumer may "warrant" to fit (and use) a mortice deadlock: alternatively, the policy may exclude burglary claims unless a mortice deadlock was fitted (and in use) at the time of the loss. Under strict law these two provisions have different consequences:

(a) The first may be considered a warranty. If so, section 33 of the Marine Insurance Act 1906 provides that if the policyholder commits a minor breach (by for example fitting the lock a week after the promised date) the insurer is discharged from all future liability under the policy. The insurer would not be liable for a subsequent burglary, even if the mortice lock had been fitted by the time the burglary took place.

(b) The second approach would be a "temporal condition". The insurer could only refuse to pay a claim if it could show that the lock was not in use at the time of the burglary. However, it would not have to show that the lack of a lock made any difference. It could refuse a claim even if the burglars had climbed in through a smashed window.

Thus it seems odd to require a causal connection test in the first example but not the second.

[9] CP, para 8.4.

[10] CP, para 12.59.

10.12 Meanwhile insurers argued against granting businesses protection against unfair terms in all contracts written on the insurer's standard terms. Standard terms were said to be used in many types of contract, not just those affecting small and medium businesses. In April 2009 we published a further Issues Paper which proposed that the protection against unfair terms should only apply to consumers and to "micro-businesses", that is the smallest businesses with nine or fewer staff.[11]

Why it is not worth legislating on warranties just for consumers

10.13 We do not think that there is need to reform sections 33 and 34 of the 1906 Act just in a consumer context. Consumer contracts rarely use warranties in the narrow sense of the 1906 Act. In our survey of 50 FOS cases concerned with policy terms, we did not find any consumer policies that used strict warranties in this way. Many insurers confirmed this position in their responses. Warranties are used much more extensively in a small business context.[12]

10.14 Effectively, our proposals were a tidying up exercise, in which the more extreme provisions of the Marine Insurance Act 1906 would be repealed. The purpose of our reform was to resolve inconsistencies in the law rather than to address a substantive injustice. In the absence of a widespread or specific consumer problem, our current view is that this would be done more effectively alongside the business provisions.

Could we clarify the Unfair Terms in Consumer Contracts Regulations?

10.15 Where insurers do use unfair terms in their policies, insureds already have protection, not only before the FOS and under FSA rules, but also under the Unfair Terms in Consumer Contracts Regulations 1999. In the consultation paper we commented that the Regulations were not well understood, with widespread misunderstandings about when terms are exempt from review because they are "core terms".[13]

10.16 In 2005 the English and Scottish Law Commissions published a joint Report and draft Bill on Unfair Contract Terms.[14] This was not intended to make substantive changes, but aimed to rewrite the existing law on unfair terms in clearer and more accessible terms. In May 2008 we said that we would give further consideration to whether implementing the relevant consumer sections of our draft Bill on Unfair Contract Terms in an insurance context would be helpful by making the law clearer and more explicit.[15]

[11] Issues Paper 5: Micro-businesses – should micro-businesses be treated like consumers for the purposes of pre-contractual information and unfair terms? (April 2009).

[12] We recently compared five consumer policies with 16 micro-business policies. None of the consumer policies we looked at contained references to "warranties". However, four of the micro-business policies contained warranties. Two contained a section on warranties, each with over 10 separate provisions. Similarly, our analysis of ombudsman decisions found several small business disputes over warranties: see CP, paras 7.25 to 7.37.

[13] CP, para 7.42.

[14] Unfair Terms in Contracts (2005) Law Com No 292; Scot Law Com No 199.

[15] Reforming Insurance Contract Law: a summary of responses to consultation on consumer issues (May 2008), para 4.24.

10.17 However, that option is no longer open to us. In October 2008, the European Commission published a proposal for a directive on consumer rights on the basis of "maximum harmonisation".[16] "Maximum harmonisation" means that legislation within member states must exactly mirror the EU directive. It cannot give consumers either more or less protection in any respect. Chapter V of the proposal includes provisions on a single regime for unfair terms across the European Union.[17]

10.18 If this proposal were carried, it would no longer be open to member states to introduce their own separate legislation on unfair terms in consumer contracts. This would apply both to general provisions and provisions which affected only one sector, such as insurance. In practical terms, this means that any future legislation on unfair terms in consumer insurance contracts must await the outcome of negotiations over the European Commission's proposals.

10.19 **We do not recommend that legislation which applies only to consumer insurance contracts should attempt to reform the law on warranties.**

NON-CONTESTABILITY PERIODS IN LIFE INSURANCE

10.20 Particular problems may arise in long-term business where many years often elapse between filling in the proposal form and making the claim. In the consultation paper, we noted that many jurisdictions dealt with this issue by imposing cut-off or "non-contestability" periods. This means that the insurer is prevented from relying on a non-fraudulent misrepresentation at the applications stage once the policy has been in force for a set period – usually between two and five years.

10.21 In our first Issues Paper, we asked whether insurers should be prevented from relying on non-fraudulent misrepresentations after the policy has been in force for three years. This drew strong reactions, both for and against. Some argued that it would increase consumer confidence. Others thought it would encourage fraud, increase costs and lead to inconsistent treatment between consumers.

10.22 We were told that at present most life insurers do not investigate misrepresentations made more than five years previously in the absence of evidence of fraud. It was suggested that it would increase consumer confidence to have this good industry practice built into law, without adding substantially to costs. On this basis we asked whether in consumer life insurance, insurers should be prevented from relying on a negligent misrepresentation after the policy has been in force for five years.[18]

Responses

10.23 Respondents were again split on this issue. Of the 61 consultees who addressed this issue, 34 were in favour; 24 thought that there should not be a cut-off period; while three would have preferred the shorter period of three years.

[16] COM (2008) 614/3.

[17] See Chapter V. The proposal also deals with consumer information, withdrawal rights and consumer sales.

[18] CP, para 12.23.

10.24 The FOS commented that it did not think this proposal would have a significant effect if the other proposals were enacted. However, it did see some benefit. Some insurers gave tentative agreement, on the basis that the proposal did not extend to fraud, only applied to life cover, and was for five years (rather than the original three).

10.25 However, a majority of insurers (including most life insurers) opposed the proposal on the grounds that it would lead to more misrepresentations in life policies and would increase costs. Insurers feared the effect of such a rule on consumer behaviour. For example SCOR Global Life accepted that it was already standard practice in the life industry to disregard minor matters if the policy has been in force for five years or longer. However, it argued that it was hard to predict how consumers would react if this was known to be a hard and fast rule.

10.26 Some argued that there was no logic in applying more restrictive tests to life insurance than to other long term insurance, including critical illness and income protection. Others, however, suggested that fraud was more of a problem in relation to critical illness and income protection insurance because the insured was alive to enjoy the benefits of it. Insurers said they needed greater protection in relation to these policies, and would strongly oppose any suggestion that a non-contestability provision should be applied to critical illness or income protection policies.

Our recommendation

10.27 We accept that a five-year cut-off applying only to life insurance was an arbitrary measure, and not essential to the scheme. Although some insurers may decide to offer a five-year cut-off period to reassure consumers, we do not think it should be included within legislation. It is difficult to know how consumers would respond to such a change, and we would not wish to give the impression that careless answers are acceptable.

10.28 **We do not recommend that the law should prevent insurers from obtaining a remedy for a careless misrepresentation because a set period has passed since the misrepresentation was made.**

SHOULD THE COURTS FOLLOW INDUSTRY GUIDANCE?

10.29 Industry guidance or codes of practice may go further than our draft Bill in protecting consumers. We have therefore considered whether the courts should refuse to allow an insurer to reject a claim where this would otherwise be allowed in law, but where it would contravene an industry code or written guidance.

10.30 To this end, Parliamentary Counsel drafted a provision which could be included within Schedule 1 of the draft Bill. It read as follows:

> The insurer may not take advantage of any remedy provided for under this Schedule if, or to the extent that, it would be unreasonable to do so according to written guidance generally recognised by insurers providing the type of insurance in question.

10.31 Whilst it is unusual for legislation to refer to industry guidance in this way, it is not unknown. For example, the Mineral Workings (Offshore Installations) Act 1971, Schedule, paragraph 15, referred to "the provisions of any recognised industrial code of practice" and the Income Tax Act 2007, section 997, mentioned "generally accepted accounting practice".

The ABI's Code of Practice for long-term protection insurance

10.32 We have considered this provision in the light of the ABI's 2008 Guidance on non-disclosure on long term protection insurance,[19] which was upgraded to the status of a code in 2009.[20] In some ways, the ABI's Code of Practice goes further to protect consumers than our core scheme requires.

10.33 There are three instances in which the ABI's Code would prevent an insurer from pursuing remedies which would be available to it under our draft Bill. These are where:

(1) The insurer conducts an unjustified trawl through medical records.[21] An insurer may not use information from unjustified trawls to reject claims.

(2) A deliberate or reckless misrepresentation would only have made a small difference to the premium.[22] Here the ABI says that the insurer should not avoid the whole policy but should apply a proportionate remedy.

(3) The consumer has bought a combined policy covering, for example, critical illness, life, total permanent disability (TPD) and waiver of premiums benefits. Under the Code, the TPD and the waiver of premiums benefit are regarded as severable.[23] Thus if a consumer made a deliberate or reckless misrepresentation which was relevant only to the TPD cover, the insurer should only avoid the TPD cover and should pay other claims. While this is a useful indication of current industry practice, it is not necessarily the law. In law whether a benefit is severable would depend on the true construction of the policy.

[19] ABI Guidance, "Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products" (January 2008).

[20] ABI Code of Practice, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009).

[21] Above, paras 3.6 and 3.7.

[22] Above, para 8.3.2. The Code states that "the severe remedy of avoiding a policy from the outset should be confined to the most serious cases of non-disclosure". It goes on to explain that insurers should not avoid the policy where:

> The degree of materiality associated with the non-disclosure is relatively low and, in cases where a premium rating would have applied, the underlying risk premium rating resulting from the non-disclosed information in aggregate would not have been more than +50% (or £1/mil) for the applicable life assured.

[23] Above, para 6.2.

10.34 The FOS has indicated its intention to enforce the Code. Under section 228 of the Financial Services and Markets Act 2000, it must determine complaints by reference to what is fair and reasonable in all the circumstances of the case. To this end, it may have regard not only to the law but also to accepted industry practice. Thus, even after the enactment of our draft Bill, the FOS would continue to have regard to relevant codes of practice. The FOS may therefore be more favourable to the consumer than the law requires.

10.35 The question is whether the courts should be required to take into account industry guidance or codes, where these are more favourable to the consumer.

The arguments for

10.36 The advantage of requiring the courts to have regard to industry codes is that it would reflect the practice of the FOS. It would prevent the confusion caused by two sets of rules, one applied by the courts and another by the FOS. It would also prevent unfairness to consumers with claims over £100,000, who therefore fall outside the FOS compulsory jurisdiction.

10.37 Furthermore, as discussed in Part 3, the ABI has put a strong case in favour of flexibility, arguing that consumer protection needs to change with an evolving market. Requiring the courts to take account of industry codes in this area would enable those working in the market to update the law by addressing perceived problems as they come to light.

The arguments against

10.38 There are three arguments against the provision.

(1) It would effectively give the ABI and other industry bodies the power to bind non-members, which may not be appropriate.

(2) It may introduce uncertainty. It may not always be clear what constitutes "written guidance generally recognised by insurers". Furthermore, the various codes and forms of guidance are not necessarily written as legal documents, which means they may be difficult to apply in a court of law.

(3) The provision may have a chilling effect in discouraging industry representatives from putting guidance in writing.

10.39 The ABI argued strongly against including the provision. In its response to us on an early version of the draft Bill, it wrote:

> One of the major advantages of industry guidance is that it is not as rigid as primary legislation. Its flexibility allows it to adapt and respond to the changing needs of the market. This will be lost if, in effect it is elevated … to legislative status.

10.40 The ABI suggested that if the provision were to be included in legislation, it would "raise questions over the future status, role and appropriateness of the Code". It would be highly unusual for a trade body to be able to bind non-members and it would "also make it more difficult for guidance to be agreed, with the obvious consumer detriment".

10.41 We are not entirely convinced that codes of practice lose their flexibility if those who agree them become legally bound by them. However, we accept that the ABI may be reluctant to impose its views on non-members, and we would not wish to discourage the industry from agreeing codes and guidance.

Our conclusion

10.42 Having considered the arguments on this issue, we have decided, on balance, to omit the paragraph from the draft Bill. We do not wish to give the ABI or other industry bodies the power to bind non-members if this is thought to be inappropriate. Nor would we wish to discourage the industry from agreeing codes to be applied by the FOS.

10.43 **We do not recommend that the courts should have the power to prevent insurers from seeking a remedy otherwise available under our draft Bill because the insurer's actions contravene recognised industry guidance**.

PART 11
ASSESSING THE IMPACT OF OUR RECOMMENDATIONS

11.1 We have published a full assessment of the impact of our recommendations, which is available separately on our websites.[1] It looks generally at the costs and benefits of our proposals. It also considers the specific impact on competition, small firms, gender equality, disability equality and legal aid. In this Part we summarise our findings.

11.2 The draft Bill is not substantively different from current FOS guidelines. Insurers are already expected to treat their customers fairly, and the FOS will already overturn insurers' decisions which breach its guidance. There are, however, some areas of confusion, where some insurers do not appear to understand what the FOS requires. Our aim is to clarify ombudsman guidance and improve compliance with it. We think that insurers will be less likely to reject claims if to do so would contravene the law, and if they do, consumers will be more likely to seek redress. The intended effects of our recommendations are to increase compliance with good practice and improve confidence in the insurance industry.

PREVIOUS STUDIES

11.3 Two studies were commissioned into the costs and benefits of the proposals made in our 2007 consultation paper. Alongside the consultation paper, we published a report from London Economics, which used the critical illness market as a case study for the impact of reform.[2] The ABI also commissioned an independent report from PricewaterhouseCoopers (PwC) into the financial impact of our proposals. This major study was published in November 2007.[3]

11.4 In assessing the impact of our proposals we have drawn heavily on the PwC report. It is important, however, to stress that PwC considered a range of options (including a five year non-contestability period) which we are no longer recommending. Furthermore, insurers have changed their approach since 2007. We have therefore recalculated the costs and benefits identified by PwC, looking only at the options currently under review, and taking into account recent developments.

11.5 The impact of our recommendations will differ between protection insurance and general insurance. Below we consider each in turn.

[1] See www.lawcom.gov.uk/insurance_contract.htm; www.scotlawcom.gov.uk.

[2] London Economics, *Final Report: A proposed model for assessing the economic impact of proposed changes to the law relating to non-disclosure and misrepresentation* (June 2007). See Appendix B to the consultation paper.

[3] PricewaterhouseCooper LLP, *ABI Research Paper 5: The Financial Impact of the Law Commission's Review of Insurance Contract Law* (November 2007).

LIFE AND PROTECTION INSURANCE

The effect on claims payments

11.6 Both the PwC and London Economics reports identified the main effect of our proposals as leading to more proportionate payments and fewer outright rejections.[4] This is because the consultation paper proposed a narrower definition of "deliberate or reckless" and a wider definition of "negligent" than the one which was then used by many insurers.

11.7 London Economics took critical illness as a case study, and calculated the cost of increased proportionate settlements as £10 million across critical illness claims as a whole.[5] Interestingly, PwC came to a similar conclusion using a different methodology. It calculated the cost of an increase in proportionate settlements as £11 million for policies covering both term insurance and accelerated critical illness cover, plus another £0.5 million for stand-alone critical illness claims.[6]

11.8 Across the whole protection market, PwC calculated that clarifying the definition of deliberate or reckless, and increasing the number of proportionate payments would increase the amount of claims paid by up to £22 million.[7]

11.9 We think these costs and benefits represented a reasonable estimate of the cost of implementing our proposals at the time of calculation in 2007. At the time, critical illness insurers declined around 12% of claims for reasons of non-disclosure.[8] Thus the effect on premiums would have been greatest in the critical illness market, where PwC estimated that it would add around 0.4% to premiums.[9]

11.10 However, the practice of insurers has now changed. In January 2008, the ABI responded to public concern by issuing formal written Guidance on non-disclosure in protection insurance.[10] In particular, the Guidance adopted the definition of deliberate or reckless that we proposed in our consultation paper. In January 2009 the ABI upgraded the status of the Guidance to that of a Code of Practice.[11] This means that compliance with the Code is now a condition of ABI membership. At the same time, the number of critical illness complaints reaching the FOS has fallen sharply.[12]

[4] PwC, above, p 52; London Economics, above, p 36.

[5] London Economics, above, p 47.

[6] PwC, above, pp 53-54.

[7] Above, pp 52-54 and 124.

[8] London Economics, above, p 43; PwC, above, p 44.

[9] Above, p 55.

[10] ABI, "Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products" (January 2008).

[11] ABI, "Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products" (January 2009).

[12] In 2006-07, the FOS closed 308 complaints about non-disclosure in critical illness insurance, whereas in 2008-09 the FOS closed only 105.

11.11 This means that many of the costs (and benefits) of our consultation paper proposals have already materialised. However, compliance is not total. In 2008-09, the FOS overturned the insurer's decision in just over half of all complaints about critical illness insurance, compared with a fifth of complaints about motor insurance.[13] Law reform would therefore consolidate existing trends and extend accepted industry good practice to the minority of claims handlers who do not currently apply the ABI Code. It would not, however, have a dramatic effect on overall claims payment.

11.12 We think that at least 80% of the costs predicted by PwC have already become part of industry practice. This suggests that the cost of our reforms in increasing the claims paid by insurers to consumers will be in the region of £4.4 million.

11.13 In terms of costs and benefits, this represents a direct cost of £4.4 million to those insurers who currently do not comply with the ABI Code and who will review their practices in the light of the new legislation. At the same time, it represents a direct benefit of £4.4 million to those consumers who will now receive a proportionate payment of their claim rather than an outright refusal. In the long term, however, any additional cost of claims is likely to translate as an increase in premiums, in the order of 0.08%.

The effect on sales

11.14 PwC considered how far a 1% increase in premium would affect sales. It concluded that even such a large premium increase (12.5 times larger than the increase we predict based on our final recommendations) would have no noticeable effect on sales or demand. In its report PwC commented that:

> The more general economic and commercial concerns are likely to dominate fluctuation in sales and demand and that, in the current environment among the top 10 providers it is not uncommon to have premium rates differing by up to 25% for the same risk. We do not, therefore, expect any noticeable effect on sales or demand from the changes arising from the Law Commission's proposals.[14]

11.15 The report stressed that "it is important to note, however, that demand will not only change due to changing price but also due to benefits that individual consumers may perceive from the Law Commission's proposals".[15] Thus as consumers become more confident of being treated fairly, consumer insurance sales are likely to increase.

[13] For further details, see Appendix C.

[14] PwC, above, pp 140-141.

[15] Above.

11.16 Confidence that insurers will treat claims fairly is crucial to the market for protection insurance. A collapse in confidence may therefore lead to a sudden collapse in sales. In 2007, the Chartered Insurance Institute commented in its response to us that the high refusal rates for critical illness insurance had led to poor public confidence in this market. The FSA data show that sales of stand-alone critical illness policies fell by 49% from 86,000 in 2006-07 to 44,000 in 2007-08.[16] Swiss Re suggested that "concerns around the viability of the product, premium increases and generally negative comment around entitlement to, and payment of claims, were all seen as contributing factors to this decline".[17]

11.17 Furthermore, the practice of the minority of insurers may undermine confidence in the products offered by the majority. In 2007, declinature rates for reasons of non-disclosure for critical illness claims varied between 3% and 17%, depending on company policy. Yet this information may not be readily accessible to consumers, which means that the reputation of the majority of insurers may be undermined by a limited number of firms. We think that underpinning good practice with clear law will address this problem.

11.18 By increasing consumers' confidence that insurers will behave fairly, our reforms are likely to increase sales. Swiss Re has identified a "protection gap", calculated as the difference between the resources needed and the resources available to maintain a family's living standard after the death of the primary earner. We think that this gap is more likely to reduce than increase following our proposed reforms.

11.19 The Government and the insurance industry recently set out a vision for insurance in 2020, which suggests a greater role for protection insurance in dealing with unemployment, ill-health and long-term care.[18] This makes it even more important that consumers should have confidence that valid claims will be paid.

GENERAL INSURANCE

11.20 The effect on general insurance is more difficult to calculate. PwC identified the main effect of the changes as encouraging insurers to ask better questions, especially at renewal:

> At the renewal stage it is likely that the insurers would need to implement a more robust process in terms of the information sent to the insured, which would include developing systems to generate more detailed statements to be sent and agreed by the insured.[19]

[16] Financial Services Authority, *Pure Protection Contracts: Product Sales Data Trends Report* (September 2008), p 2.

[17] Swiss Re, *Term and Health Watch* (May 2008).

[18] Insurance Industry Working Group, "Vision for the Insurance Industry in 2020" (July 2009), p 43.

[19] PwC, above, p 82.

11.21 At present, it is common for insurers to ask very general questions on renewal. Consumers often do not know what type of reply is required. Thus the FOS will not allow the insurer to refuse a claim for a failure to answer a general question where most reasonable consumers would not have provided the information. Under the reformed scheme, this will be built into law.

11.22 PwC pointed out that insurers might respond in one of two ways. They may improve the questions asked, or they might increase the number of claims paid. PwC costed only the first strategy, estimating that the process of gathering better information might add up to two or three minutes to the underwriting process. This time was costed at £15 to £30 an hour.[20] Based on these assumptions, PwC calculated that the reforms might add between £20 million and £80 million to the cost of general personal lines insurance, which would represent 0.1% to 0.3% of premiums.[21]

11.23 In theory, asking only general questions on renewal saves insurers money. As general questions rarely receive a reply, the insurer does not have to incur the costs of reading or processing the information. Additionally, on a literal interpretation of the Marine Insurance Act 1906, an insurer could argue that it is entitled to refuse a claim because a consumer failed to answer such a general question. If the consumer complains, however, the FOS requires the claim to be paid where it is clear that most consumers in the market would have failed to respond to the question.

11.24 Although there are some examples of harsh decisions, we do not think that general insurers routinely refuse claims on this basis. The proportion of general insurance claims rejected for non-disclosure is much lower than for critical illness and other protection insurance claims. As PwC acknowledges:

> In the current process only a small number of claims are repudiated for non-disclosure, therefore it is likely that these costs are lower than the costs associated with increasing the processing time.[22]

11.25 Under our recommended reforms, insurers may continue to ask very few questions. However, the draft Bill provides that if an insurer decides on this strategy, it must pay claims where no reasonable consumer would have realised that the information was required.

[20] Above, pp 83-84.

[21] Above, p 128.

[22] Above, p 83.

11.26 Nor do we think that the cost of processing additional information will apply to every claim. It will only apply to the minority of claims in which the consumer has information which the insurer would want to know about. General characteristics, which apply to large segments of the population, can simply be built into the general risk pool. For protection insurance, PwC estimated that only a quarter of the population had something to disclose.[23] Applying the same assumption to general insurance would reduce the estimated cost range by 75%. The new figures would be £5 million to £20 million a year, representing 0.025% to 0.1% of premiums.

11.27 In conclusion, we think that PwC has overestimated the extent to which firms currently ignore FOS guidelines. It has therefore overestimated the effect of reforming the 1906 Act in accordance with FOS guidelines. In our view the costs will not exceed £20 million a year, representing 0.1% of premiums.

THE WIDER BENEFITS

11.28 PwC noted that there were "significant non-financial benefits for the consumer and the industry". These include:

(1) improved peace of mind that a claim would be paid even if the consumer makes an innocent mistake;

(2) improved regard for and confidence in the insurance industry; and

(3) continued encouragement to improve clarity of questions in the underwriting process.[24]

11.29 We agree with PwC that these will be important benefits of putting existing guidelines into legislation. We also think that there is likely to be a reduction in the costs of resolving disputes if both parties know where they stand under clear legal provisions.

SPECIFIC IMPACTS

11.30 In the full impact assessment on our website, we consider the impact of our proposals on competition, small firms, disability equality, gender equality and legal aid.

11.31 In summary, we think our proposals will promote fair competition, as they will prevent firms which treat their customers fairly from being undermined by firms which fail to abide by the rules. They will also help smaller insurance firms, which have less access to FOS decisions, and therefore may have less understanding of what the FOS requires.

[23] Above, p 58.

[24] Above, p 4.

11.32 We think that clearer law will also help disability equality. Many consumers whose claims are refused for reasons of non-disclosure are particularly vulnerable through illness or disability. In our 2007 survey of ombudsman decisions, two-thirds of complainants suffered from some form of illness or disability: 25% suffered from cancer, 12% from multiple sclerosis and 6% from severe back, neck or joint pain.

11.33 It has been argued that general questions about visits to the doctor disadvantage women. This is because there are substantial differences between men and women in the way that they use GPs. According to the General Household Survey 2007, men aged between 16 and 44 consult a GP on average twice a year. Women in the same age group consult a GP five times a year.[25] Thus if a question asks "have you been to the doctor in the last 3 years?", the average 16-44 year old man is expected to recall six occasions, while the average woman in that age range is expected to recall 15. We think that discouraging general questions of this type will therefore help increase gender equality.

11.34 Finally, we conclude that our recommendations will have only a minimal impact on legal aid. Most cases will continue to be dealt with by the FOS. The cases most likely to go to court will be those where a substantial sum is at stake, over the £100,000 FOS limit. Very few people with an insurance claim of over £100,000 will fall within the legal aid means test.

CONCLUSION

11.35 The main impact of our recommended reforms lies in improving compliance with FOS guidelines. The extent of non-compliance cannot be estimated with precision, though we have been greatly assisted by the work commissioned by the ABI from PricewaterhouseCoopers LLP.

11.36 We estimate that the reforms will result in additional claims payments of £4.4 million in the life and protection market, and between £5 million and £20 million in the general insurance market. This may be seen as a cost to insurers and a benefit to those consumer policyholders who receive a full or partial payment of their claims. We anticipate, however, that the cost of additional claims would be passed on to consumers. This would add around 0.08% to the cost of life and critical illness insurance and 0.025% to 0.1% to general insurance.

11.37 This means that consumers as a group would both bear the costs and receive the benefits of the reforms. Consumers would be required to pay between 2.5p and 10p for every £100 of premium currently paid. When claims are rejected unfairly, this often occurs at a particularly vulnerable time, for example when consumers have been bereaved, diagnosed with a serious illness or rendered homeless through fire or flood. We think that consumers would be happy to pay these small additional premiums for the increased peace of mind that they will be treated fairly, and that valid claims will be paid.

[25] Office for National Statistics, *General Household Survey 2007* (January 2009), table 7.18.

11.38 The anticipated benefits also lie in clearer questions, fewer disputes and increased peace of mind for consumers. It is anticipated that reform will improve consumers' trust and confidence in the insurance industry which, in turn, will improve sales.

PART 12
LIST OF RECOMMENDATIONS

We make the following recommendations:

DEFINITIONS AND SCOPE

12.1 The draft Bill should apply to insurance entered into by an individual for purposes wholly or mainly unrelated to the individual's trade, business or profession.[1] (Paragraph 5.19)

12.2 There should be no exemption for high value goods. (Paragraph 5.23)

12.3 The definition of insurance should be left to the common law. (Paragraph 5.26)

NO DUTY TO VOLUNTEER INFORMATION

12.4 There should be no duty on a consumer proposer to disclose matters about which no questions were asked.[2] (Paragraph 5.36(1))

12.5 Insurers should be permitted to ask general questions, but in assessing the reasonableness of the consumer's response, the court or ombudsman may take into account the clarity and specificity of the question.[3] (Paragraph 5.36(2))

A NEW DUTY TO TAKE REASONABLE CARE NOT TO MISREPRESENT

12.6 Consumers should be under a duty to take reasonable care not to make a misrepresentation to the insurer.[4] (Paragraph 5.40)

12.7 The draft Bill should clarify that a failure to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation for the purposes of the draft Bill (whether or not it could be under the present law).[5] (Paragraph 5.54)

12.8 The draft Bill should apply to misrepresentations made before the contract is entered into or varied.[6] (Paragraph 5.66)

12.9 Where a consumer acts honestly and with reasonable care when making a misrepresentation, the insurer should not be granted a remedy for that misrepresentation. (Paragraph 5.90(1))

[1] See draft Bill, cl 1.

[2] See draft Bill, cl 2(4).

[3] See draft Bill, cl 3(2)(c).

[4] See draft Bill, cl 2(2).

[5] See draft Bill, cl 2(3).

[6] See draft Bill, cl 4(1).

Reasonable care

12.10 The standard of reasonable care should be that of a reasonable consumer, and should only take into account individual circumstances if the insurer was or ought to have been aware of them.[7] (Paragraph 5.90(2))

12.11 The degree of care a consumer is expected to take in completing a proposal form should be assessed in the light of all the relevant circumstances.[8] (Paragraph 5.90(3))

12.12 The draft Bill should provide guidance on the type of factors that are relevant, such as the type of insurance, the insurer's explanatory material, whether an agent was used and the clarity of the questions.[9] (Paragraph 5.90(4))

12.13 The draft Bill should specify that a dishonest misrepresentation is always to be taken as showing a lack of reasonable care.[10] (Paragraph 5.90(5))

INSURERS' REMEDIES FOR MISREPRESENTATION

Inducement and materiality

12.14 To receive a remedy for misrepresentation, the insurer must show that without the misrepresentation, it would not have entered into the contract at all, or would have done so only on different terms.[11] (Paragraph 6.12(1))

12.15 The insurer need not show that the matter would have been relevant to another hypothetical prudent insurer in the market. (Paragraph 6.12(2))

Deliberate or reckless misrepresentations

12.16 The insurer may avoid the policy and refuse all claims if the consumer acted deliberately or recklessly. That is, if the consumer:

(1) knew that the statement was untrue or misleading, or did not care whether or not it was untrue or misleading, and

(2) knew that the matter was relevant to the insurer, or did not care whether or not it was relevant to the insurer.[12] (Paragraph 6.33)

[7] See draft Bill, cl 3(3) and (4).

[8] See draft Bill, cl 3(1).

[9] See draft Bill, cl 3(2).

[10] See draft Bill, cl 3(5).

[11] See draft Bill, cl 4(1)(b).

[12] See draft Bill, cl 5(2).

12.17 The insurer should have to show, on the balance of probabilities, that the consumer acted deliberately or recklessly. However, the task should be made easier by two presumptions. These are that the consumer:

(1) had the knowledge of a reasonable consumer; and

(2) knew that the matter was relevant, if the insurer asked a clear and specific question.[13] (Paragraph 6.39)

12.18 Where the consumer has made a deliberate or reckless misrepresentation, the insurer need not return any of the premiums paid, except to the extent that it would be unfair to the consumer to retain them.[14] (Paragraph 6.47)

Careless misrepresentations

12.19 Where the consumer has made a careless misrepresentation, the insurer is entitled to a compensatory remedy as follows:

(1) If the insurer would not have entered into the contract on any terms, the insurer may avoid the contract (but must return the premiums);

(2) If the insurer would have entered into the contract on different terms (apart from those relating to the premium), the contract is treated as if it were made on those terms;

(3) In addition, if the insurer would have charged a higher premium, the insurer may reduce the amount of the claim proportionately.[15] (Paragraph 6.66)

12.20 Following the discovery of a careless misrepresentation:

(1) in non-life insurance, either side should be entitled to cancel future cover on reasonable notice; and

(2) for life insurance, the insurer should be required to continue the policy on amended terms.[16] (Paragraph 6.100)

[13] See draft Bill, cl 5(5).

[14] See draft Bill, Sch 1, para 2.

[15] See draft Bill, Sch 1, paras 4 to 8.

[16] See draft Bill, Sch 1, para 9.

Misrepresentations before a variation

12.21 Where a qualifying misrepresentation is made before an insurance contract is varied, the remedy should depend on whether the variation can reasonably be treated separately from the insurance policy.

(1) Where the variation can be separated, the remedy should only apply to the subject-matter of the variation.

(2) Where it cannot be separated, the remedy should apply to the whole policy.[17] (Paragraph 6.104)

BASIS OF THE CONTRACT CLAUSES

12.22 Basis of the contract clauses should be abolished. Representations should not be capable of being converted into warranties by means of a policy term or statement on the proposal form.[18] (Paragraph 6.112)

CONTRACTING OUT

12.23 It should not be possible to contract out of the draft Bill, except in favour of the consumer.[19] (Paragraph 6.116)

12.24 A choice of law clause should not be used to put a consumer in a worse position in respect of pre-contractual disclosures and representations if UK law would otherwise apply.[20] (Paragraph 6.122)

GROUP INSURANCE

12.25 Group insurance should be defined widely, so as to cover insurance contracts intended to provide cover to a person who is not a party to the contract, but who would be a consumer if he or she had taken out the cover directly with the insurer.[21] (Paragraph 7.27(1))

12.26 Where a group member provides information to the insurer:

(1) any misrepresentation should have consequences only for the cover of that individual;[22] and

(2) any dispute should be determined in accordance with our proposals for consumer insurance.[23] (Paragraph 7.27(2))

[17] See draft Bill, Sch 1, paras 10 to 12.

[18] See draft Bill, cl 6.

[19] See draft Bill, cl 10.

[20] See draft Bill, cl 10(2).

[21] See draft Bill, cl 7(1).

[22] See draft Bill, cl 7(4).

[23] See draft Bill, cl 7(2).

12.27 The draft Bill should not:

(1) affect the duties of a business group policyholder to provide information;[24] or

(2) include specific provisions in respect of "free cover". (Paragraph 7.27(3))

INSURANCE ON THE LIFE OF ANOTHER

12.28 Where a consumer takes out insurance on the life of another, and information is provided to the insurer by the person whose life is insured, that information should be treated as if it were provided by a party to the contract.[25] (Paragraph 7.36)

INTERMEDIARIES

12.29 Intermediaries should be considered to act for the insurer if at the time of the conduct in question:

(1) the intermediary was the appointed representative of the insurer;

(2) the intermediary had express authority from the insurer to collect pre-contract information as its agent;

(3) the intermediary had authority to enter into the insurance contract on behalf of the insurer.[26] (Paragraph 8.24)

12.30 In other cases, the intermediary acts for the consumer, unless it appears that the intermediary acts for the insurer. This would need to be determined in the light of all the circumstances, weighing the factors in each case.[27] (Paragraph 8.25)

AMENDMENTS TO OTHER STATUTES

12.31 Sections 18 to 20 of the Marine Insurance Act 1906 (or any common law rules to the same effect) should not apply to consumer insurance contracts.[28] (Paragraph 9.18)

12.32 For consumer motor insurance, an insurer should only be entitled to a declaration under section 152(2) of the Road Traffic Act 1988 if it would be entitled to avoid the policy under the draft Bill.[29] (Paragraph 9.35)

REJECTED PROPOSALS

12.33 We do not recommend that legislation which applies only to consumer insurance contracts should attempt to reform the law on warranties. (Paragraph 10.19)

[24] See draft Bill, cl 7(5).

[25] See draft Bill, cl 8.

[26] See draft Bill, Sch 2, para 2.

[27] See draft Bill, Sch 2, para 3.

[28] See draft Bill, cl 11(1) & (2).

[29] See draft Bill, cl 11(3).

12.34 We do not recommend that the law should prevent insurers from obtaining a remedy for a careless misrepresentation because a set period has passed since the misrepresentation was made. (Paragraph 10.28)

12.35 We do not recommend that the courts should have the power to prevent insurers from seeking a remedy otherwise available under our draft Bill because the insurer's actions contravene recognised industry guidance. (Paragraph 10.43)

(Signed)

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16 November 2009

APPENDIX A
DRAFT BILL AND EXPLANATORY NOTES

The draft Consumer Insurance (Disclosure and Representations) Bill begins over the page with a Contents section. The draft Bill is then set out with the clauses on the left-hand pages and explanatory notes on clauses on the corresponding right-hand pages.

Consumer Insurance (Disclosure and Representations) Bill

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DRAFT

OF A

B I L L

TO

Make provision about disclosure and representations in connection with consumer insurance contracts.

BE IT ENACTED by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

Main definitions

1 Main definitions

In this Act—

"consumer insurance contract" means a contract of insurance entered into by an individual wholly or mainly for purposes unrelated to the individual's trade, business or profession;

"consumer" means the individual who enters into a consumer insurance contract, or proposes to do so;

"insurer" means the person who is, or would become, the other party to a consumer insurance contract.

EXPLANATORY NOTES

CLAUSE 1: MAIN DEFINITIONS

A.1 This draft Bill applies only to consumer insurance contracts, made between a consumer and an insurer.

A.2 Clause 1 defines a "consumer insurance contract". It is similar in substance to the definition of a "consumer" used elsewhere. For example, the Financial Services Authority (FSA) rules define a consumer as:

> Any natural person who is acting for purposes which are outside his trade or profession".[1]

A.3 The FSA definition follows that used in the EU Directive on Distance Marketing of Consumer Financial Services[2] and is similar to the definitions used in other EU consumer directives[3] and the Brussels Convention.[4] We intend that our definition should be interpreted in line with the developing case law on these definitions.[5]

A.4 Clause 1 refers to "an individual", which means the same as "a natural person" in the FSA definition. A company or other corporate body falls outside the definition. The phrase "trade, business or profession" is intended to be interpreted widely, and (for example) includes an individual who lets a property commercially, even if it is not their main job.

A.5 However, the definition in clause 1 differs from the FSA and other definitions in that it expressly provides for mixed use contracts. Where a policy covers some private and some business use, one needs to consider the main purpose of the insurance. For example, insurance would be considered to be "consumer insurance" if private vehicle insurance covered a limited amount of business use, or if home contents insurance covered some business equipment. However, insurance on a car used mainly as a taxi, with the occasional private trip, would fall outside the scope of the draft Bill.

A.6 The draft Bill does not define insurance. The common law definition of insurance continues to apply.

A.7 For further discussion of this clause, see paragraphs 5.5 to 5.26.

[1] ICOBS Rule 2.1.1(3).

[2] Directive 2002/65/EC, art 2(d).

[3] See, for example, the Directives on Unfair Terms in Consumer Contracts (93/13); Doorstep Selling (85/577); Distance Selling (97/7) and Consumer Sales (99/44).

[4] Brussels Convention on Jurisdiction and Enforcement of Judgments in Civil and Commercial Matters 1968, art 13.

[5] See *Benincasa v Dentalkit Srl,* Case C-269/95 [1997] ECR 1-3767; *Standard Bank London Ltd v Apostolakis (No 1)* [2002] CLC 933; and *Prostar Management Ltd v Twaddle* 2003 SLT (Sh Ct) 11.

Pre-contract and pre-variation information

2 Disclosure and representations before contract or variation

(1) This section makes provision about disclosure and representations by a consumer to an insurer before a consumer insurance contract is entered into or varied.

(2) It is the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer.

(3) A failure by the consumer to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation for the purposes of this Act (whether or not it could be apart from this subsection).

(4) The duty set out in subsection (2) replaces any duty relating to disclosure or representations by a consumer to an insurer which existed in the same circumstances before this Act applied.

(5) Accordingly—

(a) any rule of law to the effect that a consumer insurance contract is one of the utmost good faith is modified to the extent required by the provisions of this Act, and

(b) the application of section 17 of the Marine Insurance Act 1906 (contracts of marine insurance are of utmost good faith), in relation to a contract of marine insurance which is a consumer insurance contract, is subject to the provisions of this Act.

EXPLANATORY NOTES

CLAUSE 2: DISCLOSURE AND REPRESENTATIONS BEFORE CONTRACT OR VARIATION

A.8 Clause 2 is central to the reforms. It abolishes the duty of disclosure in consumer insurance contracts and replaces it with the duty "to take reasonable care not to make a misrepresentation". This removes the consumer's duty to volunteer information to the insurer. Instead, consumers are required to answer insurers' questions honestly and to take reasonable care that their replies are accurate and complete. If consumers do provide insurers with information which was not asked for, they must also do so honestly and carefully.

A.9 Clause 2(1) stipulates that the duty arises during pre-contractual negotiations. The clause covers statements which the consumer makes before entering into a new contract or varying an old one. There is no explicit reference to renewals, as in law these are regarded as new contracts. However, renewals are covered by the duty.

A.10 The new duty is set out in clause 2(2). There is a considerable body of case law defining a misrepresentation which is relevant to this provision. In particular, even though it is literally true, a statement may amount to a misrepresentation because it is incomplete.[6] In practice, this may be a significant issue on renewal, where a consumer is asked to confirm or amend the information previously given. Clause 2(3) confirms that a failure to reply is capable of being a misrepresentation for the purposes of the draft Bill.

A.11 Clause 2(4) states that the duty contained in clause 2(2) replaces the current duty of disclosure. This derives from the duty of "utmost good faith" set out in section 17 of the Marine Insurance Act 1906. Clause 2(5) modifies the duty of utmost good faith so that a consumer is no longer required to volunteer information to the insurer. This is so fundamental that it is set out in the draft Bill at an early stage.

A.12 The Marine Insurance Act 1906 applies directly to marine insurance but it has also been held to be an authoritative statement of common law principles to be applied to other non-marine insurance contracts. Therefore clause 2(5) works in two ways. Clause 2(5)(a) applies to any common law rule to the same effect as section 17. Clause 2(5)(b) then applies to any consumer insurance contracts which are also marine insurance (such as insurance on private yachts).

A.13 Note that section 17 also imposes duties on the parties after a contract has been formed. These "post-contractual duties" are not affected by this draft Bill.

A.14 The existing law on disclosure and representations made before entering an insurance contract is set out in more detail in sections 18 to 20 of the Marine Insurance Act 1906. These sections are entirely disapplied from consumer insurance contracts by clause 11.

A.15 For further discussion of this clause, see paragraphs 5.27 to 5.66.

[6] See *Winter v Irish Life Assurance plc* [1995] 2 Lloyd's Rep 274.

3 Reasonable care

(1) Whether or not a consumer has taken reasonable care not to make a misrepresentation is to be determined in the light of all the relevant circumstances.

(2) The following are examples of things which may need to be taken into account in making a determination under subsection (1)—

(a) the type of consumer insurance policy in question, and its target market,

(b) any relevant explanatory material or publicity produced or authorised by the insurer,

(c) how clear, and how specific, the insurer's questions were,

(d) whether or not an agent was acting for the consumer.

(3) The standard of care required is that of a reasonable consumer: but this is subject to subsections (4) and (5).

(4) If the insurer was, or ought to have been, aware of any particular characteristics or circumstances of the actual consumer, those are to be taken into account.

(5) A misrepresentation made dishonestly is always to be taken as showing lack of reasonable care.

EXPLANATORY NOTES

CLAUSE 3: REASONABLE CARE

A.16 This clause explains the standard of reasonable care referred to in clause 2(2). Whether the consumer has taken reasonable care depends on all the relevant circumstances.

A.17 Clause 3(2) sets out factors which may assist. These include the type of insurance in question, any relevant explanatory material and how clear and specific the question was. However, an insurer might be justified in using a more specialist question if the consumer had the benefit of advice from an agent. Where a consumer has failed to comply with the insurer's request to amend particulars (under clause 2(3)), the court may consider the clarity of the accompanying explanatory letter. The list is non-exhaustive: for example the court may bear in mind other factors, such as whether the insurer has made it easy for the consumer to reply.

A.18 Clause 3(3) states that the test is objective, looking at the standard expected of a reasonable consumer in the market. The test does not usually take into account any particular characteristics of the actual consumer, such as their age or knowledge of English.

A.19 However clause 3(4) provides for an exception where the insurer was aware or ought to have been aware of the consumer's individual circumstances. We intend this test to focus in a practical way on the understanding of the relevant staff at the time the reply is received. We do not intend that the insurer should be deemed to know information held by other departments, which is not available to the staff at the time.

A.20 In some cases, a consumer may have a better than average understanding of the question. It is therefore possible, at least in theory, that someone might act "reasonably" if one applies the standards of an average consumer, but may nevertheless act dishonestly given his or her greater knowledge. For example, an average consumer may not understand references to "paraesthesia". However, if the actual consumer has medical training, he or she might be fully aware of the issues and might have acted dishonestly in failing to reply to the question. Clause 3(5) states that acting dishonestly is always a breach of the duty (even if another, less well-informed consumer, might have made a reasonable mistake about the same issue).

A.21 For further discussion of this clause, see paragraphs 5.67 to 5.90.

Qualifying misrepresentations

4 Qualifying misrepresentations: definition and remedies

(1) An insurer has a remedy against a consumer for a misrepresentation made by the consumer before a consumer insurance contract was entered into or varied only if—

(a) the consumer made the misrepresentation in breach of the duty set out in section 2(2), and

(b) the insurer shows that without the misrepresentation, that insurer would not have entered into the contract (or agreed to the variation) at all, or would have done so only on different terms.

(2) A misrepresentation for which the insurer has a remedy against the consumer is referred to in this Act as a "qualifying misrepresentation".

(3) The only such remedies available are set out in Schedule 1.

EXPLANATORY NOTES

CLAUSE 4: QUALIFYING MISREPRESENTATIONS: DEFINITION AND REMEDIES

A.22 This clause sets out the circumstances in which an insurer will be entitled to a remedy for a misrepresentation. Two conditions must be met. First, clause 4(1)(a) states that the misrepresentation must have been made in breach of the duty set out in clause 2(2).

A.23 Secondly, clause 4(1)(b) provides that the insurer must establish that had it known the true facts it would not have entered into the contract or agreed to the variation or would have made at least one change to the insurance contract. This reflects the current law on inducement as developed following the House of Lords decision in *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*.[7]

A.24 Under the current law, it cannot be presumed that an insurer was induced to enter the contract. Instead, the insurer must prove inducement on the balance of probabilities – though it may sometimes be possible to infer inducement from the facts in the absence of direct evidence.[8] The draft Bill reflects this aspect of the current law.

A.25 However, under the current law a misrepresentation is only actionable if it is "material", in that it would influence the judgment of a hypothetical prudent underwriter.[9] The draft Bill does not preserve this requirement. It is enough for the insurer to show that it was induced by the misrepresentation, and that a reasonable consumer would have provided the information. The insurer does not also have to show that the misrepresentation would have influenced other underwriters in the market.

A.26 If the conditions in clause 4(1) are met, the misrepresentation is termed a "qualifying misrepresentation" and attracts the appropriate remedy set out in Schedule 1.

A.27 For further discussion of this clause, see paragraphs 6.6 to 6.12.

7 [1995] 1 AC 501.

8 See *Assicurazioni Generali v Arab Insurance Group* [2002] EWCA Civ 1642, [2002] All ER (D) 177 and *Laker Vent Engineering Ltd v Templeton Insurance Ltd* [2009] EWCA Civ 62.

9 Marine Insurance Act 1906, s 20(2).

5 Qualifying misrepresentations: classification and presumptions

(1) For the purposes of this Act, a qualifying misrepresentation (see section 4(2)) is either—

- (a) deliberate or reckless, or
- (b) careless.

(2) A qualifying misrepresentation is deliberate or reckless if the consumer—

- (a) knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and
- (b) knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.

(3) A qualifying misrepresentation is careless if it is not deliberate or reckless.

(4) It is for the insurer to show that a qualifying misrepresentation was deliberate or reckless.

(5) But it is to be presumed, unless the contrary is shown—

- (a) that the consumer had the knowledge of a reasonable consumer, and
- (b) that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer.

EXPLANATORY NOTES

CLAUSE 5: QUALIFYING MISREPRESENTATIONS: CLASSIFICATION AND PRESUMPTIONS

A.28 Clause 5 distinguishes between “deliberate or reckless” misrepresentations (where the insurer may avoid the policy) and careless ones (where the insurer is granted a compensatory remedy).

A.29 Clause 5(2) defines a “deliberate or reckless” misrepresentation. Consumers act deliberately if they act with knowledge. Consumers act recklessly if they act “without care”. In the leading case of *Derry v Peek* it was said that:

> A man who makes a statement without care and regard for its truth or falsity commits a fraud. He is a rogue.[10]

A.30 This was distinguished from making a statement which one genuinely believes to be true but without taking sufficient care to check the facts. That would be simply careless. Clause 5(2) reflects the common law definition of recklessness as set out in *Derry v Peek*.

A.31 Under clause 5(2), there are two requirements. First, that the consumer knew that (or did not care whether) a representation was untrue or misleading and, second, that the consumer knew that (or did not care whether) the matter was relevant to the actual insurer. This reflects the substance of the definition adopted by the Association of British Insurers in its 2009 Code of Practice.[11]

A.32 The draft Bill defines a “careless” misrepresentation by elimination. Under clause 5(3), a representation is careless if it is in breach of the duty in clause 2(2) to take reasonable care, but is not deliberate or reckless. Careless misrepresentations are therefore the residuary category.

A.33 Clause 5(4) provides that the onus of proving that a misrepresentation was “deliberate or reckless” is on the insurer. However, the insurer is helped by the two presumptions in clause 5(5). Where the presumptions apply, the burden of proof is reversed.

A.34 The effect of the presumptions may be illustrated by an example, in which a consumer fails to mention a heart attack in response to a clear and specific question. As most reasonable people would know that they had suffered a heart attack, the insurer does not need to prove that the consumer acted deliberately or recklessly. Instead, it is up to the consumer to show that he or she did not know about the heart attack, or did not understand the question. Thus the consumer might explain that the doctor failed to mention a minor heart attack, or might provide other evidence of lack of understanding.

A.35 For further discussion of this clause, see paragraphs 6.13 to 6.39.

[10] (1889) LR 14 App Cas 337, by Lord Bramwell, p 350.

[11] ABI Code of Practice, “Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products” (January 2009), para 2.1.

Specific issues

6 Warranties and representations

(1) This section applies to representations made by a consumer—
   (a) in connection with a proposed consumer insurance contract, or
   (b) in connection with a proposed variation to a consumer insurance contract.

(2) Such a representation is not capable of being converted into a warranty by means of any provision of the consumer insurance contract (or of the terms of the variation), or of any other contract (and whether by declaring the representation to form the basis of the contract or otherwise).

EXPLANATORY NOTES

CLAUSE 6: WARRANTIES AND REPRESENTATIONS

A.36 This clause abolishes "basis of the contract" clauses.

A.37 Under the current law, an insurer may add a declaration to a proposal form or policy stating that the consumer warrants the accuracy of all the answers given, or that such answers "form the basis of the contract".[12] This has the legal effect of turning representations into warranties. The insurer is discharged from liability for claims if the consumer made any misrepresentation, even if it was immaterial and did not induce the insurer to enter into the contract.

A.38 Clause 6(2) prevents a term in the policy or on the proposal form from converting representations into warranties in this way.

A.39 The clause is limited in scope. It remains possible for insurers to include specific warranties within their policies. The warranty *may* deal with an issue that is similar to one covered by a question on the proposal form. However, insurers can not employ a device that purports to convert a representation into a warranty.

A.40 For further discussion of this clause, see paragraphs 6.105 to 6.112.

[12] *Dawsons Ltd v Bonnin* [1922] 2 AC 413, 1922 SC (HL) 156.

7 Group insurance

(1) This section applies where—

(a) a contract of insurance is entered into by a person ("A") in order to provide cover for another person ("C"), or is varied or extended so as to do so,

(b) C is not a party to the contract,

(c) so far as the cover for C is concerned, the contract would have been a consumer insurance contract if entered into by C rather than by A, and

(d) C provided information directly or indirectly to the insurer before the contract was entered into, or before it was varied or extended to provide cover for C.

(2) So far as the cover for C is concerned—

(a) sections 2 and 3 apply in relation to disclosure and representations by C to the insurer as if C were proposing to enter into a consumer insurance contract for the relevant cover with the insurer, and

(b) subject to subsections (3) to (5) and the modifications in relation to the insurer's remedies set out in Part 3 of Schedule 1, the remainder of this Act applies in relation to the cover for C as if C had entered into a consumer insurance contract for that cover with the insurer.

(3) Section 4(1)(b) applies as if it read as follows—

"(b) the insurer shows that without the misrepresentation, that insurer would not have agreed to provide cover for C at all, or would have done so only on different terms."

(4) If there is more than one C, a breach on the part of one of them of the duty imposed (by virtue of subsection (2)(a)) by section 2(2) does not affect the contract so far as it relates to the others.

(5) Nothing in this section affects any duty owed by A to the insurer, or any remedy which the insurer may have against A for breach of such a duty.

EXPLANATORY NOTES

CLAUSE 7: GROUP INSURANCE

A.41 Group schemes are an important form of insurance. Many schemes are set up by employers to provide protection insurance for their employees. The policyholder is typically the employer, who arranges the scheme directly with the insurer. The group members (typically employees) have no specific status. As they are not policyholders, the duty to disclose set out in the Marine Insurance Act 1906 does not apply to them. This means that if a group member makes a misrepresentation, the insurer's remedies are uncertain.

A.42 Clause 7(1) defines a group scheme to which this clause applies. The provision is drafted widely. It not only covers the typical employment schemes, but may also cover block building policies taken out by landlords for tenants, or buildings insurance taken out by freeholders for long leaseholders. It is possible for group insurance to cover only one member, where (for example) a freeholder takes out insurance for a single leaseholder.

A.43 To fall within the clause:

(1) A policyholder (A) must take out a policy which is of direct benefit to a third party (C). The policy must normally do more than simply cover A's liability towards C. It must also provide some additional cover for C (such as life insurance or contents insurance).

(2) C must not be a party to the contract.

(3) The cover would be consumer insurance if C had taken it out directly. For example, life or household contents insurance would normally be consumer insurance.

(4) C must provide the insurer with information before the insurer becomes liable for the element of cover that benefits C. Thus an employee may be asked to fill out a health questionnaire.

A.44 Where a group member makes a misrepresentation:

(1) The misrepresentation has consequences only for the cover of that individual (not for the policy as a whole) (clause 7(4)).

(2) The scheme under the draft Bill applies. Thus the insurer is entitled to a remedy if:

(a) It has been induced to provide that particular element of cover (clause 7(3)); and

(b) C acted without reasonable care (clause 7(2)).

A.45 In group schemes, the policyholder would normally be a business, and would therefore be governed by the law applicable to business insurance. This includes a duty to disclose, which is unaffected by this draft Bill (clause 7(5)).

A.46 For further discussion of this clause, see paragraphs 7.2 to 7.27.

8 Insurance on life of another

(1) This section applies in relation to a consumer insurance contract for life insurance on the life of an individual ("L") who is not a party to the contract.

(2) If this section applies—

(a) information provided to the insurer by L is to be treated for the purposes of this Act as if it were provided by the person who is the party to the contract, but

(b) in relation to such information, if anything turns on the state of mind, knowledge, circumstances or characteristics of the individual providing the information, it is to be determined by reference to L and not the party to the contract.

EXPLANATORY NOTES

CLAUSE 8: INSURANCE ON LIFE OF ANOTHER

A.47 Where a consumer takes out insurance on another person's life, the person whose life is being insured (L) may be asked questions about their age and state of health. The insurer may rely on this information. However, as L is not a party to the contract, L would not normally owe a duty to take reasonable care to give correct information. This clause imposes the same duties on L as clause 2 imposes on the policyholder. If L breaches this duty, it gives the insurer the same remedies.

A.48 Note that this clause only covers "information provided to the insurer by L" (see clause 8(2)(a)). The clause does not apply to information provided by the policyholder. That is dealt with under the rest of the draft Bill, and it is unaffected by this clause.

A.49 Clause 8(2)(b) stipulates that where L has provided the information, if anything turns on a state of mind or knowledge of the individual, that must be decided with reference to L. In other words, where L provided the information, the issue is whether L (rather than the policyholder) acted with reasonable care, acted carelessly, or acted deliberately or recklessly.

A.50 The result is that where a consumer takes out insurance on the life of another, both the consumer and the life insured are under a duty to take reasonable care not to make a misrepresentation. If either (or both) fail in this duty, the insurer has a remedy.

A.51 For further discussion of this clause, see paragraphs 7.28 to 7.40.

9 Agents

Schedule 2 applies for determining, for the purposes of this Act only, whether an agent through whom a consumer insurance contract is effected is the agent of the consumer or of the insurer.

EXPLANATORY NOTES

CLAUSE 9: AGENTS

A.52 It is common for consumers and insurers to use an intermediary to place insurance. Intermediaries may operate under a variety of titles, such as broker, agent or insurance consultant. Intermediaries may also act in a variety of ways. They may, for example, see one or both parties in person, or deal with them over the telephone or through a website.

A.53 Under normal agency law, a person is responsible for the actions of their own agent. This rule is specifically preserved in clause 12(4), and has the following consequences:

(1) If the intermediary acts for the *consumer*, the intermediary's knowledge and behaviour are considered to be those of the consumer. Thus if the intermediary has acted deliberately or recklessly, the insurer is entitled to avoid the policy, even if the consumer has acted honestly and reasonably. If the intermediary acts carelessly, the insurer has a proportionate remedy against the consumer. The consumer would then need to bring a separate action for professional negligence against the intermediary.

(2) If the intermediary acts for the *insurer*, then any wrongdoing by the intermediary is the responsibility of the insurer. The insurer must pay the claim, and pursue a separate action against the intermediary.

A.54 It is therefore important to know for whom an intermediary acts when helping a consumer complete an insurance application. Schedule 2 sets out a test for determining the issue.

A.55 Note that Schedule 2 applies only for the purposes of this draft Bill. It applies only to consumer insurance, and only to questions of whom an intermediary was acting for in transmitting information from the consumer to the insurer.

10 Contracting out

(1) A term of a consumer insurance contract, or of any other contract, which would put the consumer in a worse position as respects the matters mentioned in subsection (3) than the consumer would be in by virtue of the provisions of this Act is to that extent of no effect.

(2) That includes a term about the law applicable to the contract, if in the absence of such a term the law applicable to the contract would be the law of England and Wales or the law of Scotland.

(3) The matters are—

(a) disclosure and representations by the consumer to the insurer before the contract is entered into or varied, and

(b) any remedies for qualifying misrepresentations (see section 4(2)).

(4) This section does not apply in relation to a contract for the settlement of a claim arising under a consumer insurance contract.

EXPLANATORY NOTES

CLAUSE 10: CONTRACTING OUT

A.56 Clause 10(1) prevents insurers from contracting out of the provisions of the draft Bill to the detriment of the consumer. A policy term, or a term in any other contract, is rendered void to the extent that it would put the consumer in a worse position. Clause 10(3) makes it clear that this clause only covers the issues within the scope of the draft Bill.

A.57 The clause does not affect terms requiring disclosures after a contract has been agreed. In particular, protection insurers may still add terms to their contracts requiring consumers to disclose changes to their health between agreement and the inception of the cover. These terms must be fair, within the meaning of the Unfair Terms in Consumer Contracts Regulations 1999, and the FOS has jurisdiction to ensure that the terms are applied in a fair and reasonable way.

A.58 Clause 10(2) prevents attempts at circumventing the provisions of the draft Bill through choice of law clauses.

A.59 Clause 10(4) states that clause 10 does not apply to contracts to settle claims. A settlement of a claim will therefore continue to provide certainty for the parties. It would not be possible for a consumer to go behind a settlement by alleging that it was less favourable than their entitlement under the draft Bill.

A.60 For further discussion of this clause, see paragraphs 6.113 to 6.122.

Final provision

11 Consequential provision

(1) Any rule of law to the same effect as the following is abolished in relation to consumer insurance contracts—

(a) section 18 of the Marine Insurance Act 1906 (disclosure by assured),

(b) section 19 of that Act (disclosure by agent effecting insurance),

(c) section 20 of that Act (representations pending negotiation of contract).

(2) The Marine Insurance Act 1906 is amended as follows—

(a) in section 18, at the end add—

"(6) This section does not apply in relation to a contract of marine insurance if it is a consumer insurance contract within the meaning of the Consumer Insurance (Disclosure and Representations) Act 2009.";

(b) in section 19, the existing text becomes subsection (1), and after that add—

"(2) This section does not apply in relation to a contract of marine insurance if it is a consumer insurance contract within the meaning of the Consumer Insurance (Disclosure and Representations) Act 2009.";

(c) in section 20, at the end add—

"(8) This section does not apply in relation to a contract of marine insurance if it is a consumer insurance contract within the meaning of the Consumer Insurance (Disclosure and Representations) Act 2009.".

(3) In section 152 of the Road Traffic Act 1988 (exceptions to duty of insurers to satisfy judgment against persons insured against third-party risks), in subsection (2)—

(a) in paragraph (a), after "avoid it" insert "either under the Consumer Insurance (Disclosure and Representations) Act 2009 or, if that Act does not apply,";

(b) in paragraph (b), after "policy or security" insert "under that Act or", and for "it" substitute "the policy or security".

EXPLANATORY NOTES

CLAUSE 11: CONSEQUENTIAL PROVISION

A.61 This clause affects:

(1) the Marine Insurance Act 1906, sections 18, 19 and 20; and

(2) the Road Traffic Act 1988, section 152(2).

Marine Insurance Act, sections 18, 19 and 20

A.62 Sections 18 to 20 provide content to the obligation to act with the utmost good faith during the pre-contractual phase of the relationship between insurer and insured. Clause 11(1) abolishes any rule of law to the same effect as these provisions in consumer insurance. This is necessary because the 1906 Act has been taken to state the common law position in relation to pre-contract information and disclosure in non-marine insurance. Clause 11(2) then amends the 1906 Act itself to disapply these provisions from consumer marine insurance.

Road Traffic Act 1988, section 152(2)

A.63 The Road Traffic Act provides for a scheme of compulsory motor insurance. Motor insurers generally have an obligation to satisfy judgments obtained by third parties, even if the insured has breached the insurance contract. There is a limited exception in section 152(2), by which an insurer may obtain a declaration that it is entitled to avoid a policy because the insured has made a non-disclosure or misrepresentation. However, the effect of this section is much more limited than first appears. Under an agreement between the Motor Insurance Bureau and the government, insurers have undertaken to ensure that the third party is compensated. Section 152(2) only applies where there are two or more possible insurers who might be obliged to pay the third party.

A.64 Clause 11(3) amends section 152(2), so that an insurer is only entitled to avoid a consumer insurance policy under section 152(2) if it may avoid the policy under this draft Bill.

A.65 For further discussion of this clause, see Part 9.

12 Short title, commencement, application and extent

(1) This Act may be cited as the Consumer Insurance (Disclosure and Representations) Act 2009.

(2) This Act comes into force at the end of the period of 1 year beginning with the day on which it is passed.

(3) This Act applies only in relation to consumer insurance contracts entered into, and variations to consumer insurance contracts agreed, after the Act comes into force.

(4) Nothing in this Act affects the circumstances in which a person is bound by the acts or omissions of that person's agent.

(5) This Act extends to England and Wales and to Scotland (but not to Northern Ireland).

EXPLANATORY NOTES

CLAUSE 12: SHORT TITLE, COMMENCEMENT, APPLICATION AND EXTENT

A.66 Under clause 12(2) and (3), the lead time for introduction is a year, to enable insurers to prepare for the new regime: see paragraphs 4.48 to 4.49.

A.67 Clause 12(4) confirms that ordinary principles of agency law will continue to apply to consumer insurance. This is discussed in the notes to clause 9 and in Part 8 of the report.

A.68 The draft Bill extends to England and Wales and to Scotland (clause 12(5)). Neither the Law Commission nor the Scottish Law Commission has the requisite mandate to make recommendations or draft legislation to cover Northern Ireland, the Channel Islands or any other jurisdiction.

SCHEDULES

SCHEDULE 1

Section 4(3).

INSURERS' REMEDIES FOR QUALIFYING MISREPRESENTATIONS

PART 1

CONTRACTS

General

1 This Part of this Schedule applies in relation to qualifying misrepresentations made in connection with consumer insurance contracts (for variations to them, see Part 2).

Deliberate or reckless misrepresentations

2 If a qualifying misrepresentation was deliberate or reckless, the insurer—
   (a) may avoid the contract and refuse all claims, and
   (b) need not return any of the premiums paid, except to the extent (if any) that it would be unfair to the consumer to retain them.

Careless misrepresentations — claims

3 If the qualifying misrepresentation was careless, paragraphs 4 to 8 apply in relation to any claim.

4 The insurer's remedies are based on what it would have done if the consumer had complied with the duty set out in section 2(2), and paragraphs 5 to 8 are to be read accordingly.

5 If the insurer would not have entered into the consumer insurance contract on any terms, the insurer may avoid the contract and refuse all claims, but must return the premiums paid.

6 If the insurer would have entered into the consumer insurance contract, but on different terms (excluding terms relating to the premium), the contract is to be treated as if it had been entered into on those different terms if the insurer so requires.

7 In addition, if the insurer would have entered into the consumer insurance contract (whether the terms relating to matters other than the premium would have been the same or different), but would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim.

8 "Reduce proportionately" means that the insurer need pay on the claim only X% of what it would otherwise have been under an obligation to pay under

EXPLANATORY NOTES

SCHEDULE 1: INSURER'S REMEDIES FOR QUALIFYING MISREPRESENTATIONS – PART 1: CONTRACTS

General

A.69 The Schedule starts with the remedies available for qualifying misrepresentations made before the contract is entered into. This would include a renewal.

Deliberate or reckless misrepresentations

A.70 Paragraph 2 specifies the remedies for deliberate or reckless misrepresentations. Under subparagraph (2)(a), the insurer is entitled to avoid the contract. Under subparagraph (2)(b), the insurer may keep the premiums, except where this would be unfair to the consumer. In paragraphs 6.40 to 6.53 of the report, the Law Commissions provide guidance on the type of case in which it would be unfair for the insurer to keep the premiums.

Careless misrepresentations – claims

A.71 If the misrepresentation was careless, the insurer is entitled to a remedy which aims to put it in the position in which it would have been had the consumer fulfilled his or her duty under clause 2(2). This involves asking what the insurer would have done if the consumer had taken reasonable care to provide the correct information. The remedies are as follows:

(1) Where an insurer would have declined the risk altogether, the policy may be avoided, the claim refused and the premiums returned (paragraph 5).

(2) Where the insurer would have contracted on different terms (except for those relating to the premium), those terms are applied to the claim. Thus if the insurer would have excluded a particular type of claim, the insurer should not be obliged to pay claims that would fall within the exclusion. For example, if a consumer carelessly failed to reveal hearing loss, and the insurer would have excluded hearing loss from the policy, the insurer would not be obliged to pay claims related to the loss of hearing but would be required to pay other claims. Similarly, if an insurer would have imposed a warranty or excess, the claim should be treated as if the policy included the warranty or excess (paragraph 6).

(3) Where an insurer would have increased the premium, the claim should be reduced proportionately to the under-payment of premium. For example, if an insurer only charged £1,000 but should have charged £1,500, the consumer would receive two thirds of the claim. This is often referred to as a "proportionate" settlement (paragraphs 7 and 8).

In some cases, both paragraphs 6 and 7 will apply: the consumer will obtain a proportionate settlement of the element of the claim that falls within the different contract terms.

A.72 These issues are discussed in the report, at paragraphs 6.54 to 6.82 and Appendix B.

the terms of the contract (or, if applicable, under the different terms provided for by virtue of paragraph 6), where—

$$X = \frac{\text{Premium actually charged}}{\text{Higher premium}} \times 100$$

Careless misrepresentations — treatment of contract for the future

9 (1) This paragraph—
(a) applies if the qualifying misrepresentation was careless, but
(b) does not relate to any outstanding claim.

(2) Paragraphs 5 and 6 (as read with paragraph 4) apply as they apply where a claim has been made.

(3) Paragraph 7 (as read with paragraph 4) applies in relation to a claim yet to be made as it applies in relation to a claim which has been made.

(4) If by virtue of sub-paragraph (2) or (3), the insurer would have either (or both) of the rights conferred by paragraph 6 or 7, the insurer may—
(a) give notice to that effect to the consumer, or
(b) terminate the contract by giving reasonable notice to the consumer.

(5) But the insurer may not terminate a contract under sub-paragraph (4)(b) if it is wholly or mainly one of life insurance.

(6) If the insurer gives notice to the consumer under sub-paragraph (4)(a), the consumer may terminate the contract by giving reasonable notice to the insurer.

(7) If either party terminates the contract under this paragraph, the insurer must refund any premiums paid for the terminated cover in respect of the balance of the contract term.

(8) Termination of the contract under this paragraph does not affect the treatment of any claim arising under the contract in the period before termination.

(9) Nothing in this paragraph affects any contractual right to terminate the contract.

PART 2

VARIATIONS

10 This Part of this Schedule applies in relation to qualifying misrepresentations made in connection with variations to consumer insurance contracts.

11 If the subject-matter of a variation can reasonably be treated separately from the subject-matter of the rest of the contract, Part 1 of this Schedule applies (with any necessary modifications) in relation to the variation as it applies in relation to a contract.

12 Otherwise, Part 1 applies (with any necessary modifications) as if the qualifying misrepresentation had been made in relation to the whole contract (for this purpose treated as including the variation) rather than merely in relation to the variation.

EXPLANATORY NOTES

Careless misrepresentations – treatment of contract for the future

A.73 Paragraph 9 addresses the effect of a careless misrepresentation on the future of the contract.

A.74 If the insurer would not have entered into the contract at all, then paragraph 5 applies. The insurer may avoid the contract (and must return the premiums). This means that the contract no longer exists, and the insurer may refuse all past and future claims.

A.75 However, where the insurer would have contracted on different terms or for a higher premium (or both):

(1) in non-life insurance, either side is entitled to terminate future cover on reasonable notice;

(2) for life insurance, the insurer must continue the policy on amended terms.

A.76 In a non-life insurance contract, where an insurer discovers a careless misrepresentation (either in the context of an existing claim or otherwise), it has a choice: it may notify the consumer that it intends to treat the contract as subsisting on different terms (subparagraph (4)(a)); or it may terminate the contract (subparagraph (4)(b)). If it decides to terminate the contract, then it must give reasonable notice to the consumer, and refund the amount of the premium that relates to the balance of the contract term (subparagraph (7)). If an insurer simply does nothing, it is very likely to be found to have waived its rights, under the English law of waiver or the Scots law of personal bar.

A.77 If the consumer receives notice that the insurer intends to continue the contract on different terms, the consumer also has a choice: he or she may agree to continue the contract on amended terms; or he or she may terminate the contract (subparagraph (6)). Again, the consumer must give reasonable notice, and is entitled to a refund of the part of the premium which relates to the future.

A.78 Where the contract is wholly or mainly life insurance, however, a careless misrepresentation does not give the insurer the option to terminate the contract. Instead, the contract will continue on amended terms (subparagraph (5)). If the insurer would have charged more, the insurer may give the consumer the option to pay the additional premium. It is not, however, obliged to do this. It may prefer to continue the existing premium and pay only a proportion of the claim. However, the insurer must notify the consumer of the amended terms in accordance with subparagraph (4)(a). The consumer may then choose to continue the contract or to terminate it as described above.

A.79 This is discussed further in the report, at paragraphs 6.83 to 6.100.

A.80 The explanatory notes for Part 2: Variations are included overleaf.

PART 3

MODIFICATIONS FOR GROUP INSURANCE

13 Part 1 is to be read subject to the following modifications in relation to cover provided for C under a group insurance contract as mentioned in section 7 (and in this Part "A" and "C" mean the same as in that section).

14 References to the consumer insurance contract (however described) are to that part of the contract which provides for cover for C.

15 References to claims and premiums are to claims and premiums in relation to that cover.

16 The reference to the consumer is to be read—
- (a) in paragraph 2(b), as a reference to whoever paid the premiums, or the part of them that related to the cover for C,
- (b) in paragraph 9(4) and (6), as a reference to A.

PART 4

SUPPLEMENTARY

17 Section 84 of the Marine Insurance Act 1906 (return of premium for failure of consideration) is to be read subject to the provisions of this Schedule in relation to contracts of marine insurance which are consumer insurance contracts.

EXPLANATORY NOTES

PART 2: VARIATIONS

A.81 Where a misrepresentation was made before a variation, it is necessary to ask whether the variation can reasonably be treated separately from the rest of the contract.

(1) If the variation can be treated separately, the remedy applies only to the variation (paragraph 11).

(2) If it cannot be treated separately, the remedy applies to the whole contract. Thus if the consumer acted deliberately or recklessly, the insurer may avoid the whole contract (paragraph 12).

A.82 Examples of how these provisions would operate are given in Appendix B, paragraphs B.28 to B.45.

PART 3: MODIFICATIONS FOR GROUP INSURANCE

A.83 Under clause 7(4), where a member of a group scheme breaches the duty to take reasonable care not to misrepresent, this has consequences only for the cover of that individual, and not for the policy as a whole.

A.84 Part 3 therefore modifies the remedies available to the insurer, so that where a group member has made a qualifying misrepresentation, the remedies only affect the group member's cover, and not the rest of the contract.

A.85 In group schemes, the premiums for the particular cover in question will sometimes be paid by the policyholder and sometimes by the group member. Paragraph 16(a) provides that when deciding whether it would be unfair for the insurer to retain the premiums under paragraph 2(b), one needs to consider whether it would fair to the person who actually paid the premiums.

A.86 However, paragraph 16(b) stipulates that the right to terminate cover under paragraph 9 belongs to the policyholder rather than the group member.

PART 4: SUPPLEMENTARY

A.87 Section 84 of the Marine Insurance Act 1906 sets out an insurer's duties to return premiums. Section 84(3)(a) states that where the policy is avoided by the insurer from the commencement of the risk, the premium is returnable, provided that there has been no fraud or illegality on the part of the assured. Under paragraph 17, this is to be read subject to paragraph 2, which allows the insurer to keep the premiums in some cases.

SCHEDULE 2

Section 9.

RULES FOR DETERMINING STATUS OF AGENTS

1 This Schedule sets out rules for determining, for the purposes of this Act only, whether an agent through whom a consumer insurance contract is effected is acting as the agent of the consumer or of the insurer.

2 The agent is to be taken as the insurer's agent in each of the following cases—

(a) when the agent does something in the agent's capacity as the appointed representative of the insurer for the purposes of the Financial Services and Markets Act 2000 (see section 39 of that Act),

(b) when the agent collects information from the consumer, if the insurer had given the agent express authority to do so as the insurer's agent,

(c) when the agent enters into the contract as the insurer's agent, if the insurer had given the agent express authority to do so.

3 (1) In any other case, it is to be presumed that the agent is acting as the consumer's agent unless, in the light of all the relevant circumstances, it appears that the agent is acting as the insurer's agent.

(2) Some factors which may be relevant are set out below.

(3) Examples of factors which may tend to confirm that the agent is acting for the consumer are—

(a) the agent undertakes to give impartial advice to the consumer,

(b) the agent undertakes to conduct a fair analysis of the market,

(c) the consumer pays the agent a fee.

(4) Examples of factors which may tend to show that the agent is acting for the insurer are—

(a) the agent places insurance with only a small proportion of the insurers who provide insurance of the type in question,

(b) the insurer provides the relevant insurance through only a limited number of agents,

(c) the insurer permits the agent to use the insurer's name in providing the agent's services,

(d) the insurance in question is marketed under the name of the agent,

(e) the insurer asks the agent to solicit the consumer's custom.

EXPLANATORY NOTES

SCHEDULE 2: RULES FOR DETERMINING STATUS OF AGENTS

A.88 As discussed in relation to clause 9 (and confirmed in clause 12(4)), the normal principles of agency law apply where an intermediary assists a consumer in completing an insurance application. Schedule 2 provides rules to determine whether an intermediary is to be considered to be acting for the insurer or for the consumer in carrying out this task.

A.89 Under paragraph 2, the intermediary is always considered to act for the insurer in the following three cases:

(1) Where the intermediary acts as an appointed representative under section 39 of the Financial Services and Markets Act 2000. Section 39(3) states that:

> The principal of an appointed representative is responsible, to the same extent as if he had expressly permitted it, for anything done or omitted by the representative in carrying on the business for which he has accepted responsibility.

At present, the section only applies to regulatory matters under the 2000 Act, though it is often taken to apply more widely. Paragraph 2(a) extends the same principle to acts done by the intermediary in relation to collecting and transmitting pre-contract information.

(2) Where the intermediary has been given express authority to collect information as the insurer's agent.

(3) Where the intermediary has express authority to bind the insurer to the contract.

It is common for intermediaries to "change hats" during the transaction, acting for the consumer in advising on the choice of insurer, and acting for the insurer in binding it to cover. Paragraph 2 focuses on the intermediary's capacity at the time of the action in question.

A.90 In other cases, paragraph 3 sets out a general test. The intermediary acts for the consumer unless, in the light of all the relevant circumstances, the intermediary acts for the insurer. Even if there are some factors indicating a close relationship between insurer and insured, these may be outweighed by specific factors indicating that the intermediary acts for the consumer.

A.91 Paragraphs 3(3) and 3(4) list some factors which may be relevant. These factors are indicative and non-exhaustive. The factors listed do not necessarily determine the issue, and other factors may be relevant.

A.92 For further discussion of this Schedule, see Part 8 of the report.

APPENDIX B
COMPENSATORY REMEDIES IN COMPLEX CASES

INTRODUCTION

B.1 This Appendix considers how compensatory remedies apply in three complex cases: where the consumer has taken out double insurance; where the consumer recoups part of the loss from a third party; and where the consumer makes a misrepresentation before varying the contract. It concentrates on cases in which the insurer would have charged more had it known the true facts, and is therefore only liable for a proportion of the claim.

DOUBLE INSURANCE AND CONTRIBUTION

B.2 Where an insured takes out two or more indemnity policies to cover the same risk, the law prevents the insured from receiving more than the total amount of the loss. However, at common law, the insured may choose from which insurer to claim. In order to do justice between insurers, the law permits insurers to claim contributions from each other. This right is not contractual, instead depending "on an equity which requires someone who has taken the benefit of a premium to share the burden of meeting a claim".[1]

B.3 Here we consider how this would work when one of the insurance policies contains a careless misrepresentation, leading to a proportionate payment.

B.4 We think that three points of principle should determine the outcome in such cases. First, an insurer who is liable to make only a proportionate payment should be required to pay less than an insurer who is fully liable for the same claim. Second, the substantive liability of each insurer should not depend on which claim the consumer happens to make first. Third, a consumer should not lose their entitlement to receive payment under a valid policy simply because they have made a mistake in taking out a second, unnecessary policy.

The case law on calculating contributions

B.5 Birds comments that broadly there are two approaches to calculating contributions. However, there has been a "noticeable lack of case law" on the issue, and the one to be applied in any particular circumstances depends "as much on the practices of insurers as on binding legal authority".[2] Below we illustrate these approaches with an example.

[1] *Legal & General Assurance Society Ltd v Drake Insurance Co Ltd* [1992] QB 887, by Nourse LJ. In Scots law, this right is founded in the law of unjustified enrichment. See *The Sickness and Accident Assurance Association Ltd v The General Accident Assurance Corporation Ltd* (1892) 19 R 977 and *Caledonia North Sea Ltd v London Bridge Engineering Ltd* 2000 SLT 1193.

[2] *Birds' Modern Insurance Law* (7th ed 2007) p 341.

A scenario

B.6 The consumer (C) insures their house for £200,000 with insurer A, and for £100,000 with insurer B. The policy with A is perfectly valid, with no element of misrepresentation. However, in entering into the policy with B, C makes a careless misrepresentation – such that, had it not been made, B would have required double the premium. A fire causes damage of £100,000, covered as an insured risk.

"Maximum liability"

B.7 Under this approach each insurer pays that proportion of the loss that its sum insured bears to the total of the sums insured.

B.8 In our scenario, the insured's policy with A has a limit of £200,000. The policy with B *purports* to have a limit of £100,000, but we feel the courts would note that the sum insured on the policy with B is *in fact* £50,000 as a result of the misrepresentation and application of proportionality. Following this logic, A would cover four-fifths of the loss (£80,000) and B one-fifth (£20,000).

B.9 We do not think this would be the right approach, as the maximum liability under the policy may be an arbitrary amount, with little relationship to the importance or cost of the policy. The courts have therefore applied another approach in circumstances where the maximum liability approach would give rise to arbitrary or inappropriate outcomes.

"Independent liability"

B.10 Under this approach it is asked what each insurer would independently have been liable for and the contributions are assessed according to the proportions that each such figure bears to the total of the figures. This approach has judicial support as the correct approach for liability insurance[3] where claims may be small in comparison to large and varying policy limits. There is some support for it also becoming the correct basis in law for calculating contribution generally.[4] We think this is right. The independent liability approach is simpler, clearer and easier to apply.

B.11 In our scenario, insurers A and B would independently be liable for £100,000 and £50,000 each, and so the contributions would reflect the proportions of those figures to the sum of those figures. They would therefore be £66,667 and £33,333 respectively.

Should liability be shared equally between the parties?

B.12 We have considered whether the law would permit A to argue that contributions should be split equally, thus removing the benefit of the partial proportionality defence from B, on the basis that to do otherwise would result in unfairness to A.

[3] See *Commercial Union Assurance Co v Hayden* [1977] QB 804.

[4] See, for example, *MacGillivray on Insurance Law* (11th ed 2008) para 23-050.

B.13 However, we think not, for two reasons. First, while a similar argument has succeeded in relation to the removal of the benefit of a procedural defence,[5] it appears not to apply to substantive defences.[6] Second, the courts have stressed that the right of contribution should be determined at the date of the loss.[7] In our scenario, the misrepresentation occurred before the loss.

In practice

B.14 This type of scenario is unlikely to reach the courts. Instead, one insurer would be faced with a claim and required to make a decision. What should take place? There are two possibilities:

(1) **C makes a claim from A.** At common law, A would pay the full claim, and seek a contribution from B. Once B had established that C made a careless misrepresentation, B would pay £33,333, as discussed above.

(2) **C makes a claim from B.** B pays what it is independently liable for – £50,000. C would then be entitled to claim the remainder from A (£50,000). However, B could also claim a contribution from A of £16,667, on the basis that B is only liable to pay one third of the total claim of £100,000.

We think that the existing law, when correctly applied, reaches this outcome.

B.15 A further complication added by current practice is the effect of rateable proportion clauses. These provide that if there is any other insurance on the property or the risk covered, the insurer will not be liable to pay or contribute more than its rateable proportion of any loss or damage. These do not, and in our view should not, affect the final distribution of the shared burden. Instead it becomes procedurally more complicated for the consumer to claim, as they have to go to both insurers. They may feel that they have been "given the run around". However, the courts have indicated that they are prepared to take a robust approach to any argument that leaves the consumer worse off as a result of a dispute over contributions.[8] We think this is the right approach.

[5] *Legal & General Assurance Society Ltd v Drake Insurance Co Ltd* [1991] 2 Lloyd's Rep 36.

[6] *Eagle Star Insurance Co Ltd v Provincial Insurance plc* [1993] 3 All ER 1.

[7] *Legal & General Assurance Society Ltd v Drake Insurance Co Ltd* [1991] 2 Lloyd's Rep 36.

[8] See, for example, Rix LJ in *Drake Insurance plc v Provident Insurance plc* [2003] EWCA Civ 1874, [2004] QB 601.

SUBROGATION

B.16 Subrogation arises where the insured receives an insurance payment and is then compensated for the same loss by a third party. The doctrine of subrogation permits the insurer to recoup the money it has already paid from the compensation the insured receives.[9] The aim is to prevent the insured from being over-compensated by receiving both insurance money and compensation from a third party. As the courts have put it, the insured "shall be fully indemnified, but shall never be more than fully indemnified".[10]

B.17 The question is what should happen when a consumer insured receives both a proportionate remedy and partial compensation from a third party. Should the compensation received from a third party be kept by the insured, paid over to the insurer, or split between insured and insurer? Again, a scenario illustrates the issue.

A scenario

B.18 A has a policy of home contents insurance with insurer B. A's home is burgled and £5,000 of jewellery covered by the policy is stolen. However, on entering into the policy A made a careless misrepresentation to B – such that, had B known the truth, it would have required double the premium. The insurer pays a proportionate remedy of £2,500. The burglar is caught and convicted, and required to pay compensation of £1,000.

B.19 What should happen to the £1,000? Should it be paid to the insurer (on the ground that the insurer has paid £2,500 for the loss), or kept by the consumer (to cover the £2,500 loss still outstanding), or split 50:50? We think the correct result, in logic and under existing legal principles, is that the payment should be split, for the reasons we set out below.

The case law

B.20 Until recently, there were no clear answers on what happens where an insured is only partially covered for the loss and recovers a partial payment from a third party. However, in *Lord Napier and Ettrick v Hunter*[11] the House of Lords offered two approaches for calculating how the money should be allocated between insurer and insured.

Approach (1) – "ultimate loss"

B.21 Lord Jauncey in his judgment examined the earlier authorities, and drew from them the principle that the effect of recoveries gained before indemnification by the insurer should be equated with that of recoveries gained after indemnification. He then drew from this the further proposition that the loss which the insurer had undertaken to meet was the "ultimate loss" – that is, the initial loss diminished by any recovery made.

[9] *Randal v Cockran* (1748) 1 Ves. It also confers on an insurer the right to receive the benefit of all rights and remedies of the insured against third parties in relation to the loss, but this facet is not the focus of this problem.

[10] *Castellain v Preston* (1883) 11 QBD 380, by Brett LJ.

[11] [1993] 2 WLR 42.

B.22 Applying this approach to our scenario the initial loss is £5,000 – the recovered £1,000 is then to be taken into account as diminishing that loss to an "ultimate loss" of £4,000. It is this loss which the insurer B has undertaken to meet. When the proportionate remedy is taken into account, the insurer should end up paying the insured half of this – that is, £2,000. In effect the compensation is split. The consumer would owe the insurer half of the £1,000 recovered.

Approach (2) – "top down"

B.23 Lord Templeman considered a hypothetical scenario and applied a "top down" approach.[12] He assumed that a hypothetical insured suffered a loss of £160,000, for which they had a policy with a limit of £100,000 and an excess of £25,000. On these figures, the insurer would pay £100,000, leaving the insured to cover the excess of £25,000 and the top £35,000 of loss. He then assumed that £130,000 was recovered from a third party.

B.24 How should the £130,000 be distributed? Lord Templeman considered that each slice of the insured's loss should be treated as if covered by three separate insurers. For the first £25,000 of loss (the excess), the insured was considered to be their own insurer. The insurer was liable for the next £100,000. And for the top slice of uninsured loss (£35,000), the insured again acted as their own insurer. The recovered monies should be applied to these slices from the top down – to the £35,000 first, then to £95,000 of the next slice. This meant the insured could keep £35,000, had to pay £95,000 to the insurer, and had to cover the excess themselves.

B.25 This approach would lead to a different outcome when applied to our scenario. The proportionate remedy means A suffers an uninsured loss of £2,500 over and above that covered by the payment from the insurer, B. The recovery of £1,000 should be applied first to the uninsured loss – this section being analogous to the top slice in Lord Templeman's example. As A will still not be fully compensated for this top slice after receiving the £1,000, A would owe nothing more to the insurer.

The right approach

B.26 We think that Lord Jauncey's "ultimate loss" approach is the right approach where proportionate remedies are involved. In theory, the question as to which of the approaches set out in *Lord Napier and Ettrick v Hunter* is correct remains a matter to be decided. In the case itself it was the excess which was at issue, and both approaches led to the same outcome on the facts; the insured bore the cost of the excess. However, the different judgments might give rise to different results if applied in other scenarios.

[12] M Hemsworth, "Subrogation: the problem of competing claims to recovery monies" [1998] *Journal of Business Law* 111.

B.27 We think that the "ultimate loss" approach is the most appropriate in the case of proportionate payments for three reasons:

(1) Its logic is consistent with the aim of a proportionate payment. If the insurer had known the true facts, it would have been obliged to pay the full £5,000, and then would have been entitled to all of the £1,000 recovered – resulting in a net "liability" of £4,000. As it would have charged double the premium, the proportionate remedy would have halved this to £2,000 – the net outcome of the "ultimate loss" approach.

(2) The outcome should not depend on the order in which payments are made. If A had recouped £1,000 immediately (as where the burglar had dropped a ring worth £1,000 on the way out), A would claim for a loss of £4,000 and receive £2,000. The outcome should be the same here.

(3) The consideration of "slices" of insurance in the "top down" approach does not lend itself readily to proportionate remedies. The unpaid £2,500 in our scenario is not the "top slice" of loss. Instead the whole loss is to be shared equally.

VARIATIONS

B.28 When seeking to vary a contract of insurance, it is clear that only information relating to the variation itself must be disclosed; there is no requirement to disclose information relating to the rest of the original policy. Should there be a non-disclosure or misrepresentation, the courts seem to have settled on the view that only the variation is voidable, rather than the entire policy.[13]

B.29 The draft Bill states that where there is a qualifying misrepresentation in relation to a variation, and that variation can reasonably be treated separately from the subject-matter of the rest of the contract, the remedy should only apply in relation to the variation.[14] However, where the variation cannot reasonably be treated separately from the policy, the remedy should apply to the entire policy.[15] This means that where the insurer has a right to avoid, and the variation can be treated as separate, the insurer is entitled to avoid the variation only. But if the variation cannot reasonably be separated, the insurer may avoid the entire policy. Similarly, where the insurer is entitled to a compensatory remedy, the remedy might be applied to either the variation or to the entire policy.

B.30 The following scenarios illustrate these principles. In each case we consider what should happen when:

(1) The insurer has a right to avoid.

(2) The insurer has a right to pay only a proportion of the claim.

[13] Discussed further at paras 6.101 to 6.104.

[14] Draft Bill, Sch 1, para 10.

[15] Draft Bill, Sch 1, para 11.

Scenario – variation to increase cover

B.31 A insures a car for £10,000. A pays a premium of £500 and warrants not to drive more than 10,000 miles. During the life of the policy, A wishes to increase this mileage limit to 20,000 miles. The insurer agrees to do so for an additional premium of £500.

B.32 Can this variation reasonably be treated separately from the rest of the policy? Given that A paid a set amount of money for a set amount of additional cover, we think it can be. This leads to the results set out below.

(1) Avoidance

B.33 A made a careless misrepresentation in relation to the variation. But for the misrepresentation, the insurer would not have agreed to this variation.

B.34 First, assume A writes off the car after driving 9,000 miles. Under our proposals, the insurer can avoid only the variation, leaving the original contract intact. Therefore A is entitled to claim £10,000. A has only driven 9,000 miles, under the original limit of 10,000 miles, so the original policy applies.

B.35 Second, assume that A writes off his car after driving 10,001 miles. Again, the insurer can avoid the variation. A is now in breach of the warranty in the original insurance contract and so is entitled to nothing.

(2) Proportionate payment

B.36 A made a careless misrepresentation in relation to the variation. Had it known the truth, the insurer would have agreed to the variation, but would have charged an additional £1,500 rather than an additional £500. If the write-off occurs after 9,000 miles, the consumer is entitled to claim the full £10,000. However, if the write-off occurs at 10,001 miles, the consumer is entitled only to a proportionate payment (that is £3,333).

Scenario – variation to reduce an excess

B.37 B insures a house for £200,000. B pays a premium of £1,000 and the excess is £1,000. B subsequently wishes to reduce the excess. The insurer agrees to reduce the excess to £100 in return for an additional premium of £20.

B.38 Again, the first question to ask is whether the subject-matter of the variation can reasonably be treated separately. Given that B paid a set amount of money for a set amount of additional cover, we think it can be. Indeed, the excess could have been insured with another insurer – for possibly the same net result.

(1) Avoidance

B.39 B made a careless misrepresentation when arranging the variation. But for the misrepresentation, the insurer would not have agreed to the variation. B's house is destroyed in a fire. The insurer is entitled to avoid the variation and B will be able to claim £199,000. B will also be able to reclaim the additional £20 premium.

(2) Proportionate remedy

B.40 B made a careless misrepresentation such that, had the insurer known the truth, it would have charged £40 on top of the original £1,000, instead of £20, for the reduced excess. In this case the insured is effectively paying a premium of £20 for £900 of cover (the reduction in the excess). But for the misrepresentation, B would have had to pay £40 for the same cover. A proportionate remedy should therefore be applied to the excess. The insurer should only have to pay half of the additional cover it gave – amounting to £450. This means that B would receive a total payment of £199,450.

Scenario – variation to reduce premium

B.41 C insures a house for £200,000, for a premium of £2,000. Subsequently, C wishes to reduce the premium, and by agreeing to additional warranties (including installing locks and fire alarms) C reduces the premium to £1,600. Following a flood, the house suffers £100,000 of damage.

B.42 We think that in a case like this the variation cannot be separated from the main contract. Here the variation goes to the price of the overall policy, rather than a part of the price referable to a separate part of the policy.

(1) Avoidance

B.43 On entering into the variation, C made a deliberate or reckless misrepresentation. If the insurer was only entitled to "avoid the variation", the consumer would simply need to repay £400, in return for reverting to the original cover. This would not be appropriate to show society's disapproval of the conduct.

B.44 Instead, in a case like this, where the consumer has obtained a discount of the whole price through deliberate or reckless conduct, the appropriate result would be to avoid the whole policy.

(2) Proportionate remedy

B.45 C made a careless misrepresentation in relation to the variation, such that had the insurer known the truth, then it would have still charged the original £2,000. In other words, the insurer would have charged £2,000 rather than £1,600. This means that C would be entitled to four-fifths of the claim (£80,000).

APPENDIX C
UPDATING THE SURVEY OF FOS DECISIONS

INTRODUCTION

C.1 Our 2007 consultation paper included the results of a survey of Financial Ombudsman Service (FOS) decisions.[1] With the help of the FOS, we analysed 190 final ombudsman decisions relating to non-disclosure or misrepresentation in consumer insurance. These decisions were made between February 2003 and December 2005.

C.2 Before finalising our policy, we wished to see whether the issues had changed since 2005. To that end, the FOS very kindly provided us with 47 recent final ombudsman decisions dealing with non-disclosure in consumer insurance.

C.3 We were particularly interested to see if the FOS approach had changed since the ABI had published its guidance in this area in January 2008.[2] As many of the problems concerned critical illness insurance, we were keen to ensure that we read a reasonable number of such cases. We therefore asked the FOS for up to 20 decisions concerning critical illness, and 30 cases concerning other types of insurance.

C.4 We are very grateful to the FOS for allowing us access to these cases. We undertook to preserve the anonymity of both complainants and insurers and we have been careful to remove any details which would identify the parties.

TYPES OF POLICY

C.5 We were provided with 17 critical illness cases and 30 concerned with other issues. All but one of the decisions were made between January 2008 and July 2009.[3] Out of the 30 "other" cases, 11 concerned motor insurance, 11 concerned buildings insurance, and six concerned protection insurance (other than critical illness). The remaining case was about pet insurance.

[1] Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134, Appendix C.

[2] ABI Guidance, "Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products" (January 2008).

[3] One decision looked at dated from May 2006.

C.6 This gave us a broad spread across different types of insurance, but the make up of the cases in our sample is not necessarily the same as the make up of cases coming to the FOS generally. Note that we only looked at final ombudsman decisions. The FOS reports that 90% of the cases it deals with are resolved by adjudicators rather than an ombudsman.[4] Our sample was therefore weighted towards larger, more difficult complaints, over household policies for example, rather than the smaller, more straightforward motor cases, which are more likely to be resolved by an adjudicator.

INFORMATION NOT DISCLOSED

C.7 As in the 2007 survey, we looked at the main information that the insurer said was not disclosed in each case. At that time, health issues dominated the sample although the non-disclosure of the policyholder's past claims record, past losses or previous convictions also gave rise to problems.

C.8 The picture remains very much the same. Again, health issues made up the majority of non-disclosures – in 26 of the 47 cases (including all of the critical illness cases). Criminal charges, convictions and previous claims together made up another 12 cases. In motor insurance, there were two cases in which the insurer said the policyholder had misled them about the identity of the owner of the vehicle, and two cases where modifications to vehicles were not disclosed. In property insurance, two cases involved issues about the use of the property. The other cases involved a variety of issues.

WAS A QUESTION ASKED?

C.9 We recorded whether the consumer had been asked a specific question about the relevant information. In the great majority of cases, a relevant question was asked. There were only five cases in which the insurer attempted to avoid a policy for non-disclosure because the applicant had failed to volunteer information. This is consistent with the findings of the 2007 survey.

WAS THE QUESTION CLEAR?

C.10 As in 2007, we found that even if a question was asked, it may not necessarily have been "clear". The survey again showed that questions relating to health, in particular, may be wide-ranging, and these remain a significant problem. In 15 cases we thought one or more of the questions could be considered unclear. Below, we give some examples of commonly-asked questions that have the potential to cause problems.

C.11 First, it appears that questions still sometimes list many different disorders or problems within a single sentence. The worst examples mix symptoms with conditions, and serious conditions with minor problems. For example:

[4] FOS Annual Review 2007-08.

> Have your natural parents, brothers or sisters suffered before the age of 65 from any of the following: heart disease, stroke, high blood pressure, diabetes, kidney or bladder disease, cancer, nervous disorder or any hereditary illness or disease?

Questions about blood pressure are a particular problem, given the prevalence of raised blood pressure in the general population and the lack of any generally agreed understanding of what constitutes "high blood pressure".

C.12 Second, some questions are extremely wide. For example:

> Apart from the answers given above, have you within the last 7 years consulted a doctor, psychiatrist, consultant, clinic, osteopath etc concerning your mental or physical health?

C.13 Third, some questions are not time-limited, and test the limits of consumers' memories. For example:

> Have you ever had any other illness or injury or condition requiring hospital treatment or investigation?

C.14 Similarly, questions in household policies may ask whether things have *ever* happened to the property:

> Has the property ever been damaged by subsidence, ground heave or landslip?

For older properties, especially those which are more than a hundred years old, this sort of question may be extremely difficult to answer.

C.15 A final problem is that some questions are vague or ambiguous. For example:

> Have you ever had any disorder for which regular treatment was prescribed?

The word "regular" in the context of this question could take on a wide variety of meanings.

EVALUATING THE CONSUMER'S STATE OF MIND

C.16 The FOS states that it categorises misrepresentations in three ways: deliberate/ reckless, inadvertent (sometimes referred to as careless or negligent) and innocent. The difficulties in reaching clear definitions of these categories, and consistent application, were explored in the consultation paper.[5] We read through each of these decisions to see how the ombudsman had classified the behaviour.

[5] CP, Appendix C, paras C.60 to C.65.

C.17 Given the small number of cases examined, our findings should be interpreted with care. However, it appears that the FOS may now be more likely to find that a misrepresentation is “inadvertent”, “careless” or “negligent” (that is, of the intermediate type, where it would be appropriate to apply a proportionate remedy). In our 2007 survey, only 9% of cases were classified as “inadvertent”. Yet out of the 47 cases we read in 2009, 11 (30%) were put into the intermediate category, described as negligent, inadvertent or careless. It would seem that both the industry and the FOS are becoming more confident in applying this category.

CARELESS NON-DISCLOSURE AND PROPORTIONATE PAYMENTS

C.18 If the non-disclosure is found to be inadvertent (or careless/negligent), the FOS asks what policy terms the insurer would have offered if it had been aware of the true information. In practice there are three possibilities: if the insurer would not have entered into the policy, the policy can be avoided; if it would have charged a higher premium, it will be ordered to pay a proportion of the claim; and if it would have inserted an exclusion, then the claim should be paid but subject to the exclusion.[6]

C.19 We were interested to see the number of cases in which the insurer made a partial payment of the claim, making a reduction to reflect the increased premium it would have charged. In our 2007 survey, we found that proportionate payments were relatively rare – occurring in eight out of 190 cases in that survey (4%). There were only three cases in which the insurer offered a proportionate settlement.

C.20 In our survey, eight out of 47 cases resulted in a proportionate payment (17%). In three cases the FOS imposed a proportionate outcome and in five cases the insurer offered it. This suggests that insurers may now be more likely to think in terms of proportionate outcomes.

THE SUCCESS RATE

C.21 Across all the consumer cases in our sample, there was a substantial change to the insurer’s decision in 22 cases, and a small change in one case. The insurer’s original decision was upheld in 23 cases, and one case was referred to court. In broad terms, the consumer was successful in around half of cases.

[6] Discussed in more detail in Part 2 above.

APPENDIX D
LIST OF CONSULTEES

List of those who responded to *Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134.

Academics

Professor John Birds
Professor Malcolm Clarke
Ray Hodgin
Professor John Lowry
Professor Rob Merkin

Brokers and broker organisations

AON Limited
Arthur J Gallagher (UK) Limited
British Insurance Brokers' Association (BIBA)
Institute of Insurance Brokers
Jardine Lloyd Thompson Group PLC
LifeSearch Limited
Lockton Companies International Limited
Marsh and Guy Carpenter
T H March & Co Limited

Business insureds

Association for Consultancy and Engineering (ACE)
Association of Insurance and Risk Managers (AIRMIC)
Barclays
Chamber of Shipping
Construction Industry Council
HSBC
Institute of Chartered Accountants in England and Wales (ICAEW)
Network Rail Group Insurance Team
Royal Institution of Chartered Surveyors (RICS)

Consumer groups

Age Concern England
Financial Services Consumer Panel
Multiple Sclerosis Society
National Consumer Council
UNLOCK

Insurers and insurance organisations

Ace European Group Limited
Aegon UK PLC
Allianz Insurance PLC
Association of British Insurers (ABI)
Aviva PLC
Bright Grey
Brit Insurance Holdings PLC
Catlin Underwriting Agencies Limited
Chartered Insurance Institute
Endsleigh Insurance Services Limited
Fortis Insurance Limited (FIL)
Friends Provident
Group Risk Development Group (GRiD)
International Group of P&I Clubs
International Underwriting Association of London (IUA)
Investment & Life Assurance Group (ILAG)
Leeds Marine Insurance Association
Liverpool Underwriters & Maritime Association
Lloyd's
Lloyd's Market Association (LMA)
Munich Re UK Life Branch
Nationwide Building Society
NFU Mutual
Norwich Union Marine
RBS Insurance
RGA Reinsurance UK Limited
Royal & SunAlliance Insurance PLC
SCOR Global Life Reinsurance UK Limited
Scottish Re Limited
Scottish Widows PLC
Swiss Re
Xchanging Claims Services
Zurich Financial Services

Lawyers, judges and legal organisations

Addleshaw Goddard LLP
Association of Personal Injury Lawyers (APIL)
Beachcroft LLP
British Insurance Law Association (BILA)
British Maritime Law Association
City of London Law Society
Clyde & Co LLP

Davies Arnold Cooper
Dewey & LeBoeuf
Faculty of Advocates
Forum of Insurance Lawyers (FOIL)
Freshfields Bruckhaus Deringer LLP
John Habergham, AMJ Solicitors
Herbert Smith LLP
Jonathan Hirst QC
Angela Horne, Hill Dickinson LLP
Keoghs LLP
Kirkpatrick & Lockhart Preston Gates Ellis LLP (K&L Gates)
Law Reform Committee of the Bar Council
Law Society of Scotland
London Common Law and Commercial Bar Association
Lord Justice Rix

Others

Association of Friendly Societies (AFS)
Debra and Stephen Brook
Derrick G Cole and Geoffrey H Lloyd
Commercial Court Users Committee
Richard Eveleigh
Financial Ombudsman Service (FOS)
Financial Services Authority (FSA)
Peter Franklin
John Henderson
Simon Mansell
Mark Wibberley
Colin Woodley

CONFIDENTIAL RESPONSES

We received a further 12 responses from consultees who did not wish to be identified.