The Law Commission
Consultation Paper No 182
and
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INSURANCE CONTRACT LAW: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured

A Joint Consultation Paper

THE LAW COMMISSION

THE SCOTTISH LAW COMMISSION

INSURANCE CONTRACT LAW: MISREPRESENTATION, NON-DISCLOSURE AND BREACH OF WARRANTY BY THE INSURED

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OUTLINE

1.1 This Consultation Paper examines three areas of insurance contract law:

- misrepresentation and non-disclosure by the insured before the contract is made;
- warranties and similar terms; and
- cases where an intermediary was wholly or partially responsible for pre-contract misrepresentations or non-disclosures.

1.2 **A more comprehensive summary is available on our websites at http://www.lawcom.gov.uk and http://www.scotlawcom.gov.uk.** Here we list some of our main provisional proposals and indicate where to find more information about them in the Consultation Paper.

THE NEED FOR REFORM

1.3 Insurance contract law is partly set out in the Marine Insurance Act 1906. This Act incorporates general principles of insurance law and has been held to apply to all forms of insurance contracts, not simply to marine insurance. However, it has not kept pace with the times and can produce results that fail to meet the expectations of the market.

1.4 Consumers have a degree of protection against the strict effects of the law:

- Insurers issued Statements of Practice in which they agreed not to rely on their strict legal rights in some circumstances. These have been withdrawn but remain influential.
- The Financial Services Authority (FSA) adopted the substance of some of these Statements into its rules regulating the conduct of insurance companies.
- The Financial Ombudsman Service (FOS) provides a dispute resolution service to consumers and small businesses, which makes decisions on the basis of what is "fair and reasonable". When deciding what is "fair and reasonable" the FOS often uses the Statements of Practice as guidance.

1.5 However, the existence of these different systems of law, regulation and guidance means that it is difficult for both insurers and consumers to find out what their rights and obligations are. The FOS issues guidance but it does not publish its decisions. Moreover some cases fall outside its jurisdiction. The position for both insurers and consumers can therefore be unclear and inaccessible.

1.6 For businesses, the Statements of Practice and most of the FSA rules do not apply. Only those businesses with a turnover of less than £1 million are entitled to bring cases to the FOS.

1.7 We therefore conclude that the overlapping layers of regulation and discretion are not a substitute for law reform. We propose reforms which are intended to give potential policyholders confidence in insurance by ensuring that it meets their reasonable expectations while protecting the legitimate interests of insurers and not imposing undue costs or unnecessary restrictions.

OUR REFORMS

1.8 Our reforms deal separately with consumers and businesses. We define consumers as individuals who take out insurance for purposes wholly or mainly unrelated to their businesses (*see paras 4.5 to 4.12*).

- For consumers we propose a mandatory regime which is based largely on existing FOS practice.

- For businesses, we propose a new default regime, based on accepted good practice. These rules could be altered by contractual terms, provided that the alterations are made clear to the business.

PRE-CONTRACT INFORMATION FROM THE INSURED

1.9 It is clearly important that insurers are able to obtain sufficient information from potential policyholders to assess risks properly. However, the current law on disclosure can operate as a trap and allows claims to be rejected even where policyholders have acted honestly and reasonably.

Consumers

1.10 The following proposals will bring the law broadly into line with FOS practice:

- At present, consumers have a duty to volunteer all information that would have an effect on the mind of a prudent insurer. We propose to replace a consumer's duty to volunteer information with a requirement to answer questions carefully and honestly (*paras 4.13 – 4.49*).

- A consumer who answers questions (or gives other information) honestly and takes reasonable care should be protected (*paras 4.100 – 4.152*).

- Where the consumer deliberately or recklessly gives an incorrect answer to a question or other incorrect information, the insurer will be entitled to avoid the policy and refuse all claims under it. We ask if the insurer should also be entitled to retain the premiums (*paras 4.50 to 4.99*).

- Where the consumer has been negligent when answering questions or giving information, the law should aim to put the insurer in the position in which it would have been had it been aware of the full facts:

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

    - 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 declined the risk altogether, the policy may be avoided, the claim refused and the premiums returned (*paras 4.153 – 4.189*).

1.11 We ask whether in consumer life insurance, the insurer should be prevented from relying on a negligent misrepresentation after the policy has been in force for five years or more. This would go further than current FOS practice, but reflects similar statutory provisions which are already in place in other jurisdictions (*paras 4.190 – 4.204*).

Businesses

1.12 For businesses, we propose changes to the "default regime" (that is, the rules which apply in the absence of any contractual terms to the contrary).

- We propose that businesses should continue to have a duty to volunteer information, but the duty should be limited to facts that a reasonable insured in the circumstances would realise the insurer wanted to know about *(paras 5.24 – 5.48*).

- A business that answers questions or provides information honestly and takes reasonable care should be protected (*paras 5.49 – 5.84*).

- We ask whether, for businesses, the law should distinguish between dishonest and negligent conduct. Where a business has made a negligent non-disclosure or misrepresentation, should the insurer be placed in the position it would have been in had it been aware of the full facts, along the lines recommended for consumer cases (*paras 5.85 – 5.108*)?

1.13 Under our proposals, insurers and businesses would be free to agree different rules. However, we propose special controls which would prevent insurers from contracting out of the default regime in standard term contracts to the extent that the terms altering the default position have not been made clear to the insured and would defeat the insured's reasonable expectations (*paras 5.109 – 5.147*).

Group insurance and insurance on the life of another

1.14 Group insurance schemes are typically those where an employer arranges insurance for the benefit of employees and, sometimes, their partners and dependants. The current law does not deal with this situation and insurers have developed principles of good practice to deal with group insurance. We propose reform to bring the law into line with that good practice *(paras 6.3 – 6.41*).

1.15 We also propose that where the policyholder insures someone else's life, a misrepresentation by the person whose life is insured should be treated as if it were a misrepresentation by the policyholder (*paras 6.53 – 6.75*).

WARRANTIES AS TO THE FUTURE

1.16 Under current law, where a policyholder gives a warranty about future actions, any breach will discharge the insurer from all further liability, even in respect of claims which have no connection with the breach. We propose that the following rules should apply to all warranties as to the future:

- Any warranty should be set out in writing. Additionally, in consumer cases, any warranty must be brought properly to the consumer's attention (*paras 8.8 – 8.20*).

- A breach of warranty would not automatically discharge the insurer from liability. Instead, the insurer should pay a claim where the insured can prove on the balance of probabilities that the event constituting the breach did not contribute to the loss (*paras 8.21 – 8.48*).

- For consumer insurance, these rules would be mandatory *(paras 8.49 – 8.50*).

- In business insurance the parties could agree other consequences for breach of warranty. There would be special controls where the business contracts on the insurer's standard terms. The insurer would not be permitted to rely on a warranty, exception or definition of the risk in a standard term contract if it would render the cover substantially different from what the insured reasonably expected (*paras 8.51 – 8.80*).

PRE-CONTRACT INFORMATION AND INTERMEDIARIES

1.17 Insurance is often bought through brokers and other intermediaries who give guidance on application forms and pass information to insurers. It is not always clear for whom the intermediary is acting, and a policyholder often bears the consequences of any mistakes or wrongdoing by the intermediary.

1.18 We propose to clarify that "tied agents" who sell the products of a limited range of insurers should be treated as acting for the insurer. Where intermediaries are clearly independent, they should be considered to be acting for the policyholder. We ask whether the test of an intermediary's independence should be whether the intermediary has made a "fair analysis" of the market, as defined by the Insurance Mediation Directive (*paras 10.02 – 10.74*).

CONCLUSION

1.19 It is not possible in an outline of this length to introduce all of our proposals. Consultees are therefore encouraged to read both the fuller summary available on our websites and the relevant sections of this paper. We look forward to receiving views by **16 November 2007**, sent to the address at the front of this report.

ABBREVIATIONS USED IN THIS REPORT

1906 Act	Marine Insurance Act 1906
ABI	Association of British Insurers
ALRC	Australian Law Reform Commission
BILA	British Insurance Law Association
COB	Conduct of Business Sourcebook (FSA Handbook, dealing with investment insurance)
DISP	Dispute Resolution Sourcebook (FSA Handbook)
FOS	Financial Ombudsman Service
FSA	Financial Services Authority
FSCS	Financial Services Compensation Scheme
FSMA	Financial Services and Markets Act 2000
ICOB	Insurance Conduct of Business Sourcebook (FSA Handbook)
LRC	Law Reform Committee (the Law Commission's predecessor)
MAT	Marine, Aviation and Transport
NCC	National Consumer Council
OFT	Office of Fair Trade
PRIN	Principles for Businesses Sourcebook (FSA Handbook)
SLIP	ABI Statement of Long-Term Insurance Practice 1986, issued by the Association of British Insurers. (A copy of this can be found in Issues Paper 1, Appendix B)
SGIP	ABI Statement of General Insurance Practice 1986, issued by the Association of British Insurers. (A copy of this can be found in Issues Paper 1, Appendix B)
UCTA	Unfair Contract Terms Act 1977
UTCCR	Unfair Terms in Consumer Contracts Regulations 1999, SI 1999 No 2083

PART 1
INTRODUCTION

OUTLINE OF THE PROJECT

1.1 The English and Scottish Law Commissions are undertaking a joint review of insurance contract law. Our aim is to ensure that the law balances the interests of insured and insurer, reflects the needs of modern insurance practice and allows both insured and insurer to know their rights and obligations.

1.2 In January 2006 we issued a joint scoping paper, which explained that we would be considering the law of misrepresentation, non-disclosure and breach of warranty.[1] We then asked whether there were other areas in need of review. We received 118 responses from a wide variety of organisations and individuals, which indicated strong support for a wide-ranging review.[2]

1.3 Given the many topics to be considered we have decided to publish two consultation papers. This first paper considers:

(1) misrepresentation and non-disclosure by the insured before the contract is made;

(2) warranties (including basis of the contract clauses); and

(3) misrepresentation and non-disclosure before the contract is made when the contract is made through an intermediary.

The remaining topics will be dealt with in a separate consultation paper in 2008. They will include post-contractual good faith, insurable interest and damages for the late payment of claims.

1.4 In order to share our thinking as it developed, we published three Issues Papers: Paper 1 on Misrepresentation and Non-Disclosure in September 2006; Paper 2 on Warranties in November 2006; and Paper 3 on Intermediaries and Pre-Contractual Information in March 2007. The papers were discussed at a series of seminars and meetings (listed in Appendix D), including two private seminars with an invited audience.[3] The feedback from these papers has been very helpful and has led us to modify our views in several respects. Although this consultation paper draws heavily on material in the Issues Papers, some proposals are explained more clearly, while others have changed.

1.5 We seek views on our provisional proposals and questions by **16 November 2007.** We would be grateful if responses could be sent to the Law Commission at the addresses given at the front of this paper.

[1] Law Commission and Scottish Law Commission, Insurance Contract Law: A Joint Scoping Study: see Law Commission website at http://www.lawcom.gov.uk/insurance_contract.htm.

[2] Law Commission and Scottish Law Commission, Analysis of Responses and Decisions on Scope, August 2006: see website above.

[3] Notes of these meetings are available on our website, above.

1.6 When we have decided the scope of the reforms, we will consider how they would best be implemented. One possibility would be to draft a new Insurance Act to replace the Marine Insurance Act 1906 (1906 Act). Another would be to replace some sections of the 1906 Act and leave others in force. Following the second consultation paper, we will also consider whether there is a need to codify insurance law more generally.

PROBLEMS WITH THE LAW

1.7 The two Law Commissions have a statutory duty under section 3 of the Law Commissions Act 1965 to review the law with a view to "its simplification and modernisation". The Law Commissions have reached the view that the law of misrepresentation, non-disclosure and breach of warranty in the field of insurance is neither simple nor modern and is in urgent need of reform.

1.8 British insurance law developed during the eighteenth and nineteenth centuries. It was largely codified in the 1906 Act, whose general provisions have been held to be relevant to insurance of all types. The 1906 Act is an impressive piece of work: it covers much ground and is written in clear, forthright terms. However, the courts have found it difficult to develop the principles of the codified law or to adapt them to changing economic conditions. Although the nature of the insurance market has changed markedly, insurance law remains much as it was a hundred years ago.[4]

1.9 In the sections below we look first at the strict law and then consider more recent developments in regulation and ombudsman practice which modify the legal position.

Misrepresentation and non-disclosure by the insured before the contract is made

1.10 Insurers need to receive information from potential policyholders about the nature of the risk. They use this as the basis of their decisions on whether to accept risks at all and, if so, at what price and on what terms. Some of this information can only be obtained from would-be policyholders.

[4] As Lawton LJ put it in *Lambert v Cooperative Insurance Society Ltd* [1975] 2 Lloyd's Rep 485 at 492,

> It was said by [Counsel], with some force, that when the law first began to develop in the 18th century those who sought to get the benefit of insurance cover were really acting with the same sort of knowledge and understanding as the underwriters from whom they were seeking cover. Nowadays when the ordinary citizen seeks to take out insurance cover for his house and belongings he is not acting on equal terms with the insurance companies.

He went on to say that much as he sympathised with that point of view only Parliament could alter the law.

1.11 The 1906 Act therefore imposes heavy duties on those applying for insurance. They are required to volunteer information to the insurer about anything that would influence a prudent underwriter's assessment of the risk. If the policyholder fails in this duty, the insurer is entitled to refuse all claims. It can "avoid the policy", which means that it can treat the policy as if it never existed. Similarly, the insurer can avoid the policy if the policyholder makes a material representation of fact that turns out to be untrue. It does not matter that the policyholder had no reason to know that the statement was untrue.

1.12 This leads to three difficulties:

(1) *The duty of disclosure may operate as a trap.* Many insureds, particularly consumers and small businesses, are unaware that they have a duty to disclose. It may not occur to them to volunteer information for which they have not been asked. Even if they do realise they have such a duty, they may have little idea of what would be relevant to an insurer.

Lambert v Cooperative Insurance Society Ltd[5]

In 1963, Mrs Lambert took out a policy of insurance to cover the family's jewellery with the Cooperative Insurance Society (the Cooperative). She renewed the policy every year.

Nine years later, she made a claim for loss of the jewellery. The Cooperative refused to pay her claim on the grounds that Mrs Lambert had not disclosed her husband's previous criminal convictions. The Cooperative had never asked Mrs Lambert any questions about criminal convictions, although it had had an opportunity to do so when Mrs Lambert first filled out the application form and every year at renewal.

The Court of Appeal reluctantly concluded that the Cooperative was entitled to refuse to pay Mrs Lambert's claim, despite the fact that she did not realise that the Cooperative wanted to know about previous convictions.

The Court said the case showed the unsatisfactory state of the law. Mrs Lambert "is unlikely to have thought that it was necessary to disclose [this] fact… She is not an underwriter and has presumably no experience in these matters. 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."

(2) *Policyholders may be denied claims even when they act honestly and reasonably*. An insured who misunderstands a question on the proposal form, and reasonably thinks that some information is not relevant to the insurer, may find that the insurer can avoid the policy. The same is true if the insured has given factual information that is inaccurate, or only partly accurate, even though the insured honestly and reasonably believed that what they said was correct.

[5] [1975] 2 Lloyd's Rep 485.

(3) *Where the insured acts carelessly, the remedies may be overly harsh*. Where the insured was honest but careless in answering a question, the insurer has an absolute right to avoid the policy. This applies even though, had it been given the correct or full information, the insurer would still have entered the policy, albeit at a higher premium or subject to different exceptions. Avoidance over-compensates insurers for their loss by allowing them to refuse those claims that have effectively been paid for, as well as those that have not.

Ombudsman case study 27/5[6]

Mr and Mrs C held a critical illness insurance policy. When he arranged the policy, Mr C failed to disclose that Mrs C had suffered from ear infections, leaving her with some loss of hearing. Mrs C was then diagnosed with leukaemia, which was wholly unconnected with her hearing problems.

If the insurers had known about the hearing problem, it would merely have imposed an exclusion relating to Mrs C's hearing. Nevertheless, the insurer avoided the policy from the outset on the grounds of misrepresentation, and refused to pay the substantial claim for leukaemia.

Under the strict law, the insurers were entitled to do this. However, the ombudsman held that it was unreasonable and disproportionate. As the misrepresentation was merely inadvertent, the insurer should only reject those claims which would have fallen within the hearing exclusion. Other claims, including the leukaemia claim, should be paid.

Warranties and basis of the contract clauses

1.13 Insurers have an obvious interest in ensuring that policyholders take precautions against loss. The law therefore takes a strong approach to enforcing policyholders' promises. The 1906 Act sets out severe consequences where a policyholder promises that "a particular thing shall be done or shall not be done, or that some condition shall be fulfilled". The law applies the same approach where the policyholder "affirms or negatives the existence of a particular state of facts".[7] Such promises are called warranties and "must be exactly complied with, whether material to the risk or not".[8] The insurer is not required to pay any claims that arise after the date of the breach, even if the breach is later remedied or had nothing to do with the loss in question.

1.14 Again this may lead to three problems:

6 Financial Ombudsman Service, *Ombudsman News,* (April 2003), Issue 27.

7 Marine Insurance Act 1906, s 33(1).

8 Marine Insurance Act 1906, s 33(3).

(1) *The insurer may use warranties of past or present facts to add to the remedies the law already provides for misrepresentation.* Where a statement is made into a warranty in the contract, and the fact stated is not true, the insurer may treat the policy as discharged. This applies even if the statement was not relevant to the risk; the insurer did not rely on it; and it had no connection to any claim that has arisen.

De Hahn v Hartley[9]

In June 1779 a policy of insurance was taken out on a ship which was sailing from Liverpool to the British West Indies. This was a dangerous business and the policy of insurance described the vessel as having "sailed from Liverpool with 14 six-pounders, swivels, small arms and 50 hands or upwards".

However, the ship had set off from Liverpool with only 46 hands. It docked at Anglesey six hours later where it picked up a further six men. The ship then sailed to Africa with 52 hands. Off the coast of Africa the ship (still with 52 hands) was captured and lost.

The underwriter refused to pay for the loss and the Court agreed. The Court held that the warranty was not strictly true. It was irrelevant that it had been remedied only six hours later whilst the ship was still in the relatively safe waters around Britain.

(2) *A statement on the proposal form may be converted into a warranty using obscure words that most insureds will not understand.* If a prospective policyholder signs a statement on a proposal form stating that the answers given form the "basis of the contract", this has the effect of converting all the answers into warranties. The insurer may avoid the contract for any inaccuracy, even one that did not increase the risk.

[9] (1786) 1 TR 343. See also *Yorkshire Insurance Co v Campbell* [1917] AC 218.

***Dawsons Ltd v Bonnin*[10]**

A furniture removal firm in Glasgow (Dawsons) took out insurance for one of its removal lorries. The proposal form included the following clause: "which proposal shall be the basis of this contract and be held as incorporated herein". This converted all the answers on the form into warranties.

Dawsons filled out the form, and gave its business address in central Glasgow. When it was asked where the lorry would normally be parked it inadvertently wrote "above address". In fact, the lorry was usually parked in the outskirts of Glasgow.

The lorry was destroyed in a fire and Dawsons made a claim. At Court, it was argued that Dawsons' mistake about the address did not add to the risk and arguably reduced it. The Court held that this did not matter: the insurance company was entitled to refuse to pay all claims under the policy.

(3) *Where a policyholder gives a warranty about future actions, any breach will discharge the insurer from all further liability, even from claims that have no connection with the breach.* For example, if a policyholder warrants that they will maintain a burglar alarm, any failure to do so may (depending on the construction of the contract) allow the insurer to refuse a claim for storm damage or flood. The insurer may also refuse claims for burglary arising after the alarm has been repaired.

Misrepresentation and non-disclosure before the contract is made when the contract is made through an intermediary

1.15 Insurance is often arranged through a broker or an intermediary. If the policyholder gives correct information to a broker, but the broker fails to pass on the information to the insurer, or passes it on incorrectly, the insurer will frequently have the right to avoid the policy even though the policyholder may not have been at fault. The policyholder may have thought he was dealing with a representative of the insurer and the insurer may have been in a better position to prevent mistakes occurring.

PREVIOUS CRITICISMS OF THE LAW

1.16 Recommendations for reform of the topics covered by this consultation paper were made by the Law Reform Committee as long ago as 1957.[11] In the fifty years since, several authoritative reports have subjected insurance contract law to severe criticism. Details of these reports are set out in Appendix A, together with a history of the government's and industry's response.

[10] [1922] 2 AC 413; 1922 SC (HL) 156.

[11] Fifth Report of the Law Reform Committee (1957) Cmnd 62. However, in the same year a report by the Law Reform Committee for Scotland made no proposals for reform, concluding that there was "no demand in Scotland for any alteration in the law with regard to the subject of our remit": Fourth Report of the Law Reform Committee for Scotland (1957) Cmnd 330, para 25.

1.17 When in 1980 the English Law Commission considered non-disclosure and breach of warranty, its conclusion was that the law was "undoubtedly in need of reform" and that such reform had been "too long delayed".[12] Reform was also urged in a report published by the National Consumer Council (NCC) in 1997.[13]

1.18 A major factor in our decision to return to this area was a report by the British Insurance Law Association (BILA) in 2002.[14] This report was prepared by a sub-committee with an impressive breadth of membership — academics, brokers, insurers, lawyers, loss adjusters, a self-regulatory body and trade associations. It included the text of lectures given by two senior members of the judiciary, Lord Justice Longmore and Lord Justice Rix, and a foreword contributed by Lord Justice Mance.[15] BILA declared itself "satisfied that there is a need for reform" and put forward detailed proposals for change.

1.19 Despite the many proposals for reform, there has been no 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 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 describe these developments below and say why we do not think they are a substitute for law reform.

DEVELOPMENTS AFFECTING CONSUMERS

Self-regulation rather than legislative change

1.20 In 1977 the industry bodies issued Statements of Practice, covering both general insurance and life insurance, by which insurers undertook not to enforce the strict letter of the law unreasonably. In 1980 the Law Commission strongly criticised this approach, because:

(1) the statements did not have the force of law and, indeed, the liquidator of an insurance company would be bound to disregard them;

(2) they left insurers as the sole judge of whether rejection of a claim was reasonable;

(3) they only covered policyholders in their private capacity and did not protect businesses.

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

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

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

[15] As he then was.

1.21 The Law Commission proposed statutory reform of the 1906 Act. However, in 1986, the Government thought that "the case for legislation is outweighed by the advantages of self-regulation".[16] It accepted improvements to the Statements of Practice and the development of the Insurance Ombudsman Bureau as a substitute for law reform.

1.22 The statements have now been largely replaced by regulations issued by the Financial Services Authority and by the day-to-day decisions of the Financial Ombudsman Service.

FSA Regulation

1.23 The Financial Services and Markets Act 2000 set up the Financial Services Authority (FSA) as a 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.

1.24 The FSA Handbook consists of high-level principles which are supplemented by much more detailed rules. High-level principle 6, for example, states that a firm must pay due regard to the interests of its customers and treat them fairly.

1.25 The more detailed rules are contained in the Conduct of Business Sourcebook (COB) and the Insurance Conduct of Business Sourcebook (ICOB) (together FSA Rules). Where an insurer deals with a retail customer, FSA Rules prevent the insurers from relying on the strict letter of the law dealing with non-disclosure, misrepresentation and breach of warranty. A retail customer is defined as an individual acting for purposes which are outside his trade, business or profession.[17] These provisions draw heavily on the 1986 Statements of Practice.

1.26 Unlike the Statements of Practice, the FSA Rules are binding on insurers. The FSA may take disciplinary action against the firm and may, for example, impose a fine.[18] 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.[19] However, this would be a difficult, unusual and expensive course of action.

The Financial Ombudsman Service

1.27 The Financial Ombudsman Service (FOS) was also set up under the Financial Services and Markets Act 2000 and replaces the previous voluntary schemes, including the Insurance Ombudsman Bureau. 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.

[16] Hansard (HC), vol 92, cols 356-7w.

[17] As found in the FSA handbook glossary.

[18] Financial Services and Markets Act 2000, s 66.

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

1.28 For most consumers with disputes about insurance, the FOS offers the only realistic method of redress. The courts are not only expensive but they are forced to apply the 1906 Act.

1.29 As part of this review, we have undertaken several analyses of ombudsman decisions. We started with a survey of around 200 final decisions concerned with non-disclosure and misrepresentation; we then looked at 50 cases concerned with policy terms; and then read through another 18 cases that raised issues about the involvement of an intermediary.

1.30 As our work developed, it became increasingly clear that the FOS is developing its own jurisprudence, in a way that demands much more of insurers than the strict law and often goes further than FSA Rules. However, the discretionary nature of ombudsman decisions makes it difficult for insurers and consumers to understand what is required of them.

Are the FSA Rules and the FOS a substitute for law reform?

1.31 We consider the detail of the FSA requirements and FOS guidance in Parts 3, 7 and 9. We conclude that the overlapping layers of regulation and discretion are not a substitute for law reform.

1.32 We think that reform of consumer insurance law is still necessary because

(1) the FSA Rules are intended primarily to regulate the market rather than to grant private rights to individual insureds, and so do not offer individuals adequate protection;

(2) while the FOS provides a valuable service to individual consumers who have been treated unfairly, there are cases outside its jurisdiction (including claims over £100,000 and those requiring witnesses to be cross-examined);[20]

(3) the overall position is incoherent, unclear and inaccessible both to consumers and their advisers and to insurers. The law says one thing, the FSA rules require another and the FOS reaches decisions based on a third. Our research showed that the FOS overturned insurers' decisions in a significant number of cases, and some insurers seemed unaware of the way the FOS would approach cases. Similarly, many consumers fail to make a complaint to the FOS because they are unaware of their right to do so.[21]

1.33 We therefore make specific proposals for the reform of consumer insurance. By "consumer", we mean the same as the FSA definition of a "retail customer" – that is, an individual who is acting for purposes outside his trade, business or profession. The main effect would be to bring the law into line with accepted standards of good practice, as recognised by the FSA and the FOS.

[20] See para 3.23 below.

[21] See para 3.61 below.

The business market

1.34 Business insureds have little protection against the rigours of the law if an insurer decides to stand on its strict legal rights. The Statements of Practice and most FSA Rules apply only to retail customers. Businesses with a turnover of less than £1 million are eligible to bring complaints to the FOS. For the smallest businesses, the FOS will apply the same protections as they provide to consumers. For medium businesses, they will apply rules that are closer to the general law. Our survey of non-disclosure cases suggested that small businesses made relatively little use of the FOS,[22] though the reasons for this are unclear.

1.35 Large businesses often negotiate additional protections as terms of their contracts. For example, a large company told us that they would never accept warranties in their insurance contracts. We also understand that warranties are also routinely excluded in the marine market.

1.36 However, many medium businesses may not be able to negotiate better terms. Their dealings with insurers are not governed by the FSA Rules and if they take a case to the FOS, the FOS will apply rules that are closer to the strict law. As we explain in Part 7, sometimes the courts attempt to do justice by giving a very strained interpretation to the language of insurance contracts to circumvent the provisions of the 1906 Act. On other occasions, however, the language is so unambiguous that this is not possible, and the business is left with an outcome that is no longer in line with their expectations or with good market practice.

1.37 For reasons we explain below, we have concluded that there is a need to change the "default position" under UK law. The law should follow good market practice, unless the parties have agreed otherwise. We also propose safeguards where a business contracts on the insurer's standard terms, and these standard terms undermine the policyholder's reasonable expectations.

CRITERIA FOR EVALUATING THE LAW

1.38 Our starting point is that the law should strike a fair balance between the interests of insurers and policyholders. It should give potential policyholders confidence in insurance by ensuring that it meets their reasonable expectations while protecting the legitimate interests of insurers and not imposing undue costs or unnecessary restrictions. It should also be coherent, clear and readily understandable.

1.39 Below we explore these criteria and their implications for reforming the law.

[22] Only seven of the 197 final ombudsman decisions on non-disclose we first looked at (4%) were brought by businesses. The FOS assisted us in looking for more cases, but we were only able to find another five.

"Fairness" and reasonable expectations

1.40 It has often been said that the law is "unfair". The 1980 Law Commission Report stated that aspects of the 1906 Act were "unjust",[23] while the 1997 NCC Report said that large parts of that law were "heavily biased against the interests of consumers".[24] We think it is important to identify why the results reached by the 1906 Act are "unfair". The answer is that they often defeat policyholders' reasonable expectations.

1.41 Insurance is intended to be an effective risk-transfer mechanism, bringing peace of mind to the purchaser. The insured exchanges the risk of a loss of an unknown amount for the payment of a known premium. This process performs a valuable function in enabling consumers and businesses to plan their financial affairs prudently. If the insurer avoids a policy, the transfer of risk fails and the peace of mind has proved to be illusory. Where the insured had a legitimate and reasonable expectation of cover, that expectation should be respected. If not, confidence in the market will be undermined.

Reasonable expectations in the consumer market

1.42 In the consumer market, it has long been accepted that the strict letter of the law no longer corresponds to the expectations of the market. In particular, consumers expect that if they act honestly, carefully and reasonably in filling in application forms, they will obtain the cover they are paying for. This is clearly reflected in the Statements of Practice, the FSA Rules and the FOS practice.

1.43 For example, under the Association of British Insurers' Statement of General Insurance Practice 1986, 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.[25] This has now been incorporated into FSA Rules.[26] To the extent that the law still permits an insurer to avoid on this ground, it fails to match good market practice or to meet the insured's reasonable expectations.

Reasonable expectations in business insurance

1.44 The law also fails to match accepted standards in the business market. For example, we were told that good market practice is to avoid a policy for misrepresentation only where there has been some element of dishonesty in the proposal. Yet the law allows insurers to avoid for mistakes that were made honestly and reasonably.

1.45 It may be argued that business customers should adjust their expectations to correspond with the law. However, many business insureds are not experts in insurance. They do not understand the law or the effect of the policy offered. The current rules on non-disclosure, misrepresentation and warranties bear particularly harshly on them. As the Law Commission said in 1980:

[23] Insurance Law Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 6.9.

[24] See Appendix A para A.44 below.

[25] ABI Statement of General Insurance Practice 1986, "claims" para b(i).

[26] ICOB Rule 7.3.6 and COB Rule 8A.2.6. The rules are discussed at para 4.101 below.

> Neither consumers nor ordinary businessmen who are not in the insurance market have the knowledge or experience to identify all facts which may be material to insurers. Both are therefore to this extent in need of protection and both may properly be regarded as consumers vis-à-vis insurers.[27]

Lord Justice Longmore also stressed this point: a fishmonger insuring business premises is in as much need of protection as a lawyer insuring his home.[28]

1.46 It is true that business insurance is often arranged through a broker who will advise the business. However, many types of business insurance are sold directly to the business, or through an intermediary who does not offer detailed advice. Businesses may not realise they need independent advice, or may not be able to afford it, or may take the view that the chances of a problem occurring are low enough that it is not worth spending time or money on advisers.

1.47 Even for large commercial risks, where policyholders do understand the law, the insurance market is built on trust and generally accepted standards of market practice. Policyholders therefore often expect the insurer to deal with their case in accordance with good market practice. Unfortunately, there is a wide divergence between the rules laid down in the 1906 Act and accepted practice.

1.48 If the law permits insurers to avoid for an innocent misrepresentation, it is inevitable that some insurers will rely on their strict legal rights. When we asked one firm whether insurers would ever attempt to avoid a policy for an innocent non-disclosure, this is the answer we received:

> Some would, especially in a climate where money is tight… Yes… With the big commercial [risks]… they're subscribed to by three, five, twenty different insurers. And you could have three or four who are perhaps looking at insolvency problems or whatever and will in truth seize on any opportunity they can. So… to take comfort in the thought that the market as a whole will not take the point on innocent disclosure – you might be surprised really. There would be a risk that some parts of it would.[29]

1.49 We think that the law should generally follow accepted practice, in the absence of an agreement to the contrary. Not every term is thought about or negotiated in advance. Currently the law imposes a default regime that undercuts, rather than supports, accepted market practice. In so doing, it risks defeating the reasonable expectations of the insured.

[27] Insurance Law, Non-disclosure and Breach of Warranty (1980) Law Com No 104, para 4.36.

[28] "An Insurance Contracts Act for a new Century?", Pat Saxton Memorial Lecture, 5 March 2001 (set out in Appendix A of BILA, Insurance Contract law Reform (2002)), para 42.

[29] Interview with an insurance lawyer, carried out for this project.

1.50 The parties should be free to depart from good practice where they agree to do so. For business insurance it is important to preserve flexibility for the parties to make the arrangements that suit them best. For example, a particular insured may be happy to agree that the insurer should have rights that depart from the "norm" in exchange for a reduced premium.

1.51 That should remain possible, subject to a proviso. The agreement should be a genuine one in the sense that the insured was made reasonably aware of the terms on offer. When the terms are in a standard form policy, there is a risk that even terms to which the policyholder has "signed up" do not in fact meet its reasonable expectations. In Parts 5 and 8 we set out proposals to address the problems of standard form contracts.

Confidence in the market place

1.52 Where insurance fails to meet customers' reasonable expectations, confidence in the market can be undermined. Dissatisfied customers spread the word, and those who have had an insurance claim rejected frequently have a deep sense of grievance. We are concerned that the bad press from which insurers sometimes suffer may deter consumers from buying insurance when it would be in their best interests to do so. It is clear from the comments we have received that some insurers share this concern.

1.53 In relation to business insurance, there may be an additional problem. The market for many kinds of business insurance is international. UK insurance law has been described as the least insured-friendly of all western jurisdictions.[30] We have been struck by how far it is now out-of-line with the standards adopted in other European and Commonwealth jurisdictions, and with those of most states in the USA. The English concept of a warranty, for example, has been described as "a prodigal aberration" from generally understood European principles of fairness.[31]

1.54 The fact that UK insurance law differs from that of its competitors may be a positive advantage. The parties may prefer UK law because, though it can operate harshly, it is predictable, and does not depend on vague standards of fairness. However when, in the absence of an express term, the law allows insurers to act in a way that contravenes recognised good market practice, there is a risk that insureds will find their expectations of UK law disappointed. They may turn away from UK law to systems that are less harsh, or at least that require the position to be made more transparent.

1.55 We have received conflicting views about whether the present state of English law deters businesses from seeking insurance in the London market. Some brokers have suggested that it is a factor; others suggest that the attractiveness of the London market ebbs and flows according to many complex factors. We would be interested in receiving views on this point.

[30] Interviews with insurance lawyers.

[31] John Hare, The Omnipotent Warranty: England v The World (November 1999). This paper was presented at the International Marine Insurance Conference, see http://web.uct.ac.za/depts/shiplaw/imic99.htm (last visited 1 May 2007).

1.56 Meanwhile, we think the precautionary principle should apply. The default regime should accord with the standards of fairness and good practice that the London market claims.

Clear, coherent principles

1.57 The current rules applying to consumer insurance are particularly confusing, based on overlapping law, regulation and ombudsman practice. The law gives the insurer rights – for example, to avoid a policy for a consumer's honest and reasonable failure to disclose a material fact. It then says that an insurer who exercises those rights will be liable to a fine under the FSA Rules and may be ordered by the FOS to pay the claim. To put it bluntly, this is a nonsense.

1.58 The law is defective because it does not set out its basic requirements in clear, accessible rules that are available to both insurers and consumer advisers.

Insurers' legitimate interests

1.59 The law has long recognised that insurance is a special form of contract, which is particularly vulnerable to opportunistic behaviour by the insured. We therefore need to bear in mind the problems that the law of non-disclosure, misrepresentation and warranties is designed to address.

Adverse selection

1.60 The law of non-disclosure and misrepresentation guards against a particular problem with insurance, namely that the policyholder may know more about the risk than the insurer. Clearly, insurers need to receive this information in order to decide whether to accept risks and, if so, at what price and on what terms. Without this information exchange, the market may suffer from "adverse selection". In other words, those people who know their risk is high will be more likely to buy a policy than those who know their risk is low. If the insurer cannot differentiate the two, it will be forced to put up premiums. As the insurance becomes more expensive, the pool will become smaller, until the market is no longer viable.

1.61 It is therefore important that the law sends a clear message to consumers that they must take all reasonable care to answer the questions they are asked accurately and completely. Where consumers fail to take care, our proposals are designed to compensate insurers for their loss. Where consumers act deliberately or recklessly in giving false answers, our proposals go further. They are designed to deter this behaviour by allowing the insurer to refuse all claims under the policy and to retain the premium. Business applicants will also be required to volunteer information, by disclosing everything a reasonable insured would consider the insurer would want to know about, even if the insurer has not asked a question about it.

"Moral hazard" and the need for precautions

1.62 The law of warranties is designed to guard against a second danger associated with insurance. This is that a policyholder who has insured a risk may fail to take proper precautions by, for example, leaving doors unlocked, or fires unattended. This is said to be a form of "moral hazard".[32] The law has therefore taken a very strict approach to warranties.

1.63 In considering our proposals, we have tried to balance the need to encourage policyholders to take precautions and their reasonable expectations of cover. Again, we have been highly influenced by accepted market practice. In the consumer area, our proposals are designed to match the law to what is already required by the FSA and expected by the FOS. For businesses, our proposals attempt to match the default rules to current market practice, while allowing parties to negotiate an alternative solution if they wish.

Suspicions of fraud

1.64 We have heard one argument for the current law that we do not think is legitimate. It is sometimes suggested that harsh rules may not be reasonable in themselves but are useful where an insurer suspects but cannot prove fraud.

1.65 The following example emerged from our survey of ombudsman decisions:

> A policyholder claimed for the loss of a valuable diamond ring shortly after insuring it. The insurer went through every detail of her case. They eventually avoided the policy on the grounds that she had failed to mention a previous loss. The proposal form had asked if she had "suffered loss, damage or liability during the last five years, whether insured or not". Some time earlier, the policyholder's young son had spilled candle wax on the carpet. She phoned the insurer to ask if she could claim, but was told that accidental damage was not covered. A few months later she redecorated the room and replaced the carpet. The insurer said she should have disclosed this uninsured loss. The ombudsman ruled that the phrase "suffered loss" could not be intended to include all damage to a home caused by young children (Case 11).

1.66 We do not believe that a reputable insurer would really worry about a failure to mention spilt candle-wax. It may well be that some other suspicion or concern was at play here – though as no other concern was mentioned, it is difficult to be certain. It seems fair to assume that the insurer's attitude was this: if it suspects but cannot prove that the insured was lying about the loss of a ring, it should be entitled to avoid the policy on other grounds, even if those grounds have little merit in their own right.

[32] Moral hazard is opportunism characterised by an informed person's taking advantage of a less-informed person through an unobserved action. A more obvious form of moral hazard is making a claim for a loss, which has not in fact been suffered in the hope that the insurer will not notice, or be able to prove, the fraud. That issue will be dealt with in our second consultation paper.

1.67 In 1980, the Law Commission rejected this argument forcefully, as it effectively allows the insurer to be "judge and jury in its own cause".[33] We also reject the argument. We think the use of technical defences is counter-productive and likely to bring both the law and the insurance industry into disrepute. We say this for three reasons:

(1) Some policyholders will be suspected wrongly, and will suffer real injustice as a result.

(2) The public perceives insurers to be nit-picking over irrelevancies. This may even encourage less scrupulous policyholders to "get their retaliation in first" by, for example, over-valuing claims.

(3) If cases are disposed of on spurious technical grounds, genuine allegations of dishonest behaviour are not pursued.

1.68 This paper proposes to remove technical and unmeritorious defences. Instead, allegations of dishonesty should be dealt with on their own terms. We will consider fraudulent claims in the second consultation paper, but in general we accept that the standard of proof required for dishonesty must not be set too high. Our proposals on fraud at the pre-contract stage are designed to allow insurers to establish dishonesty where it is more probable than not.

The cost of cover

Transferring risks to the pool

1.69 The insurance market is highly competitive, and policyholders generally get what they pay for. This means that any increase in the number of claims paid will lead to an increase in premiums. The proposals we make to increase policyholders' rights are made because we think that, if policyholders were fully aware of the issue, they would be happy to pay a small increase in premiums for the additional cover it would provide.

1.70 For example, in Part 4 we provisionally propose that the law should be changed to prevent insurers from avoiding the policy where a consumer was both honest and careful in giving information. In Part 5 we propose the same rule for businesses, in the absence of an agreement to the contrary. We are not suggesting that the cost of the change should be borne by the insurer or its shareholders. Rather it is a judgement that it would be better for the risk to be met by the pool of premiums paid by policyholders. If a policyholder is genuinely and reasonably unaware of a fact, the risk of making an inaccurate statement is outside their control. And policyholders normally wish to transfer risks outside their control to the pool. That is why they are buying insurance.

[33] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104 at para 6.10 when it made this explicit condemnation of the provisions on warranties.

1.71 We think that consumers would almost invariably wish to transfer risks in this way. That is why the rule is already enshrined in FSA Rules and FOS practice. For businesses, that is the normal starting point, and part of generally accepted commercial practice. However, if a business wishes to negotiate a different allocation of risk, it should be free to do so.

Costing the effect of our proposals

1.72 Any increase in premiums will be small, but it is difficult to say how small. In our final report, we hope to produce estimates of what the increase might be. That involves an assessment of current practice. In the consumer market, most of our proposals are already FSA requirements or represent normal ombudsman practice: the effect on reputable insurers will therefore be slight or even negligible. The main effect will be on those firms who are prepared to disregard FSA Rules and FOS practice, but would find it more difficult to disregard clear law. It is not easy to gauge the extent of this non-compliance. In Part 11 we discuss the issues involved in measuring the effect of our proposals, while Appendix B sets out a report from independent economists to illustrate how a possible model might work.

1.73 At this stage, we invite views on the methodology and ask for data. Following consultation, we will attempt to assess the costs and benefits of our proposals, together with their associated administrative and transitional costs.

CONSUMER INSURANCE: ENSHRINING EXISTING PRINCIPLES OF GOOD PRACTICE INTO LAW

1.74 Thus for consumer insurance our proposals aim to bring the law into line with consumers' reasonable expectations and good practice, as these are reflected in the Statements of Practice, the FSA Rules and the practice of the FOS.

Three principles

1.75 For example, at the pre-contract stage, we think that it is important that the law should continue to require consumers to take reasonable care to answer the questions they are asked accurately and completely. However, reform should be guided by three principles:

(1) Insurers should ask questions about what they want to know; consumers should not be expected to give information that has not been asked for.

(2) A consumer insured who was both honest and careful in giving pre-contract information should not have a claim turned down on the basis that the information was incorrect or incomplete.

(3) A consumer who was honest in giving pre-contract information, but less careful than they should have been, should not automatically lose their claim. The outcome should depend on what the insurer would have done had it known the true situation.

1.76 These principles are influenced by the Statements of Insurance Practice and FSA Rules, and are no more than the FOS currently expect. However, we think the law should be restated in similar terms, so as to be coherent, clear and accessible. For reasons we develop in Part 4, these should be minimum rights and obligations that can be altered only in favour of the consumer.

Benefits

1.77 These reforms will, we believe, bring positive benefits to both policyholders and insurers.

(1) **Clarity**: the standards to be applied would be much clearer. The current complexity invites confusion.

(2) **Fair competition**: as the FOS has pointed out to us, responsible insurers are less likely to be undercut by those with lower standards:

> At present any insurer operating to good industry practice or to an even more enlightened standard for consumers is conscious that they can be undermined in pricing or cost terms by any insurer who chooses to offer a service that is strictly in accordance with the law. The insurer offering to meet only the minimum of legal obligations is protected by the privacy offered by the FOS process and by the difficulty that consumers and their legal advisers may have in attempting to assert legal rights that are novel in insurance law terms.

(3) **Increased consumer confidence**: if consumers perceive higher standards within the industry, this may encourage consumers to insure more comprehensively than they do at present.

BUSINESS INSURANCE: SETTING OUT DEFAULT RULES THAT MEET REASONABLE EXPECTATIONS

1.78 We see three main reasons for reforming business insurance law: to protect businesses that are not expert in insurance; to provide a default regime that corresponds to legitimate expectations; and to ensure that UK insurance law remains competitive with that of other jurisdictions.

1.79 Again, we think the default regime should reflect certain principles:

(1) The business insured should only be required to give such information as a reasonable insured in the circumstances would appreciate was relevant to the insurer.

(2) A business insured who was both honest and careful in giving pre-contract information should not have a claim turned down on the basis that the information was incorrect or incomplete.

1.80 We ask what the appropriate remedy should be if a business insured was honest in giving pre-contract information, but less careful than they should have been. The question is whether the law should aim to put the insurer back into the position it would have been in had the correct information been given, or whether the law should go further and entitle the insurer to reject all claims under the policy.

1.81 The parties should be free to agree other terms if they wish, but this should be subject to a proviso. Where the parties contract on the insurer's standard terms, the clause changing the default rules must not defeat the insured's reasonable expectations.

1.82 These changes would bring the law into line with good market practice, promote fairer competition and increase confidence in the UK market.

EUROPE

1.83 There is a further reason to review the United Kingdom's insurance contract law. This is the possibility that the European Community will take steps to harmonise the law across Europe, or possibly to create a European law of insurance contracts.

1.84 There are European initiatives that may eventually have some influence on insurance contract law.[34] In particular, work is being conducted by the Restatement of European Insurance Contract Law Project Group ("the Innsbruck Group"),[35] which is drafting the rules for the Common Frame of Reference on Insurance Contract Law. These rules could perhaps form the basis for a European Directive. Alternatively, they may possibly be used as a "28th regime"[36] optional contract law instrument, which the parties could chose as an alternative to the law of a specific jurisdiction.[37] Thus a German firm seeking insurance in London for its offices in the Baltic states might prefer to specify the "28th regime" as the applicable law rather than writing the policy under German, English or Lithuanian law.

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

[35] http://www.restatement.info/ (last visited 1 May 2007).

[36] This phrase, commonly used in Brussels, seems to ignore the fact that the UK has two quite distinct laws of contract.

[37] See J Basedow, "The Case for a European Insurance Contract Code" [2001] JBL 569; J Basedow, "Insurance contract law as part of an optional European Contract Act" [2003] LMCLQ 498; M Clarke and Heiss, "Towards a European Insurance Contract Law? Recent developments in Brussels 2" [2006] JBL 600.

1.85 Most of those to whom we have spoken regard harmonisation of insurance contract law as a distant prospect. Certainly European legislation is not so imminent to be a reason to delay this review. However the possibility of European initiatives is a good reason for the review to take place now. Several of those to whom we have spoken commented that there would be more chance of influencing the outcome of harmonisation if domestic reform had already taken place. The reason given was that our current insurance contract law is perceived as being both unfair and unusual, so that any suggestion that it should form the basis of a harmonised regime is unlikely to be successful. If it had recently been reviewed and brought up-to-date, it would be easier to sell as the basis of a European regime.

STRUCTURE OF THE PAPER

1.86 In Part 2 we give an overview of the law of misrepresentation, non-disclosure and breach of warranty.

1.87 Parts 3, 4, 5 and 6 consider **pre-contract information from the insured**. This involves considering the law not only of non-disclosure and misrepresentation but also of warranties of past or present fact. As we have seen, the law allows insurers to use such warranties to provide additional remedies for inaccurate statements. Part 3 considers the present position for consumers, looking in detail at FSA rules and ombudsman practice. Part 4 sets out our proposals for the reform of consumer law (that is insurance taken out by individuals acting outside their business or profession). Part 5 sets out reform proposals affecting business insurance. Finally, Part 6 considers some particular problems concerning pre-contract information that arise in group insurance, co-insurance and insurance on the life of another.

1.88 Parts 7 and 8 look at **warranties for the future and similar terms**. Part 7 analyses the problems, and Part 8 sets out proposals for reform.

1.89 Parts 9 and 10 then deal with **pre-contract information and intermediaries**. Problems arise where an intermediary has failed to pass on pre-contract information to the insurer, or has given the policyholder misleading advice about what they should tell the insurer. In some circumstances the law also imposes an obligation on intermediaries to give insurers information known to them in some other way. Part 9 considers the law, regulation and problems, while Part 10 sets out proposals for reform.

1.90 Part 11 considers how one might measure the costs and benefits of our proposals, while Part 12 lists the provisional proposals and questions for consultation.

1.91 Finally the report includes four appendices:

(1) Appendix A is a chronological account of the previous reports and the self and statutory regulation introduced in response to the criticisms that have been made.

(2) Appendix B is a report commissioned from London Economics to develop a methodology for exploring the economic impact of our reforms. It is the first stage towards assessing the costs and benefits of our proposals, and includes a draft case study of the critical illness market. We welcome comments on the methods used to develop this case study, and would be grateful for help in gaining access to further data in this area.

(3) Appendix C describes the survey we undertook of Financial Ombudsman Service decisions on issues of misrepresentation and non-disclosure.

(4) Appendix D is a list of meetings held and written responses received in relation to our three Issues Papers.

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[38] See http://www.lawcom.gov.uk/docs/merkin_report.pdf.

PART 2
THE CURRENT LAW

INTRODUCTION

2.1 Where an insured does not provide their insurer with accurate information when the contract is made, the law provides the insurer with a number of remedies:

(1) the insurer may be entitled to avoid the contract, and possibly to claim damages, for misrepresentation. The remedies for misrepresentation applicable to contracts in general are modified in the case of insurance contracts;

(2) the insurer may be able to avoid the contract on the ground of non-disclosure. This is a rule specific to contracts of insurance and a limited number of other contracts and arises out of the principle of utmost good faith.

(3) the insurer may have obtained a "warranty" that statements made by the proposer are accurate. This may be done by means of a "basis of the contract" clause on the proposal form, or by warranties contained in the policy itself. Warranties, unlike misrepresentations, are terms of the contract. A warranty is effectively a contractual promise that a fact is as stated. However, the consequences for breach of such a term are different in insurance law than under general contact principles, because any breach results in the contract being discharged automatically.

2.2 Warranties are also employed by insurers for three other purposes. First, they can be used to define the initial risk undertaken. Secondly, they can be used to require the insured to take precautions that will reduce the risk to the insurer. Thirdly, the insurer may use warranties to limit its exposure when there is a change in the risk that is not due to any act or omission by the insured.

2.3 In this Part we set out the current law on misrepresentation, non-disclosure and breach of warranty.[1]

2.4 Some of these rules of law apply to contracts of all types; they derive from the common law and the Misrepresentation Act 1967.[2] Others are peculiar to insurance law. They were developed by the common law but were partially codified by the Marine Insurance Act 1906 ("the 1906 Act").

The Marine Insurance Act 1906

2.5 Though strictly the 1906 Act is concerned only with marine insurance, many of its provisions are presumed to be equally applicable to other types of insurance:

[1] We consider the current law on information known to intermediaries and not passed on to the insurer in Part 9.

[2] The 1967 Act does not apply in Scotland.

> Although the issues arise under a policy of non-marine insurance it is convenient to state them by reference to the Marine Insurance Act 1906 since it has been accepted in argument, and is indeed laid down in several authorities, that in relevant respects the common law relating to the two types of insurance is the same, and that the Act embodies a partial codification of the common law.[3]

A contract of the utmost good faith

2.6 The fact that the normal rules of contract law, and in particular the law of misrepresentation, apply to insurance contracts is sometimes obscured by the fact that an insurance policy is one of a small number of types of contract that are *uberrimae fidei* - of the utmost good faith.[4] At the pre-contractual stage, the effect of the duty of utmost good faith is that each party has obligations:

(1) to refrain from misrepresenting material facts, and

(2) to disclose material facts even if no question is asked.

2.7 In contrast, ordinary commercial contracts start from the premise of *caveat emptor* – let the buyer beware.[5] A party to a contract *caveat emptor* must not misrepresent facts, but is under no obligation to disclose facts about which it is not asked.

2.8 Misrepresentation and non-disclosure are often pleaded and considered together. In commercial litigation before the courts, the law of non-disclosure has tended to dominate, with relatively little attention being applied to misrepresentation in an insurance context:

> Historically, misrepresentation in the strict sense has not been of particular importance in the insurance context. This is partly because the extreme width of the duty to disclose material facts, as described below, has meant that often non-disclosure has subsumed questions of misrepresentation. Cases have frequently failed to distinguish between the two defences taken by an insurer, and indeed it appears to be standard practice for an insurer, where possible, to plead both defences.[6]

2.9 The difference between the two has been described as follows:

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

[4] Other such contracts include contracts to subscribe for shares in a company, family settlements, and partnerships: see *Chitty on Contracts* (29th ed 2004) para 6-139.

[5] Though they are often subject to implied terms, such as those set out in the Sale of Goods Act 1979, ss 13, 14 and 15, which may have the indirect effect of requiring that the seller disclose defects.

[6] J Birds & N J Hird, *Birds' Modern Insurance Law* (6th ed 2004) p 101.

> In general, non-disclosure means that you have failed to disclose something which was not the subject of a question but which was known to you and which you ought to have considered for yourself would be material, whereas a representation is something directly said in answer to a specific question, and in the present case there can be no reasonable doubt that, if in answer to the question "Has a person who is going to drive the car been convicted of an offence?" you answer "No," you are making a direct representation that such person has not been convicted. [7]

2.10 The duty of good faith is reciprocal in that it applies in principle to both parties. Section 17 of the 1906 Act states:

> A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.

The duty bears rather differently on the insurer than it does on the insured, and raises different issues of policy. We will not consider the insurer's duty of good faith in this consultation paper.

2.11 The duty of good faith imposed by section 17 applies not only at the pre-contractual stage but throughout the life of the contract. Its application at later stages - "post-contractual good faith" - raises rather different issues. We will consider post-contractual good faith in our second consultation paper.

MISREPRESENTATION

2.12 In the consumer area, most insurers ask set questions of the proposer. The cases brought before the Financial Ombudsman Service (FOS) usually involve an inaccurate answer to one or more of those questions. Non-disclosure thus has come to assume a residual function in the consumer sector. We therefore start by setting out the law of misrepresentation, before considering the law of non-disclosure.

Avoidance for misrepresentation

2.13 Under the general law, a party who entered a contract relying on a material misrepresentation of fact by the other party may avoid the contract. The 1906 Act recasts this in the form of a duty on the insured. Section 20(1) provides:

> 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.

[7] *Zurich General Accident and Liability Insurance Co v Leven* 1940 SC 406, 415, by Lord President Normand.

Thus if, when a claim is made, the insurer discovers that the insured made a misrepresentation at the time the policy was taken out, it may refuse to pay that claim or any other under the policy. It may also recover any payments already made. There is a right to avoid even if the misrepresentation was made without fraud (in other words, the misrepresentor honestly believed what they said) or even negligence (in other words, even if the misrepresentor had reasonable grounds for believing that what they said was true).

2.14 In England and Wales section 2(2) of the Misrepresentation Act 1967 gives the court a discretion to refuse to permit rescission for non-fraudulent misrepresentation.[8] It must then award damages in lieu of rescission.[9] In principle this section might be applied to an insurance case, but it has been held that it should not normally be applied to commercial insurance, because avoidance of the contract acts as a deterrent.[10] It is unclear whether it might apply to consumer cases, and we have not found a case in which the point has been taken.

2.15 We will see that the insurer's right to avoid the policy on the ground of a misrepresentation that was not fraudulent, and possibly not even negligent, is controversial. It is restricted by the Statements of Good Practice issued by the Association of British Insurers, the Financial Services Authority rules (FSA Rules) and the decisions of the FOS.

Belief or fact?

2.16 The distinction between fraudulent and non-fraudulent misrepresentation is sometimes important, however. First, the honesty of the proposer is relevant if they give a statement of opinion. Under the general law, a representation is a statement of fact, and a statement of opinion or belief is not in itself a statement of fact. However, the person expressing the opinion or belief impliedly represents that they genuinely believe it to be true. If they state as an opinion something which they do not honestly believe, they make a fraudulent misrepresentation. Section 20(3) of the 1906 Act provides:

> A representation may be either a representation as to a matter of fact, or as to a matter of expectation or belief.

[8] There is no equivalent provision in Scots law.

[9] The measure of damages is obscure. See Issues Paper 1, paras A23 to A24.

[10] *Highland Insurance Co v Continental Insurance Co* [1987] 1 Lloyd's Rep 109, 118 by Steyn J (as he then was) commented "The rules governing material misrepresentation fulfil an important 'policing' function in ensuring that the brokers make a fair representation to underwriters. If s 2(2) were to be regarded as conferring a discretion to grant relief from avoidance on the grounds of material misrepresentation the efficacy of those rules will be eroded."

2.17 In general contract law the courts have often held that there is not only a representation that the opinion or belief is honestly held but also, depending on the circumstances, one that the opinion is based on reasonable grounds.[11] Insurance law differs in that there is no representation that there are reasonable grounds for the opinion or belief. The absence of this requirement derives from section 20(5) of the 1906 Act:

> A representation as to a matter of expectation or belief is true if it be made in good faith.

2.18 An illustration of this principle is to be found in *Economides v Commercial Union Assurance Co*.[12] 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.[13]

Return of premiums

2.19 Secondly, avoidance normally requires restitution: the parties must be restored to the positions they were in prior to the contract being made. Thus the policyholder may demand the return of the premium paid, but there is an exception in the case of fraudulent misrepresentation. For marine insurance, section 84(3)(a) of the 1906 Act states:

> Where the policy is void, or is avoided by the insurer as 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...

For non-marine insurance, the point is not wholly clear, and depends on general principles of contract law or the law of unjustified enrichment.[14]

Damages for misrepresentation

2.20 Thirdly, in principle an insurer that has suffered a loss as the result of a misrepresentation may be able to recover damages from the insured. Damages may be claimed if the misrepresentation was fraudulent or negligent but not if it was non-negligent.

[11] *Brown v Raphael* [1958] Ch 636.

[12] [1998] QB 587.

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

[14] See *Berg v Sadler & Moore* [1937] 2 KB 158; *Clough v London and North Western Railway Co* (1871-72) LR 7 Ex 26; and *Standard Life Assurance Co v Weems* (1884) 11 R (HL) 48.

2.21 In both jurisdictions the victim of a fraudulent misrepresentation is entitled to claim damages. A misrepresentor commits the tort of deceit in English law or entitles the other party to reparation in Scots law if they make a material statement that they know is not true, or if they know the statement may or may not be true and make it nonetheless,[15] and the other party suffers a loss through relying on the untrue statement.

2.22 In each jurisdiction there is now also, in effect, liability in damages created by statute for negligent misrepresentation by one of the parties to the contract.[16] In England and Wales, a party who makes a non-fraudulent misrepresentation will nonetheless be liable in damages "as if he were fraudulent" unless he proves that he had reasonable grounds to believe, and did believe up to the time the contract was made, that the facts represented were true.[17] In Scots law, liability in damages for negligent misrepresentation exists at common law.[18]

2.23 However, in practice the insured's liability for damages appears to be unimportant. A leading authority on English insurance writes that there are no known cases in which an insurer has claimed damages from an insured.[19] This is perhaps not surprising, even in cases of fraud. The main potential loss to the insurer will normally be prevented by avoidance of the policy, and if there has been fraud the insurer's right to retain the premium may cancel out any further loss.

Materiality

2.24 Under both the general law of misrepresentation and section 20(1) of the 1906 Act, the insurer may avoid the contract only if the fact that was stated incorrectly was material. The test of materiality is set out in section 20(2) of the 1906 Act:

> A representation is material which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk.

This applies both when the information is volunteered by the insured and in the much more usual case when it is given in answer to a question on the proposal form or asked by the insurer.

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

[16] There may also be liability for negligent misrepresentation at common law, including where the misrepresentation is made by a person who is not party to the contract. However, in the light of the statutory provisions, negligence in common law is of no relevance in this context.

[17] Misrepresentation Act 1967, s 2(1).

[18] The barrier to claiming damages created by *Manners v Whitehead* (1898) 1 F 171 was removed by the Law Reform (Miscellaneous Provisions) (Scotland) Act 1985, s 10(1).

[19] M Clarke, *The Law of Insurance Contracts* (4th ed 2002) para 23-15.

2.25 It might be thought that when a proposal form asks a question, the answer would always be material and, if it were inaccurate, would amount to a misrepresentation. However this is not so. Many questions are asked in rather general terms and it is difficult to know the full extent of what is wanted. For example, an insured who is asked if they have had medical tests for illness may not interpret this as referring to routine tests (for example blood pressure checks) or even to non-routine tests that were completely negative. Their answer may be inaccurate or incomplete. Whether the insurer will have a remedy depends on whether or not the incorrect or missing information was material within the meaning of section 20(2). If it was, the insurer will have a remedy for misrepresentation. If it was not, the insurer will have no remedy even though the proposer knew that its answer was not wholly accurate.

2.26 Materiality is a particular problem when very broad questions are asked. The following example is taken from a study of cases considered by the FOS.[20]

> Have you any physical defect or infirmity or is there any ailment or disease from which you suffer or have suffered or to which you have a tendency?

Taken literally, this would require a list of every illness from which the insured has ever suffered, and asks for information about illnesses to which they have "a tendency" even if they haven't yet suffered from them. A consumer insured might quite reasonably assume that they are being asked only about serious or chronic illnesses which they have suffered from, and answer accordingly.

2.27 When is a statement "material"? Until 1994, there were two vital questions relating to the interpretation of the section 20(2) test:

(1) Does "would influence the judgment" require that the influence would be decisive? There are no doubt many matters of which an insurer would wish to be aware. Some will be decisive in the decision-making process - for example, a prior conviction for insurance fraud may of itself lead an insurer to decline an application. Others will not be decisive but may, taken with other factors, affect an insurer's assessment of the risk.

(2) Can an insurer avoid a policy if it was not induced to enter into it by the misrepresentation?

2.28 For English law, these questions were answered in the landmark case of *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd.*[21] The House of Lords decided that:

(1) A material circumstance is one that would have an effect on the mind of the prudent insurer in assessing the risk and it is not necessary that it would have a decisive effect on the insurer's acceptance of the risk or on the amount of premium charged.

[20] See para 3.36 below.

[21] [1995] AC 501. The case mainly concerns non-disclosure, but the tests apply equally to misrepresentation.

(2) Before an insurer may avoid a contract for misrepresentation of a material circumstance it has to show that it was induced by the misrepresentation to enter into the policy on the relevant terms.

2.29 In Scots law, the *Pan Atlantic* test of materiality applies other than for life insurance.[22] Materiality in the case of life assurance is judged by the "reasonable assured" test, set out in *Life Association of Scotland v Foster*.[23] Lord President Inglis described the insured's duty as follows:[24]

> His duty is carefully and diligently to review all the facts known to himself bearing on the risk proposed to the insurers, and to state every circumstance which any reasonable man might suppose could in any way influence the insurers in considering and deciding whether they will enter into the contract.

2.30 In *Cuthbertson v Friends' Provident Life Office,*[25] Lord Eassie observed that the *Foster* test has two elements:

(1) For any fact to be material, it must be material in the view of the reasonable underwriter - "If the fact were regarded by such an underwriter as of no significance, *cadit quaestio*[26]."

(2) Additionally, the insurer must show that either:

(a) "The proposer appreciated that the fact in question would have had that significance", or, assuming that the proposer did not have that appreciation,

(b) "A reasonable person making the proposal and possessed with the factual knowledge possessed by the actual proposer would think that fact to be material to the insurer".

2.31 We will see that the definition of materiality in section 20(2) as interpreted in the *Pan Atlantic* case is controversial, because it may result in an insured who gave incomplete or inaccurate information having their policy avoided even though they honestly and reasonably believed that the information omitted or mis-stated was of no importance to the insurer. We will also see that the insurer's right to avoid in consumer cases is restricted by the Statements of Good Practice, the FSA Rules and the decisions of the FOS.

[22] *Hooper v Royal London General Insurance Co Ltd* 1993 SC 242.

[23] (1873) 11 M 351.

[24] Above at 359.

[25] 2006 SLT 567; 2006 SCLR 697. The case concerned critical illness cover. It was common ground between the parties, and accepted by the court, that the test applicable to life assurance also fell to be applied to critical illness cover.

[26] "The question falls" - that is, the fact is sufficient to settle the matter.

Misrepresentations that are not relevant to the risk

2.32 We end this section with a point of clarification. In most cases the issue is whether a particular fact was or was not relevant to the risk – that is, to the likelihood and magnitude of an insured loss. There has been a recent suggestion - without a decision being reached - that a fact is not material unless it goes to the risk insured: [27]

> The non-payment of premium is either material on its own or not, and since it seems to go to the owner's credit risk, and not to the risk insured, I would have thought it was not material. [28]

However, there is conflicting earlier authority,[29] and it is difficult to reconcile the suggestion with the clear wording of section 20(2) of the 1906 Act. The 1906 Act applies to failures to disclose or misrepresentations of facts that are material. What is material is defined in terms not as to what is relevant to the risk (that is the likelihood that the insured will suffer a loss and its likely size) but what "would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk."[30] A failure to disclose or a misrepresentation about the insured's credit record is within the section if it would influence a reasonable insurer's decision whether or not to accept the risk.

Renewals

2.33 With the exception of some types of life insurance, most insurance policies are for a fixed term. Typically this is one year, at the end of which the policy falls due for renewal. Although the process is referred to as renewal, the legal position is clear: a new contract is formed. The law of misrepresentation (and, as we shall see, non-disclosure) therefore applies to renewals in the same way as it applies to fresh applications for insurance.

NON-DISCLOSURE

The obligation to disclose material facts

2.34 The duty of utmost good faith puts the potential parties to a contract of insurance under an obligation to disclose all material facts, subject to the exceptions discussed below. Under current law the insurer may avoid the contract for non-disclosure at the time of an application or renewal even if it asked no questions at all.

2.35 Section 18(1) of the 1906 Act expresses the obligation on applicants in the following terms:

[27] *North Star Shipping Ltd v Sphere Drake Insurance plc* [2006] EWCA Civ 378, [2006] 2 Lloyd's Rep 183, [50] by Waller LJ.

[28] Similarly, in the 1980 Report, para 8.6, the Law Commission argued that the general law of misrepresentation may give the insurer a right to avoid the contract when there has been a misrepresentation of the insured's ability to introduce other customers. This was thought to be outside the scope of the duty under the 1906 Act, apparently because it is not material to the risk but affects the insurer's decision whether or not to enter the contract on the relevant terms in some other way.

[29] *The Dora* [1989] 1 Lloyd's Rep 69.

[30] See Marine Insurance Act 1906, s 18(2) and s 20(2).

> Subject to the provisions of this section, the assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured, and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him. If the assured fails to make such disclosure, the insurer may avoid the contract.

It is only business policyholders who are deemed to know every circumstance which in the ordinary course of business ought to be known by them.[31] It seems that consumer insureds need only disclose facts that are actually known to them.

2.36 Thus for consumers a practical significance of the distinction between misrepresentation and non-disclosure, as pointed out in the *Zurich General Accident* case,[32] is that misrepresentation of a material fact will afford grounds for avoidance of the policy whether or not the proposer was aware that it was incorrect, whereas avoidance for non-disclosure will be restricted to facts of which the proposer was aware and the insurer would have regarded as material.

2.37 We will see that in relation to consumers at least, the duty to disclose is controversial. In our Scoping Paper we quoted Professor Malcolm Clarke's criticism of the current position:

> Applicants in England may complete the form with scrupulous care, but still find that there was something else material to prudent insurers which, apparently, the particular insurer did not think to ask about but which, nonetheless, the applicant was expected to think of and disclose.[33]

Again the Statements of Good Practice, the FSA Rules and the decisions of the FOS restrict the circumstances in which an insurer may avoid the contract for non-disclosure.

The test of materiality

2.38 The test of materiality in relation to the duty to disclose is set out in Section 18(2) of the 1906 Act:

> Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk.

2.39 This is the same test as found in Section 20(2) of the 1906 Act, and the points made earlier in relation to misrepresentation apply.

[31] Marine Insurance Act 1906 section 18(1) provides that "…the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him".

[32] *Zurich General Accident and Liability Insurance Co v Leven* 1940 SC 406.

[33] M Clarke, *Policies and Perceptions of Insurance Law in the Twenty-first Century* (2005) p 103.

Exceptions

2.40 Section 18(3) states four exceptions to the general duty of disclosure:

> (a) any circumstance which diminishes the risk;
>
> (b) any circumstance which is known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know;
>
> (c) any circumstance as to which information is waived by the insurer;
>
> (d) any circumstance which it is superfluous to disclose by reason of any express or implied warranty.

Remedies

Avoidance

2.41 As with misrepresentation, the remedy for non-disclosure is that the insurer may avoid the contract. If the non-disclosure was fraudulent, the insurer may be entitled to retain the premium.

Damages

2.42 A breach of the duty of good faith does not of itself give rise to a right to damages. In *Banque Keyser v Skandia*, Steyn J suggested that such a right existed:

> Once it is accepted that the principle of the utmost good faith imposes meaningful reciprocal duties, owed to the insurers and vice versa, it seems anomalous that there should be no claim for damages for breach of those duties in a case where that is the only remedy.[34]

However, this suggestion was rejected when the case proceeded to the Court of Appeal. Amongst five reasons given was the fact that damages are simply not mentioned in the sections of the 1906 Act that deal with the obligation of good faith:

> We think the clear inference from the Act of 1906 is that Parliament did not contemplate that a breach of the obligation would give rise to a claim for damages in the case of such contracts. Otherwise it would surely have said so. It is not suggested that a remedy is available in the case of non-marine policies which would not be available in the case of marine policies. [35]

[34] [1987] 2 WLR 1300 1332, by Steyn J.

[35] *Banque Finaciere de la cite SA (formerly Banque Kayser Ullmann SA) v Westgate Insurance Co (formerly Hodge General & Mercantile Co Ltd* [1990] 1 QB 665 781, by Slade LJ.

Despite some contrary suggestions,[36] it seems to be accepted as settled law in England and Wales that even deliberate non-disclosure does not give rise to liability in damages, as deceit or fraud requires a positive misrepresentation.[37] However, in Scots law, although silence does not usually constitute a misrepresentation, where the law recognises a duty to disclose, a failure to do so will amount to a misrepresentation.[38]

WARRANTIES

Undertakings for the future and affirmations of fact

2.43 As we said above,[39] insurers use warranties for a number of purposes: to provide an additional remedy if information given by the proposer was incorrect; as an alternative method of defining the risk; to require the insured to take specified precautions; and to allow the insurer to escape from the contract should there be a change in the risk. This is possible because the wide variety of obligations on the insured can be given warranty status if the contract makes this sufficiently clear. Section 33(1) of the 1906 Act defines a warranty as

> … a promissory warranty, that is to say, a warranty 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.

In other words, warranties may apply to past or existing facts, or to future conduct or circumstances.

Strict compliance

2.44 The 1906 Act states that a warranty "must be exactly complied with, whether it be material to the risk or not".[40] So if an insured has "warranted" that certain facts are true, the warranty will be broken although the insured was not at fault in any way (for example, if they reasonably relied on information from a third party). Further, as we shall see, if there is a breach of warranty the insurer will be discharged from liability even though the answer would not be something the prudent insurer would take into account, or though it made no difference to the actual insurer.

[36] *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank* [2001] EWCA Civ 1250; [2001] 2 Lloyd's Rep. 483 at [48], [164] and [168]; see also *Conlon v Simms* [2006] EWHC 401 (Ch); [2006] 2 All ER 1024 (partnership).

[37] *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank* [2003] UKHL 6; [2003] 1 All E.R. (Comm) 349 at [75] ("nondisclosure (whether dishonest or otherwise) does not as such give rise to a claim in damages"); *Manifest Shipping Co v Uni-Polaris Insurance Co, The Star Sea* [2001] UKHL 1; [2003] 1 AC 469 at [46].

[38] MacQueen and Thomson, *Contract Law in Scotland* (2000), p 166. See also *Gillespie v Russel* 1856 18 D 677, 686 by Lord Curriehill.

[39] See para 2.2 above.

[40] Marine Insurance Act 1906, s 33(3).

2.45 This means that in effect an insurer may avoid liability for an inaccurate representation, even if it was not material. For example, in *Dawsons Ltd v Bonnin*,[41] (details of which are given in Part 1 of this Paper)[42] the insurers were allowed to treat the policy as terminated by the breach of warranty even though the misrepresentation that caused the breach was argued to be irrelevant to the risk.

Automatic discharge from liability

2.46 The 1906 Act spells out that if a warranty is not complied with, the insurer is discharged from liability under the contract, which means that an insurer is not liable for any claims arising after the breach. Section 33(3) states that if a warranty is not exactly complied with, then

> subject to any express provision in the policy, the insurer is discharged from liability as from the date of the breach of warranty, but without prejudice to any liability incurred by him before that date.

2.47 The words "the insurer is discharged from liability "should be taken literally. In its 1980 report the Law Commission said that on a breach of warranty the insurer was "entitled to repudiate the policy". [43] In *The Good Luck*, Lord Goff criticised this formulation, saying that it was inappropriate to describe the insurer as "repudiating the policy".[44] It is more accurate to keep to "the carefully chosen words" of the 1906 Act and say that the insurer is discharged from liability as from the date of the breach.[45] This means that, following breach, the insurer has a good defence to any claim without taking further action. The insurer may, however, waive the breach and restore its liability.[46]

"Subject to any express provision"

2.48 Section 33(3) is subject to any express terms of the policy. This means that the parties can contract out of automatic termination if they wish. For example, marine insurance contracts commonly include "held covered" clauses, which allow the policy to continue after the breach of warranty. Thus the Institute Time Clauses (Hull) include the following:

[41] [1922] 2 AC 413; 1922 SC (HL) 156. In this case the warranty was created by a "basis of the contract" clause, see para 2.67 below.

[42] See para 1.14 above.

[43] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 6.2.

[44] *Bank of Nova Scotia v Hellenic Mutual War Risks ("The Good Luck")* [1992] 1 AC 233, 263-4. Lord Goff said that the Court of Appeal had been "led astray" by passages in certain books and other texts which refer to the insurer being entitled to avoid or repudiate for breach of a promissory warranty.

[45] As above 263, quoting Marine Insurance Act 1906, s 33(3).

[46] Marine Insurance Act 1906, s 34(3). The means by which such waiver can occur raises difficult legal issues, and is discussed further in Issues Paper 2 at paras 7.154 to 7.163.

> Held covered in case of any breach of warranty as to cargo, trade, locality, towage, salvage services or date of sailing provided notice be given to the Underwriters immediately after receipt of advices and any amended term of cover and any additional premium required by them be agreed.[47]

2.49 In other words, provided the insured gives prompt notice of the breach, the insurer is obliged to provide additional cover, if necessary on amended terms and for an additional premium. Where the parties cannot agree on the terms or premium, the matter may be referred to a court or arbitration.

No causal connection required between breach and loss

2.50 It follows from section 33(3) that the insurer has a defence to any claim that arises after the warranty has been broken, even if there is no causal connection between the loss and the breach of warranty.

Later remedy irrelevant

2.51 Furthermore, the 1906 Act provides expressly that once a breach has occurred, the fact that it has been remedied does not prevent the contract from being discharged. Section 34(2) states:

> Where a warranty is broken, the assured cannot avail himself of the defence that the breach has been remedied, and the warranty complied with, before loss.

2.52 For example, in *De Hahn v Hartley*[48] (details of which are given in Part 1 of this Consultation Paper)[49] the insurer was discharged from liability as soon as the ship sailed with 46 instead of 50 hands, despite the fact that this breach of warranty was remedied before the loss occurred.

Conditions precedent to attachment of the risk

2.53 A warranty in an insurance contract has sometimes been described as a condition precedent to attachment of the risk, or to the liability of the insurer under the policy.[50] A term to that effect will have the same effect as a warranty, and what we say about warranties will apply equally to a condition precedent to the attachment of the risk. However, we will see that often the courts will construe a condition in the contract as being only a condition precedent to a particular claim or as a "suspensive condition".[51]

[47] Institute Times Clauses (Hull) 1995, clause 3.

[48] (1786) 1 TR 343.

[49] See para 1.14 above.

[50] See eg Lord Blackburn in *Thomson v Weems* 9 App Cas 671 at 683-684; (1884) 11 R (HL) 48, 51; Viscount Haldane and Viscount Finlay in *Dawsons Ltd v Bonnin* [1922] 2 AC 413 423 and 429, 1922 SC (HL) 156, 162 and 166; and J Birds and N Legh-Jones, *MacGillivray on Insurance Law* (10th ed 2003*)* para 10-2.

[51] J Birds and N Legh-Jones, *MacGillivray on Insurance Law* (10th ed 2003*)* paras 10-7 and 10-8; see para 2.57 below.

Creating a warranty

Express warranties

2.54 Most warranties are created expressly by the parties. There is no single form of words that confers warranty status on a term. "An express warranty may be in any form of words from which the intention to warrant is to be inferred."[52] The use of the word "warranty" has been said to be indicative but by no means decisive.[53] As Lord Justice Rix put it in *HIH Casualty and General Insurance Ltd v New Hampshire Insurance Co*,[54]

> 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.

The case concerned film finance insurance, in which the original insured had undertaken to make six films. This was held to be a warranty, even though the word warranty was not used, because it was a fundamental term with a direct bearing on the risk.

2.55 Because of the draconian effect of a warranty, the courts will sometimes interpret it strictly so as to avoid giving it effect. They may accept that it is a warranty but hold that it does not apply, or has not been broken. Thus they may hold that:

(1) **The warranty applies only to past or present facts, and not to the future**.[55] For example, in *Hussain v Brown*, the insured had signed a proposal form to say that their premises were fitted with an intruder alarm.[56] This was said to be the basis of the contract. The statement was true at the time of the contract, though the firm later failed to pay the charges and the alarm service was suspended. The Court of Appeal held that the statement on the proposal form related only to present facts and did not make any promises about the future. Any continuing warranty would be a "draconian term" and "if underwriters want such protection then it is up to them to stipulate for it in clear terms".[57]

[52] Marine Insurance Act 1906, s 35(1).

[53] *Barnard v Faber* [1893] 1 QB 340.

[54] [2001] 2 Lloyd's Rep 161; [2001] EWCA Civ 735.

[55] *Woolfall & Rimmer v Moyle* [1942] 1 KB 66; *Kennedy v Smith* 1976 SLT 110; *Hair v Prudential Assurance Co Ltd* [1983] 2 Lloyd's Rep 667.

[56] [1996] 1 Lloyd's Rep 627.

[57] Above at 630 by Saville LJ.

(2) **The warranty is relevant to only some sections of the policy**. For example, in *Printpak v AGF Insurance Ltd*, the insured had taken out a "commercial inclusive" policy, which covered a range of risks, including fire and theft.[58] The theft section included a warranty that the insured would maintain a burglar alarm. Meanwhile Condition 5 stated that a failure to comply with any warranty would invalidate any claim. The insured suffered a fire while the alarm was not working. The Court of Appeal held that the policy was not a seamless document, but instead consisted of separate schedules, each concerned with a different type of risk. Despite the wording of Condition 5, the alarm warranty only applied to the theft risk and not the fire risk.

(3) **The wording of the warranty does not apply to the facts in question.** The leading case is *Provincial Insurance Co v Morgan*.[59] Here coal merchants declared that their lorry would be used for coal, which became the basis of the contract. On the day of the accident, the lorry was also used to carry Forestry Commission timber. However, at the time, the timber had been unloaded and only coal was on board. The House of Lords held an endorsement on the policy stating that the use was "transportation of own goods in connection with the insured's own business" did not mean that the vehicle was to be used *exclusively* for the insured's own goods. On "a strict but reasonable construction" the declaration and the clause only meant that transporting coal was to be the normal use. Transporting other goods would not terminate liability under the policy.[60]

2.56 Alternatively, the court may hold that a term is not a warranty but either a condition precedent to a particular type of claim under the policy or a "description of the risk" for which the insurer is liable.[61]

[58] [1999] Lloyd's Rep IR 542.

[59] [1933] AC 240.

[60] See also *English v Western* [1940] 2 KB 156; and *Houghton v Trafalgar Insurance Co Ltd* [1954] 1QB 247.

[61] In principle a term might also be categorised as a innominate term, which will allow the insurer to terminate the contract only if it is deprived of the substance of what it was contracting for; or as a mere term (what in general contract law would be termed a "mere warranty") that gives rise only to damages for any loss caused. The courts have sought to classify notice requirements as innominate terms but we have not found any example of other terms being classified in this way.

Conditions precedent to a claim

2.57 If the term is a condition precedent to a particular claim, a breach or failure to comply with the condition will mean that the insurer is not obliged to pay the claim, but other possible claims under the policies will not be affected. Such conditions are most likely to be procedural, requiring (for example) notice of claims within a particular period.[62]

Descriptions of the risk

2.58 Clauses which are "descriptive of the risk" simply provide that the insurer will only cover losses arising in particular circumstances, and if a loss arises in other circumstances, the insurer is not liable. For example, in *Farr v Motor Traders Mutual Insurance* the policyholder insured two taxi-cabs, stating that they were only driven for one shift every 24 hours.[63] For a short time, one of the cabs was driven for two shifts while the other was being repaired. The cab was then used for one shift a day in the normal way and a couple of months later was damaged in an accident. The Court of Appeal rejected the insurer's argument that the assured had breached a warranty. Instead the words were merely "descriptive of the risk". This meant that if the cab was driven for more than one shift per day, the risk would no longer be covered, but as soon as the owner resumed one-shift working, the insurer again became liable.[64]

2.59 Such terms are sometimes called "suspensive" conditions, on the basis that they merely suspend liability while a breach taking the risk outside the policy continues. If a policyholder remedies the problem the insurer's liability resumes.

2.60 A clause that describes the risk may be in positive terms ("You are covered for accidents while skiing on-piste") or in the form of an exception ("You are covered for accidents while skiing except when off-piste").

[62] This category of term was recognised in *Alfred McAlpine Plc v BAI (Run-Off) Ltd* [2000] 1 Lloyd's Rep 437, at para 27. Here Waller LJ cited *Weir v Northern Counties of England Co* (1879) 4 LR IR as "an example of a term not being a condition precedent [to the policy as a whole], but on its language being a term which, until it is complied with, entitles the insurer not to meet the claim". In *K/s Merc-Scandia XXXXII v Certain Lloyd's Underwriters ("The Mercandian Continent")* [2001] 2 Lloyd's Rep 563, Longmore LJ confirmed the existence of "a further category of term" would give underwriters "the right to reject the claim without having to accept the breach of contract as being a repudiation of the contract as a whole" (para 14).

[63] [1920] 3 KB 669. The case was approved in *Provincial Insurance v Morgan* [1933] AC 240. For further examples of cases where courts have rejected insurers' arguments that a term is a warranty and have instead declared it to be descriptive of the risk: see Part 3 below.

[64] Similarly, in *Roberts v Anglo-Saxon Insurance Ltd* (1927) 27 Ll L Rep 313, Bankes LJ argued that the phrase "warranted: used only for commercial travelling" did not create a true warranty:

> When persons insert clauses, whether described as warranties or whether described as part of the description of the vehicle, indicating that the vehicle is to be used in some restricted way, my opinion… would be that the parties had used that language as words descriptive of the risk, and that, as a result, when the vehicle is not being used in accordance with the description it is not covered; but it does not follow at all that because it is used on some one occasion, or on more than one occasion, for other than the described use, the policy is avoided. It does not follow at all. (p 314).

This was approved by Lord Buckmaster in *Provincial Insurance v Morgan* [1933] AC 240, 247.

2.61 Classification of the term is a matter of interpretation of the contract. There are many statements within the cases that any ambiguity should be resolved in favour of the insured.[65] If the insurer wishes to treat a condition as a warranty or condition precedent to the contract as a whole, they must use clear words.[66] They should not escape liability unless terms are put before policyholders "in words admitting of no possible doubt".[67] However, in principle a term that is clearly stated to be a warranty has to be treated as such.[68] There is thus a limit to the extent the courts can find ways of avoiding application of the warranty regime.

How far can interpretation be used to remove unfairness? *Kler Knitwear*

2.62 A difficult question is how far the courts can disregard the clear language of the policy in order to achieve justice between the parties. In *Kler Knitwear v Lombard General Insurance Co*[69] the policyholders had agreed that their sprinkler system would be inspected 30 days after renewal. In fact, the inspection was about 60 days late and showed that the system was working. The factory later suffered storm damage (which was wholly unconnected with the sprinklers). Mr Justice Morland accepted in principle that if, on a proper construction of the clause, the parties intended it to be a warranty then the Court "must uphold that intention" however harsh and unfair the consequences. However, this particular clause was merely "a suspensive condition", limiting the risk.

2.63 The surprising thing about *Kler Knitwear* was that the term was clearly stated to be a warranty and the policy later went on to spell out the consequences, namely that non-compliance would bar any claim, "whether it increases the risk or not". Birds and Hird comment that

> It is difficult to see how the insurer could have stipulated this in any clearer terms. The term itself was called a warranty and was drafted in clear and intelligible language and the consequences of non-compliance were spelled out.[70]

2.64 In *Kler Knitwear*, the judge would appear to be going further than merely resolving an ambiguity in contractual drafting in favour of the insured. Instead he is replacing a consequence that "would be utterly absurd and make no business sense"[71] with one that is fairer to the insured.

[65] *Provincial Insurance Company v Morgan* [1933] AC 240.

[66] Above at 255 by Lord Wright.

[67] Above at 250 by Lord Russell.

[68] Subject to possible challenge, in consumer cases, under the Unfair Terms in Consumer Contracts Regulations 1999. See para 3.000 below.

[69] [2000] Lloyd's Rep IR 47.

[70] J Birds and NJ Hird, *Birds Modern Insurance Law* (6th ed 2004) p 161.

[71] *Kler Knitwear v Lombard General Insurance Co* [2000] Lloyd's Rep IR 47, 48

2.65 Cases such as *Kler Knitwear* provide a partial solution to the problem of warranties. We have been told that the courts' approach to construction discourages insurers from taking purely technical points or attempting to use warranties in a wholly unreasonable way. However, it does so at the cost of introducing uncertainty and confusion into the law. As each clause must be interpreted on its own wording, it encourages similar issues to be litigated repeatedly. And in some cases, the reasoning required to produce a fair result is convoluted to the point of incomprehensibility.[72]

Implied warranties

2.66 In marine insurance, the law will also imply certain warranties into the contract. The most important implied warranty is that of seaworthiness.[73] The other implied warranties cover portworthiness,[74] cargoworthiness[75] and legality.[76] The 1906 Act also implies into a marine policy a number of conditions which operate in the same way as warranties, in that the risk may never attach or the insurer may be discharged from liability. They relate to commencement of the risk;[77] alteration of the port of departure;[78] sailing for a different destination; change of voyage;[79] deviation;[80] and delay.[81] Because of their specialised content, relating only to marine insurance, these implied warranties and conditions fall outside the scope of this paper, save that we consider the effects of a breach or the occurrence of a condition. [82]

BASIS OF THE CONTRACT CLAUSES

2.67 A basis of the contract clause is a legal device used to turn representations made in the proposal form into warranties. Typically, applicants are asked to sign a proposal form containing a clause declaring that they warrant the accuracy of all the answers they have given. The clause usually states that the answers "form the basis" of the contract.

[72] This criticism has been levelled particularly at the Supreme Court of Canada decision, *The Bamcell II*, cited in *Kler Knitwear*, and discussed in Part 5. Soyer comments that since the *Bamcell II*, "the legal status of certain clauses in marine insurance policies has now become more problematic" as "a weapon has been given to the assured to challenge the warranty status of certain clauses" (205).

[73] Marine Insurance Act 1906, s 39(1) (voyage policies) and s 39(5) (time policies). For further discussion see Issues Paper 2 Appendix A.

[74] Marine Insurance Act 1906, s 39(2).

[75] Above at s 40(2).

[76] Above at s 41.

[77] Above at s 42.

[78] Above at s 43.

[79] Above at s 45.

[80] Above at s 46; see also ss 47 (Several ports of discharge) and 49 (Excuses for deviation and delay).

[81] Above at s 48; see also s 49 (Excuses for deviation and delay).

[82] See Part 8 below.

2.68 Such clauses elevate the answers in proposal forms to contractual warranties. Thus in *Unipac (Scotland) Ltd v Aegon Insurance* the company answered two questions on the proposal form inaccurately.[83] They said they had been carrying on business for a year, while they had been incorporated for less than a year; and they said they were the sole occupiers of the premises, when they were not. Following a fire, the insurers refused to pay the claim. The policyholders brought an action arguing that they had not warranted the accuracy of the answers, only that they were true to the best of their knowledge and belief. In the absence of a specific warranty, the insurer could avoid liability on the basis of a misrepresentation only if it was material. The Court of Session rejected these arguments, stating that the words used were clear.[84] The court stressed the importance of freedom of contract in ringing terms:

> We recognise that a consequence of holding that the declaration contains an express warranty of the truth of the answers to the questions in the proposal is that if there was an error in, for example, the postcode or telephone number of the proposer, the result would be that the defenders would be entitled to avoid the policy. That however is a consequence of the parties agreeing to an express warranty with the result that the defenders would have a right to avoid the policy if an answer was untrue whether or not the untrue item was material. We are not persuaded that that would be a ludicrous result. It is simply a consequence of what parties have agreed to by contract and parties are free to agree what they like.[85]

2.69 More usually, basis of the contract clauses have been viewed with disapproval. First, the fact that a basis of the contract clause need only be on the proposal form has been seen as a departure from normal English contract law. Clarke comments that it is difficult to square basis of the contract clauses "with the notion underlying the parol evidence rule", namely that a document such as a policy "which looks like the whole of the contract should be treated as the whole of the contract".[86] However the parol evidence rule is probably no more than a presumption which can be rebutted by clear evidence that the parties intended a term not in the document to have contractual effect nonetheless.[87]

[83] 1996 SLT 1197.

[84] The clause read: "We declare that to the best of our knowledge and belief all statements and particulars contained in this proposal are true and complete and that no material fact has been withheld or suppressed. We agree that this proposal shall be the basis of the contract between is and the insurers".

[85] *Unipac (Scotland) Ltd v Aegon Insurance* 1996 SLT 1197, 1202. Lord Ross delivered the opinion of the court.

[86] M Clarke, *The Law of Insurance Contracts* (4th ed 2002) para 20 –2A1.

[87] Chitty on Contract (29th ed 2004) paras 12-097 to 12-098. In Scotland, section 1 of the Contract (Scotland) Act 1997 now provides that where a document appears to comprise all the express terms of a contract, then unless the contrary is proved it shall be presumed that it does comprise all the express terms. Since this is merely a presumption it does not appear to preclude an insurer from arguing that a basis of the contract clause in a proposal constitutes an additional express term.

2.70 Secondly, we will see that basis of the contract clauses are criticised because of their effect. Their use in consumer insurance is restricted by the Statements of Practice and the FOS would regard them as inconsistent with good practice.

2.71 In marine insurance a basis of the contract clause contained only in the proposal form would not be effective. Any express warranty must be included in, or written upon, the policy or must be contained in some document incorporated by reference into the policy.[88]

UNFAIR TERMS IN CONSUMER CONTRACTS: THE 1993 DIRECTIVE AND 1999 REGULATIONS

2.72 A major change since the Law Commission's report in 1980 is that unfair terms in consumer insurance may now be subject to review. Although insurance contracts generally are not subject to many of the terms of the Unfair Contract Terms Act 1977, consumer insurance is covered by the EU Directive on Unfair Terms in Consumer Contracts,[89] and the implementing Unfair Terms in Consumer Contracts Regulations (UTCCR).[90] The Regulations do not affect the insurer's right to avoid for misrepresentation or non-disclosure, which are set out in statute, but they are very relevant to warranties and other terms of the policy such as exceptions. Unfortunately their impact on insurance contracts, and in particular on warranties, is complex. A detailed explanation is needed.

Which terms may be reviewed?

2.73 The Directive allows a court to review the fairness of all non-negotiated terms in a consumer contract, except for core terms. These are defined in Article 4(2):

> Assessment of the unfair nature of the terms shall relate neither to the definition of the main subject matter of the contract nor to the adequacy of the price and remuneration, on the one hand, as against the services or goods supplied in exchange, on the other, in so far as these terms are in plain intelligible language.

2.74 This somewhat cumbersome sentence is re-written in Regulation 6(2):

> In so far as it is in plain intelligible language, the assessment of fairness of a term shall not relate to
>
> (a) the definition of the main subject matter of the contract, or
>
> (b) to the adequacy of the price or remuneration, as against the goods or services supplied in exchange.

[88] Marine Insurance Act 1906, s 35(2).

[89] Council Directive 93/13/EEC of 5 April 1993.

[90] The Directive was first implemented in the Unfair Terms in Consumer Contracts Regulations 1994, which were later replaced by the Unfair Terms in Consumer Contracts Regulations 1999.

These are often referred to as "core terms".[91]

2.75 In *Director General of Fair Trading v First National Bank Plc*, the House of Lords explained that the core terms provisions should be interpreted narrowly.[92] As Lord Bingham put it, the object of the Regulations and Directive "would plainly be frustrated" if the definition of core terms were "so broadly interpreted as to cover any terms other than those falling squarely within it".[93] Lord Steyn confirmed that the provision must be given a restrictive interpretation, or "the main purpose of the scheme would be frustrated by endless formalistic arguments about whether a provision is a definitional or an exclusionary provision".[94]

2.76 There has been some debate about how far these provisions apply to insurance contracts. The insurance industry has long opposed the idea that definitions of risk and exclusions should be subject to review for fairness, and was very concerned at the possible impact of the Directive. To assuage its fears, the Directive included the following words in Recital 19:

> For the purposes of this Directive, assessment of unfair character shall not be made of terms which describe the main subject matter of the contract nor the quality/price ratio of the goods or services supplied…. It follows, inter alia, that in insurance contracts, the terms which clearly define or circumscribe the insured risk and the insurer's liability shall not be subject to such assessment since these restrictions are taken into account in calculating the premium paid by the consumer.

2.77 This has been taken to mean that any terms which "clearly define or circumscribe the insured risk" are core terms within the meaning of the Directive and Regulations, and are therefore exempt from review. We examine this argument in more detail below. To make the discussion easier to follow, we deal first with exceptions and then with warranties.

Exceptions and UTCCR

Are exceptions price terms?

2.78 The words in Recital 19 do not mean that an exception within an insurance contract "relates to the adequacy of the price". An insurer may well take such exceptions into account in calculating the price, but this could be true of any term within the contract. As Lord Steyn put it in *First National Bank*:

[91] The description is not unproblematic, since the "adequacy of the price" is not a term of the contract. However it is clear that the term that sets the price cannot be reviewed simply on the ground of the "adequacy of the price". See *Chitty on Contract* (29th ed 2004) para 15-034.

[92] [2001] UKHL 52, [2002] 1 AC 481.

[93] Above at [12].

[94] Above at [34].

> After all, in a broad sense all terms of the contract are in some way related to the price or remuneration. That is not what is intended.[95]

2.79 *First National Bank* itself was about the terms of a loan. Clearly, the interest rate itself was the price (and not subject to review) but a clause stating that the same rate was payable on default was merely incidental to the substance of the bargain. The House of Lords held it was subject to review. A price escalation clause would also be subject to review "or there would be a gaping hole in the system"[96] (even if, presumably, the supplier had taken account of the presence of such escalation clause in calculating the initial price).

Do exceptions define "the main subject matter of the contract"?

2.80 Although an exception to the cover is not a price term, there is a strong argument that it does define the main subject matter of the contract, within the meaning of Article 4(2). Clearly, the main subject matter of an insurance contract is the cover the policyholder receives. MacGillivray considers that the exemption extends to terms which describe the perils insured against and specify the measure of indemnity afforded by the cover, but not to procedural requirements to give notice of claims.[97] Birds and Hird also argue that the definition of the main subject matter should be taken to include both "the risks covered and excepted". They point out that the Regulations must be read subject to Recital 19, which refers to terms which "clearly define or circumscribe the insurer's liability".[98]

2.81 This was the view taken by Mr Justice Buckley in *Bankers Insurance Co v South*.[99] A holiday-maker had taken out a travel insurance policy which exempted "compensation or other costs arising from accidents involving … possession of any … motorised waterborne craft". Whilst riding a jet ski he had been involved in an accident which seriously injured another jet skier. The victim then attempted to argue, first, that the exemption did not apply to jet skis. Secondly, if it did, it was an unfair term within the meaning of the regulations. Buckley J held that the term was in plain intelligible language and therefore exempt from scrutiny.[100] Unfortunately for our purposes, he did not develop this point. The judge also said that in any event he could see nothing unfair in the term. It was available to the holiday-maker, and he could have read it if he had wished. He also pointed out that the insurance was relatively cheap.[101]

[95] Above at [34].

[96] Above at [34] by Lord Steyn.

[97] J Birds and N Legh-Jones, *MacGillivray on Insurance Law* (10th ed 2003) para 11-36, p 294 and para 10-91, p 261.

[98] J Birds and NJ Hird, *Birds Modern Insurance Law* (6th ed 2004) p 208, note 24.

[99] [2003] EWHC 380 (Comm), [2004] Lloyd's Rep IR 2.

[100] Above at [24].

[101] Above at [24].

2.82 We accept that an exception to cover may be taken as defining the cover: for example, a clause that states cover is limited to roadworthy vehicles has the potential to be a core term. However, it does not follow that all exceptions are exempt from review as being core terms. There are two restrictions. First, the definition of the main subject matter of the contract is only exempt from review "so far as it is in plain intelligible language". Secondly, a term cannot be "the definition of the main subject matter of the contract" if it is substantially different to what the consumer reasonably expected.

2.83 We take these points in turn in the paragraphs that follow.

Does an exception have to be in plain language?

2.84 The exclusion from review only applies to core terms "in so far as these terms are in plain intelligible language". If an exclusion is not clearly worded, it will not be treated as a core term, and will be subject to review for fairness. As MacGillivray states, "failure to word a core term of the insurance clearly will result in it losing its exemption from assessment for fairness".[102]

2.85 This requirement of the Directive is not universally accepted. Clarke, for example, includes a footnote in which he refers to the argument that "if core terms are not plain and intelligible they shall be assessed for fairness". He describes this result as "startling", "new" and having "no basis in the Directive". He refers to the opening words in Recital 19, that "assessment of unfair character shall not be made of terms which describe the main subject matter of the contract". He points out that this opening phrase is "unqualified", and does not state that the term must be in plain intelligible language.[103] We do not think this view is correct. Recital 19 must be subject to the clear words of Article 4(2), which states that the exemption from assessment only applies "in so far as these terms are in plain intelligible language". Furthermore Recital 19 itself is confined to terms which "*clearly* define or circumscribe the insured risk".

Exceptions that are substantially different from what the consumer reasonably expects

2.86 Recital 20 suggests that the requirement is not just one of plain language. It says that contracts should not only be drafted in plain, intelligible language but also that "the consumer should actually be given an opportunity to examine all the terms".

2.87 This leads to the question of whether a term that is itself clearly worded can be exempt from review as a core term if it is not what the consumer reasonably expected, for instance if it is hidden among the small print of a contract where consumers are extremely unlikely to read it. When the two Law Commissions examined the law on unfair terms in contracts, we endorsed the view put forward by the Office of Fair Trading (OFT) that a term only defines the main subject matter of the contract if it is part of the way consumers perceived the bargain. As the OFT put it:

[102] J Birds and N Legh-Jones, *MacGillivray on Insurance Law* (10th ed 2003) para 11-36, 294.

[103] M Clarke, *The Law of Insurance Contracts* (4th ed 2002) para 19 –5A, 614, note 13.

> A supplier would surely find it hard to sustain the argument that a contract's main subject matter was defined by a term which a consumer had been given no real opportunity to see and read before signing.[104]

2.88 We explained that:

> In a contract for a "holiday with travel by air", a clause in the "small print" allowing the company, in the event of air traffic control strikes, to carry the consumer by rail and sea seems to be reviewable for fairness; but it can be argued that if the holiday is "with travel by air or, in the event of strikes, by rail and sea", the option of mode of travel *might* be part of the definition of the main subject matter. In other words, whether the term relates to the definition of the subject matter depends (at least in part) on how the deal is presented to the consumer.[105]

2.89 Applying the same principle to an insurance contract, take a case where a policy was sold as "insurance for winter sports adventure holidays", but a sub-paragraph of one of the lengthy policy terms excluded off-piste skiing, and no particular attempt was made to bring this to the proposer's attention. The exclusion of off-piste skiing would not be a core term. However, if the policy were sold explicitly as "suitable for skiing on piste", the same term might be exempt from review, provided it was presented in a plain intelligible way.

2.90 Our draft Bill on Unfair Contract Terms sought to clarify the law in this area, without changing it. Under clause 4(2), a term is excluded from review if it defines the main subject matter of the contract provided the definition is-

> (a) transparent and
>
> (b) substantially the same as the definition the consumer reasonably expected.

2.91 The draft Bill goes on to define "transparent" as meaning

> (a) expressed in reasonably plain language,
>
> (b) legible,
>
> (c) presented clearly, and

[104] Unfair Contract Terms Bulletin 2 (OFT 170, September 1996) para 2.26. This is quoted in Unfair Terms in Contracts (2002), Law Com Consultation Paper No 166, Scot Law Com Discussion Paper No 119, para 3.23.

[105] Unfair Terms in Contracts (2002) Law Com Consultation Paper No 166, Scot Law Com Discussion Paper No 119, para 3.23.

(d) readily available to any person likely to be affected by the contract term or notice in question.[106]

2.92 In other words, a clause that excluded fire cover if the house was unoccupied might be exempted from review, but only if it were what a consumer would reasonably expect, and if it were readily available, presented clearly, legible and expressed in reasonably plain language. If the clause were merely one of the small print terms, and no special steps had been taken to bring it to the consumer's attention, it would no longer be a core term, and a court could review it to see if it was fair.

2.93 It is not necessarily sufficient for the term to be in plain language. An exception or other clause defining the risk may be in plain language without necessarily being clearly presented, or even readily available. The Directive requires that the term relates to the main subject matter of the contract. It would be difficult to argue that an exception or definition of which consumers were quite reasonably unaware defined the main subject matter of the contract. Such a term would therefore be subject to review for fairness. It does not follow that a court will necessarily treat it as unfair, but if it is substantially different from what the consumer reasonably expected and it is not readily accessible, there must be a risk that the court will hold it to be an unfair term.

2.94 We would add that in practice it is probably necessary to include the exception in the documentation (the proposal form or descriptive summary of the policy) that the consumer is given before the contract is made. Merely to include it in the policy document will not suffice, even if the proposal form or summary refers to the policy document. Consumers' reasonable expectations will not be set by terms they only discovered after entering into the contract. Even if the consumer received the terms in advance, a term is unlikely to define the main subject matter of the contract unless it was highlighted in some way.[107]

The effect on warranties

2.95 The two limitations that may prevent an exception being a core term apply equally to a warranty. In the case of warranties, however, there are additional complications.

2.96 Take the example where the consumer warranted that they would fit a particular type of mortise lock. The question is whether the term is subject to review, or whether it is exempt because it "defines the main subject matter of the contract".

[106] Unfair Terms In Contracts (2005) Law Com No 292; Scot Law Com No 199, draft Bill, clause 14(3).

[107] See *Zockoll Group Ltd v Mercury Communications Ltd (No 2)* [1999] EMLR 385, 395. Also note UTCCR 1999 Sch 2, Art 1, which includes in the list of terms "which may be regarded as unfair" terms which have the object or effect of "(i) irrevocably binding the consumer to terms with which he had no real opportunity of becoming acquainted before the conclusion of the contract."

2.97 Just like an exception, the warranty would need to be in plain intelligible language. Equally, applying the reasoning we adopted in our project on Unfair Terms in Contracts, we think warranties, just like exceptions, would have to be part of the way the deal was presented to the consumer. The key terms document would need to make it plain that coverage was dependent on the lock being in place. However, with warranties there are possible restrictions that do not apply to exceptions.

Do warranties define the subject-matter of the contract?

2.98 First, we wondered whether a warranty, however clearly worded and prominently set out, can ever be a "core term", simply because it does not describe the subject-matter of the contract. In effect it circumscribes the insurer's liability if the right lock is not installed, and might be thought of as the kind of incidental or subsidiary term that the House of Lords, in its decision in *DGFT v First National Bank plc*, recognised as not being "core".[108] On reflection, however, we do not think this argument is correct. A warranty is correctly interpreted as an obligation on the insured, and there is no reason why (if it is clear and "reasonably expected") it should not be as "core" as the obligation to pay the premium. Indeed, in principle there is nothing to stop the insurer obtaining a warranty as to existing facts that has the practical effect of defining the risk that the insurer is prepared to underwrite.

The effect of warranties and reasonable expectations

2.99 A second restriction does seem to bite on warranties. We think that unless the insurer expressly spells out in full the effect of a breach of the warranty, it will be subject to review because it will almost inevitably fail the "reasonable expectations" test.

2.100 Consider the legal effect of a breach of the warranty. It will discharge the insurer from liability under the policy automatically, so that there is no liability for any loss even if the matter warranted was immaterial, or the loss was completely unrelated to the breach (for example, flood damage). The insurer is discharged from liability even if the breach of warranty has been cured before the claim arose. As we argued earlier, it is most unlikely that these results accord with the reasonable expectations of any insured, least of all a consumer - unless he or she happens to be an insurance lawyer. Thus for the warranty to be exempt as a "core term", the consequences of a breach of a warranty would have to be spelled out in full, in clear and intelligible language and in a way that left the consumer in no doubt about what to expect. [109]

[108] *DGFT v First National Bank Plc* [2001] UKHL 52, [2001] 1 AC 481, esp at [12] and [34]. See further Unfair Terms in Contracts (2002) Law Com Consultation Paper No 166, Scot Law Com Discussion Paper No 119, para 3.25.

[109] We do not think it matters that it is the general law of insurance, rather than the term of the contract itself, that provides for these consequences. It is true that under the Regulations terms that merely reflect what would be the law anyway are probably exempt from review. see Reg 4(2) and Recital 13 of the Directive, discussed in the Law Commissions' Consultation Paper No 166 at para 3.37. However, the insurer would not be discharged from the contract unless the warranty term had been included, so this exemption does not apply.

2.101 If the term were not sufficiently central to the way the bargain was presented to be a core term, the court would need to consider whether it was fair. It should be noted that under the UTCCR, the court is required to assess the fairness of the term at the time the contract was made. It is not asked to assess whether the term has been applied fairly in the particular circumstances of the loss. Thus if the term gives the insurer the right to avoid even when the breach of warranty was immaterial, it will be no answer that in the particular facts the loss that has been incurred was caused directly by the breach of warranty. If the warranty as a whole was unfair, the insurer simply cannot rely on it at all.

2.102 It might be argued that most warranties are fair on their face. The unfairness arises only because of the way they are applied. However, before assessing the fairness of a term the court must interpret it. Suppose, for example, that an insurer seeks to rely on the lock warranty to reject a claim for flood damage. The court would first have to decide whether the term was a true warranty, and was intended to exclude flood claims in this way. If the court accepts the insurer's case that the term has a wide meaning, then it is likely to hold that the term is unfair. The court may be influenced by the fact that this use of the term specifically breaches ICOB Rule 7.3.6. As a result, the term would not be binding on the consumer, and the insurer could not rely on it to avoid paying the claim. If the court gives the term a narrow meaning, merely to except burglary claims while the lock is not fitted, then the term is more likely to be considered fair – but it would not assist the insurer to resist liability for flood damage.

Preventive powers

2.103 A major innovation in the 1994 Regulations was that enforcement was not left to the parties alone. Instead, the Director General of Fair Trading was empowered to bring proceedings for an injunction (or interdict) against suppliers using unfair terms in their contracts with consumers. In 1999, the list of enforcement organisations was extended, and in 2001 the FSA was added. The FSA is now the organisation primarily responsible for preventing insurers from including unfair terms within their contracts.[110]

2.104 The FSA has reached agreements with insurance companies to alter terms: for example, the FSA complained about a cash-back scheme underwritten by insurers, which only met claims if consumers submitted numerous forms within strict time limits. The insurers agreed that they would accept claims within 6 months of the specified dates and would issue replacement documents on request.[111]

[110] See the Concordat between the OFT and FSA, set out in OFT, Unfair Contract Terms Bulletin 16, December 2001. An account of how the FSA uses its powers is given in FSA Handbook Enforcement Manual (Chapter 20). See also, FSA, Fairness of Term in Consumer Contracts: Statement of Good Practice, May 2005.

[111] The FSA has also taken action to prevent an insurer from varying long-term insurance premiums without giving reasons for the changes. It also took action against an insurance policy guaranteeing the return of deposits paid to home improvement suppliers. The cover ceased on the original installation date – which meant that if installation was delayed, the deposit could not be returned.

2.105 In July 2006 the FSA took action against a term in a legal expenses insurance policy which bore some similarities to a warranty. It stated that "cover will end at once" if the insured dismissed their appointed representative, or if the representative refused to act for the insured. This was thought to be unfair as the insured may have a legitimate reason for dismissing the representative (for example, in the event of fraud), or the legal representative may refuse to act for the consumer for reasons beyond the consumer's control. Following FSA intervention, the insurer rewrote the term to state that the cover will only end if the insured dismisses the representative without good reason, or the representative refuses to act for a good reason.

The impact of the UTCCR

2.106 The regulations have been in place since 1994, applying to all contracts entered into after 1 July 1995. So far, they appear to have had surprisingly little impact on the insurance industry. With the exception of *Bankers Insurance Co v South*,[112] we have not located any cases in which the issue was argued in the courts.

2.107 The Regulations have the potential to provide protection to consumers. However, we will argue later that in practice they do not give consumers adequate protection against some types of policy terms. They do not apply at all to business insurance contracts.

CONCLUSION

2.108 We set out below a brief summary of our criticisms of the current law before looking in Part 3 at how the situation for both consumers and businesses has been affected by regulation and the FOS. We then return to our criticisms in more detail in Parts 4 to 8 when we set out our proposals for reform.

2.109 The law is not in line with the reasonable expectations of the market. The law places an obligation on the insured to disclose all material facts, even if no questions have been asked of them. The definition of material in the 1906 Act is information that would influence the judgement of the prudent insurer in fixing the premium or determining whether he will take the risk. This is not a matter that many insureds will be in a position to assess.

2.110 In the case of misrepresentation, insurance contract law entitles an insurer to avoid the policy if that misrepresentation is material. Again, the definition of material is according to the standard of the prudent insurer. As a result, an insured's claim can be denied even when they have acted honestly and reasonably and where they act carelessly the remedies may be overly harsh.

[112] See para 2.81 above.

2.111 The law on warranties is similarly out of line with reasonable expectations. If an insured makes a statement which is deemed to be a warranty and that statement is not correct, the law states that the insurer is entitled to be discharged from liability. This is the case even if the statement is not material and would not have influenced the judgement of a prudent insurer in fixing the premium or determining whether he will take the risk. In the case of warranties of future conduct, the law states that the policy is also discharged even if the breach of warranty is later remedied or had nothing to do with the loss suffered. The effect is that the law will allow a policy to be avoided for the smallest inaccuracy, if that statement is deemed to be a warranty.

2.112 An obscure legal device can convert a statement on the proposal form into a warranty. If a policyholder signs the proposal form stating that they warrant the accuracy of all their answers or one stating that their answers “form the basis of the contract” then the answers in the proposal form will be elevated to warranties. This means that the law according to warranties applies and the insurer is entitled to be discharged from liability if any statement is inaccurate.

PART 3
PRE-CONTRACT INFORMATION AND CONSUMERS: ASSESSING THE CURRENT POSITION

THE CURRENT LAW

3.1 Under current law, an insurer that has been given incorrect information by the proposer has the right to avoid the contract for misrepresentation.[1] The insurer needs to show that the information induced it to enter the contract and that it would have influenced the judgement of a prudent insurer in assessing the risk. Except where the incorrect statement was one of opinion rather than of fact, it does not matter that the insured was honest, or even that they had reasonable grounds for believing that what they said was correct.

3.2 The law also allows insurers to add to these remedies. If the insurer obtained a warranty that the information was correct, it is discharged from liability even if the information was not material and did not influence the insurer's decision. An insurer may do this either by adding a specific warranty to the contract, or by using a "basis of the contract" clause on the proposal form. Again, honesty or lack of negligence on the part of the proposer is irrelevant.

3.3 Even if the insurer has not sought information from the insured, the latter is bound to disclose any material fact of which it is aware, or in the case of a business that it ought to know in the ordinary course of business. If the insurer would not have entered the policy on the same terms had it had the information, it may avoid the policy.

3.4 We have seen that the strict legal rights of consumers have been supplemented by three measures - the Statements of Practice issued by the Association of British Insurers (ABI), regulation by the Financial Services Authority (FSA) and the dispute resolution service of the Financial Ombudsman Service (FOS). Here we examine these measures and ask if they are an adequate substitute for law reform. Since the FSA Rules apply only to consumer insurance, and the FOS scheme applies only to consumers and some small businesses, we consider consumer insurance in this Part and Part 4. We then turn to business insurance in Part 5.

THE ABI STATEMENTS OF PRACTICE

3.5 The Statement of General Insurance Practice (SGIP) and the Statement of Long-Term Insurance Practice (SLIP) addressed the problem of non-disclosure in three ways:[2]

[1] See Part 2, paras 2.12 to 2.33.

[2] See para 1.20 above. The text of both SGIP and SLIP, and a more detailed description of their requirements, can be found in Appendices B and C of our first Issues Paper, available on our website. See http://www.lawcom.gov.uk/docs/insurance_contact_law_issues_paper_1.pdf

(1) Each proposal form was required to include a prominent warning, drawing attention to the consequences of failing to disclose material facts, and explaining that material facts were those which "an insurer would regard as likely to influence the acceptance and assessment of the proposal". Applicants had to be warned that if they were in any doubt about whether facts were material, they should disclose them.

(2) SGIP stated that "those matters which are generally found to be material should be the subject of clear questions". However SGIP provided no sanction if this provision was not observed.

(3) Under SGIP, 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. This effectively limited the consumer's duty to volunteer information to facts which "a policyholder could reasonably be expected to disclose".

3.6 As far as misrepresentation was concerned, insurers should not repudiate liability on grounds of misrepresentation unless it was a deliberate or negligent misrepresentation of a material fact. SGIP did not deal with the question of whether the insurer may avoid the policy without prejudice to existing claims. SLIP forbids avoidance unless the material fact in question was known by the applicant, and is one that the applicant could reasonably be expected to disclose.

3.7 SGIP did not deal with fraudulent misrepresentation and non-disclosure. SLIP notes that:

> …fraud or deception will, and reckless or negligent nondisclosure or misrepresentation of a material fact may, constitute grounds for rejection of a claim.

3.8 The 1986 SGIP effectively outlawed the use of basis of the contract clauses. It provided:

> 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. But insurers may require specific warranties about matters which are material to the risk.[3]

3.9 It also stated that an insurer may only refuse to meet a claim

> on the ground of a breach of warranty where the circumstances of the loss are unconnected with the breach, unless fraud is involved.

[3] SGIP 1986, Clause 1(b).

3.10 The SGIP has now been withdrawn. However both the SGIP and the SLIP remain important indicators of what is accepted by the industry to be good practice. They inform the rules of the FSA and the FOS often treat them as indicating what is "fair and reasonable in all the circumstances". They clearly establish that insurers should not refuse claims for honest and reasonable misrepresentations, and should not seek to rely on basis of the contract clauses. However, as we explain in Part 1, the Statements of Practice are not an adequate substitute for law reform.

THE FINANCIAL SERVICES AUTHORITY

3.11 There are several ways in which the FSA influences the approach taken by insurers to pre-contract information. As we have seen, it both encourages compliance with high level principles and sets out detailed rules.

FSA Principles and Treating Customers Fairly

3.12 As we stated in Part 1, the FSA publishes eleven high-level "Principles for Businesses".[4] The most important from the point of view of this paper is Principle 6:

> A firm must pay due regard to the interests of its customers and treat them fairly.

3.13 This principle is being explored in the Treating Customers Fairly ('TCF') initiative. We were interested to note, for example, that in the General Insurance Cluster report published in July 2006 the FSA highlighted disclosure issues as examples of both good and bad practice in claims handling:

> Good TCF examples we have seen include…
>
> 1. Firms stressing the importance of full disclosure by customers when completing a critical illness application. One firm included a case study for customers explaining the implications of non-disclosure.
>
> 2. A firm does full medical underwriting at the time of application to ensure both the firm and the customer are clear about the basis on which the cover is being provided.
>
> Examples of poor practice include…
>
> 3. Firms who provide little training to their distributors in issues such as application forms where technical medical questions can be asked and where the consequences of non-disclosure can be significant. [5]

[4] PRIN Sourcebook (FSA Handbook).

[5] FSA, General Insurance and Pure Protection Products – Treating Consumers Fairly (July 2006), p 10.

3.14 TCF is a valuable initiative which is influencing attitudes within the insurance industry. However it is not a substitute for clear legal rights.

The Rules

3.15 The more detailed rules are contained in the Insurance Conduct of Business Sourcebook (ICOB) and the Conduct of Business Sourcebook (COB). The ICOB rules require insurers to warn the insured that it has a duty of disclosure.[6] Rule 7.3.6 also restricts the insurer's right to reject a claim on the grounds of misrepresentation or non-disclosure.[7] It states:

> An insurer must not:
>
> (1) unreasonably reject a claim made by a customer;
>
> (2) except where there is evidence of fraud, refuse to meet a claim made by a retail customer on the grounds:
>
> (a) of non-disclosure of a fact material to the risk that the retail customer who took out the policy could not reasonably be expected to have disclosed;
>
> (b) of misrepresentation of a fact material to the risk, unless the misrepresentation is negligent;…

COB 8A.2.6 is in similar terms. Neither places any restriction on an insurer's right to avoid a policy for an innocent misrepresentation where no claim has arisen.

3.16 Unlike the SGIP, the FSA Rules do not specifically outlaw the use of basis of the contract clauses. As we see in Part 7, however, they do curb an insurer's use of warranties generally. For general insurance, an insurer may only rely on a breach of warranty if it was drawn to the consumer's attention before the conclusion of the contract, and the circumstances of the claim are connected with the breach.[8] The ABI has told us that the fact that the FSA Rules do not cover 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.

3.17 It should be noted that where there are breaches of the FSA Rules there are two potentially significant consequences under the Financial Services and Markets Act 2000. First an affected policyholder may bring a claim against a regulated firm for breach of statutory duty.[9] Secondly, the FSA may take disciplinary action against the firm and has the power, for example, to impose a fine.[10]

6 Insurance Conduct of Business, Rule 4.3.2(3).

7 At the time of going to press, the FSA is intending to consult on changes to these rules. We understand that the FSA is proposing changes to the wording, but that these will not affect the substance of this requirement.

8 Insurance Conduct of Business, Rule 7.3.6.

9 Financial Services and Markets Act 2000, s 150.

10 Financial Services and Markets Act 2000, s 66.

The FSA Rules are useful but unlikely to achieve full individual protection

3.18 The FSA Rules are an important step forward. They reinforce the principle established by the Statements of Practice that insurers should not reject a consumer claim for a misrepresentation, where the misrepresentation was both honest and reasonable. Furthermore, as we explain in Part 7, the provisions on warranties, when combined with the requirements of the Unfair Terms in Consumer Contracts Regulations 1999, go a long way to protect insureds from warranties and exceptions of which they are unaware. Unlike the Statements of Practice, the rules are not voluntary. If an insurer systematically ignores them, disciplinary action may be taken.

3.19 However, the FSA Rules are not an adequate cure for defects in the law. First, it is not the task of the FSA to monitor individual cases. Relatively few consumers will complain to the FSA about individual matters of misrepresentation or non-disclosure, and serious disciplinary action is unlikely in what appear to be one-off cases. In principle a breach of the FSA Rules may lead to the insurer being liable for breach of statutory duty,[11] but we doubt the practical efficacy of this remedy save when a very large sum is at stake. Those who can pursue the matter through the FOS are best advised to do so; those who cannot may well drop the matter.

3.20 Secondly, in some respects the FSA Rules do not go as far as the Statements of Practice. They are also considerably less demanding than the FOS would be, should the dispute reach it. For example, ICOB merely requires that the consumer be warned about the duty to disclose.[12] As we shall see later, the FOS disregards the duty of disclosure in the cases it considers: it takes the view that if the insurer wants a piece of information, it should ask for it.[13] Another example is that the FSA Rules permit the insurer to avoid the policy if the consumer's misrepresentation was careless, whereas if a case were brought to the FOS, it would order payment of a proportionate part of the claim.[14] The gaps between the law, FSA Rules and FOS practice add considerably to the confusion in this area: they increase the risk that insurers will make mistakes.

3.21 We explained in Part 1 that we do not consider the FSA Rules, or the more high level "Principles for Businesses"[15] which may possibly replace these detailed rules, to be an adequate substitute for law reform. What we do think is that they show the need to bring the law more closely into line with good practice and regulatory requirements.

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

[12] Insurance Conduct of Business, Rule 4.3.2.

[13] See para 3.36 below.

[14] See para 3.45 below.

[15] See para 1.31 above.

THE FINANCIAL OMBUDSMAN SERVICE

3.22 Very few consumer insurance disputes are considered by the courts. Instead, most complainants opt to use the service offered by the FOS. The FOS is a statutory body set up under the Financial Services and Markets Act 2000.[16] It replaced eight existing dispute-resolution mechanisms including the Insurance Ombudsman Bureau and the Personal Investment Authority Ombudsman. For each of the last three years, the FOS has received around 1,000 complaints a year relating to issues of non-disclosure and misrepresentation in insurance contracts.[17] These represent only a small proportion of the 14,270 insurance cases received by FOS in 2005-6. However, they raise some particularly difficult and sensitive issues.

3.23 The FOS seeks wherever possible to settle complaints by mediation. Should this prove impracticable, the case will be investigated and a view reached by an adjudicator. If either party remains dissatisfied, an appeal may be made to an ombudsman. An ombudsman has the power to make an award against an insurer of up to £100,000, which becomes binding on the insurer if accepted by the complainant. It may also instruct an insurer to take specified steps, so long as the costs do not exceed the £100,000 limit.

3.24 Compulsory jurisdiction complaints are determined "by reference to what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case".[18] As explained earlier, this means that the FOS is not bound by the strict law. It has effectively developed its own jurisprudence on the issue, which in practical terms is more important than the legal rules.

The FOS approach to issues of non-disclosure and misrepresentation

3.25 The FOS applies SLIP and takes note of SGIP. It also applies the FSA Rules. However, to meet its obligation to reach fair and reasonable decisions, the FOS has found it necessary to go significantly further than these measures.

3.26 The FOS approach to misrepresentation and non-disclosure is explained in a series of case studies and guidance notes in *Ombudsman News*.[19] In 2005 the FOS indicated that in cases where misrepresentation or non-disclosure is alleged, it asks two questions:

(1) When the customer sought insurance, did the insurer ask a clear question about the matter which is now under dispute?

[16] Financial Services and Markets Act 2000, Part 16 and Schedule 17. Rules relating to the FOS can be found in the DISP Sourcebook (FSA Handbook).

[17] The FOS provided figures indicating that between April 2005 and March 2006, it received 1,007 cases classified as non-disclosure, compared to 1,051 in 2004/05 and 967 in 2003/04.

[18] Financial Services and Markets Act 2000, s 228(2).

[19] See, in particular, *Ombudsman News*, Issue 27 (April 2003); Issue 46 (June 2005); and Issue 61 (May 2007).

(2) Did the answer to that clear question induce the insurer; that is, did it influence the insurer's decision to enter into the contract at all, or to do so under terms and conditions that it otherwise would not have accepted?[20]

3.27 Should the answer to either question be "No", the FOS will not support an insurer in avoiding the policy. Since a question is required before a policy can be avoided, this seems effectively to remove the duty to disclose.

3.28 If the answer to both questions is "Yes", the FOS determines the dispute by considering the policyholder's state of mind at the time the misrepresentation was made. The FOS has established four categories:

(1) *Deliberate*: dishonestly providing information that the policyholder knows to be inaccurate or incomplete;

(2) *Reckless*: giving answers without caring whether they are true or false;

(3) *Inadvertent*: behaviour which is "merely careless" rather than reckless;

(4) *Innocent*: where for example the question is unclear or ambiguous, or where the information is not something the consumer could reasonably know.

3.29 Where a misrepresentation is deliberate or reckless, the FOS allows an insurer to avoid the policy and to refuse to pay any claim. Usually, an insurer must refund the premiums. The FOS would only allow an insurer to retain the premiums if the consumer acted fraudulently, which would involve an intention to deceive.[21]

3.30 Where a misrepresentation is innocent, the claim must be met in full and the policy upheld.

3.31 Where the consumer acted inadvertently, 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.

[20] *Ombudsman News*, Issue 46 (June 2005).

[21] See para 4.94 below.

Research project

3.32 When we started our review of insurance contract law we were struck by comments made by Lord Justice Longmore. He suggested that if we were to conduct such a review "the records of the Ombudsman Bureau will be an early port of call".[22] With the kind co-operation of the FOS we therefore reviewed around 200 ombudsman final decisions involving allegations of misrepresentation or non-disclosure. Our findings are set out in full in Appendix C. Our intention was to understand more about the problems caused by non-disclosure and misrepresentation, and the way that the FOS handled these issues in practice. We are extremely grateful to the FOS for the help they gave us with this difficult subject.

3.33 The sample consisted of 190 consumer cases and 12 small business cases. The FOS receives relatively few small business cases. We address the position of small businesses in Part 5 below. Here we only discuss the FOS as it relates to consumers, concentrating on the 190 consumer cases. To preserve the parties' confidentiality, we agreed to publish only anonymised details of the cases. We therefore refer to cases by the numbers we have allocated to them. We have also assigned random initials to refer to the names of the parties.

The problems in practice

3.34 Although issues of misrepresentation can occur across a wide range of policies, questions about health cause particular difficulties: two-thirds of the cases in our study involved an issue about the policyholder's health. Almost half of cases concerned critical illness cover.

3.35 This meant that many complainants were seriously ill: for example, a quarter had cancer, and one in eight had multiple sclerosis. At least 16 had died by the time their cases reached a final decision. This high level of illness and disability clearly affects the ability of policyholders to pursue complaints and makes the problems particularly sensitive. It is especially important that the law in this area is clear and prevents unnecessary disputes.

The need to ask a clear question

3.36 The FOS has effectively abolished the consumer's duty to volunteer information. Ombudsmen will only permit the insurer a remedy if it has asked a question about the issue. In practice, insurers appear to accept this approach. There were only four cases in the survey in which insurers attempted to argue that a policyholder should have volunteered information at the application stage. The following case provides an example of how the FOS expects questions to be asked.

[22] *"An Insurance Contracts Act For A New Century?"*, The Pat Saxton Memorial Lecture organised by the British Insurance Law Association (5 May 2001), para 40.

Case study: no need to volunteer information about threats

The complainant's daughter had split up with her partner, who made various threats against the family. The complainant then decided to take out contents insurance (after five years without it). She was not asked if she had received threats, and she did not mention them. The household was later burgled. The insurer suspected that the ex-partner had been involved and attempted to avoid the policy on the grounds that it should have been told about the threats.

The Ombudsman applied the rules set out above, and decided that as no question had been asked, the insurer could not require the matter to be disclosed. The claim should be paid. (Case 164)

3.37 Insurers were more likely to argue that the policyholder should have volunteered information at renewal. The FOS generally expects an insurer to ask clear questions at renewal as well. An article in *Ombudsman News* points out that asking simply whether anything has changed is unlikely to produce reliable results unless the policyholder is provided with copies of the original information:

> Customers cannot be expected to remember all the details of information they provided perhaps several years earlier. So if firms ask them general questions such as 'has anything changed in the information we asked for in your proposal form?' when they are renewing a policy, the responses are unlikely to be reliable...
>
> If a firm wants policyholders to check and re-confirm all the information they provided originally, then it is good practice for the firm to send them a copy of that information, or to ask all the questions afresh. A firm that does not follow good practice may not be able to use a customer's failure to provide information as a reason to decline a claim.[23]

3.38 We found several examples where ombudsmen found that insurers had not asked sufficiently clear questions on renewal.

[23] *Ombudsman News* (December 2002), Issue 23.

Case study: clear questions should be asked on renewal

A renewal notice for contents insurance stated:

> We would remind you of the importance of informing us of any material changes that may have taken place since the inception of your insurance policy. Should you be in any doubt, please contact us immediately.

The insurer attempted to avoid the policy on the grounds that the policyholder had not mentioned that, since inception, a county court judgment had been registered against him. The ombudsman overturned the insurer's decision. The form had failed to clarify what the insurer needed to know, and few policyholders would realise that a county court judgment was material to the insurer. (Case 20)

Inducement

3.39 The FOS follows the decision in *Pan Atlantic* by requiring the insurer to show that had it known the true state of affairs it would not have entered into the contract on the same terms. In practice, insurers usually send a letter stating that had they known the facts they would have acted differently. Complainants almost never challenged such statements, and ombudsmen were left to exercise their own judgements about whether the insurer had in fact been induced. Usually, the ombudsman accepted the insurer's statement at face value. There were only a few cases in which the issue of inducement was decisive.

Case study: no inducement

In a contents insurance case, the ombudsman found that the policyholders had acted recklessly in not telling the insurer that their son had been convicted of theft. They had not read Page 2 of the renewal notice, which asked for such information.

However, there were particular circumstances surrounding the conviction, and the policyholders had been insured with the insurer for more than 14 years, during which they had an excellent claims record. The ombudsman said the insurer had not discharged their burden of proof to show that they would not have entered into the contract on the same terms. (Case 102)

The complainant's state of mind

3.40 Most cases in our study turned on the complainant's state of mind. The crucial issue was whether the policyholder had acted deliberately or recklessly on the one hand or only inadvertently or innocently. We were interested to see how ombudsmen applied these concepts in practice. As we explain in Part 4, there is some confusion over the meaning of "recklessness". Some statements by the FOS suggest it is part of the common law definition of fraud, and implies dishonesty – giving an answer without caring if it is true or false.[24] However, some statements by the FOS suggest it is a form of negligence.[25]

3.41 It was clear from our survey that ombudsmen are reluctant to accuse consumers of dishonesty. We found no cases in which the insured was said to act fraudulently, and only six in which the misrepresentation was described as deliberate. It was more common for the ombudsman to say that the conduct "was at least reckless" (applied in 31 cases). However, in many cases the ombudsman allowed the insurer to avoid the policy without accusing the consumer of acting either deliberately or recklessly. The study included 59 cases in which ombudsmen upheld the insurer's decision to avoid the policy without classifying the complainant's behaviour into one of the four categories.

3.42 In some cases, ombudsmen put the point negatively, saying they were unable to conclude that the misstatement was innocent or inadvertent. In other cases, the ombudsman merely said the information was inaccurate, without a specific finding on the claimant's state of mind. However, the most used form of words was that the policyholder did not give the questions and answers the care and attention they required:

> Mr X did not give the questions and answers the care and attention they required. (Case 2)
>
> She did not give the questions the careful attention they required and provided misleading information. (Case 71)

[24] See Derry v Peek (1889) LR 14 App Cas 337

[25] In *Ombudsman News* (June 2005), Issue 46, the FOS described both inadvertent and reckless behaviour as forms of negligence. A more recent article in *Ombudsman News* (April/May 2007) Issue 61, clarifies that recklessness denotes a degree of not caring whether a disclosure is true or false. This contrasts with not giving the answer sufficient care and attention.

3.43 These examples look only at the words the ombudsman used to justify the decision – not at the substance. The FOS told us that in recent cases, if the ombudsman had been forced to use one of the four categories, they would have labelled the misrepresentation as at least reckless. The main reason for not using the word "reckless" was to avoid angering or distressing the unsuccessful complainant, especially if they were seriously ill or recently bereaved. The FOS also pointed out that some of the cases in our survey were decided before 2003, when the ombudsman approach was still being refined. Furthermore, there may well be cases in which the insurer would not have accepted the risk had it known the truth, in which case the FOS approach would permit it to avoid the policy for a negligent misrepresentation. However, the words used in these cases give the impression that insurers may be entitled to avoid policies even if the consumer was only negligent, without necessarily considering what the insurer would have done had it known the information.

3.44 The issue of what is or is not reckless is clearly of vital importance in determining misrepresentation disputes. We return to this issue in Part 4.

Inadvertent non-disclosures: applying a proportionate remedy

3.45 It was relatively rare for ombudsmen to classify conduct as inadvertent. There were only 14 cases in the study in which the term was applied (compared with 22 cases where the misrepresentation was considered innocent). This means that proportionate remedies were relatively rare.

3.46 The study found five cases in which the ombudsman decided that had the insurer been aware of the true state of affairs, it would have charged more. The insurer was therefore ordered to pay a proportion of the claim.

Case studies: proportionate remedies

W failed to disclose an eating disorder and depression. The ombudsman said that the question was oddly worded and that W found the issue particularly difficult to talk about. She was later diagnosed with multiple sclerosis. The insurer said that their standard practice where there was evidence of depression was to increase the premium by 50%. On this basis, W received two thirds of the normal claim. (Case 23)

Y had failed to disclose that his father had died of a heart attack. He later developed Parkinson's disease. The ombudsman found that the non-disclosure was "slightly careless… but this does not amount to recklessness". The case was sent back to the insurer, for them to calculate how much they would have charged if they had known about Y's father's heart attack. (Case 138)

3.47 In eight cases, the insurer said that had it known the information, it would have inserted an exclusion. In five cases, the exclusion would not have affected the claim that had arisen, and the insurer was ordered to pay the claim.[26]

Case study: the exclusion did not apply to the claim

In Case 55, the proposal form contained an extremely wide question, which, among other things, asked if the complainant had ever suffered from back pain. She did not mention her back pain following pregnancy five years earlier. She later developed (unrelated) breast cancer. The ombudsman categorised the answer as only slightly careless, and decided that had the insurer known about the backache, they would have simply have excluded back conditions from cover. They were required to reinstate the policy subject to a back exclusion, and to pay the claim for cancer.

3.48 In other cases however, the exclusion would have applied to the claim in question.

Case studies: the exclusion did apply

In Case 96, the complainant failed to mention an upcoming opthalmological referral, in a way that was classified as inadvertent. He later developed a serious eye problem. The ombudsman reinstated the policy, but subject to an exclusion for eye conditions, which meant that his claim would not be paid.

In Case 188, the complainant failed to disclose stress and mild depression and suffered a brain haemorrhage. The ombudsman found that if the insurer had known about the stress it would have withdrawn the waiver of premium benefit. Thus the claim for waiver of premium was rejected. However, the rest of the life policy was reinstated, and the claimant was given £500 for the distress and inconvenience caused by the insurer's maladministration in avoiding the policy.

3.49 Where the insurer would not have written the policy at all, then the whole policy may be avoided, even if the policyholder had been only slightly careless. For example, in Case 109, the claimant wrongly stated that he did not suffer from depression and went on to develop a thyroid disease. The ombudsman decided that the non-disclosure could not be considered innocent. There was no need to consider whether it was reckless or merely inadvertent, as in any event the insurer would not have accepted the risk had it been aware of the facts.

[26] Another example is give in para 1.12 above.

Warranties of fact

3.50 We did not find any cases in which an insurer sought to rely on a basis of the contract clause or warranty of existing fact. There were none in either our sample of non-disclosure cases or in our further sample of cases on policy terms.[27] The FOS has told us that it would follow the Statements of Practice and refuse to allow an insurer to rely on a warranty or basis of the contract clause to avoid a policy for a non-material mis-statement. It seems generally accepted that basis of the contract clauses and specific fact warranties no longer meet industry standards in the consumer market.

Overall success rate

3.51 Across all the consumer cases in our sample, the insurer's original decision was upheld in over half the cases (57%). There was a substantial change in 38%, and a small change in 5%. This is in line with the way that FOS cases are resolved generally.

3.52 Where a decision was overturned, it was often because the insurer had used very wide questions, which can operate as a trap. Our survey included cases where insurers attempted to avoid policies on the grounds that, when asked about "any current condition", policyholders had failed to mention minor matters. These included cold symptoms (Case 75) or a mole (Case 65). There were also frequent arguments because people had forgotten hospital tests carried out many years earlier that turned out to be negative, or did not mention common conditions that were no longer a problem. We hope that if the rules were clearer, insurers would be less likely to take minor points, and would write clearer questions about what they really want to know.

Conclusion

3.53 From the work we have conducted we have no doubt that the FOS currently provides consumers with their best chance of achieving a fair result in cases where misrepresentation or non-disclosure is alleged. Its obligation to reach a decision that is "fair and reasonable in all the circumstances" enables it to set aside the strict law and to explore other solutions.

3.54 The FOS addresses the harshness of the law in three important ways:

(1) The FOS treats consumers as if there is no residual duty of disclosure. Neither the Statements of Practice nor the FSA Rules have this effect.

(2) The FOS does not offer an insurer any remedy in cases of innocent misrepresentation. It appears to take this line regardless of whether there has been a claim or not - whereas corresponding provisions in the SGIP and FSA Rules only apply where a claim has been made.

[27] See para 4.220 below.

(3) The FOS will order an insurer to settle claims on a proportionate basis where there has been "inadvertent" misrepresentation and the insurer, had it been aware of the truth, would simply have accepted the application at an increased premium. In contrast, both the Statements of Practice and the FSA Rules allow avoidance for negligent misrepresentation.

The FOS approach has had a significant influence on our thinking.

3.55 The question is whether the FOS scheme, supported as it is by the FSA Rules, is sufficient, or whether the underlying law of consumer insurance needs reform. We are satisfied that the FOS is not an alternative to law reform, for the reasons we discuss below.[28]

The FOS: advantages and disadvantages

A scheme with many advantages to consumers

3.56 From a complainant's perspective, the FOS offers many advantages over the alternative of court action:

(1) Compulsory jurisdiction complaints are determined by reference to what is "fair and reasonable in all the circumstances of the case". This leads to a much more consumer-friendly approach than the strict letter of the law.

(2) The service is free to complainants.

(3) The FOS can provide remedies not available through the courts. For example, it may instruct an insurer to reinstate a policy, or to rewrite it on different terms.

(4) An application to the FOS is a "no lose" option for complainants. If a complainant accepts the ombudsman's decision it becomes binding on both insurer and complainant. However, the complainant is free to reject the decision and pursue the matter through the courts.

(5) The FOS processes are intended to be relatively rapid.

(6) The FOS has an inquisitorial process. Once a case is accepted for investigation, the FOS will carry out its own investigations rather than merely relying on the arguments presented by the parties.

(7) The FOS has introduced several initiatives to make its service more accessible to complainants. It maintains an informative website and a range of publications. In 2006 it was capable of conducting "correspondence in Arabic, phone calls in Tagalog and emails in Urdu".[29]

(8) The processes are intended to be informal and friendly. There is no need for a complainant to be represented.

[28] See Para 3.58 below.

[29] Financial Ombudsman Service, *Annual Review 1 April 2005 to 31 March 2006*, p 49.

(9) The FOS has more experience than the courts in dealing with the types of insurance dispute within its jurisdiction. Importantly, it may also be more aware of current issues within the insurance industry, and have a better understanding of the problems typically faced by complainants.

(10) The FOS is not bound by the rules that would apply in court proceedings. It may exclude evidence that would be admitted in court, and admit evidence that would be excluded.

3.57 The FOS scheme, like the FSA Rules, is an important contribution to ensuring that insurers treat consumers in the way a reasonable insured would legitimately expect. Furthermore the scheme provides valuable remedies when that has not happened. However, we do not consider that the FOS and the FSA Rules, separately or together, are a satisfactory alternative to law reform for consumers. We have two main groups of concerns. The first group is about substance: does the FOS in fact protect consumers fully, or is it necessary to change the law? The second group relates to state of "the law as a whole".

The FOS cannot in practice protect all consumers

3.58 Our research, and concerns expressed to us by the industry itself, suggest that there are some insurers who are still refusing to pay claims and avoiding policies when that is not consistent with the Statements of Practice or would not be permitted by the FOS. Given the difficulties of understanding the complex mesh of the Statements, FSA Rules and the FOS guidance, it is not surprising that our survey found cases where the insurer appeared to be basing its decision on strict law rather than ombudsman guidance. The existence of the FOS scheme does not prevent problems arising.

3.59 If consumers go to the FOS, their case will be dealt with in a way that is fair. However, the FOS cannot handle all consumer cases.

(1) The amount of the dispute may exceed £100,000. Recommendations can be made for any sum in excess of £100,000, but the recommendation is not binding on the insurer for the amount in excess of £100,000. In relation to life insurance or building insurance, £100,000 is quite a low limit.[30]

(2) 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".[31] The FOS told us that the rule has a significant impact:

[30] Our survey included four cases where the parties had agreed to ask the ombudsman to make a non-binding recommendation (with the largest claim valued at around £250,000). Insurers cannot prevent the FOS from considering claims that amount to over £100,000. However they can decline to pay amounts in excess of £100,000. We are told by the FOS that most insurers do pay both the £100,000 award and the amount that the FOS recommends above that level, although some do not.

[31] DISP Sourcebook at para 3.3.1(10) (FSA Handbook).

> One of the principal reasons that we decline to look at a case is that we regard it as more suitable for a decision in the courts. This is frequently the case where the assessment of the evidence requires cross-examination of third parties. This creates a whole category of cases to which our process is unsuited.
>
> In declining to consider such cases, due perhaps to their reliance on the evidence of a third party (which may include a broker or intermediary or the departed salesman or representative of a firm), we must accept that, in relation to non-disclosure, the effect of a referral to the courts is that the case will be decided upon an entirely different basis.
>
> 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.

3.60 If the FOS will not deal with the case, then the consumer must go to court. The court will apply the strict letter of the law, unless the consumer goes to the difficulty and expense of showing that the insurer was in breach of the FSA Rules and makes a claim for breach of statutory duty. Even that may be less satisfactory than a claim under FOS, since the FSA Rules are less demanding of the insurer.

3.61 Further many consumers who think their claim has been unfairly rejected do not make a complaint to the FOS.[32] Consumers should know that the FOS exists because policy summaries must refer to it.[33] However, they do not know how the FOS will approach their case. Consumers may be told what their legal rights are and decide there is nothing they can do. They are unlikely to realise that the FOS will apply very different and much more favourable rules.

3.62 So our first concern is that claims are still being dealt with under the strict law and by no means all cases will get to the FOS. There are consumer insureds whose claims are not being paid when generally accepted good practice and the FOS guidance suggest that they should be.

[32] For example, in 2004, the Legal Services Commission 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). Furthermore, figures produced by the FOS suggest that some socio-economic groups are much less likely to use their service. For example, FOS complainants are more likely to read the *Daily Mail*, *Times* or *Telegraph* than to read the *Sun:* see Financial Ombudsman Service, *Annual Review 1 April 2005 to 31 March 2006*, pp 43-48.

[33] Insurance Conduct of Business, Rule 5.5 requires the summary to state "(11) how to complain to the insurance undertaking and that complaints may subsequently be referred to the Financial Ombudsman Service or any other applicable named complaints scheme."

3.63 There might of course be some worthy claims that would not be paid even if the law were brought into line with the FOS guidance. On occasions, insurers' employees may misunderstand the law or simply make wrong decisions. The problem must be much worse, however, when the law says one thing and the rules of practice another. The employee may believe that they are doing the right thing in applying the letter of the law.

Denial of a remedy in court

3.64 We think that the FOS provides an extremely valuable service but we do not think that it should be the only way in which consumers can secure justice. We believe it is unacceptable that a consumer should have to use the FOS rather than go to court in order to avoid unfair and archaic legal rules. Whilst we accept that most consumer cases will be resolved through the FOS, consumers should also obtain a just result if they choose to go to court. For example, the case may already have been the subject of a ruling by the FOS but the consumer may feel that the FOS has not reached the correct result.

Clarity and accessibility

3.65 Turning now to the state of "the law as a whole", we have equally serious concerns. The first is simply that the present position is inaccessible and incoherent. There is a growing gulf between unsatisfactory law on the one hand and the patchwork of Statements of Practice, FSA Rules and guidance from the FOS on the other. In some cases, the different elements of this patchwork may each give different and conflicting results to a question.

3.66 Take, for example, a basic issue: is an insurer required to ask an applicant for insurance any questions?

(1) Under the law, an insurer is not obliged to ask the applicant any questions. It can simply rely on the applicant's duty of disclosure.

(2) The Statements of Practice require the insurer to ask questions about matters "generally found to be material". However, no sanction is provided if this requirement is breached.

(3) Neither ICOB 7.36 nor COB 8A.2.6 requires questions to be asked.

(4) The FOS expects insurers to ask questions. It will not allow an insurer to avoid a policy for non-disclosure as opposed to misrepresentation.

3.67 The confusion surrounding this area is illustrated by the fact that both the SLIP and the ICOB Rules require consumers to be warned about a duty to disclose material facts, which the FOS does not recognise.

3.68 Understanding the FOS approach is crucial. It is difficult to do this without reading ombudsmen decisions, but these are private documents, sent only to the parties in the case. Large insurers may accumulate a databank of decisions made in their own cases but smaller insurers do not have access to them. The only public source of information about what the FOS does is found in its monthly publication, *Ombudsman News*. Although this can be helpful, it was only as we started to read and analyse the cases that we gained any real insight into how the principles worked in practice.

3.69 The existence of conflicting sources of law and practice, coupled with private decisions, makes it unnecessarily difficult for insurers and policyholders to establish their respective rights. The multiple layers of regulation, and to some extent the lack of precision in the rules of each layer, cause serious and quite unnecessary confusion. We believe that the situation has reached a stage where it can be resolved only by law reform.

Hindering development of the law

3.70 The FOS points out that there is a further problem in that its existence may have stunted the development of the law:

> We are concerned that the development of the common law has been impeded by our activities and by the very limited chance of success that any consumer may have in pursuing a non-disclosure case or misrepresentation issue in the courts.

It is not possible to prove this hypothesis one way or the other. However, we think it may well be correct to some extent. For example, we suspect that were there no Statements of Practice, FSA Rules or FOS, the courts might well have fashioned a remedy from the insurer's duty of good faith in section 17 of the Marine Insurance Act 1906 to prevent insurers from behaving unreasonably.[34]

The effective law is discretionary

3.71 We believe that it is undesirable that the FOS is routinely obliged to replace the most fundamental principles of insurance contract law with its own approach. Discretion is a valuable supplement to legal rules, but it is a poor substitute for them, for two reasons.

(1) The FOS may develop its approach without public debate or wide consultation.

(2) As the FOS is able to change its approach at will, there is a continuing degree of uncertainty.

[34] Though the section states that the remedy is avoidance, the duty of good faith is stated in broad terms and we think the courts might have developed a defensive, estoppel-like remedy to prevent an insurer taking advantage of the results of its own lack of good faith.

The risk of legal challenge

3.72 We have also been told of concerns, even among the ombudsmen themselves, that the gap between the approach being applied by the FOS and the underlying law is becoming so wide that they fear a legal challenge. Whether or not that is realistic, it would be unfortunate if the FOS or individual ombudsmen feel restricted in how far they can make insurers adhere to good practice and to depart from the strict law because of the threat of legal challenge.

THE CASE FOR LAW REFORM

3.73 The current position on pre-contractual information from the insured is a strong example of why reform is needed. We say this for five reasons.

(1) The law is out of line with what, for at least the last 20 years, the industry has recognised as good practice.

(2) It is also quite different to what is required of insurers by the FSA Rules, and with the standards of "fairness and reasonableness" that the FOS will expect the insurer to meet.

(3) Neither the FSA Rules nor the FOS scheme can offer adequate protection to all individual consumers. The FSA Rules are aimed at regulating behaviour, not at the individual rights of the consumer. Breach of the FSA Rules may give a consumer an action for breach of statutory duty but that is a cumbersome and expensive remedy.

(4) Much more effective remedies are available through the FOS but there are serious gaps in the types of claim the FOS can handle.

(5) The practical legal position – taking into account the different layers of law, rules and discretion – is needlessly complex, confusing and inaccessible, both to insured and insurer.

3.74 **We provisionally conclude that there should be a clear statutory statement of the obligations on consumers to give pre-contract information and the remedies available to insurers if they fail.**

PART 4
PRE-CONTRACT INFORMATION AND CONSUMERS: PROPOSALS FOR REFORM

INTRODUCTION

4.1 In Part 1 we set out the general criteria by which we think insurance law should be judged. Applying those criteria, we think the law on pre-contractual information from the insured requires reform.

4.2 There is a strong case for reforming the basic provisions of insurance contract law dealing with consumers' duty to provide pre-contract information. In our view, a new statute should:

(1) abolish consumers' duty to volunteer information;

(2) require consumers to be both honest and to take reasonable care to give accurate and complete answers to the questions they are asked;

(3) protect those who acted reasonably; and

(4) provide insurers with a remedy appropriate to the consumer's behaviour. The remedy should act as a strong disincentive to deliberate or reckless misrepresentations, and provide a fair solution for negligent ones.

4.3 Under our proposals, the remedy will depend on the nature of the policyholder's fault. A consumer may be found to have given incorrect or incomplete information:

(1) DELIBERATELY OR RECKLESSLY. In our view this involves a lack of honesty and openness, though it is not necessarily criminal. Such behaviour would give the insurer who entered a policy on the basis of an incorrect or incomplete statement the right to avoid the policy and to retain the premiums. This may over-compensate the insurer for their loss, but such over-compensation is justified to deter dishonesty. It is important to define carefully what we mean by "deliberate or reckless", and we discuss these terms in some detail.

(2) NEGLIGENTLY. Here the outcome should depend on what the insurer would have done had it been aware of the full facts. The remedy will attempt, as far as possible, to put the insurer in that position. We have termed this a "compensatory" or "proportionate" remedy. The insurer will only be able to avoid if it can show that it would not have entered into the contract at all. If the insurer would have added an exception, the outcome will depend on whether the claim would have fallen within the exception. If the insurer would have charged a higher premium, it must pay a proportion of the claim.

(3) BOTH HONESTLY AND CAREFULLY (OR "INNOCENTLY"). Here the insurer must pay the claim. This will usually occur where an insurer has failed to ask clear questions or present them in an understandable way. Our proposals give insurers an incentive to improve the way they ask questions.

4.4 Below we set out our proposals on these and other issues. The structure of this chapter is as follows:

(1) We define what we mean by consumer insurance (paras 4.5 to 4.12).

(2) We propose to abolish the consumer's duty to volunteer information (paras 4.13 to 4.32).

(3) It would be replaced with a duty to answer the insurer's questions honestly and carefully (paras 4.33 to 4.38). To gain a remedy, the insurer would need to show that the consumer had made a misrepresentation that induced it to enter the contract. We discuss this under the heading "basic requirements: misrepresentation and inducement" (paras 4.39 to 4.49).

(4) We then look at the types of misrepresentation and the remedies we propose for each. We start with "deliberate and reckless" misrepresentations (that is, those that were not honest) (paras 4.50 to 4.99).

(5) We then look at "innocent" misrepresentations, and discuss protections for those who have acted honestly and reasonably (paras 4.100 to 4.129). We consider the particular problems that arise when the policyholder thinks the insurer will obtain the information and propose to deal with them as part of the reasonableness test (paras 4.130 to 4.144). We also outline our reasons for not recognising a continuing duty of disclosure (paras 4.145 to 4.152).

(6) The next section considers negligent misrepresentations. We do not need to define this category, as it will include everything that was neither "deliberate or reckless" on the one hand, nor "reasonable" on the other hand. For negligent misrepresentations, the insurer will be given a compensatory remedy (paras 4.153 to 4.189).

(7) We ask whether, in consumer life insurance, the insurer should be prevented from relying on a negligent misrepresentation after the policy has been in force for five years (paras 4.190 to 4.204).

(8) We look at whether it is necessary to make special provisions for renewals (paras 4.205 to 4.217).

(9) We propose that these rules should be mandatory in the sense that any attempt to vary them by contract would be effective only if the change was to the benefit of the consumer (paras 4.214 to 4.218).

(10) Finally, we propose that both "basis of the contract" clauses and specific warranties of fact should be ineffective in consumer contracts. Insurers should not be able to use such warranties to give themselves greater rights than they would have were the statement to be treated as a misrepresentation (paras 4.219 to 4.229).

DEFINING CONSUMERS

4.5 As we explain in Part 1, the concept of a "consumer" is intended to mirror the Financial Services Authority (FSA) definition of a "retail customer": that is an individual acting for purposes which are outside his trade, business or profession.[1]

4.6 The FSA definition is taken from the Directive on Distance Marketing of Consumer Financial Services, which refers to "any natural person who is acting for purposes which are outside his trade, business or profession".[2] This is identical to the definition used in the Unfair Terms Directive,[3] which we considered at length in our joint report on Unfair Terms in Contracts.[4]

4.7 The definition is in two parts. The insured must be a natural person: that is, they must be an individual rather than a company or organisation. Secondly, the insured must not be acting for business purposes. In our report on Unfair Terms, we point out that an individual may enter into a contract partly for business purposes and partly for private purposes.[5] In an insurance context, this would arise where a self-employed contractor insures a car partly for business and partly for leisure, or takes out household contents insurance on premises that include a home-office. In these circumstances, we thought that the court should determine the main or predominant purpose of the contract.

4.8 We propose that the same approach should apply here. Thus a self-employed driver who uses a car mainly as a taxi, with only the occasional private trip, would be considered to be insuring it for business purposes. However, an individual who insures their home for £30,000, including a small office containing £3,000 of business equipment, would be a consumer.

4.9 Where an individual takes out insurance to protect their own income in the event of illness or disability, this would be considered to be a consumer contract, irrespective of 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. Equally, an individual acts as a consumer when insuring their spouse's life, but for business purposes when insuring a business partner's life. Of course, there may be marginal cases, as where one's spouse is also one's business partner. Then it would be up to the court or ombudsman to decide whether the main purpose of the insurance was to protect the business or to protect the policyholder in a private capacity.

1 As found in the FSA handbook glossary.

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

3 Directive 93/13/EEC on Unfair Terms in Consumer Contracts, Art 2(b).

4 Law Commission and Scottish Law Commission, Unfair Terms in Contracts (2005) Law Com 292 and Scot Law Com 199, paras 3.20 to 3.38.

4.10 Some consultees have asked how our regime would apply to privately-owned high-value yachts and aircraft. We understand that these are usually owned by special purpose vehicles, so the insured would not be a "natural person" and would not fall within our definition of a consumer. However, we would welcome views as to whether there is a need to exempt particularly high-value items from the consumer regime if they are owned by individuals.

4.11 **We provisionally propose that the consumer regime should apply where an individual enters into a contract of insurance wholly or mainly for purposes unrelated to his business.**

4.12 **We ask whether there is a need to exempt insurance of specific high-value items (such as jets and yachts) from the consumer regime.**

ABOLISHING THE DUTY TO VOLUNTEER INFORMATION

Is a duty to disclose needed?

4.13 It is now generally accepted as good practice that in consumer insurance, an insurer should ask questions about any material facts it wishes to know. This was set out clearly in the Statements of Insurance Practice issued by the Association of British Insurers (ABI). For long-term insurance

> Those matters which insurers have commonly found to be material should be the subject of clear questions in proposal forms.[6]

For general consumer insurance, the provision is similar:

> Those matters which insurers have found generally to be material will be the subject of clear questions in proposal forms.[7]

We saw earlier that the Financial Ombudsman Service (FOS) refuses to allow an insurer to avoid a policy for a non-disclosure where no question was asked. In considering a consumer non-disclosure case, the ombudsman will start by asking whether the insurer has provided evidence that it asked a question to which it received an inaccurate response.

4.14 Our view is that we should bring the law into line with industry practice and ombudsman guidance by requiring insurers to ask clear questions about any matter that is material to them. We would abolish consumers' residual duty of disclosure. The insurer would thus have a remedy only if there had been a misrepresentation.

4.15 In 1980, the Law Commission argued against abolishing consumers' duty in this way. It gave three main reasons:

[5] Above at paras 3.35 to 3.38.

[6] Association of British Insurers, Long Term Insurance: Statement of Normal Practice, 1(c).

[7] Association of British Insurers, Statement of General Insurance Practice.

(1) Abolition would enable "sharp practice" by consumers. For example, a consumer should not apply for house insurance without disclosing that they had received a threat to burn their house down.

(2) Without a duty of disclosure, it would be difficult to grant temporary cover before a proposal form was completed.

(3) The division between consumers and businesses is artificial; the dividing line should really be between professionals and non-professionals. Special rules for consumers would lead to complex law.[8]

It recommended retention of the duty but that the insurer should have to warn the proposer of it.

4.16 However, the insurance market has changed considerably since 1980. It is now common for insurance to be sold over the telephone or by the internet in a way that requires policyholders to answer set questions, in some cases with little opportunity or incentive to disclose additional facts. This point was put to us by the FOS:

> In many sales processes that are conducted over the phone or the internet it is very difficult for a policyholder to disclose additional facts even if they are minded so to do. It would seem inequitable to require the consumer to override the sales process set in place by the insurer in order to fulfil their legal obligations even if they are reminded of them.

4.17 Even outside telephone and internet sales, the FOS takes the approach that consumers do not need to volunteer information. As we explained in Part 3, we found a case very similar to the one noted in the 1980 report. The complainant applied for contents insurance without mentioning that her daughter's ex-partner had made threats against the family. The ombudsman decided that as no question had been asked, the insurer could not require the matter to be disclosed. The claim should be paid.

[8] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, pp 43-5.

4.18 The FOS's requirement that the insurer should not rely on a consumer proposer to volunteer information is similar to the law in all the continental jurisdictions that we have looked at. For example the French *Code des Assurances*,[9] the Norwegian Act relating to Insurance Contracts of 1989[10] and the Swedish Insurance Contracts Act of 2005[11] all state that the proposer need provide information only if requested to do so by the insurer. The same is true of the bill to reform insurance contracts law currently being considered by the German parliament,[12] and we understand it also to be the approach taken by the European Restatement Group.[13] New York law has removed the duty of disclosure except for marine insurance and reinsurance. In Australia the proposer remains under a duty to disclose what a reasonable person would think was relevant to the insurer,[14] but only if the insurer has clearly informed the insured in writing of the general nature and effect of the duty of disclosure.[15] Further, for most consumer contracts the duty is confined to matters that could not reasonably have been made the object of a specific question and applies only if the insurer expressly requests disclosure of exceptional circumstances.[16]

4.19 One difference should be noted. Many of the continental Acts do provide that the proposer does have a duty to disclose, without being asked, facts that they actually know would be decisive or relevant[17] to the insurer.[18] For example, the Norwegian legislation provides that:

[9] Code des Assurances, Art L 113-2-2. A general duty of disclosure in insurance was abolished by Loi No 89-1014 of 31st December 1989.

[10] Insurance Contracts 1989, s 4-1.

[11] Swedish Insurance Contracts Act 2005, Chapter 4 s 1.

[12] Draft of December 2006, s 19(1). See http://www.gdv.de/Hauptframe/index.jsp?oidl1=11338&oidl2=13346&oidl3=13348&contentUrl=/Themen/Recht_und_Gesetz/Hintergrundinformationen/inhaltsseite230.html (last visited 18 June 2007). An earlier draft of March 2006 is discussed by G Rühl, "*The Single European Market for Insurance*" [2006] 55 ICLQ 879.

[13] See above, para 1.84. The Group presented some draft proposals at a seminar organised by BILA on 25 May 2007. We are most grateful to Professor Helmut Heiss for providing us with further information.

[14] Insurance Contracts Act 1984, s 21(1)(b) [or what the proposer knows to be relevant, s 21(1)(a)]. For further discussion, see R Merkin, *Reforming Insurance Law: Is there a Case for Reverse Transportation? The Australian Experience of Insurance Law Reform*, available from our website on http://www.lawcom.gov.uk/docs/merkin_report.pdf.

[15] Insurance Contracts Act 1984, s 22; the insurer who has failed to do this may not exercise a right in respect of a failure to comply with the duty unless the failure was fraudulent: s 22(3). The form of the notice is now specified in regulations.

[16] See para 4.25 below.

[17] The systems seem to vary as to this requirement.

[18] New York law also renders the contract void in cases of "fraudulent concealment", but traditionally only in the cases of life or fire insurance. There are dicta suggesting that the fraudulent concealment rule may now be of general application: *The Home Insurance Company of Illinois (New Hampshire) v Spectrum Information Technologies, Inc* 930 F Supp 825 (1996 US Dist Ct) (LEXIS 12849), para A.5.

> The policyholder shall also upon his or her own initiative give details of specific circumstances which he or she must understand to be of material significance to the Insurers in their evaluation of the risk.[19]

The French system reaches similar results by making special provisions for fraudulent concealment or *réticence*.[20] The German proposals reach the same result by application of the general contract law, which gives the right to avoid for fraudulent non-disclosure,[21] and we gather that this would be the result also under the European Restatement Group's draft.[22] It is noticeable, however, that the systems that do this are all ones in which the duty of disclosure is otherwise abolished for business as well as consumer contracts. The only Act we have found that deals separately with consumer contracts, the Swedish Act of 2005, has no such rule. Like the FOS, in consumer cases the Swedish law requires the insurer to ask questions.

4.20 Our view is that in consumer cases the range of factors relevant to the insurer's decision is sufficiently well-known and predictable that the insurer can be expected to ask specific questions about the vast majority of them. Any unusual circumstance can be made the subject of a general "sweeper" question, which should bring home to the proposer the need to tell the insurer about the unusual fact just as well as a warning of a duty to disclose. We conclude that in consumer cases the duty to disclose is no longer needed. We think the law should now be brought into line with the FOS guidelines. Given existing practice, we believe this proposal will be uncontroversial. It has the following advantages:

(1) It would focus the attention of insurers on what they needed to know at the application stage;

(2) It nevertheless leaves insurers free to ask whatever questions they wish, or indeed to choose to ask no questions at all;

(3) It gives applicants for insurance a clear indication of the information that is required from them;

(4) It simplifies the overall legal position by bringing substantive law into line with accepted good practice and the FOS guidelines.

[19] Insurance Contracts 1989, ss 4-1.

[20] *Code des Assurances,* Art L 113-8.

[21] The right to avoid for fraudulent non-disclosure was stated explicitly in § 21(5) of the version of March 2006. There is no equivalent in the draft of December 2006 but it is thought that this is because it is unnecessary: the same result follows from the general rules of contract law, which remain applicable by virtue of § 22.

[22] See para 1.84 above. The draft incorporates the so-called Principles of European Contract law (see O Lando and H Beale (eds) *Principles of European Contract Law (Parts I and II)* (Kluwer, 2000); O. Lando, E. Clive, A. Prüm and R. Zimmermann (eds) *Principles of European Contract Law, Part III* (Kluwer 2003). Article 4:107 of the Principles provides a right to avoid a contract that was entered after "fraudulent non-disclosure of any information which in accordance with good faith and fair dealing ought to have been disclosed."

General questions

4.21 As we have seen, proposal forms may include some extremely wide questions. This example, from the FOS study, asks the proposer if they had ever been ill:

> Have you any physical defect or infirmity or is there any ailment or disease from which you suffer or have suffered or to which you have a tendency?

4.22 Insurers may react to the abolition of the duty of disclosure by asking even wider questions, along the lines of "is there anything we might wish to know about?". We therefore need to consider whether such questions should be allowed and, if so, how they should be interpreted.

4.23 General questions may serve a useful function, particularly if there is no general duty on consumers to disclose facts that an insurer may never think of asking about – such as the threat to burn down the house. The general question avoids at least the first criticism of the duty to disclose made by the 1980 report, that the consumer may not realise they have such a duty. It warns the consumer that they should mention issues that increase the risk. The problem with such questions, however, is that the consumer may be left in doubt as to what is wanted.

4.24 We think there is a practical distinction between very general questions that stand alone, and those which follow a series of specific questions and clearly direct the proposer's mind to unusual circumstances that the insurer might not know about. The former are much less likely to elicit useful information about unusual factors than are the latter.

4.25 There are different ways of dealing with general questions. One way is the Australian approach for consumer insurance, by which insurers may only ask general questions if they have first asked specific questions, and then only about matters that the insurer could not reasonably be expected to make the subject of a specific question.[23] If the insurer asks a general question when it should have asked a specific question, it is taken to have waived the duty of disclosure in respect of those matters. Effectively, the court will strike out the question and disregard the answer.

[23] Insurance Contracts Act 1984, s 21A(4).

4.26 The second approach would be to permit general questions but for the court to ask whether a reasonable consumer would understand that this question was asking about this particular information. This is the French approach. Article L 112-3 para 2 effectively codifies the position reached through case law.[24] It provides that if an insurer asks a question expressed in "general terms", it cannot complain when it receives a vague response.[25] Its effect is to discourage insurers from asking vague, open-ended questions as it could leave them without recourse when a misrepresentation is made.

4.27 The FOS also appears to take the second approach. As we have seen, it requires insurers to ask clear questions, but it does not judge the clarity of the question in isolation. Ombudsmen ask whether a reasonable proposer should have realised that the question was asking about the particular information at issue.

4.28 If we take the health question above, most consumers would realise that they should mention a recent diagnosis of cancer but it is unclear whether they are expected to mention an operation for an in-growing toenail 5 years ago. The first approach would ask whether the insurer should have made its health questions specific. If so, the general question would be struck out altogether, with the result that consumers would no longer be required to mention any health issues (including the cancer). The second would absolve a consumer of the requirement to mention the toenail (on the grounds that the insurer did not make this sufficiently clear) but would still require the cancer to be declared.

4.29 Striking out unduly wide questions would concentrate insurers' minds on the need to ask for information in a clear, sensible way, but it could lead to surprising decisions in some circumstances. The second approach would do justice in the individual case.

4.30 On balance, we propose the second approach. In response to a general question, the proposer would be required to provide such information as a reasonable person in the circumstances would provide, bearing in mind the way the question was presented, the nature and extent of the insurance cover and the circumstances in which it was sought. This is an objective test, which we discuss more fully below. It gives an insurer an incentive to make its questions clear: the wider and vaguer the question, the more it would be reasonable for the policyholder to fail to mention something.

Provisional proposals: the duty of disclosure

4.31 **We provisionally propose that there should be no duty on the consumer proposer to disclose matters about which no questions were asked.**

[24] Lambert-Faivre, *Droit des Assurances* (11th edition), p 245 at para 316.

[25] Lorsque, avant la conclusion du contrat, l'assureur a posé des questions par écrit à l'assuré … il ne peut se prévaloir du fait qu'une question exprimée en termes généraux n'a reçu qu'une réponse imprécise. [When, before the conclusion of the contract, the insurer has asked the insured written questions it cannot take advantage of the fact that a question expressed in general terms has only received a vague answer.]

4.32 **We provisionally propose that where the insurer asks a general question, the insurer should have no remedy in respect of an incomplete answer unless a reasonable consumer would understand that the question was asking about the particular information at issue.**

THE DUTY TO ANSWER QUESTIONS HONESTLY AND CAREFULLY

4.33 In Part 1 we suggested that consumers who act honestly and reasonably should be protected. The other side of the coin is that policyholders should have a duty to answer questions honestly and to take reasonable care that their replies are accurate and complete. Equally, if the consumer provides the insurer with information that was not asked for, they must do so honestly and carefully. Where a consumer's answer or statement was not honest, because it involved a deliberate or reckless misrepresentation, the law should provide a remedy that not only compensates the insurer fully but also provides an element of penalty against the dishonest consumer. Where the consumer was honest but not sufficiently careful, the law should aim to compensate the insurer. But consumers who act both honestly and reasonably should be protected. They should receive what they think they have paid for, and their claims should be paid in full.

4.34 In the sections that follow, we discuss an insurer's rights when a consumer has made a misrepresentation. We start by setting out two basic aspects of the test. As under current law, before an insurer may avoid the policy or resist paying a claim, it must show that:

(1) the consumer made a misrepresentation

(2) which induced the insurer to enter into the contract.

We discuss each element in turn.

4.35 We then consider how to categorise the conduct of the insured. We start by describing what we have termed "deliberate or reckless" misrepresentations, which do not show a sufficient degree of honesty. We deal with this issue in some detail, as many respondents to our first Issues Paper expressed concern about it. We seek to allay fears that insurers would need to prove "fraud" to a criminal or near-criminal standard.

4.36 We then look at what amounts to "acting reasonably". An insured may act reasonably either because they did not know the information required, or because they did not realise that the question was asking for that particular information. Our survey of ombudsman cases showed that many innocent mistakes occurred because consumers simply did not understand what the questions were asking for: consumers often failed to realise that a question about hospital treatment was asking them to disclose negative tests, or that a general question about health sought information about minor issues. We explain that where a reasonable insured would not understand that a question required the information to be given, the policyholder will be protected.

4.37 A policyholder who is honest but who did not take the degree of care and attention required in the circumstances is negligent. For negligent misrepresentations, the aim of the law should be to put the insurer back into the position it would have been in had it known the true position. We have termed this "a compensatory remedy" and we explain how it will work in practice.

4.38 Under the current law an insurer may avoid for misrepresentation only if the misrepresentation was material, in the sense that it would influence the judgement of a prudent insurer.[26] We do not think that it is necessary to retain this test. As we explain below, in effect it will be superseded, since what will normally matter will be whether in the circumstances the insured who did not give the correct information was nonetheless acting reasonably. Effectively we are replacing a test based on what is relevant to a hypothetical prudent underwriter with a test based on what a reasonable insured in the circumstances should have realised was relevant to this particular insurer.

BASIC REQUIREMENTS: MISREPRESENTATION AND INDUCEMENT

4.39 To found a claim for misrepresentation, an insurer will need to show that the policyholder made a misrepresentation, which induced it to enter a contract on the terms it did.

Misrepresentation

4.40 A misrepresentation will typically consist of an inaccurate answer to a question the insurer has asked. As discussed above, consumers will not be required to volunteer information in the absence of questions. However, if a consumer does make a voluntary statement, this statement must also be made honestly and carefully. A misrepresentation is any inaccurate statement made by the prospective policyholder before a contract is entered into.

4.41 The common law also requires a party who has made a statement which at the time was correct, but which ceases to be correct before the contract has been entered, to inform the other party. If they do not, this is treated as a misrepresentation.[27]

4.42 It is worth emphasising that an answer may amount to a misrepresentation although what is stated is literally accurate, if the answer is misleading because it is incomplete. Suppose the proposer is asked whether they have ever suffered from particular illnesses. If the proposer mentions some illnesses but not others, or mentions that they have suffered from them at specified dates in the past but fails to mention that they are currently under investigation for a suspected recurrence, there is a misrepresentation.

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

[27] See paras 4.145 to 4.152 below.

4.43 We would also point out that a simple failure to answer a question may also amount to a misrepresentation. There are two ways of not answering a question. In some cases, failure to answer a question may appear to a reasonable person to be an answer in itself. For example, in *Roberts v Avon Insurance Company Limited*[28] the applicant was asked to complete the following declaration which contained a blank space:

> I have suffered no similar loss, except...

It was held that a failure to fill in the blank space was in itself a definitive answer that there had been no similar losses. In our view, insurers should have a remedy for implied answers of this type.

4.44 In other cases, however, it will be clear that no answer has been given. When the insurer reads the form, it should be aware that the question has been missed. Here we think the onus should be on the insurer either to decline the application or to follow up the issue with the insured. This is the view taken in Australia. The 1984 Act precludes an insurer from raising an allegation of non-disclosure or misrepresentation when a question in a proposal form has not been answered or has an obviously incomplete answer.[29]

Inducement

4.45 Where the consumer has made a misrepresentation, the next stage is for the insurer to show that had it known the true facts it would not have entered into the contract on the same terms. This is no different to the current law's requirement that the insurer prove inducement, under the second limb of the test in *Pan Atlantic*.[30]

4.46 Suppose the proposer omits to mention a medical test they have undergone. The insurer has been induced if, had it known the true position, it would have charged more or added an exception. The situation is different if the insurer would have ordered a medical examination, but that examination would have given the proposer a clean bill of health and the insurer would ultimately have accepted the proposal on same terms. In that case, there is no inducement.

Conclusions: misrepresentation, inducement and materiality

4.47 We think that it is worth considering whether the rules on misrepresentation and inducement should be stated expressly in any new Insurance Act. We think that it would serve to clarify the position and, most importantly, to bring home to proposers and their advisers the full extent of the obligation to answer questions honestly and carefully. We would welcome views on this question.

4.48 **We provisionally propose that the insurer will not have a remedy for misrepresentation unless the consumer made a misrepresentation which induced the insurer to enter the contract.**

[28] [1956] 2 Lloyd's Rep 240.

[29] Insurance Contract Law Act 1984, s 21(3).

[30] *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] AC 501.

4.49 **We ask whether the rules on what constitutes a misrepresentation and on inducement should be stated expressly in any new Insurance Contracts Act.**

DELIBERATE AND RECKLESS MISREPRESENTATIONS: ACTING WITHOUT HONESTY

4.50 Where an insured has induced the contract by a misrepresentation that was not honest, it is right that a penalty should be imposed, even if it results in over-compensating the insurer for the loss they have suffered. As Lord Steyn stated in *Smith New Court Securities Ltd v Citibank*,[31] a generous measure of damages is appropriate where the misrepresentor has behaved in a morally reprehensible way. This shows society's disapproval of the behaviour and discourages wrongdoing. Similarly, where a policyholder is morally blameworthy, the insurer should be permitted to avoid the contract from the start. This is true even if, had the insurer been given the correct information, it might still have accepted the risk with only a slight increase in premium.

4.51 Below we also ask whether insurers should be entitled to keep the premium in these circumstances.[32]

The confusion over fraud

4.52 In our first Issues Paper, we said that if the proposer has made a dishonest or reckless misrepresentation, the insurer should always be entitled to avoid the contract. We described this behaviour as fraudulent. We set out the common law definition of fraud in civil cases, as given in *Derry v Peek*:[33] the representor must either know that the statement is false or have "no care whether it is true or false". If the insured also knew that the statement was material to the insurer (or realised that it might be material and did not care whether it was or not), we said that the insured had behaved fraudulently.

4.53 The case where the consumer knows the statement to be false is often referred to as deliberate fraud, while simply not caring is typically referred to as recklessness. According to *Derry v Peek*, both are fraudulent.

4.54 The responses we received did not necessarily disagree with the definition we put forward, but there was widespread concern over our use of the word "fraud". This was for three reasons: fraud is often associated with a criminal offence; there are social inhibitions against alleging fraud; and the FOS uses the word in a particular way. We explore each below. The result was that respondents thought that we were limiting the insurer's right to avoid much more severely than was our intention.

[31] [1997] AC 254, 280.

[32] See paras 4.95 and 4.98.

[33] *Derry v Peek* (1889) LR 14 App Cas 337.The concept of fraud in Scots law has a different history from that in English law, but as regards fraudulent misrepresentation inducing a contract, the test for proving fraud set out by Lord Herschell in *Derry v Peek* has been adopted in Scots Law. See *Boyd & Forrest v Glasgow & South Western Railway Co* 1912 SC (HL) 93 ; *Robinson v National Bank of Scotland* 1916 SC (HL) 154.

Criminal fraud

4.55 First, some insurers associate fraud with a criminal offence. They feared that they would not be able to show fraud unless they had strong evidence of an intention to deceive, which implies criminal behaviour, proved to the criminal standard of beyond a reasonable doubt. This was not what we said or what we meant. The criminal offence includes elements that are not part of the requirements of fraud as a matter of civil law, nor of our proposal. Thus, for example, in England and Wales, under section 2 of the Fraud Act 2006, fraud by false representation requires an intention to "make a gain for himself or another, or cause a loss to another or expose another to a risk of loss". This is not part of our test. In civil law it is fraud to make a statement that you know to be untrue if you know that someone will act on it, even if there is no intention to cause them any loss.[34] The proposer only needs to be aware that the statement they are making is incorrect, and that the issue is relevant to an insurer, in the sense that the insurer would want to know about it.[35] They need not be aware that the insurer would be induced to enter the contract as a result, or that this will lead to a gain for them or a loss to the insurer.[36]

4.56 The word "dishonest" also has criminal associations. It is a major element in a wide range of criminal behaviour and is often taken to mean that the behaviour is sufficiently blameworthy to constitute a crime.[37] In *R v Ghosh*,[38] for example, it was held that a defendant should only be taken to act dishonestly if they were aware that their conduct would be regarded as dishonest by reasonable, honest people. This is not the test we are proposing here. For example, someone who failed to disclose an eating disorder because they felt uncomfortable talking about it may well be considered fraudulent under the test in *Derry v Peek* without falling within the *Ghosh* definition. We think it is right to describe a person who has deliberately or recklessly given incorrect information to another, knowing or not caring that the other may act on it, as not acting "honestly", but we do not want the word to import criminal definitions or standards of proof.

[34] For example, see *Brown, Jenkinson & Co Ltd v Percy Dalton (London) Ltd* [1957] 2 QB 621.

[35] On this point, see para 4.60 below.

[36] We suspect the same kind of misapprehension may have prompted a number of respondents to the Issues Paper to say that at the pre-contractual stage it would be hard to prove fraud because it would only be an intention to commit fraud at that stage. Whatever the position in criminal law, in civil law it is fraud to make a deliberate or reckless statement that induces the insurer to issue a policy, and the insurer is entitled to avoid the policy. It is not necessary to show that the insured has put in a claim to which they are not entitled or intended to do so.

[37] See the discussion in the Law Commission's final report on Fraud (2002) Law Com No 276, p 38.

[38] [1982] QB 1053. This was the Court of Appeal decision that set out the criminal test for dishonesty.

Inhibitions about alleging fraud

4.57 Secondly, insurers (and we suspect, the FOS) seem reluctant to label a proposer as fraudulent. Even if they think that a policyholder lied about their health, they do not think it appropriate to write to a recently bereaved family alleging fraud. There are strong social inhibitions about saying that a recently deceased father or mother had acted fraudulently in failing to mention their smoking or a cancer test. Insurers seem to do so only in very clear cases, where it is absolutely clear that the proposer had tried to deceive them.

The way the FOS uses the word fraud

4.58 The FOS lists explicitly four types of conduct at the pre-contract stage: deliberate, reckless, inadvertent and innocent. If the proposer made a deliberate or reckless proposal, the insurer may avoid the policy. However, the FOS then appears to draw a distinction. If the misrepresentation was deliberate or reckless, the insurer should return the premium. If, however, the insured acted fraudulently, the insurer may keep the premium. This amounts to a fifth category. The FOS guidance explains that fraud occurs "where the dishonesty is intended to deceive the insurer into giving them an advantage to which they are not entitled".[39] Again, this may have led some people to misunderstand our approach.

4.59 To meet these problems, it may be helpful to speak of deliberate or reckless misrepresentation rather than of fraud. Below we explain what we mean, first by deliberate misrepresentations and then by reckless misrepresentations.

Deliberate misrepresentation should give a right to avoidance

4.60 We do not think that avoidance should require the insurer to show that the proposer had a criminal intention. Nor should it require proof beyond reasonable doubt. We think that a proposer who knew that what they said was untrue, and knew that it was relevant to the insurer's decision, cannot expect to enforce the policy. The insurer should be entitled to avoid it and, we suggest, retain the premium. To avoid any further confusion, we refer to this case as one of "deliberate misrepresentation" rather than of "fraud".

4.61 We should point out that our proposal requires more than that the proposer made a statement that they knew to be false. They must also have believed that the inaccuracy or omission is of something that is, or at least might be, relevant to the insurer. This seems to be a necessary element of fraud in current English (though not Scots) law. The English cases indicate that making a false statement amounts to the tort of deceit only if you intend the other party to act on it, or realise that they may do so.[40] If the proposer genuinely believes the inaccuracy is irrelevant to the insurer there would then be no fraud.

[39] (June 2005) Issue 46.

[40] For example, *Tackey v McBain* [1912] AC 186, PC; see J Cartwright, *Misrepresentation, Mistake and Non-disclosure* (2nd ed, 2007), para 5.19; compare *Chitty on Contracts* (29th ed, 2004) para 6-029, which argues that it may suffice that it was obvious that the claimant might rely on the statement.

4.62 We stress this point, because some of those who responded to the Issues Paper argued that any knowingly untrue statement should entitle the insurer to avoid the policy if he relied upon the misrepresentation. According to this argument, a proposer who knowingly makes any untrue statement disqualifies himself from protection against avoidance of the policy. To require the insurer to prove in addition that the proposer knew that the statement was relevant to the insurer, or was reckless as to whether or not it was relevant, would be to impose an unreasonable burden upon the insurer. Our provisional view, however, is that the insurer should not have an automatic right to avoid on the ground of a deliberate or reckless misrepresentation unless the proposer knew that the fact was, or at least might be, relevant to the insurer. Suppose that a proposer has suffered minor problems with asthma, but is told by her doctor that insurers are only interested in serious asthma attacks requiring use of a nebuliser or hospitalisation. The proposer therefore honestly believes that the minor asthma is not material and she answers the question, "do you suffer from asthma?", "no".[41] On these facts, we do not think the insurer should have an automatic right to avoid. If the proposer acted unreasonably, the insurer's remedies should depend on what it would have done had she answered the question correctly.[42]

4.63 The same would be true if the proposer had genuinely misunderstood what a question on the proposal form was seeking. For example, suppose the question is, "have you suffered any uninsured losses during the last two years?" The proposer answers "no", although she knows perfectly well that, the week before, her child spilled candle-wax on a carpet, which is not a loss covered by either her existing policy or the one for which she is applying. If she genuinely thought that the insurer was only interested in previous losses of a kind that would be covered by the new policy, the insurer should not have the same automatic right to avoid as if she had known that the incident was relevant and had deliberately not mentioned it.

4.64 Of course it may not be possible to give direct proof that the proposer knew that what they said was untrue and relevant, particularly when the proposer is no longer alive. But in many of the examples quoted to us, the evidence is overwhelming. If a proposer answers a clear question by saying that they have never smoked when in fact they smoked 20 cigarettes a day, they are certainly making the statement knowing that it is untrue. It is also difficult to believe that someone does not know that the issue is relevant to an insurer when, first, the insurer has asked a specific question and, secondly, the link between smoking and health is almost universally known.[43] It is important that the definition and the standard of proof allow insurers routinely to avoid contracts in these circumstances.

[41] See para 9.2 below.

[42] See para 4.154 below.

[43] A policyholder might have a possible defence if they could show they were illiterate or did not speak English, but the onus would be on them to show how the mistake had happened. We anticipate that this would be quite difficult. If the insured had used their own agent, and the agent had acted dishonestly, the insurer would still be entitled to avoid (see Part 10).

Reckless misrepresentation

4.65 In the responses to our first Issues Paper there was also some confusion over our intentions in cases of recklessness. Some readers gained the impression that we thought that insurers should not have an automatic right to avoid the policy for reckless misrepresentations. Again, this was not our intention. In our view a clear distinction should be drawn between negligence, which is just carelessness but does not involve dishonesty, and recklessness. Making a reckless misstatement is not honest and in our view should be treated in the same way as making a deliberate misrepresentation, as it is for general civil fraud.

The FOS categories: deliberate or reckless rather than inadvertent

4.66 At present, the FOS states that it will allow an insurer to avoid a policy where:

(1) customers *deliberately* mislead the insurer by dishonestly providing information they know to be untrue or incomplete; or

(2) customers mislead the insurer by *recklessly* giving answers without caring whether those answers are true or false.[44]

4.67 At first sight this definition looks very like the civil definition of fraud which we intended to follow. In *Derry v Peek*,[45] Lord Bramwell was careful to distinguish a lack of interest in whether a statement is true (which is equivalent to fraud) from a "lack of reasonable ground for believing it to be true" (which is merely negligent).

4.68 However, the word "reckless" has the potential to confuse. Some statements by the FOS suggest that it is using the reckless category to include gross or serious negligence, rather than a form of dishonesty. In 2005, *Ombudsman News* gave the following example:

> An example of recklessness might be where a customer signs a blank proposal form and leaves it to be filled out by someone else. The customer has signed a declaration that *'the above answers are true to the best of my knowledge and belief'*, but does not know what those answers will be.[46]

4.69 Signing a blank form is almost certainly careless. It may be thought to be extremely careless. However, it is not necessarily dishonest. Clearly if someone suspects that an agent will fill in the wrong answers, and does nothing to stop them, this is reckless. On the other hand, if the customer has given an agent the necessary information and trusts them to complete the form correctly, this is foolish rather than fraudulent.[47]

[44] *Ombudsman News* (June 2005) Issue 46.

[45] (1889) LR 14 App Cas 337.

[46] *Ombudsman News* (June 2005) Issue 46.

[47] As we explain in Part 10, an insurer may be able to avoid the policy on the basis of their own agent's dishonesty, but this will depend on the agent's state of mind. If the agent made a careless mistake that the insured failed to check, both have been negligent but neither has been dishonest.

4.70 The issue is further confused by the explanation the FOS has given of the inadvertence category:

> A customer may also have acted in good faith if their non-disclosure is made *inadvertently*. These are the most difficult cases to determine and involve distinguishing between behaviour that is merely careless and that which amounts to recklessness. Both are forms of negligence.[48]

4.71 At times, the way the FOS has used the term "inadvertent" rather than "negligent" suggests that it meant to cover only mild carelessness. This leaves unclear the position if a customer has been seriously negligent but not dishonest. Either this must be within the FOS's "reckless" category, or there is a gap in the scheme. Our survey of ombudsman cases suggests that ombudsmen sometimes allow an insurer to avoid a policy where the consumer "did not give the questions and answers the care and attention required", even if they did not act knowingly.[49]

4.72 However, in May 2007, the FOS issued a fresh explanation of what it sees as the distinction between recklessness and inadvertence.[50] It states that:

> recklessness denotes a degree of *not caring* whether a disclosure is true or false. This contrasts with the situation where a lack of sufficient care and attention has resulted in an incorrect answer being given – regardless of how incorrect that answer may be.

The FOS has therefore clarified that it does not see negligence, even serious negligence, as a form of recklessness. We agree.

4.73 The FOS also confirmed that it would not be reckless to sign an application form without reading it when the consumer "genuinely believed the intermediary had accurately recorded" all their answers.

4.74 It is not always easy to keep the proposer's state of mind separate from the means of proof. For example, the FOS has written:

> We are likely to conclude that non-disclosure is "clearly reckless" if a policy holder appears not to have had any regard for accuracy when completing the proposal form. Typically, in such cases, the matters the policy holder failed to disclose will be of significance, and will be well-known by the policy holder. We will find it difficult to believe that the policy holder could simply have overlooked these matters. But we will not have found sufficient grounds to conclude that the non-disclosure was deliberate.[51]

[48] *Ombudsman News* (June 2005) Issue 46. The FOS is not the first body to confuse recklessness and negligence. The SLIP also treats recklessness like negligence as opposed to fraud.

[49] In these cases it was not possible to tell whether the insurer would have accepted the risk had they known the truth, so we cannot say whether avoidance would have been permitted under our scheme.

[50] *Ombudsman News* (April/May 2007) Issue 61.

[51] *Ombudsman News* (April 2003) Issue 27.

Though it brings together the two questions, we have no quarrel with this statement. The conclusion being reached is that the policy holder knew that the statement was incorrect and must have known that the statement might be relevant to the insurer. We agree that in this sort of case a finding of recklessness is justified.

4.75 However, saying that a policyholder ***must have known*** is very different to saying merely that they ***ought to have known***. The latter is only negligence. It is not dishonest and in our view it should be treated differently. As we explain later, in cases of negligence the insurer should not have an automatic right to avoid. We think that the outcome should depend on what the insurer would have done had it known the truth.[52] This should apply even where the negligence was more than slight carelessness.

4.76 We have received comments in response to our Issues Paper arguing that it is essential to allow the insurer to avoid a policy as of right when, for example, the proposer has not revealed that they are a smoker. We think our proposals would have this effect. A proposer who smokes knows that they do so. If in answer to a specific question, for example "do you smoke or have you done so in the last *x* years", they answer "no" when the true answer is "yes", the only possible conclusion is that they were at least reckless or most probably deliberate – they "must have known".[53]

4.77 What this shows is that there is a need for clearer guidance on the difference between acting without the requisite degree of honesty – "deliberately or recklessly" – and acting without the requisite degree of care.

Our definition

4.78 In our view, an insurer should be entitled to avoid the policy if the proposer has made a deliberate or reckless misrepresentation, that is, if they make a representation which they both:

(1) know to be untrue (or know may be untrue, and make nonetheless, not caring whether or not it is true); and

(2) know to be relevant to the insurer (or know may be relevant and do not care whether or not it is relevant).

There are several points to make about this definition.

Motive is not relevant

4.79 First, motive is irrelevant. It is not necessary for the insurer to show that the proposer was attempting to get something for nothing. They may, for example, fail to mention a previous bout of depression because they are embarrassed by it, rather than because they wanted cheaper insurance.

[52] See para 4.154 below.

[53] The proposer might be able to rebut the natural presumption that they must have known by showing that the form was so badly designed that they ticked the "no" box meaning to tick the "yes" box, but it would take some doing. If so, the remedy is in the insurer's hands.

Relevance

4.80 Secondly, our definition requires that the insured knows that the matter is or may be relevant to the insurer. By "relevant" we mean that it is something an insurer would take into account in assessing the risk: the consumer does not have to think that the matter would be decisive.

4.81 As we explain below, where the insurer has asked a clear question, there will be a natural presumption that the proposer realised it would be relevant. The issue becomes important where the insurer has asked general or confusing questions.

Recklessness

4.82 On the approach we are proposing, the insurer would have the right to avoid not only where the proposer acted deliberately but also where they were reckless: as it was put in *Derry v Peek*, where a proposer made a statement "careless whether it be true or false".

4.83 This would apply, for example, where an insured was asked about previous losses, and said "no" without attempting to remember what had happened; or where a proposer knew that they do not know the answer to a question, but answered it as though they did. Suppose, for example, an insurer includes a question about genetic predisposition which asks if either of the policyholder's parents died of a heart attack below the age of 60. The insured knows that he is adopted, and has no knowledge of his biological parents. The honest answer to the question would be "I don't know". If he simply says "no", and that turns out to be inaccurate, he is reckless. We think he has acted dishonestly rather than merely carelessly. However, the insurer would need to allow for "don't know" answers on the form. If an internet screen forces consumers to answer either "yes" or "no", the position would be different.

4.84 Not every statement that conceivably might not be true is reckless. There may be occasions on which a person thinks there is a possibility that what they plan to say may be untrue, but the likelihood is so low and the difficulty of discovering the truth so great that – particularly when they are simply presented with a yes/no question – they are not acting unreasonably in taking the risk. Recklessness involves not just a suspicion but the conscious taking of an unreasonable risk.

4.85 We have considered whether it would be helpful to define recklessness along these lines. However, our current thinking is that the issue could be left to the common law. Below we ask if consultees agree.

The burden of proof

4.86 Insurers often accept the principle that automatic avoidance should only apply where there is fraud. Their main concern is about proving fraud. Many insurers have told us they would only allege fraud if they were able to prove it on a criminal standard of proof, which is difficult and expensive.

4.87 As we indicated earlier, our test would not involve a criminal standard of proof. The insurer would only need to show on the balance of probabilities that the insured must have known that a statement was or might be untrue, and that they must have known that it was or might be relevant. This is the standard burden of proof in civil cases. It is true that in respect of the defendant's state of mind, the courts take a cautious approach:

> The more serious the allegation is, the greater the proof needed to persuade a court that it can be satisfied that the allegation is established. In other words, the very gravity of an allegation of fraud is a circumstance which has to be weighed in the scale in deciding as to the balance of probabilities.[54]

However, as the words quoted show, it is still a question of the balance of probabilities.[55] The position is the same under Scots law.[56]

4.88 We think that the task of proving fraud might be helped by two presumptions. Such presumptions may be particularly useful in life insurance cases where the proposer has died by the time of the claim, and little evidence of their state of mind is available.

4.89 The first is that a proposer should be presumed to know what someone in their position would normally be expected to know. This would cover many of the examples that have been put to us: a person would normally be expected to know that they smoked; or that they had suffered a heart attack; or that their house had flooded while they had been living there. An insurer need not bring specific evidence of knowledge in such circumstances. Instead, it could argue that the policyholder must have known the information. The onus would then be on the policyholder to bring evidence about why they did not know. In the case of smoking, for example, it is hard to see how the onus could be discharged.

4.90 By contrast, a policyholder would not necessarily be expected to know that they had high blood pressure; or that their pins and needles were a symptom of multiple sclerosis; or that their house had flooded before they moved in. The fact that they should have known, or should have taken steps to find out, is different from saying that they must have known.

4.91 Secondly, if an insurer asks a clear question about an issue, we think the proposer should be presumed to know that the issue is relevant to the insurer. This would not help insurers if they asked vague, general or ambiguous questions. But where a question was clear, the onus would be on the policyholder to show why they did not think the issue was relevant.

[54] *Smith New Court Securities Ltd v Scrimgeour Vickers (Asset Management) Ltd* [1977] AC 254, 274 by Lord Steyn.

[55] See Cartwright, *Misrepresentation, Mistake and Non-disclosure* (2nd ed 2007) para 5.46.

[56] See *Mullan v Anderson* 1993 SLT 835, 842 by Lord Morison and *1st Indian Cavalry Club Ltd v Customs & Excise Commrs* 1998 SC 126, 138 by Lord Hamilton.

4.92 However, we are not sure that these presumptions need to be stated expressly in any legislation. In the examples we have given, there would be a natural evidential presumption that the proposer knew the relevant matter. Again we would welcome views.

Returning the premiums

4.93 Where a contract is avoided from the start, the normal rule is that the insurer must return any premiums paid. For marine insurance, there is an exception where the insured has acted fraudulently or illegally. Section 84(3)(a) of the MIA 1906 states:

> Where the policy is void, or is avoided by the insurer as 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...

4.94 For non-marine insurance, the point is not wholly clear, and depends on general principles of contract law and the law of unjustified enrichment.[57] The FOS states that where an insured acts fraudulently, the premiums may be retained.[58] However, in practice we did not find any cases in which a finding of fraud had been made. In most cases involving deliberate misrepresentations, the premiums are returned.

4.95 Earlier we argued that where an insured had made a deliberate misrepresentation, a high penalty should be imposed on the grounds that the misrepresentor has behaved in a morally reprehensible way. A measure of over-compensation is appropriate to show society's disapproval of the behaviour and discourage wrongdoing. This would suggest that where an insured has made a deliberate or reckless misrepresentation, the insurers should be entitled not only to avoid but also to retain the premium. We would welcome views on this.

Conclusion: deliberate or reckless misrepresentations

4.96 **We provisionally propose that an insurer should have the right to avoid a policy where it has relied on a misrepresentation by the consumer proposer at the pre-contractual stage and the insurer shows that, on the balance of probabilities, the proposer made the representation:**

(1) **knowing it to be untrue, or being reckless as to whether or not it was true; and**

(2) **knowing it to be relevant to the insurer, or being reckless as to whether or not it was relevant.**

4.97 **Do consultees agree that the definition of "reckless" can be left to the common law?**

[57] See *Berg v Sadler & Moore* [1937] 2 KB 158 and *Clough v London and North Western Railway Co* (1871-72) LR 7 Ex 26 and *Standard Life Assurance Co v Weems* (1884) 11R (HL) 48.

[58] See para 4.58 above.

4.98 **We ask whether, where an insured has made a deliberate or reckless misrepresentation, the insurer should be entitled to retain the premium.**

4.99 **We ask whether the statute should provide expressly that:**

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

(2) **if an insurer has asked a clear question about an issue, the proposer would be presumed to know that the issue is relevant to the insurer.**

INNOCENT MISREPRESENTATIONS: PROTECTING THE INSURED WHO ACTED HONESTLY AND REASONABLY

4.100 We have said that the consumer insured's current duty of disclosure should be replaced by a clear statement that they have a duty to be honest and careful in ensuring that their answers to questions, and any other statements they volunteer, are accurate and complete. Conversely, if a consumer insured has acted both honestly and carefully (that is without negligence) in giving pre-contract information, the insurer should not be entitled to refuse to pay the claim, or to avoid the policy, on the ground that there was a misrepresentation.

4.101 This would be a change to the current law, but is no more than was required by the ABI Statement of Practice,[59] and is currently required by both the FSA Rules[60] and expected by the FOS.[61] We propose that for consumer cases this should also be the law, as it is in many other jurisdictions.[62]

[59] See para 3.5 above.

[60] The FSA Rules are contained in the Investment Conduct of Business Sourcebook (ICOB) and the Conduct of Business Source Book (COB). For the restriction of the right to avoid for misrepresentation see ICOB Rule 7.3.6 and COB Rule 8A.2.6.

[61] See para 3.22 above.

[62] Norway, Insurance Contracts1989 Act § 4-2 (no remedy unless blame "more than merely slight"); Sweden, Insurance Contracts Act 2005, Chapter 4 s 2; and, we understand, under the proposed scheme of the European Restatement Group, save that the insurer would be permitted to terminate for the future if it would not have concluded the contract had it known of the information concerned. The French Code des Assurances, Art L 113-9 seems to allow a proportionate remedy for non-negligent and negligent misrepresentation. The same is true under the proposals for reform in Germany, December 2006, VVG § 19. (However, a French commentator has suggested that, like the duty to disclose that existed until 1989, the duty in current French law to answer questions applies only to facts that are known to the proposer: Lambert-Faivre, *Droit des Assurances* (11th ed), Dalloz, p 245 at para 317). The French provisions and the German proposals apply also to business insurance. Australia also requires fault in that the test of materiality depends on the reasonable insured and the insurer has no remedy for non-negligent misrepresentation: Insurance Contracts Act 1984 s 26. In New York law, however, it makes no difference whether the misrepresentation was innocent or fraudulent.

Different ways in which policyholders may act reasonably

4.102 The change would affect two types of case. The first is where the consumer gives information that they honestly and reasonably believe to be correct when in fact it is not. The second is where they answer a question incorrectly or incompletely because, reasonably, they do not appreciate that the information they state inaccurately or fail to give is relevant to the insurer. We discuss each in turn.

Not knowing that the statement is inaccurate

4.103 A proposer who in answer to a question says that they have had no symptoms of a specified illness, because their doctor had not told them that the problem they have experienced is a possible indication of the illness, is acting reasonably. Our survey of FOS cases suggests this was a particular problem for those experiencing the early signs of multiple sclerosis. Doctors may not tell patients that they suspect a slight numbness in the fingers may be serious because they do not want to worry the patient.

4.104 Another example would be a consumer who says that their house does not suffer from subsidence, when in fact it does, because the signs of subsidence are not obvious to the untrained eye and the consumer has not spotted them. Similarly, they may give incorrect information because they have been misled by a third party, for example, they have relied on a survey report that the property shows no signs of subsidence.

4.105 In cases of this kind, the FOS would not permit the insurer to refuse to pay the claim or to avoid the policy. The law should provide the same.

Not knowing that the information is relevant

4.106 Our survey of FOS cases suggests that the most common form of reasonable misrepresentation is the second type. The consumer knows that their answer is not literally accurate, or was incomplete, but they quite reasonably think they have provided all the information the insurer wanted. Consumers may not realise that a question about hospital treatment is asking them to disclose tests that were entirely negative; or that a general question about health matters seeks information about minor issues such as colds, moles and ingrowing toenails as well as serious illnesses. They may not understand the concept of "an uninsured loss", or may not think that "psychiatric illness" includes stress. They may therefore give inaccurate or incomplete answers.

4.107 Much depends on how the question was asked. If the question was clear and specific, the consumer who does not reveal the relevant condition will almost certainly have been careless, at least. But if the question was vague or too general, even an honest and careful consumer may give an inaccurate or incomplete answer because they do not think the information withheld is relevant. If their understanding was reasonable, then again both the FSA Rules and the FOS require the insurer to pay the claim.

4.108 Our proposal involves the law becoming the same as the FSA Rules require and the FOS expects. The insurer will only have a remedy where the consumer actually knew, or a reasonable consumer in the circumstances would have realised, that the question was asking about these facts and that the facts were relevant to the insurer. Our proposal will in effect implement the recommendations of both the Law Commission's 1980 Report and the British Insurance Law Association Report. It will bring English law into line with Australian law.[63]

4.109 In our first Issues Paper we formulated a new test based on what a reasonable insured would appreciate was relevant in all the circumstances. After setting out the requirement for inducement, we said:

> (1) …
>
> (2) Additionally, the insurer must show either
>
> > (a) that the proposer appreciated that the fact in question would be relevant to the insurer;[64] or, if not,
> >
> > (b) that a reasonable insured in the circumstances would have appreciated that it would be relevant to the insurer.[65]

4.110 We said that "relevant" means that the fact was one the insurer would want to know about (the standard established in the *Pan Atlantic* case[66]), not necessarily a fact that would be decisive.

4.111 Many participants at our seminars supported the idea that consumers who act reasonably should be protected. Unfortunately, several respondents found the wording of our test confusing and worrying. Some did not understand that the two limbs of the tests were alternatives, not cumulative. They appeared to think that insurers would need to prove what the proposer actually appreciated, and they thought this would be too difficult. We envisaged that most insurers would base their case on (b) – that a reasonable insured would appreciate a fact's relevance. The addition of (a) was designed to protect insurers in the rare circumstances where a question was unclear and a hypothetical consumer might not appreciate a fact's relevance, but the proposer did – for example because they have been told by their broker that it is relevant.

[63] See Insurance Contracts Act 1984 s 26(1): if a statement is made on the basis of "a belief that a reasonable person in the same circumstances would have held, the statement shall not be taken to be a misrepresentation". Continental systems often do not have a requirement of materiality separate from one of inducement: in other words, the insurer need only show that had it known the truth it would not have made the contract it did (see for Germany Rühl, "*The Single European Market for Insurance*" [2006] 55 ICLQ 879, 890-891. However the effect of non-fraudulent misrepresentation is usually very different.

[64] This is drawn from the Scottish case of *Cuthbertson v Friends' Provident Life Office* 2006 SLT 567; 2006 SCLR 697.

[65] The original version read "appreciated that the fact in question would have that significance." At the seminar on 21 September 2006, it was pointed out that this formulation was confusing and we changed it to indicate what we meant (see Issues Paper 1, para 6.30 n 6).

[66] See para 2.28 above.

Judging what is "reasonable" for the insured

4.112 A further issue is how to define the concept of "reasonableness". What circumstances should be taken into account in assessing whether an action is reasonable? This is particularly important in relation to the issue of relevance, as different insureds may have very different amounts of knowledge about what insurers want to know.

4.113 We think any test should depend on the type of policy, the normal characteristics of the sort of policyholders likely to purchase the policy and the way the policy was advertised and sold. If insurance is advertised as being quick and easy to buy, the standard of care required of the policyholder would be less than if consumers are told to set aside at least half an hour to read and fill out a lengthy form.

4.114 The more difficult question is how far the test should take into account the circumstances of the particular policyholder in question. In Australia, as the Insurance Contracts Act 1984 was passing through the Commonwealth Parliament, there was considerable debate over this. A draft which originally looked at what "a person in the circumstances of the insured could reasonably be expected to know" was changed to reflect what "a reasonable person in the circumstances could be expected to know".

4.115 Although the words seem similar, the two versions apply different tests. The first looks at the particular idiosyncrasies of the insured, taking into account (for example) their age, education, and knowledge of English. The second sets up a more objective standard. For example, under the second test a "reasonable insured" will know that, if an insurer has asked about signs of subsidence, it will wish to know about a lengthening crack over the front door. Under the first test, in contrast, a policyholder who always left home maintenance to their spouse and who has just been bereaved may quite reasonably not realise the significance of the crack. A failure to mention it might then be excused under the first, more subjective test.

4.116 There is a difficult policy balance here. The insurer cannot be expected to know about every idiosyncrasy of every insured. It cannot know that the person completing the form has suffered bereavement, or understands very little about house maintenance or medical terms. On the other hand, it seems harsh to penalise a policyholder for falling below some objective standard when the failure was quite reasonable given their particular circumstances.

4.117 We think that the basic test should be objective. The insurer cannot be expected to make allowances for particular characteristics of which it does not know. Thus, in the example given above, the recently bereaved widow would be considered negligent because she did not measure up to the required standard of reasonable care. However, the situation would be different if the insurer actually knew that the insured faced particular problems: for example, where a proposal is made over the phone it may be evident that the proposer speaks little English. Alternatively, an insured may admit to knowing nothing about medical terms and ask for help.

4.118 We think the test should take into account any particular circumstances of the insured known to the insurer. This fits with the notion of "know your customer". In discussions the FOS supported this approach:

> In so far as factors of age, infirmity, limited mental capacity, poor command of language or limited literacy are known to the insurer then there would seem to be a strong public policy argument for the law not permitting the insurer to simply ignore these characteristics of their customers.

4.119 **We provisionally propose that**:

(1) **An insurer should not be able to rely on a misrepresentation if the insured was acting honestly and reasonably in the circumstances when they made the misrepresentation.**

(2) **In assessing reasonableness, the type of policy, the way the policy was advertised and sold, and the normal characteristics of consumers in the market should be taken into account.**

(3) **The test of whether the consumer proposer acted reasonably should also take into account any particular characteristics or circumstances affecting a consumer insured, so far as these were known to the insurer. It would not take into account individual circumstances which were not known to the insurer.**

A single test of whether the consumer acted reasonably?

4.120 We have explained that a consumer may have made a misrepresentation reasonably either because they had reasonable grounds for believing what they said was true or because they reasonably thought that any inaccuracy or omission was not relevant to the insurer.[67] A further question is whether any new legislation should contain provisions dealing with the "two limbs" separately, so that there is an explicit statement of the new "relevance" test, or should contain simply a more general test of reasonableness. The test could state that an insurer will not have a remedy against an honest insured if they acted in the way a reasonable consumer would have acted in all the circumstances. However relevance appears to be such an important question in insurance cases that we would welcome views on whether any new Act should include, as part of the general principle, a statement of the test of relevance along the lines indicated earlier.[68]

[67] See paras 4.107 and 4.108 above.

[68] The Australian Insurance Contracts Act 1984 provides interesting alternative formulations. S 23 deals specifically with ambiguous questions and states that where

(a) a statement is made in answer to a question asked in relation to a proposed contract of insurance…; and

(b) a reasonable person in the circumstances would have understood the question to have the meaning that the person answering the question apparently understood it to have;

that meaning shall, in relation to the person who made the statement, be deemed to be the meaning of the question.

4.121 **We ask whether the legislation should specify that the insurer is entitled to a remedy for a misrepresentation only if:**

(1) **a reasonable insured in the circumstances would have appreciated that the fact which was stated inaccurately or was omitted from the answer would be one that the insurer would want to know about; or**

(2) **the proposer actually knew that the fact was one that the insurer would want to know about.**

The burden of proof

4.122 Should the insurer bear the burden of proving that the insured failed to take appropriate care, or should the insured bear the burden of proving that they acted reasonably? Normally it is for a party alleging negligence to prove it, but in the loosely analogous case of liability under section 2(1) of the Misrepresentation Act 1967 the burden is reversed.[69]

4.123 We think that in the cases of misrepresentation by consumer insureds, the burden should be on the insurer to show that the consumer acted unreasonably. This should apply whether they should have known that the answer they gave was incorrect, or should have known that any inaccuracy or omission was relevant to the insurer.

4.124 **We provisionally propose that the burden of showing that a consumer proposer who made a misrepresentation did so unreasonably should be on the insurer.**

Materiality: an end to the test based on a hypothetical "prudent insurer"?

4.125 Under section 20 of the Marine Insurance Act 1906, an insurer is only granted a remedy for misrepresentations which are "material". This is defined under section 20(2) as meaning that the representation:

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

4.126 Under the approach we are proposing, there are two important factors.

(1) First, was the misrepresentation important to this particular insurer, in that it induced the insurer to enter into the contract on these terms? This is the inducement test set out above.

(2) Secondly, should a reasonable insured in the circumstances have realised that the matter would be relevant to an insurer?

[69] The Misrepresentation Act 1967 does not apply to Scotland.

This would effectively replace the "prudent insurer" test under section 20. We do not think it necessary to retain the "prudent insurer" test within our reformed scheme. To do so would make it necessary for the insurer to show not only that the consumer should have known that the inaccuracy or omission was relevant to them, but also that the inaccuracy or omission would have been relevant to the "prudent insurer".

4.127 This change may help insurers, since the current "prudent insurer" test may cause problems to innovative insurers. Some insurers may wish to develop niche markets, by selecting which risks they underwrite on facts that seem irrelevant to the generality of insurers. For example, an insurer may set premium rates on the basis that all their policyholders are members of a particular profession or union. This means that a question about occupation may be crucial to them, even if it is irrelevant to most prudent underwriters. The insurer may ask a clear question, which succeeds in communicating the importance of the question to a reasonable policyholder. However, there is a danger under the current law that the insurer might be left without a remedy. The fact will not be material because it will fail the first limb of the *Pan Atlantic* test: the representation would not influence the judgement of the hypothetical prudent insurer, as required by section 20(2).

4.128 We do not see any reason to add to an insurer's burden by requiring that it also show that the information would have influenced the judgement of other hypothetical insurers in the market. Under our proposed scheme, the materiality test, as presently understood, would no longer apply.

4.129 **We provisionally propose that insurers should not be required to prove that a misrepresentation is "material" in the sense that it would be relevant to a "prudent insurer".**

WHERE THE POLICYHOLDER THINKS THE INSURER WILL OBTAIN THE INFORMATION

4.130 A common reason why consumers do not fill in forms completely is because they think the insurer already has access to the information and will check it for itself. In one survey, the main reason consumers gave for failing to provide all the relevant information on their medical history was that they assumed the insurer would ask their doctor.[70] Similarly, problems may occur where the insured knows that the insurer holds detailed information about previous claims, or is in a much better position to check an area's flood history. Below we summarise some of the complaints that have been made.

Authority to receive GP reports

4.131 There have been many complaints about the confusion that may occur where insurers ask for authority to obtain GP reports, and then do not obtain them. In 1993, Dr Julian Farrand, then Insurance Ombudsman, drew attention to the problem:

[70] Swiss Re Life and Health, *The Insurance Report* (2005) p 28.

> ...the reasonable expectation of the ordinary policyholder for life assurance would surely be that, where the details of a doctor are asked for, he would be approached by the assurer and would supply all relevant details before the proposal could be accepted... Indeed, many people wonder why assurers ask for such details if they only intend to use them if a claim is made. By underwriting the risk without carrying out full enquiries at the underwriting stage, the assurer lulls the policyholder into a false sense of security that he has cover when the reality is that he has none because as soon as a claim is made, the assurer will write to his doctor and discover the information then said to be material. If it is that material, it should have been investigated earlier and the risk declined or a higher premium charged, or cover restricted.[71]

Failing to check available databases

4.132 As the National Consumer Council has noted,[72] insurers may have access to relevant information through various databases. At present there is no general obligation on insurers to check these databases at the time of an application, mid-term adjustment or renewal.

4.133 One example is the Claims and Underwriting Exchange, which is a database of incidents reported to subscribing insurers and which may provide a more accurate record of past claims and losses than policyholders can give from memory. Another example is information about flood risks. It may not be unreasonable for a consumer to assume that the insurer will be well-informed of the known risk in the particular area.[73]

Failing to check own files

4.134 There have also been complaints where insurers have failed to check their own files. Professor Clarke points to the approach of other jurisdictions:

> In the United States and in Canada, if insurers fail to look in their data files, they are deemed to have waived disclosure of the information which the files contain. So should it be in England today.[74]

The general problem

4.135 In our first Issues Paper, we considered whether special rules were needed to deal with cases of this type. The difficulty is that the law cannot be prescriptive about what checks an insurer should carry out in any given circumstances.

[71] The Insurance Ombudsman Annual Report (1993) paras 6.52 to 6.53.

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

[73] In fact the insurer will need this information to ensure it complies with the ABI commitment on flood cover - http://www.defra.gov.uk/corporate/ministers/statements/em051111.htm (last visited on 22 June 2007).

[74] MA Clarke, The Law of Insurance Contracts (4th ed 2002).

4.136 These are all examples of a more general criticism of the practice of "underwriting at the claims stage" – in other words, only investigating the accuracy of statements made by a proposer if and when a claim arises. It seems particularly harsh to reject a claim because a consumer has not taken the trouble to find out the true facts before entering into a contract, when the same can equally be said of the insurer. Such an approach may undermine confidence in the market.

4.137 However, it was pointed out that requiring the underwriter to check the information for every policy at the underwriting stage, rather than waiting to see which policies generate a claim, may add significantly to costs. Obtaining medical reports is expensive and adds to the time of arranging insurance. Most insurers only ask for such reports selectively, but where they do wish to ask for a report, it saves time and trouble to have an authorisation to hand.

4.138 For GP reports, the problems can be reduced considerably by including clear warnings on the form that insurers will not necessarily ask for a report. In February 2006, the ABI issued guidance on how to design better forms.[75] We are pleased to note that this suggests optional warnings to be included on application forms, including:

> PLEASE DO NOT ASSUME THAT WE WILL WRITE TO YOUR DOCTOR, IT REMAINS YOUR RESPONSIBILITY TO COMPLETE THE APPLICATION FORM PROPERLY.

4.139 We think that much of the problem lies in the design of the forms. We hope that the industry will continue to work on ways of communicating with customers about the checks that will be carried out.

4.140 Insurers told us that they faced practical difficulties in checking their own files. Information may be held in different forms (including paper files and microfiches, as well as computer records), across different sites, and by different companies within the same group. Particular problems occur where separate companies have merged and hold incompatible record systems. It would not be appropriate to impose a rule that insurers should always check their records. We considered a milder rule requiring insurers to check only when reasonably practical, but we fear this could be counter productive. It may discourage insurers from attempting to make old record systems searchable, on the grounds that this would lead to higher expectations of what was reasonably practical. Thus if the attempt to make old record systems searchable was only partially successful, insurers would lose their rights to avoid policies where the system should have revealed a previous claim but failed to do so.

4.141 In the end, we do not think that it would be right to impose a duty on insurers to check the kinds of information that we have mentioned, even if the duty is qualified, as in "so far as is reasonably practical". The issue can be dealt with as part of the general reasonableness test, set out above.

[75] ABI, *Application Form Design for Life and Health Protection Insurances* (2006).

4.142 The proposer should take care to give full and accurate answers to those questions. However there may be cases in which the proposer reasonably thinks that the question does not require information that the insurer has at its finger-tips. A policyholder who is renewing motor insurance and is asked whether anything has changed since the last renewal may reasonably think it need not mention the accident that it discussed with the very same insurer two weeks earlier. The person who is told that "we will contact your doctor" may reasonably think they can leave the questions about previous illnesses blank. The householder who is asked "are there any other factors affecting the risk that we might want to know about" might reasonably think that they do not have to provide crime statistics for the area they live in. It is a question of reasonableness. Was it reasonable in all the circumstances for the consumer to give the answer that they did? If so, the insurer should not be able to reject the claim on this ground.

4.143 **We provisionally propose that in considering whether an insured acted with insufficient care in failing to give information, the judge or ombudsman should consider how far it was reasonable for the insured to assume that the insurer would obtain that information for itself.**

4.144 **In particular, if the insurer indicated that it may obtain information from a third party (by for example asking the insured for consent to obtain it) it should not be allowed to rely on an honest misrepresentation if the insured reasonably thought that the insurer would obtain the relevant information from the third party before accepting the proposal.**

A CONTINUING DUTY OF DISCLOSURE

4.145 Our comparative work has thrown up a question which may become more important if innocent misrepresentation is no longer a ground for avoidance. If later the insured discovers that they have made a misrepresentation, should they have a duty to inform the insurer?

4.146 There are two situations which must be distinguished. The first is where the insured learns that they have made a misrepresentation before their proposal has been accepted, the second where that happens only afterwards.

Further disclosure before the proposal has been accepted

4.147 The current law of misrepresentation requires that a party who has stated a fact that at the time was true, but which ceases to be true before the contract has been made, must correct the statement.[76] Thus if a proposer states that they are in good health, as they honestly believe they are, but before the proposal has been accepted they are told that they are suffering from cancer, they must inform the insurer.

4.148 We think this should remain the law, provided that the consumer acted unreasonably (or dishonestly) in failing to tell the insurer. We agree with the approach to this question taken by the FOS, which is that the insurer should normally warn consumer insureds of this duty.

[76] For example, *With v O'Flanagan* [1936] Ch 575. See *Chitty on Contracts* (29th ed 2004), paras 6-017 and 6-018.

Disclosure after the proposal has been accepted

4.149 Insurance policies sometimes oblige the insured to notify the insurer if they become aware of certain changes of circumstance after the contract has been agreed. In critical illness policies, for example, it is common for insurers to include contract terms stating that the insured must notify the insurer of any changes in circumstance between the conclusion of the contract and the commencement of cover.

4.150 We have considered whether policyholders should be under a duty to correct innocent misrepresentations, even after the contract is concluded. We think that such a duty could cause problems. For example, when people are first diagnosed with cancer it usually becomes clear that they have been suffering from the illness for some time, even though they did not know it. Where an insurer was already on cover, it would be inappropriate for it to cancel the contract because the proposer had quite innocently represented that they did not have cancer several months ago.

4.151 In the UK, most non-life policies are renewable annually. For these policies, such a duty with concomitant rights of adjustment is not needed: on renewal, the insured will normally be asked what has changed since last year. Nor do we think it would be a sensible default rule in long-term insurance. Difficult issues might arise over when the cancer started – before or after the date of the proposal? We think that insurers who require to be notified of changes of circumstances should have to make this an express term of the policy. In most cases the term would be subject to the test of fairness under the Unfair Terms in Consumer Contracts Regulations 1999.[77]

4.152 **We provisionally propose that:**

(1) **If before their proposal is accepted a consumer proposer becomes aware that a statement they have made has become incorrect, they should continue to have a duty to inform the insurer, and if the consumer fails to do so unreasonably or dishonestly, the insurer should have a remedy;**

(2) **There should be no general obligation to inform the insurer of changes that become known to the insured only after the policy has been agreed.**

NEGLIGENT MISREPRESENTATIONS: THE REMEDIES

4.153 Many misrepresentations will be made honestly but negligently. This may cover a broad swathe of conduct – where, for example, the policyholder failed to take sufficient care to understand what the insurer wanted to know or to check their facts. Here the insurer should have a remedy. However, a right to avoid in all cases goes further than is necessary to protect the insurer. Where, for example, the insurer would have underwritten the risk at only a small increase in premium, avoidance imposes a disproportionate penalty on the insured. It allows the insurer to refuse claims that would have arisen in any event.

[77] See para 2.73 above.

4.154 Few of the legal systems that we have looked at allow the insurer a right to avoid the contract and refuse to pay claims that have arisen in every case of negligent misrepresentation by a consumer policyholder. In most European systems the standard approach is to require the insurer to pay a proportion of the claim.[78] The insurer may also have the right to cancel the contract for the future, possibly after a short period of notice.[79]

4.155 We have noted that the FOS also applies compensatory remedies for inadvertence. The provisional proposals we make here are designed to bring the law into line with existing FOS practice.

4.156 We do not see a need to define negligent conduct. Misrepresentations will be treated as negligent if they are not deliberate or reckless (according to our definition) but were made without reasonable care.

A compensatory remedy

4.157 Where a non-disclosure or misrepresentation is negligent, the law should aim to place the insurer in the position it would have been had it known the true facts, but no better. This means that the court should ask what terms the insurer would have offered had the misrepresentation or non-disclosure not occurred. If a claim has already arisen:

(1) It may be that it would be excluded under the terms that would have been agreed, or in an extreme case it may be that a policy would not have been offered at all. In such a case the insurer should not have to meet the claim.[80]

(2) If the insurer would have demanded an increase in premium and a claim has arisen, proportionality should be applied. In other words, if the misrepresentation or non-disclosure led to the consumer only paying 50% of the correct premium, the insurer should only have to pay 50% of the claim.

4.158 This is effectively the approach adopted by the Australian ICA 1984, section 28(3). The section provides that in cases of negligent misrepresentation,

[78] Norway, Insurance Contracts Act 1989,s 4-2; Sweden, Insurance Contracts Act 2005 Chapter 4 s 2 para 2. For France and Germany, see N 62 above. Under the current approach of the European Restatement Group, in cases of negligent misrepresentation the outcome would depend on what the insurer would have done if it had been given the correct information. If it would not have insured the risk at all, nothing would be payable. If it would have insured it at a higher premium or on different terms, the claim would be payable proportionately or in accordance with the terms the insurer would have agreed to. However, only claims that were causally connected to the misrepresentation would be affected: see further below, para 4.173.

[79] For example, Norway, Insurance Contracts Act 1989, s 4-3, Sweden, Insurance Contracts Act 2005, Chapter 3 s 7. (14 days notice); France, Code des Assurances, Art L 113-9 (10 days notice). The European Restatement Group draft would also permit termination for the future.

[80] Some respondents to the Issues Paper pointed out that the insurer might have both applied an exception or excess and have increased the premium. That is obviously correct but it causes no special difficulty. If the claim falls within the exception or excess, it need not be paid. If it does not, a proportion of the claim should be paid under (2).

> the liability of the insurer in respect of a claim is reduced to the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred or the misrepresentation had not been made.

If the insurer would not have accepted the risk had it known the truth, or if it would have inserted an exception which applies to the claim, the insurer's liability is reduced to nil.[81]

4.159 Proportionality has long been used in French law where the insured's bad faith has not been proved. Under Article L113-9 of the *Code des Assurances*, where a misrepresentation is discovered after a loss has occurred:

> the compensation shall be reduced in proportion to the rate of the premiums paid in relation to the rate of premiums that would be owed if the risks had been truthfully and exhaustively declared.

4.160 In 1980, the Law Commission rejected proportionality as an option on two main grounds. The first is that an insurer may react to information in a variety of ways: by declining the risk altogether; by imposing additional warranties; by imposing an exclusion clause; or by increasing the excess which the insured must bear. The Commission thought that the proportionality principle was only really useful where the insurer would have charged a higher premium.

4.161 Secondly, the Commission thought that it would be too difficult to calculate how much the premium would have been in hypothetical circumstances. It argued that tables of tariffs would only be able to assist in straightforward (but unusual) circumstances, where, for example, a life assurance proposer had mis-stated their age.

> However, in the usual case where the undisclosed fact is qualitative rather than quantitative in nature – for example, failure to disclose a gastric complaint in an application for life assurance, or non-disclosure of a previous motoring conviction in an application for motor insurance – tables of tariffs will almost certainly be unable to assist, and disputes would proliferate into litigation with the inevitability of conflicting expert evidence about what the notional premium should be.[82]

The Commission argued that in France judges often determined a fair deduction as a matter of fact and discretion, rather than arithmetical precision.

[81] See R Merkin, Colinvaux's Law of Insurance (8th ed 2006) at p 163 for discussion of the interpretation of this section. There are special provisions dealing with life insurance (s 29) and misstatements of age (s 30).

[82] Insurance Law Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 4.8.

4.162 We accept the first argument made in the 1980 report; as we have said, we would not require the insurer to pay any part of the claim if it would not have accepted the risk or would have inserted a relevant exception. But as to the second argument, we think that experience has shown that the 1980 report exaggerated the difficulties. As the National Consumer Council pointed out, the Insurance Ombudsman Bureau applied proportionality, and its current successor, the FOS also does so. We found cases in FOS files where they had no trouble in dealing with an exclusion that would have been added, or in working out the effect on a premium of an additional motoring conviction. The approach appears to have gained acceptance from the industry,[83] and we note that it also has the support of the British Insurance Law Association.

4.163 However, it is necessary to think through the effect of various scenarios on the remedy available.

Exclusions

4.164 In our survey of FOS files, it was relatively common for insurers to state that had they known about the insured's health problems, they would have excluded a particular condition from cover. The question then becomes - what effect would the exclusion have on the claim that has arisen? In several cases, the exclusion did not affect the claim. For example, a claimant who failed to mention her hearing loss later died of leukaemia. The insurer stated that had they known of the hearing problem they would have excluded hearing-related problems from the cover. Rightly, the insurer was ordered to meet the claim for leukaemia in full. Similarly, a woman who failed to mention back pain following pregnancy later developed (unrelated) breast cancer. The insurer was required to reinstate the policy subject to a back exclusion, and to pay the claim for cancer.

4.165 In other cases, a claim may fall within the terms of the exclusion. For example, a complainant who failed to mention an upcoming opthalmological referral later developed a serious eye problem. The FOS instructed the insurer to reinstate the policy, but subject to an exclusion for eye conditions. This meant that the claim was not covered.

4.166 In some cases this result may appear harsh on a policyholder who had made a momentary lapse of judgement, and who is deprived of a large claim. However, it is a fair result from the insurer's point of view. And, from the insured's point of view, it is fairer than the current law, which allows the policy to be avoided and all claims rejected, whether affected by the misrepresentation or not.

Warranties and excesses

4.167 We did not find any cases where insurers argued that they would have imposed an excess or an additional warranty requiring special precautions to be taken. However, in principle, we see no reason why they could not be dealt with in the same way. The court or ombudsman should ask what the effect would be if the policy had included the new terms. If a claim satisfies the new terms, it must be paid.

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

An additional premium

4.168 Where the insurer would have accepted the proposal subject to a higher premium, then the insurer should have to pay a proportionate amount of the claim.

4.169 Proportionality works best when there is clear evidence of what the premium would have been. We accept that in some cases the evidence may be disputed, and that precision may not be possible. Instead, the judge will have to work out what seems a reasonable premium given the evidence available. French commentators admit that there are many cases where the court is unable to put an accurate percentage on the reduction, and the decision has "an element of arbitrariness".[84] However, it is still the best way of redressing the balance between the parties, which has been upset by the false statement. We think problems in calculating the appropriate reduction are unlikely to be frequent in consumer cases.

4.170 In any event, in our view it is preferable to allow judges to aim imprecisely at the correct figure than to apply one that is clearly wrong (as where a policy is avoided altogether when there would have been only a small increase in the premium). There are many occasions in which the courts are forced to place arbitrary figures on the level of damages, particularly in personal injury cases. The level of imprecision involved here would appear to fall within acceptable limits.

Declining the risk

4.171 If the insurer would have declined the risk altogether, the starting point must be that it should not have to meet the claim. In principle, we think it is right to hold insurers to a contract that they would have entered into had they known the true facts, but wrong to force them to abide by a contract they would not have assented to. In these circumstances, the insurer should be entitled to rescind the contract by returning the premiums and treating the contract as no longer in existence. The claim need not be paid.

4.172 This is fair where all reasonable insurers would have declined the risk because they were concerned about the loss that has in fact occurred. However, difficult cases may arise where, for example, this insurer would have declined the risk but other insurers would have accepted it. Below we discuss whether judges and ombudsmen should have a discretion to do justice in harsh cases.

[84] Lambert-Faivre, *Droit des Assurances* (11th ed), Dalloz at p197.

No reinsurance

4.173 It may occasionally happen that, had the insurer known the true state of affairs, it would have taken out special reinsurance. It might have done this because, though it would normally carry the entire risk itself, it would not have wanted to do so given the increased risk; or because it has concluded a reinsurance treaty but the facts not disclosed would take the particular risk outside the terms of the treaty. In either case, should the insurer be entitled to refuse to pay so much of the risk as it would have reinsured? We do not think a special provision is needed for such cases. Had the insurer taken out reinsurance for the additional risk, it would have charged an appropriately higher premium. Its liability will therefore be reduced under the proposals we have made earlier.

An alternative approach

4.174 We should explain that we have considered an alternative approach which was suggested both by some senior figures in insurance and by members of the public who contacted us. This is that in cases of negligence[85] the policyholder should not be able to recover for losses that were causally connected to the misrepresentation. Take the case where a proposer stated that she did not suffer from a particular disease when in fact she did, because she was careless in reading the question. It could be argued that the insurer should not have to pay any claim that was related to the disease in question, but should have to pay claims for other policy risks that were not related to that disease.[86]

4.175 There is a logic in this argument. The insured is covered for the risks that the insurer thought it was underwriting and not those about which it had been misled. However we have rejected this approach for three reasons. First, it seems harsh on the insurer who would not have accepted the proposal at all. Had they known the truth, they would never have come on risk at all. Secondly, it would prevent insurers avoiding for misrepresentations that are not related to the occurrence of the risk but to other factors. For example, few insurers will accept a proposal from a proposer with a record of criminal dishonesty although there will often be no causal connection between the previous convictions and the loss suffered subsequently. Thirdly, we think that the test of causal connection would prove very difficult to apply in practice. If a motorist gives a careless answer which does not reveal the fact that they have had a spate of previous accidents, is there a causal link between the misrepresentation and their next accident? If a proposer carelessly misunderstands a question about stress or depression, and answers that they have suffered from neither, should a claim for another form of serious illness be allowed or not? Many people argue that there is a correlation between depression and other forms of illness, but proving a causal link is very difficult.

4.176 We think that the proportionate approach we have described provides a better approach. If the insurer, had it known the truth, would not have accepted the proposal at all, it should be allowed to avoid the policy. If it would have charged a higher premium it should pay a proportionate part. It should only have to pay unrelated claims if it would have accepted the proposal subject to a relevant exception.

[85] We assume that the suggestions were not meant to apply either to cases of deliberate or reckless misrepresentation, nor to "innocent" misrepresentation.

[86] We understand this also to be the current approach of the European Restatement Group.

A discretion to prevent avoidance in harsh cases

4.177 In general, we think that a compensatory remedy will be fair between the parties. However, it may operate harshly in some cases where an insurer shows it would have declined the risk and the whole policy is effectively avoided.

4.178 One problem is where the individual insurer would have declined the risk but others would have accepted it for only a small increase in premium. Another is where the insurer would have declined the risk, but for reasons that have nothing to do with the claim in hand. Suppose, for example, a consumer negligently failed to recognise subsidence cracks, and the subsidence was so serious that the insurer would not have accepted the subsidence risk. It seems perfectly reasonable to permit the insurer to refuse a subsidence claim. But it may seem harsh to permit the insurer to refuse to pay for fire damage that was not connected with the subsidence in any way.

4.179 The position may seem even more unfair if the action was negligent only on a strictly objective test, rather than one that takes account of the insured's particular circumstances. Earlier we gave the example of a recently bereaved widow who left house maintenance to her husband. Although an objectively reasonable consumer should have recognised the effect of the crack over the door, in her subjective circumstances, it was reasonable for her not to notice them. However, under the rules we have outlined, the insurer may refuse the fire claim if it could show it would have declined the risk altogether had it known the true facts.

4.180 We would welcome views about whether the courts or the FOS should have a discretion to mitigate the harsh effects of avoidance in some cases. Such a discretion could be used where the policyholder's negligence was minor, and where the insurer has not suffered substantive prejudice (or where any prejudice that it has suffered could be adequately compensated by a reduction in the claim).

4.181 We note that the Australian Law Reform Commission recommended such a discretion even for fraud. They thought that in some circumstances avoidance could be seriously disproportionate to the harm suffered by the insurer. They therefore recommended that courts should have a discretion not to avoid, but instead to adjust the rights of the parties, having regard to all relevant facts, including the need to deter fraudulent behaviour. This recommendation was implemented in the Insurance Contract Law Act 1984.[87]

4.182 In our view, however, this is excessively lenient towards dishonest behaviour. It is our intention that a discretion to prevent avoidance in appropriate circumstances should apply only where the misrepresentation is negligent.

[87] Insurance Contract Law Act 1984, s 31; see Rob Merkin's, *Reforming Insurance Law: Is There a Case for Reverse Transportation?* http://www.lawcom.gov.uk/docs/merkin_report.pdf.

Effect on future cover

4.183 The foregoing discussion concentrates on claims that have already arisen. We need to consider whether the insurer should also be obliged to remain on cover. Current law allows the claim to be refused because the insurer can avoid the policy as a whole. For innocent misrepresentation, current ombudsman practice is to refuse to let the insurer avoid; in the case of inadvertent misrepresentation, it is to require that the cover continues on amended terms.

4.184 We think, on balance, that where the risk would have been declined altogether had the negligent misrepresentation not occurred, the insurer should remain entitled to avoid the policy. Unlike for deliberate misrepresentations, the insurer would need to return the premium.

4.185 In other cases, the insurer should offer to remain on cover on the terms it would have granted had it been aware of the full facts. If a higher premium would have been charged, a pro rata additional premium may be charged to cover the remaining term of the contract. The policyholder should be given the choice of accepting these new terms or cancelling the policy. If the insurer wishes to discontinue the policy, it should have to reserve a right to cancel it on notice, as we are told most policies already do.[88]

Conclusion: a compensatory remedy for negligent misrepresentations

4.186 **We provisionally propose that, in consumer cases, where the policyholder has made a negligent misrepresentation, the court should apply a compensatory remedy by asking what the insurer would have done had it known the true facts. In particular:**

(1) **where an 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 declined the risk altogether, the policy may be avoided, the premiums returned and the claim refused;**

(4) **where an insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium.**

4.187 **We ask whether there is a case for granting the courts or ombudsman some discretion to prevent avoidance where the insurer would have declined the risk but the policyholder's fault is minor, and any prejudice the insurer has suffered could be adequately compensated by a reduction in the claim.**

[88] The net effect will be in line with the continental provisions that allow cancellation after notice on the ground of a misrepresentation which was not a ground for avoiding the policy or refusing the claim. These apply to both negligent and non-negligent cases.

4.188 **We provisionally propose that where a consumer proposer has made a negligent misrepresentation, the insurer should be entitled to cancel the policy on that ground only where it would have declined the risk. (This proposal would not affect any contractual right to cancel upon notice.)**

4.189 **We provisionally reject the proposal that a consumer who has acted negligently should be entitled to enforce any claim unrelated to the risk.**

NEGLIGENT MISREPRESENTATIONS IN LIFE POLICIES: SHOULD THE LAW IMPOSE A CUT-OFF PERIOD?

4.190 A particular problem arises in long-term insurance business where many years may elapse between filling in the proposal form and making the claim. In life policies, in particular, it becomes extremely difficult for the insurer, the beneficiaries or the deceased's personal representatives to assess the reasonableness of a statement made many years earlier by someone who has now died. Assessments of innocence and negligence in such circumstances may seem unreal and unfair.

4.191 Many jurisdictions deal with this issue by imposing a cut-off period for defences other than fraud. In essence, the insurer is prevented from relying on any misrepresentation at the application stage once the policy has been in force for a set period – usually between two and five years. The attraction of such a provision is that insurers are encouraged to find out all they need to know as early as possible.

4.192 In Issues Paper 1 we quoted the New Zealand Insurance Law Reform Act 1977. Section 4 states that life insurers may not avoid for a misrepresentation unless the statement was substantially incorrect; material; and

> was made either:
>
> (i) fraudulently; or
>
> (ii) within the period of 3 years immediately preceding the date on which the policy is sought to be avoided or the date of the death of the life insured, whichever is the earlier.

4.193 Similar rules apply in Australia,[89] and also in many US jurisdictions, where the period is typically two years. A general cut-off applicable to insurance of all types has been proposed in Germany, though there the period is five years.[90]

4.194 The Issues Paper asked whether in consumer life insurance, the insurer should be prevented from relying on any non-fraudulent misrepresentation after the policy has been in force for three years.

[89] Insurance Contracts Act 1984, s 29(3) and (4).

[90] Draft bill of December 2006 Versicherungsvertragsgesetz (VVG) § 21(3). In the case of fraudulent failure to disclose there would be a 10-year cut-off.

Reactions

4.195 This question excited considerable comment, both in the insurance press and in the responses we received. Strong arguments were put both for and against the proposal.

4.196 The main arguments against a cut-off period were that it would encourage fraud; increase costs and premiums; and lead to inconsistent treatment between cases on different sides of an arbitrary line. The ABI said "it would tip the balance too far in favour of the insured" while HBOS said that it would "reward the disingenuous". Matt Rann, Head of Underwriting at Aegon Scottish Equitable, was quoted as saying:

> Are we encouraging people to take a punt on survival? The consumer could take a bet on living three years and decide not to disclose to avoid paying higher premiums.[91]

4.197 Others did not think that consumers would deliberately pay premiums for a life insurance policy that may prove useless, but thought that there was an issue of equity between the careful and the careless. As Roger Edwards at Bright Grey put it:

> I do not think a non-contestability clause will increase the number of people being fraudulent but it would mean that those people are more likely to get away with it and is that fair on the people who have disclosed?[92]

4.198 Another common theme was that insurers would either need to be more careful in obtaining full medical disclosure, or would have to pay more claims, or both. Either would increase costs, which the ABI argued would exclude people by making life insurance less affordable.

4.199 The main argument for a cut-off period is that it would increase trust in the market. As Nick Kirwan of Scottish Widows put it:

> This is the right thing to do. The biggest single issue in the industry is consumer trust. Non-contestability could boost trust and encourage consumers to take out insurance policies.[93]

It was also argued that it would discourage churning within the industry. Consumers would wish to keep existing policies rather than starting again.

4.200 Many people commented that a five-year cut-off period would have less immediate impact on the market:

> Five years might be acceptable as many companies do not really look for non-disclosure after five years, so the impacts might not be as dramatic.[94]

[91] Matt Rann, reported in *"Law Commission proposals would introduce non-contestability after 3 years*", MoneyMarketing 5/10/06.

[92] Matt Rann, reported in *"No contest",* MoneyMarketing 16/11/06.

[93] Nick Kirwan, reported in *"No contest",* MoneyMarketing 16/11/06.

It was felt that the likelihood that there was an initial non-fraudulent misrepresentation is reduced considerably if the proposer has survived five years. A reinsurer referred us to figures from the USA which measure the number of successful claims against the number that one would predict from the actuarial models. These show a higher than anticipated pay-out in Years 3 and 4 (leading to suggestions that consumers have misdescribed the risk) but little effect in Year 6 onwards.

Our views

4.201 A cut-off period would not benefit fraudsters directly as it would not apply where the misrepresentation was shown to be deliberate or reckless. It is possible that some people may deliberately give false answers in the hope that they will live five years, and that any inaccuracies will then be viewed as careless rather than reckless. However, this would be a risky thing to do: they may die within five years, and even if they live longer, their dishonesty may be discovered. The main reason for taking out insurance is to reduce risks rather than increase them. We do not think that consumers will be attracted to the idea of spending premiums on an uncertain policy that may well fail to pay out when it is needed.

4.202 However, there would be some cost to the proposals. Insurers would not be entitled to reduce payments or refuse on the ground that the consumer was negligent. This means either that insurers will have to take more time and trouble in assessing risk initially, or they will be forced to pay more in claims.

4.203 Our current view is that serious thought should be given to imposing a five-year cut-off period in respect of life insurance. It would only apply to claims made after a death. So in policies which involved both life cover and critical illness cover, the cut-off period would apply only to claims made after death. For life insurance, insurers would still be able to avoid for deliberate or reckless mistakes after five years, but not for purely negligent ones. This would effectively institutionalise current practice by which insurers do not conduct full investigations of past medical records where the death has taken place more than five years later. It would therefore not add greatly to costs, but would reassure consumers that insurers will not take technical points by dragging through old records many years after the events.

4.204 **We ask whether in consumer life assurance the insurer should be prevented from relying on a negligent misrepresentation after the policy has been in force for five years.**

RENEWALS

4.205 Our provisional proposals on misrepresentation and non-disclosure will apply to renewals of policies as much as to new applications. If an insurer requires information from the policyholder at renewal it will therefore need to ask a clear question. Under our proposals there will be no residual duty of disclosure.

[94] Matt Rann, reported in *"No contest",* MoneyMarketing 16/11/06.

4.206 In Part 3 we identified one potential pitfall peculiar to renewals – the question which simply asks the policyholder whether there has been any change in circumstances.[95] If the policyholder has not retained or been given a copy of any information previously supplied to the insurer, it may be hard to answer such a question accurately.

4.207 We agree with the FOS that good practice dictates that if an insurer wants to ask such a question, it should send the insured copies of all the information previously provided.

4.208 In Issues Paper 1 we asked whether we should build this practice into the law. We considered whether the statute should provide that insurers should lose their rights to rely on non-fraudulent misrepresentations made in response to such questions unless copies of previous answers have been provided. We thought that the copies could be provided in one of two ways – either as paper or electronic duplicates of the original documents, or as paper or electronic output of data stored on an insurer's computer systems, having been extracted from the original documents.

4.209 This suggestion provoked mixed responses. One major insurer supported it. It explained that for some general insurance business, it has started to provide consumers with a one page document showing 'material facts' they hold in relation to the policy.

4.210 Other insurers opposed the suggestion strongly on the grounds that it would add to administrative costs on renewals. We were surprised by some of the arguments put forward. For example, one insurer described the proposal as "inoperable in practice". It said that where insurance companies have merged and IT systems have changed, the insurer would not have access to the initial application form. However, it seems likely that important facts, such as that a car is parked on the street and not in a garage at night, will be noted somehow on the insurer's records of the policy. The insurer must have access to these or it will not be in a position to issue a renewal notice. Furthermore, if the insurer cannot find out what was on the previous proposal form, we question whether the insured can reasonably be expected to do so.

4.211 General questions at renewal stage may be particularly confusing. In answering whether anything has changed, the insured needs to know what sort of matters the insurer wishes to know about and this is often far from clear. For example, a policyholder will not know whether the insurer thinks a household insurance claim is relevant to a motor policy, or whether the insurer wants to know about their injury in a cycling accident. We are concerned by a recent practice which charges policyholders for notifying changes, and so discourages them from mentioning things that "are probably not important". We think that insurers could be much more specific about what policyholders are expected to mention at renewal.

[95] See paras 3.37 to 3.38.

4.212 However our view is that this issue can be dealt with by the general principles outlined above. Earlier we proposed that general questions should be permitted, but that the court should ask whether a reasonable consumer would understand that the question was asking about the particular information at issue. We think that in the case of the many general questions asked at renewal, consumers may, quite reasonably, have little idea of what the question is asking about. We are confident that judges and ombudsmen will apply this test appropriately in the circumstances. In the meantime, we hope that insurers will look hard at their renewal forms, bearing in mind that if their questions are inappropriately vague or wide, they can expect little redress if consumers do not tell them what they want to know.

4.213 Information to be provided by the insured at renewal is therefore not an issue about which we make a specific proposal.

MANDATORY RULES

4.214 Should the new law be mandatory, in the sense that the parties would not be free to vary it by adopting different policy terms, or only default rules that will apply in the absence of agreement to the contrary?

4.215 For consumer insurance, the parties are not in any case completely free to vary the rules, unless the change is in the insured's favour. This is because of the Unfair Terms in Consumer Contracts Regulations 1999 (UTCCR).[96] As we explained in Part 2, unless the term had been individually negotiated, almost any term that purported to alter the rules we propose would be subject to review on the grounds of fairness. The rules would thus be at least "semi-mandatory".

4.216 However, we think that the basic rights that are discussed in this Part so far should be mandatory, just like the requirements of the FSA Rules. This is for three reasons:

(1) the rights conferred are so basic that no consumer should be deprived of them;

(2) even if, in principle, a fully-informed consumer should be able to waive his or her rights, the number of consumers who would be both sufficiently informed and wish to give up their rights is so small that it is simpler to have one rule for all; and

(3) having mandatory rules is simpler for the industry and avoids the risk of less scrupulous insurers undercutting the more scrupulous by offering cheap policies that offer less protection in ways that the buyers will not understand.

4.217 Consumer rights in relation to the quality of goods are mandatory; we think that so far as possible, the same should be true in relation to insurance. When we discussed this issue at seminars there was general agreement that the rules should be mandatory in this sense.

[96] Unfair Terms in Consumer Contracts Regulations 1999, SI 1999 No 2083. See para 2.72 above.

4.218 **We provisionally propose that it should not be possible to contract out of the new rules governing misrepresentation and non-disclosure in consumer insurance except in favour of the consumer.**

BASIS OF THE CONTRACT CLAUSES AND WARRANTIES

4.219 If the law of misrepresentation and non-disclosure is reformed, it is necessary to consider "basis of the contract" clauses and warranties of existing or past fact.

The problem with "basis of the contract" clauses

4.220 A basis of the contract clause is a legal device by which an insurer may add to the remedies the law provides for misrepresentation. If an insured states that the answers they have given on a proposal form constitute "the basis of the contract", all answers are given warranty status. This means that any mistake discharges the insurer from liability under the contract, even if the mistake would be irrelevant to the prudent insurer, did not induce the particular insurer to enter the contract, or was made innocently.

4.221 It is now generally accepted that, in the consumer market, insurers should not rely on such clauses. The Statement of General Insurance Practice barred their use, and the FOS would almost certainly reject any defence that was based on one. The FSA Rules do not mention basis of the contract clauses, but we agree with the ABI that the use of such clauses contravenes the insurers' duty to treat customers fairly.[97]

4.222 Our aim is to bring the law into line with current practice. Not every case can be taken to the FOS and the requirement to treat customers fairly cannot provide a guarantee that basis of the contract clauses will never be used. It is true that if the matter came to court, a basis of the contract clause might be challenged under the Unfair Terms in Consumer Contracts Regulations, but we see no reason why the onus should be on the consumer to prove that such clauses are unfair.

4.223 We do not see our proposal as controversial. The Law Commission's 1980 report recommended that basis of the contract clauses should be of no effect, and they have been outlawed in Australia and New Zealand.[98] At the working seminars there seemed to be widespread agreement with the suggestion in our Issues Papers that basis of the contract clauses should always be ineffective in consumer insurance.

[97] See para 3.16 above.

[98] Warranties of this kind appear to be unknown in continental systems.

Warranties of fact in the policy

4.224 In consumer insurance it would not be adequate merely to require that the warranty must either be in the policy, or "contained in some document incorporated by reference to the policy".[99] If all the law required were a clause in the policy that the insured warrants the truth of every statement made in another document, consumers would be no more likely to understand the effect than if the "basis of the contract" clause were in the proposal form. At the very least we think that in consumer insurance warranties of existing fact should be effective only if each fact warranted is specifically set out in the policy or in a schedule to it. However, we would go further. For reasons we explain below, we think that even warranties of specific fact in consumer policies should be of no effect.

The Law Commission's 1980 proposals: specific warranties of past or existing fact

4.225 The Law Commission's 1980 report recommended that specific warranties as to past or existing fact should remain effective, subject to three provisos:

(1) the fact warranted must be material (there would be a presumption that it was material);

(2) once a claim had occurred, the insurer would not be entitled to refuse to pay the claim if the insured showed that the warranty was not intended to safeguard against the kind of event that materialised or that the breach of warranty did not increase the risk of the event occurring in the way it did;[100]

(3) the insurer would not be permitted to rely on a breach of warranty unless the insured was supplied with a written statement of the warranty either at or before the contract was made, or as soon as possible thereafter.[101]

4.226 It must be asked what purpose a warranty of this kind would serve. What rights would it have given the insurer over and above its rights under the Law Commission's proposals on misrepresentation? The fact warranted would have to be material in each case. Because of the requirement for a causal connection, the right to refuse the claim (and also to cancel the policy) would be more restrictive than the right to avoid for misrepresentation. So it seems that the only advantage the insurer would get from obtaining a warranty of fact would be that the liability for breach of warranty would be strict – in other words, it might be able to avoid paying even though the insured was in no way at fault in giving the incorrect information.

4.227 We have already argued that consumers should not lose their rights when not only were they honest but they can show that they were not negligent. We have also reported the general agreement at the working seminars that this rule should be mandatory in consumer cases. It would undermine this to say that the insurer may achieve the same result by use of a warranty.

[99] To use the words of the Marine Insurance Act 1906, s 35(2).

[100] Draft Bill, Clause 10 (5)(a).

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

Our proposals

4.228 Therefore we provisionally propose that, for consumer insurance, the legislation should adopt the approach taken by the Australian Insurance Contracts Act 1984, section 24. This provides that a statement by the insured about the existence of a current state of affairs should take effect only as a representation, not as a warranty. Where a statement is inaccurate, the insurer's remedies should be those we have already proposed for misrepresentation (and would depend on whether the misrepresentation was deliberate or reckless, negligent or reasonable). This means that the insurer would need to show that the statement induced it to contract on those terms. It also means that an insurer could not avoid liability for a misstatement that was reasonable in all the circumstances, even if it was written into the contract as a warranty.

4.229 **We provisionally propose that an insured's statement of past or current facts made before a contract is entered into should be treated as a representation rather than a warranty.**

PART 5
PRE-CONTRACT INFORMATION AND BUSINESSES: PROPOSALS FOR REFORM

INTRODUCTION

5.1 The 1980 Report by the Law Commission took the view that the problems with insurance law are not confined to the consumer market. The British Insurance Law Association (BILA) also argued for reform of the law governing business insurance.[1] In this Part we discuss whether there is a need to reform the duties the law places on business insureds to provide pre-contract information and the remedies available to the insurer if the duty is broken. Our view is that change is required to align the law of business insurance with normal and accepted practices within the industry, and to meet the reasonable expectations of the insured.

Flexibility in a varied market

5.2 One problem with establishing rules to govern business insurance is that the market covers such a wide range of parties and risks. Major businesses may be extremely knowledgeable about insurance. They spend large sums on insurance, and receive sophisticated advice from specialist staff and brokers. Some are in the insurance business themselves. They negotiate their contracts with care, and obtain the terms they want. It is important that the law does not interfere with this process.

5.3 At the other end of the scale, many businesses are in a similar position to consumers. They buy insurance on standard terms, either directly from the insurer or through an intermediary who may not offer detailed advice. They are unlikely to understand the full terms of their policies. They may not realise they need advice, or if they do, may not be able to afford it – or may consciously take the view that the chances of a problem occurring are low enough that it is not worth spending time or money on advice.

5.4 Even if smaller businesses do understand the terms of their policies, they usually lack the bargaining position to obtain the changes they may want in policy terms. Suppose, for example, that a mid-range business wishes to obtain cover even if it has made an innocent, non-negligent misrepresentation, but the insurer's standard terms do not provide this. It can ask for special cover, but the insurer will often be reluctant to make a special provision for a particular proposer, unless the proposer is either a particularly important client or is prepared to pay a large increase in premium. This is not a question of the insurer being obstructive: to have different policy terms for each client can cause significant increases in the costs of preparing the policies and administering them later. But whatever the reason, if the insured would in fact have been willing to pay a sufficient additional premium for the improvement in cover, there is a form of market failure – the terms of the contract are inefficient.

[1] British Insurance Law Association, *Insurance Contract Law Reform* (September 2002). See also Lord Justice Longmore's lecture, which is reproduced as an appendix to that report.

5.5 We have therefore sought solutions that protect less sophisticated parties while being sufficiently flexible to respond to the demands of sophisticated businesses.

Default rules should reflect reasonable expectations

5.6 The law should start from a default position based on generally accepted standards within the industry, so as to meet the reasonable expectations of the parties. We think it should correspond more closely than the current law with what insureds want – and, given the generally high standards of the vast majority of insurers, what most insureds probably think that they are getting when they buy insurance in the UK market.

5.7 However, if the parties wish to agree different terms, they should be able to do so. Wherever possible, the parties should remain free to agree what they want.[2]

5.8 That said, it is important that such agreements do not take policyholders by surprise. The insured should know, or at least have a reasonable opportunity to discover, what they are agreeing to. We propose controls on terms that are part of the insurer's standard terms of business and were not clearly brought to the insured's attention. Below we provisionally propose that an insurer should not be allowed to rely on such a standard term to alter the default rules if it would mean that the policy cover was substantially different to what the insured reasonably expected. This question would be judged in the light of the way the policy was presented when it was arranged.

Boundary issues

5.9 One possible approach to a highly varied market is to set different rules for different types of insurance. The law could, for example, not only distinguish between consumers and businesses, but also between small and larger businesses. Many jurisdictions provide different rules for marine insurance, including France, Australia and New York. Some jurisdictions also differentiate between insurance and reinsurance. In 1980, the Law Commission advocated one law for general insurance and another for marine, aviation and transport insurance (MAT) and reinsurance.

5.10 Many of those who responded to our Issues Papers urged us to avoid too many boundaries, each of which may cause its own awkward boundary disputes. Rules to define boundaries are, by their nature, complex and arbitrary, and add to legal expense.

5.11 The first question we have considered is whether it is necessary to have one law for consumers and another for businesses. Although we would wish to keep any differences between the legal regimes to a minimum, we think that some differences are necessary, particularly concerning the duty of disclosure. However, we see the differences between consumer and business law as being variations from a common core, rather than separate regimes.

[2] See para 5.115 below. In only one case do we suggest mandatory rules for business insurance: we propose that warranties should have to be set out in a schedule to the policy.

5.12 We also consider whether special rules are needed for MAT insurance, for reinsurance, to protect third parties and for small businesses. Our provisional view is to avoid special categories such as these, and to produce a law with sufficiently flexible tests that can apply across the board. However, it is an issue on which we welcome views.

Understanding the practical effect

5.13 We think that in some aspects the current law is so far removed from what a business insured would normally want, and from what the unadvised business insured would reasonably expect, that it is no longer fit for purpose. To leave it unreformed risks undermining confidence in insurance written under UK law.

5.14 This judgement is necessarily based on our perceptions of the difficulties faced by both insurers and insureds, and of the impact of the current law. We would welcome information from all sides of industry on the extent to which the issues we identify in this paper cause problems in practice. We want to know if they have an impact on the market – and in particular whether they have a positive or negative impact on the competitiveness of insurance policies written under English or Scots law. We are also keen to ensure that any recommendations we make are both workable and would represent significant improvements in the law.

Summary

5.15 This Part is in five further sections. Here we give a brief overview of our thinking.

Retaining the duty of disclosure

5.16 In the business context, our view is that the duty should be retained.[3] It is part of the way the UK market works; it is probably necessary for unusual risks; and where the insured is represented by an experienced broker the system generally works well. Furthermore, abolishing the duty could lead to an empty formalism, in which insurers go through the motions of asking general questions. However, the duty under current law should be restricted, unless the parties agree otherwise, to information that a reasonable insured would think would be relevant to the insurer.

Protecting the honest and careful

5.17 We think that policyholders who act honestly and carefully deserve greater protection. This requires two changes to the default rules.

(1) The duty to disclose should be modified. As just explained, an insured should no longer be required to disclose everything a prudent insurer would wish to know. Instead, the question will be looked at from the point of view of a reasonable insured. An insured who honestly and reasonably did not realise that a matter was relevant would be protected.

[3] In Part 4 above, relating to consumer insurance, we provisionally propose abolishing the insured's duty to volunteer information. Instead, the onus should be on insurers to ask questions.

(2) Similar protections would apply where an insured made an inaccurate representation of a relevant fact, but did so honestly and reasonably in all the circumstances.

Distinguishing between dishonest and negligent conduct?

5.18 We consider whether the law should distinguish between dishonest and negligent misrepresentations. In Part 4 we argued that an insurer's right to avoid a policy in all circumstances over-compensates the insurer for the loss it has suffered. It entitles the insurer to refuse all claims under the contract, not just those additional claims affected by the insurer's lack of knowledge. We argued that this is appropriate where an insured has behaved dishonestly, but not where the insured has behaved negligently. For negligent misrepresentations, we thought the remedy should depend on what the insurer would have done had it known the full facts. If it would have charged a higher premium, it should pay a proportion of the claim. If it would have included an exception, it should be entitled to refuse claims falling within the exception. An insurer would only have the right to avoid the entire policy if it would not have accepted the risk at all.

5.19 We think there are good arguments for applying the same principles to business insurance. However, it has been suggested that problems would occur in practice. Some insurance lawyers said it would be too difficult to prove dishonesty, and too difficult to show what an insurer would have done had it known the information. It was also said that policyholders should be under a strong incentive to act carefully as well as honestly. We discuss these arguments, and leave it as an open question: should the default rules continue to allow insurers to avoid a policy for all cases of negligent non-disclosure or misrepresentation, or should a compensatory remedy be applied?

Contracting out

5.20 As we have already stressed, the rules we have set out should be merely default rules. The parties should be free to reach an agreement that an insurer may avoid a policy as a result of a failure to pass on pre-contract information, even if the failure was honest and reasonable, or only negligent.

5.21 However, this must be done in a clear and transparent way. We argue that insurers should not be able to use a "basis of the contract" clause on a proposal form to convert all the answers given into warranties. If insurers are to use warranties of past or present facts, the facts must be specified in the policy or accompanying documents. As we explain in more detail in Part 8, we also think that if a policy merely states that a fact is warranted, this should be interpreted as giving the insurer the right to refuse only those claims that have some causal connection with the loss. If the insurer wishes to avoid all claims under the policy for a breach of warranty, the contract must specify this explicitly.

5.22 Where the parties contract on the insurer's standard terms, special controls would apply to terms which expanded the default regime to give insurers additional rights to refuse claims on the basis of the insured's failure to provide accurate pre-contract information. Such terms would be permitted only if enough was done to bring them to the insured's attention. The insurer would not be entitled to rely on such a term if it would defeat the insured's reasonable expectations.

Different rules for different markets?

5.23 At the end of this Part we consider the possibility of separate legal regimes for MAT insurance; for reinsurance; for third party insurance; and for small businesses. However, we do not wish to create artificial and complex boundaries unless it is strictly necessary to do so. Our current view is that the reformed regime we propose would be sufficiently flexible to cover all forms of business insurance.

RETAINING THE DUTY OF DISCLOSURE

5.24 Business insurance covers a much wider range of situations than consumer insurance. While there are some businesses that are consumer-like in that they are small and unsophisticated, the rules for business insurance cannot be shaped for them alone. We think that the rules for business insurance should differ from those we have set out for consumers. The first rule that we think may need to be different relates to the duty of disclosure.

Arguments for and against the duty

5.25 In Part 4 we provisionally proposed that consumers should no longer have a duty of disclosure, that is, a duty to volunteer information. Rather, insurers should have to ask for the information they need. They should be entitled to ask questions in general terms ("Are there any other facts that we ought to know?") but the answers given should be judged by what the reasonable consumer would think was being asked about. Thus if the consumer reasonably thought that a fact they did not reveal was not material, the insurer would have no remedy.

5.26 In Issues Paper 1 we argued that for businesses the duty of disclosure should be retained but modified. Business insureds should no longer be required to disclose everything a prudent underwriter would want to know. Instead, an insured would only need to disclose a matter if a reasonable insured in the circumstances would realise that it would be relevant to an underwriter.[4]

5.27 At the seminar, two participants argued forcefully that our tentative proposals did not go far enough. They thought the duty of disclosure should be abolished in all cases.[5] Underwriters know what information they need and should ask for it. If they do not, they should bear the consequences. We have considered this argument carefully. However, our view remains that in business insurance the pre-contractual duty of disclosure on the insured should be retained. There are four reasons for this.

[4] We added that an insured would also need to disclose something if they realised it was relevant, even if a reasonable insured would not.

[5] As we noted in paras 4.18 and 4.19, many of the other legal systems that we have examined have partly abolished the duty of disclosure for both business and consumer insurance, but most retain a rule that deliberate failure to disclose a fact that is known to be relevant gives the insurer the right to avoid. The only system we looked at which in this respect distinguishes between business and consumer insurance, the Swedish Insurance Contracts Act of 2006, puts business insureds under a duty to disclose "information of clear significance for the risk assessment " even though the insurer has not asked for it: Insurance Contracts Act (SFS 2005:104), Ch 8 s 8.

(1) The duty of disclosure has become part of the way the UK business insurance market works. For many business policies, there is no proposal form. Instead the broker presents the risk, and the underwriter relies on the broker and client to present that risk honestly. It would be possible to distinguish insurance that was preceded by a proposal form (whether a paper form or on a website) and insurance where there was no such form, and require disclosure only in the latter. However we would prefer not to set boundaries between types of insurance, as these always cause problems in marginal cases.

(2) Business insurance involves a much greater variety of unusual risks than consumer insurance. That would make it harder for the insurer to ask questions about all relevant matters.

(3) A greater proportion of business insurance is conducted through full-time professional intermediaries, who can advise as to what is required. This means that the risk of an insured not realising that it has a general duty to disclose is reduced.

(4) Requiring insurers to ask questions even when both parties are sophisticated in insurance matters could lead to an empty formalism. If underwriters ask a general question such as "and finally, is there anything else that we should know about?" the duty would effectively be restored.

5.28 We still think that it would be appropriate to expect insurers, as a matter of good practice, to warn insureds about the duty to disclose when it is reasonable to think that the insured may not be aware of the need, particularly on renewal. But we doubt it is necessary to provide a legal remedy, such as preventing the insurer from avoiding, for failure to do so.

5.29 For these reasons, we think that the duty of disclosure should be retained, but its scope should be modified to protect those who act honestly and reasonably in all the circumstances. We explain this below.

5.30 **We provisionally propose that a duty of disclosure should continue to apply to business insurance contracts.**

PROTECTING THE HONEST AND CAREFUL INSURED

5.31 Previously in this report we have outlined a general principle: an insured who was both honest and careful in giving pre-contract information should not have a claim turned down on the basis that the information was incorrect or incomplete. We think this should apply to business insurance as well as to consumers, at least in the absence of a clear and genuine agreement to the contrary.

5.32 To some extent the current law of non-disclosure already protects the honest and careful insured. This is because the duty to disclose applies only to facts that the insured actually knows or ought to have known in the ordinary course of business. In contrast, if the insured makes a material misrepresentation, it is irrelevant that the insured did not know and had no reason to know the fact that made their statement incorrect. The insurer may avoid the contract even though the insured was perfectly honest and had reasonable grounds for believing that their statement was true.

5.33 An insured may also have acted reasonably if they reasonably believed that the fact they did not disclose was not relevant to the insurer. The current test of materiality requires the insured to disclose any facts that would influence a prudent insurer in fixing the premium or deciding whether to accept the risk. Similarly, if the insured gives information that is inaccurate or incomplete, and the misrepresentation was material to the prudent insurer, it is irrelevant that the insured honestly and reasonably believed that the inaccuracy or omission was irrelevant to the insurer.

5.34 We think that in all the situations just described, if the insured acted both honestly and reasonably, the insurer should have no right to refuse to pay a claim under the policy.[6] This should be the default rule, that is, the rule that applies unless the parties have agreed otherwise.[7]

5.35 In what follows we discuss first the case where the information which the insurer claims should have been disclosed was unknown to the insured. Then we discuss the case where the insured made a representation which they honestly and reasonably believed to be true. Finally we discuss cases where the insured reasonably believed that what they failed to disclose, or the inaccuracy in what they told the insurer, was not relevant – in other words, the materiality test.

Disclosure of information unknown to the insured

Facts the insured should have known

5.36 The duty of disclosure applies to facts that the proposer knows.[8] However, under section 18(1) of the Marine Insurance Act 1906 (1906 Act), the insured is

> deemed to know every circumstance which, in the ordinary course of business, ought to be known by him.

[6] Many of the continental systems we have examined seem to require the insurer to pay when the business insured gave information that was incorrect but acted in good faith and without negligence. See Norwegian Marine Insurance Plan 2007 (http://www.norwegianplan.no/eng/index.htm) arts 4.4. and 4.7; Swedish Marine Insurance Plan 2006 (http://www.sjoass.se/orgvillpdf/SPL/SPLeng.ver.pdf) art 4.6; Swedish Insurance Contracts Act 2005 (SFS 2005:104) chapter 8 s 9 (remedies only where insured acted intentionally or negligently). The proposed German legislation (see above, para 4.19 n 22) will not permit the insurer to refuse a claim on the basis of a misrepresentation that was neither deliberate nor negligent, VV § 19. Nor would the current approach of the European Restatement Group. French law, in contrast, gives the insurer a proportionate remedy in such cases: Code des assurances, art 113-9.

[7] Swedish Insurance Contracts Act 2005, ch 8 s 9, allows the insurer to contract out of the rules described in the previous note except that the incorrect information must be material to the risk. The German proposals would be mandatory even in business insurance.

Thus if a business insured ought to know the material circumstance, it has a duty to disclose it. If it fails to do so, the insurer may avoid the policy. The presumption appears to be irrebuttable, in the sense that it is no answer for the insured to prove that in fact it did not know the material circumstance.

5.37 We do not think it would be appropriate to retain this irrebuttable presumption in the scheme we propose below. This is for two reasons.

5.38 First, we are asking whether the law should distinguish between "deliberate or reckless" behaviour and negligent behaviour, so that an insurer only has an automatic right to avoid where the insured has behaved in a way that is not honest. If this approach were to be adopted, it would often be necessary to decide whether the proposer's non-disclosure or misrepresentation was "deliberate or reckless", or merely negligent. Part of our proposed test of whether an action was "deliberate" would involve asking if the proposer knew the truth.

5.39 Given that section 18(1) provides that business insureds are deemed to know what they ought to know in the ordinary course of their business, the effect of the section under our proposed scheme might be unfortunate. A business insured that failed to disclose a matter that they did not know, but ought to have known in the ordinary course of their business, might be treated as if they knew the information and had acted deliberately in failing to disclose it. We think that would be inappropriate.

5.40 Secondly, we think it would be better to replace the "deemed to know" test under section 18(1) with a simple test of whether or not the insured who was unaware of a material fact, and therefore did not disclose it, was reasonable or negligent.

[8] See paras 2.35 and 2.36 above.

5.41 The circumstances in which the insured is "deemed to know" facts are not wholly clear. It has been said that in practice the courts have interpreted section 18(1) rather narrowly "and allowance is made for the fact that businesses are imperfectly organised."[9] In a case where it was argued that the insured should have known that its servants were operating a system that risked goods being wrongly delivered, though it had not caused problems before, Mr Justice McNair held that the duty had not been broken. He said that an overly restrictive interpretation of the section would mean that only prudent businesses which knew everything they should know could benefit from insurance: yet "one of the purposes of insurance is to cover yourself against your own negligence or the negligence of your servants".[10] It has been held that companies are not obliged to make enquiries into matters outside their own knowledge before taking out insurance.[11] However, businesses are not entitled to turn a blind eye to a material circumstance, or rely on the incompetence of employees or agents who fail in their duty to inform them of problems.[12]

5.42 Whatever the correct interpretation of section 18(1), it is hard to see any justification for applying a standard less demanding than the normal standard of negligence. This is the more so if remedies in the case of negligence are to be modified so as to put the insurer into the position it would have been in had it known the truth, as discussed in detail below.

5.43 Thus the duty of disclosure imposed on business insureds should be to disclose relevant facts[13] which the insured knew or which it ought reasonably to have known. There would no longer be any question of deemed knowledge. Nor would what the insured ought to have known be strictly limited to what it might have discovered "in the ordinary course of business". The question of whether the business insured should have known a relevant fact of which it was not actually aware should be treated in the same way as other forms of negligence.

5.44 **We provisionally propose to simplify the test in section 18(1) of the Marine Insurance Act 1906 ("that the insured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him"). The duty of disclosure should be limited to facts which the business insured knew or which it ought to have known.**

The burden of proof

5.45 There is also an issue as to the burden of proof. In cases of non-disclosure, should it be up to the insurer to show that the insured should have known the relevant fact, or for the insured to show that its ignorance was reasonable?

9 J Birds and N Legh-Jones, MacGillivray on Insurance Law (10th ed 2003) at para 17-13.

10 *Australia & New Zealand Bank v Colonial & Eagle Wharves* [1960] 2 Lloyd's Rep 241, 252.

11 *Simner v New India Ass Co* [1995] LRLR 240. Otherwise it is hard to find authority for a generous interpretation of section 18: see *London General Insurance Co v General Marine Underwriters Assoc* [1921] 1 KB 104.

12 J Birds and N Legh-Jones, MacGillivray on Insurance Law (10th ed 2003) at para 17-13 and *Inversiones Manria SA v Sphere Drake Insurance Company* [1989] 1 Lloyd's Rep 69.

13 By this we mean facts that a reasonable insured would have known would be relevant to the insurer, or which the particular insured actually knew to be relevant: see para 5.84 below.

5.46 On the one hand, it seems right to say that if the insured is arguing that the proposer should have known a particular fact, the insurer should have to prove it. On the other hand, in cases of misrepresentation, the burden of disproving negligence is on the misrepresentee: Misrepresentation Act 1967, s 2(1).[14] Under that section a party who makes a misrepresentation is liable as if the representation were fraudulent unless they prove that they had reasonable grounds for believing, and did believe, that the fact represented was true.

5.47 In our view the burden of proof should be on the same party in both cases, or there will be awkward questions about whether silence on a particular point was a mere non-disclosure or amounted to a misrepresentation. We think the burden should be on the insurer in both cases. In cases of misrepresentation, this would be different to the rule for contracts in general but we think the difference is justified. In most contracts, the remedy of avoidance is far less draconian than it is in insurance. In the case of a misrepresentation about property sold, for example, avoidance will mean the misrepresentee loses the benefit of the contract but gets back the property. In insurance, however, avoidance after a claim has arisen leaves the insured with only the premium, which is of little value. Proof of negligence will not necessarily give the insurer the right to avoid (see the discussion below) but it will be a pre-requisite to it. It seems fair to place the burden of proof on the insurer.

5.48 **We provisionally propose that the burden of proving that a business insured should have known a particular fact should be on the insurer.**

Representations the proposer honestly and reasonably believed to be true

Comparison to non-disclosure

5.49 Under section 20 of the 1906 Act the insurer may avoid the contract for any misrepresentation of a material fact, even if the misrepresentation was made honestly and without any lack of care. Innocence is no defence. It is to this that we turn now.

5.50 In Part 4 we provisionally proposed that an insurer would not be able to reject a claim on the basis of a misrepresentation if a consumer insured had acted reasonably in all the circumstances. Thus if the proposer makes an inaccurate statement, but has reasonable grounds to believe the statement was accurate, the insurer should have no right to reject any claim or to avoid the policy. We think the same rule should be the starting point in business insurance.

5.51 The reason for this proposal is simple. It would bring the law into line with good market practice and with what we believe business insureds reasonably expect. As we explained in Part 1, we think the normal expectation is that an insured who was not at fault in giving incorrect or incomplete pre-contract information should be entitled to claim on the policy. We are told that this is also accepted in the insurance market as the attitude that a responsible insurer should take. In the course of this review, insurers often told us that they would not reject claims for honest and reasonable failures to disclose (though they sometimes said that other, less scrupulous insurers would take the point). The law should uphold good practice and reasonable expectations.

[14] This Act does not apply in Scotland.

5.52 For business insurance, this would only be a default rule. If the parties wish, they should be free to agree that the insurer should have the right to reject claims or avoid the policy because of any failure to disclose or any incorrect statement. However, such agreements must not take the insured by surprise. Below we propose controls where the parties contract on the insurer's standard terms of business. A standard term that adds to the default rules should not be permitted if it would make the cover substantially different from what the insured reasonably expected.[15]

5.53 We think that in practice, most insureds would be happy to pay a small additional premium for the added protection of knowing that so long as they act reasonably their insurance claims would be paid. They may agree to a cheaper but less reliable policy if they wish, but this must be done explicitly.

5.54 The change would bring the law of misrepresentation into line with the law on non-disclosure where, as we have seen, the insured is only under a duty to disclose what it knew or ought to have known. Suppose that an employer is genuinely and reasonably unaware that a junior employee has a criminal conviction. The employer is not under a duty to volunteer information about the criminal conviction. However, if the insurer asks if any employees have criminal convictions, and the insured says they do not, the insurer may avoid the policy, however reasonable the mistake. In our view, if the parties wish to make the insurance dependent on particular circumstances about which the proposer was reasonably ignorant, this should be done explicitly within the contract.[16] It should not be an unexpected result of the general law.

Comparison with general contract law

5.55 It has been put to us that insurers should at least have the same rights as other contracting parties. Under general principles of contract law, a contracting party has the right to rescind a contract that they have entered on the basis of an innocent misrepresentation. Therefore, it is argued, the same should apply to insurance contracts.

5.56 English law already recognises that where the effect of rescission would be disproportionately harsh on the misrepresentor, there should be a discretion to prevent rescission. Section 2(2) of the Misrepresentation Act 1967 states that for non-fraudulent misrepresentations, the court or arbitrator may declare the contract subsisting and award damages in lieu of rescission, if it is of the opinion that

> it would be equitable to do so, having regard to the nature of the misrepresentation and the loss that would be caused by it if the contract were upheld, as well as to the loss that rescission would cause to the other party.

[15] See paras 5.146 and 5.147 below.

[16] As we explain later, it may be done through a clause establishing different remedies for misrepresentation or through a warrant of past or current fact.

5.57 Insurance law is currently harsher on the misrepresentor than general contract law. There is authority that section 2(2) should not be applied to insurance contracts, because it is thought that the risk of avoidance exerts a discipline on the market.[17] This may be true in cases of negligence, but we cannot see that such discipline is needed when the insured has taken reasonable care. But, again because of the draconian effect of avoidance in insurance,[18] and because of the need for certainty, we would go further than leaving the right to rescind to the discretion of the court. We believe that when there has been no negligence in making a misrepresentation that induced a policy of insurance, the insurer should have no right to refuse to pay the claim or avoid the policy unless they have reserved that right in the policy.

5.58 **We provisionally propose that if a business insured has made a misrepresentation but the proposer honestly and reasonably believed what it said to be true, the insurer should not be able to refuse to pay any claim or to avoid the policy, unless the parties have agreed otherwise.**

The burden of proof

5.59 We have already considered where the burden of proof should lie. We concluded that the burden of proof should be on the same party as in cases of non-disclosure, and that it should be on the insurer. This will be different to the rule in contract law generally, but we think the difference is justified by the particular nature of insurance contracts.

5.60 **We provisionally propose that the burden of showing that the insured did not have reasonable grounds for believing that what it said was true should be on the insurer.**

Materiality

5.61 We explained earlier that an insured who fails to disclose a fact or who makes a misrepresentation may act honestly and reasonably in two ways. First, they may reasonably not know the fact or may have reasonable grounds for believing that what they said was true. That is the case we have just considered. Alternatively, a party may know a fact but may decide not to disclose it because they think that it is not something that the insurer would be concerned with. The same issue can arise in cases of a positive statement which is incorrect. The proposer may know that what they are saying is not literally true, but they may honestly and reasonably think that the difference between what they are saying and the strict truth is of no concern to the insurer. In both cases the issue is part of whether or not the fact is "material".

5.62 In Issues Paper 1, we stated that in order for an insurer to be entitled to a remedy for non-disclosure, it would need to meet a two-part test. Broadly, we said that an insurer would need to show:

(1) "inducement", in that had it been aware of the true facts it would not have entered into the contract on the same terms; and

[17] See para 2.14 above.

[18] See para 5.47 above.

(2) the matter was either one which the insured realised was relevant, or which a reasonable person in the circumstances would have realised was relevant.

5.63 The first limb represents current law. The second limb was effectively a replacement for the "materiality" test currently set out in section 18(2) of the 1906 Act. This states that a fact must be disclosed if it "would influence the judgment of a prudent underwriter in fixing the premium or determining whether he will take the risk".

5.64 As we explained in Part 4, some respondents found the way we formulated the test in Issues Paper 1 confusing. Below we use slightly different words to make the test clearer. However, we think the test is right in substance. As the Law Commission argued in 1980, the ambit of the duty of disclosure should be considered from the point of view of a reasonable insured, not a prudent underwriter.

5.65 The test is designed to meet the long-standing criticism that the current duty of disclosure is too stringent and produces something of a trap for policyholders. As the Law Commission said in 1980:

> an honest and reasonable insured may be quite unaware of the existence and extent of this duty, and even if he is aware of it, he may have great difficulty in forming any view as to what facts a prudent underwriter would consider material.[19]

The "prudent insurer" test does not fit with the reasonable expectations of the business insured. The insurer should not be able to rely on non-disclosure of a fact unless the reasonable insured would have realised that it would be a fact that the insurer would take into account.

5.66 The same issue can arise in cases of alleged misrepresentation. Suppose the insurer asked the proposer to list all uninsured losses, without specifying what types of loss should be included. The proposer may reasonably think that an insurer would not want to know about minor and routine losses which would not be covered by the policy. At present, however, the law does not ask what a reasonable insured should have realised was relevant, but asks what a prudent insurer would want to know.[20] The test we have suggested for non-disclosure should also apply to misrepresentations in these circumstances. The insurer should not have a remedy unless the reasonable insured would have realised that the inaccuracy or omission was relevant to the insurer, or it is shown that the particular insured knew that the fact was relevant.

[19] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 9.3.

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

5.67 This is the same rule that we provisionally proposed for cases of misrepresentation in consumer insurance, where it would be mandatory. In business insurance the "reasonable insured" test would be only the default rule: the parties should be able to agree on a stricter standard if they so wish. In practice we doubt insurers will wish to do so. If they are concerned that an insured may not give them the information they need to know, it will normally be simpler to ask specific questions. As we explain below,[21] the insured will very seldom be able to argue that they reasonably believed a fact was not relevant if the insurer has specifically asked about it.

A flexible test

5.68 One advantage of the "reasonable insured" test is that it is sufficiently flexible to adapt to the many different circumstances in which insurance is used and sold, to a variety of policyholders. In particular, it will take into account the knowledge not only of the insured but of its professional advisers such as the broker. In the more sophisticated markets, where both the insurer and the insured are experts or are professionally represented, we would expect almost no difference between what a reasonable insurer and a reasonable insured would regard as material. Here the two tests are effectively synonymous. As the gap between the two sides grows, so does the effect of the reform. A "reasonable insured" test has the advantage that it does not require legislators to draw arbitrary lines by, for example, distinguishing businesses by their size or level of sophistication. As BILA put it in their 2002 report, the test

> would enable the court to differentiate between the duty of a large industrial company with a professional insurance department, as compared with a small company on an industrial estate where the insured's knowledge of insurance law may well be very limited.[22]

5.69 In assessing what a reasonable insured in the circumstances would understand to be material to the underwriter in question, a court would take into account what the insurer – in its proposal form, or orally – had explained to the insured. It would also take into account whether the policyholder had received professional advice from an intermediary.

The nature of the evidence

5.70 We have been told that there are advantages in the present "prudent underwriter" test, because the issue of what underwriters think is material may be determined by expert evidence from the industry. Solicitors acting for insurers can locate expert underwriters and ask them to give evidence in court. They expressed concern that a "reasonable insured" test was inherently uncertain. In the absence of any recognised reasonable insureds to give evidence, they thought it would merely invite the judge to substitute his or her own opinion for that of the industry.

5.71 It can be argued that it would be an improvement were there to be less need to rely on expert evidence. In 1980, the Law Commission saw the prominence granted to insurers' evidence as a serious criticism of the current law:

[21] See para 5.74 below.

> Such evidence will usually be readily available to the insurers, who will have no difficulty in selecting appropriate witnesses. However the insured will often be at a considerable disadvantage in finding expert witnesses prepared to challenge those of the insurer and the position of such witnesses is often invidious. Some judicial doubt has also been cast on the cogency of such evidence.[23]

5.72 We expect that in many cases involving businesses, judges would indeed draw on their own understanding to ask how a reasonable business of the kind involved would regard the matter. The parties may feel it unnecessary to provide expert evidence.

5.73 However, in more specialist markets, there will still be a need for expert evidence. We do not see that receiving evidence will be problematic. The court would hear evidence of what, in the witness's experience, the insured could reasonably have been expected to appreciate, in the light of what they were told and the general circumstances. We anticipate that this evidence may be given by a range of experienced professionals, including insureds, brokers or underwriters.

Questions and warnings

5.74 It would always be open to the insurer to make it clear to the insured that some particular fact is relevant, even though this might not occur to the reasonable insured. The most obvious way to do this is by asking specific questions. Alternatively, a warning may be given that the proposer should disclose particular kinds of information, for instance information about the criminal records of employees.

Over-disclosure

5.75 It has been put to us that the current law sometimes operates against the interests of insurers in that they get too much information when the insured is sophisticated. The duty of disclosure is so wide and, to many insureds, so imprecise that an insured may conclude that the safest option is to give the insurer all the information it is able to gather. We have been told that applicants often provide insurers with more information than they are able to process. As one experienced insurance lawyer put it:

> We are now at the stage where commercial brokers are tending to walk into underwriters with three CDs and tell them, 'it's all in there'.

[22] BILA, *Insurance Contract Law Reform* – Recommendations to the Law Commissions (2002) para 12.

[23] Insurance Law, Non-Disclosure and Breach of Warranty, Law Com No 104, para 3.21. For judicial criticism of insurers' evidence, see *Roselodge Ltd v Castle* [1966] 2 Lloyd's Rep 113, 132. The judge dismissed the evidence of three expert underwriters on the grounds that they were far from objective: "they were anxious to defeat the claim if it could be legitimately defeated". In *Reynolds v Phoenix Assurance Co*, the judge also disbelieved the insurers' witnesses' claims that evidence of a previous conviction was material by pointing out how rarely any insurer was actually told about such convictions: [1978] 2 Lloyd's Rep 440, 460. See also J Birds and N Hind, *Birds Modern Insurance Law* (6th ed, 2004), p 116.

5.76 We were told, for example, about a South American highway authority that provided the insurer with a survey report on each road, in Spanish: "It took us 2 weeks to get it translated". With the development of information technology, the problem is likely to increase.

5.77 To some extent, if the parties have the ability to transmit large quantities of information, they will. However, we think that a narrower test of what is material just might do less to encourage the present tendency to inundate the insurer with information.

Insureds who are professionally advised

5.78 At this point we need to deal with an argument that was raised in response to our first Issues Paper. We were urged to consider drawing a distinction between business insureds who are professionally advised and those who are not, and to confine any reforms to the latter. The argument would apply more widely than just to how to treat the honest and reasonable insured, but this is the point at which it first becomes relevant and we explain here why we have not adopted that approach.

5.79 We agree that a business insured who uses an insurance intermediary is less likely to find that the law or the contract terms do not match its reasonable expectations. And if it is not given proper advice and ends up disappointed, it may be able to recover from its advisor. In formulating our proposals for business insurance, we have taken into account the likelihood that the insured will be professionally advised, and this will often be critical in applying the tests we propose. For example, the test of what a reasonable insured would be expected to disclose will depend on the advice received. However we feel unable to draw a sharp line between those who are professionally advised and those who are not, for the simple reason that it is impossible to define professional advice in a precise way. Furthermore, if businesses realised that their rights would reduce as soon as they used an advisor, this may act as a disincentive to receive the advice they need.

5.80 As we will see when we consider pre-contract information and intermediaries, there are many different types of insurance professional who may be involved in the making of an insurance contract, and it would be hard to define which of them should count for this purpose. Some will give careful advice, others may be much less involved, for example merely introducing the proposer to the insurer.

5.81 In Part 10, we provisionally propose that some insurance professionals should be treated as the insurer's agent; others will continue to be treated as agents of the insured. For example, we think that "tied" agents should normally be considered to act for the insurer, while independent advisers normally act for the insured. However these categories are imprecise and difficult to distinguish. While the fact that an insured received independent advice should be taken into account in applying the tests we propose, it is difficult to draw hard and fast lines.

5.82 We have therefore concluded that our proposed reforms should also apply to business insureds who have been professionally advised.

Conclusion: modifying the test of materiality

5.83 **We provisionally propose that the current test of "materiality", namely what may influence the judgement of a prudent insurer, should be replaced by a "reasonable insured" test. This would ask what a reasonable insured in the circumstances would think was relevant to the insurer. This should apply to all business insurance, as part of a general principle that an insured who was both honest and careful in giving pre-contract information should not have a claim turned down on the basis that the information was incorrect or incomplete.**

5.84 **We provisionally propose that, in order to be entitled to a remedy for the insured's non-disclosure or misrepresentation, the insurer must show that:**

(1) **had it known the fact in question it would not have entered into the same contract on the same terms or at all; and**

(2) **it must also show either:**

(a) **that a reasonable insured in the circumstances would have appreciated that the fact in question would be one that the insurer would want to know about; or**

(b) **that the proposer actually knew that the fact was one that the insurer would want to know about.**

SHOULD THE LAW DISTINGUISH BETWEEN DISHONEST AND NEGLIGENT CONDUCT?

5.85 In Part 4 we divided misrepresentations into three categories, and provisionally proposed that for consumer insurance, separate remedies should be applied to each. The categories are:

(1) "Deliberate or reckless", involving a degree of dishonesty by the insured: here the insurer should be entitled to avoid the policy.

(2) "Negligent", where the insured did not show the degree of care required: the insurer would receive a compensatory remedy, based on what the insurer would have done had it known the correct information.

(3) "Innocent", where the insured was both honest and reasonable: the insured should be protected.

5.86 We have already set out our proposals on innocent misrepresentation in business insurance. In this section we ask whether the law for business insurance should follow our proposals for consumer insurance by distinguishing between behaviour that is dishonest and that which is merely negligent. Should the insurer be entitled to avoid for both types of misrepresentation and non-disclosure? The alternative possibility is that insurers should only be given an unqualified right to avoid where the insured has behaved dishonestly. For negligent conduct, the remedy would be based on what the insurer would have done had it known the information.[24]

5.87 We set out the consequences of a "compensatory remedy" in more detail in Part 4. The court would start by asking what the insurer would have done had it been aware of the true position.

(1) Where an 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 required precautions to be taken (for example in the form of a warranty) or would have imposed an excess, the policy would be treated as if it contained those terms.

(3) Where an insurer would have declined the risk altogether, the policy would be avoided and the claim may be refused.

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

[24] The continental systems that we have examined all apply a proportional approach to claims that have arisen before it is discovered that the insured made a non-fraudulent misrepresentation, in business as well as consumer insurance. Some allow the insurer to refuse to pay the claim if it would not have accepted the proposal if it had been given the correct information: see Norwegian Insurance Contracts Act of 16 June 1989, No. 69, s 4-2; Swedish Insurance Contracts Act 20005, chapter 8 s 9. However the French Code des assurances applies a proportional remedy to all such claims, art 113-9, and the German draft proposals (see above, para 4.101 n 68), § 19, appear to be similar. This also seems to be the current approach of the European Restatement Group. The insurer is normally permitted, however, to cancel the contract for the future.

The Australian Insurance Contracts Act 1984, s 29(3) provides that in the case of non-fraudulent misrepresentation or non-disclosure, "the liability of the insurer in respect of a claim is reduced to the amount that would place the insurer in a position in which the insurer would have been if the failure had not occurred or the misrepresentation had not been made." This has been interpreted as meaning that if the insurer would not have accepted the risk, its liability is reduced to nil: see Merkin, Reforming insurance law: Is there a case for reverse Transportation?, para 4.53 (available at http://www.lawcom.gov.uk/docs/merkin_report.pdf).

5.88 In Part 4 we argued that avoidance in every case of negligence over-compensates the insurer for the loss it has suffered. It entitles insurers to refuse all claims under the contract, not just those additional claims that it would not have accepted had it known the truth. The insurer may simply have imposed an exception or charged a small additional premium, yet it is able to refuse claims that were within the contemplation of both parties at the time the contract was entered. We thought that such a measure of over-compensation is only appropriate where an insured has behaved dishonestly. Where the insured has behaved negligently, the law should ask what the insurer would have done had it known the full facts.

5.89 Many people accepted the logic behind this proposal. However, respondents put forward three main arguments against changing the remedies for negligent conduct in business insurance:

(1) It would be difficult to prove that an insured acted dishonestly.

(2) It would be difficult to show what an insurer would have done if it had known the true position; our proposals would lead to both insurers and insureds spending large sums on expert witnesses, who simply contradicted each other.

(3) There should be strong incentives to encourage insureds to act carefully.

5.90 We look at each of these arguments in turn, starting with what we mean by acting "deliberately or recklessly", without the required degree of honesty, and how this might be proved.

Acting without the required degree of honesty

5.91 We think that there is no case for restricting the insurer's right to avoid the policy (and therefore to refuse to pay any claim) where a business insured was not acting honestly when it failed to provide information or gave inaccurate information. As in consumer insurance, by acting without honesty we mean acting deliberately or recklessly, as in the definition of fraud at common law.

Defining "deliberate or reckless" conduct

5.92 In Part 4, we stated that a misrepresentation should be taken to be deliberate or reckless where the proposer made it both

(1) knowing it to be untrue (or being reckless as to whether it was true or not); and

(2) knowing it to be relevant to the insurer (or being reckless as to whether it was relevant or not).

5.93 We explained that it would not be necessary to show that the insured intended to cause a loss, or otherwise acted in a way that would amount to criminal or near criminal behaviour.

5.94 We think the same rule should apply in the business context.

Proving that an action was deliberate or reckless

5.95 As we explained in relation to consumer insurance, at common law the standard of proof for fraud remains the balance of probabilities. The same rule applies in business insurance cases. The insurer should not have to prove fraud "beyond reasonable doubt" before it has the right to avoid the policy.

5.96 The point has been made that where the insured is a company it can be particularly difficult to prove a state of mind. It is difficult to pin down who knew what at which stage, or to impute knowledge to the controlling mind of the organisation. Given that the courts take a particularly cautious approach where allegations of dishonesty are involved, the task may be extremely difficult.

5.97 Earlier we said that under section 18(1) of the 1906 Act, the insured is

> deemed to know every circumstance which, in the ordinary course of business, ought to be known by him.

We explained that if, as we suggest in this section, the insurer should be entitled to avoid as of right only in cases of fraud, this irrebuttable presumption should no longer apply. A proposer would not be treated as making a deliberate non-disclosure of a fact he did not know merely because in the ordinary course of business he ought to have known it.

5.98 Normally it will be for the insurer to prove fraud on the balance of probabilities. Should there be a rebuttable statutory presumption that the insured knows what in the ordinary course of business it ought to know, in order to make it easier to prove fraud? The advantage is that it would reinforce the need for organisations to investigate safety issues properly. Suppose, for example, that a company failed to mention that its building contained crumbling ceiling tiles made of asbestos, and the court comes to the view that the company should have known this, and should have known that an insurer would want to know about it. Clearly, the company has not acted reasonably. Under the scheme we are considering, the question would be whether it acted "negligently" or acted "deliberately or recklessly". The effect of the presumption would be to place the onus on the company directors to show that they were merely negligent, by proving first that they did not know about the asbestos, and secondly that they did not suspect asbestos and deliberately fail to enquire about it. It would clearly be open to the company to produce evidence to this effect, but we imagine that in some circumstances it might be quite difficult.

5.99 However, as we pointed out when we discussed proof of fraud in the consumer context, if it is shown that the matter was one that the insured would normally be expected to know, there will be an evidential presumption that the insured did know about it. This may make a statutory presumption unnecessary. We would welcome views.

Applying a compensatory remedy in practice

5.100 Several insurance lawyers expressed concern about how the courts would determine what an insurer would have done had it known the information. They thought this would be a particular problem when the insurer would have charged a higher premium, leading to a proportionate reduction of the claim. Unlike consumer insurance, there are rarely rating tables to refer to. Instead it was suggested that each side would bring experts to contradict what the other side said:

> Each side will have an expert each, which will say the opposite of the other. It's not as if they all have rating books and tariffs… In France, for example, there are fixed tariffs.
>
> What would actually happen at the box is that we would propose a premium, and the broker would say, 'Oh, that's a bit steep. Charlie down the road does it for half that.' And they would end up with a number without any science at all.

5.101 The problems are likely to be greater in relation to business insurance than they would be for consumer insurance, but we do not see them as insuperable. However unscientific the negotiations may be, they would be a more accurate assessment of the loss involved than the current law, which permits avoidance even though the insurer would have accepted the risk on only slightly different terms. Of course the insurer may in fact agree to pay something, but the current law allows unscrupulous insurers to wield a dominant weapon in negotiations.

Are strong incentives required to prevent negligent behaviour?

5.102 A more difficult question is whether in business insurance, where the average insured is far more likely to be aware of what it should be doing, it is desirable to create stronger incentives. This was the reason given for refusing to apply the discretion to refuse rescission under the Misrepresentation Act 1967 section 2(2) to contracts of insurance. If business insureds know that if they make a careless mistake they will not recover anything under the policy, they have a stronger incentive to be careful. Insureds may be willing to carry the small increase in premiums necessary to cover the cost of innocent mistakes as one of the pooled risks, but be unwilling to "pay for" any part of other insureds' carelessness. A business which knows that it is well-run and careful may wish to see this reflected in a lower premium. We invite views on this issue.

Cases where another insurer would have accepted the risk

5.103 For consumers we also asked whether the courts should have an additional discretion. We suggested this may apply where the insurer would have declined the risk, but the policyholder's fault is minor, and other insurers would have accepted the risk at a higher premium. This may also apply where the misrepresented fact is unrelated to the claim.

5.104 On balance, we think that such a discretion is more appropriate to consumers than to businesses, but we would welcome advice on the issue.

Cancelling for the future

5.105 We also asked whether insurers should be entitled to cancel policies for the future in all cases, or only where they would have declined the risk. We noted that the FOS would sometimes require insurers to amend the terms of a policy, and abide by it in the future. Again, we think this may be appropriate only in consumer cases.

5.106 Our starting point in business cases is that where the insured has made a negligent misrepresentation or non-disclosure, even if the insurer should have to pay a proportion of the claim in question, it should be entitled to cancel the policy for the future. We think insurers should have to give reasonable notice and return a proportionate part of the premium.

Conclusion: distinguishing between dishonest and negligent conduct?

5.107 **We invite views on whether the law should distinguish between dishonest and negligent misrepresentation/non-disclosure. For negligent conduct, should the law provide a remedy which (unless the parties have agreed otherwise) aims to put the insurer into the position it would have been in had it known the true circumstances?**

5.108 **If so:**

(1) **Should there be a rebuttable presumption that the insured knew any fact that in the ordinary course of business they ought to have known?**

(2) **Do respondents agree that where the insurer would have declined the risk, the insurer should be entitled to avoid the policy, and the court should have no discretion to apply a proportionate solution?**

(3) **Do respondents agree that negligent misrepresentation or non-disclosure should be a ground on which the insurer may cancel the policy after reasonable notice, without prejudice to claims that have arisen or arise within the notice period?**

CONTRACTING OUT OF THE DEFAULT REGIME

5.109 We argued earlier that the parties should be free to agree what rules should govern a contract for business insurance. They should, if they wish, be able to reach an agreement that an insurer may avoid a policy as a result of a failure to pass on pre-contract information, even if the failure was honest and reasonable, or only negligent. However, this would be subject to controls where the parties contracted on the insurer's standard terms, and the issue was not brought home to the insured.

5.110 It is already open to insurers to use contractual terms to expand their remedies for non-disclosures and misrepresentations. The main ways they do this are through the use of specific fact warranties and basis of the contract clauses. We start by considering the criticisms that have been made of these devices. We conclude that there are particular reasons to prohibit the use of basis of the contract clauses, even in business contracts. However, our regime would permit specific fact warranties, subject to controls on their use in standard terms. The parties would also be free to agree that the insurer would have specified remedies for misrepresentation, which may apply even if the proposer was honest and careful in giving information.

5.111 We then set out provisional proposals to prevent an insurer from using standard terms to change the default rules where it would undermine the insured's reasonable expectations to do so.

Basis of the contract clauses and warranties

5.112 We saw earlier that the law on warranties, as it applies to statements of existing or past facts by the insured, has been the subject of strong criticism:

(1) If the insurer obtains a warranty from the insured as to a past or present fact, and the fact stated is not true, the insurer may treat the policy as discharged. This applies even if the insurer did not rely on the statement, the incorrect statement had no connection to any claim that has arisen, and the insured honestly and reasonably believed that what they said was correct.

(2) A statement of fact by a proposer can be converted into a warranty by a "basis of the contract" clause contained only in the proposal form. Except in marine insurance, the warranty need not be set out in the policy or another document referred to in the policy.

"Basis of the contract" clauses

5.113 "Basis of the contract" clauses have been the subject of judicial criticism for many years.[25] We think the criticism is justified. Unless advised by a specialist, no insured is likely to appreciate that a clause only in the proposal form will turn every statement made in the proposal into a warranty, with potentially draconian consequences. Quite simply, the effect of a "basis of the contract" clause is incompatible with the reasonable expectation principle. At our seminar on warranties, there seemed to be general agreement that the law should be changed.

5.114 The question is how. Assuming that warranties of fact are to continue to be effective in business insurance, there seem to be two options:

[25] The Law Commission's report on Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, sets out criticism of such clauses dating back to 1853: see para 7.2 of the report and *Anderson v Fitzgerald* (1853) 4 HK Cases 483, 10 ER 551.

(1) The law could allow statements to be incorporated en bloc, but only if the incorporation clause were in the policy itself. This is the current law for marine insurance. Section 35(2) of the 1906 Act states that the warranty must either be in the policy, or "contained in some document incorporated by reference into the policy".

(2) The legislation could permit an insurer to convert a statement of existing fact into a warranty, but only if it did so as a specific term set out in the policy or an accompanying document. This was the approach taken by the Law Commission's 1980 report. It would allow a statement of existing fact to be treated as a warranty, but the insurer would not be permitted to rely on a breach of warranty unless the insured was supplied with a written statement of the warranty either at or before the contract was made, or as soon as possible thereafter.

5.115 Given the importance of warranties, and the serious consequences that follow from a breach, we think the insured should have the opportunity to check the accuracy of the information it gave. We doubt the first approach would really give the insured an adequate warning, since the clause might do no more than incorporate the answers given in proposal form into the contract, without the insured being given a copy of the form. We think that the second approach is needed. This rule would have to be mandatory, otherwise the mere insertion of a "basis of the contract" clause might be taken as contracting out and the new rule would be nugatory.

5.116 **We provisionally propose that a warranty of past or present fact must be set out in a specific term of the policy or an accompanying document. The law should not give any effect to a term on a proposal form or elsewhere which converts answers into warranties en bloc.**

5.117 Furthermore any warranty contained with a set of standard terms, would be subject to the proposals set out below.

Specific warranties of past or present fact

The effect of a past or present fact warranty

5.118 A warranty of past or present fact allows an insurer to extend the remedies the law provides for misrepresentation. Where an insurance contract states that a past or present fact is "warranted", the insurer is discharged from all liability if the fact proves to be untrue. This is so even if the fact

(1) was not material, in the sense of being something that would influence the judgement of a prudent insurer; and

(2) did not induce the insurer to enter into the contract.

5.119 At present, these advantages are limited. It will be rare for an insurer to wish to avoid liability for a misrepresented fact that was not material. Nor is it likely to wish to avoid for a fact that did not affect its decision to enter the contract, though it may wish to spare itself the expense of proving inducement. However, under our reformed regime, warranties as to existing facts may well become more important. They would allow the insurer to refuse a claim on the basis of a misrepresented fact, even if the misrepresentation was wholly innocent.

5.120 Suppose, for example, an insurer asked an insured if any of its staff had criminal convictions. The insured did not realise that one member of staff was convicted of burglary in his youth, and it had no realistic way of finding out this information. Under our proposals set out above, this would be considered an innocent misrepresentation, and the insurer would be required to pay claims under the policy. An insurer may therefore ask the insured to "warrant that no staff have previous criminal convictions".

5.121 Here we first consider whether a warranty of this kind should allow the insurer to refuse payment where the insured has made a reasonable and innocent mistake. We then discuss the more difficult question, which is whether such a warranty should be effective even if the fact was immaterial and had no connection with the claim.

Permitting strict liability for misrepresented facts

5.122 In Part 4, we argued that in consumer contracts any warranty of existing facts should be treated as a misrepresentation. In other words, the insurer should not have a remedy if the consumer quite reasonably did not realise the fact warranted was incorrect. We do not think that this rule is appropriate for business contracts. A business may well be prepared to take the risk that a fact warranted turns out to be incorrect, in return for a lower premium. The market should be free to agree such arrangements, provided the parties understand the consequences of what they are doing.

5.123 A fundamental principle behind our proposals is that in business insurance the parties should be free to vary the "default rules", provided that the variation is in accordance with the parties' reasonable expectations. There are two possible approaches to contracting out of the default regime we have proposed.

(1) The parties could agree that the insurer would have a remedy in the event of non-fraudulent, non-negligent misrepresentation.

(2) The insurer could obtain a warranty from the proposer that the statements are correct, and liability for breach of warranty should remain strict.

5.124 Is one approach better than the other, or should the parties be free to choose either? We have not found this an easy question to answer, and our thinking on it has changed over time.[26] Our conclusion is that the parties should be free to use either method.

(1) They should be free to agree that the insurer will have one or more specified remedies for misrepresentation even if the proposer was neither dishonest nor careless in giving the information.

(2) They should also be free to obtain a warranty from the proposer that the statements are correct. This would give the insurer the right to refuse claims where a fact turned out to be untrue, even if the insured had behaved honestly and carefully.

5.125 Both types of term should be subject to the controls on the use of standard terms set out below.

The legal effect of warranties: materiality and causal connection

5.126 In 1980, the Law Commission recommended that specific warranties as to past or existing fact would only be effective if the warranty was material (though there would be a presumption that it was material). As we explain in Part 7, it also recommended that an insured should have a right to be paid a claim if there was no causal connection between the breach of warranty and the claim. Thus it would be open to the insured to show that the warranty was intended to safeguard against a different risk, or did not increase the risk that the loss would occur in the way in which it did.[27]

5.127 Returning to our example in which the insured warranted that its staff had no criminal convictions: is it right that any conviction should allow the insurer to refuse claims, even if:

(1) the conviction was so minor as to be immaterial (such as a speeding conviction);

(2) the claim was for some other type of risk (such as storm damage); or

(3) the conviction had no connection with the claim (as where an employer makes a claim under a theft policy following a theft by employee A who has no previous convictions, but another employee, who acted entirely honestly on this occasion, has a previous conviction for dishonesty)?

[26] In the first Issues Paper, we suggested that the parties to a business insurance contract should be free to modify the rules on misrepresentation. In the second Issues Paper we suggested that the same rules should be made mandatory, because a clause in the agreement along the lines of "section x of the Insurance Contract Act 20xx shall not apply to this contract" would leave most insureds none the wiser. We now take the view explained in the text.

[27] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 10.36.

5.128 On the one hand, we do not wish to interfere with freedom of contract. On the other hand, we are concerned that many insureds would not understand the full effect of a warranty. They would not think that the insurer would refuse claims for breaches that are immaterial, and where the breach has no connection with the loss.

5.129 Our view is that parties should be free to agree that in the event of a particular fact being untrue, the insurer is discharged from all liability, but they must do so explicitly. As we explained earlier, all warranties must be set out in writing. If it is stated that the proposer may thereby lose its rights even if it has made an honest and reasonable mistake, that should be clear enough. We also think that if the word "warranty" is used - if the contract simply states that the insured "warrants" that a fact is true - then this will be enough to show that there is to be strict liability. Thus if the fact were untrue, it would not matter that the insured honestly or reasonably thought the fact was true.

5.130 However, the word "warranty" should not automatically imply that an insurer would be discharged from all liability under a contract, even for minor or technical breaches that have no connection to the claim. Instead, the starting point would be that an insurer could only use this breach of warranty as a defence to a claim if the fact was material and had some causal connection to the claim that had arisen.[28] If the insurer wished to go further than this, the contract would have to spell out the full consequences of the breach of warranty in clear terms.

5.131 **We provisionally propose that the parties to an insurance contact should be free to contract out of the default regime we have proposed in two ways. The policy or accompanying document could contain a written term that**

(1) **the insurer would have one or more specified remedies for misrepresentation even if the proposer was neither dishonest nor careless in giving the information; or**

(2) **the proposer warrants that specified statements are correct.**

5.132 **Liability for breach of a warranty of fact should remain strict but, unless the contract provides otherwise, the insurer should not be able to rely on the breach of warranty**

(1) **if it was not material to the contract; or**

(2) **as a defence to a claim for a loss that was in no way connected to the breach of warranty.**

[28] We explain these issues in more detail in Part 8. In Part 8 we also propose that a breach of warranty should give the insurer the right to cancel cover for the future.

Controlling the use of standard terms to defeat reasonable expectations

5.133 As we explained earlier, problems arise when businesses that are not insurance experts contract on an insurer's standard terms. They may fail to understand the terms and their implications; and even if they do understand them, they may lack the ability to alter them. These controls would not apply to the generality of contracts negotiated in the Lloyd's market, where a broker usually puts forward terms on behalf of the insured. In those circumstances, it would be up to the broker to negotiate terms that best reflect its client's interests. However, they would apply where a business buys an off-the-shelf product, on terms which the insurer has already devised.

5.134 Here we propose controls on terms by which an insurer attempts to alter the default regime in its favour. In Part 8 we propose controls on other contractual terms which defeat an insured's reasonable expectations. The proposal we are making here is more limited. It only applies to terms that give insurers greater rights to refuse claims on the basis of the insured's failure to provide accurate pre-contract information than the default regime would allow.[29]

5.135 The controls would not try to address the case in which the proposer understands the term but lacks the bargaining power to obtain a more favourable term. It would address only the question of what the proposer reasonably expected.[30]

5.136 There would be three limbs to the test:

(1) Did the insured contract on the insurer's written standard terms of business?

(2) Does one of the standard terms purport to give the insurer greater rights than the default regime to refuse claims on the basis of the insured's failure to provide accurate pre-contract information?

(3) If so, does the term defeat the insured's reasonable expectations?

"Written standard terms of business"

5.137 We have borrowed the concept of "written standard terms of business" from the Unfair Contract Terms Act 1977 (UCTA). We discuss the Act in Part 8, and set out sections 3 and 17.[31] These provisions apply not only to consumers but also where one party contracts on the other's "written standard terms of business".

[29] In some ways the provision is similar to section 3 of the Misrepresentation Act 1967, which states that

> If a contract contains a term which would exclude or restrict--
> (a) any liability to which a party to a contract may be subject by reason of any misrepresentation made by him before the contract was made; or
> (b) any remedy available to another party to the contract by reason of such a misrepresentation,
> that term shall be of no effect except in so far as it satisfies the requirement of reasonableness.

However, s 3 applies to negotiated terms, which our proposal does not.

[30] See para 5.145 below.

[31] See paras 8.59 and 8.60.

WHEN DOES A PARTY CONTRACT ON THE OTHER'S STANDARD TERMS?

5.138 In UCTA, "written standard terms of business" was deliberately left undefined. As we explained in our joint Consultation Paper on Unfair Terms in Contracts, the question is simply whether the parties ultimately dealt on one party's standard terms, regardless of whether negotiations preceded the conclusion of the contract.[32] The fact that negotiations resulted in some small amendments to some of the terms does not prevent the set of terms remaining standard;[33] but at some undefined point there may be sufficient alteration so that the terms as a whole are no longer the party's written standard terms.[34]

5.139 In our final report on Unfair Terms we considered whether this approach was correct.[35] It is not perfect. On the one hand, the fact that some terms had been altered after negotiation did not necessarily mean that the parties were aware of the term now in question. On the other, the test makes it possible to challenge a term that had in fact been negotiated but was ultimately left unchanged. On balance, however, we thought the UCTA test was as good as any we were able to devise. We think it would also be an appropriate test to use in a new provision on standard form insurance contracts.

INDUSTRY STANDARD TERMS

5.140 Difficult questions can arise where a party always contracts on industry-wide standard terms. If an insurer routinely adopted the agreed industry wording for its contracts, these would be considered the insurer's standard terms.

5.141 During consultation for our report on Unfair Terms in Contracts, several consultees suggested that there should be a special exemption for terms drafted by a trade association. However, we decided against such an exemption:

> The reason is that there can be no guarantee that terms will be fair simply because they were drawn up by a third party and are used widely in the relevant market. The terms might have been drawn up by a trade association that represents the interests of one party and not those of the other party; and yet may be used in the vast majority of contracts in the market because, for example, the other party usually lacks the sophistication or the bargaining power to demand terms more favourable to it.[36]

[32] See the discussion in our Joint Consultation Paper on Unfair Terms in Contracts (2002) Law Com Consultation Paper No 166; Scottish Law Com Discussion Paper No 119, paras 5.49 – 5.53 and *St Albans City and District Council v International Computers Ltd* [1996] 4 All ER 481.

[33] *Pegler Ltd v Wang (UK) Ltd* [2000] EWHC Technology 127 (25 February 2000): "A standard term is nonetheless a standard term even though the party putting forward that term is willing to negotiate some small variations of that term."

[34] *Salvage Association v CAP Financial Services Ltd* [1995] FSR 654: "[i]n such circumstances, whether it continues to be correct to describe the terms of the contract eventually agreed by the parties as the standard terms of business of the party who originally put them forward will be a *question of fact and degree* to be decided in all the circumstances of the particular case."

[35] Unfair Terms in Contract (2005) Law Com No 292; Scot Law Com No 199.

[36] Above, at para 5.61.

However, the provenance of the terms and the degree to which they are accepted in the market would be relevant to any decision about whether they are reasonable. We pointed out that it would be highly unlikely that an accepted industry term would be considered unfair.

5.142 We understand that in the Lloyd's market it is common for the broker to put forward industry standard terms. Where this happened, the terms would not be subject to control, as they would not be regarded as the insurer's terms. If the insurer routinely put forward industry terms, the court would then move to the final stage of the test, and ask whether the terms defeated the insured's reasonable expectations. Where the terms were well-known and understood throughout the industry, a reasonable insured would understand the term and its effects. The third limb of the test set out above would not be met.

Defeat reasonable expectations

5.143 Under sections 3 and 17 of UCTA, the court will uphold a standard term provided it is "fair and reasonable". Section 3 of the Misrepresentation Act 1967[37] also refers to the same test. We have considered whether to use the "fair and reasonable" test in this context.

5.144 Under UCTA, a term may be unfair for either procedural or substantive reasons. A term is procedurally unfair if it was not brought to the other party's attention: if for example, it was written in legal gobbledegook or hidden in small print. A term may be substantively unfair if it is extremely harsh, and only imposed as a result of unequal bargaining power. In practice, most unfair terms have elements of both types of unfairness: given how harsh the term was, more should have been done to bring it to the other party's attention. However, it is possible for a term to be unfair even if the other party was fully aware of it but lacked the power to resist it.

5.145 The test we are provisionally proposing in this context would be more limited. It would look only at procedural issues: did the insured appreciate the existence of the term, or did it undermine its reasonable expectation? If the insurer showed that the insured knew about the term and its implications before entering the contract, the term would stand, even if the insured only agreed to the term because it had no alternative. We think this would provide insurers with a measure of certainty in their contracts: if they did enough to bring a term to the insured's attention, they would know that the term would be upheld. However, we would welcome views on this.

Conclusion: controlling the use of standard terms

5.146 **We provisionally propose that special controls should apply where**

(1) **the insured contracts on the insurer's written standard terms of business; and**

(2) **one such term purports to give the insurer greater rights than the default regime would allow to refuse claims on the basis of the insured's failure to provide accurate pre-contract information.**

[37] The 1967 Act does not apply in Scotland.

5.147 **The insurer should not be permitted to rely on such a term if it would defeat the insured's reasonable expectations.**

DIFFERENT RULES FOR DIFFERENT MARKETS?

5.148 In this section, we consider whether special rules are needed for different markets. We deal in turn with marine, aviation and transport (MAT) insurance; reinsurance; third party insurance; and small businesses. Our starting point is that we should avoid creating artificial and complex boundaries unless it is strictly necessary to do so. However, we welcome views.

Marine, Aviation and Transport insurance

5.149 The 1980 report excluded MAT insurance from the scope of its reforms. It argued that the people working in this market were generally professionals "who could reasonably be expected to be aware of the niceties of insurance law".[38] The law was certain and understood, and worked satisfactorily.

5.150 However, the Commission accepted that the line between MAT and other insurance was not clear, and that some insureds, such as individuals with pleasure craft, did need additional protection. The Commission expressed unease with the definitions of MAT used in previous regulations, and suggested some omissions. It also proposed that the Secretary of State should be empowered to vary the definition by regulation.

5.151 Here we are not minded to make a distinction between MAT and other forms of insurance, for three reasons.

(1) We are told MAT is no longer regarded as such a separate and distinct form of insurance.

(2) It would be overly complex to require lawyers to apply one law to (for example) major construction projects, and quite a different law to ships.

(3) The boundary between MAT and other insurance is extremely difficult to draw and to draft. We would not only need to extend protection to consumers who own pleasure craft but also many small leisure businesses and fishermen who do not fall within the description of professionals "who could reasonably be expected to be aware of the niceties of insurance law". The result would be complex regulations, with arbitrary dividing lines.

In these markets, the parties are able to negotiate for the solutions they wish, and our proposals allow the parties to do this.

5.152 **We provisionally propose that the proposals made to the law for business insurance should apply equally to marine, aviation and transport insurance.**

[38] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 2.8.

Reinsurance

5.153 Our starting point is that the same rules should apply to reinsurance and insurance, unless a good case is made for distinguishing between the two.

5.154 We recognise that there are important practical differences between the ways in which insurance and reinsurance are conducted. A member of our Advisory Panel suggested that three matters in particular should be considered:

(1) Much reinsurance is placed under obligatory treaties. If a risk falls within the terms agreed, the insurer is obliged to place it under the treaty and the reinsurer is bound to accept it. Disclosure of the details of individual risks is not typically required.

(2) Facultative business coming in to the London market from abroad is frequently written on a fronting basis, so that the local insurer is simply the conduit for passing the risk to reinsurers. In that situation, the majority of material facts will relate not to the reinsurance itself but to the underlying risk – which will have been written under a contract governed by a foreign law with its own disclosure rules.

(3) The parties entering into reinsurance agreements are both conducting insurance as a business and may be assumed to have a level of knowledge significantly greater than that of the typical policyholder.

5.155 We do not think that any of the above are reasons to apply different rules to reinsurance. First, we do not think that the rules we have provisionally proposed would cause problems for reinsurance. In particular, the change in the test from "prudent insurer" to "reasonable insured" would have almost no effect, since insurers are well aware of what reinsurers wish to know. Second, most reinsurance contracts are the subject of intense negotiation and careful drafting. In that situation, the default rules matter little. Thirdly, if some matter is overlooked by the parties to a reinsurance arrangement, we think that the proposals we make are just as likely as, and probably rather more likely than, the current law to meet the reasonable expectations of the parties.

5.156 **We provisionally propose that amendments made to the law for business insurance generally should apply equally to reinsurance.**

Third-party claims

5.157 A number of comments have been made to us which raise the question of whether it is desirable that the rights of a third party are affected by the acts or omissions of the policyholder.

5.158 Under the Road Traffic Act 1988 an insurer is obliged to meet third-party claims in motor insurance cases, even where a policy has been avoided for misrepresentation or non-disclosure by the policyholder.[39] For most lines of business there is no such protection - the third party will have rights only against the policyholder.

[39] Road Traffic Act 1988, s 151.

5.159 If the policyholder is insolvent, the third party can bring a claim directly against the insurer under the Third Parties (Rights Against Insurers) Act 1930. However, defences such as misrepresentation or non-disclosure which are available to the insurer against the policyholder can also be used against a third party.[40]

5.160 We can see that there may be arguments for giving third parties Road Traffic Act style protection – particularly where insurance is compulsory under statute, contract or professional rules. For example, a professional may be obliged to effect professional indemnity insurance. Such insurance is intended to provide compensation for clients affected by the professional's negligence. However, we suspect that in such cases the matter is best left to the relevant statutory scheme or the relevant professional body. Parliament or the body concerned can decide first whether such insurance should be compulsory and second the terms on which it should be written, which might include modifying the rights of an insurer to rely on misrepresentation or non-disclosure. In doing so, it can take into account the availability or otherwise of such cover in the insurance market.

5.161 **Our provisional view is that we should not extend the existing rights of third parties as part of the current project, but we welcome views on this issue.**

Small businesses

5.162 There is a particular problem with very small businesses. As Lord Justice Longmore put it:

> How can it be right that a lawyer insuring his home and household possessions can rely on the more relaxed test of non-disclosure under the Statements of Practice, but the small trader, e.g. the garage owner or the fishmonger insuring his premises, cannot?[41]

In 1980, the English Law Commission pointed to harsh cases involving small businesses, especially where the non-disclosed issue related to moral hazard. For example, in *Locker & Woolf Ltd v Western Australian Insurance Co*, a fire claim was rejected on the grounds that the applicant had not revealed that the partnership had previously been refused motor cover.[42]

[40] *The Fanti* [1991] 2 AC 1. We discussed the problems this can cause in our joint report Third Parties (Rights Against Insurers) Act 1930 (1998) Law Com No 152; Scot Law Com No 104.

[41] "An Insurance Contracts Act for a new Century?", Pat Saxton Memorial Lecture, 5 March 2001 (set out in Appendix A of BILA, Insurance Contract Law Reform (2002)) para 42.

[42] See Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104 para 3.22 and Working Paper No 83, para 28. *Locker & Woolf Ltd v Western Australian Insurance Co* [1936] 1 KB 408.

5.163 It is important to bear in mind the makeup of the small business sector. Many small businesses are in fact very small: 69% of all UK enterprises have no employees at all,[43] 20% have between one and four employees, and a further 5% have between five and nine employees.[44] The number of enterprises with no employees (mostly sole traders) strongly points to the vulnerability and lack of sophistication of small businesses. Moreover, even Small-and-Medium-sized Enterprises (SMEs) (a category covering businesses with up to 250 employees) rarely seek legal advice. Statistics published by the DTI suggest that only 3% of SMEs sought legal advice in the previous 12 months.[45] In addition, many entrepreneurs who run small businesses are relatively young (25% are 25 or younger, 46% are 35 or younger).[46] Furthermore, only 64% of entrepreneurs have vocational training or a degree: around 5% have no educational qualifications at all.[47] These factors suggest that many small businesses are in a similar position to consumers.

5.164 We do not think that many people running non-insurance small businesses would understand the full extent of the duty of disclosure that the law requires. They are unlikely to understand, for example, that they must volunteer information about criminal offences their employees have committed,[48] or any previous rejection for insurance. A small business is also less likely to understand the advisability of going through a broker, and may be put off by fears (rational or not) that doing so will add to the cost of arranging insurance.

[43] They are sole proprietorships and partnerships comprising only the self-employed owner manager(s) and companies comprising only an employee director.

[44] Statistics are taken *UK 2003*, issued by National Statistics, and relate to 2001.

[45] Small Business Service, *Omnibus Survey* (November 2001) p 22.

[46] Small Business Service, *Small Firms: Big Business,* chapter 3 (Characteristics of Entrepreneurs).

[47] 5.5% have no educational qualifications, 30.4% have not gone beyond secondary school, 32.6% have had some vocational training, 16.5% have a first degree and 15% have a postgraduate degree: Small Business Service *Small Firms: Big Business,* ch 3 (Characteristics of Entrepreneurs).

[48] See for example, *Roselodge v Castle* [1966] 2 Lloyd's Rep 113, where a theft policy was avoided because the owner did not disclose that his sales manager had been convicted of smuggling diamonds.

The position of small businesses under the FOS scheme

5.165 At present, the FOS makes a distinction between small businesses based on its assessment of the sophistication of the business in question. The most vulnerable businesses will be treated as consumers, while others will not. For example, in a survey we made of FOS decisions on misrepresentation and non-disclosure,[49] a fish and chip shop was treated in the same way as a consumer, while an insurance broker was not. We found some cases where small businesses had been expected to volunteer information in the absence of questions. For example, the FOS held that a landlord should have revealed that his tenant was unsatisfactory even though the proposal form did not ask about this, whereas a consumer would not have been expected to make a disclosure on a matter about which no question had been asked.[50]

Options for reform

5.166 In the Law Commissions' joint report on Unfair Terms in Contracts, we concluded that businesses with nine or fewer employees were often particularly vulnerable and required specific protection against unfair contract terms. We have considered whether such "micro businesses" are also vulnerable in applying for insurance. Should they, for example, be treated as consumers and only be required to answer the questions asked?

5.167 We think that the arguments that we used in our report on Unfair Terms in Contracts, which have been accepted in principle by Government, apply equally to insurance. In essence, these were that a small business is, in most relevant respects, in no better position than a consumer. As a result they seldom have a good understanding of the small print of contracts. Even if they do, they very seldom have the resources or the bargaining power to persuade the other party to offer improved terms.

5.168 The problem with having special rules for small businesses, however, is that it is extremely hard to define small business in a way that is neither over-inclusive nor arbitrary.

5.169 The problem of over-inclusiveness is that some firms may have very few employees but be highly sophisticated. In the context of unfair contract terms, we were told that in the capital markets it was common to use special purpose vehicles to conduct extremely complex deals. We developed several additional tests to exclude such companies, including a value limit on the contracts that could be reviewed and an exclusion for all financial services contracts (on the grounds that they were already regulated). We recommended that insurance contracts should be excluded, as they are from many sections of the Unfair Contract Terms Act 1977.

[49] See Appendix C, para C.100 below.

[50] See Appendix C, para C.101(2) below.

5.170 The same issues arise here. A ship, for example, may be owned by a one-ship company, and be managed using agents rather than employees. In defining a small business, it may well be necessary to look at the turnover and assets of the business, either instead of or as well as the number of employees. Any definition would need to be based on factors that are transparent to an insurer. An insurer would need to know, for example, how the definition applied to an overseas entity that may be no more than a shell for a particular purpose.

5.171 The problem of arbitrariness is even more pervasive. What is "small" in this context? What is magic about having less than a particular number of employees or a turn-over of less than a particular figure? Sometimes, as with unfair terms in general, we have concluded that arbitrary rules are essential, but in the context of our proposals for insurance, and particularly the proposal on standard form contracts, we think they may not be.

5.172 There are three possible approaches. The first is to retain the rules we recommend for business insurance for small businesses, but only to the degree that would be reasonable in the circumstances. We think this would enable the FOS to continue to take the approach it currently takes, by deciding that some small businesses are so similar to consumers that they should not be expected to volunteer information. It should also be possible for a court to reach the same result, considering all the circumstances of the case. The principal drawback of this approach is the uncertainty. Insurers will not be able to predict accurately whether a particular small business should or should not be treated as a consumer.

5.173 The second approach would be to adopt precise definitions of small businesses. We could use an adapted version of the definition used in our Report on Unfair Terms in Contracts, or one that would catch larger firms. We were particularly interested in the Norwegian approach, which disapplies the consumer regime when at least one of five criteria are satisfied:

> (a) when the insurance relates to undertakings which at the time of concluding the contract, or at subsequent renewals, meet a minimum of two of the following requirements:
>
> (1) the number of employees exceeds 250;
>
> (2) the sales earnings are a minimum of NOK 100 million [£8.4 million] according to the most recent annual accounts;
>
> (3) assets according to the most recent balance sheet are a minimum of NOK 50 million [£4.2 million];
>
> (b) when the business takes place mostly abroad;
>
> (c) when the insurance relates to a ship… or to installations [as defined in the Maritime Act];
>
> (d) when the insurance relates to aircraft; or

(e) when the insurance relates to goods in international transit, including transportation to and from the Norwegian Continental Shelf.[51]

5.174 Using this sort of definition would ensure that foreign businesses and those taking out marine and aviation insurance would still be required to volunteer information. For domestic risks, the definition considers employees, turnover and assets. However, the test is complex and brings back issues of how to define MAT, which we had hoped to avoid.

5.175 The third approach would be not to have special rules protecting small businesses, on the ground that they will be adequately protected by our proposals, including the "reasonable insured" test and controls on the use of standard terms. Where a small business contracted on the insurer's written standard terms, the insurer could not use a policy term to give itself greater rights than the default position would allow, unless it was what the insured reasonably expected. In Part 8 we provisionally propose to extend similar protections to warranties, exceptions and definitions of the risk.[52]

5.176 We think this is largely consistent with the approach we took in our report on Unfair Terms in Contracts. We did not recommend that small businesses should be treated in the same way as consumers in every respect, only that they should have the right to challenge "non-core" terms in contracts that were not individually negotiated. Our provisional conclusion is that small businesses would be adequately protected by the "reasonable insured" test we have proposed, coupled with the controls on standard term contracts. However, we welcome views.

5.177 **We would welcome views on whether there is a case for greater protections for smaller businesses.**

[51] Norwegian Insurance Law Act 1989, ss 1 to 3.

[52] See paras 8.54 to 8.80 below.

PART 6
GROUP INSURANCE, CO-INSURANCE AND INSURANCE ON THE LIFE OF ANOTHER

6.1 So far we have considered issues of pre-contractual information that arise between only two parties - the insurer and the insured. Here we consider more complex situations, where the same issues arise in a context involving a third party. We look first at group insurance, for example where an employer enters into an insurance contract for the benefit of employees but the beneficiaries are not parties to the insurance contract. We then outline the position in co-insurance, where two or more policyholders enter into an insurance contract together. Finally we explain the effect of our proposals where a policyholder insures the life of someone else, either singly or jointly.

6.2 These issues cross the divide between consumer and business insurance. Group insurance is usually taken out by a business, but the most common type of scheme provides benefits to individual employees in a private capacity. Co-insurance may be taken out by either businesses or by consumers. Similarly, policyholders may insure the lives of others for either private or commercial reasons.

GROUP INSURANCE

Introduction

6.3 Here we consider how issues of non-disclosure and misrepresentation should be treated in group schemes. We consider primarily group insurance for employees. At the end of the section we ask whether there are other types of group insurance that need to be considered and whether any reform is needed for them.

6.4 Group insurance for employees forms a significant sector within the insurance marketplace. The reinsurer Swiss Re kindly provided us with figures valid as at the end of 2006. These show that over 60% of all long-term income protection benefits are provided under group schemes and that over 50% of those with this type of cover hold it through group membership. Nearly 40% of all life cover is provided under group life insurance. Given its importance it is surprising that the relevant law seems undeveloped. That is probably because group insurers (of whom there are not large numbers) have developed fair practices. We think the law should now be brought into line with these good practices.

What is group insurance for employees?

6.5 For the purposes of this section we use the term “group insurance” to refer to the type of scheme arranged by an employer with an insurer. Although the employer is the policyholder, the policy provides for the payment of benefits in respect of those employees who are eligible for membership of the scheme and have joined it. In some cases membership will be automatic, in others it may be optional: often it will be offered as part of a flexible benefits package. Schemes may also provide benefits to employees’ spouses, partners or dependants.

6.6 Various types of insurance are provided under this sort of arrangement, for example:

(1) Income protection insurance.

(2) Life insurance.

(3) Medical expenses insurance.

(4) Critical illness insurance.

6.7 Though all written as "group insurance", these schemes are arranged in different ways and receive different types of taxation treatment. For example, income protection claims payments are made to the employer. The employee will continue to receive a salary – in whole or in part – and this will be taxed as earnings in the usual way. Life insurance claims payments are made to trustees who will make payments at their discretion, but frequently in line with any wishes expressed by the employee. The payments may therefore escape inheritance tax. Group medical expenses and critical illness insurances are treated as a benefit to the employee and must be declared on a P11D form where applicable. Employees are liable for tax on any premiums paid on their behalves.

6.8 We are not concerned here with three other common arrangements:

(1) "Affinity" schemes under which an insurer offers special terms to individuals who fall within a particular group, for example offering medical cover to the employees of a university. The employees who wish to take advantage of these schemes will simply contract individually with the insurer, and will pay the premiums. In the case mentioned the individual contracts would all be separate consumer contracts within the meaning of our scheme, even if the university authorities negotiated the general terms of cover with the insurer.

(2) Policies that an employer may effect purely for its own benefit. For example, an employer may effect key person insurance on crucial personnel. Although such insurance provides benefits on the death or serious illness of an employee, the intention is to cover the resulting loss to the employer. This is business insurance within the meaning of our scheme.

(3) Policies that an employer may effect to meet specific statutory or contractual obligations to its workforce. For example, an employer may effect insurance intended to cover its own liability for statutory sick pay. Although an employee may gain some indirect benefit from the existence of such an arrangement, the employer would in any event have been obliged to make the payments. The same will be true if the employer has entered contractual undertakings to its employees to provide them with certain benefits. The contracts between the employer and the employees are not contracts of insurance. If the employer has taken out insurance to cover its contractual liability, that is straightforward business insurance and will fall within the provisional proposals we made in Part 5.

6.9 There may, however, be cases where an employer enters into an insurance contract partly to cover its own liabilities and partly to benefit its employees. For example, employment contracts may provide that the employer will pay sick pay for six months in any event, and may make payments for a longer period if the circumstances are covered by insurance. After six months, the employee has a direct interest in whether the circumstances are covered by insurance, even if technically he or she is receiving a salary payment rather than an insurance benefit. Our proposals are intended to apply to situations where the employee has a direct interest in the insurance claim in this way.

Characteristics of group insurance

6.10 In the kind of group insurance that concerns us here, the insured takes out a policy for the benefit of the members of the group scheme. However, the individual members are not party to the policy of insurance. Furthermore, we are informed that insurers invariably exclude the possibility of members gaining rights under the Contracts (Rights of Third Parties) Act 1999. Rather the intention is that the insurer will make payments under the scheme in respect of the member concerned. The payments may be made without the member or their beneficiaries having any enforceable right to them.[1] In Scotland, members might acquire a *jus quaesitum tertio* (a right acquired by a third party in a contract between others) but only if there was an intention to benefit them.

6.11 Group life schemes are generally established by way of a trust, which may be linked to a pension scheme or set up on a stand-alone basis. The insurer will make payment to scheme trustees – the policyholder – who will pass it on to the member's nominee or estate. However we understand that this will almost invariably be a discretionary trust under which the beneficiaries will have no enforceable rights to any particular sum or to direct the trustees to act in any particular way. Members may complete an "expression of wish" form. However, the trustees are not bound to act upon this.

6.12 Typically, members do not pay for the cover they receive directly, though they may do so indirectly as part of their remuneration package. In some schemes, employees have the option of purchasing additional cover, either by choosing benefits from a menu or by making voluntary contributions. Under these "menu" (or "flex") systems, an employee may be given a choice of benefits, for example between a better company car or private dental insurance. Members may also be able to pay extra to include spouses, partners and dependants within the scheme for some types of benefits.

[1] See *Green v Russell* [1959] 2 Ch 226, CA.

6.13 Group insurances are underwritten on a different basis to individual contracts. In particular there is less concern about the risk presented by individuals, since this is less significant when viewed within a pool of employees. Typically an insurer will grant a level of "free cover". This is cover granted to each member without individual underwriting - that is, without collecting any information from the member or from other sources such as the employer or the member's doctor. Certain basic requirements must still be satisfied. These basic requirements might include the fact that the member is within a given age range or not on sick leave on the day the policy commences. In many cases "free cover" may be substantial – we were given an example of £1 million cover per person.[2] Additionally, extended cover may be purchased for particular members, but individual underwriting is then likely to be required. The insurer will usually obtain the necessary information directly from the individual member. However, individual underwriting is relatively rare. We were told that in one scheme only 13 members were individually underwritten, out of a total membership of 3,500.

6.14 There are specialist advisers who advise employers on group insurance. Individual members will often not receive any individual financial advice.

6.15 In group insurance, issues of non-disclosure and misrepresentation may arise with the policyholder (the employer) and in this event the normal legal rules apply. Thus were the policyholder to make a misrepresentation that was material to the scheme – for example, an employer misrepresenting the physical conditions under which its employees work – the insurer would be entitled to avoid and could therefore refuse to pay any benefits to members.

6.16 It is also possible for problems to arise where a member of a scheme has been individually underwritten and has provided inaccurate or incomplete information. Since the member is not party to the policy of insurance, this type of problem is not covered by general rules of insurance contract law. Insurers therefore deal with such situations mainly by being pragmatic in their approach and sometimes by way of contractual terms.

6.17 A contract may deal with this situation through the use of warranties or basis of the contract clauses. For example, the main insurance contract may contain a term stating that the information given by individual scheme members forms the "basis of the contract", or that the employer "warrants" the truth of members' statements. As a matter of strict law, this would enable an insurer to avoid the entire policy for a misrepresentation by a single individual about his or her own health. However, we were told that no insurer would attempt to apply the law in such a way, as it would go much further than necessary to protect an insurer's interests. Some contracts may therefore include more specific and tailored remedies.

[2] In some cases, employees may opt to extend their "free cover". In some schemes this may be done as part of the general risk, without individual underwriting. The level of "free cover" may therefore be expressed as a range rather than a set amount.

6.18 We were told that whatever the contractual terms, the outcome would follow normal industry practice. Where an individual member has provided inaccurate or incomplete information, group insurers will seek a remedy only in respect of payments made to that individual. Furthermore, they will not seek to refuse the full amount of the claim. The claim will be met to the level of the "free cover". The policy itself will remain in force. Avoidance or cancellation of a policy is only likely where there has been serious misrepresentation or non-disclosure by the employer, or inaccurate or incomplete information has been provided by an individually-underwritten member of the scheme who is a "controlling mind" of the business.

Are special rules required for group insurance?

6.19 Most of the key principles of insurance contract law were settled at a time when group insurance simply did not exist. There is little settled law relating to group insurance, with only a handful of cases having been heard by the courts.

6.20 Under the approach that we have proposed elsewhere in this paper, the rules of law that apply in any given case will depend on whether a policyholder is a business or a consumer. Without special rules, group insurance would therefore be subject to the business insurance regime. We are not satisfied that this is appropriate. In particular, we have concerns relating to the individual members of schemes and the potential impact on their cover should they fail to provide the insurer with accurate information.

6.21 We appreciate that this is not strictly speaking an issue about pre-contractual information. First, members are not parties to the contract. Second, information will frequently be provided at times subsequent to the formation of the contract - for example, when an employee becomes eligible to join the scheme, or when an application is made for an employee's benefits to be increased. Third, the remedies available to the insurer are those granted by contractual terms rather than by the common law.

6.22 Nevertheless, when an insurer seeks information from a member of a scheme the process is broadly comparable to the underwriting of an individual contract, and similar forms are frequently used. This therefore seems a suitable point at which to consider the matter.

Financial Ombudsman Service

6.23 The Financial Ombudsman Service (FOS) is able to consider a complaint brought against an insurer by an employee who is or was intended to be a beneficiary under a group insurance scheme. This jurisdiction is based on the definition of "eligible complainant" within the FSA Rulebook. Under rule 2.4.10 of the Dispute Resolution Sourcebook (DISP), complaints from non-policyholders are specifically allowed in some circumstances. Under rule 2.4.12, these circumstances include where "the complainant is a person for whose benefit a contract of insurance was taken out or was intended to be taken out".

6.24 In practice we understand that the FOS regards itself as able to consider complaints unless the policy was effected to benefit purely the employer,[3] or to meet an obligation that the employer would have to the employee in any event. This means it looks at precisely those cases in which we are currently interested.

6.25 It appears that the FOS has had little difficulty in dealing with such cases. Where the misrepresentation is made by a member of the scheme, the dispute is treated in the same way as if the member were the policyholder. Thus the insurer will be required to treat the member fairly and reasonably, applying the same standards as we described in Part 3.

A case for reform?

6.26 Is the current situation satisfactory, or should the law be reformed? We have already stressed how significant group insurances are within the long-term insurance marketplace. Equally the cover can be vital to individual scheme members. Consumers who already enjoy membership of a group insurance scheme are less likely to purchase individual contracts. Those who have individual contracts may cancel them or allow them to lapse if they subsequently gain membership of a scheme.

6.27 Our starting point is that any misrepresentation made by a group member should be treated in the same way as it would be treated if the group member were the policyholder and had arranged the insurance directly with the insurer. If the cover provided is such that, were the member to arrange it individually, it would be classified as consumer insurance, the individual member's claim would be considered according to the tests we have proposed for consumer insurance.

6.28 This would bring the law into line with the FOS approach and accepted practice in the market. If what we have been told about common industry practice is correct, the impact will be limited.

6.29 It means that, in group schemes for employees, the insurer would not be entitled to reject a claim where a member had acted honestly and reasonably. If the member were negligent, the insurer's rights should depend on what the insurer would have done had it been given the correct information. If, for example, it would have given only the minimum "free cover", the member's benefits should be limited accordingly. On the other hand, if the member had made a deliberate or reckless misrepresentation, that member's claim could be refused and that member could be excluded from benefits under the scheme.

6.30 The obligation will be to make a payment under the scheme, rather than necessarily to make a payment directly to the member. If, for example, the scheme requires money to be paid to pension trustees, the insurer's obligation will remain an obligation to the trustees.

[3] Eg where the employer insured a key person, as described in para 6.8(2).

6.31 There is one question on which we have not reached a provisional view. Under the proposals set out in Part 4, an insured who has acted deliberately or recklessly will normally be denied any benefit under the policy. However, accepted practice under group schemes is that where a member is denied individual cover because of a deliberate or reckless misrepresentation, he or she may receive the minimum "free cover" generally available. We invite views on whether group insurance should follow the normal rules set out in Part 4. Alternatively, should they be more generous and follow existing practice by providing the minimum level of "free cover"?

6.32 We have considered whether there may be instances in which an employee lies to an employer in a non-insurance context, and the employer then passes on that lie without the employee being aware of the use to which it was put. For example, suppose a job applicant takes 10 years off their age when filling in an application form, to improve their chances of selection, without being aware that this is relevant to an insurance scheme. Do we need to make special provisions about how lies of this type should be dealt with? Our initial thought is that we do not. Such cases will normally be dealt with by policy terms. For example, if a policy states that it only provides life cover to those aged under 65 and (unbeknown to their employer) an individual employee is aged 70, the individual will not fall within the terms of the scheme. The claim may be rejected because it does not fall within the coverage of the policy, rather than because a misrepresentation has been made. However, we welcome views on this point.

6.33 Our proposal means that disputes about misrepresentations by individual scheme members may be dealt with by the courts as well as by the FOS. We think this will have a further advantage. Under current law, issues of confidentiality might prevent the FOS from receiving relevant information from an employer about a complaint has been brought by an employee. The employer may well have relevant information, for example about what employees were told they need or need not say if they were applying for individual arrangements beyond the minimum "free cover". It seems unfortunate that this should not be taken into account – whichever side it favours.

Misrepresentations by the policyholder

6.34 We saw earlier that the policyholder is the employer. If the employer fails to disclose a material fact or makes a material misrepresentation, the insurer is as a matter of law entitled to avoid the policy as a whole. For example, the employer may misrepresent the nature of the business. It may (for instance) describe its employees as clerical workers, when in fact they are building contractors.

6.35 Under our reforms, misrepresentations by the policyholder will continue to be regarded as commercial matters, to be dealt with under the business regime set out in Part 5. We ask if consultees agree. Should a non-disclosure or misrepresentation by the policyholder provide the insurer with the same rights to avoid a policy as would apply in the case of other business insurance?

6.36 In some ways it may seem harsh that employees could be deprived of important cover for mistakes that are not their fault. However, that is the nature of third party claims: there are many situations in which third parties may be deprived of compensation because an insurer has avoided a policy where the insured is at fault but the third party is not. As we pointed out earlier, reforms that would affect the rights of particular classes of third party are not within the scope of this project.[4]

Other types of group insurance

6.37 We understand that group insurance is sometimes taken out in other contexts, where the cover provided for the member of the group would be business insurance, were it to be arranged directly with the insurer. For example, the main contractor on a large construction project might take out insurance covering all sub-contractors working on site.

6.38 We understand that normally in such a case the sub-contractors would be made co-insureds under the policy. We discuss co-insurance below. However the policy might be arranged so that the sub-contractors acquired rights as beneficiaries under the contract,[5] or (perhaps by accident rather than by design) they might have no enforceable rights at all against the insurer. Again there will be the possibility that a sub-contractor, though not a party to the policy, might misrepresent or fail to disclose relevant information. The legal effect of this is unclear, but it would be unfortunate were it to give the insurer the right to avoid the policy as a whole. This can be prevented by the use of a "severability" clause so that the benefits due to each member will be treated independently. The question is whether in group insurance that serves a business function this should become the default rule, in much the same way as we have provisionally proposed for group insurance for employees. The insurer would only have the right to reject claims from other members, or to avoid the policy as a whole, because of incorrect information from a member, if the contract explicitly so provides.

Group insurance: proposals and questions

6.39 **We provisionally propose that in group insurance for employees, a misrepresentation made by a group member should be treated as if the group member were a policyholder who had arranged insurance directly with the insurer. This means that:**

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

(2) **as the insurance is such that if the policyholder had arranged it directly it would be consumer insurance, any dispute concerning a misrepresentation by the group member would be determined in accordance with our proposals for consumer insurance.**

6.40 **We ask:**

[4] See above, paras 5.157 to 5.161.

[5] Under the Contracts (Rights of Third Parties) Act 1999. This Act does not apply in Scotland.

(1) **Where a member has made a deliberate or reckless misrepresentation, but the insurer would have given a certain level of "free cover" without that information, should the insurer be entitled to refuse all benefits in respect of that member? Alternatively, should the insurer be obliged to provide the free cover that would have been provided in any event, provided the basic eligibility criteria for the scheme are met?**

(2) **Do consultees agree that a non-disclosure or misrepresentation by the policyholder, that is the employer, should provide the insurer with the same rights to avoid a policy as would apply to other business insurance?**

6.41 **We ask consultees if they have experience of problems in other types of group insurance, other than those written by employers in respect of employees. For these types of policy, should a misrepresentation or non-disclosure by a group member be treated as if the group member were the policyholder and had arranged the insurance directly with the insurer?**

CO-INSURANCE

6.42 Two or more people may wish to take out an insurance policy together. They may do this because they share the same interest or, in Scotland, right in the subject matter of the insurance (as with spouses insuring the matrimonial home) or for convenience, because they each have an interest or right in the subject matter of the insurance (for example, a landlord and tenant). Companies within the same corporate group may wish to arrange insurance together in order to obtain insurance more efficiently and at a lower premium. Where a single insurance policy covers two or more policyholders, the policy is said to be one of co-insurance.

6.43 If one of the co-insureds under a policy of co-insurance fails to disclose or misrepresents a material fact during the placement of the insurance, an issue arises as to whether the other co-insureds are prevented from recovering under the policy as a result of their co-insured's wrongdoing.

The current law

6.44 The law draws a distinction between "joint" policies and "composite" (or "several") policies. Co-insureds under a joint policy stand or fall together. However, where the policy is composite, an innocent co-insured is unaffected by their fellow co-insured's failure in their disclosure obligations.[6]

[6] In *Woolcott v Sun Alliance and London Insurance Ltd* [1978] 1 Lloyd's Rep 629 the policy was composite, and it is implicit that a different decision would have been reached had the policy been joint. In 1924, in the context of wilful misconduct by one co-insured but not the other, Lord Sumner commented: "fraud is not something absolute, existing in vacuo; it is a fraud upon someone. A man who tries to cheat his underwriters fails if they find him out, but how does his wrong invest them with new rights against innocent strangers to it?": *P Samuel & Co Ltd v Dumas* [1924] AC 431 at p 469.

6.45 The reason co-insureds under joint and composite policies are treated differently is a technical one. A joint policy creates a single contract whereas a composite policy represents a bundle of contracts.[7] This is significant because a contract cannot be rescinded unless total rescission can be achieved.[8] It is not, therefore, possible to rescind a joint contract of insurance in respect of the culpable co-insured but affirm it in relation to the innocent co-insured. The whole contract must be avoided, leaving nothing for the innocent co-insured to found an action on. In the case of composite insurance the insurer can avoid their contract with the culpable co-insured without affecting their contract with any innocent co-insureds.

6.46 Whether a policy is joint or composite is a matter of interpretation. The courts have placed significant emphasis on the nature of the interests or rights held by the co-insureds.[9] Co-insureds who share the same interest or rights in the subject matter of the insurance, such as joint owners or, in Scotland, co-owners,[10] will be considered to have a joint policy. Where the interests or rights are different, such as a mortgagor and mortgagee (standard security grantor and holder in Scotland) or landlord and tenant, the policy is said to be composite in nature. This means that where a husband and wife insure the possessions which they own jointly or, in Scotland, in common, they will normally be considered to have a joint policy. However, if flat sharers joined together to insure their separate possessions in a single policy, the policy would normally be considered to be composite.

6.47 It is not certain whether a policy that is composite in nature can be made joint by clear and unambiguous wording to that effect.[11] We have not found any cases in which the wording is sufficiently clear and unambiguous to make insurance on different interests or rights into a joint policy.

[7] In *Arab Bank Plc v Zurich Insurance Co* [1999] 1 Lloyd's Rep 262, at p 277, Rix J clarified that "in a typical case of a composite policy where there are several assureds with separate interests, the single policy is indeed a bundle of separate contracts. That is the prima facie position". See also M Clarke, *The Law of Insurance Contracts* (4th ed 2002) at para 27-2C6.

[8] See *Sheffield Nickel v Unwin* (1877) 2 QBD 214 ("a contract cannot be rescinded in part and stand good for the residue. If it cannot be rescinded *in toto*, it cannot be rescinded at all." Lush J at p 214) and *United Shoe Machinery v Brunet* [1909] AC 330 ("The party defrauded cannot avoid one part of a contract and affirm another part, unless indeed the parts are so severable from each other as to form two independent contracts", Lord Atkinson at p 340).

[9] In a passage which has been followed, Sir Wilfred Greene MR explained the difference between joint and composite policies in *General Accident Fire & Life Assurance Corp Ltd v Midland Bank Ltd* [1940] 2 KB 388 at p 405.

[10] In English land law, a distinction is made between co-owners who hold as "joint tenants" and those who hold as "tenants in common". Joint tenants would be presumed to take out joint insurance. Tenants in common may be co-insureds under a composite policy.

[11] *New Hampshire Insurance Co v MGM Ltd* [1997] LRLR 24 and *Directline Insurance Plc v Khan* [2002] Lloyd's Rep IR 364 seem to assume that this is possible. This would be consistent with the English law of joint and several obligations generally, which is characterised by the rule in *Slingsby's Case* (1587) 5 Co Rep 18b. Parke B described the rule as follows: "a covenant will be construed to be joint or several according to the interests of the parties appearing upon the face of the deed, if the words are capable of that construction; not that it will be construed to be several by reason of several interests, if it be expressly joint": *Sorsbie v Park* (1843) 12 M & W 146 at p 158.

The FOS approach

6.48 In our survey of FOS cases we did not come across any instances where there was a dispute about whether the policy was joint or composite. We therefore contacted the FOS to find out about their approach in cases of co-insurance where one of the parties has been guilty of some form of fault, such as misrepresentation or fraud, and the other party has acted innocently and reasonably.

6.49 The FOS provided the following principles as an indication of their approach:

(1) If there is a joint risk under a policy of co-insurance the co-insureds are likely to "sink or swim" together.

(2) If there are separate risks under a policy of co-insurance the co-insureds are more likely to be treated separately. In particular, if each co-insured answered questions about their own risk then the other co-insured would be unaffected by those answers.

(3) Where non-disclosure or good faith is in issue the state of mind of each co-insured is likely to be assessed individually.

(4) If a co-insured was likely to benefit from their own dishonesty then the FOS would consider making an exceptional decision to prevent it.

Our views

6.50 Co-insurance can arise in other contexts, most notably where one party has made a fraudulent claim or deliberately brought about a loss. Several jurisdictions have grappled with cases where one spouse burns down the matrimonial home and the innocent spouse claims in respect of their own interest.[12] For this reason, we intend to deal with co-insurance in our second consultation paper when dealing with fraudulent claims.[13]

6.51 In the context of pre-contract information, we think the current law is satisfactory. It appears fair that if one of the joint insureds makes a misrepresentation that gives the insurer a remedy, the remedy should apply equally against the other joint insured. Thus in this paper we are not proposing any changes to the law in this area. However, we would welcome views.

6.52 **We ask whether consultees are aware of any problems concerning the law of co-insurance in relation to issues of non-disclosure and misrepresentation.**

[12] In the United States see *Hedtcke v Sentry Insurance Co.* (1982) 109 Wis 2d 461, 326 NW 2d 727 (Wis). In Canada see *Scott v Wawanesa Mutual Insurance Co* [1989] 1 SCR 1445 and *Higgins v Orion Insurance Co Ltd* (1985) 17 DLR (4th) 90. In New Zealand see *Maulder v National Insurance Company of New Zealand Ltd* [1993] 2 NZLR 351.

[13] We will also consider the position of people or organisations who are not a party to a contract of insurance but are nevertheless seeking to enforce rights under the contract, for example by seeking to enforce a right under the Contracts (Rights of Third Parties) Act 1999 or a similar right in Scots law.

INSURANCE ON THE LIFE OF ANOTHER

Different types of life insurance

6.53 There are many ways in which life insurance may be structured. An individual may insure their own life, so that any benefit is paid to their estate. They may insure their own life and assign the benefit to another. Alternatively, they may insure another's life, so that they receive the benefit if the other person dies.

6.54 Take a typical case in which a husband and wife wish to take out life insurance. It would be possible for each to take out a separate life insurance policy on their own life, with either the payments paid to their estates or assigned to the other. Alternatively, they may each take out separate policies on each other's lives, so that each benefits if the other dies. Another variation is to take out a "joint life, first death" policy, which is usually structured as a joint policy on each other's lives: if the husband dies first, the wife receives a payment, and vice versa. Or the couple may take out a policy that pays only if they both die (referred to as insurance on the "death of the last survivor").

6.55 Life insurance may raise difficult legal issues about insurable interest (particularly if the parties are cohabiting rather than married). We do not examine these issues here. Instead, we intend to consider them in our second consultation paper. Here we focus on a limited issue. How should the law treat a misrepresentation by the life insured, where they are not the policyholder under the contract?

Consumer life-of-another policies: misrepresentations by the life insured

6.56 This issue arises where a consumer policyholder takes out insurance on another person's life, for example, where a husband insures his wife's life. The person whose life is being insured is asked questions about their age and state of health, and the insurer relies on the information to underwrite the risk. However, this person is not a party to the contract. Under current law they are under no duty to disclose information, and if they misrepresent the position, this will not of itself give the insurer the right to avoid the policy unless the policyholder knows of the misrepresentation.

6.57 The insurer may, reasonably, want the policyholder to be contractually bound by the information provided. Under current law, the easiest way to achieve this is to use a basis of the contract clause. The policyholder signs a form to say that the answers given by the life insured form "the basis of the contract". This converts all the answers provided by the life insured into warranties.

6.58 The problem with basis of the contract clauses is that they go much further than is required to protect the insurer's legitimate interests. By converting every statement by the person whose life is insured into a warranty, the insurer is automatically discharged from liability for any breach. Even an innocent and reasonable mistake by the person whose life is insured would prevent the policyholder from recovering under the policy, whether it was material to the risk or not. We think this goes too far.

6.59 In Part 4 we provisionally propose to abolish basis of the contract clauses in consumer contracts. Instead, statements of past or current fact would be treated as representations rather than warranties. This solves the problem that an insured may be deprived of benefit because of an innocent or immaterial mis-statement. However, we do not wish to deprive insurers of a remedy where the person whose life is insured makes a negligent or fraudulent representation. We think a special provision is required in these circumstances.

6.60 In the absence of an agreement to the contrary, the policyholder should normally bear the risk that the person whose life is insured has acted negligently or dishonestly. We therefore provisionally propose to treat any representation made by the person whose life is to be insured as if it were a representation made by the policyholder. We think this would achieve a fairer balance between the insurer and the policyholder in life-of-another policies.

6.61 Under such a scheme, the state of mind of the person completing the questionnaire would be imputed to the policyholder. If the person whose life was insured had acted deliberately or recklessly, the insurer could avoid the policy. If they acted negligently, the insurer would have a proportionate remedy. If however, the person whose life was insured innocently and reasonably gave the wrong answer to a question, then the policyholder would be deemed to have made an innocent misrepresentation. The insurer would be required to pay the claim.

6.62 However, this would not excuse the policyholder if they were themselves negligent or fraudulent. If the policyholder realised that the person whose life was insured had made an innocent and reasonable error but then deliberately did not correct it, the insurer would be entitled to avoid the policy for deliberate misrepresentation. Similarly, if the policyholder did not realise the misrepresentation was false but ought to have done, then the insurer would be entitled to a remedy for negligent misrepresentation.

6.63 **We provisionally propose that in consumer life-of-another policies, representations by the life to be 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 negligently, it will have the remedy that is appropriate for that kind of conduct.**

6.64 **We ask whether parallel issues arise in other consumer contexts and, if so, whether the same solution is appropriate.**

Consumer insurance: "joint lives, first death" policies

6.65 We have been asked to spell out how our proposals will affect a particularly common form of consumer life insurance. This is where spouses take out a joint policy on each other's lives to be paid on the first death.

6.66 Take an example where both parties filled in separate parts of the proposal form about their own health. The wife was completely truthful, but the husband deliberately misrepresented his health (without the wife's knowledge).

6.67 A claim may arise in two ways. The first is that the husband dies and the wife makes a claim. Under current law and ombudsman practice, the insurer may refuse the claim. Usually, the insurer will rely on a basis of the contract clause, by which the wife has adopted the husband's answers as her own. Under our proposals, the result would be the same, though it would be reached using a different legal mechanism. The husband's misrepresentation would be treated as if it had been made by the wife.

6.68 The second possibility is that the wife dies, and the husband makes a claim.[14] We were told that, in practice, the insurer is unlikely to investigate or discover the husband's dishonesty. However, if it does, current law and ombudsman practice would allow the insurer to avoid the policy. As a matter of strict law, the insurer is entitled to avoid the whole policy on the grounds of the husband's misrepresentation. In policy terms it could also be said that the husband should not benefit from a policy secured through his own dishonesty. Again, this would also follow from our proposals. We would welcome views on whether consultees agree that this is the right result.

6.69 We would also be interested in hearing views on a further matter. Where the "guilty" party dies, the FOS may use its discretion to order the insurer to continue the policy on the life of the innocent party. In the example given above, where the husband dies, the FOS may permit the insurer to refuse the claim concerning the husband's death, but is likely to order it to continue the policy as a single life policy, under which the wife insures her own life. This is particularly important where other cover, such s critical illness cover, accompanies the life cover. The insurer may be ordered to adjust the premiums accordingly. We do not see that this can be required as a matter of law. However, we are interested in receiving views on whether this is the right result. If so, should the courts or ombudsman be given a discretion to adjust joint life policies in this way?

6.70 **We ask whether in a "joint life, first death" policy, consultees agree that the insurer should be entitled to refuse claims where either the deceased or the beneficiary has made a deliberate or reckless misrepresentation**.

6.71 **We welcome views on whether, if a claim is refused following the death of a guilty party, the court or ombudsman should have discretion to order the insurer to continue the policy as a single life policy, payable on the death of the innocent party**.

Business insurance: a default rule?

6.72 Life-of-another policies may also be taken out for business reasons, as where a business insures the life of a key employee. Here the parties may wish to make different arrangements. For example, in some cases the policyholder may not wish the person whose life is to be insured to be approached at all – and, if they are approached, they may wish to come to different arrangements about how their representations are to be treated.

[14] If the policy covers both life and critical illness, and the wife makes a claim for critical illness, the FOS would allow the wife's claim. We think this follows from legal principles. The critical illness element is separate, and is not a joint policy. The wife has not misrepresented her position.

6.73 In business contracts, we propose that the default rule should be the same as for consumer life insurance: representations made by the person whose life is insured should be treated as if they were representations by the policyholder. However, the parties would be free to come to different arrangements about how a representation by the life insured was to be dealt with.

6.74 As we explain in Part 5, our provisional proposals afford the parties considerable freedom to come to their own arrangements. For example, if the answers were set out specifically in the policy or in a schedule to the policy, they could be accorded warranty status. However, this could not be done by a basis of the contract clause, which simply said that the answers on another form formed the "basis of the contract" or were warranties. The insurer would need to set the answers out specifically in the contract or in a schedule to the contract so that the policyholder had a chance to examine them. Where the parties contracted on the insurer's standard terms, our provisional proposals would also prevent a warranty from being written in such a way as to defeat the insured's reasonable expectation of cover. This would, for example, control an insurer who sought to rely on a clause in the small print stating that the policy may be avoided for a misrepresentation by the life insured that had no bearing on the risk.

6.75 **We provisionally propose that in business life-of-another policies, the default rule should be the same as for consumer insurance: representations by the life to be insured should be treated as if they were representations by the policyholder. However, this would be subject to the terms of the contract.**

PART 7
WARRANTIES AS TO THE FUTURE AND SIMILAR TERMS: THE CURRENT POSITION

INTRODUCTION

7.1 An insurer may wish to ensure that the risk covered by the policy is not increased by either the conduct of the insured or some other change of circumstances. Several legal devices can be employed to achieve these aims.

7.2 In respect of the insured's own conduct, there are two principal devices.

(1) The insurer may obtain undertakings from the insured to do certain things, for example to maintain an alarm system. Typically the undertaking will be in the form of a warranty.[1] As we saw earlier, a warranty must be complied with exactly, and any breach discharges the insurer from further liability under the policy, or at least the relevant section of the policy.

(2) The insurer may exclude losses caused by certain types of behaviour from the risks covered by the policy. This can be done by an exception or by making compliance with specified requirements a condition precedent to the relevant claim.

7.3 Typically, policies will cover changes of circumstances that occur for other reasons, but insurers may seek to exclude or reduce the effect of particular changes in the risk. Again a variety of methods may be employed.

(1) The insured may be required to warrant the continued existence of certain facts, for example that a ship will retain its Lloyd's classification.

(2) The insured may be required to notify the insurer of a change in circumstances, so that the insurer can decide whether to cancel the cover or amend its terms. For example, standard clauses used in marine insurance provide that a breach of warranty will not automatically discharge the insurer from liability. Instead the insured must notify the insurer immediately of the occurrence.[2]

[1] Alternatively it may take the form of a condition precedent to the attachment of the risk: see paras2.57 to 2.53 above. The legal effect seems to be the same as that of a warranty.

[2] Thus clause 3 of the Institute Time Clauses (Hull) 1995 states:

> Held covered in case of any breach of warranty as to cargo, trade, locality, towage, salvage services or date of sailing provided notice be given to the Underwriters immediately after receipt of advices and any amended term of cover and any additional premium required by them be agreed.

(3) The policy may contain exceptions that have similar effects to warranties. For example, a warranty that a vehicle is "kept in a roadworthy condition" may be re-written as an exclusion, that an accident will not be covered "unless the vehicle is in a roadworthy condition". The difference is a warranty applies if the car becomes unroadworthy even if it is then repaired; exclusion applies only to accidents where the vehicle was unroadworthy at the time. However, an exclusion may well apply even in the absence of a causal connection. For example, if a car has broken headlights the exclusion would apply, even if the accident took place in daylight, and the defective headlights played no part in it.

7.4 The legal effect of warranties has been heavily criticised. In this Part we begin by analysing the particular difficulties caused by warranties. However, it is important to see these within a broader framework of techniques that may be used to achieve the same ends. It is not always possible to distinguish clearly between warranties and other terms.

WARRANTIES AS TO FUTURE CONDUCT OR CIRCUMSTANCES

Criticisms of the current law

7.5 We set out the current law on warranties in Part 2. The principal criticisms of warranties as to the future have been that, because a breach of warranty automatically discharges the insurer from liability, insurers may refuse to pay a claim because of actions or omissions that:

(1) *are immaterial to the risk*. For example, an insurer may refuse to pay a claim because the insured innocently said that a lorry was (or would be) kept at the wrong address, even though this did not increase the risk.[3]

(2) *are irrelevant to the loss that has occurred*. For example, a failure to employ watchmen may discharge an insurer from liability for a claim for storm damage that no watchman could have prevented.[4]

(3) *have already been remedied*. For example,[5] if the warranty requires an alarm system to be kept operational the whole time and for some weeks it breaks down, there is no cover even after the alarm has been repaired.

7.6 These rules are unfair, we argued earlier, because they are contrary to what the insured who does not have a specialist adviser at their elbow would reasonably expect.

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

[4] See *Forsikringsaktieselskapet Vesta v Butcher* [1989] AC 852.

[5] Likewise, once a ship has entered an excluded zone, it remains uninsured even if it leaves that zone as soon as possible: *Bank of Nova Scotia v Hellenic Mutual War Risks ("The Good Luck")* [1992] 1 AC 233.

7.7 There is a further problem. The insured may simply not realise that the policy imposes a warranty obligation on them. The same is true of exceptions and other kinds of term that may be employed to produce similar effects. If the policy has not been individually negotiated and the warranty or exception is one of many standard terms, the insured may not know it is there until it is too late. It may be argued that this is the insured's fault for not reading the policy. Of course there is truth in this, but the law has long recognised that parties often do not read contract documents for understandable and excusable reasons. Insurance policies are usually long and complicated. Although in recent years there have been significant improvements in the clarity of policy documents, the average consumer would probably not be able to understand many of the terms without a good deal of trouble and a great deal of time. Many business insureds are in a similar position: there just isn't enough time.

7.8 As we see below, in consumer insurance there are controls to prevent insurers from hiding important terms in the small print, most notably the Unfair Terms in Consumer Contracts Regulations 1999 and FSA rules. However, there are no similar protections for businesses. In other sectors, businesses can rely on the protections against standard term contracts provided by sections 3 and 17 of the Unfair Contract Terms Act 1977, but insurance contracts are excluded from much of the 1977 Act.

Unfair Terms in Consumer Contracts Regulations 1999

7.9 The 1993 Directive and the Unfair Terms in Consumer Contracts Regulations (UTCCR) 1999 protect consumer insureds against unfair terms. We explained their effect in Part 2.

7.10 A consumer may be aware of the existence of a warranty but unaware of its implications. For example, a consumer may realise that the insurer requires certain locks, but not realise that a failure to install these locks discharges the insurer from liability for flooding. We have argued that such a term is unlikely to be considered a core term within the meaning of the regulations. This means that a court may review whether the term is fair. We think a term may well be unfair if it gives the insurer the right to treat itself as discharged for a breach that was immaterial, or for a breach that was not causally connected to the loss that occurred.

7.11 We have shown that the regulations can also be used to challenge exclusions and descriptions of the risk if they were not in plain language and were not made obvious to the policyholder. The regulations exempt from review terms that are part of the "definition of the main subject matter" and are "in plain, intelligible language". However, we have argued that a term cannot be part of the main subject matter of the contract if it undermines what the consumer reasonably expected. In other words, the insurer should take reasonable steps to ensure the consumer is aware of warranties, descriptions of the risk and exclusions. Simply including the terms in the contract documents is not enough.

Consumer insurance: Statements of Practice, FSA rules and the FOS

7.12 For consumers the legal position has been modified in practice by the Statements of Insurance Practice, the Financial Services Authority (FSA) Rules and the Financial Ombudsman Service (FOS). The current position is as follows.

Statements of Insurance Practice

7.13 The 1986 Statement of Long-Term Insurance Practice (SLIP)[6] provides:

> Except where fraud is involved, an insurer will not reject a claim or invalidate a policy on grounds of breach of a warranty unless the circumstances of the claim are connected with the breach …[7]

7.14 As we explained in Part 1, the Law Commission's 1980 report criticised voluntary statements of this type.[8] Insurers are not legally bound to abide by the statements, and the provision leaves the insurer as sole judge of whether "fraud is involved". We agree with the 1980 report: far from being an argument against reform, the statements are "evidence that the law is unsatisfactory and needs to be changed".

Financial Services Authority Rules

WARRANTIES: REQUIRING A CAUSAL CONNECTION BETWEEN THE BREACH AND THE CLAIM

7.15 Insurance Conduct of Business Rule 7.3.6 states that insurers may not:

> except where there is evidence of fraud, refuse to meet a claim made by a retail customer on the grounds:
>
> (c) in the case of a general insurance contract, of breach of warranty or condition, unless the circumstances of the claim are connected with the breach.[9]

7.16 Conduct of Business Rule 8A.2.6, which applies to long-term insurance, is in similar terms, except that it only applies to breaches of warranty and not to conditions. It goes on to state that the warranty must be "material to the risk" and must be "drawn to the attention of the policyholder before the conclusion of the contract".

7.17 The FSA rules replicate two of the difficulties identified with the ABI Statements. First they only cover retail (that is, consumer) insurance, while warranties bear most heavily against small and medium businesses. Secondly, they continue to permit insurers to repudiate claims where they suspect but cannot prove fraud: although the insurer must show some evidence of fraud, it is not clear that it has to be conclusive evidence. We explained in Part 1 why we think that it would be wrong to continue to permit an insurer to refuse to pay a claim on an irrelevant technicality when the real reason is they suspect fraud but cannot prove it.

[6] The 1977 Statement of Long-Term Insurance Practice (SLIP) did not specifically refer to warranties at all, and merely said that "an insurer would not unreasonably reject a claim".

[7] SLIP 1986, Clause 3(b). The SGIP (now withdrawn) contained a similar provision.

[8] See para 1.20 above.

[9] At the time of going to press, the FSA is intending to consult on changes to these rules. We understand that the FSA is proposing changes to the wording, but that these will not affect the substance of this requirement.

7.18 Unlike the statements, the FSA rules are binding on insurers. In the case of repeated breaches, the FSA may bring disciplinary action against the insurer, leading to fines or (ultimately) withdrawal of authorisation. However, a breach of the rules does not have the simple effect that the insurer is liable to the insured. The insured may have an action for breach of statutory duty, but that is not an easy remedy for a consumer insured to pursue.

7.19 Moreover, the result is that the overall position is hard to understand, because of the difference between the strict law and the regulatory requirements. It is also incoherent in a technical sense. The COB and ICOB rules are difficult to reconcile with the decision in *The Good Luck* that, following a breach of warranty, the insurer need not take steps to repudiate a policy but is instead automatically discharged from liability.[10] It would appear that an insurer may breach an FSA rule by doing no more than refusing to meet a claim for which it is not liable. This conflict between law and regulation on such a fundamental issue is unfortunate. It risks bringing both into disrepute. We do not think that FSA rules remove the need for reform. Rather, like the statements, they appear to be evidence that the law is unsatisfactory and needs to be changed.

BRINGING SIGNIFICANT OR UNUSUAL TERMS TO THE CONSUMER'S ATTENTION

7.20 The FSA rules provide help where warranties and exceptions differ from what the consumer reasonably expected. Consumer insureds must be told of "significant or unusual exclusions or limitations".[11] Unless the sale is by telephone or other medium which makes it impossible, the information should be contained in a policy summary,[12] "in a durable medium", and the summary must be given to the consumer before the contract is made.[13] With telephone and similar sales, the consumer must be told of significant or unusual exclusions or limitations before the contract is made, and a summary must be sent to them immediately afterwards.

7.21 These provisions are valuable. As we shall see, the FOS frequently refuses to allow an insurer to rely on a term if it took an insured unfairly by surprise. However, the FOS approach is not necessarily well known to insureds. FSA research reveals many instances in which insurers seek to rely on policy small print,[14] and consumers may not know enough about FOS practice to challenge this conduct. We think there is a need for greater clarity in this area. Clear legal rules should support existing good practice.

[10] *Bank of Nova Scotia v Hellenic Mutual War Risks ("The Good Luck")* [1992] 1 AC 233.

[11] ICOB 5.3.6 R and 5.5.5 R.

[12] The summary must either be separate from other documents or, if in another document, be prominent and separate from the other contents: ICOB 5.5.2 R.

[13] ICOB 5.3.1 R and 5.3.6 R.

[14] FSA, *General Insurance and Pure Protection Products: Treating Customers Fairly* (July 2006), discussed below.

TREATING CUSTOMERS FAIRLY

7.22 In Part 3 we highlighted the requirement that insurers must treat their customers fairly, and drew attention to the work carried out as part of the *Treating Customers Fairly* initiative.[15] The General Insurance Cluster report published in 2006 highlights examples of good and bad practice in this area. One example given of poor practice was that:

> Some insurers refuse claims for unconnected breaches (eg not paying out on a claim related to an escape of water due to an alarm breach).[16]

7.23 The report points out that although firms are required to make significant and unusual exclusions clear to their customers, they do not always do so, "but at times overwhelm them with information so they are unable to pick out the key messages".[17] However, there are many examples of good practice in this area, where for example, home insurers make it clear "exactly what is expected of customers under a policy if they have a burglar alarm or other home security device".[18]

7.24 These are valuable initiatives but for the reasons given in Part 3 in relation to pre-contract information, we do not consider that they provide adequate remedies to individual consumers who have not been treated fairly.[19]

The Financial Ombudsman Service

7.25 The FOS has a general discretion to decide cases according to what is fair and reasonable. In practice, dissatisfied consumers are more likely to take a case to the FOS than to court. To understand how the FOS currently approaches disputes over policy terms, we read 50 ombudsman final decisions concerning terms in consumer policies, and a further 18 cases involving terms in small business insurance. We are very grateful to FOS for allowing us access to these cases. To preserve the parties' confidentiality, we agreed to publish only anonymised details of the cases. We therefore refer to cases only by the numbers and initials we have allocated to them.[20]

CONSUMER POLICIES: ISSUES OF CAUSAL CONNECTION

7.26 Our analysis of these ombudsman cases suggests that warranties are not common in consumer cases. Although a few exclusions appeared to be written in wide terms, it is doubtful if a breach is intended to discharge the insurer from all liability under the policy (as spelled out under section 33(3) of the Marine Insurance Act 1906).

[15] See para 3.12.

[16] FSA, *General Insurance and Pure Protection Products: Treating Customers Fairly* (July 2006) p 18.

[17] As above, p 11.

[18] As above, p 14.

[19] See para 3.18 above.

[20] A fuller discussion of our findings is to be found in the report published on our website.

7.27 However, issues of causal connection can arise for exclusion terms as well as for warranties. There were cases within the sample in which the FOS overturned an insurer's decision to reject a claim where the breach the insurer relied on did not cause the loss in question.

7.28 In Case 42, the complainant claimed for a stolen bicycle, but the firm rejected the claim because at the time of the theft it was not locked to a secure structure. The complainant argued that this would not have made any difference: many bicycles were stolen at the same time, including locked bicycles. The ombudsman ordered the firm to pay the claim, commenting:

> The Insurance Conduct of Business (ICOB) rules state that an insurer should not refuse to meet a claim as a result of a breach of warranty or condition, unless the circumstances of the claim are connected with the breach. Although the firm is relying on an exclusion to reject this claim, it is no different to a warranty in that it requires the complainant to do something to ensure that the cover applies. As I do not believe the lock would have made any difference, I am satisfied that the complainant has provided sufficient evidence to establish that his failure to lock his bicycle was not connected to his claim.

CONSUMER POLICIES: REASONABLE EXPECTATION AND TRANSPARENCY

7.29 It was relatively rare for ombudsmen to refer explicitly to the UTCCR 1999 in their decisions. Among the 50 cases we looked at, the regulations were mentioned in only two. Neither of these cases was directly relevant to the issues discussed here.[21] However, we found several cases in which the ombudsman refused to uphold an exclusion clause contained within the policy small print, if it undermined the consumer's reasonable expectation and was not brought specifically to the consumer's attention. In his 1990 report, the Insurance Ombudsman stated that he would apply the spirit of the Unfair Contract Terms Act 1977 to cases brought to the Insurance Ombudsman Bureau. FOS continues this tradition. This also reflects the requirement in ICOB Rule 5 that significant or unusual exclusions should be brought to the consumer's attention. When a term undermines consumers' reasonable expectations, the FOS is likely to regard it as significant or unusual. Ombudsmen will be reluctant to uphold such a term unless the insurer has made sufficient efforts to bring it to the consumer's attention. This is particularly important if insurers wish to require policyholders to install a particular security measure, or to exclude claims arising "indirectly" from an existing medical condition.

7.30 For example, in Case 43 the policy required that "high value caravans" should have an alarm. The ombudsman held that it was not made sufficiently clear to the complainants that their £9,000 caravan would be classified as high value. It was not enough to include the requirement in the policy document. Such an important term should be brought to the policyholder's attention before the contract was concluded.

[21] For further details, see Case 25 and Case 9, set out in Issues Paper 2, Appendix B.

7.31 Case 14 concerned a critical illness policy offering a defined sum in the event of a heart attack. A policy term defined "heart attack" as "the death of a proportion of heart muscle as a result of inadequate blood supply", as evidenced by three symptoms: chest pain; "electrocardiograph changes"; and raised cardiac enzymes. The complainant was diagnosed and treated for a heart attack involving pain and elevated enzymes, but which did not show changes on an ECG. The insurers refused the claim on the grounds that one of the essential elements of the definition was not met.

7.32 The ombudsman pointed out that neither the key features document nor the headline illness highlighted that a heart attack was only covered if it was of a certain severity or if it involved satisfying a three-limb test.

> When a definition significantly restricts the meaning of the headline illness in a way that is inconsistent with either a policyholder's or a doctor's reasonable understanding of when a critical illness or event has occurred, then I consider it would be unfair of a firm to rely on a narrow interpretation of a definition to defeat an otherwise valid claim. In my judgement, the complainant's claim should be met because it falls within the spirit of what the policy was designed to cover and how it was sold.

7.33 Thus the FOS is prepared to strike down a narrow definition of the risk contained within the policy small print if this was not in accordance with reasonable expectations and was not made clear to the consumer.

SMALL BUSINESS CASES

7.34 We looked at 18 complaints brought by small businesses concerning the use made of policy terms. From this, it appears that warranties are much more commonly used in business insurance. The sample included cases brought by

(1) a Chinese restaurant, about a warranty that the wok should never be left unattended (SB case 4);

(2) a pub, about warranties over how the deep fat frying range should be cleaned (SB case 14); and

(3) a self-employed builder about an "application of heat warranty", setting out precautions the insured was required to take when using a blow torch (SB case 10).

7.35 We did not find any cases in which an insurer had attempted to refuse a claim solely because of a breach of warranty that had no connection with the claim. However, insurers might raise secondary issues about such breaches. In Case 10, the insurer drew attention to a breach that did not cause the loss as a supporting argument when it had decided to refuse a claim for other reasons.

7.36 In this case, the self-employed builder had caused a serious fire to his client's premises. The insurer argued that it was not liable because the builder had not taken several of the precautions he should have taken in his use of a blow torch. One of their arguments was that the warranty required the insured to have a portable fire extinguisher with him "at each area of work". The complainant had a portable fire extinguisher at the premises, but it was not in the room where he was working. However, one of the client's fire extinguishers was nearby, and was used. Unfortunately, however, the fire had started underneath the exterior flashing and was already out of control by the time it was discovered. The ombudsman eventually found for the builder, and gave short shrift to the insurer's argument concerning the fire extinguisher:

> Given the fire extinguisher that was nearby… I am not persuaded that the complainant failed to comply with this part of the warranty.

7.37 We think it would be rare for insurers to refuse claims solely for breaches of warranty that have no connection with the claim. However, if the law permits technical defences, some insurers will make use of them when they have other reasons to refuse claims. The FOS may well use its discretion to reject such technical defences, but they add to the cost and complexity of resolving disputes. It can also damage the reputation of the industry if insurers are seen to be nit-picking over irrelevancies.

Business insurance

7.38 With the exception of those small businesses (less than £1m turnover) to which the FOS is prepared to apply the same rules as it applies to consumers,[22] business insureds are subject to the full rigour of the law of warranties. They are not protected by the Unfair Contract Terms Act 1977, which exempts insurance contracts from its provisions. This is unlike other types of contract, where those who deal on the other party's standard terms of business are granted protection against unfair terms, which undermine reasonable expectations.[23]

EVALUATION OF THE PRESENT POSITION

7.39 In 1980 the Law Commission described the law on breach of warranty as wrong and unjust.[24] We agree. It is wrong because it does not accord with policyholders' reasonable expectations. If a policyholder is slow in repairing a fire alarm, they may well know that their fire cover will be suspended while the problem persists. However, those unfamiliar with the niceties of insurance law are unlikely to realise that they will continue without fire insurance after the alarm has been fixed. Nor are they likely to realise that this may also invalidate their flood cover.

[22] See para 1.34 above.

[23] See para 8.4 below.

[24] Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 6.9.

7.40 Insurers have told us that they rarely apply the strict letter of the law. They would not, for example, refuse to pay a claim because of a breach that had already been remedied before the loss. It is difficult to know how many claims are turned down each year for breaches of terms that are not causally connected to the loss. Our own small survey of complaints brought to the FOS does not suggest that the practice is widespread, though we note that the FSA reports cases where it has occurred.[25] The case for reform does not depend on evidence of widespread abuse. If insurers no longer think that the 1906 Act embodies fair principles, this is itself strong evidence that the law should be brought into line with acceptable practice.

Consumer insurance

7.41 The law applying to warranties in consumer insurance differs from that applying to business insurance because of the UTCCR 1999. The practical position also varies, as consumers have the protection of the Statements of Practice, the ICOB and COB Rules and the FOS.

7.42 The UTCCR 1999 are helpful to consumer insureds but we do not think that by themselves they are adequate. First, the Regulations are not widely understood, and appear not to have been used to their full potential in insurance cases that fall within the topics covered in this Issues Paper. In addition, the effect of the Regulations is not as clear as it should be. The two Law Commissions have already made recommendations to rewrite the Regulations in a clearer and more accessible way, so that the implications behind the Directive are made explicit.[26] The recommendations have been accepted in principle, subject to a regulatory impact assessment. We believe that if our draft Bill were implemented, what is required of insurers would be made significantly clearer.

7.43 Secondly, we do not think that in practice all the problems for consumers are solved by the Regulations. The consumer should not be required to make the complex and difficult argument that the warranty (1) is not a core term and (2) is unfair. We think that it is important that consumers are protected by a firm rule that a breach of warranty should not absolve the insurer from liability if the breach was immaterial or there was no causal connection between it and the claim.

7.44 Nor do we think that the Statements of Insurance Practice, the ICOB and COB Rules and the FOS are a substitute for keeping the law up-to-date, any more than they are in relation to misrepresentation and non-disclosure. The statements are insufficient in substance, since they appear to permit the insurer to take advantage of the technical defences of the law where there is some evidence of fraud, even if it cannot be proved. The FSA rules do not provide ready remedies for the individual insured. The FOS scheme is admirable but is not widely understood. Furthermore, it makes no sense to have multiple levels of regulation each with different requirements.[27]

[25] FSA, *General Insurance and Pure Protection Products: Treating Customers Fairly* (July 2006) p 18.

[26] Unfair Terms In Contracts (2005) Law Com No 292; Scot Law Com No 199.

[27] See paras 1.31 to 1.33 above.

7.45 It is our conclusion that although the UTCCR, the FSA Rules and the FOS offer valuable protection to consumer insureds in relation to breaches of warranty, there is a clear need for reform of the underlying law in consumer insurance cases.

Business insurance

7.46 The problems with the law on breach of warranty also apply to business insureds. In fact, the practical problems faced by businesses are often more serious, as they do not receive protection from UTCCR or from FSA rules.

7.47 We do not think it accords with the expectation of any class of insured that the insurer should be discharged by an immaterial breach of warranty, or one that has been cured before any claim arose. Nor would policyholders reasonably expect a claim to be rejected on the ground of a breach of warranty that had no connection to the loss. We propose below that the parties should be able to agree expressly that a breach of warranty should have such consequences. However, we do not think that this should be the "default" rule for breach of warranty.

7.48 The only protection for insured businesses lies in inviting the court to construe a term to give it a fair meaning. The courts are often prepared to do this, sometimes finding ambiguities in the words used, or that the parties cannot have intended them to have the effect of a warranty, even when the words appear firm and clear.[28] However, we do not think that this is an adequate substitute for law reform. The process of re-interpreting the effect of contractual terms can cause considerable complexity and difficulty.[29] And in some cases the courts are prepared or feel constrained to give terms their traditional (harsh) meaning.[30]

7.49 The problems caused by the harshness of the law can affect any business, but they appear most severe for small and medium businesses. They may not understand the importance of words such as "warranty" and, even if they do, they lack the bargaining position to change the insurer's standard wording. Furthermore, they may lack resources to argue cases before the courts. Insurers may therefore be able to use the harshness of the law as set out in the 1906 Act as a negotiating tool.

[28] The clearest example of this is *Kler Knitwear v Lombard General Insurance Co* [2000] Lloyd's Rep IR 47.

[29] The problems are illustrated by the case law relating to a notification clause, where different views have been reached about when a notification clause may be considered an innominate term: see *Alfred McAlpine Plc v BAI (Run-Off)* [2000] I Lloyd's Rep 437 and *Friends Provident Life and Pensions v Sirius International Insurance* [2005] 2 Lloyd's Rep 517, [2005] EWCA Civ 601.

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

7.50 Large businesses are more able to protect themselves. They have the resources to employ staff who understand the issues, and the bargaining position to renegotiate terms. We were told, for example, that one large company refuses to agree to warranties in any circumstances. This does not suggest, however, that reform is unnecessary for large businesses. Rather it suggests that all businesses might benefit from the change we are proposing. The fact that businesses which are able to do so exclude the rule, and presumably pay any resulting increase in premium, suggests that it is a poor rule in the first place.

7.51 Finally, as we explore below, the UK approach to warranties is out-of-line with the expectations of an international market. The notion of a warranty is unknown to civil law systems, and increasingly is being abandoned by other common law systems. It no longer accords with international conceptions of fairness.

COMPARATIVE LAW

Common law jurisdictions

7.52 We note that the effect of a breach of warranty under UK law is now out-of-step with the majority of other jurisdictions we have looked at.

7.53 Both Australia and New Zealand have attempted to correct the perceived defects in the law by legislation to curb the insurer's right to refuse claims for a breach of warranty. The provisions are considered in detail in Part 8, when we consider what reforms might be appropriate in this country. The Australian legislation does not apply to marine insurance, but the Australian Law Reform Commission has recommended reform in that area also.

7.54 In Canada, the Marine Insurance Act 1993 is based on the 1906 Act. However courts have limited its application "to situations where the warranty is material to the risk and the breach has a bearing on the loss."[31] Where cases do not meet this criterion, the courts tend to find that the clause is not a true warranty at all. The leading case is the Supreme Court decision in *Century Insurance Company of Canada v Case Existological Laboratories Ltd. ("The Bamcell II")*.[32] The Bamcell II was a converted barge used for oceanographic experiments. The owners had negotiated a policy, which included the following term

> Warranted that a watchman is stationed on board the BAMCELL II each night from 2200 hours to 0600 hours with instructions for shutting down all equipment in an emergency.

7.55 In fact, the owners never placed a watchman on board. However, there were no problems at night. The loss occurred mid afternoon, and therefore the breach had "absolutely no bearing whatever on the loss"[33]. As a result, Ritchie J held:

[31] Christopher Giaschi, "Warranties in Marine Insurance" (10 April 1997), Association of Marine Underwriters of British Columbia, Vancouver, http://www.admiraltylaw.com/papers/warranties.htm (last visited 23 May 2007).

[32] [1984] 1 WWR 97.

[33] Above at 104, by Ritchie J.

> The clause would only have been effective if the loss had occurred between 2200 hours and 0600 hours, and it was proved that there was no watchman stationed aboard during those hours. To this extent the condition contained in the clause constituted a limitation of the risk insured against but it was not a warranty.[34]

7.56 US marine insurance law used to follow the British approach and was considered to be a federal matter. This, however, changed in 1955 following the Supreme Court decision in the *Wilburn Boat* case.[35]

7.57 The case concerned a small houseboat, kept on a lake between Texas and Oklahoma. The policy contained various stipulations that the policyholders had breached. Contrary to the terms of the policy, the insured had pledged the boat, carried passengers on several occasions and had at times leased the vessel. A fire destroyed the boat while it was moored, in circumstances that had nothing to do with the breaches of warranty. The insurers argued that, under Federal law, there was no need for a causal link between the breaches and the loss. The policyholders, however, argued that the matter should be dealt with under Texan law, where breaches of the policy would not defeat the claim unless they contributed to the loss. Eventually the case found its way to the Supreme Court, which held that insurance law was a matter for each state.

7.58 The case has generated considerable debate within the US: some see it as a necessary part of the state/federal balance; others as a source of uncertainty and complexity.[36] One element behind the decision, however, may have been the Supreme Court's unhappiness with the harshness and rigidity of the English approach.[37]

7.59 The result is that the way warranties are to be interpreted and applied is largely a matter for state law. Some states, such as Texas, require a causal connection between the breach and the loss before permitting the insurer to avoid paying a claim.

7.60 By contrast, in New York, the requirement is that a breach of warranty will avoid an insurance contract, provided that it "materially increases the risk of loss, damage or injury within the coverage of the contract".[38] If the contract specifies two or more kinds of loss (such as fire and theft) the breach will only affect the particular kind of loss to which the warranty relates. This does not mean that the breach must cause or contribute to the specific loss, but it must be such that would materially increase the risk of a loss of the same sort. In other words, a breach of a burglar alarm condition would not affect a fire claim, but it would avoid a theft policy, so as to permit the insurer to refuse a claim for theft, however the thieves had entered the building.

[34] Above at 104, by Ritchie J.

[35] *Wilburn Boat v Fireman's Fund Insurance Co* [1955] AMC 467.

[36] For a discussion, see B Soyer, *Warranties in Marine Insurance* (2nd ed 2006) p 182.

[37] T Schoenbaum, "Warranties in the Law of Marine Insurance: Some Suggestions for Reform of English and American Law", 23 Tul Mar LJ 267 (1998-1999) 314.

[38] New York Insurance Code, Article 31, s 3106(b).

Civil law jurisdictions

7.61 The notion of a warranty that has the effect prescribed by the 1906 Act is unique to the common law. Many civil lawyers express astonishment at the idea that insurers can avoid liability for trivial breaches of obligations even if the breach has been remedied or is unconnected with the loss. Most other European States require that a breach be causally connected to the loss in some way before it can absolve the insurer from payment.

7.62 Baris Soyer provides a detailed analysis of the English, German and Norwegian approach to breach of warranty in marine insurance.[39] He shows that in both Germany and Norway, provisions exist to exempt the insurer from liability if the nature of the risk changes during the life of the policy. However, unlike the English law, these require some degree of culpability and causation.

7.63 An example will illustrate the main differences. Under German law, the insurer is not normally liable if the insured put a vessel to sea in an unseaworthy condition. But this is subject to two important limitations. First, the exemption only applies to loss caused by the conduct. If, for example, the loss was unrelated to the unseaworthiness, the insurance policy continues. Secondly, it is open to the insured to show that they were not "responsible" for the unseaworthiness - ie that it was not a deliberate or negligent act.[40] Norwegian law is similar.[41] By contrast, under the 1906 Act, voyage polices contain an implied warranty "that at the commencement of the voyage the ship shall be seaworthy for the purposes of the particular adventure insured".[42] This means that if the ship is not seaworthy at the beginning of the voyage, all liability is avoided even if the insured is not at fault; or the defect is remedied; or the loss is totally unconnected with the defect.

7.64 Trine-Lise Wilhelmsen, a Professor at the Scandinavian Institute of Maritime Law, comments that for most people in the Civil Law world, the UK concept of a warranty is "hard to understand and even harder to explain". Although the words may seem "deceptively simple", the consequences lack "logical reason" and cannot be explained in terms of either legal fairness or economic efficiency.[43]

[39] B Soyer, *Warranties in Marine Insurance* (2nd ed 2006).

[40] B Soyer, *Warranties in Marine Insurance* (2nd ed 2006) pp 186-187. See also Comite Europeen des Assurances, *Insurance Contract Law in Europe* (2004). This explains that German law requires an insured to notify details of an increased risk, but if they fail to do so, the insurer "may only refuse to pay compensation if there is a causal link between the occurrence of the risk insured against and the failure to notify details or the increased risk" (p 81): see article 23 and following of the "Versicherungsvertragsgesetz" or Insurance Contract Law of 30 May 1908, as amended 26 November 2001.

[41] Under section 3-33 of the Norwegian Marine Insurance Plans 1996, the insurer is not liable for "loss that is a consequence of the ship not being in a seaworthy condition, provided that the assured knew or ought to have known of the ship's defects at such a time as it would have been impossible for him to intervene".

[42] Marine Insurance Act 1906, s 39(1).

[43] "Duty of Disclosure, Duty of Good Faith, Alternation of Risk and Warranties: An Analysis of the Replies to the CMI Questionnaire", CMI Yearbook 2000 pp 392 and 409.

7.65 John Hare, Professor of Shipping Law at the University of Cape Town is even more outspoken. He describes the Anglo-American marine insurance warranty as "a prodigal aberration from the European *ius communis* of marine insurance". He suggests that "the prodigal, in whatever systems it has raised its unwelcome head, ought to be brought back into the fold in the interests of the very fairness, justice and equity to which English law so properly aspires".[44]

7.66 UK warranty law is inconsistent with the mandatory, but milder, provisions concerning alteration of risk in several Civil Law countries. Wilhelmsen comments that if there are to be attempts towards harmonisation, it is unlikely that many other European States will move towards the British model:

> The mandatory provisions in Danish and Swedish [Insurance Contract Acts] concerning alteration of risk do not seem to permit the far more harsh regulation of warranties. Also the French and Italian legislations are more favourable towards the assured than the common law principle of warranties. In an attempt towards harmonisation, this implies either that the common law systems are willing to soften their regulation, or that a double set of clauses are suggested. It does not seem realistic that the legislators in the four mentioned civil law countries will open the door for the stricter principle of warranties, the Norwegian political attitude on this point. Also it would seem to go backwards into the future to adopt legal principles from 1906 instead of the principles of the far more modern insurance legislation in the civil law countries.[45]

CONCLUSION

7.67 We conclude that the law on breach of warranty requires reform in both consumer and business insurance. The question is exactly what shape the reform should take.

[44] John Hare, *The Omnipotent Warranty: England v The World*, paper presented at International Marine Insurance Conference, November 1999, http://web.uct.ac.za/depts/shiplaw/imic99.htm (last visited 23 May 2006).

[45] Duty of Disclosure, Duty of Good Faith, Alternation of Risk and Warranties: An Analysis of the Replies to the CMI Questionnaire", CMI Yearbook 2000, p 393.

PART 8
WARRANTIES AS TO THE FUTURE AND SIMILAR TERMS: PROPOSALS FOR REFORM

INTRODUCTION

8.1 In this Part we make two principal proposals for reform of the law on breach of warranty, for both consumer and business insurance. The first is that the insurer should not be entitled to rely on a breach of warranty unless the insured has been provided with a written statement of what they have undertaken. The second is that the insurer should not be entitled to reject a claim on the ground that the insured has broken a warranty unless there was a causal connection between the breach and the loss. However a breach of warranty would give the insurer the right to cancel the contract for the future.

8.2 For consumer insurance, the rule requiring a causal connection would be mandatory. For business insurance it would be possible for the parties to agree on the effect a breach of warranty should have, provided they use clear language to express their intentions. Where the insured contracted on the insurer's standard terms, there would also be controls to ensure that the cover was not substantially different from what the insured reasonably expected.

8.3 We have considered whether these proposals should apply only to warranties, or whether they should also apply to other terms, such as exclusions, which have a similar effect. In our second Issues Paper on Warranties, we suggested following the New Zealand model. This approach applies a causal connection test not just to warranties but to any term that excludes liability because of events or circumstances likely to increase the risk of a loss occurring. However, such a test would need to provide for certain exceptions: it should not require a causal connection for terms which, for example, limit the age of a driver or the geographical coverage of the policy. Concerns were expressed that the New Zealand model would be unduly complex.

8.4 On balance, we think that it would be preferable to confine the causal connection test to warranties in the narrow sense: that is, to terms by which the insured promises that a certain thing should or should not be done, or that some condition shall be fulfilled. The causal connection test should not apply to exceptions or to definitions of the risk. Where insureds and insurers negotiate terms, narrow definitions of the risk are not a problem: policyholders know what they are getting. In the case of consumers, the problems caused by such terms are already dealt with under the Unfair Terms in Consumer Contracts Regulations 1999 (UTCCR). The main difficulties arise where businesses contract on the insurer's standard terms. We think that these are best addressed through specific controls on standard terms that do not meet the insured's reasonable expectations.

8.5 We consider first the written statement, then the need to introduce a causal connection between the loss and a breach of warranty. We discuss what terms the causal connection test should apply to and how the test should be phrased.

8.6 We then set out our proposals for where a business insured contracts on the insurer's standard terms. We propose controls based loosely on sections 3 and 17 of the Unfair Contract Terms Act 1977 (UCTA). However, the test we propose would be narrower than the "reasonableness" test in UCTA. Unlike the UCTA test, the courts would not be invited to consider the substance of the term. Any term would be permitted provided the insurer had done enough to bring it to the insured's attention.

8.7 Next, we consider whether a breach of warranty should give the insurer the right to terminate cover for the future. We conclude this Part by considering the implications of our reforms for marine insurance and re-insurance.

A WRITTEN STATEMENT

8.8 In 1980, the Law Commission recommended that insurers should not be entitled to rely on a breach of warranty unless the insured was supplied with a written statement of the warranty either before the contract was made, or as soon as possible thereafter. This recommendation is particularly relevant to future warranties, whereby the insured "undertakes that some particular thing shall or shall not be done".[1] However it would have applied also to the warranties as to specific past or existing fact.

8.9 We think a similar reform is still needed. This would not involve any significant change in practice: insurers will almost always put significant terms in writing. It would, however, bring the law into line with good practice.

8.10 The 1906 Act already requires that, in marine policies, express warranties must be in writing.[2] As in the 1980 Report by the Law Commission, we would go further than the 1906 Act. The 1906 Act is satisfied by a reference in the policy to a written proposal, even though the proposer was not supplied with a copy. In 1980 the Law Commission recommended that the insured should be supplied with a written statement of the warranty either at or before the contract was made, or as soon as possible thereafter. We repeat this as a provisional proposal. For these purposes, writing would include printed and electronic forms.[3]

8.11 We think that this requirement should extend to all forms of insurance. Where cover is conditional on an insured carrying out a specific task, or refraining from an activity that would be normal in the circumstances, it is important that there should be clarity on both sides about what is required. The proposal should therefore apply to consumer and to business insurance, whether negotiated or on standard terms.

[1] See Marine Insurance Act 1906, s 33(1).

[2] Marine Insurance Act 1906, s 35(2) states that "an express warranty must be included in, or written upon, the policy, or must be contained in some document incorporated by reference into the policy".

[3] The Law Commission discussed the definition of writing at length in its 2001 Advice to Government, *Electronic Commerce: Formal Requirements in Commercial Transactions*. It argued that the definition of writing in Schedule 1 of the Interpretation Act 1978 would include any "words in visible form", including those held electronically.

8.12 **We provisionally propose that a claim should only be refused because the insured has failed to comply with a warranty if the warranty was set out in writing. It should be included in the main contract document or in another document supplied either at or before the contract was made, or as soon as possible thereafter.**

8.13 For consumer insurance, it should not be enough for the warranty to be buried somewhere in the small print of an insurance policy. The insurer should take specific steps to bring the obligation to the insured's attention. This is already regarded as good practice: The Financial Services Authority (FSA) requires that significant or unusual terms are brought to a consumer's attention.[4] The Financial Ombudsman Service (FOS) already makes enforcement of the term dependent on this requirement.[5] We found several cases where the FOS refused to uphold an unusual term because it was not brought to the customer's attention. We think the same protections should apply in a court of law. Like the FOS, a court should only enforce a specific obligation on the consumer if the insurer took sufficient steps to bring it to the consumer's attention.

8.14 To some extent this result can already be achieved under the UTCCR. If the term was not individually negotiated, it will nearly always be subject to review on the grounds that it was unfair.[6] However we have already argued that it would be better to have a specific provision that will give the insurer clearer guidance as to what it should do, as well as giving slightly stronger protection to the consumer, who should not have to prove that the term was unfair. They should not be bound by a warranty that was not adequately brought to their attention.

8.15 The insurer should spell out both what the consumer must do (as in "you must fit a five-lever mortise lock") and the consequences of not doing so (as in "if you do not, we may refuse any claim connected with your failure").

8.16 There are different approaches to implementing this principle. One would be to impose detailed rules about how policyholders' obligations should be spelled out. For example, rules could state that the obligation should be in the product summary (required by ICOB Rule 5.3.1); or on the cover note; or in a separate letter; or in one of the three. The statement could be required to be in plain language, legible and clearly presented; or one could go further and specify a minimum point size and prescribed warning. The FSA already has powers to make rules of this sort.

8.17 The alternative would be to set out the general principle that unusual terms should be brought to the consumers' attention. It would then be left to the courts to decide whether the obligation has been complied with, bearing in mind any relevant FSA rules or guidance.

[4] ICOB Rule 5.

[5] See para 7.29 above.

[6] In principle, the warranty might be exempt as a core term. We gave our reasons for thinking that warranties will seldom benefit from this exemption at para 2.98 above.

8.18 The first approach is more certain; the second is more flexible. It is more adaptable to new methods of sales and product information. Given the FSA's current emphasis towards a more principles-based approach, with fewer detailed rules, we are inclined to favour the second approach. This would mean that a court would be left to decide whether the insurer had met its obligation to bring the warranty or similar obligation to the policyholder's attention, having regard to any rules or guidance specified by the FSA.

8.19 **In consumer insurance, we provisionally propose that an insurer may only refuse a claim on the grounds that the insured has broken a warranty if it has taken sufficient steps to bring the requirement to the insured's attention. In deciding whether the insurer has taken sufficient steps, the court should have regard to FSA rules or guidance.**

8.20 It is equally important for business insurance that the insured is made clearly aware of their obligations. We have wondered whether the way in which the written statement has to be presented should be regulated even for business insurance. For example, a warranty could be required to be set out in a schedule to the policy, along with the summary of the cover. However, we think it is better to apply a more flexible approach. This would be to provide that where the written statement of the warranty is merely one of the standard terms of the policy, it should be subject to a general control. The insurer would not be able to rely on it if it had the effect of making the cover substantially different to what the insured reasonably expected. We explore this proposal below.[7]

REQUIRING A CONNECTION BETWEEN THE BREACH AND THE LOSS

8.21 The greatest and most obvious problem with the law on warranties is that it permits the insurer to escape liability for technical breaches that have nothing to do with the loss in question.

8.22 We think there is a need to introduce some form of causal connection test to protect policyholders from unfair treatment. An insured may readily agree to a warranty that their sprinkler system will be inspected, believing that if the failure of the sprinkler system causes a loss they will not be indemnified. However, policyholders would not understand this to mean that the insurers would refuse to pay if the breach were later remedied, or if the loss were totally unconnected with the sprinklers. This result defies logic and normal expectations, is inconsistent with good practice as recognised by the industry's own Statements of Practice and risks bringing the UK insurance industry into disrepute. Whether we are discussing consumer or business insurance, the current law can properly be described as unjust.

8.23 We provisionally conclude that the law for both consumer and business insurance should afford policyholders some protection against claims being denied for a breach of warranty unconnected with the loss.

[7] See para 8.54 to 8.80 below.

8.24 Although our general policy is clear, difficult questions arise about how this policy should be implemented. There are two issues: deciding which types of clause the causal connection test should apply to, and defining the nature of the causal requirement.

8.25 There are several possible models to follow. In 1980 the Law Commission recommended reforms that would apply only to warranties. It thought that an insured should be able to challenge the insurer's decision not to pay a claim if there were shown to be no links between the breach and the loss.

8.26 Similarly both New Zealand and Australia have enacted statutes requiring a causal connection. However, unlike the 1980 report, they are not confined to warranties but apply to any term which limits liability for events or circumstances likely to increase the risk of a loss. Here we look first at the scope of any reform and then at how to define the causal connection.

The scope of the reform: distinguishing between warranties and other types of term

8.27 The 1980 Report applied only to warranties, that is to terms phrased in a way which placed an obligation on the insured. For example, if the insured "warranted to maintain the car in a roadworthy condition", then a causal connection would be required. Take the case where the car was not roadworthy because a headlight was defective, but the accident occurred in broad daylight. It would be open to the insured to argue that a fault with the headlights could not have increased the risk of a loss. However, if the same provision were expressed as an exception or description of the risk (that the insurance only applied "while the car was roadworthy") then the insured could not take advantage of the defence. The insurer could refuse the claim. Birds and Hird argued that this was a major flaw with the 1980 recommendations. The reform would merely encourage insurers to find other means of achieving the same ends.[8]

8.28 Under current law, the effect of a breach of warranty is usually more serious than the effect of breach of another term. A "condition precedent to liability" under the policy has the same effect as a warranty; if the condition is not complied with, the insurer is discharged from liability as from the date the non-compliance started, and so there need be no connection between the non-compliance and any subsequent loss claimed.[9] In contrast, "conditions precedent to a claim" and "exceptions" do not result in the discharge of the insurer. The insured is simply not covered for the particular claim or for claims that arise while the exception applies. They are temporal exceptions: if for example, cover is dependent on a car being roadworthy, when the car is repaired, liability resumes. Nonetheless, these types of term may operate in a way that the insured reasonably does not expect, because again there may be no connection between the condition or exception and the loss. For example, we do not think that an insured would reasonably expect to lose all motoring cover, even for daylight driving, simply because the car has a defective headlight.

[8] J Birds and NJ Hird, *Birds Modern Insurance Law* (6th ed 2004) p 166, note 36.

[9] *Conn v Westminster Motor Insurance* [1966] 1 Lloyd's Rep 407.

8.29 In relation to consumer insurance, we do not think there is a problem with exceptions. If the effect of the exception takes the consumer insured unreasonably by surprise, the consumer can challenge its fairness under UTCCR 1999.

8.30 However, comments we have received suggest that there is a problem in business insurance. Business insureds are sometimes taken by surprise by exceptions in their policies that mean that they cannot claim for some loss that they honestly thought would be covered. In Australia and New Zealand it was thought that there was a problem and their Insurance Acts have measures to deal with it.

A purposive approach?

8.31 Both the New Zealand and Australian legislation[10] take a purposive approach. They apply not only to terms written as warranties but also to other terms that have a similar effect. For example, section 11 of the New Zealand Insurance Law Reform Act 1977 applies to provisions in an insurance contract that meet two tests:

(1) they must "exclude or limit the liability of the insurer… on the happening of certain events or the existence of certain circumstances"; and

(2) this must be because the events or circumstances were (in the view of the insurer) "likely to increase the risk of such loss occurring".

8.32 Where a term falls within this definition, the insurer may not rely on it to exclude or limit liability if the insured proves that the loss was not caused or contributed to by the events or circumstances in question.

[10] In Australia the solution was Insurance Act 1984 s 54. This has given rise to problems of interpretation which we set out in the second Issues paper, but there is no call for its complete repeal: see paras 6.25-6.35. The problems relate primarily to "claims made and notified" policies. For further discussion, see R Merkin, *Reforming Insurance Law: Is there a Case for Reverse Transportation?* A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform, at para 8.31-8.34 (www.lawcom.gov.uk/docs/merkin_report.pdf).

8.33 It may be helpful to illustrate how this definition works. Section 11 would apply to a clause stating that the car was only insured while it was roadworthy. This clause purports to exclude or limit the liability of the insurer in certain circumstances (that the car is unroadworthy) because when a car is unroadworthy, the risk of a loss increases. An insurer would not be entitled to rely on this clause if the policyholder proves that the loss was unrelated to the unroadworthiness. For example, if the car had bald tyres, but was destroyed by a tree falling on it during a gale, the insured could show that the bald tyres did not contribute to the gale, and the insurer would be required to pay the claim. In contrast, the reform would not affect a clause which requires an insured to give notice of a loss within a given period of time. A failure to give notice could not increase the risk of a loss occurring, as the clause would only apply once a loss had happened. Such a clause would not come within the ambit of the legislation.[11]

8.34 In 1998, the New Zealand Law Reform Commission reviewed the way section 11 operates in practice.[12] They expressed concern that the courts had interpreted it to impose liability on insurers even if the policyholder was in blatant breach of a term delimiting the risk.[13] They thought that the exclusion should not apply to a provision which:

(1) defines the age, identity, qualifications or experience of a driver of a vehicle, a pilot of an aircraft, or an operator of a chattel; or

(2) defines the geographical area in which a loss must occur if the insurer is to be liable to indemnify the insured; or

(3) excludes loss that occurs while a vehicle, aircraft or other chattel is being used for commercial purposes other than those permitted by the contract of insurance.

8.35 In Issue Paper 2, we advocated a similar approach. We thought that the causal connection test should not apply, for example, where a motor policy specified that drivers must be aged 30 or over, and the vehicle was driven by a 20 year old. The insurer should be entitled to refuse the claim, even if the accident was caused by someone else's fault. Similarly, if a marine insurance contract excluded a war risk area, such as the Gulf, the insurer should not be liable for any loss that took place in the Gulf, even if the location did not cause the loss. The same should apply if a car insured for private use is being used full-time as a taxi. There comes a point where the activity generating the loss is so far removed from the activity covered by the policy that the policy should not apply at all.

[11] Similarly, a clause which stated that the contract could be avoided if the premium was not paid would also not fall within the definition. The failure to pay the premium would not be likely to increase the risk of a loss.

[12] New Zealand Law Commission, Some Problems of Insurance Law (1998) No 46, Ch 1.

[13] *New Zealand Insurance Co Ltd v Harris* [1990] 1 NZLR 10; *State Insurance Ltd v Lam* 1996, unreported.

8.36 We see attractions in following the New Zealand approach. It avoids formalism. If the reform were confined to warranties, there is a danger that insurers would circumvent the reform by drafting policies in more ingenious ways. Under the New Zealand approach, the court looks at the substance of the term rather than the way it was written.

8.37 However, when we advocated this approach in Issues Paper 2, several consultees thought that it would be unduly complex. Particular concerns were expressed about the list of excluded terms (relating, for example, to the driver's age, or to the geographic area, or to commercial purposes). The list was thought to be arbitrary. It would, for example, allow an insurer to include a term in a marine policy that the ship is not covered while it is in the English Channel, but would require a causal connection where the insurer specified that a ship must retain its classification.

8.38 It was suggested that a better approach would be to confine the causal connection test to warranties, as narrowly understood, but to limit unexpected exceptions. As with the 1980 Report, the causal connection test would only apply to terms by which the insured promises that a certain thing should or should not be done, or that some condition shall be fulfilled, or that certain facts are true. In business insurance, it would only be a default rule. The parties would be entitled to specify wider consequences for a breach, provided that they did so clearly enough. The main mischief occurs where the insured contracts on the insurer's standard terms, and here it was thought that an "unfair terms" approach should apply, along the lines of the protections set out in the Unfair Contract Terms Act 1977.

8.39 Below we set out a causal connection test which would only apply to warranties in the narrow sense. We then propose specific controls on terms in standard form contracts which defeat the insured's reasonable expectations.

Defining the causal connection

8.40 The 1980 Law Commission recommendations and the New Zealand and Australian statutes all put the burden of proof firmly on the insured to show the lack of connection. We also intend that the burden of proof should be on the insured. However, the three models differ in the words they use to define the type of causal connection required. The Bill in the Law Commission's 1980 Report required the insured to prove that the breach did not "*increase the risk*" that the event giving rise to the claim would occur in the way it did. Under the New Zealand Act, the insured must prove that the event did not "*cause or contribute to"* the loss.[14] In Australia the insured need only prove that it did not "*cause*" the loss.[15]

[14] The New Zealand Insurance Law Reform Act 1977 s 11 states the insured has a right to be indemnified if he can prove, on the balance of probabilities, that the loss was not "caused or contributed to by the happening of such events or the existence of such circumstances".

[15] The Australian Insurance Contracts Act 1984, s 54(3) states that "Where the insured proves that no part of the loss that gave rise to the claim was caused by the act, the insurer may not refuse to pay the claim by reason only of the act". The 1984 Act does not apply to marine insurance but in its *Review of the Marine Insurance Act 1909* (2001) No 91, the ALRC recommended a requirement of proximate cause: para 9.129.

8.41 We have considered whether there is any substantive difference between "increasing the risk" of a loss, on the one hand, and "contributing to" a loss or "causing" a loss on the other. The Australian Law Reform Commission (ALRC) thought there was, and criticised the English wording as being too narrow. The ALRC pointed out that even if a breach did not cause or contribute to the loss, it might increase the risk that the loss would occur. It gave the example of modifications to a car that increased the risk that the brakes would fail. The ALRC suggested that if a collision was caused entirely by the driver's carelessness, and the brakes worked admirably, the modifications might still be said to have increased the risk of a collision.[16] It thought that in such a case the insurer should have to pay, and so it recommended the insured need only prove that the breach did not "cause" the loss.

8.42 This result does not necessarily follow from the words used. A court could decide that "the way the accident did in fact occur" was that brakes worked perfectly. Therefore, the modifications did not "increase the risk" of this particular accident. However, examples given in the 1980 Report suggest that the Law Commission did intend a restrictive approach. One example was a fidelity policy where the insured employer promised not to employ staff without first taking up satisfactory references. The Law Commission stated that if an employer failed to take up references on an employee, who then stole the employer's money, the insurer should "clearly be entitled to reject the claim, because the commercial purpose of the warranty was to guard against this very type of loss". It should not be open to the insured to show, for instance, that the employee would have produced satisfactory references if he had been asked. Thus the Law Commission did not envisage that the insured would bring evidence of whether the breach affected this particular loss in these circumstances.

8.43 The Australian approach appears more generous to policyholders. The insured need only show that the insured's act or omission did not "cause" a claim. This might suggest that the breach must be a dominant or major cause of the loss,[17] or that the loss would not have happened but for the breach. We think this is too generous to policyholders.

8.44 It should be enough that the breach contributed to the loss: it would not be necessary that it should be the main cause of the loss. Under our proposals it would be open to the insured to attempt to prove that the failure to take up references did not contribute to the loss because the employee's references would have been satisfactory. However, the insured would need to prove this on the balance of probabilities. It would not be sufficient simply to invite the court to speculate about "might have beens".

8.45 **We provisionally propose that in both consumer and business insurance the policyholder should be entitled to be paid a claim if it can prove on the balance of probability that the event or circumstances constituting the breach of warranty did not contribute to the loss.**

[16] ALRC, Insurance Contracts (1982) No 20, at para 228.

[17] For marine insurance, the ALRC did recommend that the breach should be the proximate cause (that is the effective or dominant cause) of the loss; see *Review of the Marine Insurance Act 1909* (2001) No 91; http://www.austlii.edu.au/au/other/alrc/publications/reports/91/ch9.html.

Partial loss

8.46 The Australian provisions protect policyholders when a breach of warranty causes only part of the loss. Section 54(4) of the Australian Insurance Contracts Act 1984 states that:

> Where the insured proves that some part of the loss that gave rise to the claim was not caused by the act, the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act.

For example, if a fire spreads from a well-maintained section of a building (A) to one where the sprinklers are not working (B), the insured is entitled to the part of their claim relating to the well-maintained section.

8.47 We think that such an outcome is fair to the policyholder and the insurer. Our only question is whether an express provision is needed; a court might be able to reach this result in any event. On balance, we think it is a useful clarification of the causal connection test. If the fire spreads from section A to section B, the faults in section B cannot be said to have contributed to the loss in section A. It would, of course be different if the fire spreads from the faulty section. Here the breach would have contributed to the further loss.

8.48 **We provisionally propose, in relation to both consumer and business insurance, that if the insured can prove that a breach contributed only to part of the loss, the insurer may not refuse to pay for the loss that is unrelated to the breach.**

A MANDATORY OR DEFAULT RULE?

8.49 We have said that the current law of warranties is unjust because it defeats the reasonable expectations of the insured. We think this will almost always be the case in consumer insurance, and for the reasons given when we discussed pre-contract information,[18] we recommend that for consumers the rule should be mandatory.

8.50 **We provisionally propose that the causal connection rules should be mandatory in consumer insurance.**

[18] See para 4.214 to 4.215 above.

8.51 For business insurance it is arguable that it should be possible to alter the rule by agreement. We find it hard to envisage a case in which the insurer would have a legitimate reason for turning down a claim that had arisen after the insured had failed to take some precaution such as maintaining an alarm, if there was absolutely no connection to the loss. However in Part 5 we noted that insurers occasionally use warranties of existing fact as a way of defining the risk that they are prepared to undertake. Thus a ship may be warranted as having a particular classification because the insurer is unwilling to underwrite any other class of ship, whether for losses connected to the class or not. The same approach may sometimes be used in relation to future changes of circumstances: the ship must continue to have its classification. It would be open to the parties to include a term by which the insured "warranted" that a ship would retain a classification, and which then spelled out in clear terms that as soon as the ship lost its classification, the insurer's liability would cease.

8.52 The first safeguard is that clear words should be required to alter the rule. That seems self-evident. However, a number of those who have given us views on the reform of warranties have urged a stronger approach. This is that when the relevant term is merely one of the insurer's standard policy terms, it does not make the cover substantially different from what the insured reasonably expected. We return to this issue below.

8.53 **We provisionally propose that in business insurance the parties should be free to vary the rules on the effect of a breach of warranty by agreement. However, where the insured contracts on the insurer's standard terms, there should be safeguards to ensure that the term does not make the cover substantially different from what the insured reasonably expected.**

A "REASONABLE EXPECTATIONS" APPROACH

8.54 In Issues Paper 2 we considered an alternative to a wide causal connections test. We had called it an "unfair terms" approach, because it was based on UCTA. Initially, we rejected this approach as too uncertain but, as we have indicated, consultees urged us to look at it again.

8.55 The test we are now provisionally proposing asks whether the effect of the term is that the cover is substantially different from what it was reasonable for the insured to expect to be covered in the circumstances. It would apply only where a business insured contracted on the insurer's written standard terms of business.

8.56 We have seen that a similar rule already applies in consumer insurance, where the UTCCR requires terms other than the main definition of the subject matter to be fair. We have suggested that unexpectedly narrow definitions of the risk and unexpectedly wide exclusions can be challenged under the Regulations.[19] However, there is no similar protection for commercial insurance.

[19] See Part 3 above.

8.57 In other areas of commercial life, businesses are given protection against unfair terms by sections 3 and 17 of UCTA. However, these sections do not apply to insurance contracts. It was suggested that the problems of defining when a causal connection should be required could be avoided by adapting sections 3 and 17 so as to apply to standard terms that have the effect of restricting the cover.

8.58 The test we are now proposing is more limited than the UCTA test, as it does not consider the substance of the term – only whether enough was done to bring it to the insured's attention. It would therefore be more accurate to label this approach as a "reasonable expectations" approach rather than an "unfair terms" approach.

The Unfair Contract Terms Act 1977, sections 3 & 17

8.59 In England and Wales, section 3 subjects certain clauses to a requirement of reasonableness. It applies between contracting parties where one of them deals as a consumer or on the other's written standard terms of business. Section 3(2)(b) prevents the party who wrote the standard terms of business from claiming to be entitled

> (i) to render a contractual performance substantially different from that which was reasonably expected of him, or
>
> (ii) in respect of the whole or any part of his contractual obligation, to render no contractual performance at all, except in so far as… the contract term satisfies the requirement of reasonableness.

8.60 In Scotland, the issue is dealt with by section 17, which enacts the same substantive provision, using slightly different words. It provides that a term in a consumer contract or standard form contract "shall have no effect for the purpose of enabling a party to the contract…

> (b) in respect of a contractual obligation, to render no performance, or to render a performance substantially different from that which the consumer or customer reasonably expected from the contract
>
> if it was not fair and reasonable to incorporate the term in the contract.

8.61 In February 2005, the two Law Commissions produced a joint report and draft Bill to amend the law of unfair contract terms. We did not suggest any substantive reform of these sections. However, we recommended that they should be replaced as a single section to apply to the whole of Great Britain, written in clearer language.[20]

[20] Clause 9(3) of our draft Bill applies where one party to a business contract ("A") deals on the written standard terms of business of the other ("B"). It states that:

> Unless the term is fair and reasonable, B cannot rely on any of those terms to claim it has the right –
>
> (a) to carry out its obligations under the contract in a way substantially different from the way in which A reasonably expected them to be carried out, or
>
> (b) not to carry out all or part of those obligations.

8.62 These provisions require the court to start with three questions:[21]

(1) What contractual performance did A reasonably expect?

(2) What contractual performance does B claim to be entitled to render?

(3) Is there a substantial difference between the two?

If so, the court must then ask whether the term is fair and reasonable, given the circumstances that were or ought to have been in the contemplation of the parties when the contract was made.

8.63 These questions must be approached broadly as a matter of fact. As Lord Bingham pointed out in *Zockoll Group Ltd v Mercury Communications Ltd,* the "answer cannot depend on the proper construction of the contract".[22] If a party could only reasonably expect that which the contract actually provided there would never be any discrepancy between the two.

Written standard terms of business

8.64 As we explain in Part 5, UCTA does not define "written standard terms of business". The case law suggests that the question is one of fact.[23] The court must look at the terms as a whole, not the particular term in question. The fact that negotiations resulted in small amendments to some of the terms does not prevent the set of terms remaining standard;[24] but at some point there may be sufficient alteration so that the terms as a whole are no longer standard.

8.65 In Part 5 we say that this approach is not perfect. However, it is as good as any we can devise. We think it would be an appropriate test to use here.

Industry standard terms

8.66 We also noted in Part 5 that there would not be a blanket exemption for industry standard terms. However, the provenance of the terms and the degree to which they are accepted in the market would be highly relevant to any decision about whether they meet reasonable expectations. Where terms are routinely used within the industry, a reasonable insured would expect them. We think the same approach should be followed in our present proposal.

[21] See *Zockoll Group Ltd v Mercury Communications Ltd* [1999] EMLR 385, by Lord Bingham.

[22] As above, at 395.

[23] See paras 5.138 to 5.139 above, and the discussion in our joint consultation paper on Unfair Terms in Contracts (2002) Law Com Consultation Paper No 166; Scottish Law Com Discussion Paper No 119, at paras 5.49 to 5.53.

[24] *Pegler Ltd v Wang (UK) Ltd* [2000] EWHC Technology 127 (25 February 2000): "A standard term is nonetheless a standard term even though the party putting forward that term is willing to negotiate some small variations of that term."

Reasonable to incorporate or reasonable to rely?

8.67 Under the UCTA model, the court must assess whether the term was a reasonable one to include in the contract.[25] This means that a widely-worded clause may be invalid even though it would be fair and reasonable to apply it on the facts that have actually occurred. This prevents a business using a very draconian clause and then seeking to justify its application to the particular facts. In contrast, the Supply of Goods (Implied Terms) Act 1973 asked whether it would be fair to allow reliance on the term.

8.68 In this context, we think it would be more suitable to look at how the term is applied, rather than on whether it should have been included. The court would not look at the term in the abstract. Instead, it would ask whether to apply it to the facts would make the cover substantially different from what was reasonably expected.

A general test of fairness?

8.69 Under section 3 of UCTA the court must ask whether a term "satisfies the requirement of reasonableness."[26] Under section 17, the term must be "fair and reasonable".

8.70 In this context, we do not intend to use a general test of reasonableness. The court would only need to ask whether the term rendered the cover substantially different from what it was reasonable for the insured to expect in the circumstances. As we explain in Part 5, a reference to fairness might suggest that the court should examine the substance of the proposal. This is not our intention. If enough was done to bring the term to the insured's attention, the insured should be bound by it. Conversely, if a court were to find that the term undermined that which the insured reasonably expected this would be tantamount to saying that it was unfair.

The arguments for a "reasonable expectation" approach

8.71 The provision we are proposing for insurance contracts which are on the insured's written standard terms would give substantially improved rights to businesses, and in particular to small and medium businesses that are forced to contract on the insurer's standard terms of business.[27]

8.72 We see four main advantages:

[25] The test is whether the term was a fair and reasonable one "to be included in the contract" (England and Wales, s 11(1)) or "to incorporate" (Scotland, s 24(1)).

[26] UCTA 1977, s 3. For the wording of UCTA 1977, s 17 see para 8.59 above.

[27] We do not think that extending sections 3 and 17 and their replacement to insurance would make any difference to consumer contracts. As discussed earlier, the Unfair Terms in Consumer Contracts Regulations already require that a term must be fair, if it enables the insurer to render a contractual performance substantially different from that which was reasonably expected. Furthermore, in 1990, the Insurance Ombudsman stated that he would apply the spirit of the Unfair Contract Terms Act 1977, and the Financial Ombudsman Service has continued this tradition.

(1) The protection only applies to standard policy terms. It does not interfere with the freedom of large businesses to negotiate contracts on an individual basis. We are told that for most insurance obtained through Lloyds, the broker puts forward terms and the parties then negotiate on this basis. These contracts would not be affected by the proposal.

(2) It applies to any term that defines cover in a way that policyholders would not reasonably expect, whether it be a warranty, a condition precedent to liability or to cover, an exception or a narrow definition of the risk. It would not affect other terms such as notification clauses, since these do not affect the cover, though it could be extended to do so if that were thought to be desirable.[28]

(3) The section would apply only if the effect of the term were to render the cover substantially different from what the insured reasonably expected. This would depend on how the term was presented and what information was given to the insured. The reform would provide a strong incentive to insurers to re-write their contractual documents in a way that their policyholders can understand.

(4) It would provide a better solution than treating small businesses as if they were consumers. We would prefer to make a distinction on the basis of how the contract was negotiated rather than attempt to find some other proxy for those who need protection and those who do not, such as size or nature of the business.

The arguments against

Freedom of contract

8.73 It is often argued that the law should not interfere with freedom of contract. Instead, a dynamic and innovative market is best served if the parties are allowed to agree what they want. This argument was put to the joint Law Commissions when we first recommended unfair contract terms legislation in 1975.[29] In 1975 we replied that:

> It is valid only to the extent that there is true freedom of contract to interfere with, and the objection has no validity where there is no real possibility of negotiating contract terms, or where a party is not expected to read a contract carefully or to understand its implications without legal advice.[30]

8.74 It is of course difficult to distinguish between situations where there is genuine freedom of contract and those where there is not. The fact that the contract is on standard terms suggests that freedom is limited. Where one party does not fully understand what the standard terms require, it is limited still further.

[28] Notification of claims will be considered in our second Consultation Paper.

[29] Exemption Clauses: Second Report by the two Law Commission (1975) Law Com No 69; Scot Law Com No 39, at paras 66 and 67.

[30] As above, para 67.

Uncertainty

8.75 The second argument is that legislation of this type introduces unacceptable uncertainty into the law. The insurance industry put this argument with great force when it secured an exception from UCTA in 1977.

8.76 Before the 1977 Act was passed, fears were expressed that it would lead to great uncertainty and an unacceptable level of litigation. A problem with UCTA is that it can be used for its "nuisance potential". In other words, debtors can buy more time in which to pay debts by putting in weak defences, claiming that terms are unfair even if they were readily agreed to at the time. However, this is less likely to be a problem with insurance, where the onus will be on the policyholder to bring the claim. There are already many deterrents to stop small and medium businesses from bringing weak claims against insurers.

8.77 In practice, UCTA has generated only moderate amounts of litigation.[31] It must be remembered that the existing law is uncertain: there is a danger that cases raising the same issues as *Kler Knitwear* will be litigated repeatedly, as insurers test out new and better wording to remove any possibility of ambiguity. If insurers wish to gain certainty, the answer lies in explaining to policyholders what is required.

Conclusion

8.78 We have concluded that the "reasonable expectations" approach would be more satisfactory than applying the causal connection test to a wide range of terms. It would focus more directly on the real question, which is whether the term undermines the reasonable expectations of the insured and, because it would be confined to standard policy terms, it would create less uncertainty than the New Zealand model.

8.79 **We provisionally propose that in business insurance an insurer should not be permitted to rely on warranties, exceptions or definitions of the risk in its written standard terms of business if the term renders the cover substantially different from what the insured reasonably expected in the circumstances.**

8.80 We have not proposed the same provisions for consumer insurance as the consumer's position is covered by the Unfair Terms in Consumer Contracts Regulations 1999.

TERMINATING FUTURE COVER

Replacing section 33(3) of the Marine Insurance Act 1906

8.81 The reforms we have proposed are incompatible with the idea that an insurer is automatically discharged from liability from the date of the breach. Section 33(3) of the 1906 Act states that

[31] A Westlaw search showed 86 reported cases in which s 3 of UCTA 1977 has been cited since 1977. A similar search of the term "insurance warranty" showed 149 cases in the same period.

> …subject to any express provision in the policy, the insurer is discharged from liability as from the date of the breach of warranty, but without prejudice to any liability incurred by him before that date.

If an insurer is automatically discharged from liability from the date of the breach, it cannot logically be liable to pay a subsequent loss unconnected with the breach. Thus under our proposals, section 33(3) of the 1906 Act would have to be replaced. The question is what to put in its place, and how this would affect an insurer's right to bring a policy to an end following a breach of warranty.

Separating past claims from future cover

8.82 In 1980 the Law Commission said that the issue of past claims and future repudiation should be treated separately. An insurer should be able to pay past claims and repudiate the policy for the future; it should also be entitled to reject claims, without repudiating in the future. We agree. Under the proposals already outlined, a breach of warranty would allow the insurer to refuse a claim connected with the breach, though (unless the contract provided otherwise) it would remain liable to pay unconnected claims. This is a separate question from the insurer's right to terminate the policy for the future.

A right to repudiate

8.83 We think the consequences for a breach of warranty should be brought closer to normal contract principles. Normally, one party is only able to repudiate a contract for another's breach if the breach has serious consequences,[32] or this has been agreed in advance. Furthermore, a breach does not automatically bring a contract to an end. Instead, it gives the other party the choice. When an injured party becomes aware of the breach, it may either decide to repudiate the contract or to affirm it and continue with the relationship.

8.84 We think this brings the law closer to reasonable expectations. The insured would not reasonably expect the insurer to have the right to terminate the contract for a breach of the policy terms unless the breach had serious consequences or the contract expressly provided for cancellation.

Notice

8.85 In Issues Paper 2 we asked whether the insurer should have to give notice before it terminated a policy for breach of warranty. There was some support for this, because otherwise an insured may be left unexpectedly without cover.

8.86 In Australia, the insurer cannot bring a contract to an end as a result of the breach, but it is entitled to terminate the contract using a cancellation clause. Under section 59 of the Insurance Contracts Act 1984, the insurer must give at least three days notice in writing. In Norway, circumstances covered by a warranty would normally be considered as an alteration in the risk. This would permit the insurer to terminate the contract, but only after 14 days notice.[33]

[32] As under the approach in *Hong Kong Fir Shipping Co v Kawasaki Kisen Kaisha* [1962] 2 QB 26.

[33] Norwegian Marine Insurance Plan 1996, ss 3-10.

8.87 If the policyholder's breach of warranty was a serious one, we see no reason why the insurer should have to give notice. The insured's predicament was its own fault. If the breach was minor, we can see a case for requiring notice. On the other hand, we do not wish to interfere with freedom of contract. Under our proposals, in business insurance, the parties would be free to negotiate alternative outcomes for breach of specific terms, and could include cancellation clauses within their contracts.

8.88 On balance, we do not think it is necessary to make specific provision for notice periods. In a consumer contract, a cancellation clause would be subject to the fairness test of UTCCR. In a business insurance policy where the term in question is one of the standard policy terms, the insurer would not able to rely on it if it would make the cover substantially different from what the insured reasonably expected. A clause hidden in the small print might well have that effect and would therefore be invalid.

8.89 **We provisionally propose that a breach of warranty or other term should give the insurer the right to terminate the contract, rather than automatically discharging it from liability, but (unless otherwise agreed) only if the breach has sufficiently serious consequences to justify termination under the general law of contract.**

Liability for premiums

8.90 If the reforms were to provide that a breach of warranty gives an insurer the right to bring a contract to an end, this raises a further question: should the insured continue to be liable to pay premiums after the contract is terminated?

Future premiums

8.91 Under general contract law, where one party accepts the other's wrongful repudiation, the effect is to bring to an end both parties' primary obligations under the contract. As Lord Diplock put it:

> (a) there is substituted by implication of law for the primary obligations of the party in default which remain unperformed a secondary obligation to pay money compensation to the other party for the loss sustained by him in consequence of their non-performance in the future and (b) the unperformed primary obligations of that other party are discharged.[34]

[34] *Photo Production Ltd v Securicor Transport Ltd* [1980] AC 827, 849.

8.92 This means that neither the innocent nor the guilty party are required to perform any further primary obligations under the contract (though ancillary clauses, dealing with matters such as arbitration, may survive).[35] If the guilty party has been paying by instalments, the normal rule is that the insured remains liable for any payments that fall due before the repudiation is accepted,[36] but not for payments due after that date. The primary obligation to pay the instalments is replaced with a secondary obligation to pay damages for loss of profits. This contrasts with the rule for breach of warranty under section 33(3) of the 1906 Act, under which only the insurer is discharged from liability: the insured remains liable to pay future instalments of the premium. As we have seen, under the current law if the insured breaches a payment of premium warranty, the insurer is automatically discharged from further liability, but the insured must continue to make payments.[37]

8.93 The question is what would happen if we were to repeal section 33(3) and replace it with an insurer's right to accept repudiation? It is unclear whether the normal rule would apply, so that the insured would cease to be liable for the premium. The insurer might be able to argue that the separate instalments did not constitute different payments for divisible periods of cover (with, for example, each monthly instalment paying for each month's cover). Instead, it could be said that the premium was one single indivisible payment for one single period of cover: it was just that the contract permitted the single premium to be paid over the course of time.

8.94 This latter argument was accepted in *Chapman v Kardirga.*[38] Chadwick LJ commented:

> the Judge [at first instance] was wrong to hold that the effect of the payment of premium clause [which allowed payment by quarterly instalments]…was to apportion the premium payable under the policy to discreet periods of the term of the policy; that is to say, to convert what was (but for the payment of premiums clause) a premium payable in respect of the entire risk into a series of premiums payable in respect of risks during successive periods…The fact that the successive instalments are due and payable on dates which occur at three monthly intervals during the term of the policy does not, in my view, lead to the conclusion that the premium, which comprises the aggregate of those instalments, is itself divisible between successive three month intervals.[39]

[35] See *Yasuda Fire & Marine Insurance Co of Europe v Orion Marine Insurance Underwriting Agency Ltd* [1995] 1 Lloyd's Rep 525.

[36] *Hundai Heavy Industries Co Ltd v Papadopoulos* [1980] 1 WLR 1129, where the party in default was entitled to claim an instalment which fell due on 15 July despite the fact that they had cancelled the contract on 6 September.

[37] In *JA Chapman v Kadirga and others* [1998] CLC 860.

[38] As above.

[39] As above.

8.95 If it were accepted that the premium became due immediately (with payment postponed into instalments) then the insured would remain liable to pay the whole premium even after the repudiation was accepted. We do not think that this result would be fair. It would allow the insurer to make a windfall profit from the insured's breach of warranty, by keeping the premiums and not incurring any liability. In our view, the normal default rule should be that the insured would no longer be liable to pay premium instalments that fell due after the contract has been terminated.

8.96 **Do consultees agree that if the insurer accepts the insured's breach of warranty, so as to terminate future liability, the insured should cease to be liable for future premiums?**

Premiums paid in advance

8.97 A more difficult question is what should happen if the insured has paid the premium in advance. Under normal contract principles, the insured would only be entitled to the return of the premium if there had been a total failure of consideration.[40] For this, the breach, and the acceptance of the breach, must have occurred before the cover started.

8.98 However, for many types of contract, the courts are prepared to divide the bargain into constituent parts. Where some of the advance payment can be attributed to a particular part of the contract, and the consideration for that part has wholly failed, the guilty party may recover that portion of money. This would apply in a yearly insurance contract where it was possible to divide the total cover into 12 separate monthly parts. It would mean that if a breach of warranty were accepted in Month 2, the insured would be entitled to be repaid 10/12ths of the advance premium, less any damages due to the insurer for administrative expenses and loss of profit.

8.99 The question is whether this is a desirable result. We are keen to improve communication and trust between insurers and insured, and we are concerned that allowing the insurer to retain the whole premium may operate to undermine such trust. Suppose, for example, a shop owner has warranted that the shop will be protected by a working burglar alarm at all times, and the burglar alarm breaks down. Ideally, the shop owner would contact the insurer to tell them about the problem as soon as possible. However, if this would permit the insurer to cancel the policy and retain ten months' premium, the owner would be better off keeping quiet. They might calculate that the alarm would be fixed soon, before any loss happens. Furthermore, under our reforms, the insurer would remain liable for losses unconnected with the problem, giving the insured a clear incentive not to alert the insurer.

8.100 **We ask whether an insurer who terminates a policy following the insured's breach of warranty should normally provide a pro-rata refund of the outstanding premium, less any damages or reasonable administrative costs.**

[40] See *Rover International Ltd v Cannon Film Sales (No. 3)* [1989] 1 WLR 912. In *Stocznia Gdanska SA v Latvian SS Co* [1998] 1 WLR 574, 588, Lord Goff stated that "the test is not whether the promisee has received a specific benefit, but rather whether the promisor has performed any part of the contractual duties in respect of which the payment is due".

Waiver and affirmation

8.101 The changes we have proposed to section 33 of the 1906 Act would have consequences for the law on waiver. The 1906 Act specifically states that "a breach of warranty may be waived by the insurer".[41] However, since the House of Lords decision in *The Good Luck*,[42] there has been a considerable academic debate over how breaches of warranty may be waived.[43]

8.102 In English contract law, there are two ways in which a party may be taken to have waived their rights when faced with the other party's repudiatory breach.[44] The first way is by making a choice between two inconsistent courses of action. The wronged party has a choice: either to treat the breach as discharging the contract (ie to "repudiate" or "terminate" the contract), or to affirm the contract. If they affirm, it seems the right to repudiate will be lost provided that the wronged party knew of the facts giving rise to the right to repudiate and, it would appear, that they possessed the right in question.[45] The wronged party must then evince a decision to relinquish that right by words or conduct. Once the party has made the choice to affirm the contract, it is bound by that decision. This type of waiver is sometimes called "waiver by election".

8.103 The second way is through "waiver by estoppel".[46] This requires the wronged party to make an unequivocal representation by words or conduct that it will not rely on its legal rights. The other party must show that it relied on the representation by doing something or refraining from doing something, in circumstances where it would be inequitable for the wronged party to rely on its legal rights. Normally, the other party would have to show that it has altered its position to its own detriment.[47]

41 See Marine Insurance Act 1906, s 34(3).

42 *Bank of Nova Scotia v Hellenic Mutual War Risks Association (Bermuda) Ltd* [1992] 1 AC 233.

43 See B Soyer, *Warranties in Marine Insurance* (2nd ed 2006) ch 6; M Clarke, The Law of Insurance Contracts (4th ed 2002) para 20-7A; and J Birds and N Legh-Jones, MacGillivray on Insurance Law (10th ed 2003) para 10-104.

44 For a full discussion of the authorities on this point see *Peyman v Lanjani* [1985] I Ch 457. In *Habib Bank Ltd v Tufail* [2006] EWCA Civ 374; [2006] All ER (D) 92 (Apr) Lloyd LJ drew a distinction between affirmation, "where knowledge of the right to rescind is essential" (at [20]) and "acquiescence", which requires the other party to show that it relied on the representation.

45 See *Chitty on Contracts* (29th ed 2004) para 24-003.

46 See *Chitty on Contracts* (29th ed 2004) paras 24-007 to 24-008.

47 See *Tool Metal Manufacturing Co Ltd v Tungsten Electric Co Ltd* [1955] 1 WLR 761; and *Emery v UCB Corporate Services Ltd* [2001] EWCA Civ 675.

8.104 Often both forms of waiver involve similar types of inconsistent acts. For example, after learning of a breach an insurer may accept premiums,[48] or issue a policy document,[49] or handle a claim. For affirmation, the issue would be whether the insurer had the requisite knowledge and whether the act shows that it intended to continue with the policy. For "waiver by estoppel" the focus shifts to the policyholder's perceptions and conduct. Did the act appear to show that the insurer did not intend to rely on its legal rights? If so, did the policyholder in fact rely on this representation by, for example, failing to take out another insurance policy? It is usually more difficult for the policyholder to show waiver by estoppel because it has to prove that it relied on the representation, usually to its detriment. The policyholder would not need to prove that the insurer knew that it had the right to deny liability, but the policyholder would need to show that a reasonable policyholder in their position would think that the insurer was aware of the right.[50]

8.105 It is now thought, following *The Good Luck*, that affirmation, or waiver by election, is not applicable to a breach of an insurance warranty of assurance. In *HIH Casualty & General Insurance Ltd v AXA Corporate Solutions*, Lord Justice Tuckey explained with apparent approval the reasoning of the trial judge:[51]

> where there is a breach of warranty there is no scope for traditional waiver by election because the insurer is automatically discharged from liability upon breach and therefore has no choice to make. This is why only waiver by estoppel availed HIH, if it did… [52]

8.106 This puts a heavier burden on the policyholder as they not only have to show that the insurer made an unequivocal representation, but also that they relied on it.

[48] As MacGillivray says "the acceptance of premium after receipt of knowledge of a breach of warranty or condition is an act so inconsistent with an intention to repudiate liability that it is frequently a ground of waiver": J Birds and N Legh-Jones, MacGillivray on Insurance Law (10th ed 2003) para 10-109. See for example, *Yorkshire Insurance Co v Craine* [1922] 2 AC 541 and *Cia Tirrena Assiccurazioni v Grand Union Insurance Co* [1991] 2 Lloyd's Rep 143.

[49] See, for example, *Sulphate Pulp Co v Faber* (1895) 1 Comm Cas 146.

[50] As the judge of first instance said in *HIH Casualty & General Insurance Ltd v AXA Corporate Solutions* [2002] Lloyd's Rep IR 325:

> the point is not so much the awareness of [reinsurer] as to its rights to treat the cover as discharged but whether it appeared to a reasonable person in the position of [the reinsured] that the reinsurer was so aware and was prepared to forego its rights. That is a gloss that is important and can easily be overlooked in this analysis.

[51] [2003] 1 Lloyd's Rep IR 1.

[52] Para 7. Note also Longmore J's view in *Kirkaldy & Sons Ltd v Walker* [1999] Lloyd's Rep IR 410, 422 that "since the breach of warranty does not give rise to any election by the insurer, eg, to choose to keep the contract on foot, the doctrine of waiver by election has no application". We have some doubts whether these decisions are consistent with the wording of the Act, which refers simply to waiver without mentioning reliance, but the cases are clear. See B Soyer, *Warranties in Marine Insurance* (2nd ed 2006) ch 6.

8.107 Scots law has not developed a classification equivalent to the English law distinction between waiver by election and waiver by estoppel. The decision of the House of Lords in *Armia Ltd v Daejan Developments Ltd*[53] has generally been regarded as authority for the proposition that a party relying on the other party's abandonment of a right must demonstrate that he has conducted his affairs on the basis of the waiver, although he need not go so far as to show that he has suffered prejudice as a consequence of relying upon it.[54] In reaching this decision, the House of Lords referred to certain English authorities while cautioning that the Scots law of personal bar should not be assumed to be the same as the English law of estoppel.

8.108 We think that if the change we have suggested to section 33 is put into effect, so that the contract is not discharged automatically by a breach of warranty but the insurer has the right to repudiate (or, as some prefer to say, terminate) for breach, the question of whether the insurer is precluded by its subsequent conduct from exercising that right can be left to the general law of contract. Thus in English law, for example, the insurer might lose its right by either affirmation or estoppel. We think this is just. There is a case for allowing an insured to found upon a waiver by the insurer without having to show that they relied on the representation. Where an insurer who is aware of a breach expressly states that it does not insist upon its rights, it is difficult to see why an additional requirement of proving reliance should be imposed upon the insured.[55] The same may be said where the waiver is clear from actions of the insurer.

8.109 We do not think it is necessary to include a specific provision on this point in any new legislation, but we would welcome views on the point.

8.110 **We provisionally propose that loss by waiver of the insurer's right to repudiate the contract should in future be determined in accordance with the general rules of contract. We welcome views on whether it is necessary to include a specific provision on this point in any new legislation.**

[53] 1979 SC (HL) 56.

[54] Above at 68-69 by Lord Fraser of Tullybelton and 71-72 by Lord Keith of Kinkel.. See eg *Moodiesburn House Hotel Ltd v Norwich Union Assurance Ltd* 2002 SLT 1069.

[55] This requirement in Scots law (see above) has been questioned (in non-insurance cases) in *Presslie v Cochrane McGregor Group Ltd* 1996 SC 289 and *Howden (James) & Co Ltd v Taylor Woodrow Property Co Ltd* 1998 SC.

THE IMPLICATIONS FOR MARINE INSURANCE

8.111 In Part 5 we argued against making a distinction between Marine, Aviation and Transport insurance (MAT) and other forms of insurance as far as non-disclosure and breach of warranty are concerned. We were not convinced that MAT was a separate and distinct market.[56] We thought it would be overly complex to apply one law to (for example) major constructions, and quite a different law to ships. We think the same applies here.

8.112 It might be argued that marine insurance should be treated differently because the law has traditionally taken a stricter approach to marine warranties. Below we reject this argument. We also consider the implications of our reform for the implied marine warranties and voyage conditions contained in sections 39 to 46 of the 1906 Act.

Express warranties

8.113 The courts have tended to construe warranties more strictly in marine cases than in other forms of insurance. It is said that in marine policies there is a presumption that any statement of fact written into the policy and bearing on the risk is to be construed as a warranty.[57]

8.114 However, we have been told that express warranties are now very rare in marine policies. There does not appear to be any great demand for them from the market. We do not think that the present rules on warranties meet the needs and expectations of an international market. We have not found any commentators outside the common law sphere who consider it fair for an insurer to fail to pay a claim for a breach which is not connected to the loss. Several criticise the rule in scathing terms.[58] Even within jurisdictions that share the legacy of the 1906 Act, it is rare for a court to accept insurers' arguments that a claim unrelated to a breach should not be paid. It was rejected by the US Supreme Court in *Wilburn Boat*, and by the Supreme Court of Canada in *Bamcell II*.[59] The Australia Law Reform Commission reviewed marine insurance law in 2001, following complaints from the fishing industry, and recommended that a breach of warranty should only justify avoiding a claim if it proximately caused the loss.

8.115 **We provisionally propose that the causal connection test outlined above should also apply to express warranties in marine insurance. They should also apply in aviation and transport insurance.**

[56] In 1980, the Law Commission accepted that the line between MAT and other insurance was not a clear one, and that some individuals with pleasure craft did need additional protection. It expressed unease with the definitions of MAT used in previous regulations, and suggested some omissions. It also proposed that the Secretary of State should be empowered to vary the definition by regulation. (Insurance Law, Non-Disclosure and Breach of Warranty (1980) Law Com No 104).

[57] J Birds and N Legh-Jones, MacGillivray on Insurance Law (10th ed 2003), para 10-30, referring to *Thomson v Weems* (1884) 9 App. Cas. 671, 684; *Yorkshire Insurance Co, v Campbell* [1917] AC 218, 224.

[58] See, for example, Professor Trine-Lise Wilhelmsen *Duty of Disclosure, Duty of Good Faith, Alternation of Risk and Warranties: An Analysis of the Replies to the CMI Questionnaire*, CMI Yearbook 2000 p 392. and Professor Hare *The Omnipotent Warranty: England v The World*, paper to the International Marine Insurance Conference, November 1999.

[59] See paras 6.51 and 6.52 above.

The implied marine warranties

8.116 The 1906 Act implies four warranties into marine insurance contracts: seaworthiness, portworthiness, cargoworthiness and legality.[60] In Issues Paper 2 we described these implied warranties[61] and suggested that the causal connection test should also apply to them. We think this is right, for the reasons given below.

8.117 Some respondents urged us to consider a more radical solution: that the implied warranties should be abolished and the parties should agree expressly to any warranties they wish to include. Below we ask for views on this.

Seaworthiness

8.118 The main effect of a causal connection test would be upon the warranty of seaworthiness in voyage policies. It would effectively reverse the ruling in *De Hahn v Hartley*,[62] by permitting warranties to be remedied. If, for example, a ship leaves port with insufficient crew, and later takes more crew on board, the insurer would be liable for subsequent losses. It would also mean that a technical breach (such as not carrying the required medicines or not having the correct certificates on board) would not discharge the insurer from liability for an unconnected loss.

8.119 Our proposals are mild: in a voyage policy, the insured would only be paid if it could show, on the balance of probabilities that the breach did not contribute to the loss. This goes nowhere near as far as the requirement in time policies, where the *insurer* has to prove that the breach was a *real or dominant cause* of the loss. It does, however, go some way to lessening the difference between voyage and time policies. Given that the industry has lived with the time policy rule for over 100 years, we do not think that this lesser rule in voyage policies should cause undue difficulties.

Portworthiness and cargoworthiness

8.120 These warranties are less likely to be a major cause of dispute, and we do not think that the proposed reform would have any great effect on the market.

8.121 At present, it may be possible for an insurer to argue that, if a problem in port is remedied before the ship is put to sea, the insurer is discharged from liability for an unconnected loss at sea. We do not think this result would be fair. Again, we believe that the insured should be able to put forward a defence that the breach did not contribute to the loss.

[60] See Marine Insurance Act 1906, ss 39, 40 and 41.

[61] See Issues Paper 2, Appendix A.

[62] (1786) 1 TR 343.

Legality

8.122 The warranty of legality raises more complex issues. Insurance contracts, like all other contracts are subject to the general doctrine of illegality. This means that if the parties agree to insure an illegal adventure, the contract would not be enforceable in any event. Similarly if, unbeknown to the insurer, the insured intended to engage in an illegal activity the contract would be unenforceable by the insured.[63] These results are independent of the law on warranties, and would not be affected by the proposed reforms. The insured would not be entitled to enforce an illegal contract even if the loss was unconnected to the risks posed by the illegal conduct.

8.123 There is some uncertainty about how far the implied warranty of legality under section 41 of the 1906 Act imposes additional requirements on insurance contracts. Under normal contract law, if one party commits a statutory offence in the course of performance (such as overloading a ship) this does not affect the enforceability of the contract.[64] It is possible that section 41 goes further than normal contract law in these circumstances. If an insured could prevent the ship from being overloaded and fails to do so, this may be a breach of the implied warranty that "the adventure shall be carried out in a lawful manner". If this is a correct interpretation of the law, we think the rule needs to be tempered. Under our proposed reform, it would be open to the insured to argue that the overloading was not intended at the outset, but was only a subsequent illegality. If the insured could prove that the overloading did not contribute to the loss, the insurer would remain liable.

Are the implied marine warranties still needed?

8.124 In discussions, it was suggested that we were not being sufficiently radical. In 2001, the ALRC recommended that the implied warranties should be abolished.[65] If the parties wished to include them in their contracts, they should do so expressly. It was pointed out that at present, most parties agree to exclude the implied warranties, but it would be possible for an insured to be caught unaware. It would be simpler and easier to put the onus on the parties to agree expressly to the terms they require. We would be interested in hearing views on this issue.

8.125 **We ask whether the implied marine warranties in the Marine Insurance Act 1906 continue to serve a useful function or whether they should be abolished.**

8.126 **If the marine warranties are to be retained, we provisionally propose that they should be subject to the same causal connection test as express warranties.**

[63] *Archbolds (Freightage) Ltd v Spanglett* [1961] 1 QB 374.

[64] *St John Shipping Corp v Joseph Rank Ltd* [1957] 1 QB 267.

[65] ALRC, Review of the Marine Insurance Act 1909 (2001) No 91.

Implied voyage conditions

8.127 There are other provisions within the 1906 Act that operate in a similar way to warranties. They are expressed as conditions precedent to the attachment of the risk.[66] For example, section 43 states that

> Where the place of departure is specified in the policy, and the ship instead of sailing from that place sails from any other place, the risk does not attach.

8.128 This can lead to very technical arguments. For example, in *Molinos Nacionales v Pohjola Insurance Company Ltd*,[67] the ship was said to sail from Tallinn, but instead sailed from Muuga, an adjacent port separated from Tallinn by a headland only 3 miles across, and managed by the same port authority. The difference in port had no bearing on the risk. Mr Justice Coleman described the insurer's argument that the risk did not attach as having "no merit whatsoever". However, the Act and earlier authorities permitted insurers to avoid a voyage policy for "trivial, entirely immaterial, deviations". He was therefore forced to conclude that the insurers should be allowed to defend the claim on these grounds, and were entitled to proceed to trial.

8.129 Other parts of the 1906 Act raise similar issues. Under section 44, for example, the policy does not attach if the ship sails to the wrong destination. Under sections 45 and 46, if the destination is changed or there is a deviation, the insurer is discharged.

8.130 During consultation, the implied voyage conditions received little discussion. Few people seemed aware that they existed. Again, we ask whether there are reasons to retain them, or whether the parties should agree expressly to any conditions they require.

8.131 **We ask consultees whether there are good reasons to retain the implied voyage conditions contained in sections 43 to 46 of the Marine Insurance Act 1906**.

8.132 **If the voyage conditions are to be retained, we provisionally propose that they should be subject to the same causal connection test as express warranties**.

Should the reforms apply to reinsurance?

8.133 Our view is that unless there are very good reasons to the contrary, the law on reinsurance should follow, as closely as possible, the law that governs the original insurance contract.

[66] See para 2.53 above.

[67] (unreported) High Court, 5 May 1998.

8.134 An example of the problems that can be caused where the laws differ can be found in *Forsikringsaktieselskapet Vesta v Butcher*.[68] The plaintiffs were a Norwegian insurance company who had insured the owners of a Norwegian fish farm against the loss of their fish. The plaintiffs had then reinsured 90% of the risk with London underwriters. Both the original policy and the reinsurance policy stated that a 24-hour watch be kept of the farm, and that "failure to comply" would render the policy null and void. Although the terms were identical, the applicable law was not. The original policy was governed by Norwegian law while the reinsurance policy was governed by English law.

8.135 The fish were lost in a storm. The farm had failed to keep a 24 hour watch, but this was unconnected to damage caused by the storm. Under Norwegian law, the breach did not prevent liability from arising, despite the express words of the policy, because it was not causative of the loss. The Norwegian insurers paid the claim. However, when they sought to recover 90% of the loss from the London underwriters, the reinsurers pleaded breach of warranty. The House of Lords eventually held the reinsurers liable as, on a true construction of this particular policy, they had agreed to cover all the risks involved in the original policy. It was unfortunate, however, that the dispute took so long to resolve.

8.136 In 1980 the Law Commission recommended against extending the reforms to reinsurance contracts generally. It thought that the parties to reinsurance contracts would be "aware of the well-known and long-standing rules of law and practice governing the market in which they operate" and that its general recommendations on breach of warranty would be inappropriate to the market.[69] It did however, attempt to protect insurers against the sort of anomalies that arose in the *Vesta* case. It recommended that where the reassured "substantially repeats the warranty broken by the insured", the reinsurer would not have greater rights against the reassured than the reassured had against the original policyholder.

8.137 The greater the variation in the law applying to different types of insurance contracts, the more scope there is for confusion to arise. We would not wish to create differences between insurance and reinsurance law unless those differences were clearly necessary. We fear that the specific provisions to prevent anomalies of the type suggested by the 1980 Report would add to the complexity of the law.[70] We see no reason why the rules we have recommended should not also be the default rule for reinsurance. If these do not meet the needs of the parties, insurers and reinsurers are sufficiently sophisticated to negotiate different rules in their place.

8.138 **We provisionally propose that the reforms proposed in relation to warranties should apply to reinsurance as well as to direct insurance.**

[68] [1989] AC 852.

[69] See para 8.12 above.

[70] There already appears to be scope for argument about whether a clause in an insurance contract has be incorporated within a re-insurance contract in "manipulated" or "unmanipulated" form: see *HIH Casualty and General Insurance Ltd v New Hampshire Insurance Co* [2001] 2 Lloyd's Rep 161; [2001] EWCA Civ 735. We would not wish to encourage disputes of this type.

PART 9
PRE-CONTRACT INFORMATION AND INTERMEDIARIES: ASSESSING THE CURRENT POSITION

INTRODUCTION

9.1 In this Part and the next we consider the interaction between agency law and the law of misrepresentation and non-disclosure. We look at three issues:

(1) *The pre-contractual receipt of information by intermediaries*. What should the consequences be if an applicant for insurance gives material information to an intermediary and the intermediary fails to convey that information accurately to the insurer? Under current law, the issue depends on whether the intermediary is acting as the agent for the insurer or for the insured. If the intermediary acts for the insured, the insurer may avoid the policy. If they act for the insurer, the insurer is deemed to be aware of the information. However, in many situations the legal status of an intermediary is unclear.

(2) *The completion of proposal forms by intermediaries*. An intermediary may enter incorrect information onto a proposal form that is then signed by the applicant for insurance. There is case law to suggest that an intermediary acts as the agent of the applicant when completing a proposal form, even if they are the agent of the insurer for most or all other purposes. Furthermore, it suggests that if an insured signs a proposal form, they must be bound by it. We consider whether the principles set out in the leading case on this subject*, Newsholme Brothers v Road Transport and General Insurance Co Ltd*,[1] should be reformed.

(3) *Section 19 of the 1906 Act*. This provision imposes an independent duty of disclosure on an agent to insure. We consider whether change is needed to the scope of the duty and to the results if the duty is breached.

THE NATURE OF THE PROBLEM

A consumer example

9.2 The following case taken from our survey of ombudsman decisions illustrates how the issues discussed in this paper impact on consumers:

[1] [1929] 2 KB 356.

Case study: poor advice from an intermediary

Mrs A took out a critical illness policy. A sales agent took her through an application form, which asked a series of questions about her health including: "have you ever had asthma, bronchitis or other respiratory disorder". The agent recorded a "no" against this question, and Mrs A then signed the form to say the answers were correct.

Five years later, Mrs A was diagnosed with cancer and made a claim under the policy. The insurer refused the claim and attempted to avoid the policy because she had a medical history of asthma.

Mrs A complained to the Financial Ombudsman Service on the grounds that the agent had told her that her asthma was irrelevant. Her account of events was that she had told the representative about her asthma and explained that it was mild and fully controlled by an inhaler. The agent then asked if she had ever been hospitalised for it or used a nebuliser and she said no. On this basis, the agent told her that it was "run of the mill", and the form was only asking about serious matters. The agent, however, denied the conversation and said he would never tell a consumer not to disclose a health matter, however trivial.

9.3 This is not untypical of many cases reaching the Financial Ombudsman Service (FOS). In our survey of 190 consumer cases involving non-disclosure or misrepresentation, 25 (13%) involved allegations about what an intermediary said or did during the sales process.

9.4 Cases such as these pose several difficulties for ombudsmen and the courts. In addition to the practical problem of deciding where the true facts lie, the ombudsman must also decide whether the agent was acting for the insurer or for the insured. This depends upon the status of the agent: a broker is presumptively the agent of the insured; an employee of the insurers acts for them; and the position of a third party (such as a bank or building society) is uncertain. However, even if the agent was acting for the insurer, there remain difficult questions about how far the insured should be held to the form they have signed.

9.5 There are several variations on these facts. The intermediary may complete the form asking questions over the phone, so that the proposer does not see the form or sign it before it is submitted. In some cases it may be signed in blank by the insured. Alternatively the insured may complete the form herself but omit information, or give an incomplete answer, because the agent has told her that the information is not relevant. Another variation is that the proposer reveals information to the intermediary who simply fails to pass it on to the insurer.

9.6 The issue is far from new. Reported cases involving agents of insurers date back to 1892,[2] and there has been a more recent batch of cases involving brokers.[3] It would appear that for as long as consumer insurance has been sold through agents, there have been allegations that agents induced misrepresentations.

An example from business insurance

9.7 Mrs A's was a consumer case, but similar problems arise in the context of business insurance. In *Roberts v Plaisted*,[4] for example, Mr Roberts insured a hotel through a Lloyd's broker. The hotel operated a discotheque, which the broker was shown when he inspected the premises. Following a fire, Mr Roberts made a claim for £70,000. The underwriters sought to avoid the contract on the ground of non-disclosure of the existence of the discotheque. The Court of Appeal said that "it may seem remarkable" that Mr Roberts would lose his claim, even though he had shown his broker the discotheque, when the broker was at fault for not passing on the information.[5] However, that was the state of the law. The court was only able to decide in favour of Mr Roberts by finding that the disclosure had been waived.

9.8 Our survey of FOS cases suggests that problems of this kind are particularly common in complaints by small businesses: they arose in 8 out of the 12 small-business complaints about non-disclosure and misrepresentation in our survey.

PREVIOUS REPORTS ON THE STATUS OF AGENTS

9.9 In 1957 the Law Reform Committee (LRC) recommended a simple solution to these issues. It thought that intermediaries should always be considered as the intermediary's agent for disclosure purposes:

> Any person who solicits or negotiates a contract of insurance should be deemed, for the purposes of the formation of the contract, to be the agent of the insurers, and the knowledge of such person should be deemed to be the knowledge of the insurers.[6]

[2] See *Bawden v London, Edinburgh and Glasgow Assurance Co* [1892] 2 QB 534, where an agent selling accident insurance completed a form on behalf of an illiterate one-eyed man. The form contained a warranty that the proposer had no physical deformity.

[3] *Hazel v Whitlam* [2005] Lloyd's Rep IR 168, [2004] EWCA Civ 1600; *Friends Provident v Sirius International* [2006] Lloyd's Rep IR 45, [2005] EWCA Civ 601; *Tioxide Europe v CGU International Insurance* [2006] Lloyd's Rep IR 31, [2005] EWCA Civ 928.

[4] [1989] 2 Lloyd's Rep 341.

[5] Above, per Purchas LJ at 345.

[6] Fifth Report of the Law Reform Committee (1957) Cmnd 62, para 14.

9.10 This proposal appears to be very broad-brush. The LRC cannot have meant it literally: if so, it would apply to the consumer who is going on holiday with a group of friends and agrees to arrange a travel policy to cover them all. The context suggests that the LRC had in mind "agents nominated by insurance companies" – meaning, presumably, people or firms who, at least for some purposes, acted as an agent of the insurer.

9.11 This comes closer to the class of agents that in 1977 the Government was considering making "the responsibility of the company for whom they act". Their proposal was that anyone who was not registered as an "insurance broker" but who "was used" by an insurer "to sell insurance" would be treated as the insurer's agent, at least in consumer cases.

9.12 Our provisional proposals are narrower than the changes that the Government was apparently contemplating in 1977. We are not proposing changes in relation to independent intermediaries, who search the market on the policyholder's behalf. Our proposals relate only to intermediaries who offer products from a single insurer or limited number of insurers only. We think there is a case for treating these intermediaries as agents of the insurer for the purposes of receiving pre-contract information from the insured.

9.13 However, we would welcome views both on whether further reform is needed and on how agents might most usefully be grouped for the purpose of defining the scope of any reforms.

THE STRUCTURE OF PARTS 9 AND 10

9.14 The remainder of this Part is divided into the following sections:

(1) We outline agency law as it applies to insurance and consider how the law applies to some of the arrangements now seen in a rapidly changing market place.

(2) We deal with "the *Newsholme* problem" – the case where the agent completes the proposal form and the proposer signs it not noticing a mistake.

(3) We consider the agent's independent duty of disclosure under section 19 of the 1906 Act.

(4) We end this Part by looking at the current position for consumers, taking into account the Financial Services Authority (FSA) rules and the approach of the FOS.

9.15 Part 10 sets out our proposals for reform, first as it applies to consumer insurance and then as to business insurance.

THE CURRENT LAW

Introduction

9.16 Relationships between policyholders, intermediaries and insurers are governed by the general law of agency. This consultation paper does not attempt to review general agency principles. Instead we begin this section by outlining some of the features of the insurance marketplace which may appear surprising when viewed against such principles. We then consider when an intermediary or other agent will be treated as an agent of the insured and when they will be treated as the agent of the insurer. We highlight some aspects of the FSA rules and conclude by considering how the law and the FSA rules apply to some current market practices.

Remuneration

9.17 Intermediaries who act as agents of applicants for insurance are commonly remunerated by commission, which is typically expressed as a percentage of the premium payable. This commission is paid not by an intermediary's principal, the applicant, but by the third party, the insurer. The level of commission may be agreed between the intermediary and the insurer without reference to the applicant. In some cases the applicant will not be informed of the sum of commission paid.

9.18 Nevertheless, intermediaries are regularly regarded as agents of the insured. On general agency principles, it would be expected that an intermediary should account to its principal for any benefit received from a third party. However in insurance it is accepted that the intermediary will retain the commission - indeed this will normally be its only remuneration, with no fee being paid by the applicant.[7]

9.19 We are not concerned directly with the question of how intermediaries are remunerated. However, we will see that it is a relevant factor. The fact that the proposer does not have to pay the intermediary may give the impression that the intermediary in some sense “represents” the insurer. This may affect the proposer’s understanding on questions of pre-contract information, encouraging the proposer to rely on what the intermediary has said.

[7] Fee based advice is available for some types of insurance, but is uncommon in either consumer or commercial markets.

Dual Agencies

9.20 Intermediaries may on occasion act for both the insurer and the applicant for insurance — sometimes in the course of the same transaction. In our Scoping Paper we gave the example of an independent intermediary who acts as the agent of the applicant in identifying a suitable motor insurer, then switches to being the agent of the insurer to issue a cover note.[8] Outside the consumer context, it is common for an intermediary to give independent advice to a proposer and then use a binding authority to accept the risk on behalf of the underwriters. In the reinsurance market, brokers owe duties up and down the reinsurance chain, and the courts have faced difficulties in determining who the primary principal is in any one situation.[9]

9.21 The primary concern with dual agency arrangements is the potential for conflicts of interest.[10] In this paper we are not addressing all the issues concerned with agency in insurance, and conflicts of interest is a subject to which we may need to return. For the moment, we simply note that "dual agency" may make it that much more difficult for an applicant to understand the agency position.

The status of an intermediary: whose agent?

9.22 The issue of whether an intermediary is acting for an insurer or insured is complex. Under the general law of agency, the court would normally start by looking at any express agreement between the insurer and the intermediary: in particular, did the insurer give the intermediary actual authority to act as their agent for the purposes of receiving information or explaining the questions asked? In the absence of any express authority, the court may look for implied authority, by asking what was normal in that particular market. Finally, even if an agent was acting outside the terms of their actual authority, the insurer may still be held liable for their actions if the insurer held them out as having apparent authority to do what they did. These general principles have been interpreted and applied to different sorts of insurance intermediaries.

[8] See the arrangements discussed in *Drake Insurance v Provident Insurance* [2004] Lloyd's Rep IR 277, where the Court of Appeal almost summarily held that the broker was acting for insurers when issuing the cover.

[9] See *HIH Casualty and General Insurance v JLT Risk Solutions Ltd* [2006] Lloyd's Rep IR 493, [2006] EWHC 485 (Comm).

[10] Under general agency law one would expect an intermediary to seek the consent of its principal before it acted for the third party. However, in the example we give of motor insurance, we are told that the intermediary will not typically seek explicit consent from the applicant before acting for the insurer.

The broker as agent for the insured

9.23 It is long-established that brokers, including Lloyd's brokers, normally act as agents for the insured, even if they carry out specific functions for the insurer (such as arranging re-insurance or appointing loss adjusters).[11] The fact that the broker acts for the insurer for some limited purposes does not undermine the general proposition that for other purposes (such as receiving pre-contract information) they act as agents for the insured.

9.24 The case law applying to Lloyd's brokers has been applied more generally within the commercial sector. In *Arif v Excess Insurance Group*,[12] a hotel owner bought insurance through his bank to cover a hotel owned by a partnership he was involved with. When the insurers sought to avoid the policy on the grounds of lack of insurable interest, the policyholder argued that the bank knew he was buying insurance on behalf of the partnership. The Court of Session, however, found that the bank had acted as his agent rather than the insurer's agent, and so this knowledge could not be imputed to the insurer. They dismissed the pursuer's arguments that the bank should be considered the insurer's agent because it had advised him to insure through the insurer, submitted the form and been paid a commission:

> I am quite unable to hold that there is anything in these averments which takes the case out of the ordinary position in which insurance brokers or agents act for the insured. The fact that the bank already acted for the pursuer in banking matters merely confirms the view that the bank's insurance services department acted for the pursuer in arranging the insurance.[13]

9.25 In *Winter v Irish Life Assurance plc*,[14] the same principle was applied to a consumer policy. The policyholders bought life insurance through a large firm of brokers. The brokers knew that both policyholders suffered from cystic fibrosis, but this information was not disclosed to the insurer. The court held that the brokers acted for the policyholders, not the insurers. It was not sufficient that the insurers paid the brokers commission, or gave them publicity material over-printed with the brokers' name, or provided guidance and training about how the forms should be filled in. The judge stressed that the policyholders approached the brokers to find them insurance. He said that the position might have been different if the insurer had provided the broker with the names of various leads and asked them to approach clients to sell the insurer's products.

[11] See, for example, *Rozanes v Bowen* (1928) 32 Lloyd's Law Reports 98; *Anglo-African Merchants v Bayley* [1970] 1 QB 311 and *Roberts v Plaisted* [1989] 2 Lloyd's Rep 341.

[12] 1986 SC 317.

[13] Above at p 319 by Lord Sutherland.

[14] [1995] 2 Lloyd's Rep 274. See also *Hazel (t/a KGM motor policies at Lloyds) v Whitlam* [2005] Lloyd's Rep IR 168, [2004] EWCA Civ 1600, where the broker failed to pass on the fact that the policyholder was training as a golf professional.

When is the intermediary the agent of the insurer?

9.26 Although an intermediary will usually be considered as the insured's agent for disclosure purposes, there are some instances in which the intermediary will be held to be acting for the insurer.

EMPLOYEE OR APPOINTED REPRESENTATIVE OF THE INSURER

9.27 The insurer's own employees will normally be regarded as acting for the insurer, unless they have exceeded the terms of their authority by acting outside the scope of their employment.[15]

9.28 The Financial Services and Markets Act 2000 states that if an insurer appoints a firm or person as its "appointed representative", it is responsible for the representative's actions or omissions. Under section 39(3), the principal

> 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.

9.29 Technically, it could be argued that this only covers regulatory issues, within the scope of the Act, rather than all issues of civil liability. However, it appears accepted practice within the industry that if an appointed representative gives poor advice about how to complete a form, the insurer is responsible for it.

AUTHORITY TO GIVE COVER

9.30 Some cases suggest that an intermediary should be regarded as the insurer's agent if it has specific authority to bind the insurer to cover. In *Stockton v Mason*,[16] a consumer asked his broker to transfer cover from one car to another. The broker told him that was fine for a temporary period, and the consumer assumed that insurance had been issued on the same terms as before. In fact, however, the insurance only covered the insured and not other authorised drivers. The Court of Appeal held that the fact the broker had authority to bind the insurer to temporary cover meant that the representations they gave about that temporary cover were made on behalf of the insurer.

[15] Even where an employee has acted outside the scope of their authority, they may still be regarded as the insurer's agent on the grounds that they had apparent authority to act as they did.

[16] [1978] 2 Lloyd's Rep 430.

> There must be every day thousands of cases, not only in motor insurance but in other forms of non-marine insurance, where persons wishing to become insured or wishing to transfer an insurance ring up their brokers and ask for cover or ask for fresh cover or ask to transfer the cover from an existing vehicle to another. In every case they rely upon the broker's statement that they are covered as constituting a contract binding upon the insurance company.… The broker, in dealing with the matter, is acting as agent for the insurance company and not as agent for the person wishing to have insurance.[17]

9.31 In *Woolcott v Excess Insurance Co Ltd*,[18] it was assumed that the same principle also applied to issues of disclosure. The parties accepted that where an agent had authority to bind the insurer, the insurer was taken to know what the agent knew. Therefore, if the agent was aware of the insured's criminal history, the insurer could not avoid the policy on the grounds that the criminal history had not been disclosed.

9.32 It is unclear how far the principle in *Stockton v Mason* may be taken. It is likely that if the broker had authority only to issue temporary cover notes, its agency would relate only to the temporary cover. The broker would therefore be acting for the insured in respect of the main cover.

SOLICITING BUSINESS ON BEHALF OF THE INSURER

9.33 There are statements within the case law to suggest that if an insurer uses agents to solicit business then the insurer assumes responsibility for those agents. MacGillivray explains that an independent agent would not be regarded as acting for an insurer even if he solicits business for prospective applicants for insurance "unless the solicitation is done on the instructions of the insurers with whom the risk is placed":

> The kind of case where the broker is found to be the insurers' agent is where he is employed by them or is tied to them and in that capacity, initiates the relationship between the insurers and the assured.[19]

This statement has received judicial support.[20]

[17] Above, at p 432.

[18] [1979] 1 Lloyd's Rep 231.

[19] para 18-6.

[20] See *Winter v Irish Life Assurance plc* [1995] 2 Lloyd's Rep 274 and *Arif v Excess Insurance Group* 1987 SLT 473.

"TIED AGENTS"?

9.34 This raises questions about the status of an agent who only sells the products of one insurer, particularly if the agent is not told to actively solicit business from consumers.

9.35 At the time of polarisation (explained below), it was suggested that an independent agent who analysed the market "was seen as primarily the agent of the insured (or person seeking insurance)[21]" while "a tied agent was essentially the agent of the insurer".[22] The phrase "tied agent", however, is ambiguous. It may mean any agent who advises only about a single insurer. Alternatively, it may mean an agent who is the insurer's "appointed representative" within the meaning of the Financial Services and Markets Act 2000. Increasingly these two categories differ.

9.36 As we have seen, an insurer is normally taken to be responsible for the acts of its appointed representative. However, it does not necessarily follow that an intermediary selling the products of only one insurer is that insurer's agent, if they are independently authorised. We have not been able to find any recent cases in which an intermediary has been held to be the insurer's agent in the absence of specific authority to bind the insurer to cover. Furthermore, the early cases on the subject have been doubted.[23] The dividing line between intermediaries who act as agents for the insurer and those who act as agents for the insured remains unclear.

The regulatory regime

9.37 Before January 2005, only investment intermediaries were regulated by the FSA. Within the investment market, intermediaries were required to be "polarised": they either had to be independent and offer access to the whole market place, or be tied-agents of a particular firm. Since 2005, general insurance intermediaries have come within FSA regulation, but the policy has shifted towards "depolarisation". Firms may now be able to sell products from a range of providers, but not the whole market.

9.38 The FSA rules are discussed in more detail in below. For the moment it is sufficient to note that an intermediary must disclose whether they provide advice or information

[21] There is clear authority for this: see *Winter v Irish Life Assurance plc* [1995] 2 Lloyd's Rep 274 and *Arif v Excess Insurance Group* 1986 SC 317.

[22] M Clarke, *The Law of Insurance Contracts* (5th ed 2006) p 232.

[23] In *Arif v Excess Insurance Group* 1986 SC 317, counsel for the insured relied on *Cruickshank v Northern Accident Insurance Co* 1895 3 SLT 167; *Bawden v London, Edinburgh and Glasgow Life Insurance Co* [1892] 2QB 534; and *Keeling v Pearl Assurance Co Ltd* (1923) 129 LT 573. However, the Court of Session said that *Cruickshank* was best explained turning on a different point; *Bawden* was no longer good law, and in *Keeling* the agent was a salaried employee of the insurers rather than a tied agent.

(1) on the basis of a fair analysis of the market; or

(2) from a limited number of insurers; or

(3) from a single insurer.[24]

9.39 This information may sometimes be relevant to whether the intermediary acts for the insurer or the insured, but it will not determine the issue. As we explain below, intermediaries are not required to declare for whom they act when they explain the documentation, fill in forms or pass on information.

The rapidly changing market place

9.40 The existing case law and regulatory regime now has to be applied to a rapidly changing market place, in which there is a wide variety of different arrangements between insurers and distributors. Below we consider a few examples of current practice, and discuss how the law may apply to them.

Agents for insured

9.41 In the following range of examples, the intermediary is clearly acting for the insured.

(1) A multi-national broker advises A plc, a telecommunications company, on policies to cover a range of risks, both in the UK and in other jurisdictions where it is operating.

(2) A Lloyd's broker places an overseas oil rig liability risk for B Incorporated. The business originates through a chain of two further professional intermediaries, one of which is not a UK firm.

(3) An independent intermediary searches the market and arranges motor insurance for Mr C.

(4) An independent financial advisor assists Ms D to identify the whole-of-life policy which best suits her needs from those available across the market.

(5) A solicitor, dealing with a house purchase for Ms E, assists her in applying for buildings insurance as required by the lender.

9.42 In other cases, however, the issue may cause more confusion.

[24] FSA Handbook, ICOB 4.2.8R(6).

"White labelling": branding insurance products with the distributors' name

9.43 One particular trend has been towards joint ventures between insurers and "High Street names" (such as supermarkets, banks or building societies). The insurance is branded with the name of the supermarket (for example), so that only keen readers of documentation will realise that the insurer is a different organisation.[25]

9.44 For insurance sold by telephone,[26] we have been told that these partnerships often follow two basic models. In the first, consumers will be asked to ring a call centre run by the High Street name (such as the bank). The call centre will be empowered under the terms of their agreement with the underwriter to bind the underwriter to the cover. In these circumstances, the High Street name is clearly acting as agent for the insurer in asking questions, receiving information and issuing cover.

9.45 In the second model, however, consumers are told to ring a number that takes them through to a call centre operated by the insurer (though again, the call centre may be branded with the High Street name). It will therefore be the insurer's responsibility to ask questions and advise consumers about the standard of care required in answering them. In these circumstances, often, the distributor will be a mere "introducer" – handing out leaflets about the product, but not advising on its suitability. From the distributor's point of view, this has the advantage that it lessens the burden of FSA regulation.

9.46 In the case of a leaflet in a supermarket this may work well. The consumer's dealings will be entirely with the insurer and there should be no possibility of the distributor misleading them about the nature of the questions asked. However, things may go wrong. FSA research about investment products shows that introducers may well give advice about products, even though they should not (and equally advisers may not give advice, even though they should).[27] The same may occur in the insurance market.

[25] ICOB rule 5.6 states that the insurance intermediary must clearly communicate the identity of the insurance undertaking to the customer. Although the information is available for those who wish to read it, many consumers react to an overall branding impression rather than the specific words of policy summaries and disclosure documents.

[26] The same models may occur in internet sales – the website may either be hosted by the distributor on behalf of the insurer, or by the insurer themselves. However, internet sales offer less scope for human error.

[27] FSA, *Depolarisation disclosure – mystery shopping results*, Consumer Research Report 48 (March 2006).

9.47 The problem is particularly acute when a consumer has already established a good relationship with an adviser in another context (for example, in applying for a mortgage). If the adviser then gives them a leaflet about associated insurance products, the consumer may well ask questions about the insurance, and it may be tempting for the adviser to say more than they should. They may for example (wrongly) attempt to reassure a worried client that mortgage protection insurance will not involve long and intrusive questioning, and that the consumer does not have to give details about a period of depression more than three years ago. If the insurer later avoids the policy for misrepresentation, difficult questions arise. Is the insurer responsible for the advice given by the adviser or does the consumer have a separate cause of action against the adviser for negligent professional advice?

9.48 There is no very clear answer to this question. The adviser does not have actual authority to act on behalf of the insurer by giving advice. However, this may not be apparent to the consumer. One could perhaps argue that the insurer has granted the High Street name apparent authority to deal with queries by permitting publicity material that deliberately gives the impression that the High Street name is underwriting the policy.

Selling the products of one insurer, but with no authority to "bind cover"

9.49 In some cases, the intermediary may only offer the insurer's product, even though it does not brand it as its own. The intermediary may well not be the insurer's appointed representative: it may, for example, be independently authorised or the appointed representative of another insurance intermediary. We have considered the case where the joint arrangement between intermediary and insurer allows the intermediary to talk the consumer through the questions. If the intermediary then has binding authority to issue cover on the insurer's behalf, we think the law is fairly clear. A court would almost certainly hold that the intermediary is acting as an agent of the insurer for disclosure purposes.[28] However, the law is much less clear where the intermediary merely submits the completed and signed form to the insurer for a decision.

9.50 It is possible for this arrangement to occur in a variety of settings. The intermediary may be engaged in another business. For example, a car distributor may offer its customers insurance at the point of sale. The intermediary may be a well known financial provider, as where a building society offers income protection through a named insurer, and authorises its financial consultants to talk customers through the form. Alternatively, the intermediary may be a small business, selling insurance under some sort of franchise arrangement.

[28] See *Woolcott v Excess Insurance Co Ltd* [1978] 2 Lloyd's Rep 430, where it was assumed before the Court of Appeal that where an agent had authority to bind the insurer, the agent's knowledge was attributed to the insurer. Therefore, if the agent was aware of the insured's criminal history, this had effectively been disclosed to the insurer. See also *Stockton v Mason* [1978] 2 Lloyd's Rep 430, where an agent had authority to issue temporary cover notes. The court found that the insurer was bound by the representations the agent had made about the nature of the policy.

9.51 Again, the law in this area is far from clear, and there is potential for confusion.

Selling the product of a limited number of insurers

9.52 If the position in relation to intermediaries who offer only a single insurer's product is doubtful, the situation in relation to those who offer a limited number of insurers' products is completely unclear. We have to assume that under current law they do not act as agent for the insurer unless some special arrangement has been made.

9.53 Agents of this sort are often described as "multi-tied". However, the phrase is used loosely and does not have a clear meaning. Initially, it was taken to mean that an agent was the appointed representative of several insurers. However, such formal arrangements are not necessary. Increasingly, intermediaries simply join a limited number of "panels", involving flexible arrangements between the insurer and the intermediary.

9.54 Our study of FOS cases showed that the greatest problems over misrepresentation relate to health issues, especially in critical illness, income protection and term insurance. We were therefore interested to see research sponsored by Scottish Re in 2005 about how such products were sold.[29] It concluded that most intermediaries selling these forms of protection insurance remained independent and searched the market (or at least had an independent arm to their business). However, 15% of intermediaries were said to have "multi-ties", usually in addition to their independent function, and this included one very large intermediary. The report said that "multi-ties" were likely to increase in the future. The report highlighted the variety of arrangements between insurers and intermediaries, pointing out that there was no clear distinction between "panels" and "ties". It commented:

> Currently, we are seeing a grey area where panels and multi-tied packages appear to offer very similar benefits… The customer must be very confused. Indeed, we ourselves struggle to distinguish certain panels from multi-ties.[30]

[29] CWC Research, *The Protection Report 2005* (Clive Waller Consulting in association with Peter Le Beau, Le Beau Visage).

[30] Above, p 8.

Transcribing information to screen

9.55 We were also interested to note another development in the protection market. Despite the increased use of tele-sales and websites, most protection insurance is still sold face to face, using a paper form.[31] Insurers are increasingly paying intermediaries additional commission to transcribe the information from paper to an electronic medium, so that it can then be submitted to the insurer electronically. Intermediaries complain that some transcription processes are time-consuming and painful, with opportunity for error.[32]

9.56 We are not clear who bears responsibility for any errors that occur when an intermediary transcribes information to screen at the insurer's behest. The courts may well maintain the current rule that independent intermediaries should be considered to be the agent of the insured. However, it could be argued that if an insurer is paying an intermediary to transcribe information in a specific way using the insurer's system, then the intermediary completes this particular task as the insurer's agent. The insured will not know that the task is taking place, or have any control over the process.

Why does it matter?

9.57 We will see later that in some ways the issues relate to procedure rather than substance. If the insurer succeeds in avoiding the policy because the intermediary is negligent, the consumer would have a good claim against the agent for negligence. The claim may be brought either through the courts or the FOS. However, no-one's interests are served if the consumer pursues a long complaint against the insurer and is then told to start all over again against a different firm. The complainant suffers unnecessary stress and delay; the FOS has two complaints instead of one; and the industry may experience significant damage to its reputation. There is an obvious need for clarity in this area. We explore this further below.

[31] Above, p 4.

[32] Above, pp 5-6.

THE *NEWSHOLME* PROBLEM

Introduction

9.58 It is common practice for intermediaries to complete proposal forms on behalf of applicants. Applicants may well be deterred by the length or complexity of proposal forms, and find it easier to be led through the questions by the intermediary, either face to face or over the telephone. Typically, the intermediary records the answers on the proposal form, which is then signed by the applicant.[33]

9.59 Problems arise when an intermediary introduces inaccuracies when completing a proposal form. Such inaccuracies may arise in different ways — for example:

(1) The correct information is given to the intermediary, who fails to record it accurately.

(2) An intermediary completes the proposal form based on their own knowledge, and gives it to the applicant to sign. The answers are inaccurate or incomplete. However, the applicant either fails to check the answers, or checks but does not notice the errors.

(3) An intermediary asks the applicant to sign a blank proposal form, which it later completes inaccurately from its own knowledge or from information supplied by the applicant.

(4) The intermediary wrongly interprets a question when putting it or explaining it to the applicant. Although the applicant accurately answers the question as interpreted — and the answer is correctly recorded — information required by the insurer is omitted.

9.60 The question then arises — who is responsible for these inaccuracies? There are two issues to consider. First, would the intermediary normally be considered as acting for the insured rather than the insurer? As we discussed above, an independent broker or intermediary is normally considered the agent of the insured. This means that any remedy the insured may have lies against the intermediary, not the insurer. The insurer is entitled to avoid the policy and leave the insured to bring an action for professional negligence against their own professional adviser.

[33] According to CWC Research, *The Protection Report 2005,* this remains the most common way in which protection insurance is sold. It reports that in 2005 three-quarters of applications were completed face to face, usually on paper (p 2). There is also a reluctance to abandon signatures (p 6).

9.61 However, the case law suggests a further complication. Even if the intermediary was the insurer's agent (because, for example, they were the insurer's employee, or appointed representative) then the insurer may still be entitled to avoid the policy for misrepresentation. The basis for this rule is not entirely clear. Some judicial statements suggest that there is a "transferred agency": the insurer's agent becomes the insured's agent for the purposes of filling out the form. Others suggest that the signature on the form may be the crucial element: applicants should be bound by the answers they give on the forms they have signed.

The basic rule

9.62 The basic rule is set out in the case of *Newsholme Brothers v Road Transport and General Insurance Co Ltd*.[34] The plaintiffs insured a motor-bus through a man named Willey, who was said to be appointed by the Road Transport and General Insurance Co Ltd to canvass and procure proposals for them. The exact terms of his appointment were not available to the court, but in the usual course of events he would have been considered the insurer's agent. He completed a proposal form, which was later approved for cover by the insurers.

9.63 When a claim occurred it was found that Willey had entered inaccurate answers to three of the questions on the proposal form, even though he had been given the correct information by Newsholme Brothers. The insurer repudiated liability for breach of warranty and rejected the claim.

9.64 The Court of Appeal held that the insurer was entitled to repudiate liability since in completing the proposal form Willey had been acting as the agent of Newsholme Brothers. Lord Justice Scrutton set out the court's reasons as follows:

> If the answers are untrue, and [the agent] knows it, he is committing a fraud which prevents his knowledge being the knowledge of the insurance company. If the answers are untrue, but he does not know it, I do not understand how he has any knowledge which can be imputed to the insurance company. In any case, I find great difficulty in understanding how a man who has signed, without reading it, a document which he knows to be a proposal for insurance, and which contains statements in fact untrue, and a promise that they are true, and the basis of the contract, can escape from the consequences of his negligence by saying that the person he asked to fill it up for him is the agent of the person to whom the proposal is addressed.[35]

9.65 This suggests two reasons: first the agent ceases to act for the insurer as soon as he completes a proposal form with answers which he knows to be untrue; and secondly insureds must be bound by what they sign.

[34] [1929] 2 KB 356.

[35] *Newsholme Brothers v Road Transport and General Insurance Co Ltd* [1929] 2 KB 356 at 374-5.

9.66 Similar authority exists in Scotland in the case of *McMillan v Accident Insurance Company Ltd*.[36] Other cases suggest that the rule will apply even where the intermediary has answered questions on a proposal form without asking the applicant for the required information.[37]

Possible exceptions

9.67 A small number of reported cases reach a different result. It is unclear that any principle can or should be drawn from these exceptional cases. In *Bawden v London, Edinburgh and Glasgow Assurance Co,* the matter misrepresented was a physical infirmity that was plainly evident to the insurer's agent.[38] However, Professor Clarke suggests a wider rule to protect the vulnerable applicant for insurance.[39] Some support for this suggestion is to be found in *Stone v Reliance Mutual Insurance Society Ltd*,[40] where the misrepresentations related to previous policies and claims history. Lord Denning commented:

> The society seek to repudiate liability by reason of the untruth of two answers in the proposal form. They seek to fasten those untruths onto the insured. They do so by virtue of a printed clause in the proposal form. They make out that it was the insured who misled them. Whereas the boot is on the other leg. The untrue answers were written down by their own agent. It was their own agent who made the mistake. It was he who ought to have known better. It was he who put the printed form before the wife for signature. It was he who thereby represented to her that the form was correctly filled in and that she could safely sign it. She signed it trusting to him. This means that she, too, was under a mistake, because she thought it was correctly filled in. But it was a mistake induced by the misrepresentation of the agent, and not by any fault of hers. Neither she nor her husband should suffer for it.[41]

[36] *McMillan v Accident Insurance Company Ltd* 1907 SC 484.

[37] See *Biggar v Rock Life Assurance Co* [1902] 1 KB 516; *Keeling v Pearl Assurance Co* (1923) 129 LT 573; *Life and Health Assurance Association Limited v Yule* (1904) 6F 437; and *Arif v Excess Insurance Group Ltd* 1986 SC 317.

[38] *Bawden v London, Edinburgh and Glasgow Assurance Co* [1892] 2 QB 534.

[39] M Clarke, *The Law of Insurance Contracts*, (5th ed 2006) at 308 [10-3A]

[40] [1972] 1 Lloyds Rep 469.

[41] As above at p 475.

However, it is not obvious that this approach will be applied beyond cases in which the applicant is blind or illiterate,[42] or where (as in *Stone*) the agent was authorised by the insurer to collect the information and complete the form, and for this reason remained the agent of the insurer when doing so.[43]

Criticisms of the *Newsholme* rule

9.68 The *Newsholme* rule appears to rest on two arguments: that the agent ceases to act for the insurer as soon as he commits a fraud by entering information which he knows to be untrue; and that the insured must be bound by their signature. Both arguments may be criticised.

9.69 First, it is undoubtedly true that the insurer should not be bound by a contract where the insured and the agent have committed a fraud together. The insured's fraud must taint the contract. It cannot be excused by the agent's participation because the agent has neither actual nor apparent authority to participate in a fraud. However, the situation may be different where the agent has committed a fraud on his own initiative (because, for example, he was anxious to gain his commission). If a sales representative is employed by the insurer as the insurer's agent, it might be thought that the insurer should carry greater responsibility for the fraud than the insured.

9.70 As far as the signature is concerned, this may be decisive in a legal regime which makes the insured strictly liable for all misstatements, however caused. In *Newsholme*, for example, the proposal form contained a basis of the contract clause whereby the plaintiffs warranted the strict accuracy of everything they had signed. Such a rule, however, makes less sense under the reforms we have provisionally proposed, where the insurer's remedy for misrepresentation depends on the insured's state of mind and where (in consumer cases) warranties of past or existing fact will not give the insurer additional rights. An insured may sign a form with a misstatement fraudulently, or negligently without checking, or completely innocently, because they reasonably believed what the agent has told them. The signature should not necessarily determine the issue.

9.71 In Part 10 we propose reforms to this rule.

[42] See J Birds and N Legh-Jones, MacGillivray on Insurance Law (10th ed 2003) at para 18-42.

[43] Above at para 18-44.

MARINE INSURANCE ACT 1906, SECTION 19

9.72 Section 19 of the 1906 Act places a duty of disclosure on an agent who effects insurance on behalf of a prospective policyholder. The section is in two parts. The second part (section 19(b)) is relatively uncontroversial. It simply says that the broker must disclose everything the insured must disclose, if it comes to the broker's attention in time. However, the first part (section 19(a)) is more problematic. It appears to impose an additional duty on the broker to disclose matters that the broker knows but the insured does not know.

9.73 This raises several difficult issues. First, the insurer's remedy for breach is to avoid the policy, which penalises not the broker (who was at fault) but the innocent insured. Secondly, where there is a chain of intermediaries, the duty seemingly only applies to the final agent in the chain, the "agent to insure". Finally, it is unclear how far the duty extends to knowledge that the intermediary received in a different capacity.

The agent's duty of disclosure

9.74 Section 19 reads as follows:

> 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-
>
> (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 come to his knowledge too late to communicate it to the agent.

Application of section 19

9.75 It is generally accepted in the case law that section 19 applies to non-marine insurance. Even if the section is not directly applicable, it is taken to codify the common law.[44]

9.76 We can see no reason in principle why section 19 does not apply in consumer cases. However, we are not aware of any reported consumer case where this has been an issue.

[44] *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136, 1139.

Section 19(b)

9.77 We have not received any criticism of this provision, which requires the agent to disclose every fact that the applicant is bound to disclose. At first sight, this seems reasonable. However, where an agent breaches the duty, the insurer's only remedy is to avoid the policy. Where an insured has failed to disclose something it should have disclosed, the insurer already has a right to avoid. Section 19(b) appears to add little to an insurer's existing remedies for non-disclosure.

Section 19(a)

9.78 This provision is problematic - partly because of the consequences of a breach and partly because of uncertainties regarding its scope.

WHAT ARE THE CONSEQUENCES OF BREACH?

9.79 Section 19 does not set out the consequences if an agent to insure breaches the obligations it imposes. This is in contrast to sections 18 and 20 which state respectively that pre-contractual non-disclosure by a policyholder or misrepresentation by the policyholder or the policyholder's agent give the insurer the right to avoid the policy.

9.80 Nevertheless, it is well established that a breach of section 19(a) does give the insurer the right to avoid.[45] This seems odd, as the burden falls on the insured who, by definition, will be ignorant of the matter: if the circumstances were also known to the insured the case would fall within section 19(b).

9.81 This leaves the question of whether such a breach also gives the insurer a right in damages against either the agent to insure or against the policyholder. In *HIH Casualty and General Insurance Co v Chase Manhattan Bank*, the court found that breach of section 19 did not give rise to damages as such.[46] The agent could be liable to the insurer in damages but only where the agent's conduct amounted to a negligent or fraudulent misrepresentation, assuming that the necessary common law requirements for such an action could be established. The agent to insure would not be liable for pure non-disclosure, even though the duty to disclose was imposed upon him by section 19(a).

WHO IS AN "AGENT TO INSURE"?

9.82 The section only applies to "an agent to insure", who "effects" the insurance for the insured. There is some uncertainty over the definition of an agent to insure.

[45] R Merkin, *Colinvaux's Law of Insurance* (8th ed 2006), p164 [6-43].

[46] [2003] 2 Lloyd's Rep 61, [2003] UKHL 6.

9.83 Section 19 is based on two nineteenth century cases arising out of the reinsurance of a steamship, the *State of Florida*.[47] In 1884, Blackburn Low & Co insured the *State of Florida*, sailing from New York to Glasgow. The insurers asked their Glasgow agents, Rose, Murison and Thomson, to place a reinsurance contract. Rose, Murison and Thomson did this by contacting their own London agents, who placed the insurance through a Lloyd's broker. The insurers then arranged a second reinsurance contract using other (different) agents. After the ship was lost, it became known that before the first reinsurance had been placed, Mr Murison, a partner in the Glasgow firm, had spoken to the ship owners. During the conversation, the owner mentioned that there had been reports that the *State of Florida* had been lost and that some of its crew had been seen on another vessel. However, these rumours were not known to the insurer. In *Blackburn Low v Haslam*,[48] the Court of Appeal found that the reinsurers could avoid the first policy, placed by the Glasgow agents through the chain of intermediaries. However, in *Blackburn Low v Vigors*,[49] the House of Lords found that the second policy, placed through other agents, was unaffected. The knowledge of the Glasgow agents could not be imputed to the insurers in these circumstances.

9.84 The Blackburn Low litigation suggests that there is a distinction between an agent who is part of a chain for placing insurance, and an agent who is not part of a chain. Only the former is caught by section 19. If an agent is not involved in placing the insurance, there may be some circumstances in which that agent's knowledge is imputed to the principal, so that the principal is deemed to know it. Where this happens, the principal will be in breach of their own duty of disclosure under section 18 by failing to disclose it to the insurer. However, *Blackburn Low v Vigors* shows that knowledge may be imputed in this way only in limited circumstances.[50]

9.85 In 1995, the Court of Appeal re-examined the issue of who is an agent to insure, in *PCW Syndicates v PCW Reinsurers*.[51] This time two of three Court of Appeal judges took a narrower view of section 19, and held that only the final placing broker fell within the section:

[47] *Blackburn Low & Co v Haslam* (1888) LR 21 QBD 144 and *Blackburn Low & Co v Vigors* (1887) LR 12 App Cas 531.

[48] (1888) LR 21 QBD 144.

[49] (1887) LR 12 App Cas 531.

[50] In *Simner v New India Assurance* [1995] LRLR 240, it was suggested that the agent's knowledge would be imputed to the assured only where the assured relied on the agent for information or where the agent was in a predominant position. See also *ERC Frankona Reinsurance v American National Insurance* [2006] Lloyd's Rep IR 157.

[51] [1996] 1 WLR 1136. See the discussion in *ERC Frankona Reinsurance v American National Insurance Co* [2006] Lloyd's Rep IR 157.

> It seems to me, both from a reading of the words used in Section 19, and from an examination of the authorities upon which that Section was based, that the "agent to insure" only encompasses those who actually deal with the insurers concerned and make the contract in question.[52]

9.86 At first sight, this does not seem consistent with *Haslam*, where the information was known only to the Glasgow agents, who asked other brokers to place the re-insurance. Lord Justice Saville explained *Haslam* on the basis that placing brokers are deemed to know every circumstance which in the ordinary course of business ought to be communicated to them. Thus the Glasgow agents should have passed the rumours about the ship "down the line to the brokers who actually effected the cover". The placing brokers were deemed to know what the Glasgow agents knew.

9.87 From the current state of the authorities it appears that where there is a chain of intermediaries, section 19 imposes a duty only on the final placing broker who effects the cover.[53] However, placing brokers will be deemed to know everything which ought to be communicated to them.

9.88 The problem with this approach is that the issue of what ought to be communicated will depend on the arrangements between the different agents in the chain. Even if there is an implied term that agents should communicate between themselves, this must be subject to an express agreement to the contrary (which will not be known to the insurer). This means that the insurer's rights against the placing broker will depend on other agreements within the chain to which the insurer is not privy.

WHAT IS THE SCOPE OF THE DUTY UNDER SECTION 19?

9.89 The reference in section 19(a) to "every material circumstance" might suggest that materiality is the only restriction on the duty of disclosure of an agent to insure. An agent to insure would then be obliged to disclose material facts even if knowledge of those facts was gained when not acting in that capacity. This was the view taken by Hoffmann LJ (as he then was) in two cases, albeit that in each his comments were obiter. The first was *El Ajou v Dollar Land Holdings plc*, a company law case decided in 1993:

[52] Above, at p 1149.

[53] For criticisms of the position, see R Merkin, *Colinvaux's Law of Insurance (*8th ed 2006), at para 6-40.

> First, there are cases in which an agent is authorised to enter into a transaction in which his own knowledge is material. So for example, an insurance policy may be avoided on account of the broker's failure to disclose material facts within his knowledge, even though he did not obtain that knowledge in his capacity as agent for the insured. [54]

9.90 This was followed in 1994 by *Societe Anonyme d'Intermediaries Luxembourgeois v Farex G*:

> In particular, the agent's duty to disclose material circumstances known to him in any capacity, coupled with the generous rules which exist for the attribution of the knowledge of many individuals to a corporate agent, may entitle an insurer to repudiate in circumstances which are far from any ordinary understanding of lack of good faith.[55]

9.91 However, uncertainty remains and in *PCW Syndicates v PCW Reinsurers*, Staughton LJ suggested that the duty was restricted to information received as agent to insure:

> I do not find in the authorities any decision that an agent to insure is required by section 19 to disclose information which he has received otherwise than in the character of agent for the assured. [56]

Conclusion

9.92 In theory, it is possible to argue that section 19(a) applies to consumer cases. This means that if a retailer arranged product insurance for its customers, the insurer could invalidate the customers' policies on the basis of the retailer's knowledge. So, for example, if the retailer was aware that a particular brand of washing machine was prone to a particular fault, the insurer could avoid the policies it had written on those machines. This would come as a shock to the consumers who knew nothing about the faults and had paid premiums to be covered in just such an event. We are not aware that any insurer has attempted to take such a point and we doubt if it would be commercially feasible to do so. In Part 10 we propose the repeal of section 19(a) in consumer insurance.

9.93 There is a more open question about whether section 19(a) serves a useful purpose in the commercial field. If it is to be retained, there is a need to look again at the remedy, at its effect on chains of intermediaries and on its scope. We return to these questions in Part 10.

[54] [1994] BCC 143 at 156.

[55] [1994] CLC 1094 at 1111.

[56] [1996] 1 WLR 1136 at 1147.

CONSUMERS – THE CURRENT POSITION

Introduction

9.94 In this section we look at how the strict legal rights of the consumer are supplemented by regulatory measures. In January 2005, the UK implemented the Directive on Insurance Mediation[57] by bringing insurance intermediaries within the ambit of the Financial Services Authority (FSA). This has made it much easier for consumers to pursue disputes against intermediaries. Authorised intermediaries are now required to carry professional indemnity insurance;[58] to be within the Financial Services Compensation Scheme (FSCS); and to be members of the Financial Ombudsman Service (FOS). This means that where an intermediary has acted negligently or fraudulently in misrepresenting the policyholder's position to an insurer, the policyholder has access to an independent complaints system. And if the intermediary becomes insolvent, the policyholder may pursue a court judgment or ombudsman decision against either the professional indemnity insurer or the FSCS.

9.95 The problem, however, is that FSA regulation has done little to clarify against whom policyholders should bring their complaints. Although the FSA requires intermediaries to make various disclosures about their status, these were not designed to address the issue of whom the agent is acting for at any given time. We have found several cases in which consumers have pursued complaints against an insurer to a final ombudsman decision: at the end of long, involved proceedings, they have been told that they brought the complaint against the wrong organisation and need to start again at the beginning. This brings insurance law – and the insurance industry – into disrepute. It is unsatisfactory for the consumer, for the insurer, and for the FOS alike. There remains a need for greater clarity in this area.

9.96 We start by outlining the ambit of FSA regulation. We then discuss how the FSA rules do (or do not) clarify issues of agency; and consider the powers of the Financial Services Compensation Scheme. We then describe the powers and approach of the FOS and outline our findings from a sample of FOS cases.

[57] 2002/92/EC of 9 December 2002, OJ L 009, 15/01/2003 p 0003. The ICOB rules also implement the Distance Marketing Directive and other insurance directives. The Davidson Review points out that in some respects the UK has "over-implemented" some aspects of these directives. The scope is wider (for example, by including motor warranties) and includes more extensive disclosure requirements. Whereas the Directive only requires an intermediary to establish a basic complaints system, the FSA rules require intermediaries to be members of FOS (see Davidson Review on the Implementation of EU Legislation, *Final Report*, November 2006, pp 18-23 at http://www.cabinetoffice.gov.uk/regulation/reviewing_regulation/davidson_review).

[58] FSA Handbook, MIPRU 3.2.1.

9.97 As we indicated earlier, we are not aware of any consumer case in which an insurer has relied on section 19 of the 1906 Act. There are no relevant rules issued by the FSA, and no report of any case decided by the FOS. In this section we therefore consider purely the first two issues in which we are interested – the status of an intermediary for the purposes of disclosure, and the incorrect completion of a proposal form by an intermediary.

The ambit of FSA regulation

9.98 Since January 2005, insurance mediation has become a regulated activity within the ambit of the FSA.[59] The starting point is that businesses need to be authorised or exempt if (for example) they complete proposal forms and send them to insurers,[60] or if they help policyholders fill in application forms.[61] Similarly, a business must be authorised or exempt if it recommends that a prospective policyholder does or does not buy a specific product.[62]

Exemptions

9.99 If a business merely provides information or introduces the applicant to another provider the position is complicated. Some forms of information provision may fall outside the regime altogether. For example, the mere passive display of advertising leaflets in reception would not be caught,[63] and there are special exemptions for journalism.[64] Similarly FSA regulation does not extend to one-off introductions that are not part of an on-going arrangement, or to introductions to people offering independent advice where the introducer has no stake in the outcome.[65]

9.100 However, there is a spread of activities between the mere display of literature, and helping prospective policyholders to fill in forms. This might include giving advice about the sort of cover which may be required, explaining the terms of the policy, or giving consumers information about how to fill in forms.

[59] The ambit of FSA regulation is set out in the Financial Services and Markets Act 2000 (Regulated Activities) Order 2001 (SI No 544), as amended (referred to below as the Regulated Activities Order).

[60] Regulated Activities Order, art 25(1), as interpreted by the FSA in their Perimeter Guidance, PERG 5.6.1.

[61] Regulated Activities Order, art 25(2), as interpreted in PERG 5.6.4.

[62] Regulated Activities Order, art 53, as interpreted in PERG 5.8.5.

[63] As above. PERG 5.6.4 specifically states that "a mere passive display of literature advertising insurance (for example, leaving leaflets advertising insurance in a dentist's or vet's waiting room and doing no more) would not amount to the article 25(2) activity".

[64] Regulated Activities Order, art 54.

[65] See PERG 5.6.18.

9.101 For these types of activity, there is a limited exemption for professions or businesses who only provide such information or introduction incidentally to their main business.[66] In the FSA's view, the insurance aspect must be complementary to the main business.[67] For example, the exemption covers a dentist who introduces dental insurance, or a vet who introduces pet insurance. However, if a vet were to introduce dental insurance, this would not be complementary and would therefore require authorisation or exemption.

9.102 A much more extensive exemption applies to travel agents and tour operators who arrange travel insurance and to retailers who arrange product insurance for "non-motor" goods.[68] The insurance must be complementary to the goods, such as a mobile phone shop that arranged mobile phone insurance. The rationale behind this exemption is that it is limited to insurance that is relatively cheap and simple. The premium must not exceed 500 euros,[69] and the policy must not last longer than 5 years.[70] Furthermore it must be

> of such a nature that the only information that [the agent] requires… is the cover provided by the contract.[71]

9.103 Where travel agents, tour operators[72] and product retailers fall within their exemption, they may arrange insurance, fill in forms and advise on insurance contracts without any form of FSA regulation. The Treasury recognised that there were concerns about this, and promised to review the exemption two years after implementation. The Treasury has called for evidence on the subject.[73]

The effect

9.104 The effect of these provisions is that most intermediaries who misadvise consumers about their disclosure requirements or who wrongly fill in proposal forms will be within the scope of FSA regulation. For most UK organisations, they must either be authorised in their own right, or must be appointed representatives of other authorised bodies.

[66] Regulated Activities Order, art 72C.

[67] See PERG 5.6.7.

[68] Regulated Activities Order, art 72B.

[69] Above, at art 72B(1)(c).

[70] Above, at art 72B(1)(b).

[71] Above, at art 72B(1)(g).

[72] Technically, the exemption applies to insurance covering travel risks linked to travel booked with the provider. This means it may extend more widely than just travel agents and tour operators, and include airlines, ferries, holiday villa rental companies, hotels and car hire companies selling risks of loss to baggage.

[73] HM Treasury, *Travel Insurance Review: Call for Evidence*, November 2006. On 26 June 2007, as this report was going to press, the Treasury announced that the sale of travel insurance alongside a holiday would be regulated by the FSA: see http://www.hm-treasury.gov.uk/newsroom_and_speeches/press/2007/press_71_07.cfm.

9.105 If the intermediary is authorised, a consumer or small business is able to pursue a complaint against them to the FOS. If the intermediary becomes insolvent, the consumer or small business may enforce the court or FOS award either against the intermediary's insurer or against the Financial Services Compensation Scheme (discussed below). If the intermediary is an appointed representative, the policyholder may pursue a claim or complaint against the representative's principal.[74]

9.106 Not all intermediaries will be covered, as some will fall within the exemptions. The most extensive exemption is for travel operators arranging travel insurance and for product retailers arranging product insurance. If, for example, a small travel agent mis-sells travel insurance, a consumer will not be able to complain against them to the FOS. However, travel or product insurance rarely involves lengthy proposal forms: in our survey of FOS cases involving misrepresentation and non-disclosure issues, only 3% concerned travel insurance. Travel insurance is much more likely to lead to disputes about exclusions in the policy terms,[75] but that raises other issues. We are not aware of any cases where consumers have been unable to bring complaints against travel agents or product retailers who have filled in proposal forms incorrectly.

9.107 Professions or businesses that give incidental information about insurance products are not meant to fill in forms or give advice about how to fill in forms. It is always possible that some will overstep the mark, and give advice that they are not meant to give. Where a vet exceeds their authority and mis-advises a consumer about how to fill in a form about pet insurance, the consumer would have no recourse to the FOS. However, we are not aware that this is a problem in practice.

FSA requirements

9.108 The FSA Rules require agents to disclose certain matters to their customers before concluding an initial insurance contract with them. The matters which must be disclosed include:

(1) whether the firm is authorised and regulated by the FSA, or whether it is an appointed agent for another principal which is authorised and regulated by the FSA;

(2) details of any holding in the insurer, if this constitutes more than 10% of the voting rights or capital of the insurer; and

[74] Under section 39(3) of the Financial Services and Markets Act, "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".

[75] In our survey of 50 FOS cases involving disputes about policy terms, 14 (28%) involved travel insurance – the largest category in the survey: see Issues Paper 2, Warranties, Appendix B.

(3) whether the firm has or will provide advice or information

(a) on the basis of a fair analysis of the market; or

(b) from a limited number of insurers; or

(c) from a single insurer.[76]

9.109 The intermediary must also inform its clients if it holds money on behalf of the insurer. The relevant rule states that:

> Where a firm holds, or is to hold, money as agent for an insurance undertaking it must ensure that it informs those of its clients which are not insurance undertakings and whose transactions may be affected by the arrangement (whether in its terms of business, client agreements or otherwise in writing) that it will hold their money as agent of the insurance undertaking and if necessary the extent of such agency and whether it includes all items of client money or is restricted, for example, to the receipt of premiums.[77]

9.110 As we discussed above, some of these issues may be relevant to whether the intermediary acts for the insured or for the insurer for disclosure purposes.[78] If an intermediary provides advice to the insured on the basis of a fair analysis of the market, they are likely to act for the insured. If, however, they act as the insurer's appointed representative they will typically be the insurer's agent. But the information disclosed will often not determine the issue. As we have seen, it is unclear whether those who sell from a single insurer will be regarded as the insurer's agents if they do not actively solicit business for the insurer. The position of those selling from a limited number of insurers is also uncertain. Furthermore, the fact that the intermediary holds money on behalf of the insurer may be some evidence of an agency agreement between them, but would not be determinative. FSA regulation does not require intermediaries to say for whom they act.

9.111 Under ICOB 4.3.2 an intermediary is required to explain the potential impact of non-disclosure, but again there is no specific mention of the agency issue.

9.112 The FSA Rules do not address the situation where an intermediary incorrectly completes a proposal form. Thus the rule in *Newsholme* is left unchanged.

[76] FSA Handbook, ICOB 4.2.8R(6).

[77] FSA Handbook, CASS 5.2.3(3).

[78] See para 9.22.

9.113 However, the FSA Rules do require that intermediaries carry professional indemnity insurance.[79] This provides some protection for both consumers and businesses that an intermediary will be able to meet any claims brought against them.

The Financial Services Compensation Scheme (FSCS)

9.114 This is a long-stop protection for consumers and small businesses. A consumer or small business may obtain a decision from a court or the FOS against the intermediary, but then find it unenforceable because the intermediary is insolvent. In such circumstances, the matter may be referred to the FSCS. If the FSCS finds that an intermediary is unable to meet its liabilities it may be declared "in default". At this point, the FSCS may consider claims for compensation.

9.115 Claims are considered in accordance with the Compensation Sourcebook part of the FSA Handbook. There are financial limits on compensation, which reflect the limits applicable under predecessor schemes. For investment insurance claims, an eligible investor could receive up to £48,000 towards any loss. This figure comprises 100% of the loss up to £30,000, and 90% of the loss thereafter to a limit of £50,000. For non-investment insurances, there is a distinction between compulsory insurances, such as motor insurance, and non-compulsory insurances such as household insurance. Claims in respect of compulsory insurances are met in full, whereas claims in respect of non-compulsory insurances are paid in full for the first £2,000 but are limited to 90% of any loss above this figure.

The Financial Ombudsman Service (FOS)

Powers

9.116 Since 2005, the Financial Ombudsman Service has been able to investigate complaints brought against insurance intermediaries as well as against insurers. If accepted by the complainant, an ombudsman's decision is binding on the regulated firm to a maximum cash limit of £100,000. An ombudsman is obliged to make decisions based not solely on law but on what is "fair and reasonable in all the circumstances of the case".[80]

Agency cases

9.117 We were interested to establish what line the FOS takes on the agency issues we are considering. In theory, for example, it would be possible for an ombudsman to take the view that an insurer should, in some circumstances, be liable for the acts or omissions of an independent intermediary. Such a decision could be based on what the ombudsman considered fair and reasonable, rather than on the law.

[79] FSA Handbook, MIPRU 3.2.1.

[80] Financial Services and Markets Act 2000, s 228(2).

9.118 This was the view taken by a predecessor to the FOS, the Insurance Ombudsman Bureau. In 1989 the then Insurance Ombudsman, Dr Julian Farrand, indicated that he would "in appropriate cases" hold an insurer liable for the acts of an independent intermediary. Subsequently he expressed the view in IOB News (an internal publication) that signed forms should not always be regarded as conclusive. To find out how far the FOS took a similar approach, we looked at a selection of their decisions on the issue.

Research at the FOS

9.119 For the first paper on misrepresentation, the FOS very helpfully provided us with access to a sample of final ombudsman decisions on the issue, including 190 consumer cases and 12 from small businesses. As we have seen, issues of agency arose in 25 of the consumer cases (13%) and in 8 small business cases (66%). The FOS then provided us with a further sample of decisions, selected specifically because agency issues had been raised. We are very grateful for the help they have given us.

WHOSE AGENT?

9.120 As far as independent intermediaries are concerned, the FOS appears to follow the legal position. Independent intermediaries who search the whole market will normally be regarded as the insured's agent. If they misadvise a client in such a way that the client misrepresents their position to the insurer, the insurer will normally be able to avoid the policy. The client will then be left to bring a separate complaint against the intermediary.

9.121 In a typical case we saw, the policyholder had effected a life and critical illness policy through an independent financial adviser. A subsequent claim for breast cancer was declined on the ground that in her answers on the application form she had failed to disclose that she had been treated for depression and a sore throat. The policyholder complained about the insurer to the FOS, stating amongst other points that the adviser had been aware of these conditions. This latter point was addressed briefly by the ombudsman in the final decision:

> With regard to the complainant's allegation that the advisor completed the application form on her behalf and was aware of her conditions, I would reiterate my adjudicator's observation that the adviser was an Independent Financial Adviser, rather than agent or representative for whom the firm was vicariously liable.

9.122 This type of point appears to be raised regularly. It is, we suspect, symptomatic of the lack of understanding that exists among insureds regarding the role of an independent intermediary for disclosure purposes. Complainants are rarely legally advised, and are unlikely to understand the law of agency as it applies to insurance intermediaries.

9.123 The complainant has the right to raise a new complaint against the adviser rather than the insurer. Now that the FOS jurisdiction has been extended, the harshness of the rule has been reduced.[81] However, the complainant will need to return to the very start of the complaints process and contact the adviser. This does not make redress easy or accessible. In the case to which we refer above, this was the advice given to the complainant by the ombudsman:

> If the complainant feels that the adviser negligently completed the application on her behalf…, or failed to record material information, then she must complain to the financial adviser.

9.124 Although FOS procedures are outside the scope of our current review, we would hope that more could be done to assist consumers to bring complaints against the correct organisation, if necessary considering complaints in tandem where the status of an agent is disputed.

9.125 The position with agents offering the products of a single insurer is more complex. The FOS told us that they will often consider such agents to be acting as the insurer's agents in completing the form, and that insurers will on occasion agree with this analysis. This appeared to be borne out by the cases we saw. Often insurers were prepared to take responsibility for the intermediary's actions, but without disclosing the full nature of their agency agreement with them.[82] This makes it difficult to be specific about the exact nature of the relationships involved.

COMPLETION OF PROPOSAL FORMS

9.126 Perhaps the most interesting findings in our survey relate to the manner in which the FOS tackles cases where the policyholder signed a proposal form that had been completed by an intermediary and which contained incorrect or incomplete information.

9.127 Where it considers it appropriate the FOS will treat the policyholder as liable for errors in a signed form. For example, we reviewed a case where an independent financial adviser had completed the proposal form. In a complaint against the adviser, it was alleged by the policyholder that medical information he had disclosed had been omitted. The ombudsman rejected the complaint as unproven:

[81] The most notable change being the extension of the scheme to cover general insurance intermediaries with effect from 15 January 2005.

[82] We did not see any cases in which the insurer had provided copies of their agency agreement with the intermediary. We have been told that these agreements are commercially sensitive, and that insurers would not disclose them lightly.

> Unfortunately, the firm has contemporaneous documentary evidence in the form of a signed declaration from you in which you state that the answers recorded were true and complete to the best of your knowledge and belief. Moreover, you confirmed that you had read and understood the application. That declaration also specifically states the following:
>
> > If this application form has been filled in by someone else on your behalf you must read all of the answers to the questions on the form carefully before signing this declaration.

9.128 However, it is clear that in many cases the FOS will not regard signed forms as conclusive. Furthermore, where tied agents were involved we did not find any specific mention of *Newsholme* and there was evidence that the FOS regularly departs from that decision.

9.129 For example, one case in our survey involved a life and critical illness policy effected jointly by a husband and wife. When the wife died, a claim was made. The insurer avoided the policy on the ground of misrepresentation and rejected the claim. One of the questions in the application form required disclosure of any visit to a doctor. The answer given did not include details of various medical appointments made by the wife. Although the form was completed by the insurer's tied agent, it had been signed by both the husband and the wife.

9.130 In an initial assessment, an adjudicator at the FOS supported the insurer. However the husband appealed to an ombudsman. The ombudsman pointed out that the tied agent had made other mistakes in completing the form and concluded that some of the questions simply had not been put to the couple:

> In view of the large number of what would seem obvious errors on the application form and the fact that several questions which appear to require a "yes" or "no" answer where either "N/A" or no answer is shown, I consider it most likely that [the tied agent] did fail to ask all the questions...and that this resulted in the complainant's late wife's failure to disclose her investigations.

9.131 Under *Newsholme* such errors would have been made when the intermediary switched from being a tied agent to being the agent of the applicants for the completion of the form. Nevertheless, the ombudsman found grounds for deciding against the insurer:

> I accept that the complainant and his late wife should have read the application form before signing it, but consider it most likely that they did not do so because [the tied agent] did not make the importance of this clear to them.

9.132 The reasoning appears to be that there is a duty on an insurer's agent to explain the importance of thoroughly checking the form.

9.133 We were also interested to note the following case where the ombudsman was given the full tape of a telephone interview in which a sales representative took a consumer through the health questions in a critical illness application.

Case study: signing a form with mistakes

Mr and Mrs B had applied for cover jointly. Mrs B telephoned a call centre, where a member of staff took her through the questions; the representative then printed out a copy of her replies, which both Mr and Mrs B signed. One of the questions asked was whether either policyholder had ever suffered from stress, anxiety or depression or required tranquillisers or anti-depressants. They both answered "no". In fact, Mr B had been prescribed anti-depressants for 10 months in the previous two years.

The tape showed how the questions had been asked. The representative had started by explaining that people no longer need to fill in large forms: "we've got rid of all that side of it" and "we can actually do everything over the phone these days". For the first question she asked if "either of you" had suffered from heart attacks or cancer, but after that she stopped referring to "either of you" and asked Mrs B only about herself. Crucially, for the question about anti-depresssants she asked "have *you* ever taken tranquillisers or anti-depressants?". At the end she finished by saying "there'll be two forms, we just need a signature from both of you on each and popped back in the envelope". She said nothing about checking through the form, or reading it carefully.

In light of this evidence, the ombudsman ordered the insurer to apply a proportionate remedy.

9.134 This case illustrates how insurance firms may be caught between reassuring consumers that applying for insurance is a straightforward, easy process and the need to warn them about their duty of care to ensure that all answers are accurate. The sales and the underwriting sections of an insurance company may have different priorities in this area.

CONCLUSIONS FROM OUR FOS RESEARCH

9.135 It seems that a consumer who takes an "intermediary" case to the FOS may have a better chance of recovering from the insurer than under the strict law. However, it is not clear when the mistakes of the intermediary will, in effect, be imputed to the insurer rather than to the insured; and some decisions at least still apply the *Newsholme* doctrine. The courts have failed to reach consistent decisions where an insured blames the agent for mistakes in the form. On the one hand, contracting parties rely on the certainty of a signature, and people must usually be taken to mean what they sign. On the other hand, the reality is that consumers often sign forms that they do not understand or have not read, relying on agents to explain and clarify the questions. The same tensions can be seen within ombudsman decisions.

9.136 We think there is a need to clarify how both ombudsmen and the courts should approach cases in which the policyholder has signed a form containing a misrepresentation but then adduces oral evidence about the context in which that misrepresentation was made. In Part 10 we outline how we think this issue should be approached under the new regime proposed in Parts 4 and 5.

PART 10
PRE-CONTRACT INFORMATION AND INTERMEDIARIES: PROPOSALS FOR REFORM

10.1 In this Part we consider reforms to address the problems that arise where an intermediary has given poor advice about completing a proposal form or has failed to pass accurate information to an insurer. We consider consumer insurance first, followed by business insurance.

CONSUMERS

10.2 We start by discussing what is at stake in issues concerning the intermediary's status. We then outline the possible justifications for making insurers responsible for their agents. We think there is a need to clarify the law in this area, but not to the extent that the Law Reform Committee (LRC) recommended in 1957. We provisionally propose a more limited reform, namely that an intermediary dealing with a consumer should be regarded as acting for an insurer for the purposes of obtaining pre-contract information, unless it is genuinely searching the market on the insured's behalf.

10.3 We then consider whether to overturn the rule in *Newsholme,* that an insured is liable for any errors on a signed proposal introduced by an agent. We provisionally propose that where an agent would otherwise be considered the insurer's agent, they should remain the insurer's agent for the purpose of completing a proposal form.

10.4 Finally we consider the effect of section 19 of the 1906 Act.

What is at stake?

Who should pursue the claim against the intermediary?

10.5 In many cases the question is not whether the consumer should have a remedy. If the intermediary is at fault, the consumer will normally have a remedy against the intermediary for professional negligence. The question is whether the consumer should be obliged to pursue that remedy, or whether the insurer should have to pay the claim and pursue their own remedy against the intermediary.

The effect of an intermediary's status

10.6 In Part 4 we made proposals for reforming the law where a consumer has given an inaccurate or incomplete answer to the insurer's questions. We think it would be helpful to set out how we see the issue of the intermediary's status as interacting with these proposals:

(1) If an independent intermediary is acting for the insured then the insured bears responsibility for the fraud or negligence committed by their agent. This means that:

(a) *If the intermediary acts deliberately or recklessly* in giving bad advice or failing to pass on accurate information, the insurer may avoid the policy. This is true even if the consumer was wholly innocent. The consumer must pursue a remedy against the intermediary.

(b) *If the intermediary is negligent (and the consumer is not),* the insurer has a proportionate remedy. The complainant must pursue the intermediary for their remaining loss.

(c) *If both the intermediary and the consumer are negligent*, the insurer has a proportionate remedy. The consumer may pursue the intermediary for loss, but this would be subject to a defence of contributory negligence.

(d) *If both the intermediary and consumer took reasonable care*, the insurer must pay the claim.

(2) If the intermediary is the agent of the insurer (for example, where the intermediary has authority to bind the insurer or where the agent is the insurer's appointed representative), the intermediary's actions are considered to be the insurer's actions. This means that:

(a) *If the intermediary acts deliberately or recklessly (and the consumer does not),* the insurer must pay the claim.

(b) *If the intermediary is negligent (and the consumer is not),* the insurer must pay the claim.

(c) *If both the intermediary and the consumer are negligent*, the insurer has a proportionate remedy against the consumer on the grounds of their own negligence.

(d) *If both the intermediary and consumer took reasonable care*, the insurer must pay the claim.

Justifications for transferring the risk

10.7 In general terms, we see four possible justifications for treating the intermediary as agent of the insurer in a broader range of cases than at present. The justifications differ in their implications. Some suggest that the insurer should be made responsible for a wider range of intermediaries; others suggest a narrower range.

Deep pockets

10.8 In the past it may have seemed sensible to make the insurer accept responsibility for the intermediary simply because the intermediary was likely to be without substantial means. Now that intermediaries are required to carry professional indemnity insurance and to be members of the Financial Services Compensation Scheme (FSCS), we no longer see any merit in this "deep pocket" argument.

10.9 Some intermediaries fall outside the scope of Financial Services Authority (FSA) regulation. This means that if the intermediary fails in its duties to the consumer, the consumer cannot bring a complaint against them to the Financial Ombudsman Service (FOS); and if the intermediary becomes insolvent there is no right to compensation from the FSCS. As we explained in Part 9, travel operators arranging travel insurance and product retailers arranging product insurance are exempted from regulation in this way. Furthermore, other professions or businesses may give incidental information about complementary insurance products: they are not meant to give advice about completing forms, but they might overstep the mark. If they do so, the consumer has no right to complain to the FOS or to be compensated by the FSCS. However (as we explain below) we are not aware that these gaps in protection cause problems in practice. We do not think they require special measures.

Ease of enforcement

10.10 It is easier for the insured to claim on the policy than to bring an action for negligence against the intermediary. Inevitably there are delays in pursuing a complaint against an intermediary, even through the FOS. There will be further delays if the intermediary cannot pay and a claim has to be made under the FSCS. Even if a claim against an intermediary is ultimately successful, the consumer may have been left without funds at a time when they were most needed. If the insurer were to be responsible for paying the insured and recouping damages from the intermediary, the consumer would be paid more quickly.

10.11 It would also prevent the consumer who brings a claim against the insurer on the assumption that the insurer is responsible from having to "start all over again". That however could be avoided by procedural changes within FOS. It may, for example, be possible to introduce a system whereby a joint complaint could be made against both the insurer and the intermediary.

10.12 We do not think that ease of enforcement alone justifies changing the law.

Reasonable expectations

10.13 We have already said that there appears to be a common understanding among some consumers that certain intermediaries are representatives of the insurer even though as a matter of law that is not the case. To most consumer insureds, the intermediary may well be seen as much a "part of the industry" as the insurer itself, and they will not understand that in law the intermediary acts for them and not the insurer. It is not surprising that such an insured thinks it suffices to give the relevant information to the intermediary or to follow their advice about how to answer questions. This point was put to us forcibly by the FOS:

> The applicant for insurance is frequently unaware that the insurance intermediary is acting as their agent in respect of this part of the overall process of applying for and receiving insurance cover. Indeed, it appears from the experience of the Financial Ombudsman Service that most consumers applying for insurance cover believe that the intermediary is acting as the seller of the insurance policy (and they do not consider whether they act on behalf of the insurance company or on their own account). The exception is where the intermediary is expressly offering a service that reviews insurers and offers the cheapest or most suitable policy.[1]

10.14 The FOS points out that where the intermediary has a tied arrangement with the insurer, has control over the policy terms and retains a large proportion of the income, the consumer may reasonably see the intermediary as "acting on the other side of the transaction".

10.15 Much of our joint review is about bringing the law into line with the reasonable expectations of insureds. Where insurer and intermediary are, in the eyes of the reasonable insured, closely linked, it seems reasonable to place the risk of mistakes by the intermediary on the insurer.

10.16 There are two possible approaches to this issue. One is to distinguish between different types of intermediary. The other is to require clarificatory statements by the intermediary.

DISTINGUISHING BETWEEN TYPES OF INTERMEDIARY

10.17 There are some circumstances where a well-informed consumer is less likely to get the general impression that an intermediary is part of the insurer's organisation, rather than acting for them. This occurs if the intermediary is not limited in the policies it offers and therefore, in accordance with FSA requirements, has indicated that its recommendation is based on a fair analysis of the market. That seems to us to suggest that the intermediary is working for the customer, not for the insurer. In contrast, where the intermediary can only offer products from one particular insurer, we think there is a sufficient risk that the customer will think of the intermediary as working for that insurer to justify treating them as the insurer's agent. We think the same applies when the intermediary can only offer products from a limited number of insurers.

CLARIFICATORY STATEMENTS

10.18 The alternative approach is to treat the intermediary as the agent of the insurer unless steps have been taken to make it clear that this is not the case. This would suggest that the intermediary would be treated as the insured's agent provided that it had issued clear warnings to this effect. The warnings would need to state that (1) any doubts over what is material must be resolved with the insurer and (2) that the insured must check that each and every material fact is actually communicated to the insurer, not just to the intermediary.

[1] Response by Peter Hinchliffe sent on 22 January 2007.

10.19 We think this is a less attractive approach for three reasons. First, we share the FSA's hesitations about the effectiveness of warning notices. The more warnings that are required, the less effective each becomes. The Davidson Review has argued strongly that the disclosure obligations on intermediaries should be reduced, not extended.[2] Secondly, we think that having to give customers a warning of this kind would hurt the reputation of intermediaries. There is a risk that consumers would infer that intermediaries are less than competent. Thirdly, the obligations of the insurer would depend on what was or was not done by the intermediary in the particular case. The insurer may be liable for an intermediary's actions without realising that it would be.

Market discipline

10.20 A final justification for imposing the risk of mistakes by the intermediary on the insurer is that this is more likely than the current law to provide proper market discipline. Put bluntly, intermediaries should be strongly encouraged not to make mistakes, and those who regularly do so should not remain in business. However, individual consumer insureds will deal with intermediaries only rarely, and are in a poor position to influence or monitor the intermediary's business practices. Insurers, on the other hand, have many opportunities to monitor and influence intermediaries. The intermediary is, after all, remunerated by commission from the insurer. In 1981, insurers recognised this by voluntarily agreeing to use their best endeavours to ensure that intermediaries complied with the provisions of a code of practice.[3]

PERVERSE INCENTIVES

10.21 A problem with the current law is that it may not do enough to encourage insurers to control the actions of those selling its products.

10.22 Under the current law, where an intermediary is taken to act for the insured, the intermediary's fault is imputed to the insured. Where insurance is sold through a fraudulent intermediary, the insurer may therefore avoid the policy. This means that the insurer is insulated from the economic effects of the intermediary's actions. In the box below, we use hypothetical figures to illustrate this.

[2] Davidson Review on the Implementation of EU Legislation, *Final Report*, November 2006, at http://www.cabinetoffice.gov.uk/regulation/reviewing_regulation/davidson_review.

[3] See ABI General Insurance Business Code of Practice, withdrawn January 2005.

The fraudulent intermediary: an example

An insurer writes critical illness policies, from which it anticipates one claim for every 100 policies. The average premium during the lifetime of the policy is £1,000, of which £500 is used for underwriting costs.[4] The average payment where a claim is made is £50,000.

One intermediary on the panel is fraudulent. To gain the maximum commission, he routinely tells his clients to lie about their health, so that their applications will be accepted without delay.

He tells 100 clients to lie about their health, and deliberately suppresses their various ailments. These misrepresentations mean that the risk has doubled: this group produces not one claim but two claims. Clearly, if the insurer were not granted a remedy, it would have to pay £100,000 in claims (instead of £50,000), leading to a loss of £50,000.

If the intermediary is taken to act for the insured, the insurer is entitled to avoid both policies. For these 100 clients, it pays no claims at all. It simply returns two premiums. It has received £100,000 in premiums, of which £50,000 was intended to cover claims, and has returned £2,000. Compared with "normal" cases submitted through honest intermediaries, the insurer retains £48,000.

10.23 Insurers' reputations suffer when their intermediaries are fraudulent, so we do not think that an insurer would ever condone such behaviour. However, the perverse incentives contained within the current rules may not encourage insurers to take action as swiftly and as firmly as they might do otherwise.

WHICH INTERMEDIARIES ARE INSURERS BEST ABLE TO CONTROL?

10.24 This might suggest that any intermediary who is remunerated by commission from the insurer should be the insurer's responsibility. We do not go so far, however. Insurers are best placed to control the actions of those with whom they have a close relationship, and who provide them with large volumes of business.[5] We think the case for making insurers responsible for the actions of their intermediaries is strongest where the intermediaries belong to panels set up by the insurer.

[4] The other £500 covers sales commission, administration costs etc. On the basis of underwriting costs alone, the policy breaks even.

[5] Where the volumes are large enough, insurers can carry out statistical checks to make sure that their policyholders are not suspiciously healthy, compared with the general population.

10.25 Insurers may find it more difficult to control small firms, or those who genuinely search the market and put only a small percentage of business their way. If insurers were made responsible for the actions of all intermediaries, the reform could have a deleterious effect on small, independent brokers. Insurers, we suspect, would find it hard to police lots of small independent intermediaries adequately and would want only to deal with larger firms. This would distort the market in an undesirable way, since it would drive small intermediaries out of business even if their standards were irreproachable.

Clarifying the agent's role: our proposals

10.26 We agree with the FOS that there is a need to clarify for whom an intermediary is acting in receiving pre-contract information. We do not think there is a case for making insurers responsible for their agents simply because they have deep pockets, or because it would make it quicker and easier for consumers to be paid. However, the law should, as far as possible, meet the reasonable expectations of consumers. It should also give an incentive to control intermediaries' mistakes to the party best placed to exercise that control.

10.27 We do not go as far as the recommendation made by the LRC in 1957, namely that all intermediaries who receive commission from the insurer should be regarded as the insurer's agents. We think this might disadvantage small independent intermediaries, who might find that insurers are no longer prepared to deal with them. However, there is a real need to clarify the law in this area.

10.28 Our provisional proposal is that the intermediary should be regarded as the insurer's agent for the purposes of obtaining pre-contract information, unless the intermediary is genuinely searching the market on the insured's behalf. This means that single tied agents and multi-tied agents will be taken to act for the insurer. Similarly, aggregators may also be considered as acting for the insurer if they only offer access to a limited panel of insurers. If the insurer's own agents act fraudulently or negligently, the insurer will have to bring an action against the agent, rather than seek a remedy against the innocent insured.

10.29 **In consumer insurance, we provisionally propose that an intermediary should be regarded as acting for an insurer for the purposes of obtaining pre-contract information, unless it is clearly an independent intermediary acting on the insured's behalf.**

10.30 It has been put to us that it is difficult to define concepts such as "multi-ties" and "searching the market". Under the Insurance Mediation Directive, an intermediary must tell a customer whether their advice is based on "a fair analysis",[6] a concept defined in the following terms:

[6] Directive 2002/92/EC, art 12.1(i).

> When the insurance intermediary informs the customer that he gives his advice on the basis of a fair analysis, he is obliged to give that advice on the basis of an analysis of a sufficiently large number of insurance contracts available on the market, to enable him to make a recommendation, in accordance with professional criteria, regarding which insurance contract would be adequate to meet the customer's needs.

10.31 We would welcome views on whether the same test should be used for the purposes of distinguishing between insurer's agents and insured's agents. In other words, should only those intermediaries conducting a fair analysis of the market be treated as the consumer's agent? The advantage of aligning the tests in this way is that it is simpler: the distinction already exists (albeit for other purposes) and customers must be told whether the intermediary is providing a fair analysis. On the other hand, it has been pointed out that offering independent advice is not the same as ensuring a proposal form is filled in correctly. An intermediary may offer independent advice but then become the insurer's agent for the purposes of binding the insurer to cover. Alternatively, an intermediary may act for a consumer in completing a form without necessarily offering advice on which product to buy.

10.32 **We ask if the test for whether an intermediary is independent and acts as the consumer's agent should depend on whether the intermediary searches the market and conducts "a fair analysis", as defined by the Insurance Mediation Directive.**

10.33 As discussed above, we have considered whether special protection is needed for those dealing with intermediaries who are exempt from FSA regulation, such as travel agents selling travel insurance,[7] product retailers selling product insurance or businesses wrongly giving advice about incidental products. Our current view is that no additional protection is required. The issue does not appear to cause problems in practice, as (for example) it is rare for travel insurance to be avoided for non-disclosure or misrepresentation. Furthermore, product retailers and travel agents rarely carry out a fair analysis of the market, so they will usually be considered as agents for the insurer in any event. However, we would welcome views on this.

10.34 **We ask whether any additional protection is necessary when consumers have been given bad advice about completing proposal forms by intermediaries who are not subject to FSA regulation?**

[7] On 26 June 2007, as this report was going to press, the Treasury announced that the sale of travel insurance alongside a holiday would be regulated by the FSA: see http://www.hm-treasury.gov.uk/newsroom_and_speeches/press/2007/press_71_07.cfm.

Completion of proposal forms: the *Newsholme* rule

10.35 As we explained in Part 9, even if an intermediary acts for all other purposes as the agent of the insurer, if it completes a proposal form it may do so as agent of the consumer. A problem arises if the intermediary introduces errors into the form. Should a consumer sign a proposal form that has been incorrectly completed, it may lead to the policy being avoided and any claim being rejected. The *Newsholme* case contained two strands of reasoning: that there was a "transferred agency" and that insureds should be bound by their signature.[8]

Abolishing the "transferred agency" rule

10.36 The *Newsholme* case appeared to suggest that even if an intermediary was otherwise an agent of the insurer, it should be considered to be an agent of the insured for the purposes of completing a form. We do not think this can be right. Insurance intermediaries routinely complete forms on behalf of consumers, and both consumers and insurers expect them to do so. Even if an insurer's agent does not have explicit authority to fill in a form, he or she will have apparent authority to do so. As far as the consumer is concerned, the agent will be acting for the insurer in completing a normal part of the sales process.

10.37 We think it would be helpful to clarify the law in this area. We propose that an intermediary who would otherwise be regarded as acting for the insurer in obtaining pre-contract information remains the insurer's agent while completing a proposal form. This would be true unless both the insured and the intermediary are parties to a fraud together. If the intermediary is fraudulent but the insured is not, we think the insurer should bear liability for the fraud of their own agent (and if only the insured is fraudulent, the issue of the intermediary's status does not arise).

10.38 **We provisionally propose that an intermediary who would normally be regarded as acting for the insurer in obtaining pre-contract information should remain the insurer's agent while completing a proposal form.**

The proposer's signature

10.39 In *Newsholme*, the proposers signed a basis of the contract clause in which they warranted the truth of every statement made. In Part 4, we proposed abolishing basis of the contract clauses. Insurers would no longer be able to require consumers to sign warranties, holding themselves to the absolute truth of every statement made. Instead the court or ombudsman would need to focus on the consumer's state of mind: was the misrepresentation made deliberately or recklessly, negligently or innocently? We have been asked to clarify what effect a policyholder's signature would have on this decision.[9]

[8] *Newsholme Brothers v Road Transport and General Insurance Co Ltd* [1929] 2 KB 356. See Part 9, above.

[9] Our third issues paper on Intermediaries and Pre-contract Information was criticised on the grounds that it would "dilute the sanctity of the signature": see http://business.timesonline.co.uk/tol/business/law/columnists/edward_fennell/article1569739.ece.

10.40 The issue here is slightly different from the case in which the consumer honestly believed what they said to be true. In the *Newsholme* situation, the consumer usually accepts that what was written on the form is incorrect; the point is that they did not realise that it was on the form at all. However, we think the same approach should apply. If the consumer acted only negligently, or even without negligence, the insurer's remedies should be limited appropriately. Thus the proposer's signature should no longer be treated as conclusive evidence that the consumer knew or adopted the statements on the form filled out by the intermediary.

10.41 However, the policyholder's signature should provide strong evidence that they made or adopted the representations on the form. Further, in considering whether the consumer has been negligent, we would expect the court or ombudsman to take heed of any warnings on the form. Suppose, for example, the consumer had signed a declaration stating that they understood the need to check the form carefully and that they had done so, but it later emerged that they had signed the form without reading it. This would suggest negligence. In *O'Connor v Kirby* the Court of Appeal held that the insured was negligent in failing to check the form.[10] The insured applied for car insurance through an independent intermediary, who made a mistake filling in the form. The intermediary then handed him the form and asked him to check through it. The insured did this rapidly and failed to notice the mistake. The court found that the insured had been negligent in failing to check the form and had caused the loss.

10.42 However, there may be contrary evidence. Suppose that the insurer's representative had told the consumer that the form contained precisely the (correct) information the proposer had given and that the proposer did not need to read it. The intermediary may even have presented the form to the proposer in such a way that they did not see the written warning. In such a case we do not think the signature should be taken to be conclusive evidence of negligence. We all regularly sign documents that we have not read carefully; but most of us think that in our private lives this is excusable when the other party knows "what we meant" or "what the true position is". When coupled with a general impression that the intermediary represents the insurer, the failure to check may be excusable.

10.43 The policyholder may also claim that the answers were incorrect because the intermediary had given them misleading advice as to how to answer. In this case the proposer knows what is written on the form, and claims he was misled into making that statement. The signed declaration does not address the issue at stake. Nor would a signature help the court or ombudsman decide a case where the policyholder argued that they genuinely thought their answer was correct.

10.44 **We provisionally propose that a consumer insured's signature on a proposal form that has been completed incorrectly by a third person should not be regarded as conclusive evidence that the insured knew of or adopted what was written on the form.**

[10] [1972] 1 QB 90.

Marine Insurance Act 1906, section 19

10.45 As we have indicated, we are not aware of any reported case where section 19 has been applied to consumer insurance. However, it clearly applies to non-marine insurance as well as marine insurance. We therefore think that as a matter of technical law the section applies equally to consumer and to business insurance.

Section 19(b)

10.46 At first sight, the obligation under section 19(b) seems reasonable. After all, the insured's agent should be required to disclose those matters that the insured is obliged to disclose. However, a breach of the section does not give the insurer a right to damages against the intermediary. The insurer's only remedy lies in avoiding the policy against the insured, which it would be able to do in any event.

10.47 Where an agent acts for a consumer, the agent's failure to answer questions honestly and carefully becomes the consumer's failure. In these circumstances, we do not think that section 19(b) gives the insurer any additional protection. Although it would be possible to preserve section 19(b) within the proposed new regime, to do so seems otiose. The only reason for preserving it would be if it gave the insurer a right in damages against the intermediary. We ask whether a right to damages against an intermediary would be a useful additional protection to insurers.

10.48 **We welcome views on whether there are any reasons to preserve section 19(b) for consumer insurance. If so, should a breach grant the insurer a right in damages against the intermediary?**

Section 19(a)

10.49 Substantial criticisms can be made of section 19(a) in relation to consumer insurance. If it is needed at all, we think it requires substantial reform. In particular:

(1) It seems wrong that insurers should be entitled to avoid policies with insureds because of a fault that lies exclusively with a third party. As we explained in Part 9, this could undermine the purpose of product insurance where the retailer is aware of defects in the product.

(2) The extent of the duty is unclear, and is difficult to reconcile with an obligation of confidentiality. Suppose, for example, an agent arranges critical illness cover first for a mother and then some time later, with a different insurer, for her daughter. The agent knows that the mother has a hereditary condition, of which the daughter is unaware. Should it be disclosed by the agent? At the very least, we do not think that the duty should extend to information provided in confidence by a third party.

(3) How far does the knowledge extend? Would agents to insure be obliged to make internal enquiries or search their records? If it is a national firm, what are they required to do about information held at other branches? On balance, we do not think such a duty should extend beyond the relevant transaction.

10.50 This question may of course be academic, since we have been unable to find an insurer who has relied on section 19(a) in a consumer case. If such cases exist, we should be interested to receive details.

10.51 **We ask whether section 19(a) of the Marine Insurance Act 1906 should cease to apply in consumer cases, so that the agent to insure would have no duty to disclose matters other than those which the consumer is bound to disclose in response to the questions asked by the insurer.**

10.52 **If there are reasons to preserve an extended duty under section 19(a):**

(1) **Should the remedy lie in damages against the intermediary, rather than in avoidance against the insured?**

(2) **Should any information given in confidence by a third party be excepted from the scope of the duty?**

(3) **Should the duty be curtailed to information received in the course of the relevant transaction?**

BUSINESS INSURANCE

The status of the intermediary: whose agent?

10.53 Above we provisionally proposed that an intermediary dealing with a consumer should be regarded as the insurer's agent for the purposes of obtaining pre-contract information, unless the intermediary is genuinely searching the market on the insured's behalf.

10.54 In a business context, it is relatively rare for insurance to be sold through agents who deal with only one or a limited number of insurers. It may occur, but we have been told these types of agent deal only with small to medium businesses. We think that in these circumstances, the proposals we made for the consumer market should apply to businesses. Small businesses may be in as much need of protection as consumers, and the insurer will normally be in a better position to exercise control than the insured. Thus where a business buys insurance through an intermediary who does not genuinely search the market on the insured's behalf, we think that the intermediary should be considered to act for the insurer.

10.55 In Issues Paper 3 we suggested that this rule should only apply where the insured was a small business. However, this leads to problems of definition. There is no easy way of distinguishing between businesses in need of protection and those that are not. It would also mean that an intermediary would be taken to be acting for the insurer one day and for the insured next, when it sells an identical policy to another business, which happens to be just over the threshold limit. We are told that policies sold through intermediaries dealing with only one or a limited number of insurers are usually standard products, sold to relatively unsophisticated businesses. It is therefore easier to distinguish this sector by the nature of the intermediary rather than by the nature of the insured.

10.56 The great majority of business will be placed through independent brokers negotiating in the London market. For these types of insurance we propose no change. Here policyholders are much more likely to be sophisticated repeat players. They can exercise market discipline themselves, without the need to attribute the mistakes of intermediaries to insurers.

10.57 Moreover, we think that in some cases to do that would be positively unfair to insurers. We understand that many insurance arrangements are in effect conceived and set up by brokers, who then have to sell the idea to underwriters as much as they do to insureds. In such a case it may be the broker who takes a judgement about what is material to the underwriter. It would not be right to visit their mistakes on the insurer.

10.58 We think the question of intermediaries who deal with larger businesses is best left to the development of common law, allowing judges to apply principles of agency law to the facts in hand. This means that for most commercial insurance, we are not proposing a change in the current law.

10.59 **We provisionally propose that, in a business context, an intermediary should be regarded as acting for an insurer for the purposes of obtaining pre-contract information, if it deals with only a limited number of insurers and does not search the market on the insured's behalf.**

10.60 **For businesses using other intermediaries, the issue of whom the intermediary is acting for in respect of disclosure issues should be left to the common law.**

The *Newsholme* rule

10.61 Some of the completed form cases – indeed, *Newsholme* itself – were business insurance cases. We think the proposal to abolish the "transferred agency" rule made in relation to consumer insurance should apply equally to business insurance cases.

10.62 **We provisionally propose that in the business context, an intermediary who would normally be regarded as acting for the insurer in obtaining pre-contract information remains the insurer's agent while completing a proposal form.**

10.63 The observations we make on the effect of a signature in relation to consumers are also relevant to business insureds. The proposer's signature should not be conclusive evidence that the proposer knew of or adopted what was written on the form. However in business insurance there is one important caveat. In a business context it would be permissible for the insurer to seek warranties of specific facts. Thus if the insured signed a warranty to state that a fact was correct, this would give the insurer additional rights to refuse claims. The warranty will be enough to put the proposer on warning that they should check the form carefully. The warranty should be binding on the proposer just like any other term. It would however be subject to the controls we have proposed in Parts 5 and 8 to prevent standard form contracts from defeating reasonable expectations.

10.64 **We provisionally propose that a business insured's signature on a proposal form that has been completed incorrectly by a third person should not be regarded as conclusive evidence that the insured knew of or adopted what was written on the form. However, this should not reduce the effect of a warranty of fact given by a business insured.**

Marine Insurance Act 1906, section 19(a)

10.65 Earlier we suggested three potential problems with the agent's independent duty to disclose under section 19(a):

(1) The remedy for non-disclosure by the agent is avoidance of the policy rather than damages against the agent;

(2) Where there is a "chain" of intermediaries, the duty appears to apply only to the agent who deals directly with the insurer, not any other agent in the chain; and

(3) It is not clear whether the duty is to disclose any information the agent has, or only that gained in its capacity as agent for the particular insured.

Remedy

10.66 The subsection only bites when the information is known to the agent but not to the insured (and is not information that the insured ought to be aware of in the ordinary course of business.) By definition, therefore, the insured is not at fault. Our provisional proposal is that in these circumstances it is contrary to the insured's reasonable expectation that it should lose its rights under the policy and bear the burden of seeking recovery from the agent. It seems better to replace the insurer's right to avoid by a right to claim damages from the agent.

10.67 This would be a significant change in the law, as section 19 does not currently provide insurers with a right to damages. Such responses as we have received to date from both insurers and brokers suggest that this would produce fairer or more satisfactory outcomes.

10.68 We would welcome views on whether the right to damages should apply to all contracts of insurance placed within the UK, or only to those governed by the law of a part of the UK.

Chains

10.69 An intermediary may well have material information that is not known to either the insured or the final intermediary who deals with the insurer. Under the current law there is no incentive on the middle intermediary to reveal the information. In fact, it would seem open to the parties to reach an express agreement that the information does not have to be communicated up the chain.

10.70 We welcome views on whether producing brokers should be obliged to pass information up the chain, so that the final intermediary should be responsible for passing it to the insurer. However, we would need to be careful to ensure that the provision did not apply too widely to remote agents.[11]

The scope of information covered

10.71 Agents may well have information about the risk to be insured that they did not receive in the character of agent for the insured. It seems inefficient to excuse its non-disclosure. It is also difficult to determine what information is received "in the character of agent for the insured", or whatever test is to be used. We agree that it would be harsh on the insured were the insurer able to avoid because of such "unconnected" information, but that objection falls away if the remedy is to be damages against the intermediary rather than avoidance of the policy.

10.72 We would make an exception, however, for information which the intermediary is under an obligation not to divulge, for example information obtained in confidence.

Conclusion

10.73 **We provisionally propose that where a broker breaches section 19(a), the insurer should no longer be entitled to avoid the policy against the insured. Instead a remedy in damages should lie against the broker.**

10.74 **We ask whether:**

(1) **The right to damages should apply whenever insurance contracts are placed within the UK, or only where the contract is subject to the law of a part of the UK?**

(2) **Producing brokers should be obliged to pass relevant information up the chain to the placing broker?**

(3) **The law should specifically state that an intermediary is not required to disclose information given to it in confidence by a third party?**

[11] This would include the type of agents in *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136 and *ERC Frankona Reinsurance v American National Insurance Co* [2006] Lloyd's Rep IR 157.

PART 11
ASSESSING THE COSTS AND BENEFITS OF REFORMS

LONDON ECONOMICS' REPORT AND MODEL FOR ASSESSING COSTS AND BENEFITS

11.1 It is important to look carefully at the costs in relation to the benefits of our proposals. To this end we commissioned London Economics to develop a possible methodology for exploring the impact of our reforms. London Economics is an independent economic consultancy firm.[1]

11.2 Their report is at Appendix B. It concentrates on the reforms set out in Part 4, namely those that relate to the provision of pre-contract information by consumers.[2]

11.3 London Economics' report is not intended to provide definite costing. As will be seen, many of the figures are based on assumptions rather than actual data. Instead, we hope the report will act as a focus for discussion about how the impact of our proposals might be measured. In the light of the discussion generated by this report, we will develop the methodology and, where possible, use it to cost the effect of our final recommendations.

CONTENTS OF LONDON ECONOMICS' REPORT

The UK insurance market

11.4 The report brings together available information about the size of the consumer insurance market in the UK. The figures are based largely on the Annual Expenditure and Food study, supplemented by ABI data, and we are grateful to the ABI for their help with this. However, there are significant gaps in our knowledge. We were not able to find even basic information on the number and size of claims made under, for example, buildings and contents insurance. We would welcome any help that insurers can provide in this and other areas.

Remedies for non-disclosure and misrepresentation

11.5 The report analyses the economic effect of the current strict law remedy of avoidance for all non-disclosure and misrepresentation and compares this to other suggested remedies, such as dealing with the claims in a proportionate manner. This shows that avoidance goes further than is necessary to compensate the insurer for the loss it has suffered from the misrepresentation. This is because avoidance permits insurers to refuse those claims that would have occurred in any event. The report then illustrates the effect of a proportionate remedy, which attempts to put the insurer into the position it would have been in had it been aware of the full facts.

[1] Their website is at www.londecon.co.uk.

[2] It does not deal with the non-contestability period in life insurance which we raise as a possibility in para 4.190. See further at para 11.38 below.

Cases brought to the Financial Ombudsman Service

11.6 The report then analyses complaints to the Financial Ombudsman Service (FOS), using published data, data supplied privately by the FOS and our review of FOS cases. A point which arises starkly from the London Economics report is that some forms of insurance are much more likely to lead to problems than others. In comparison to their overall size, vehicle and household insurance lead to relatively few complaints to the FOS about non-disclosure and misrepresentation. Problems with non-disclosure are dominated by protection policies in general, and critical illness policies in particular.

11.7 When one measures the number of complaints about non-disclosure issues reaching the FOS per £m of premium income, the number of critical illness complaints appears more than a hundred times greater than for buildings or contents insurance. Although recent figures suggest that the number of complaints about critical illness claims is dropping, the number is still of a different order of magnitude than for other forms of insurance.

11.8 In some market sectors, we think that the effect of our proposals may be too small to measure. This could be true for vehicle insurance. When it comes to third party vehicle claims, insurers are already obliged to pay claims irrespective of any misrepresentations by the policyholder.[3] This means that the impact of our proposals on motor claims will only affect first party claims.

11.9 London Economics has used its analysis of the market and of the cases brought to the FOS to develop a list of insurance markets that it believes should be subjected to a full cost benefit analysis to assess the impact of our final recommendations for reform. This is set out in Table 14, together with the reasons for the selection.[4] The list includes: vehicle insurance; buildings insurance; contents insurance; private medical insurance; critical illness insurance; income protection insurance; and life assurance. Consultees are asked to comment on the draft list. We also ask for help in gathering information to assist in that analysis.[5]

11.10 **We welcome views on which insurance markets should be included in a full cost benefit analysis of the impact of our final recommendations**.

A CASE STUDY: CRITICAL ILLNESS

Critical illness

11.11 London Economics' report uses critical illness as a case study to illustrate how a model for measuring the impact of our reforms might work. This is not because critical illness is a typical market. The critical illness market is extreme. Our proposals would have more effect on this market than on any other. However, the size of the problem means that more information is available, and the effects are more easily perceived than in other areas.

[3] See Road Traffic Act 1988, s 151.

[4] Appendix B, p 31 below.

[5] Appendix B, para 5.2, p 39 below.

11.12 The figures in the model should be treated with caution. Most are based on assumptions and estimates. The figures are included to demonstrate the workings of the model, not to provide an accurate assessment of the costs of our proposed reform.

Type 1 and Type 2 firms

11.13 To analyse the effect of our proposals on the critical illness market, the report divides insurance companies into Type 1 or Type 2 firms. Type 1 firms are assumed to abide by FOS guidance and FSA regulations, and to have institutionalised the requirements to treat customers fairly. On the other hand, Type 2 firms are assumed to abide by the letter of the law and no more. Our reforms would therefore have little impact on Type 1 firms whereas Type 2 firms would be forced to change their practices dramatically. The model assumes most firms are Type 1, though a few are Type 2.

11.14 In practice, we doubt that any insurers are either fully Type 1 or fully Type 2. Even good insurers may occasionally make mistakes and it is unlikely that any insurers ignore all FSA rules in this area. However, some insurers seem better than others, and for analytical purposes it may be helpful to simplify reality in this way. We have been told that Type 2 firms are more likely be “closed book” firms, which are no longer selling policies and do not have a brand reputation to protect. It is also possible that some smaller firms struggle to understand what the FOS expects of them.

11.15 Despite the fact that no insurers are fully Type 1 or Type 2, analysing the effect of the reforms on these two categories of firm will display a full range of the potential economic effect of our reforms. Individual insurance companies will be able to judge where they will fall within that spectrum.

11.16 **We ask whether the economic analysis of our reforms should look separately at firms that follow FSA rules and FOS practice (Type 1) and those that follow the law (Type 2). We welcome views on the numbers and type of firms that do not currently follow FOS practice.**

The cost of claims

11.17 The model suggests that the impact of our proposals on Type 1 firms would be relatively slight. These insurers will benefit from having the rules more clearly laid out, and will be much less likely to be undercut by unscrupulous operators. For the most part, however, their claims handling will be unaffected. They will continue to follow the good practice expected by the FOS and codified in our proposals.

11.18 When we commissioned this model from London Economics, we thought that it was possible that Type 1 firms may be required to pay a few more proportional settlements. As we explain in Part 4, our proposals clarify the dividing line between "reckless" and "negligent" misrepresentations. By and large our proposals follow the FOS written guidance, but it may be that the FOS allows some cases of serious carelessness to be classified as "reckless", which under our proposals would be considered "negligent". This means that in some cases where Type 1 firms are currently avoiding the policy they will be required to apply an exclusion or make a proportionate payment.[6]

11.19 The most recent edition of *Ombudsman News* issued by the FOS, however, suggests that there is little difference between our proposed definition of reckless and negligent misrepresentations and the FOS practice.[7] It is possible that there would be almost no cases where Type 1 firms were currently avoiding the policy and would, as a result of our reforms, have to apply an exclusion or make a proportionate payment.

11.20 However, this clarification arrived too late for us to alter our instructions to London Economics. They have therefore estimated that the introduction of our reforms to the definition of recklessness would lead to some additional costs for Type 1 firms. They estimate these additional costs would translate into no more than a 1-1.5% increase in premiums.[8] In return for this increase in premiums, honest consumers will receive payments in some cases that would currently be refused.

11.21 The effect on Type 2 firms would be more dramatic. The report assumes that firms who currently ignore FOS guidance would find it much more difficult to ignore clear legal rules set out in a new Insurance Contracts Act. London Economics have calculated that these firms will need to increase their premiums by 85 to 95%. If so, these firms would either have to rethink their business model (and essentially become Type 1 firms) or go out of business.

[6] For example, in a case where a consumer carelessly failed to mention back pain and later developed unconnected breast cancer, the claims handler should ask what the firm would have done if it had known about the back pain. If it would only have excluded back pain from the policy, it should pay the cancer claim. If it would have charged double the premium, it should pay half the claim.

[7] *Ombudsman News*, (April/May 2007) Issue 61.

[8] Appendix B, p 46 below.

The retention of premiums

11.22 The case study also demonstrates the effect of retaining premiums. Our survey of FOS decisions suggests that at present most insurers refund a consumer's premium when they avoid a policy for a deliberate or reckless misrepresentation. We ask whether, in future, insurers should be entitled to retain premiums in such circumstances.[9] In the critical illness market, London Economics have calculated that this would lead to insurance companies being entitled to retain approximately £1.3 million in premiums.[10]

Administrative costs

11.23 Any legal change has administrative costs. Firms need to read and understand the new legislation, review their proposal forms and contract documents, and train their staff. Those we have talked to suggest that the administrative costs involved in our proposals would not be great. Insurers have to review documents and train staff regularly in any event. Provided that firms were given sufficient notice of the changes, much of the necessary work could be incorporated into the normal routine of running an insurance company. However, we would welcome views about the administrative costs associated with our proposals.

11.24 London Economics have divided administration costs into one-off costs and recurrent costs. One-off costs relate to the production of new forms and the costs of becoming familiar with the new legal framework.

11.25 Recurrent costs relate to new types of investigation work carried out by firms. As a result of our proposals, it is possible that firms would choose to take additional steps at the pre-contractual stage to gather information on applicants for insurance. For example, firms might expand their use of tele-underwriting to assess risks more accurately at the application stage. This will be a commercial decision for each firm and is not a requirement of our proposals. London Economics has characterised these potential costs as recurrent administration costs. They have applied them at the same level to both Type 1 and Type 2 firms, though in practice those Type 1 firms that have chosen to undertake this level of investigation may well be doing so already and will not therefore incur this increase in costs.

11.26 It should be noted that in the discussions both we and London Economics have had with various organisations, there has been no consensus on whether there would be any increase in administration costs, or how much they would be. It may be unrealistic to assume that there will be no additional costs and therefore London Economics have included these figures. However, additional information is needed from consultees on whether they envisage that extra administration costs will be incurred and what level these would be at.

[9] See paras 4.93 to 4.95 above.

[10] Appendix B, p 48 below.

The overall effect

11.27 The model shows that in the consumer sphere, the main effect of our changes would be to increase compliance with FSA requirements and FOS guidance. At present, firms may fail to comply with FOS standards either because they do not understand what is required, or because consumers will only rarely challenge their decisions. We think that a new Insurance Contracts Act would address both problems: insurers will understand the rules better, and consumers will find it easier to seek advice about their rights. Thus there will be less non-compliance, and more claims paid.

11.28 Table 18 of the report shows the provisional aggregate static economic impact of the proposed reforms on the critical illness insurance market.[11] The report assumes that both Type 1 and Type 2 firms would be able to offset the increased costs of claims and administration against an increased premium charged to customers. This means that the impact on insurers would be minimal.[12] Both the costs and the benefits would fall on consumers as a whole. For Type 1 firms, London Economics have calculated that the costs would translate into a mere £3.04 increase per policy. For Type 2 firms, however, the impact would be considerable. At present Type 2 firms are assumed to avoid all policies for non-disclosure or misrepresentation. After our reforms, they will need to pay all claims where there has been innocent non-disclosure or misrepresentation. They will also need to apply a proportionate remedy to those claims where there has been negligent misrepresentation. Therefore their claims costs will increase dramatically. If it is assumed that these costs are passed on to consumers, London Economics have calculated that this will translate into an increase of £212.03 per policy. It is most unlikely that any consumer would pay this increase and therefore Type 2 firms would either go out of business or have to convert into Type 1 firms.

11.29 The beneficiaries of the reforms, as shown in Table 18, are honest consumers who previously would have had their claims wrongly turned down. Honest consumers are shown to be £9.855 million better off. Those consumers who make deliberate or reckless misrepresentations will be £1.321 million worse off.

11.30 Overall, London Economics estimate that the aggregate benefit to the critical illness market of our reforms would be £0.861 million to £1.120 million per annum. This covers the impact across all firms, consumers and the wider economic impact.[13]

[11] Appendix B, p 56 below.

[12] The Table suggests that Type 1 firms will be between £0 and £0.241 million better off as a result of our reforms, while Type 2 firms will be between £0 and £0.016 million better off. This reflects the uncertainty over administrative costs. The Table assumes that administration costs will fall within a range and that costs at the highest point of that range are all passed to consumers in increased premiums. This leads to firms being "better off" if administration costs are less than the highest point of the estimated range.

[13] For example, it is estimated that after the reforms, fewer cases will go to the FOS meaning that the costs for the FOS will reduce.

11.31 However, accurately quantifying the effect of our proposed changes would require accurate information, first about the current level of non-compliance, and secondly about the improvement our reforms would bring about. Although we think our reforms would make it more difficult for firms to contravene the standards the FOS currently expects, we would never suggest that a new statute would eradicate all malpractice. Some firms that currently fail to comply with the FSA rules and the FOS guidance would also fail to comply with the proposed Insurance Contracts Act. In the absence of this data, any costings are highly speculative and should be treated with great care.

11.32 The effect of our proposals also depends on the way that non-compliance is distributed in the market. If the main problem is that a few firms are failing to comply with FOS guidance, under our proposals these firms will either have to change or go out of business. However, if there are pockets of non-compliance within some otherwise well-run firms, the change may result in increased premiums across a wider pool of consumers.

11.33 It is clear that more accurate data is necessary to assess the impact of the reforms and consultees are requested to comment on the model, the results and to provide additional information where they can.

11.34 **We ask whether the economic effect of our reforms should be assessed using the model commissioned from London Economics, which is set out at Appendix B to this Consultation Paper.**

11.35 **We ask whether consultees are able to provide us with further data to enable us to carry out this assessment.**

Is there still a role for low-cost, low-payout policies?

11.36 It has been suggested that our policies would disadvantage low-income households because consumers would be forced to pay more for better quality policies. It would be more difficult to sell low-cost policies that pay fewer claims. It is true that our proposals are designed to prevent policies being sold that appear to promise payments, where that promise is undermined by small-print exclusions or harsh claims-handling guidance.

11.37 However, there is nothing in our reforms to prevent insurers from offering low-cost policies that provide payment in only very limited circumstances, provided those circumstances are clearly presented to the consumer. In the case of critical illness policies, the most obvious way this can be done is to limit the illnesses covered to a few clear conditions, such as cancer, strokes and heart attacks. Provided that the limitations of the policy are clearly presented in a transparent way, it will still be open to insurers to design low-cost, low pay-out policies if they think these meet a market need.

LIFE INSURANCE: THE EFFECT OF A FIVE YEAR CUT-OFF PERIOD FOR NEGLIGENT MISREPRESENTATIONS

11.38 In Part 4 we ask whether in life insurance, insurers should have no remedies for negligent misrepresentations made more than five years before the death. This proposal does not apply to critical illness policies, and so is not taken into account in the case study outlined above.

11.39 Unlike our other proposals, this would go further than existing FSA requirements and FOS guidance. It represents a change of practice and would need to be costed separately. We are currently working with reinsurers in the life insurance sector to understand the effect of our proposals in greater depth. We would particularly welcome comments on the costs and benefits of this particular proposal. These will need to be examined with care and assessed separately from the cost of our other proposals.

11.40 **We propose that the effect of a five year cut-off period for negligent misrepresentations should be costed separately from the costs of our other proposals**.

11.41 **We ask whether consultees who are reinsurers in the life insurance sector are able to provide us with data to enable us to carry out this assessment.**

CONCLUSION

11.42 The preliminary economic analysis we have commissioned suggests that where consumers are already buying insurance from reputable insurers they will be asked to pay only a very small extra premium for the increased protection and peace of mind that the insurance will provide. In return all consumers would be protected against the more exploitative arrangements – those that appear to promise peace of mind, but fail to deliver when they are needed. Reputable firms will incur few if any extra costs and disreputable firms will be forced to change their practices if they are to remain in business.

11.43 At present, we do not have sufficient robust data to quantify the effects of our proposals with precision. We ask consultees, first, to comment on the model we propose in Appendix B, and, secondly, to give us the best estimate they can of the cost and benefit of each proposal – or, if they would support something different, of the proposal they support.

PART 12
LIST OF PROPOSALS AND QUESTIONS

PRE-CONTRACT INFORMATION AND CONSUMER INSURANCE

The case for law reform

12.1 We provisionally conclude that there should be a clear statutory statement of the obligations on consumers to give pre-contract information and the remedies available to insurers if they fail. (3.74)

Defining consumers

12.2 We provisionally propose that the consumer regime should apply where an individual enters into a contract of insurance wholly or mainly for purposes unrelated to his business. (4.11)

12.3 We ask whether there is a need to exempt insurance of specific high-value items (such as jets and yachts) from the consumer regime. (4.12)

The duty of disclosure

12.4 We provisionally propose that there should be no duty on the consumer proposer to disclose matters about which no questions were asked. (4.31)

12.5 We provisionally propose that where the insurer asks a general question, the insurer should have no remedy in respect of an incomplete answer unless a reasonable consumer would understand that the question was asking about the particular information at issue. (4.32)

The basic requirements: misrepresentation and inducement

12.6 We provisionally propose that the insurer will not have a remedy for misrepresentation unless the consumer made a misrepresentation which induced the insurer to enter the contract. (4.48)

12.7 We ask whether the rules on what constitutes a misrepresentation and on inducement should be stated expressly in any new Insurance Contracts Act. (4.49)

Deliberate or reckless misrepresentations: where the proposer acts without honesty

12.8 We provisionally propose that an insurer should have the right to avoid a policy where it has relied on a misrepresentation by the consumer proposer at the pre-contractual stage and the insurer shows that, on the balance of probabilities, the proposer made the representation:

(1) knowing it to be untrue, or being reckless as to whether or not it was true; and

(2) knowing it to be relevant to the insurer, or being reckless as to whether or not it was relevant. (4.96)

12.9 Do consultees agree that the definition of "reckless" can be left to the common law? (4.97)

12.10 We ask whether, where an insured has made a deliberate or reckless misrepresentation, the insurer should be entitled to retain the premium. (4.98)

12.11 We ask whether the statute should provide expressly that:

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

(2) if an insurer has asked a clear question about an issue, the proposer would be presumed to know that the issue is relevant to the insurer. (4.99)

"Innocent" misrepresentations: protecting the insured who acts honestly and reasonably

12.12 We provisionally propose that:

(1) An insurer should not be able to rely on a misrepresentation if the insured was acting honestly and reasonably in the circumstances when they made the misrepresentation.

(2) In assessing reasonableness, the type of policy, the way the policy was advertised and sold, and the normal characteristics of consumers in the market should be taken into account.

(3) The test of whether the consumer proposer acted reasonably should also take into account any particular characteristics or circumstances affecting a consumer insured, so far as these were known to the insurer. It would not take into account individual circumstances which were not known to the insurer. (4.119)

12.13 We ask whether the legislation should specify that the insurer is entitled to a remedy for a misrepresentation only if:

(1) a reasonable insured in the circumstances would have appreciated that the fact which was stated inaccurately or was omitted from the answer would be one that the insurer would want to know about; or

(2) the proposer actually knew that the fact was one that the insurer would want to know about. (4.121)

12.14 We provisionally propose that the burden of showing that a consumer proposer who made a misrepresentation did so unreasonably should be on the insurer. (4.124)

Materiality: an end to the test based on a hypothetical "prudent insurer"

12.15 We provisionally propose that insurers should not be required to prove that a misrepresentation is "material" in the sense that it would be relevant to a "prudent insurer". (4.129)

Where the policyholder thinks the insurer will obtain the information

12.16 We provisionally propose that in considering whether an insured acted with insufficient care in failing to give information, the judge or ombudsman should consider how far it was reasonable for the insured to assume that the insurer would obtain that information for itself. (4.143)

12.17 In particular, if the insurer indicated that it may obtain information from a third party (by for example asking the insured for consent to obtain it) it should not be allowed to rely on an honest misrepresentation if the insured reasonably thought that the insurer would obtain the relevant information from the third party before accepting the proposal. (4.144)

Disclosure after the proposal has been accepted

12.18 We provisionally propose that:

(1) if before their proposal is accepted a consumer proposer becomes aware that a statement they have made has become incorrect, they should continue to have a duty to inform the insurer, and if the consumer fails to do so unreasonably or dishonestly, the insurer should have a remedy;

(2) There should be no general obligation to inform the insurer of changes that become known to the insured only after the policy has been agreed. (4.152).

Negligent mispresesentations: a compensatory remedy

12.19 We provisionally propose that, in consumer cases, where the policyholder has made a negligent misrepresentation, the court should apply a compensatory remedy by asking what the insurer would have done had it known the true facts. In particular:

(1) where an 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 declined the risk altogether, the policy may be avoided, the premiums returned and the claim refused;

(4) where an insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium. (4.186)

12.20 We ask whether there is a case for granting the courts or ombudsman some discretion to prevent avoidance where the insurer would have declined the risk but the policyholder's fault is minor, and any prejudice the insurer has suffered could be adequately compensated by a reduction in the claim. (4.187)

12.21 We provisionally propose that where a consumer proposer has made a negligent misrepresentation, the insurer should be entitled to cancel the policy on that ground only where it would have declined the risk. (This proposal would not affect any contractual right to cancel upon notice.) (4.188)

12.22 We provisionally reject the proposal that a consumer who has acted negligently should be entitled to enforce any claim unrelated to the risk. (4.189)

Negligent misrepresentations in life policies: should the law impose a cut-off period?

12.23 We ask whether in consumer life assurance the insurer should be prevented from relying on a negligent misrepresentation after the policy has been in force for five years. (4.204)

Mandatory rules

12.24 We provisionally propose that it should not be possible to contract out of the new rules governing misrepresentation and non-disclosure in consumer insurance except in favour of the consumer. (4.218)

Statements of past and present fact

12.25 We provisionally propose that an insured's statement of past or current facts made before a contract is entered into should be treated as a representation rather than a warranty. (4.229)

PRE-CONTRACT INFORMATION AND BUSINESS INSURANCE

Retaining the duty of disclosure

12.26 We provisionally propose that a duty of disclosure should continue to apply to business insurance contracts. (5.30)

12.27 We provisionally propose to simplify the test in section 18(1) of the Marine Insurance Act 1906 ("that the insured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him"). The duty of disclosure should be limited to facts which the business insured knew or which it ought to have known. (5.44)

12.28 We provisionally propose that the burden of proving that a business insured should have known a particular fact should be on the insurer. (5.48)

Honest and reasonable misrepresentations

12.29 We provisionally propose that if a business insured has made a misrepresentation but the proposer honestly and reasonably believed what it said to be true, the insurer should not be able to refuse to pay any claim or to avoid the policy, unless the parties have agreed otherwise. (5.58)

12.30 We provisionally propose that the burden of showing that the insured did not have reasonable grounds for believing that what it said was true should be on the insurer. (5.60)

Modifying the test of materiality

12.31 We provisionally propose that the current test of "materiality", namely what may influence the judgement of a prudent insurer, should be replaced by a "reasonable insured" test. This would ask what a reasonable insured in the circumstances would think was relevant to the insurer. This should apply to all business insurance, as part of a general principle that an insured who was both honest and careful in giving pre-contract information should not have a claim turned down on the basis that the information was incorrect or incomplete. (5.83)

12.32 We provisionally propose that, in order to be entitled to a remedy for the insured's non-disclosure or misrepresentation, the insurer must show that:

(1) had it known the fact in question it would not have entered into the same contract on the same terms or at all; and

(2) it must also show either:

(a) that a reasonable insured in the circumstances would have appreciated that the fact in question would be one that the insurer would want to know about; or

(b) that the proposer actually knew that the fact was one that the insurer would want to know about. (5.84)

Should the law distinguish between dishonest and negligent conduct?

12.33 We invite views on whether the law should distinguish between dishonest and negligent misrepresentation/non-disclosure. For negligent conduct, should the law provide a remedy which (unless the parties have agreed otherwise) aims to put the insurer into the position it would have been in had it known the true circumstances? (5.107)

12.34 If so:

(1) Should there be a rebuttable presumption that the insured knew any fact that in the ordinary course of business they ought to have known?

(2) Do respondents agree that where the insurer would have declined the risk, the insurer should be entitled to avoid the policy, and the court should have no discretion to apply a proportionate solution?

(3) Do respondents agree that negligent misrepresentation or non-disclosure should be a ground on which the insurer may cancel the policy after reasonable notice, without prejudice to claims that have arisen or arise within the notice period? (5.108)

Basis of the contract clauses

12.35 We provisionally propose that a warranty of past or present fact must be set out in a specific term of the policy or an accompanying document. The law should not give any effect to a term on a proposal form or elsewhere which converts answers into warranties en bloc. (5.116)

Contracting out of the default regime

12.36 We provisionally propose that the parties to an insurance contact should be free to contract out of the default regime we have proposed in two ways. The policy or accompanying document could contain a written term that

(1) the insurer would have one or more specified remedies for misrepresentation even if the proposer was neither dishonest nor careless in giving the information; or

(2) the proposer warrants that specified statements are correct. (5.131)

12.37 Liability for breach of a warranty of fact should remain strict but, unless the contract provides otherwise, the insurer should not be able to rely on the breach of warranty

(1) if it was not material to the contract; or

(2) as a defence to a claim for a loss that was in no way connected to the breach of warranty. (5.132)

Controlling the use of standard terms

12.38 We provisionally propose that special controls should apply where

(1) the insured contracts on the insurer's written standard terms of business; and

(2) one such term purports to give the insurer greater rights than the default regime would allow to refuse claims on the basis of the insured's failure to provide accurate pre-contract information. (5.146)

12.39 The insurer should not be permitted to rely on such a term if it would defeat the insured's reasonable expectations. (5.147)

Marine, Aviation and Transport insurance

12.40 We provisionally propose that the proposals made to the law for business insurance should apply equally to marine, aviation and transport insurance. (5.152)

Reinsurance

12.41 We provisionally propose that amendments made to the law for business insurance generally should apply equally to reinsurance. (5.156)

Third party claims

12.42 Our provisional view is that we should not extend the existing rights of third parties as part of the current project, but we welcome views on this issue. (5.161)

Small businesses

12.43 We would welcome views on whether there is a case for greater protections for smaller businesses. (5.177)

GROUP INSURANCE, CO-INSURANCE AND INSURANCE ON THE LIFE OF ANOTHER

12.44 We provisionally propose that in group insurance for employees, a misrepresentation made by a group member should be treated as if the group member were a policyholder who had arranged insurance directly with the insurer. This means that:

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

(2) as the insurance is such that if the policyholder had arranged it directly it would be consumer insurance, any dispute concerning a misrepresentation by the group member would be determined in accordance with our proposals for consumer insurance. (6.39)

12.45 We ask:

(1) Where a member has made a deliberate or reckless misrepresentation, but the insurer would have given a certain level of "free cover" without that information, should the insurer be entitled to refuse all benefits in respect of that member? Alternatively, should the insurer be obliged to provide the free cover that would have been provided in any event, provided the basic eligibility criteria for the scheme are met?

(2) Do consultees agree that a non-disclosure or misrepresentation by the policyholder, that is the employer, should provide the insurer with the same rights to avoid a policy as would apply to other business insurance? (6.40)

12.46 We ask consultees if they have experience of problems in other types of group insurance, other than those written by employers in respect of employees. For these types of policy, should a misrepresentation or non-disclosure by a group member be treated as if the group member were the policyholder and had arranged the insurance directly with the insurer? (6.41)

Co-insurance

12.47 We ask whether consultees are aware of any problems concerning the law of co-insurance in relation to issues of non-disclosure and misrepresentation. (6.52)

Consumer life-of-another policies: misrepresentations by the life insured

12.48 We provisionally propose that in consumer life-of-another policies, representations by the life to be 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 negligently, it will have the remedy that is appropriate for that kind of conduct. (6.63)

12.49 We ask whether parallel issues arise in other consumer contexts and, if so, whether the same solution is appropriate. (6.64)

Consumer insurance: "joint lives, first death" policies

12.50 We ask whether in a "joint life, first death" policy, consultees agree that the insurer should be entitled to refuse claims where either the deceased or the beneficiary has made a deliberate or reckless misrepresentation. (6.70)

12.51 We welcome views on whether, if a claim is refused following the death of a guilty party, the court or ombudsman should have discretion to order the insurer to continue the policy as a single life policy, payable on the death of the innocent party. (6.71)

Business life-of-another policies

12.52 We provisionally propose that in business life-of-another policies, the default rule should be the same as for consumer insurance: representations by the life to be insured should be treated as if they were representations by the policyholder. However, this would be subject to the terms of the contract. (6.75)

WARRANTIES AS TO THE FUTURE AND SIMILAR TERMS

A written statement

12.53 We provisionally propose that a claim should only be refused because the insured has failed to comply with a warranty if the warranty was set out in writing. It should be included in the main contract document or in another document supplied either at or before the contract was made, or as soon as possible thereafter. (8.12)

Bringing warranties to the attention of insureds

12.54 In consumer insurance, we provisionally propose that an insurer may only refuse a claim on the grounds that the insured has broken a warranty if it has taken sufficient steps to bring the requirement to the insured's attention. In deciding whether the insurer has taken sufficient steps, the court should have regard to FSA rules or guidance. (8.19)

The causal connection test

12.55 We provisionally propose that in both consumer and business insurance the policyholder should be entitled to be paid a claim if it can prove on the balance of probability that the event or circumstances constituting the breach of warranty did not contribute to the loss. (8.45)

12.56 We provisionally propose, in relation to both consumer and business insurance, that if the insured can prove that a breach contributed only to part of the loss, the insurer may not refuse to pay for the loss that is unrelated to the breach. (8.48)

A mandatory rule for consumers

12.57 We provisionally propose that the causal connection rules should be mandatory in consumer insurance. (8.50)

A default rule for businesses

12.58 We provisionally propose that in business insurance the parties should be free to vary the rules on the effect of a breach of warranty by agreement. However, where the insured contracts on the insurer's standard terms, there should be safeguards to ensure that the term does not make the cover substantially different from what the insured reasonably expected. (8.53)

Reasonable expectations approach

12.59 We provisionally propose that in business insurance an insurer should not be permitted to rely on warranties, exceptions or definitions of the risk in its written standard terms of business if the term renders the cover substantially different from what the insured reasonably expected in the circumstances. (8.79)

Terminating the contract for the future

12.60 We provisionally propose that a breach of warranty or other term should give the insurer the right to terminate the contract, rather than automatically discharging it from liability, but (unless otherwise agreed) only if the breach has sufficiently serious consequences to justify termination under the general law of contract. (8.89)

12.61 Do consultees agree that if the insurer accepts the insured's breach of warranty, so as to terminate future liability, the insured should cease to be liable for future premiums? (8.96)

12.62 We ask whether an insurer who terminates a policy following the insured's breach of warranty should normally provide a pro-rata refund of the outstanding premium, less any damages or reasonable administrative costs. (8.100)

Waiver and affirmation

12.63 We provisionally propose that loss by waiver of the insurer's right to repudiate the contract should in future be determined in accordance with the general rules of contract. We welcome views on whether it is necessary to include a specific provision on this point in any new legislation. (8.110)

Marine, aviation and transport insurance

12.64 We provisionally propose that the causal connection test outlined above should also apply to express warranties in marine insurance. They should also apply in aviation and transport insurance. (8.115)

12.65 We ask whether the implied marine warranties in the Marine Insurance Act 1906 continue to serve a useful function or whether they should be abolished. (8.125)

12.66 If the marine warranties are to be retained, we provisionally propose that they should be subject to the same causal connection test as express warranties. (8.126)

12.67 We ask consultees whether there are good reasons to retain the implied voyage conditions contained in sections 43 to 46 of the Marine Insurance Act 1906. (8.131)

12.68 If the voyage conditions are to be retained, we provisionally propose that they should be subject to the same causal connection test as express warranties. (8.132)

Reinsurance

12.69 We provisionally propose that the reforms proposed in relation to warranties should apply to reinsurance as well as to direct insurance. (8.138)

PRE-CONTRACT INFORMATION AND INTERMEDIARIES: CONSUMER INSURANCE PROPOSALS

Clarifying the agent's role

12.70 In consumer insurance, we provisionally propose that an intermediary should be regarded as acting for an insurer for the purposes of obtaining pre-contract information, unless it is clearly an independent intermediary acting on the insured's behalf. (10.29)

12.71 We ask if the test for whether an intermediary is independent and acts as the consumer's agent should depend on whether the intermediary searches the market and conducts "a fair analysis", as defined by the Insurance Mediation Directive. (10.32)

12.72 We ask whether any additional protection is necessary when consumers have been given bad advice about completing proposal forms by intermediaries who are not subject to FSA regulation? (10.34)

No more transferred agency

12.73 We provisionally propose that an intermediary who would normally be regarded as acting for the insurer in obtaining pre-contract information should remain the insurer's agent while completing a proposal form. (10.38)

The effect of a signature on a proposal form once basis of the contract clauses are abolished

12.74 We provisionally propose that a consumer insured's signature on a proposal form that has been completed incorrectly by a third person should not be regarded as conclusive evidence that the insured knew of or adopted what was written on the form. (10.44)

Section 19(b)

12.75 We welcome views on whether there are any reasons to preserve section 19(b) for consumer insurance. If so, should a breach grant the insurer a right in damages against the intermediary? (10.48)

Section 19(a)

12.76 We ask whether section 19(a) of the Marine Insurance Act 1906 should cease to apply in consumer cases, so that the agent to insure would have no duty to disclose matters other than those which the consumer is bound to disclose in response to the questions asked by the insurer. (10.51)

12.77 If there are reasons to preserve an extended duty under section 19(a):

(1) Should the remedy lie in damages against the intermediary, rather than in avoidance against the insured?

(2) Should any information given in confidence by a third party be excepted from the scope of the duty?

(3) Should the duty be curtailed to information received in the course of the relevant transaction? (10.52)

PRE-CONTRACT INFORMATION AND INTERMEDIARIES: BUSINESS INSURANCE PROPOSALS

12.78 We provisionally propose that, in a business context, an intermediary should be regarded as acting for an insurer for the purposes of obtaining pre-contract information, if it deals with only a limited number of insurers and does not search the market on the insured's behalf. (10.59)

12.79 For businesses using other intermediaries, the issue of whom the intermediary is acting for in respect of disclosure issues should be left to the common law. (10.60)

12.80 We provisionally propose that in the business context, an intermediary who would normally be regarded as acting for the insurer in obtaining pre-contract information remains the insurer's agent while completing a proposal form. (10.62)

12.81 We provisionally propose that a business insured's signature on a proposal form that has been completed incorrectly by a third person should not be regarded as conclusive evidence that the insured knew of or adopted what was written on the form. However, this should not reduce the effect of a warranty of fact given by a business insured. (10.64)

12.82 We provisionally propose that where a broker breaches section 19(a), the insurer should no longer be entitled to avoid the policy against the insured. Instead a remedy in damages should lie against the broker. (10.73)

12.83 We ask whether:

(1) The right to damages should apply whenever insurance contracts are placed within the UK, or only where the contract is subject to the law of a part of the UK?

(2) Producing brokers should be obliged to pass relevant information up the chain to the placing broker?

(3) The law should specifically state that an intermediary is not required to disclose information given to it in confidence by a third party? (10.74)

ASSESSING THE COSTS AND BENEFITS OF REFORMS

12.84 We ask whether the economic analysis of our reforms should look separately at firms that follow FSA rules and FOS practice (Type 1) and those that follow the law (Type 2). We welcome views on the numbers and type of firms that do not currently follow FOS practice. (11.16)

12.85 We ask whether the economic effect of our reforms should be assessed using the model commissioned from London Economics, which is set out at Appendix B to this Consultation Paper. (11.34)

12.86 We ask whether consultees are able to provide us with further data to enable us to carry out this assessment. (11.35)

12.87 We propose that the effect of a five year cut-off period for negligent misrepresentations should be costed separately from the costs of our other proposals. (11.40)

12.88 We ask whether consultees who are reinsurers in the life insurance sector are able to provide us with data to enable us to carry out this assessment. (11.41)

APPENDIX A
REFORMING THE LAW ON NON-DISCLOSURE AND MISREPRESENTATION

A CHRONOLOGICAL ACCOUNT OF PREVIOUS REPORTS, SELF-REGULATION AND STATUTORY REGULATION

A.1 In this Appendix we provide an outline of previous calls for reform on the law of non-disclosure and misrepresentation, together with the measures of self-regulation and statutory regulation introduced to address the problems. We do so because we believe that some knowledge of these developments is important to understanding the nature of the debate.[1]

ENGLISH LAW REFORM COMMITTEE REPORT 1957

A.2 Insurance contract law was considered by the Law Reform Committee in 1957.[2] The Committee did not make formal recommendations, but suggested three reforming provisions it felt could be enacted without legal difficulties:

(1) For the purposes of a contract of insurance no fact should be deemed material unless it would have been considered material by a reasonable insured.

(2) An insurer should not be able to rely on misrepresentation if the insured could prove that the statement was true to the best of the insured's knowledge and belief.

(3) An intermediary who arranged a contract of insurance should be deemed for the purposes of the formation of the contract, to be the agent of the insurer. Consequently anything disclosed to the intermediary would be deemed disclosed to the insurer.

These suggestions were not implemented.

A.3 A similar report by the Law Reform Committee for Scotland made no proposals for reform,[3] concluding that there was "…no demand in Scotland for any alteration in the law with regard to the subject of our remit".[4]

[1] In this short account, we have to not attempted to provide a full history, and have omitted some measures altogether, such as the Insurance Brokers Registration Council.

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

[3] Fourth Report of the Law Reform Committee for Scotland (1957) Cmnd 330.

[4] As above. at para 25.

THE STATEMENTS OF PRACTICE 1977

A.4 In 1977 the British Insurance Association (predecessor to the ABI) and Lloyd's issued a Statement of General Insurance Practice (SGIP). This was followed later in the same year by a Statement of Long-Term Insurance Practice (SLIP) issued by the Life Offices' Association (now part of the ABI) and the Associated Scottish Life Offices.

A.5 It appears that these Statements were introduced as part of an agreement with the Government, under which insurance contracts were exempted from key provisions of the Unfair Contract Terms Act 1977.[5] We are told that the title "Statement" was chosen in preference to "Code" to make it clear that in the industry's view the provisions merely confirmed current practice.

A.6 It was intended that the Statements would address some of the harsher aspects of the law for consumers. Both Statements required proposal forms to contain warnings regarding the duty of disclosure and the consequences of any breach. In addition, insurers were required to ask clear questions about matters which were generally found to be material.

A.7 The Statements did not directly change the test of materiality. Nor did they explicitly refer to avoidance. They did, however, restrict the right of an insurer to repudiate liability for a claim – and such repudiation could only take place after the policy had been avoided. The Statements did not address the situation where no claim had been made. Whilst many allegations of misrepresentation or non-disclosure are undoubtedly raised after a claim, these issues can arise in other circumstances.

A.8 SGIP provided that in cases of fraud, deception or negligence, an insurer's right to repudiate a claim remained unchanged. Otherwise - presumably in cases where a misrepresentation or non-disclosure was innocent - insurers should not:

> unreasonably repudiate liability to indemnify a policyholder:-
>
> on the grounds of non-disclosure or misrepresentation of a material fact where knowledge of the fact would not materially have influenced the insurer's judgment in the acceptance or assessment of the insurance.

A.9 This effectively anticipated the *Pan Atlantic* decision by requiring actual inducement.

A.10 SLIP was less clear:

> An insurer will not unreasonably reject a claim. (However, fraud or deception will, and negligence or non-disclosure or misrepresentation of a material fact may, result in adjustment or constitute grounds for rejection). In particular, an insurer will not reject a claim on grounds of non-disclosure or misrepresentation of a matter that was outside the knowledge of the proposer.

[5] Unfair Contract Terms Act 1977, schedule 1, para 1(2)(1)(a).

A.11 The word "or" between negligence and non-disclosure suggests that these are separate grounds for rejection of a claim. If this is correct, the only obligation on the insurer in respect of misrepresentation or non-disclosure is not to "unreasonably" reject a claim.

A.12 The weak nature of the protections offered by the Statements led one academic to describe them as “a rather pointless exercise”.[6]

A.13 Detailed criticisms of the Statements were also made in the English Law Commission's Report of 1980.[7]

ENGLISH LAW COMMISSION REPORT 1980

A.14 In 1975, a draft European Directive called for the harmonisation of the essential provisions of insurance contract law. By 1978 there was a separate draft Directive modelled on French law and aimed at achieving a measure of harmonisation. In 1978, against this background, the Lord Chancellor referred insurance contract law to the Commission.

The central problem

A.15 The report concluded that the current duty of disclosure is far too stringent. It argued that a duty of disclosure based on what a "prudent insurer" thinks is material is inherently unreasonable:

> It requires every insured to disclose any fact which a prudent insurer would consider to be material, and entitles the insurer to repudiate the policy and to reject any claim in the event of any breach of this duty. However, an honest and reasonable insured may be quite unaware of the existence and extent of this duty, and even if he is aware of it, he may have great difficulty in forming any view as to what facts a prudent insurer would consider to be material.”[8]

A.16 As a result, a policyholder may act honestly and reasonably and still find that the insurer is entitled to avoid the policy. Furthermore, the duty of disclosure can operate as a trap in relation to proposal and renewal forms. A reasonable insured may think that it is sufficient to answer the questions presented, and find that they are later deprived of the cover they thought they had bought.

[6] See J Birds, “The Statement of Insurance Practice — A Measure of Regulation of the Insurance Contract” (1977) 40 *Modern Law Review* 677.

[7] Insurance Law Non-Disclosure and Breach of Warranty (1980) Law Com No 104, paras 3.24 to 3.30.

[8] As above, at para 9.3(i).

Voluntary measures unsatisfactory

A.17 The insurance industry did not attempt to defend the law in its present form. Instead, they argued that any faults had been cured through the 1977 Statements of Practice. However, the Law Commission thought that the statements "are themselves evidence that the law is unsatisfactory and needs to be changed".[9] It gave three reasons:

(1) The Statements left insurers as the sole judge of whether rejection of a claim was reasonable.

(2) The Statements did not have the force of law and, indeed, the liquidator of an insurance company would be bound to disregard them.

(3) The Statements were restricted to policyholders effecting policies in their private capacity - but the mischiefs in the law also affected businesses.

A.18 The Commission was particularly scathing about the suggestion that insurers should have discretion "to repudiate a policy on technical grounds if they suspect fraud but are unable to prove it".[10] This placed insurers in the position of judge in their own cause.

Modifying the duty of disclosure

A.19 The Commission considered that the duty of disclosure should be modified rather than abolished. It thought that insurers still relied on information volunteered by policyholders. Without it, insurers would be less able to differentiate between good and bad quality risks, leading to higher premiums for honest and reasonable policyholders.

A.20 This approach applied to both consumers and businesses. The Commission thought that abolition would enable "sharp practice" by consumers. [11] It would also hamper the granting of temporary cover prior to a proposal form being completed. Indeed, any division between consumers and business was thought by the Commission to be artificial; it felt the dividing line should really be between "professionals" and "non-professionals". Special rules for consumers would lead to complex law, as there would then be three categories:

(1) Consumers.

(2) Businesses.

(3) Marine, Aviation and Transport risks.

So far as businesses were concerned, most other systems of law imposed such a duty and abolition might cause the British insurance industry to lose international competitiveness. Instead, the Commission attempted to draw a better balance between the interests of the insurer and those of the policyholder.

[9] As above, at para 3.28.

[10] As above, at para 6.10, when it made this explicit condemnation of the provisions on warranties.

[11] As above, at paras 4.34 to 4.42 and 10.8.

A reasonable insured test

A.21 The Commission recommended that an applicant for insurance should only be required to disclose those facts that a reasonable person in the position of the applicant would disclose. Thus an applicant for insurance would be obliged to disclose a fact only if:

(1) It is material in the sense that it would influence a prudent insurer in deciding whether to offer cover against the proposed risk and, if so, at what premium and on what terms; and

(2) It is either known to the applicant or it is one which the applicant can be assumed to know. For this purpose the applicant should be assumed to know a material fact if it would have been ascertainable by reasonable enquiry and if a reasonable person applying for the insurance in question would have ascertained it; and

(3) It is one which a reasonable person in the position of the applicant would disclose to the insurer, having regard to the nature and extent of the insurance cover which is sought and the circumstances in which it is sought.[12]

A.22 The final limb allows the court to make a distinction between, say, a small business and a large business with in-house insurance expertise. However, it was not intended that an individual's personal characteristics would be considered.

A.23 Regard should be had to the nature and extent of the insurance cover sought. A reasonable person might not disclose facts relevant to health when applying for a household policy, and a lesser degree of disclosure might be expected from those applying for mere temporary cover. The circumstances in which cover is sought should be considered. An application by telephone might be treated differently to an application made on paper.

Only reasonable enquiries

A.24 It was felt that a policyholder should be required to make reasonable enquiries, but not to undertake elaborate investigations. The Commission recommended that even if an answer on a proposal form proved to be inaccurate, a policyholder should be regarded as having met the duty of disclosure if two conditions were satisfied:

(1) The policyholder, before answering, had carried out enquiries that were reasonable having regard to the subject matter of the question and the nature and extent of the cover sought.

(2) The answer was correct to the policyholder's best knowledge and belief.

[12] As above, at paras 4.43 to 4.53 and 10.9.

In such circumstances, it was also recommended that the insurer should not be entitled to pursue an alternative remedy for misrepresentation.[13]

Proposal and renewal forms

A.25 The Commission recommended that proposal forms should contain clear, explicit and prominent warnings about the standard of answers required, the duty to volunteer information and the consequences of failing to meet these obligations.[14] A copy of the completed proposal form should be provided to a policyholder after completion or as soon after as is reasonably practicable.[15]

A.26 In the event of a failure to meet these requirements, an insurer would be unable to rely on any non-disclosure by the policyholder — subject to the court having a discretion to allow the insurer to rely on the non-disclosure if the failure caused no prejudice to the policyholder.

A.27 The Commission further recommended that if a policy had been initiated by the completion of a proposal form the insurer should only have a remedy for non-disclosure at renewal if it had taken the following steps:

(1) Supplied the policyholder with copies of any information that the policyholder had previously submitted to the insurer.

(2) Warned the policyholder of the importance of retaining such copies.

(3) Warned the policyholder of the duty to volunteer information and the consequences of failing to meet this obligation.

A.28 For policies not initiated by proposal form, only the third step was required.

Anti-avoidance

A.29 The Commission recommended measures to prevent insurers from avoiding the reforms.

A.30 First, it thought that where a policyholder's failure to provide an insurer with information amounts to both a non-disclosure and a non-fraudulent misrepresentation, an insurer's rights would be limited to those — if any — available for non-disclosure.[16]

A.31 Secondly, it recommended measures to curb the use of “basis of the contract” clauses.[17] The Commission recommended that such clauses should be ineffective insofar as they seek to create warranties as to past or present fact.

Rejected options

A.32 The English Law Commission specifically rejected two further options for reform.

[13] As above, at paras 4.61 to 4.62 and 8.5.

[14] As above, at para 10.14.

[15] As above, at para 10.15.

[16] As above, at para 8.5.

[17] As above, at paras 7.8 to 7.11

No requirement for a causal link

A.33 The Commission rejected the idea that the insurer would be required to show a link between a non-disclosure and any loss that had occurred.[18] It argued that an insurer assesses a risk at a fixed point - the time at which an application for insurance is considered. A non-disclosure may cause it to offer cover which it would not otherwise have granted, or where a different premium or different terms would have been applied. It would be wrong to hold an insurer to such a contract. Furthermore, where the non-disclosure relates to moral hazard, such as the applicant's claims record or criminal convictions, it would be rare that a link can be shown with any loss that occurs. It seems unfair that the insurer has no remedy when the applicant has acted unreasonably.

The "all or nothing" rule maintained

A.34 The Commission concluded that there should not be a remedy based on the proportionality principle.[19] It specifically rejected the idea that claims should be reduced to reflect the ratio between the premium paid and the premium that should have been paid. In many cases it would be difficult to establish what premium should have been charged. Furthermore, the insurer may not necessarily have charged a higher premium: it may have declined the risk altogether or imposed additional warranties, exclusion clauses, or excesses. In such cases a reduction in the claim paid would become arbitrary.

THE INSURANCE OMBUDSMAN BUREAU 1981

A.35 The Insurance Ombudsman Bureau ("IOB") was the first private-sector ombudsman scheme in the UK, and the first complaints-handling service formally to use the title "ombudsman". It was established on a voluntary basis by three insurers and commenced operations in March 1981. The IOB investigated complaints against insurers and was able to make awards which, if accepted by the complainant, were binding on an insurer to a limit of £100,000. Until 1994, it could consider complaints relating to general or life insurance.

A.36 The ombudsman concept met with enthusiasm from the public. Further insurers joined until almost all were members.

THE STATEMENTS OF PRACTICE 1986

A.37 The 1980 report was never implemented. Instead, the industry reached agreement with the Government that the Statements of Practice would be strengthened in place of law reform.

A.38 On 31 October 1980 the Department of Trade and Industry circulated a consultation paper seeking views on the English Law Commission's 1980 report. The responses indicated a division of opinion between consumers and others who wished to see reform, and insurers who argued that there was no need for radical or urgent change.

[18] As above, at paras 4.89 to 4.97 and 10.30.

[19] As above, at paras 4.4 to 4.17 and 10.6.

A.39 In 1984 the DTI put forward a Bill based on the 1980 report but limited to consumers. However, this was subsequently abandoned and on 20 December 1984 the Secretary of State made the following announcement:

> I am embarking on discussions with the insurance industry to see whether changes to their statements of insurance practice can be made to deal with problems in those areas. I shall review whether legislation is appropriate and feasible in the light of whatever changes may be agreed.

A.40 On 21 February 1986, the Secretary of State confirmed that the DTI had accepted changes in the Statements as an alternative to law reform:

> The insurers have informed me that they are willing to strengthen the non-life and long-term 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.

A.41 The 1986 version of SGIP remained in force until 14 January 2005. It was then withdrawn with the introduction of statutory conduct of business regulation for general insurance. However, it continues to be taken into account by the Financial Ombudsman Service as an indicator of good practice.[20] SLIP remains partially in force.

FINANCIAL SERVICES ACT 1986

LAUTRO and FIMBRA

A.42 Regulation of the conduct of investment business was introduced in 1988 under the Financial Services Act 1986. It was a two-tier system, with a statutory regulator - the Securities and Investments Board - overseeing self-regulating organisations and recognised professional bodies. The two self-regulating organisations for insurance were the Life Assurance and Unit Trust Regulatory Organisation ("LAUTRO") and the Financial Intermediaries, Managers and Brokers Association ("FIMBRA"). LAUTRO appointed IOB to act as its primary complaints-handling mechanism. For most of the time FIMBRA operated, it offered an arbitration scheme.

PIA

A.43 In 1994 LAUTRO and FIMBRA were replaced by a single self-regulating organisation - the Personal Investment Authority ("PIA"). The PIA established its own Ombudsman, leading the IOB to lose jurisdiction over life insurance.

[20] *Ombudsman News* (August 2004) Issue 39.

NATIONAL CONSUMER COUNCIL REPORT 1997

A.44 In 1997 the National Consumer Council ("NCC") published a report written by Professor John Birds, then of Sheffield University, which considered the impact of insurance law on consumers:

> Almost every household in the country regularly buys personal insurance of one kind and another, to safeguard the value of their personal belongings, home, income, health, travel and so on, in case of crime, accident or other disaster. And every time they buy – or renew – a policy, the transaction is governed by law that has remained largely unchanged for hundreds of years. Large parts of that law, it is widely acknowledged, are heavily biased against the interests of consumers.

A.45 The NCC took into account the 1986 Statements of Practice but concluded that there were still areas "where consumers are manifestly still at risk". It recommended reform in a range of areas:

> We conclude that the only effective solution to some of the serious problems encountered by consumers when it comes to buying personal insurance is legislative reform.

A.46 With regard to misrepresentation and non-disclosure, the NCC made a series of recommendations.

The test of materiality

A.47 The NCC recommended that a consumer should be required to disclose those facts within the consumer's knowledge which either the consumer knows to be relevant to the insurer's decision or which a reasonable person in the circumstances could be expected to know to be relevant.

A.48 It also recommended that an untrue statement should not be treated as a misrepresentation if the applicant honestly believed it to be true.

Remedies

A.49 The NCC recommended that avoidance should continue to be available as a remedy for fraudulent misrepresentation or non-disclosure.

A.50 For other cases, the rights of the insurer would depend on the action the insurer would have taken had it known of the true facts:

(1) If the insurer would have declined to offer cover, it should be entitled to avoid the policy.

(2) If the insurer would have offered cover, it should retain liability under the policy but should be entitled to deduct the extra premium it would have charged had there been no non-disclosure or misrepresentation.

GENERAL INSURANCE STANDARDS COUNCIL

A.51 In July 2000, a voluntary regulator was established for general insurance. Membership was open to insurers and intermediaries. Regulation was based on two codes - the GISC Private Customer Code for consumer insurances and the GISC Commercial Code for business insurances.

THE PAT SAXTON MEMORIAL LECTURE 2001

A.52 In March 2001 Lord Justice Longmore gave the Pat Saxton Memorial Lecture. He took the opportunity to propose a new Insurance Contracts Act, dealing with, amongst other issues, misrepresentation and non-disclosure. He made a number of suggestions for reform.

Test of materiality

A.53 Lord Justice Longmore identified a number of possible formulations for the test of materiality, and expressed support for a formulation that depends on what the reasonable insured would think was material. He has since said judicially:

> Is it not time that the law was changed at least to the extent that an insured's disclosure obligation should be to disclose matters which the insured knows are relevant to the insurer's decision to accept the risk or which a reasonable assured could be expected to know are relevant to that decision?[21]

Remedies

A.54 He suggested that the courts might be given a discretion to adjust the respective responsibilities of insured and insurer instead of allowing avoidance:

> It would, of course, lead to some uncertainty but that, after all, was a reason against the introduction of the concept of contributory negligence which, in the event, is a concept that has worn the test of time very well. In these days when the incidence of costs in litigation may depend on well or ill informed guesses made by the litigant, at the time they are obliged to serve pre action protocols, uncertainty is endemic, yet the court, and litigants, are quite good at getting used to it. Moreover, the Insurance Ombudsman Bureau apparently uses its discretion on occasion to apportion the loss and appears to have no difficulty with the concept.

THE FINANCIAL SERVICES AND MARKETS ACT 2000

COB

A.55 One of the earliest acts of the Labour government formed in May 1997 was an announcement that it intended to introduce statutory regulation for the financial services industry with a single regulator – the Financial Services Authority ("FSA"). This new system was introduced in 2001 under the Financial Services and Markets Act 2000 ("FiSMA").

[21] *North Star Shipping Ltd v Sphere Drake Insurance plc* [2006] EWCA Civ 378, [2006] 2 Lloyd's Rep 183, at [53].

A.56 The FSA sets out its Rules for regulated firms in its Handbook. With effect from 1 December 2001 the FSA took responsibility for conduct of business regulation of investment insurance. The relevant Rules are to be found in the Conduct of Business ("COB") sourcebook.

A.57 On 13 July 2005, the FSA announced that it would be simplifying the COB regime to make it "easier to understand, comply with, enforce and amend"[22]. It is anticipated that a revised structure for the COB sourcebook will be introduced in November 2007 at the same time as the Markets in Financial Instruments Directive ("MiFID") is implemented.

Financial Ombudsman Service

A.58 When this new system was being designed, it was decided that there should be a single complaints-handling body — the Financial Ombudsman Service.

A.59 The Financial Ombudsman Service ("FOS") therefore replaced eight existing dispute-resolution mechanisms, including the Insurance Ombudsman Bureau and the Personal Investment Authority Ombudsman. It was established under Part 16 and Schedule 17 of FiSMA. In addition, Rules relating to the FOS can be found in the *Dispute Resolution: Complaints* sourcebook ("DISP") within the FSA Handbook. Although the FOS has both a compulsory and a voluntary jurisdiction, it is the former that is of primary importance for current purposes.

A.60 Provided that certain preliminary conditions are met, the FOS can consider complaints against insurers and intermediaries. Both complainant and the complaint must be within the scope of the scheme, and the complaint must be brought within the relevant time limits and not subject to dismissal without consideration of its merits. Complaints may be referred to the FOS by private individuals, and by sole traders and small businesses with a turnover of less than £1 million.

A.61 Chapter 1 of DISP contains rules relating to the internal handling of complaints by firms:

> The purpose of this chapter is to set out the rules relating to the internal handling of complaints by firms, including the procedures which a firm must put in place; the time limits within which a firm must deal with a complaint; the referral of complaints, the records of a complaint which a firm must make and retain; and the requirements on a firm to report information about complaints to the FSA. This is to ensure that complaints are handled fairly, effectively and promptly, and resolved at the earliest possible opportunity, minimising the number of unresolved complaints which need to be referred to the Financial Ombudsman Service.

BRITISH INSURANCE LAW ASSOCIATION REPORT 2002

A.62 In 2002 the British Insurance Law Association ("BILA") submitted a report to the English Law Commission in which it recommended reform of various aspects of insurance contract law.

[22] FSA/PN079/2005.

A.63 This report is of particular interest in that it was drafted by a sub-committee whose members included insurance practitioners as well as academics and lawyers. The introduction to the report indicated clearly that the state of the law was now a matter of concern to the market:

> This Sub-Committee was formed in January 2001 to examine areas of insurance law causing concern in the insurance market and in insurance disputes, and to make recommendations to the Law Commission as to the desirability of drafting a new Insurance Contracts Act in respect of Marine and Non-Marine Insurance and/or other reforms to current legislation.

A.64 BILA made recommendations affecting both the test of materiality and the remedies available to insurers.

The test of materiality

A.65 BILA recommended that the test of materiality should be amended so that an applicant for insurance would be obliged to disclose those matters which a reasonable insured would have considered material to a prudent insurer.

Remedies

A.66 BILA recommended that avoidance should continue to be available as a remedy for fraudulent or reckless misrepresentation or non-disclosure. In addition, the insurer would have the right to retain the premium paid.

A.67 Where a misrepresentation was innocent or negligent, BILA recommended a response depending on the action an insurer would have taken had it known of the true facts:

(1) If the insurer would have declined to offer cover, it could avoid the policy but would be obliged to return the premium.

(2) If the insurer would have offered cover on different terms, it could not avoid the policy but:

(3) would not be liable for any loss proximately caused by the fact that was misrepresented or not disclosed, and

(4) could vary its liability to reflect any variation in premium deductible or excess that would have been imposed had it known of the true facts.

ICOB 2005

A.68 On 14 January 2005, the FSA took over responsibility for conduct of business regulation of general insurance. The Rules for "pure protection insurance" are contained in the Insurance Conduct of Business ("ICOB") sourcebook. On the same date, the GISC was closed and SGIP was withdrawn.

A.69 The FSA is currently conducting a post-implementation effectiveness review of ICOB. Its objectives have been described by Mr Dan Waters, Director of Retail Policy at the FSA in the following terms:

> Effectiveness reviews are part of the FSA's approach seeking to ensure that its interventions in the market make a real and beneficial difference in practice. We are seeking to introduce more principles-based regulation and simplification across the FSA Handbook as a whole in the context of our Better Regulation agenda. And the GI effectiveness review presents a good and timely opportunity to look at ICOB in fine detail from the viewpoint of restricting prescription to the point where it is only demonstrably necessary to meet our consumer protection objective.

A.70 The FSA published its interim report in March 2007.[23] The review proposes a move towards a more principles-based and proportionate approach to general insurance regulation. The essential consumer protections, including the detailed rules on non-disclosure and breach of warranty, will be retained. However, the FSA is looking at removing most of the ICOB disclosure requirements imposed on firms that go beyond minimum EU directive requirements. The report also proposes a small number of measures to improve the selling of personal protection insurance policies, such as critical illness. For example, the FSA proposes extending the cancellation period for protection policies and requiring that customer's attention be drawn to the importance of reading the policy documents to check the suitability of the cover.

APPLICATION FORM DESIGN – GUIDANCE FROM THE ABI 2006

A.71 In February 2006, the ABI issued guidance to its members on the design and wording of proposal forms for life and health insurance. This guidance, entitled *Application Form Design for Life and Health Protection Insurances* (AFD) was aimed at ensuring that all relevant information is disclosed at the application stage:

> Although not all non-disclosure arises because of faults in proposal forms, insurers should do as much as they can to ensure that the questions they ask are clear and unambiguous. Doing so assists the applicant in their understanding of what is being asked of them. Thus when completing a proposal form, they should have confidence they are giving all the necessary correct and relevant information. This will also reduce the burden on salespersons in explaining or interpreting how questions should be responded to.

SLIP is now an addendum to the AFD.[24]

A.72 The AFD has provisions relating to some of the problems that we identify in Part 4. It should, however, be noted at this stage that the AFD specifically states that its provisions are not binding on insurers except where they represent the law or the requirements of the Statements of Practice:

[23] Financial Services Authority, ICOB Review Interim Report: Consumer Experiences and Outcomes in General Insurance Markets. Available at http://www.fsa.gov.uk/pubs/other/ICOB_review.pdf. (accessed 27 April 2007).

[24] For copies of both SLIP and the AFD, see the appendices to Issues Paper 1.

In order to allow flexibility and to preserve competition between Insurers, the recommendations are not in any way prescriptive to ABI members, other than where existing legislation or Statements of Best Practice are applicable.

APPENDIX B
ASSESSING THE ECONOMIC IMPACT OF OUR PROPOSALS: A REPORT PREPARED BY LONDON ECONOMICS

A proposed model for assessing the economic impact of proposed changes to the law relating to non-disclosure and misrepresentation

Prepared by London Economics, June 2007

The following report contains its own contents list and pagination.

The main pagination of the report resumes at page 359 with Appendix C.

A proposed model for assessing the economic impact of proposed changes to the law relating to non-disclosure and misrepresentation

Final report on behalf of the

Law Commission and the Scottish Law Commission

Prepared by

London Economics

June 2007

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Tables & Figures

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1 Introduction and Terms of Reference

The Law Commission and the Scottish Law Commission[1] are undertaking a consultation exercise in summer 2007 in relation to reforming the existing laws regarding non-disclosure, misrepresentation and breach of warranty by the insured in both the retail and commercial insurance markets. As part of that consultation exercise London Economics have been commissioned by the Law Commission to produce a model for assessing the economic effects of its proposed reforms. This study presents the elementary stages for the provision of that model for further consultation. However, the modelling is currently based on a number of assumptions and hypotheses and should not be seen as the definitive or final approach upon which further analysis may take place. Rather, it is an initial attempt to conceptualise the analytical framework and highlight both the assumptions and information necessary to undertake a more rigorous analysis.

Our analysis in this document concentrates on one area of the Law Commission's proposed reforms: reform of the law dealing with pre-contractual information provided by a consumer.

This report provides some background information on the particular markets that might be affected; an analysis of the potential impacts associated with the reforms; a rationale for selecting the insurance markets that might be most appropriate for a full cost benefit analysis; the order of magnitude of some of the potential effects of the reforms and a worked example or case study relating to one of the markets illustrating the possible outcomes associated with these reforms.

This report is not intended to provide definitive conclusions on the appropriateness of particular markets that might be carried forward for further analysis nor does it provide an exact assessment of the costs and benefits associated with the introduction of these proposals. It is intended to feed into the consultation exercise and provide an initial framework for the possible estimation of the costs and benefits associated with these reforms. The report also identifies the nature of the evidence gaps that exist and suggests where those participating in the consultation exercise may be able to assist in the validation of the assumptions underpinning the modelling work and provide more robust data.

This report is set out as follows. Section 2 provides some information on the proposed reforms that are being considered by the Law Commission. Section 3 provides a brief theoretical background on consumer and firm incentives in insurance markets and alternative remedies in the case of non disclosure or misrepresentation. Section 4 provides an analysis of a variety of insurance markets that covers the degree of penetration associated with each type of

[1] For ease of reference, the phrase "Law Commission" will be used in this report. It is intended to cover both the Law Commission and the Scottish Law Commission.

policy, as well as information (where it is available) on the extent of the problem of non-disclosure and misrepresentation. Section 5 provides an analytical framework for considering the proposed reforms on firms and consumers while section 6 provides a case study of the possible impacts and outcomes associated with the reforms in respect of the critical illness insurance market.

2 What are the primary changes to be introduced?

In order to demonstrate our proposed model we attempt to illustrate how it assesses the Law Commission's proposed reforms in one area, namely its proposals to reform the law relating to pre-contractual information given by the consumer to the insurer. We do not demonstrate the model using the effect of the reforms proposed for the business or commercial insurance markets or those relating to warranties of future conduct.

We provide a summary below on what the Law Commission's proposed reforms are to pre-contractual information provided by the consumer. We then demonstrate our model and illustrate where we will need further information from consultees in order to present a more accurate assessment of the effects of reform.

2.1 The current law and the approach taken by the Financial Ombudsman Service

At present, there is a wide divergence between the strict law and the guidance set out by the Financial Ombudsman Service (FOS). Consumers have a right to take a case to the FOS if their claim is turned down by their insurer. The FOS will examine the case and has the power to impose a settlement of an amount up to £100,000 on the insurer if it decides that the insurer behaved wrongly in turning down the claim. We shall explain both the strict law and the FOS guidance below.

The strict law gives insurers the right to avoid[2] policies where the policyholder has made any inaccurate statement of fact, even if the statement was made honestly and reasonably. Insurers may also avoid a policy where the policyholder has not volunteered "material" information even if the consumer was not asked a question about that information. Material information is said to be information that would have influenced the judgment of a prudent insurer.

By contrast, the FOS does not require consumers to volunteer information, but only to answer the questions asked. Where the consumer has given an inaccurate answer that induced the insurer to enter the contract, the ombudsman will ask whether the misrepresentation was:

- Innocent;
- Inadvertent; or
- Deliberate or reckless.

[2] Avoiding a policy means that the contract is treated as if it never existed and the insurer can refuse to pay the consumer's claim but must return any premiums paid to it under that contract.

Where the misrepresentation is innocent, the FOS will require the insurer to pay the claim. Where it is deliberate or reckless, the insurer is entitled to refuse to pay the claim. For inadvertent misrepresentations, the FOS asks what the insurer would have done had it known the truth and will apply a compensatory remedy. In particular:

- Where an insurer would have excluded a particular type of claim the insurer should not be obliged to pay claims that would fall within the exclusion;
- Where an insurer would have imposed a warranty or excess, the policy would be rewritten to include the warranty or excess;
- Where an insurer would have declined the risk altogether, the policy may be avoided, the premiums returned and the claim refused;
- Where an insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium.

2.2 The Law Commission's Proposed Reforms

The Law Commission is proposing three main changes.

First, it is proposing that the law should be reformed to follow the FOS guidance. This would make it easier for insurers to know what the rules were, and would improve compliance with the FOS requirements. This will mean in effect that, as with the FOS rules, the consumer's duty to volunteer information would be abolished. Insurers should ask questions about any matter that is material to them. Where an inaccurate answer is given to a question, the remedy available to the insurer will depend on to what extent the consumer was at fault in giving that answer.

Secondly, it is proposing to clarify aspects of the FOS definitions that presently create confusion. In particular, the FOS's dividing line between "reckless" and "inadvertent" misrepresentations is unclear. The Law Commission definitions, by contrast, clearly state that recklessness should be reserved for misrepresentations that are essentially dishonest. Careless misrepresentations would be termed "negligent" and treated in the same way as the FOS currently treats "inadvertent" misrepresentations (i.e. a proportionate remedy is applied). This means that it is possible that a few cases which are presently considered "reckless" by the FOS may in future be classified as "negligent": the insurer would not necessarily be able to avoid all claims under the policy but may be required to apply an exclusion or make a proportional payment. The main effects would therefore be:

- Greater clarity;
- Greater compliance with FOS guidance;
- A few cases that are presently classified by the FOS as "reckless" misrepresentations may in future be classified as "negligent" misrepresentations and result in proportionate payment.

Thirdly, it asks whether, where a misrepresentation is deliberate or reckless, the insurer should be entitled to refuse to pay the claim and retain any premiums that have been paid to it under the policy. The FOS states that where an insured acts fraudulently the insurer may retain the premiums. However the Law Commission found that insurers tended to return premiums to consumers when they refused to pay the claim for deliberate and reckless misrepresentation. If the Law Commission receives a positive response to its question about whether premiums should be retained and this becomes law, it may have an economic effect.

3 Economic incentives in insurance markets

Before presenting information on the size and coverage of various insurance markets and the incidence of claims remaining unpaid for reasons of non-disclosure and misrepresentation, it is important to understand some of the economic incentives that consumers and firms may face. We present some information and illustrative examples of how markets may operate when non-disclosure and misrepresentation occur (in a stylized or theoretical sense) and the potential remedies that might be available.

3.1 Comparing different remedies: an illustration

To illustrate the effect of different remedies it may be helpful to provide a simple example with some alternative scenarios to illustrate alternative outcomes. The aim is to find the remedy that would most satisfactorily compensate the insurer for any loss it has suffered as a result of a consumer's failure to give accurate pre-contractual information.

3.1.1 Baseline Case

Insurer A issues life insurance policies to 1,000 people. It has good claims data, and is able to assess accurately the risks and payments involved. Of the 1,000 people insured, 800 are in normal health while the remaining 200 have high blood pressure. The insurance company knows that among its population of insureds, the risk of death for those with normal health is 2 in 100.

From this group of individuals, the insurance company therefore anticipates receiving two claims for every hundred policies. If we assume that each claim involves a payment of £10,000 and that the underwriting costs exactly cover the expected claims to be paid, this implies that the cost to the consumer of each policy is £200[3].

Insurer A also knows that 20% of its pool of individuals suffers from high blood pressure. For this group, the risk of death is double that of a person with normal health – at 4 in 100. As the cost per claim is the same (£10,000), the appropriate underwriting premium for this group of policyholders is £400 each.

If the outcomes of the insured are as expected, and the insurer knew who suffered from high blood pressure and who did not, the profile of its 1,000 policies will be represented in the Table overleaf:

[3] The insurer also adds a mark-up for sales, administration, and profit, but for the purposes of this illustration, we are only concerned with the premium necessary to cover the anticipated claims.

Table 1: Illustrative working of an insurance market with no misrepresentation

	1. Standard policy	2. Policy for people with high blood pressure.
Number of policies written	800	200
Premium per policy	£200	£400
Income from pool of policies	£160,000	£80,000
Expected number of claims	2% = 16	4% = 8
Actual number of claims	2% = 16	4% = 8
Cost per claim	£10,000	£10,000
Cost of claims for pool	£160,000	£80,000
Economic Profit	**£0**	**£0**

3.1.2 Scenario 1: Charging the full premium

However, some people fill out insurance application forms inaccurately, despite the clear warnings of the possible consequences of doing so. Suppose that the insurance company writes 150 for people with high blood pressure, instead of writing 200. The shortfall is accounted for the fact that the insurance company insures 50 people who have high blood pressure who have misrepresented their condition. These individuals should have been charged £400, but instead have been charged the standard policy rate of only £200 each.

Suppose that the various categories of policy holder suffer a critical illness in line with expectations. From the normal population, there will be 16 claims (as before) while from the group of individuals that has disclosed high blood pressure, there will be 6 claims. In the case of the group of individuals who have not disclosed their existing condition of high blood pressure, there are 2 claims.

Clearly, in the absence of any legal remedy, the insurer would be forced to pay claims from 2 individuals that should have represented or disclosed themselves to be suffering from high blood pressure. The impact of this would be that the insurer has suffered a significant economic loss of **£10,000.**

In Scenario 1, the remedy available to the insurer might be to allow the insurance company to charge the full premium they would have charged had they known the individual was suffering from high blood pressure. This is neither the current law, nor a proposal for reform suggested by the Law Commission, but it illustrates one type of proportional remedy. Even in the case where the insurer is able to charge the full premium that the insured should have paid, this remedy is only available against those individuals who have made the claim and not the entire pool of individuals that have misrepresented. Therefore, this option only reduces the economic loss suffered by the insurer by **£400**, leaving the insurer with a total expected loss of **£9,600.**

Table 2: Illustrative workings of an insurance market with misrepresentation under scenario 1

	1. Standard policy	2a. Those who have declared high blood pressure	2b. Those who should have declared high blood pressure but misrepresented their condition.
Number of policies written	800	150	50
Premium actually charged	£200	£400	£200
Income from pool of policies	£160,000	£60,000	£10,000
Expected number of claims	2% = 16	4% = 6	2% = 1
Actual number of claims	2% = 16	4% = 6	4% = 2
Cost per claim	£10,000	£10,000	£10,000
Cost of claims for pool	£160,000	£60,000	£20,000
Initial effect	£0	£0	-£10,000
Additional Premiums			£400
Overall effect	**£0**	**£0**	**-£9,600**

3.1.3 Scenario 2

Scenario 2 looks at the effect of the current law of avoidance. Suppose as before, the insurer receives 2 claims for £10,000 but rejects them on the grounds of misrepresentation.[4]The insurer avoids the policy and returns the premium to those 2 individuals while continuing to collect the premium of the remaining pool of 48 individuals.

The outcome of this scenario is that the insurer, although it has returned the premiums to those individuals who have misrepresented, is left bearing a risk in the remaining pool which is substantially less than would be expected from a pool of individuals suffering from high blood pressure.

Specifically, in a pool of 50 individuals who have high blood pressure, the insurance company would have an expectation that 2 individuals would submit a claim. If this has occurred and the firm has declined the two claims, the insurer would expect that there would be no further claims from this pool of individuals. Even if further claims did occur, the insurer would be entitled to refuse to pay any of them as a result of the misrepresentation (provided it was detected).

Therefore, the insurer receives premiums from individuals (who are misrepresenting their existing medical conditions) but is facing reduced actuarial risk of further claims. The insurance company in this scenario would expect to make an economic profit of **+£9,600** on the remaining pool of policy holders**.**

[4] This scenario assumes that the misrepresentations will be detected. If they are not, the outcome will be different.

Table 3: Illustrative workings of an insurance market with misrepresentation under scenario 2

	1. Standard policy	2a. Those who have declared high blood pressure	2b. Those who should have declared high blood pressure but misrepresented their condition.
Original number of policies written	800	150	50
Number of policies written **remaining**	800	150	48
Premium actually charged	£200	£400	£200
Income from **remaining** pool of policies	£160,000	£60,000	£9,600
Expected number of claims from remaining pool	2% = 16	4% = 6	0
Number of claims	2% = 16	4% = 6	0
Cost per claim	£10,000	£10,000	£10,000
Cost of claims for pool	£160,000	£60,000	£0
Overall effect	**£0**	**£0**	**+£9,600**

3.1.4 Scenario 3

Scenario 3 assumes that an insurer will be obliged to pay a proportion of the claims, based on the premium that would have been charged had the insurer been aware of the true state of affairs. In this scenario, the insurance company only pays half of each claim (£5,000), on a proportionate basis. This remedy attempts (as far as the law is able) to replicate the effect of the standard policy, leading to a result under which the insurer makes no economic profit or loss.

Table 4: Illustrative workings of an insurance market with misrepresentation under scenario 3

	1. Standard policy	2a. Those who have declared high blood pressure	2b. Those who should have declared high blood pressure but misrepresented their condition.
Number of policies written	800	150	50
Premium actually charged	£200	£400	£200
Income from pool of policies	£160,000	£60,000	£10,000
Expected number of claims	2% = 16	4% = 6	2% = 1
Number of claims	2% = 16	4% = 6	4% = 2
Cost per claim	£10,000	£10,000	£5,000
Cost of claims for pool	£160,000	£60,000	£10,000
Overall effect	**£0**	**£0**	**£0**

3.1.5 Summary of results

There are significantly different outcomes associated with the three alternative scenarios. In the case of misrepresentation followed by total avoidance and return of premiums, the insurer achieves an economic profit of £9,600. In the case of misrepresentation followed by partial payment, there is no economic profit earned by the insurer, while in the final case of misrepresentation followed by full payment, the economic loss suffered by the insurer is expected to be £9,600. This is summarised in the Table overleaf.

Table 5: Illustrative workings of an insurance market with misrepresentation with different remedies

	Scenario 1. Misrepresentation followed by payment of claim and receipt of additional premium	Scenario 2. Misrepresentation followed by avoidance of claim	Scenario 3. Misrepresentation followed by proportionality
Number of policies written	50	50	50
Premium that should have been charged	£400	£400	£400
Premium actually charged	£200	£200	£200
Income from pool of policies	£10,000	£10,000	£10,000
Number of claims	2	2	2
Cost per claim	£9,800 Initial £10,000 claim less additional premium of £200	£200 Both claims rejected – premiums returned	£5,000 Reduced from £10,000 proportionally
Cost of claims for pool	£19,600	£400	£10,000
Economic Profit	**- £9,600**	**+ £9,600**	**£0**

3.2 Conclusions

We have presented three simple illustrative scenarios of alternative outcomes in an insurance market depending on the options available and possible responses by firms to claims. It is a very simple theoretical example and does not reflect the proposal being considered by the Law Commission. Despite this, the illustration suggests that the ability to completely avoid a policy for reasons of negligent non-disclosure or misrepresentation (the current strict law) may provide a measure of over-compensation to some insurers.

Specifically, the ability to refuse a claim for reasons of non-disclosure or misrepresentation may not encourage some insurers to ask clear understandable questions. In an extreme case it allows insurers to make a greater profit from wrong answers than from right ones.

Assuming that the detection of misrepresentation or non-disclosure is imperfect, allowing claims on the payment of additional premiums substantially under-compensates the insurer and provides some individuals with possible incentives to misrepresent or not fully disclose to the detriment of the insurer.

In the illustration presented here, proportionality appears to provide a more appropriate way of compensating insurers for the potential loss caused by misrepresentation.

4 Baseline analysis of insurance markets and the extent of non-disclosure

4.1 Market characteristics and coverage

In this section we present some information on the size and coverage of the various consumer insurance markets using a variety of measures. Specifically, we have attempted to provide a range of measures that will allow the Law Commission to assess the specific insurance markets that might be suitable for a full assessment of the costs and benefits associated with the proposed reforms.

We have gathered together some of the existing information on the characteristics of various consumer insurance markets from a variety of sources but it is clear that there are evidence gaps and more comprehensive information would greatly assist the analysis. We would hope that the consultation exercise would help in this process and would ask consultees to provide as much information as they have available to assist with any further analysis.

The characteristics of the insurance markets we present relate to the size of the market – expressed in terms of the number of policies purchased in a particular year or the number of households with a particular type of insurance policy and the average premium charged to consumers or the average annual household expenditure on a particular type of insurance. Combining the household coverage and household expenditure on premiums provides one measure of the size or household penetration of various insurance products.

This does not imply that the markets that should be considered for a full cost benefit analysis are simply and exclusively those markets that are large in a financial sense. The reforms proposed in relation to non-disclosure and misrepresentation might affect particular types of insurance products disproportionately. As such, the Law Commission needs to take these factors into account.

Therefore, we have also attempted to gather data on a second set of characteristics describing the various insurance markets in respect of the number of claims annually, the number of claims paid out by insurers, the average size of settlement and the proportion of claims submitted that are not paid for reasons of non-disclosure or misrepresentation. We also provide some information on the number of complaints brought by consumers to the FOS that relate to non disclosure or misrepresentation.

In Tables 6 and 7 below, we present information from the 2005/2006 ONS Annual Expenditure and Food Survey, which gathers detailed information on the weekly expenditure of 6,785 households voluntarily participating in the survey of households in the United Kingdom.

The data contained in this survey does not provide universal coverage of all the insurance products in the consumer market place. For example, there is no explicit information relating to critical illness policies, which we believe has a higher than average incidence of non-payment for reasons of non-disclosure. However, we have supplemented the information from the Expenditure and Food Survey with various pieces of information collected from the Association of British Insurers (ABI), previous research undertaken relating to the regulation of insurance markets and publicly available information collected directly from insurers operating in the retail market.

Table 6: Weekly household expenditure on insurance products and household coverage

	Average weekly expenditure 2005/2006 (all households)	Recording Sample	Household Coverage	Average weekly expenditure 2005/2006 (households covered)
Buildings Insurance	£2.43	4,280	63.1%	£3.85
Contents Insurance	£2.40	5,101	75.2%	£3.19
Household Appliances	£0.10	85	1.3%	£7.98
Medical Insurance	£1.60	808	11.9%	£13.44
Vehicle Insurance	£7.40	4,876	71.9%	£10.30
Mortgage Protection	£1.70	1,381	20.4%	£8.35
Life Assurance	£5.80	2,674	39.4%	£14.70
'Other' Insurance	£1.20	1,660	24.5%	£4.90
Total	**£22.83**	**6,785**	**100.0%**	

Source 2005/2006 Expenditure and Food Survey, Office for National Statistics

The information presented in Column 5 of Table 6 indicates that the average household insurance expenditure (across all households purchasing that form of insurance) range is between £14.70 for life assurance to approximately £3.19 per week in respect of insurance relating to contents insurance.

Column 4 presents some information on the proportion of households that obtain the various types of insurance and again there is a significant variation in coverage depending on the insurance product.

At the higher end of the scale, almost 75% of households purchase contents insurance. 72% of households purchase vehicle insurance and 63% buildings/structural insurance, while just over 11% purchase private medical insurance and less than 2% purchase insurance for household appliances.

From this information, we have computed the average annual household expenditure on insurance products and this is presented in the third column of Table 7. We have ignored the information relating to the purchase of insurance related to household appliances, as we believe that the data is not particularly robust due to the exceptionally low level of household coverage – which in turn generates an exceptionally high average annual premium.

Table 7: Annualised expenditure on insurance products

	Number of households Covered	Average annual expenditure for households covered	Total annual household expenditure (£m)	Net written premium 2005 (£m) (ABI)
Buildings Insurance[1]	15.6m	£200	£3,120	£5,840[8]
Contents Insurance[2]	18.6m	£166	£3,088	
Medical Insurance	2.9m	£699[7]	£2,027	£1,470[8]
Vehicle Insurance[3]	17.8m	£536	£9,541	£11,902
Mortgage Protection[4]	5.0m	£434	£2,170	£526
Life Insurance	9.8m	£765	£7,497	£36,313[9]
'Other' Insurance	6.1m	£255	£1,556	
Accident and Health				£5,009
General Liability				£4,640
Pecuniary Loss				£4,378
Critical Illness[5]	0. 511m	£240	£123[11]	
Income Protection[6]	0.130m	£469[10]	£61	
Total	**24.8m**			

[1,2] 14% of policies sold are buildings insurance only, 32% are home contents only and 54% relate to buildings and contents insurance (FSA, 2007). CRA (2006) indicate that there are approximately 16.7m individual home insurance policies in force.

[3] There are approximately 27 million vehicle insurance policies in the UK: 90% are comprehensive, 9% are Third Party Fire and Theft and 1% are Third Party only. CRA (2006) indicate that there are approximately 24.8m individual motor policies in force.

[4] CRA (2006) indicate that there are approximately 1.78 million private healthcare policies in force.

[5] GE Insurance Solutions estimate that approximately 511,000 individual critical illness policies were sold in 2005 – quoted in Norwich Union (2005).

[6] CRA (2006) indicate that there are approximately 130,000 individual income protection policies in force.

[7] CRA (2006) indicate that the average premium for private medical insurance was approximately £826 per annum

[8] CRA (2006)

[9] Life includes Ordinary Branch business, Savings and Protection products, i.e. Bonds, Endowments, Whole of Life, Term Assurance and Collective Life.

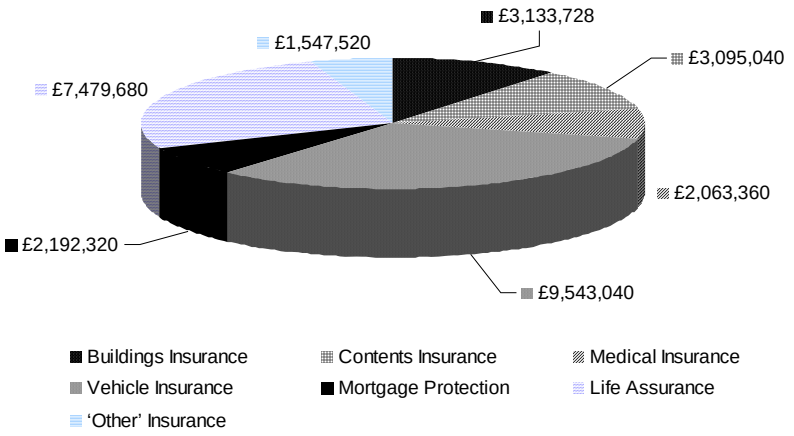
[10] Derived from CRA (2006)

[11] LE calculation

The highest average household expenditure relates to the purchase of life assurance at an average of £765 per household per annum, private medical insurance at an average of £699 per household per annum, £535 per household per annum on vehicle insurance, £434 on mortgage protection products, and £200 and £166 on buildings and contents insurance respectively.

Grossing some of these estimates by the number of households in the United Kingdom, the fourth column provides an estimate of the total economy wide expenditure on insurance products (in £ millions). This information is also presented in Figure 1 below.

Figure 1: Total annualised expenditure on insurance products



In the final column of Table 7, we have also presented recent information from the Association of British Insurers (ABI) on the relative size of the various markets. This information is not directly comparable to the information presented from the ONS Food and Expenditure Survey as the categorizations of various insurance products is not equivalent; however it does provide accurate information on the relative size of the particular markets.

4.2 Claims and non disclosure

In addition to the information presented on the number of policies sold in a particular year, we have also attempted to collect information in relation to the number of claims in each of the markets and the proportion of those claims that have been unpaid and the reasons for declination. The information is sparse and for a full economic analysis of the costs and benefits associated with the implementation of these proposals (or some variant) significant effort is required to address those information gaps. Some of the specific information required is presented later in this report.

Table 8: Number of claims, payout and reasons for non payment by insurance market

	Number of new policies	Number of claims	Proportion Paid out	Proportion refused (non disclosure)
Buildings Insurance	15,643,920[1]			
Contents Insurance	18,644,775[1]			
Medical Insurance				
Vehicle Insurance	17,822,373[1]	2,910,927[3]		
Mortgage Protection	2,456,800 (existing)	87,060	89.2%	
Life Assurance	3,303,000		81% - 99% average – 90%	1% - 15%[5] average – 10%
Critical Illness[2]	511,984[2]	17,585	72% - 90% average – 80%	3% - 17% average – 12%
Income Protection[2]	2,492,000[2] 147,285 (new)			

[1]Assumes that all policies are renewed annually

[2] ABI (2005)

[3] ABI (2005): Number of claims **paid**

[5] The remaining refused claims are refused for reasons other than non-disclosure or misrepresentation - for example, for not falling within the policy terms.

It is clear from the Table above that the information available in relation to the proportion of claims paid and reasons for declination is particularly sparse. However, we were able to gather some information directly from providers of critical illness and life insurance from insurers, as well as calculating the incidence of non-payment of motor insurance claims from data held by the ABI.

In the critical insurance market, we estimated that there were approximately 17,500 critical illness claims made against insurers in 2005, corresponding to 3% of the total number of new policies sold in that year. The average proportion of claims paid was estimated to be 80%; however there was significant variation across insurers. The claims payout rate varied between 72% and 90%. In addition to this, we were able to estimate that of the average proportion of all claims that were declined, approximately 11% were refused for reasons of non-disclosure, though again there was significant variation around the mean estimate – from as low as 3% to 17% for one insurer[6].

We would hope that as part of the consultation exercise, consultees might provide additional information to ensure that these estimates can be made more rigorous.

4.3 Complaints to the Financial Ombudsman Service

We also present some information on the extent to which consumers bring complaints to the Financial Ombudsman Service (FOS). Although it is clear that there are many reasons for bringing a complaint to the FOS (and many reasons for not doing so), we believe that this information is also useful in assessing the extent to which the markets considered to date might be affected by the proposed reforms to the laws relating to non-disclosure and misrepresentation.

The information presented here in relation to the number of claims brought to the FOS does not differentiate between misrepresentation and non disclosure but simply groups the categories together as 'non-disclosure'. In reality, of those complaints relating to non disclosure, a significant majority actually refer to cases of possible misrepresentation.

Between January and September 2005, the FOS closed 823 non-disclosure cases, of which 292 (35%) involved critical illness policies. This would suggest that a total of around 390 cases go to the FOS each year in which a critical illness claim has been declined for non-disclosure or misrepresentation.

[6] In all the evidence from insurers that we have been able to gather, there has been no differentiation between non-disclosure and misrepresentation. Therefore, any reference in the commercial literature relating to 'non-disclosure' actually covers both 'non-disclosure' and 'misrepresentation.

The Law Commission's own analysis looked just at final ombudsman decisions and found that 49% related to critical illness. This suggests that critical illness policies are more likely to proceed all the way to a final decision (which is not surprising, given how controversial and tendentious these cases seem to be).

We present a model later in this report where we estimate the approximate number of critical illness cases involving a payout refusal for reasons of non-disclosure. The estimate is 1,934. This would suggest that around a fifth of critical illness claims turned down on these grounds are taken to the FOS.

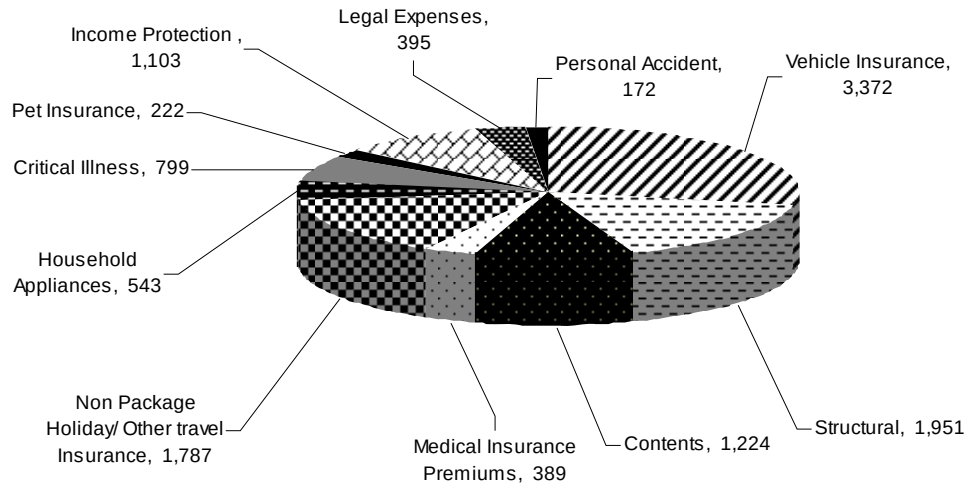
Table 9: Complaints to the Financial Ombudsman in 2006

Mortgage Endowment cases		69,149
Other Investment related cases		15,795
Banking related cases		13,709
Insurance related cases		14,270
of which	Motor Insurance (1)	3,372
	Buildings Insurance (2)	1,951
	Travel Insurance	1,787
	Loan Protection Insurance	1,315
	Contents Insurance (2)	1,224
	Pet Insurance (8)	222
	Income Protection Insurance	1,103
	Critical Illness Insurance	799
	Extended Warranty Insurance	543
	Legal Expenses Insurance	395
	Private Medical Insurance	389
	Personal Accident Insurance	172
	Other	671

Source: FOS (2006)

The proportion of complaints to the Financial Ombudsman is presented in the figure overleaf:

Figure 2: Number of complaints to the Financial Ombudsman by insurance product, 2006



The volume of complaints brought to the Financial Ombudsman is essentially independent of the size of the particular market in question. For instance, motor insurance is the largest general insurance market and accounts for between £9.5bn and £12.0bn of annual household expenditure/net written premiums but only 3,372 FOS complaints. Building and contents insurance account for almost £10bn of net written premiums in the insurance market but less than 3,200 complaints to the FOS annually. At the other extreme, income protection policies (which include income protection and critical illness insurance) account for only £0.184 billion of net premiums written yet produce more than 1,800 complaints to the FOS annually.

This does not imply that these complaints brought to the FOS are all for reasons of non-disclosure; however, it is clear that consumers are disproportionately aggrieved with the decisions made by insurance companies in areas of critical illness and income protection for whatever reason.

In Table 10 overleaf, we present some information on the number of complaints specifically relating to non-disclosure in the insurance market and combine this information with data on the size of particular market. The information from the FOS relates to January to September 2005 – so we have annualised the number of claims to reflect the expected number of complaints in a full year. We have transposed the information from the Food and Expenditure Survey presented in Table 7 to illustrate the size of the markets.

Table 10: Non disclosure complaints to the Financial Ombudsman by market size (2005)

Insurance Product	Market Size (£m)	Non Disclosure Complaints - 2005	FOS Non-disclosure complaints per £m
Buildings Insurance	£3,133	47	0.015
Contents Insurance	£3,095	88	0.028
Medical Insurance	£2,063	15	0.007
Vehicle Insurance	£9,543	181	0.019
Critical Illness	£125	390	3.115

The information in the Table indicates that for the four major general insurance markets (buildings, contents, vehicle and private medical insurance), the incidence of a complaint being brought to the FOS relating to non-disclosure is between 0.007 and 0.028 per million pounds of household expenditure. In the case of critical illness insurance, the likelihood of bringing a complaint is more than 100 times greater at just over 3 per million pounds of household expenditure.

4.3.1 Ombudsman decisions in relation to misrepresentation and non-disclosure in critical illness

Information from the Financial Ombudsman Service indicates that of **all** cases brought to their attention and resolved through an adjudicator, 12.5% of judgments found that the firm had *not* treated the customer's complaint fairly; in 10% of cases, the firm had made an offer to the customer but the adjudicator negotiated an improved settlement and in 6% of cases, the adjudicator found that the firm had generally treated the customer's complaint fairly – but the firm still agreed a goodwill payment.

Of the cases brought to their attention and resolved through an ombudsman, 36% of judgments found that the firm had *not* treated the customer's complaint fairly; in 5% of cases, the firm had made an offer to the customer but the adjudicator negotiated an improved settlement and in 2% of cases, the adjudicator found that the firm had generally treated the customer's complaint fairly – but the firm still agreed a goodwill payment.

The Law Commission looked at a sample of 93 final ombudsman decisions in which a critical illness claim had been declined for non-disclosure/ misrepresentation. The results are shown overleaf:

Table 11: Critical Illness non-disclosure: FOS decisions[7]

	Number	*%*
No change to insurer's decision	52	56
Substantial change to insurer's decision	39	42
Small change/goodwill payment	2	2
Total	93	100

The insurer's decision appeared slightly more likely to be overturned in critical illness polices than in other claims (where 33% involved a substantial change) but the relatively small sample sizes make statistical comparisons difficult to undertake.

[7] FOS figures show that it receives around 1,000 cases non-disclosure cases a year: 1,007 in 05-06; 1,051 in 04/05; and 967 in 03-04. The information presented here relates only to those cases that go to a final ombudsman decision. This is only 7% of all FOS cases (most are either resolved through mediation - 58% - or by an adjudicator - 38%). The sample (of 300 cases) was selected through identification of all non-disclosure cases from February 2003 and December 2005. 204 cases we read and analysed by the Law Commission. 7 of the cases had been misclassified and were really about policy terms and were excluded. This left 197 cases of which 7 related to small businesses and 190 related to consumers. 93 cases related to critical illness (consumers). The research upon which this information is based is presented as an annex to the consultation document.

4.3.2 How does the FOS classify the consumer's behaviour where a critical illness claim is declined?

Out of the 93 critical illness final decisions in the Law Commission's survey, the issue of the consumer's behaviour was relevant in 76 of them. Ombudsmen classified the consumer's behaviour as follows:

Table 12: Critical Illness non-disclosure and misrepresentation cases: classification of outcomes

	Number	*%*
Innocent: consumer wins	17	22
Inadvertent: proportionate remedy applied	8	11
Reckless or deliberate: policy avoided	16	21
Ombudsman does not classify, but policy nonetheless avoided	35	46
Total	76	100

4.4 Elasticity of Demand

In this section, we provide some information on the elasticity of demand[8] associated with each type of insurance in the retail market. We provide this information because it is possible that the change in the proposals suggested by the Law Commission may result in some increase in costs to insurers[9] that will in turn result in a reduction in the quantity of insurance demanded by consumers. The elasticity of demand provides an estimate of how sensitive changes in the price of a product are to changes in the quantity demanded of that product.

[8] The price elasticity of demand measures the percentage change in quantity demanded following a percentage change in the price of a good. For instance, if there is a 10% increase in the price of a good that results in a less than proportionate reduction in the quantity demanded of that good, then the good in question is described as inelastic. If the change in quantity demanded is greater (in proportionate terms) than the initial change in price, then the good is defined as being elastic. The change in the quantity demanded is made up of two elements - the substitution effect and the income effect. The substitution effect is always negative following an increase in price – and reflects the fact that the good in question is worse value for money than used to be the case. The income effect reflects the change in demand for the good at every price resulting from the erosion of purchasing power following the increase in prices. For 'normal' goods, the income effect reinforces the substitution effect while for 'inferior' goods, the income and substitution effects operate in different directions

[9] Extreme changes to the legislation may mean that certain forms of insurance become too expensive for insurers to offer. The Law Commission does not propose extreme changes.

The elasticity of demand for a product is defined as the change in the quantity demanded of a good following a change in its own price. It is normally a negative number. A good with an elasticity of between 0 and -1 is said to be inelastic (a rise in price results in a less than proportionate reduction in quantity demanded), while an elasticity of demand less than -1 is said to be elastic (a rise in price results in a greater than proportionate reduction in quantity demanded). We generally omit the negative sign for ease.

There are a number of different measures of elasticity. We have defined the elasticity of demand with respect to a particular product's own price. However, it is also necessary to understand how the demand for a good is affected by the change in the price of the same type of insurance product sold by other organisations (the cross price elasticity of demand).

If the proposed reforms affected only 1 firm in the market place who were forced to increase premiums, then it is likely that customers would simply purchase their insurance from a competitor unaffected by these reforms. In this case there is a high degree of product substitutability. However, if the proposed reforms affect all firms in some way and the price charged to consumers increases across the board, then the extent to which the demand for insurance might be affected by factors such as the complexity of the product in question, the legal requirement to hold the particular type of insurance or the extent to which the insurance product is perceived as a necessity or a luxury.

There is very little explicit information available on the elasticity of demand for insurance products with the exception of private medical insurance. We have been unable to find any information relating to the elasticity of demand for insurance products specifically for the United Kingdom.

For information, we have been able to identify the elasticity of demand for private medical insurance in the United States (0.25-0.40) indicating that if the price of private medical insurance were to increase by 10%, the quantity demanded would fall by between 2.5 and 4%. We are aware that the various insurance markets in the States may operate differently from those in the UK, especially in relation to private health insurance[10,11].

[10] Pauly, M., Withers, H., Subramanian-Viswana, K., Lemaire, J., and Hershey, J.C., (2003) "Price Elasticity of Demand for Term Life Insurance and Adverse Selection", NBER Working Paper 9925, August 2003

[11] Marquis, S., Beeuwkes Buntin, M., Escarce, J., Kapur, K., and Yegian, J., "Subsidies and the demand for individual health insurance in California", Health Services Research, October 2004

In relation to the UK insurance markets, we have incorporated some information from the recent work of the Financial Services Authority (FSA, 2007) that identifies insurance markets according to the complexity or standardised nature of the product and the degree to which the cover provided by the policy or the price is the key focus of consumers when purchasing/renewing insurance.

We also provide information on the primary means by which some of these insurance products are sold (face to face, tied to another product or online and the extent to which the opportunity arises for shopping around for alternative quotes (e.g. annual renewal). We also indicate the extent to which there is some statutory requirement to be in possession of different types of insurance and an aggregate assessment of the elasticity of demand for particular insurance products. We would appreciate comments from consultees on the assumptions made here in relation to the elasticity of demand and any other information that might assist us in assessing the sensitivity of the demand for insurance with respect to price

Table 13: Information on products sold and price being the major determinant of insurance purchase

Type of Insurance	Nature of Product	Focus	Statutory Requirement	Elasticity
Buildings Insurance	Standardised	Price	No[12]	Less elastic
Contents Insurance	Standardised	Price	No	More elastic
Medical Insurance	Complex	Mixed	No	More elastic
Vehicle Insurance	Standardised	Price	Yes	Less elastic
Mortgage Protection	Complex	Mixed	No	Less elastic
Term Assurance	Complex	Cover	No	Less elastic
Critical Illness	Complex	Cover	No	Less elastic
Income Protection	Quite complex	Mixed	No	Less elastic
Pet Insurance	Standardised	Cover	No	More elastic
Payment Protection Insurance	Complex	Cover	No	More elastic

[12] Although it is not a statutory requirement to have building insurance, it is often a requirement if the property is purchased with the assistance of a mortgage provider

From this information we have assessed that buildings and vehicle insurance are less price elastic given the fact that it is either a statutory requirement or linked to the terms and conditions of a mortgage offer. We have also described mortgage protection insurance, term assurance, income protection and critical illness coverage as being relatively inelastic given the complexity of some of the products being sold and the fact that they are sometimes linked to the sale of other financial products. We have assumed that contents insurance, private medical insurance, pet, and payment protection insurance are relatively elastic given the fact that there is no requirement to hold these types of insurance. In determining the relative elasticities, we are aware that there may be some disagreement with our assessment and we would urge consultees to provide their view on the appropriateness of our assessment.

4.5 Section Conclusion

In this section of the report, we have attempted to gather together the relevant information to allow the characterisation of the various insurance markets. We have done this by considering the market penetration of various insurance products, as well as average premiums and the extent of claims being refused for reasons of non-disclosure or misrepresentation.

Given the information presented, we believe that the following insurance markets should be assessed for a full economic cost benefit analysis, as well as the primary reason(s) for selection. We would appreciate the view of consultees on the appropriateness of the selection and the provision of any information or data that might be able to improve this first selection.

Table 14: List of insurance markets suggested for full cost benefit analysis and primary reason for inclusion

Insurance Market	Rationale
Vehicle Insurance[13]	Market penetration (number of households covered) Aggregate size of market (value of premiums) Incidence of complaints brought to FOS Inelastic Demand
Buildings Insurance	Market Penetration Aggregate size of market Inelastic Demand
Contents Insurance	Market Penetration Aggregate size of market
Private Medical Insurance	Average household expenditure Product Complexity
Critical Illness Insurance	Incidence of declination of claims for non disclosure and misrepresentation Incidence of complaints brought to FOS Average claim size
Income Protection Insurance	Incidence of complaints brought to FOS
Life Assurance	Average household expenditure Aggregate size of market Average claim size Incidence of declination of claims for non disclosure and misrepresentation Potential for higher investigation costs if a five year non-contestability period is introduced

We do not believe that the incidence of non-disclosure in other markets is such that these proposed reforms are either likely to have a significant economic impact or the information is such that it is unlikely that a full cost benefit analysis might be undertaken at an acceptable cost.

[13] Note that the proposed reforms that are being considered by the Law Commission will not change the current legislation relating to 3rd Party claims, as under Section 150 of the Road Traffic Act, insurers are not permitted to avoid a claim if it is a claim relating to a 3rd Party. The proposed reforms to current legislation will only affect 1st Party claims.

5 Identification of the potential impact of the reforms

5.1.1 Analytical Framework

In this section, we present a high level assessment of the possible economic impact of the proposed reforms relating to non-disclosure and misrepresentation in the consumer market. We adopt a standard options appraisal framework as outlined in *HM Treasury Green Book* and present the various characteristics of the market depending on whether they are inputs, processes, outputs or outcomes. We have presented our understanding of the analytical framework in Table 15 overleaf.

This analytical framework and the case study in the following section of report focus on the proposed changes outlined in section 2 of this report. We acknowledge that there are likely to be some impacts associated with other reforms recommended by the Law Commission but these are not considered in this report. We would appreciate the views of consultees on the validity of the framework for analysis, as well as a likely impact of these proposed reforms.

In theory, the *inputs* to the appraisal framework relate to the characteristics of the various insurance markets. These characteristics relate to both the types of firms and policies sold but also to the current legislation in relation to non-disclosure and misrepresentation, as well as the current behaviour of firms and consumers in the marketplace.

We have characterised the insurance markets according to the potential *types* of firms operating in the market – though this clearly abstracts substantially from the situation in reality. We have assumed that there are two types of firm operating in each insurance market – Type 1 firms generally attempt to replicate the decisions that have been made by the FOS and Type 2 firms in general do not replicate the decisions made by the FOS and apply a strict interpretation of the current legislation in respect of non-disclosure and misrepresentation.

There is no clear delineation between Type 1 and Type 2 firms and the modeling exercise presented in the next section is based on an assumption relating to that particular market. It is clear that there is overlap between the two types of firm with some Type 1 firms occasionally applying the current legislation to non-disclosure and misrepresentation rigorously and vice versa; however, any alternative characterisation of the market would be overly complex and difficult to appraise.

Table 15: Possible economic impact of proposed reforms to non-disclosure and misrepresentation

Current approach of firms to non disclosure (inputs)	Current Law and proposed changes (process) that applies to both Type 1 and Type 2 firms	Impact on firms operating in retail market (outputs)	Economic costs and benefits for firms operating in retail market (outcomes)
Insurance companies that replicate Financial Ombudsman Decisions (more reputable firms or Type 1 firms)	The strict legal rules state that an insurer can avoid the policy (refuse to pay a claim) for all types of misrepresentation and for non-disclosure. The FOS does not allow firms to avoid the policy for non-disclosure (that is, when a consumer does not volunteer information, despite the fact that it has not been asked for it). It takes the view that a firm should ask about information that is material to it. Where an inaccurate answer is given to a question, the FOS divides those misrepresentations into three types: Innocent Inadvertent Deliberate/ Reckless Where a consumer makes an innocent misrepresentation, the FOS will order the insurer to pay the claim. Where a consumer makes a deliberate or reckless misrepresentation, the FOS will allow the insurer not to pay the claim. Where a consumer makes what it calls an inadvertent misrepresentation, the FOS applies a proportionate remedy. The Law Commission proposes that the law should be reformed to follow FOS guidance.	1. Clearer rules, easier to find and understand 2. Fewer cases being taken to the FOS. 3. There may be a few more cases where the consumer has made a negligent misrepresentation being resolved using a proportionate remedy 4. Less likely to be undercut by **Type 2** firms 5. Retention of premiums paid that relate to deliberate or reckless misrepresentation	1. Reduction in training costs for claims handlers and administration costs. The FOS does not publish its cases so many insurance companies have to spend much time trying to work out what its rules are. 2. A few more negligent claims cases 3. Marginal increase in number of payouts 4. Marginal increase in premiums (mitigated by retention of some premiums) 5.Possible increase in demand for policies (assuming cross price elasticity with Type 2 firms is positive)

Table 15: Possible economic impact of proposed reforms to non-disclosure and misrepresentation

Current approach of firms to non disclosure (inputs)	Current Law and proposed changes (process) that applies to both Type 1 and Type 2 firms	Impact on firms operating in retail market (outputs)	Economic costs and benefits for firms operating in retail market (outcomes)
Insurance companies that generally ignore Financial Ombudsman Decisions and apply strict legal rules (discount firms or Type 2 firms)	The Law Commission also proposes to take away the ambiguity around the FOS's definition of reckless. As explained in section 2, the wording of the FOS' decisions appears to show that it occasionally allows an insurer to avoid a claim when the consumer has been negligent but not actually dishonest. The Law Commission proposes that the definition of reckless (and therefore the remedy of avoidance) should be reserved purely for instances of dishonest behaviour by the consumer. It therefore follows that there may be a few cases which are presently classified by the FOS as "reckless" misrepresentations which may in future be classified as "negligent" misrepresentations and result in proportionate payment, rather than avoidance. The Law Commission also asks whether the law should state that an insurer is entitled to retain premiums paid to it if it refuses to pay a claim for reasons of reckless or deliberate misrepresentation.	1. Reduction in number of full awards against Type 2 companies by FOS (ceteris paribus) 2. More claims where the consumer has not volunteered material information settled in full 3. More claims where the consumer has made an innocent misrepresentation cases settled in full 4. May be a few more claims where the consumer has made a negligent misrepresentation cases settled using a proportionate remedy 5. Fewer cases being taken to the FOS 6. Elimination of cross subsidisation 7. Retention of premiums paid that relate to deliberate or reckless misrepresentation	1. Increase in training costs for claims handlers (compared to current blanket refusal) 2. Increase in administration costs (need to ask clearer pre contract questions and request information) 3. Increase in number of proportional payouts and payouts for innocent misrepresentations 4. Increase in value of payouts 5. Increase in premiums (mitigated by retention of some premiums) 6. Drop in demand for policies and quantity demanded 7. Market exit of low quality firms

It is clear that the proportion of Type 1 and Type 2 firms in each market will vary. We would appreciate it if those participating in this consultation exercise might be able to assist us in providing assistance in determining how to divide the market between the different types of firm.

In a standard appraisal model, the 'process' normally refers to the delivery of the policy in question and especially where there may be alternative models of delivery. There may be geographical variation or, depending on the nature of the firm or consumer in question, even variation in the intensity or timing of policy. We have assumed that these proposals are universal and apply equally to all firms operating in the marketplace. The proposals will not apply retrospectively and as such there is the possibility that a 'dual system' will operate for the first few years following implementation.

The variation in this appraisal model relates to the impact of the proposed legislation on different types of firm or firm behaviour. Given the diverse classification of firms, we have attempted to assess the differential impact of the proposal on the two types of firms in the marketplace separately though there will be some elements of the proposal that will affect them in an identical manner. There may also be other impacts associated with the proposals and the consultation exercise will allow the final analysis to be augmented as better information becomes available.

5.1.2 Impact of proposals

In general terms the proposed changes to the rules on non-disclosure and misrepresentation will have different impacts depending on the type of firm in question. We therefore present a short discussion of the expected impact on each type of firm and on consumers more generally. We attempt to generate a model with some initial estimates of the economic costs and benefits associated with these proposals in relation to one specific insurance market in the next section, therefore, it is key to ensure that there is agreement regarding these possible impacts, as well as supporting data where possible.

Costs to Firms

Claims

For Type 1 firms that generally attempt to follow the decisions made by the FOS, the number of claims not paid for reasons of non-disclosure or innocent misrepresentation will remain approximately the same, as in theory the FOS already requires these claims to be paid. Similarly, the number of claims refused as a result of dishonest behaviour by the consumer is likely to stay largely the same.

The slight change in the definition of reckless/inadvertent/negligent claims means that there is the possibility that there will be an increase in the number of claims paid relating to negligent misrepresentation and a change in the average size of claims paid due to the introduction of the principle of proportionality in relation to these types of claims. It is likely that the small increase in the number of claims paid will slightly increase the average premium paid by consumers all other things being equal and the current subsidisation of some consumers will cease (or diminish).

The proposed changes to the legislation will have a greater effect on Type 2 firms compared to Type 1 firms.

In terms of the number of claims and eventual payouts, it is probable that Type 2 firms will have to pay more claims where there has been non-disclosure, or innocent or negligent misrepresentation, as Type 2 firms (according to our definition) currently avoid policies for these reasons. However, it is likely that rather than the 'all or nothing' payouts currently being made, a number may result in proportionate payouts. Therefore, it *might* be the case that the average size of each claim paid will decrease, though the total monetary value of all claims paid may increase. The aggregate impact of the proposed changed will increase the average premiums paid by consumers currently purchasing insurance policies from these (Type 2) firms.

In the analytical framework presented, we have assumed that consumers of these firms may also be more price-sensitive than consumers of Type 1 firms. As we have assumed that the policies of Type 2 are on average 5% cheaper than the policies of Type 1 firms, if there is an increase in the price of Type 2 firms' policies then there is likely to be a greater reduction in the quantity of insurance demanded from Type 2 firms compared to Type 1 firms.

We think that the proposed changes to the legislation will disproportionately affect the premiums charged by Type 2 firms. These firms will see a reduction in their current unit cost advantage and there is likely to be some degree of customer migration away from Type 2 firms to Type 1 firms. This may result in some Type 2 firms reacting by either operating less profitably, exiting the marketplace altogether or fundamentally altering their behaviour or business model and essentially converting themselves into Type 1 firms (if considered a more profitable long terms strategy).

We would appreciate the views of consultees on the validity of these expected impacts on firms.

Clarity of Questionnaires

As previously mentioned, insurance companies will not be allowed to avoid a policy for reasons of non-disclosure. Insurers will be expected to ask questions about any matter that is material to them. It is therefore likely that the questionnaires administered by all organisations will have to be amended with an increased onus on clarity and transparency.

Although there is an administration cost associated with introducing new or amended questionnaires, the proposal will allow insurance companies to deal with claims more transparently and efficiently. Therefore, even though there may be some additional cost in the initial stages, this might be more than compensated for over the longer term through reduced training costs for call handlers and general productivity gains.

Benefits to Firms

Retaining Premiums in the case of deliberate and reckless non-disclosure

It appears in practice that firms usually do not retain premiums when they refuse a claim for reasons of deliberate or reckless non-disclosure or misrepresentation. The Law Commission asks whether firms should be entitled to retain premiums in these circumstances.

Commercial Benefits

There may be some additional commercial benefits accruing to Type 1 firms from the introduction of these reforms. Currently Type 2 firms have a degree of cost advantage over Type 1 firms given the lower likelihood of making payment following a claim. The introduction of these proposed reforms will reduce the ability of Type 2 firms to undercut Type 1 firms (following the disproportionately large increase in claims paid by Type 2 consumers) and this may lead to an increase in the demanded for insurance products from Type 1 firms.

Transparency

Another possible impact for all insurance companies will be that the claims adjudication processes will be more transparent and easier to administer in future. Companies will no longer have to analyse FOS guidance to work out what its approach might be (FOS decisions are not published although it does provide newsletters explaining its approach with examples) and this may provide savings to insurance companies through decreasing costs associated with staff training in the longer term.

This will only be the case after the initial bedding down of the proposals as the changes to the legislation being proposed will not apply retrospectively and there will be a dual system of claims assessment in the first few years post introduction though this will only really apply to those types of insurance that are not renewed on an annual basis. Even for those types of insurance policy that are not renewed on an annual basis, insurance companies may opt to encourage all outstanding policies to be administered under the new regime following the introduction of these reforms to ensure the greatest cost efficiencies may be achieved.

Summary of Impacts

We have summarised the primary outcomes of the proposed legislation on Type 1 firms as follows:

- Marginal increase in number of proportionate payouts associated with negligent non disclosure
- Marginal reduction in the degree of cross subsidisation within Type 1 firm customer base
- Marginal increase in average premiums
- Possible increase in quantity demanded of policies from Type 1 firms (assuming cross price elasticity with Type 2 firms is positive[14])
- Possible reduction in training costs for claims handlers and administration costs over the longer term

We have listed what we think will be the primary outcomes for Type 2 firms below:

- Increase in number of payouts
- Increase in value of payouts
- Increase in premiums
- Drop in demand for policies
- Market exit of low quality firms
- Increase in training costs for call handlers (compared to current blanket refusal)
- Increase in administration costs (the need to ask clearer pre-contract questions and request information)
- Decline in cross subsidy (where consumers who purchase insurance that is declined for non-disclosure or innocent misrepresentation in effect subsidise consumers who disclose fully and accurately).

5.2 Information necessary to undertake a complete cost benefit analysis

We present a list of the information that is necessary to undertake a complete cost benefit analysis. This is in some respects a 'wish list' and we are aware that there are pieces of information that may not be available at an acceptable cost. However, as part of this consultation exercise, we would appreciate any information that might be available that will assist us in any further analysis undertaken.

[14] The cross price elasticity of demand is the change in the quantity demanded (of insurance) from Type 1 firms by consumers following a change in the price charged by Type 2 firms. In this example it is likely that an increase in the number of claims paid by Type 2 insurance companies (for example) will result in an increase in the prices charged by Type 2 firms. This will result in the policies sold by Type 1 firms becoming relatively more attractive, resulting in an increase in the quantity demanded, all other things being equal.

For each type of firm, we need to understand the breakdown of policies sold by each type of firms as well as the characteristics of the overall market. Specifically, in terms of **inputs, processes, outputs and outcomes**, we need to understand the following:

Inputs

- How many policies are sold by each type of firm in each market
- What is the current profile of claims made; claims declined for reasons of non-disclosure or misrepresentation; and claims paid out?
- What proportion of claims are currently contested and adjudicated by the Financial Ombudsman?

Processes

- What will be the reaction of firms to the proposed changes in legislation?

Outputs

- How many more claims in which there has been non-disclosure or innocent/negligent misrepresentation will be paid?
- How many more claims in which there has been non-disclosure or innocent/negligent misrepresentation will be settled before reaching the FOS?
- How many cases will be adjudicated by the Financial Ombudsman?
- What will be the impact on administration and training requirements?

Outcomes

- What will be the average settlement of insurance claims?
- What is the cost of resolving disputes?
- What will the associated increase in premiums be/ and what will be the change in cross subsidisation?
- What will be the increase in demand for policies from Type 1 firms (assuming cross price elasticity with Type 2 firms is positive)
- How many fewer policies will be bought as a result of price increases and how much less coverage will be purchased?
- What is the change in confidence (demand) in the insurance market from increased likelihood of (proportionate) payouts
- How many low quality firms will exit the market?

6 Case Study - Critical Illness Cover

6.1 Introduction

In this section, we present some preliminary information in relation to the market for critical insurance cover (CIC). We have provided a worked example relating to this insurance market because data we have received from the FOS and the Food and Expenditure Survey (Table 10) show that there appears to be a disproportionately large number of complaints brought to the FOS about these products and that those claims are for relatively significant amounts.

This case study provides particular focus on the consumer insurance market. Some of the costs and benefits resulting from the proposals are exceptionally difficult to quantify accurately and as such we have not provided estimates of the impact associated with these. Any assistance that we might receive from consultees would greatly assist in any future cost benefit analyses undertaken.

This case study is not intended to provide a definitive estimate of the costs and benefits associated with the introduction of these proposals. We have identified many evidence gaps that we would seek assistance completing as part of the consultation exercise. Therefore, the estimates presented here should be considered more a guide or a template for further analysis rather than a final estimate of the economic effect.

6.1.1 Product and Market Characteristics

Critical Insurance Cover (CIC) normally pays out a lump sum benefit on diagnosis of an illness that meets the defined conditions within the policy. Generally CIC policies will expire on payment of a claim, although some policies offer an option, at additional cost, to extend cover in these circumstances. The specific illnesses covered as part of the policy vary from policy to policy; however there are generally a core number of illnesses covered in all policies. The majority of CIC policies are sold as a secondary purchase at the same time as taking out a mortgage (92%). According to recent research work undertaken by the Financial Services Authority (2007), critical illness insurance is seen as a particularly complex product and is often sold on an advised and face-to-face basis.

6.1.2 Consumer policies

The information on the number of policies sold annually varies depending on the source. For instance, CRA (2006) estimate that there are 275,000 new critical illness policies sold annually, while information from the ABI indicates that there were approximately 403,000 policies in force in the United Kingdom in 2005. Information from a survey (Norwich Union, 2005) indicates that the number of critical illness policies sold in 2005 stood at 511,984. In our case study below, we have assumed that the proposed changes to non-disclosure and misrepresentation will apply to the 511,984 policies that were sold in the last year for which information exists.

6.1.3 Firms

Information from the ABI indicates that in the critical illness market, the top 5 providers account for approximately 60% of sales. The top 10 providers account for almost 79% of sales and the top 20 providers account for approximately 93% of sales (or 476,145 policies). For the purposes of this analysis and subject to the previous caveats, we have assumed that 93% of policies are sold by firms that are Type 1 firms with the remaining 7% of policies (or 35,839) being administered by Type 2 firms.

6.1.4 Average Premiums

We have not been able to access accurate information on the average critical illness premium in the market given the very wide range of products available. However, given the fact that the average claim paid is approximately £73,000 and that premiums broadly range from £20 to £35 per month (per £100,000 insured), we have estimated that the average monthly premium for critical illness insurance is £27.92 per month per £100,000 insured, which is equivalent to £244.58 per annum to insure the average claim size of £73,000[15]. We also assume that Type 2 firms on average offer premiums that undercut those premiums offered by Type 1 firms by 5% all other factors being equal (£232.35 per annum).

[15] From information presented in Cockburn, (2006), we have taken the average monthly premium paid by individuals presented in Tables 4 and 5. The annual premium for Type 1 firms is calculated as follows: £27.92 * (0.73) *12 = £244.58

6.1.5 Elasticity of demand

Given the relatively complex nature of the product being sold and the fact that critical illness products are often sold as a tied product to mortgages, we have assumed that the elasticity of demand associated with critical insurance products is relatively low - in the region of -0.25. In other words, if the price of critical insurance increases by 10% the quantity demanded of critical illness insurance will fall by 2.5%. We also assume that the reduction in critical illness insurance resulting from any increase in premiums occurs through some individuals no longer purchasing policies rather than all individuals marginally reducing the extent of their coverage.

6.1.6 Claims

There is no specific information on the number of critical illness claims annually. However, we have estimated that the number of claims in the critical illness market annually is 17,585. This is based on evidence from one of the top 5 providers in the marketplace (accounting for just under 9% of total sales) indicating that they received 1,500 claims in 2005[16].

Assuming that all firms in the marketplace have an equal likelihood of receiving a claim, the total number of claims for the market as a whole is estimated to be in the region of 17,585. This corresponds to approximately 3.4% of total policies sold annually.

6.1.7 Average Payouts

There is no market-wide information on the average payout in the critical insurance market. However, data from one insurer within the top 5 providers nationally indicates that their average payout was approximately £73,000. We have assumed that this figure is representative of the market as a whole and have assumed that there is no change in the average size of claims before and after the proposed reforms.

6.1.8 Non-disclosure and misrepresentation

The likelihood of claims payment very much depends on the type of insurer. From the specific company evidence available, the proportion of CIC claims paid out ranges between 72% and 90%. The average proportion of claims paid out is approximately 80%[17]. For the later analysis, we have assumed that the average likelihood of CIC claims payment (over the entire market) is 80%.

[16] The actual market share of this provider is 8.53%. Therefore 1,500/(0.0853) = 17,585

[17] This information is presented in Table 8 in Chapter 4. The actual percentage used in this analysis is 79.9%.

Of the claims that have not been paid out, non-disclosure accounts for between 3% and 17% of non-payment. In all the evidence from insurers that we have been able to gather, there has been no differentiation between non-disclosure and misrepresentation. Therefore, any reference in the commercial literature relating to 'non-disclosure' appears to cover both non-disclosure and misrepresentation. The average probability of declining payment on a claim for reasons of non-disclosure (including misrepresentation) is approximately 12%[18]. This suggests that there are approximately 3,535 claims[19] that are declined annually, of which 2,127 are declined for reasons of non-disclosure (including misrepresentation). The remaining claims are refused due to the insured failing to meet the definitions contained within the policy (1,407).

6.2 The effect of the proposals on non-disclosure and misrepresentation

Even though we have assumed that 93% of the market for CIC is through Type 1 firms, we have made the assumption that Type 2 firms are four times more likely to decline a claim for reasons of non-disclosure or innocent or negligent misrepresentation compared to a Type 1 firm. We assume that Type 1 firms refuse 10% of claims for misrepresentation while Type 2 firms refuse 40% of claims for non-disclosure or misrepresentation. This implies that Type 1 firms refuse 1,635 claims annually while Type 2 firms refuse 492 claims[20]. We would ask consultees to comment on these specific assumptions relating to the relative likelihood of refusing a claim for reasons of non-disclosure or misrepresentation.

[18] The actual percentage used in this analysis is 12.1%

[19] Rounded to the nearest whole number

[20] We assume that Type 1 firms receive 93% of claims in line with their market share, which equates to 16,354 annually. Assuming that 10% of claims are refused for reasons of non-disclosure or misrepresentation, this equates to 1,635 claims annually (rounded to nearest whole number).. We assume that Type 2 firms receive 7% of claims and refuse 40% for reasons of non-disclosure or misrepresentation – equating to 492.

We have assumed that, at present, of the claims unpaid (either in full or in part) for reasons of misrepresentation by Type 1 firms, 11% are negligent and 89% are deliberate or reckless[21]. We have assumed that for Type 2 firms, 10% of rejected claims are refused for non disclosure, 10% of rejected claims are refused for innocent misrepresentation, 20% are refused for negligent misrepresentation and the remaining 60% are refused for deliberate or reckless misrepresentation[22]. This information is presented in Table 16 overleaf along with the corresponding numbers of claims by classification. Again, we would ask consultees to comment on these specific assumptions.

Table 16: Baseline Assumptions[23]

	All firms	**Type 1 firms**	**Type 2 firms**
Number of new policies written	511,984 (100%)	476,145 (93%)	35,839 (7%)
Average annual premium (per policy)		£244.58	£232.35
Total gross premiums (£m)		£116.4m	£8.3m
Number of claims	17,585	16,354	1,231
Existing number of claims paid	14,050	13,410	640
Currently unpaid (total)	3,535 (20%)	2,944 (18%)	591 (48%)
Currently unpaid (non-disclosure and misrepresentation)[24]	2,127	1,635 (100%)	492 (100%)
Non-disclosure (a)	49	0 (0%)	49 (10%)
Innocent misrepresentation (b)	49	0 (0%)	49 (10%)
Inadvertent misrepresentation (c)	278	180 (11%)	98 (20%)
Deliberate/Reckless misrepresentation (d)	1,751	1,456 (89%)	295 (60%)

[21] The proportion of cases avoided as a result of deliberate and reckless behaviour corresponds with the Law Commission's survey of Ombudsman cases. However, it appears relatively high and the Law Commission would welcome input from consultees on these figures.

[22] These proportions are more speculative than the proportions for Type 1 firms. It is, however, based on conversations that the Law Commission has had with insurers. Again, it would welcome further input from consultees on these figures.

[23] Note that some of the estimates presented in the Table are rounded to the nearest whole number

[24] Numbers may not add to exact aggregate due to rounding

6.2.1 Assumed impact of the reforms

As we explained in section 5 of this report, the Law Commission proposes to remove any ambiguity around the FOS' definition of reckless. This may have an effect on Type 1 firms. Following this clarification of categories of misrepresentation, we have assumed that an additional 3.5 percentage points of claims against Type 1 firms will be redefined as being claims that involve negligent misrepresentation (rather than deliberate or reckless misrepresentation) with the remaining unpaid claims continuing to be refused for reasons of reckless or deliberate misrepresentation.

Therefore, we assume that if the Law Commission's proposed reforms are implemented, 14.5% of previously rejected claims will be classified as a negligent misrepresentation with the remaining 85.5% continuing to be classified as deliberate or reckless misrepresentation. For Type 1 firms, this reclassification results in 237 claims now being defined as negligent (an increase of 57 claims) that will potentially be subject to a proportionate remedy.

For Type 2 firms, the impact is more marked. As they do not currently implement the FOS guidelines, they will be affected by all of the reforms proposed by the Law Commission. First, we look at the effect of the clarification of recklessness. We estimate that this will mean that the 20% of claims that Type 2 firms avoids for negligent misrepresentation will become 23.5% (116 claims – an increase of 17[25]). The 60% of claims, which are being avoided for deliberate or reckless misrepresentation, will decrease to 56.5% (278 claims – a reduction of 17)

Second, instead of avoiding all claims for non-disclosure or misrepresentation, Type 2 firms will have to pay claims that involve non-disclosure or innocent misrepresentation. They will have to pay a proportionate amount (ranging from £0 to full) of claims that involve negligent misrepresentation. They will continue to be permitted to refuse to pay claims which involve reckless or deliberate misrepresentation.

[25] Rounded to the nearest whole number

Table 17: Impact of reforms on classification of non-disclosure and misrepresentation

	All firms	Type 1 firms	Type 2 firms
Impact of proposed reforms			
Reclassification of claims			
Non-disclosure (a)	49	0	49
Innocent misrepresentation (b)	49	0	49
Negligent misrepresentation (c)	353 (+75)	237 (+57)	116 (+17)
Deliberate/Reckless misrepresentation (d)	1,676 (-75)	1,398 (-57)	278 (-17)
Additional Full claims paid	98	0	98
Additional Partial claims paid	74	57	17
Total increase in the number of full claims paid (equivalent)	136	29	107
Total number of claims paid[26]	14,186 (+136)	13,439 (+29)	747 (+107)
Increase in value of claims paid		**£2.08m**	**£7.77m**
Increase percentage of claims paid		0.22%	16.72%
Percentage increase in premiums charged to cover increased claims[27]		**1.0-1.5%**	**85-95%**
Percentage change in critical illness insurance policies sold		**0.1%-0.5%**	**20%-25%**

[26] Numbers do not add due to rounding errors

[27] This estimate incorporates the fact that the current proposals confirm the right of insurance companies to retain premiums in the situation where a claim has been made that has involved deliberate or reckless misrepresentation. We have assumed that firms who do retain these premiums use them to offset any increase in premiums that might result from the increase in claims paid. We have also assumed that recurrent administration costs are passed onto consumers to consumers in their entirety.

This implies that for Type 1 firms, in addition to the 13,410 claims that are currently paid, an additional 57 will be partially paid in future (we have assumed a 50% proportionate remedy in the absence of other data). For Type 2 firms, an additional 98 will now be paid in full with a further 17 partially paid (50% proportion).

6.2.2 Primary impact on Firms

There is clearly a differential effect depending on the type of firm involved. For Type 1 firms, there is little effect given the fact that we have assumed that they already generally mimic the decisions of the FOS. Overall, we estimate that that the number of proportionate claims paid will increase by 57 – or equivalent to approximately 29 'full' claims. Prior to the proposed reforms, Type 1 firms paid out 13,410 claims. This might be expected to increase by 0.22% following the introduction of the reforms. Based on an average payout of £73,000, the total increase in the cost of claims is estimated to be **£2.08 million**[28].

For Type 2 firms, these proposals would be expected to have a significant effect given the fact that we have assumed that these firms currently ignore the decisions of the FOS. Overall, we estimate that that the number of proportionate claims paid will increase by 17. In addition to this, Type 2 firms are also estimated to pay an extra 98 full claims that they currently avoid.

Prior to the proposed reforms, Type 2 firms paid out 640 claims. This might be expected to increase by 16.72% (to 747 claims) following the introduction of the reforms. Based on an average full payout of £73,000, the total increase in the cost of claims is estimated to be more than **£7.77 million**[29].

6.2.3 Retention of Premiums

The FOS states that where an insured acts fraudulently the premium may be retained by the firm. In practice this does not appear to happen and most firms do not appear to retain premiums in the case of deliberate or reckless misrepresentation (although we would be grateful for information from consultees on this point). The Law Commission asks whether insurance companies should be permitted to retain the premiums paid by the insured in the case of deliberate and reckless misrepresentation. Given that this does not appear to be the practice at the moment, this will have an economic impact on firms.

[28] This is computed as follows: 57*(£36,500)= £2,080,500

[29] This is computed as follows: 98*(£73,000)+17*(£36,500)=£7,774,500

We assume that following the proposed changes to legislation (for Type 1 firms) 85.5% of cases involve a situation where a claim is refused for reasons of reckless or deliberate misrepresentation and premiums are retained. The equivalent rate for Type 2 firms is 56.5%. The average term of a policy when a claim is brought is approximately 39 months. Therefore the average premium that will be retained by Type 1 firms stands at £795[30] (£755 for Type 2 firms).

This implies that insurance companies will retain approximately **£1,321,170** in premiums (**£1,111,242** for Type 1 firms and **£209,928** for Type 2 firms[31]).

Combining the increase in premiums resulting from the increased likelihood of paying a claim and offsetting this against the retained premiums in the case of deliberate and reckless misrepresentation, this equates to an increase in premiums charged by Type 1 firms of approximately **£2.04 per annum** and **£211.07 per annum** for Type 2 consumers[32].

6.2.4 Training

These proposals have clear implications for the training undertaken by insurance firms. There is likely to be greater clarity and transparency in the future and training is likely to be more straightforward than may currently be the case.

However, there will be some additional training costs associated with retraining existing call handlers to operate under the current proposals. In addition, the fact that the current proposals will not apply retrospectively imply that there may be different assessment regimes operating depending on when the policy was first taken out by the consumer. This will certainly add to the cost of claims assessment in the short run, however, given the fact that most policies are renewed annually, the dual system is only likely to be in existence in the very short term.

We have been unable to assess accurately the economic impact of the change in the way in which claims are handled, but we would assume that the costs are not significantly different from zero.

We would welcome any clarification or information from consultees on this point.

[30] For Type 1 firms this is calculated as follows: £27.92*39*(0.73)=£794.88

[31] Following the proposed reforms, we assume that there are 1,398 claims against Type 1 firms that are considered deliberate or reckless. The premium retained equals 1,398*(£794.88)= £1,111,242

[32] This does not incorporate the impact of increased recurrent administration costs, which are considered later in the report.

6.2.5 One-off administration costs

There will be one-off increased costs to all types of firms associated with the necessity to provide clearer and more transparent forms. Insurance firms do generally update these forms on an ongoing basis and the costs associated with this item would not be expected to be significant. However, as with any change in legislation, there are costs associated with the time and effort required to familiarise oneself with new legal frameworks and it would be unreasonable to assume that this is negligible. On the other hand, there are also considerable costs currently involved in trying to understand the confusing overlapping systems of law, regulation and Ombudsman practice. The reforms would remove these costs.

It is therefore difficult to estimate either a cost or a benefit associated with this item in monetary terms.

However, we have assumed that the one-off costs associated with the production of new forms and general administration are equivalent to 2% of the total current premium for Type 1 firms (assumed to be £244.58 per annum) and 5% for Type 2 firms (assumed to be £232.35 per annum), then the one-off additional administration costs are **£2.329 million** for Type 1 firms[33] and **£0.416 million** for Type 2 firms – making a total across all firms of **£2.745 million.** This equates to approximately £4.89 per policy for Type 1 firms and £11.61 per policy for Type 2 firms.

We would welcome information from consultees on this point.

6.2.6 Recurrent administration costs

In addition to these one-off costs, insurance companies may take additional steps at a pre-contractual stage to gather information on potential insureds. This is potentially costly and firms will make a commercial decision when to undertake these searching costs. As this is a commercial decision, we have assumed that firms only undertake these tasks in the case of high value policies (£400,000 or greater) and have assumed that only 0.5% of policies are above this threshold level.

The estimates of these pre-administration costs need to be treated with caution. In the discussions we have had with various organisations, there has been no consensus even on whether there would be any additional administration costs let alone the level that they might be. We think that assuming that there are no ongoing administration costs may be unrealistic and any change in policy is likely to be associated with at least some administration costs. We have therefore included an item to cover these costs though additional information that might result from the consultation exercise would be particularly helpful in this aspect.

[33] For Type 1 firms this is calculated as follows: 476,145 * 0.02 * £244.58 = £2,329,110

We have assumed that the costs associated with seeking this information and assessing it is equivalent to 1/2 a month's premium[34] (approximately £56 for Type 1 firms and £54 for Type 2 firms[35]). The total recurrent cost associated with the additional pre-contractual administration is estimated to be **£0.133 million** for Type 1 firms and **£0.010 million** for Type 2 firms[36].

We have assumed that this increase in costs is passed onto consumers in the form of increased premiums. We have estimated that the additional increase in premiums charged by Type 1 firms is approximately **£0.28 per annum** and **£0.27 per annum** for Type 2 firms[37].

We have also assumed that insurers take some less costly steps (per policy) in relation to minimizing the risk of non-disclosure. In addition to the provision of more appropriate questions on forms, this might extend to "tele-underwriting", where the insurer employs nurses to talk the issues through with people over the phone, explaining what the questions are all about. Tele-underwriting is probably more expensive than the current methods, but much cheaper than medical reports.

We have assumed that 10% of the potential policies offered by firms are affected in this way and that the average cost of providing this service amounts to 3% of the annual policy cost. The cost associated with this element of administration corresponds to **£0.349 million** per annum for Type 1 firms and **£0.025 million** for Type 2 firms[38].

We have again assumed that this increase in costs is again fully passed onto consumers in the form of increased premiums. We have estimated that the additional increase in premiums charged by Type 1 firms is approximately **£0.73 per annum** and **£0.70 per annum** for Type 2 firms.

There are clearly benefits associated with additional pre-contractual checks for both firms and consumers. One benefit is that the insurance company is better able to assess the risk and therefore to set a premium that reflects that risk but this would be exceptionally difficult to assess.

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[34] We have assumed that costs for Type 1 and Type 2 firms will be identical for the sake of simplicity. However, it is likely that Type 1 firms will be doing this work already and therefore the costs for Type 2 firms will be higher than for Type 1 firms. Information on these figures from consultees would be helpful.

[35] We assume that the average monthly premium charged by Type 1 firms for CIC cover of £100,000 is £27.92 per month. Therefore to cover a risk of £400,000, half a single month's premium amounts to £55.84. A similar calculation for Type 2 firms stands at £53.05.

[36] For Type 1 firms this is calculated as follows: (.005) * 476,145 * (£55.84) = £132,939

[37] The per premium cost associated with recurrent administration is lower for Type 2 firms than for Type 1 firms due to the assumption that Type 2 firms charge marginally lower premiums compared to Type 1 firms.

[38] These estimates are calculated as follows for Type 1 firms: (0.1* 476,145)*(0.03* £244.58) = £349,366

Therefore, we have assumed that the aggregate costs (**£0.482 million** for Type 1 firms and **£0.035 million** for Type 2 firms) associated with recurrent administration are the upper limit of the costs that might be expected. The cost of ongoing or recurrent administration corresponds to approximately **£1.01** per policy per annum for Type 1 firms and **£0.97** per policy per annum for Type 2 firms.

Given the fact the degree of recurrent administration costs is a commercial decision and we have not included any benefits associated with additional administration, in our summary section, we present a range of estimates associated with recurrent administration. For Type 1 firms these are **£0.241-0.482 million** and **£0.017-0.035 million** for Type 2 firms.

6.2.7 Secondary impact on Firms

The increase in claims paid should not result in an equal increase in the premiums charged to consumers, holding the level of risk constant. We have assumed that if the effect of the reforms is as described above, insurers will charge an additional premium (equal to **£9.85million**) to cover the increased incidence of claims payout **less** any premiums that are retained as a result of deliberate or reckless misrepresentation **plus** any costs associated with recurrent administration. In the previous section, we estimated that the retention of premiums was approximately £**1.321 million** per annum and cost associated with recurrent administration stood at **£0.517 million**, which implies that the total increase in premiums paid in the market stands at **£9.050 million** per annum.

For Type 1 firms, the increase in claims paid plus recurrent administration less premiums retained stands at **£1.451 million** per annum while for Type 2 firms, the increase in claims paid plus recurrent administration less premiums retained stands at **£7.599 million** per annum.

Combining all these factors, we have estimated that the increase in premiums resulting from the increase in claims paid, the increase in premiums retained, the additional costs associated with recurrent administration approximate **£3.04** per annum for Type 1 firms and **£212.03** per annum for Type 2 firms. This corresponds to an increase in premiums of 1.25% for Type 1 firms and 91% for Type 2 firms.

The reduction in the policies purchased will be seen either through a small proportion of consumers no longer insuring themselves or a universal reduction in the amounts which consumers insure. We have estimated that the increase in premiums charged to all consumers will result in a 0-0.5% reduction in the number of policies sold annually by Type 1 firms and a 20-25% reduction in number of policies sold by Type 2 firms.

6.2.8 Impact on Consumers

Although we have considered the impact of these proposed reforms on firms, there will also be a significant impact on consumers, especially those honest consumers that currently have legitimate claims rejected by some firms. Following the proposed introduction of these reforms, we have estimated that approximately 98 individuals will now have their claims paid in full with an additional 74 receiving a partial settlement, which equates to an extra **£9.85 million** of claims being paid.

Honest[39] consumers purchasing insurance that end up making claims are the beneficiaries of the increased likelihood of claim payout. Therefore, this change in the incidence of claims payment should be considered an economic benefit to those honest consumers making claims. Conversely, those consumers who make deliberate or reckless misrepresentations will not benefit from the reforms as they will not have their premiums returned or their claims paid.

The model assumes that at present, for the customers of Type 2 firms, around 98 honest policyholders have their claims turned down in contravention of FOS guidance. Another 98 have their claims avoided for negligent misrepresentations, rather than receive a proportionate remedy. These individuals will be the main beneficiaries of the Law Commission's proposed reforms. The cost will be borne by 1) the pool as a whole in increased premiums and 2) consumers who act deliberately or recklessly, and who no longer have premiums returned.

Despite the pool as a whole paying slightly more for their insurance, this should not necessarily be considered an economic loss. The insurance product now being purchased by consumers is fundamentally different from the equivalent policy purchased prior to these proposed reforms, as there is now a greater likelihood of claims being paid in the future to those consumers that are honest.

Consumers will end up paying for the increased likelihood that the claims of honest consumers will be paid (either in full or in part) through higher premiums (**£9.05 million** per annum if firms pass on all the additional recurrent costs associated with pre contractual administration. Honest consumers making claims are likely to be **£9.85 million** better off as a result of these proposals, with consumers making claims that involve deliberate or reckless misrepresentations being approximately **£1.321 million** worse off.

[39] A consumer is said to have acted honestly if he/she (whether in answer to a question or otherwise) has made an innocent misrepresentation or a negligent misrepresentation (as opposed to having made a reckless or a deliberate misrepresentation). .

6.2.9 Behavioural Change

As mentioned in section 5 of this report, the change in the likely levels of profitability – especially for Type 2 firms – may result in a change in commercial behaviour. It is likely that all Type 2 firms will see some erosion of profits and this may result in some of these firms exiting the market place altogether.

In addition, it is also probable that some Type 2 firms will react to the proposals by offering reduced insurance services – for example, the policies sold will cover fewer identified illnesses. However, it is also the case that some organisations will adapt and change into Type 1 firms. It is impossible to predict the extent of these possible changes in the insurance market so we have not attempted to quantify the effect as part of this analysis.

The consultation exercise may be able to provide us with some information on the likely behavioural changes of different types of firm resulting from these proposals.

6.2.10 Dispute Resolution

Following the introduction of these proposals, there is likely to be a reduction in the number of complaints being filed with the Financial Ombudsman Service. This might be expected to result from the clarity and transparency of the new legislation and the reduced need to resort to the Ombudsman. CRA (2006) estimated the cost to the Ombudsman of administration of a complaint is approximately £360 per claim.

This saving is from the perspective of the FOS. We have also assumed that bringing or defending a complaint brought to the FOS is costly for all the parties involved. We have assumed that the costs associated with settling a complaint in front of the FOS amounts to 5% of the average CIC payout (£73,000), which corresponds to £3,650. This brings the total saving per case avoided to £4,010.

Assuming that there are approximately 390 complaints in the critical insurance market relating to non-disclosure or misrepresentation per annum[40] reaching the Financial Ombudsman and there is a 25% reduction in the number of complaints, this corresponds to a cost saving of **£390,975** per annum.

Views on this assumption and estimate would be welcomed.

[40] See Table 10

6.2.11 Benefits of Regulation

Some of this additional cost may be passed onto consumers without any corresponding reduction in the number of policies purchased. In fact, the recent CRA (2006) work assessed the willingness of consumer to pay for additional regulation and found that more than two-thirds of consumers were prepared to pay £5.00 per annum for additional regulation in the insurance market.

The increase in premiums calculated in this section corresponds to **£3.04** per policy for customers of Type 1 firms and over **£200** per policy per annum for Type 2 consumers[41]. Therefore, we have assumed that the increased policy cost results in a benefit to society from enhanced regulation and confidence in the insurance market. This benefit equates to **£0.987 million**[42] for customers of Type 1 firms (zero for customers of Type2 firms). This total benefit equals **£0.987 million** per annum.

6.3 Summary Estimates

Bringing together all these estimates of the costs and benefits to firms, consumers and society, for the particular costs and benefits that we are able to estimate, the aggregate impact on Type 1 firms is estimated to be between **£0.0 million** and **£0.241 million** per annum better off, while Type 2 firms are estimated to be between **£0.0 million** and **£0.016 million** per annum better off depending on the extent of recurrent administration costs (for those firms remaining in business). These calculations assume that both Type 1 and Type 2 firms are able to offset the increased costs of claims and administration against an increased premium charged to customers. In practice, we have estimated that Type 1 firms will need to increase their premiums by £3.04 per policy. Type 2 firms, however, would need to increase their premiums by £212.03 per policy. It is unlikely that any customer would pay this increase and therefore, it is likely that Type 2 firms will go out of business or else turn into Type 1 firms. Given the fact that Type 1 firms represent approximately 93% of the market, the impact in individual firms is likely to be relatively small.

There is likely to be a one-off cost associated with administration and familiarisation with the proposed legal framework. These have been estimated to be **£2.329 million** for Type 1 firms and **£0.416 million** for Type 2 firms.

[41] This estimate includes the greater likelihood of claims being paid and recurrent administration fees

[42] For Type 1 firms, this is calculated as follows. The increase in the average cost of the policy for Type 1 firms stands at 2.54. From CRA research, we have assumed that 68% of individuals would be prepared to pay up to £5.00 per annum for improved regulation and transparency. We therefore apportion all of the increase in premium as a benefit of regulation for 68% of consumers of Type 1 firms. In summary 3.04*(0.68)* 476,145=£987,635.

The aggregate impact on consumers is estimated to be **£0.470 million** per annum; however, the impact of these proposals affects consumers quite differently depending on their characteristics.

It is not possible to exactly predict the impact of these proposed reforms on all consumers. Honest consumers are likely to be better off as a result of having claims paid (which may not have been previously the case), as well as benefiting from regulation per se. Consumers that deliberately and recklessly misrepresent and are detected doing so will be worse off as a result of these proposals due to the fact that insurance companies will have the right to retain these premiums confirmed.

We estimate that the wider benefits accruing to both consumers and firms associated with a reduction in dispute resolution are estimated to be **£0.391 million** per annum.

The aggregate recurring economic benefits of these proposals on the critical illness market are estimated to be in the region of **£0.862 million** to **£1.120 million** per annum depending on the costs associated with recurrent administration costs. This is presented in the Table below.

This aggregate estimate is driven by the large impacts on consumers and in particular, the large positive impact on consumers that are honest in the claims they bring to some insurance companies and the large negative impact on those consumers that deliberately or recklessly misrepresent.

Excluding the impact on consumers, the aggregate impact on firms through the increase in the claims paid, fraudulent premiums retained, increased premiums charged; recurrent administration fees and avoidance of disputes (which benefit firms and consumers) is relatively cost neutral on an ongoing basis.

Table 18: Aggregate Static Economic Impact of Proposed Reforms

	Type 1 firms	Type 2 firms	Honest Consumers	DR[43] Consumers	Other
Increased claims paid	-£2.08m	-£7.77m	+9.855m		
Recurrent Administration Costs	-£0.482m to -£0.241m	-£0.034m to -£0.017m			
Retention of Premiums	+£1.11m	+£0.21m		-£1.321m	
Increased premiums[44]	+£1.45m	+£7.60m	-£9.050m[45]		
Dispute Resolution					+£0.390m
Benefits of Regulation			+£0.987m		
Sub-Total[46]	£0.0m to +£0.241m	£0.0m to +£0.017m	+£0.471		+£0.390m
Total economic impact[47]	**+£0.861 million to £1.120 million per annum**				

The information presented here is a simple static analysis of the expected impact of these proposals. In reality, the proposals are likely to alter the behaviour of firms and consumers, in ways that are not modeled here. Given the large expected rise in premiums for Type 2 firms, it is probable that some of these firms will exit the market.

As with any analysis of this nature, the absence of hard data make the provision of an exact estimate of the costs and benefits associated with a particular policy of proposal exceptionally difficult. As such, care should be taken with the estimates presented.

[43] DR indicates consumers who have recklessly or deliberately misrepresented

[44] Incorporating retention of premiums in the case of deliberate or reckless misrepresentation

[45] For simplicity we have not sought to distinguish between premiums paid by honest consumers and those paid by dishonest consumers.

[46] Total may not add exactly due to rounding

[47] This estimate relates to the aggregate economic impact across all firms, consumers and the wider economic impact.

Some of the estimates are based on secondary data collected at household level nationally; however, certain elements of the analysis are based on just a few pieces of information, which may not reflect reality as accurately as we would wish.

The worked example in this section is designed to provide an illustration of some of the impacts that might be associated with these proposals. We would also hope that it provides some rationale for the type and specificity of the information that are necessary for a full cost benefit analysis.

6.4 Conclusions

We have attempted to provide an indication of the economic impact of the Law Commission's proposed reforms relating to non-disclosure and misrepresentation on critical illness claims. There are significant data and evidence gaps in the analysis and we have made a number of assumptions in an attempt to fill these gaps. We would welcome any information resulting from the consultation exercise to fill some of the gaps identified as part of this research project.

We found that at an aggregate level, the proposed reforms are unlikely to have a significant impact either on firms or consumers. However, there is considerable variation in the impact of these proposals depending on the type of firm or the type of consumer. Specifically, we have estimated that although there will be a minimal impact on those firms that attempt to replicate the decisions for the Financial Ombudsman Service, there may be a negative impact on some of those firms that currently do not.

We have estimated that the proposed reforms will have a large positive impact on consumers that are honest in the claims they bring to insurance companies and will have a large negative impact on those consumers that deliberately or recklessly misrepresent.

Specifically, we have estimated that there will be an increase in the number of claims paid under these proposals and an increase in premiums charged to cover those claims. Honest consumers will benefit from the proposals in the sense their claims will now be more likely to be paid. All consumers will pay a little more for their critical illness insurance to compensate for this fact.

There are additional costs and benefits associated with these proposals. These relate to the increased one-off and on-going administration costs incurred by Firms; a reduction in the necessity to have a complaint settled by the Financial Ombudsman Service; and the general benefits associated with regulation. The largest of these costs relate to the administration costs faced by firms and this component of the analysis is the key determinant of the relative costs and benefits associated with the Law Commission's proposals.

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APPENDIX C
THE FOS APPROACH TO ISSUES OF NON-DISCLOSURE AND MISREPRESENTATION: A SURVEY OF OMBUDSMAN FINAL DECISIONS

INTRODUCTION

C.1 Each year the Financial Ombudsman Service (FOS) receives large numbers of cases concerning allegations of non-disclosure or misrepresentation by policyholders. For each of the last three years, the FOS has received around 1,000 such complaints a year.[1]

C.2 Our aim was to understand the issues involved in these disputes. We therefore set out to read around 200 final ombudsman decisions dealing with non-disclosure and misrepresentation. The FOS located around 300 decisions for us, and we read 197 cases about this area of law.[2] The great majority of these cases were brought by private consumers: only 7 of the 197 cases (4%) were brought by small businesses. We therefore attempted to increase the number of small business cases in our sample, and eventually found another 5. This means that our paper is based on 190 consumer cases and 12 small business cases.

C.3 Final ombudsman decisions are not typical of all cases. The FOS Annual Review for 2004/2005 shows that out of over 90,000 cases referred to adjudicators, over half (58%) were resolved through mediation, and more than a third (38%) were resolved after an adjudicator had given a view on the merits. Only 7% were resolved by a final ombudsman decision. However, we thought that ombudsman decisions would give us the best understanding of the detailed rules and approach that the FOS takes to non-disclosure.

C.4 All the decisions we looked at were made between February 2003 and December 2005. During 2003, the FOS clarified the way that non-disclosure cases were dealt with, and communicated this to industry and consumer groups.[3] Almost all the decisions in the sample were decided under this clarified procedure.

C.5 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 that could allow the parties to be identified. In the examples that follow, we refer to complainants by changed initials and to cases by number rather than name. These numbers have been allocated by us for the purposes of this study, and bear no relation to FOS records.

[1] FOS figures indicate that between April 2005 and March 2006, it received 1,007 cases classified as non-disclosure, compared to 1,051 in 2004/05 and 967 in 2003/04. Given some discrepancies in how cases are classified, little should be read into these differences.

[2] We originally read 204 cases, but 7 were excluded from the sample as they were about other things: two concerned post-contractual good faith; and five were about policy terms which excluded pre-existing conditions.

[3] *Ombudsman News*, Issue 27, April 2003, p 7.

C.6 Below we consider consumer and small business cases separately. We start by looking at the 190 consumer cases. We then consider the particular issues raised by small businesses.

THE CONSUMER SAMPLE

C.7 Although the cases covered a variety of different types of policy, the largest group related to critical illness. Table 1 records the type of policy, using the classifications adopted by the FOS.

Table 1: Consumer cases – by type of policy

	No.	%	No. where alleged non-disclosure related to a health issue
Motor	22	12	0
Building/contents	32	17	0
Critical Illness	93	49	92
Income protection/permanent health	19	10	19
Loan protection	7	4	7
Travel	6	3	5
Private medical/dental	3	2	3
Whole of life	2	1	2
Term insurance	2	1	1
Other	4	2	0
Total	190	100	129

C.8 There is some overlap between these categories. For example, many of the critical illness policies were used to protect a mortgage or other loan, and some policies involved elements of critical illness, income protection and life cover. What emerges most clearly from the table, however, is the preponderance of health-related insurance. In all, two thirds (68%) of the consumer cases in our sample involved an alleged non-disclosure related to the policyholder's health[4] – an issue that may arise in travel, health, life or critical illness cover.

C.9 Motor and household insurance also featured, together with a few miscellaneous categories, including pet insurance and boats.

C.10 Table 2 shows the main information that the insurer said was not disclosed. Although health issues dominated the sample, the non-disclosure of the policyholder's past claims record, past losses or previous convictions may also give rise to problems. In motor insurance, there were seven cases in which the insurer said the policyholder had misled them about the identity of the main driver or owner of the vehicle. In buildings insurance, three cases involved issues about previous signs of subsidence.

[4] This includes information about how much the policyholder smoked, and about the health of other members of the family, where this is used to assess the policyholder's own vulnerability to disease.

Table 2: Consumer cases: main information not disclosed

	No.	%
Health issue	129	68
Previous claims/losses	20	11
Criminal charges/convictions	12	6
Identity of car driver/owner	7	4
Car specification/modifications	3	2
Cracks/history of subsidence	3	2
Value of property	3	2
Other	13	7
Total	190	100

C.11 The preponderance of disputes about critical illness and permanent health cover meant that many policyholders were suffering from serious illnesses at the time they brought their complaint to the FOS. As Table 3 shows, around two thirds suffered from some form of illness or disability. A quarter suffered from cancer. The seriousness of the problems is shown by the fact that at least 16 policyholders had died by the time that their claim reached a final decision. This high level of illness and disability clearly affects the ability of policyholders to pursue complaints, and puts additional pressures on the FOS.

Table 3: Consumer cases: policyholders with illness or disability

Policyholder suffered from	**No.**	**% of all consumers**
- Cancer	47	25
- Multiple Sclerosis	22	12
- Severe back, neck or joint pain	12	6
- Heart disease	9	5
- Parkinson's disease	3	2
- Other physical illness/disability	23	12
- Mental illness/disability	7	4
All with a physical or mental disability	124	65
Base	190	100

The £100,000 limit

C.12 Life and critical illness claims may be worth a considerable amount of money. In most cases the ombudsman did not discuss the potential value of the claim, confining their decision to whether or not the policy should be avoided. However, the value of the claim did become an issue if it appeared that it may exceed the £100,000 limit, under which ombudsman awards are binding on insurers. In four consumer cases, it appeared that the £100,000 limit would be exceeded but the parties nevertheless agreed to ask the ombudsman to make a (non-binding) recommendation. The largest claim was valued at around £250,000.

The FOS approach

C.13 In April 2003 and again in June 2005, the FOS set out publicly the approach they take to issues of non-disclosure.[5] The FOS start with the legal position, as explained in *Pan Atlantic*, but say that this must be tempered by good industry practice, as clarified in the ABI Statements of Practice and FSA Conduct of Business Rules. Based on these principles, the FOS say they have developed a three stage test:

(1) The insurer must provide evidence that it asked a clear question, to which it received an inaccurate response.

(2) If so, the firm must show that the inaccurate answer influenced its decision, either to enter into the contract or all, or on the particular terms that it did enter the contract.

(3) If the answers to both 1 and 2 are yes, the ombudsman will consider the customer's state of mind, asking if the misrepresentation was deliberate, reckless, inadvertent or innocent.

C.14 If the misrepresentation is deliberate or reckless, the insurer is entitled to avoid the policy. If the misrepresentation is innocent, the insurer will be obliged to pay the claim. If, however, the misrepresentation is inadvertent, the ombudsman enquires into the terms the insurer would have offered, had they had been aware of the information. In some cases, this may result in a proportionate payment; in others, it may involve an exclusion. Sometimes, the insurer may be able to show that it would not have written the insurance at all, and the policyholder will receive nothing.

C.15 This is a complex and difficult test, which we look at in more detail below.

Stage 1: Clear questions

Was a question asked?

C.16 We recorded whether the consumer had been asked a specific question about the relevant information. To understand this information, it is important to realise that a non-disclosure may arise at different stages of the policy. Although in most cases the insurer alleged that the consumer failed to tell them something at application, it is also possible to fail to disclose information at other stages. We identified four stages at which a non-disclosure could occur: at application; between the application and the start of the policy; at renewal; and during the course of the policy.

[5] *Ombudsman News*, Issue 27, April 2003, p 7 and Issue 46, May/June 2005, p 8.

Table 4: Consumer cases: time of non-disclosure, and whether a relevant question was asked

Time of non-disclosure	No. of cases	%	Cases where it appeared no relevant question asked	
			No.	%
At application	153	81	4	3
Between application and start of policy	27	14	21	78
At renewal	6	3	5	83
During policy	4	2	2	50
Total	190	100	32	

Non-disclosure at application

C.17 As Table 4 shows, most (81%) of the alleged non-disclosures happened at the application stage – and in the vast majority of these cases it appeared that a relevant question was asked.

C.18 There were only four cases in which the insurer attempted to avoid a policy for non-disclosure because the applicant had failed to volunteer information at the application stage. In two cases, the insurer won and in two they lost.

C.19 Under the approach FOS has outlined, ombudsmen will not usually allow an insurer to avoid a policy where no question has been asked. Case 164 provides a clear example of this:

> The complainant's daughter had split up with her partner, who made various threats against the family. The complainant then decided to take out contents insurance (after five years without it). She was not asked if she had received threats, and she did not mention them. The household was later burgled. The insurer suspected that the ex-partner had been involved and they attempted to avoid the policy on the grounds that they should have been told about the threats. The Ombudsman applied the rules set out above, and decided that as no question has been asked, the insurer could not require the matter to be disclosed. They should pay the claim.

C.20 By contrast, we found two cases where the requirement was not applied quite so strictly.

> Case 144 raise issues about what is "a question". The complainant had bought motor insurance online. The online form did not specifically ask who the main driver was, but the agreement stated that the complainant was the main driver and he ticked the box at the end to say that everything was correct. In fact, he was not the main driver. The ombudsman found that this was a reckless or deliberate non-disclosure and allowed the insurer to avoid the policy.

> Case 22 is more surprising. Here the complainant's car was stolen. When he made a claim on his motor insurance, the insurer avoided the policy on the grounds that at the time of application he had not told them that the police had serious doubts about the car's history. The police apparently believed the car to have been stolen. The insurer had not asked any specific questions about this. Nevertheless, the ombudsman decided that the insurers' rejection was not unreasonable, given the inconsistencies in the complainant's version of events.

C.21 Thus it appears that there are still a few cases where insurers attempt to avoid policies because the policyholder has not volunteered information at application, even though no specific questions have been asked. However, in the great majority of consumer cases, the insurer has asked a relevant question. Out of 153 cases where it was alleged that the insured had failed to disclose an issue at the application stage, a relevant question was asked in 149 (97%).

Non-disclosure between application and the start of the policy

C.22 These 27 cases all involved critical illness cover. It is often a condition of the policy that the policyholder notifies the insurer of any changes in their health between completing the application and the date the cover starts.

C.23 For example, in Case 26, the application form stated:

> You should inform us immediately of any alteration in your health or circumstances between you completing the application and the date the risk is assumed by us.

C.24 After completing the application form, the complainant discovered a lump in her breast and was sent for a mammogram. The insurer avoided the subsequent claim for breast cancer because she had not disclosed this. The ombudsman upheld the insurer's decision on the grounds that the complainant had been given a clear warning about the need to notify the insurer of the changes.

C.25 In around half of these cases (14) the ombudsman upheld the insurer's decision; in around half (13) the ombudsman found for the complainant.

C.26 Ombudsmen were prepared to overturn an insurer's decision if the applicant had not been given a clear warning of the need to notify. In Case 12, for example, the ombudsman found for the complainant on the grounds that the requirement was stated only in the conditions and not on the application form. In Case 30, the requirement had been on the application form, but the complainant had not kept a copy. The ombudsman found that the complainant could not be expected to remember what was on a form they had sent to the insurers. Ombudsmen will also find for the complainant if the requirement to notify is not practical. In Case 12, for example, the complainant visited the Accident and Emergency Department the day before cover started. He did not leave until after business hours, when it was too late to notify the insurer of his suspected throat cancer.

C.27 The FOS has explained that in these circumstances it does not expect proposers to recall what questions they have been asked. Insurers must either re-ask the questions or send a copy of the application form. This would not extend, however, to changes that affect the fundamental nature of the contract, such as a terminal diagnosis or the destruction of the insured property before the cover started.

Non-disclosure at renewal

C.28 This form of non-disclosure is most likely to arise in contents insurance (which concerned four of the six cases in our sample). It is common for a renewal notice to ask about changes in circumstances. In Case 20, for example, the renewal notice stated:

> We would remind you of the importance of informing us of any material changes that may have taken place since the inception of your insurance policy. Should you be in any doubt, please contact us immediately.

C.29 Here the insurer attempted to avoid the policy on the grounds that the policyholder had not mentioned that, since inception, a county court judgment had been registered against them. The ombudsman overturned the insurer's decision. The form had failed to clarify what the insurer needed to know, and few policyholders would realise that a county court judgment was material to the insurer.

C.30 In Case 124, the complainants had renewed their pet insurance by direct debit. They received a renewal notice that mentioned the general duty of disclosure on page 4, but the duty was not emphasised in any way. The ombudsman held that if the insurer had wanted an update on the pet's health on renewal they should have asked specific questions.

C.31 The FOS is prepared to hold that a non-disclosure in response to a renewal notice may be sufficient to avoid a policy, but ombudsmen tended not to be sympathetic to wide requirements to disclose anything an insurer may think material. In five out of the six cases, the insurer's decision was overturned. In case 102, for example, the ombudsman found that the complainants had behaved recklessly in not reading the notice on page 2 of the renewal form and therefore failing to mention their son's criminal conviction. However, given the circumstances of the conviction and the complainants' excellent claims record, the ombudsman was not convinced that the insurer had been influenced in their decision (as required under stage 2 of the procedure).

Non-disclosure during the policy

C.32 Surprisingly, there were four cases in the sample where the insurers attempted to argue that a policyholder had an ongoing duty to inform them about changes to their circumstances during the course of the policy. Two were travel policies; two were motor policies.

C.33 Ombudsmen were not sympathetic to this argument, and in all four cases they overturned the insurer's decision. In Case 57, for example, the travel insurer argued that the policyholder should have notified them of changes to her health. The ombudsman found there was no on-going duty of disclosure. In addition to requiring the claim to be paid, he awarded the complainant £500 for distress and inconvenience caused by the delay in payment.

Was the question clear?

C.34 Even if a question was asked, it may not necessarily be "clear". The survey showed that questions relating to health, in particular, may be far-ranging. Below we give some examples of commonly-asked questions that have the potential to cause problems. We start with health questions, and then look at those found in building and contents proposal forms.

Health

C.35 Where an insurer is providing cover against death, illness or disability, they have a legitimate interest in finding out about any potential health problem. However, this can result in long, complex questions. We identified five possible difficulties.

C.36 The first problem is that questions frequently list many different disorders or problems within a single sentence. For example:

> Have you ever had cancer, stroke, kidney disease, high blood pressure, multiple sclerosis, Parkinson's Disease, any condition affecting the nervous system, a heart murmur, any other disorder of the heart, or any eye or ear disorder?
>
> Have you ever had any heart disease, high blood pressure, stroke, cancer, diabetes, kidney disorder, parasthesia, multiple sclerosis, or any eye or ear disorder OR have you ever suffered from any illness or injury which has prevented you from working for a period of two weeks or more (long or shortsightedness or minor ear infections may be excluded)?

C.37 Note that both these questions cover a wide variety of issues. They mix diagnosed conditions (such as multiple sclerosis) with symptoms (such as high blood pressure). They also mix serious life-threatening conditions (cancer) with ones that are not (any hearing loss). The danger is that people will respond to the question as a whole, rather than analysing each element separately. They may therefore treat the question as about serious diseases (such as cancer, stroke, multiple sclerosis or Parkinson's Disease) and fail to mention what they see as a non-serious matter, such as high blood pressure. Thus in Case 141 the policy was avoided because the policyholder failed to mention that his blood pressure was high, though it was not high enough to require medication.

C.38 The second problem is that some questions are extremely wide.

> Have you suffered from any physical or mental complaint or injury which has required medical or surgical investigation, operation or treatment?

> Have you any physical defect or infirmity or is there any ailment or disease from which you suffer or have suffered or to which you have a tendency?

C.39 The first question would appear to require the policyholder to start with any complications at birth and continue through every childhood and adult visit to the doctor or casualty. The second question would also appear to include colds and 'flu, whether the policyholder had seen a doctor or not.

C.40 Clearly, people do not take these questions literally: they reinterpret them as relating only to what seems relevant. However, consumers' own interpretation of relevance may be different from that of insurers. Our survey included cases where insurers attempted to avoid policies on the grounds that, when asked about "any current condition", policyholders had failed to mention cold symptoms (Case 75) or a mole (Case 65).

C.41 Thirdly, questions that are not time-limited can test the limits of consumers' memories. This is a particular problem where questions ask applicants to recall any hospital test or investigation. For example:

> Have you required specialist medical investigation?
>
> Have you ever undergone or been recommended to undergo hospitalisation, an operation, x ray or any other investigation?
>
> Have you at any time had or been advised to have any hospital investigation, consultation, operation or treatment, or are you currently having treatment for any medical or psychological condition, or are you aware of any condition for which you may need to see a doctor?

C.42 After a few years, people may forget hospital tests that fail to find anything wrong. In Case 56 an insurer attempted to avoid a policy partially on the grounds that the policyholder had failed to mention a negative MRI scan they underwent 9 years earlier.

C.43 Fourthly, policyholders may fail to understand medical terms or medical classifications, especially where the doctor has not discussed their condition in these terms. They may not realise, for example, that "hypertension" means high blood pressure. In Case 73, a woman asked about conditions "affecting the nervous system" did not realise that this included the numbness she was experiencing in her leg.

C.44 Finally, there are two everyday conditions that cause particular problems: stress and backache. Insurers routinely ask about these, often using wide questions:

> Have you ever suffered from… stress, anxiety or depression, neck, back or spinal problems… joint problems, or any form of disability.
>
> Have you suffered from any of the following conditions? (please give details even though you many not have consulted a doctor)… stress, tension, anxiety or depression.

C.45 At one level stress is a normal part of life - and many people will at some stage mention the stresses they are under to their doctor. They will not necessarily think of this as a medical condition from which they are "suffering", especially if it is a reaction to external events. For example, in Case 53 the insurer attempted to avoid the policy on the grounds that Mr C said he did not suffer from stress. However, his medical notes revealed that two years earlier an Occupational Health Nursing Officer reported that he had "raised stress levels" as his wife was depressed following her father's death and he was coping with young children. The doctor had also entered one line saying Mr C was "stressed with early morning waking". In Case 125 a woman had taken time off work for stress, but saw this as related to her matrimonial problems rather than her health.

C.46 Backache is a particularly prevalent condition. One estimate suggests that it affects over a third of adults.[6] Several people in the survey failed to mention that they had previously suffered from backache if it was no longer a problem for them. In Case 55, for example, the policyholder failed to mention that she had experienced back pain following childbirth more than 5 years previously. In Case 7 the policyholder asked her intermediary, and was told only to mention a problem that had occurred in the last 2 years.

Questions relating to building and contents insurance

C.47 In our survey, 27 cases related to contents insurance and 5 to building insurance, forming around a sixth of the total sample. In this context, most non-disclosure was about previous claims or losses (16 cases, 50%); or previous convictions (6 cases, 19%). Other issues included subsidence (3 cases); locks and alarms; or the value of the contents.

C.48 Household insurance proposal forms commonly ask questions along the following lines:

> Have any accidents, losses or claims arisen, whether insured or not?
>
> Have you or anyone living with you made a claim or had an incident which may have resulted in a claim or suffered loss, damage or liability during the last 5 years, whether insured or not?

C.49 The survey revealed three issues with questions of this sort. First, people may not remember minor claims made more that three years previously; they may be unaware that other people living with them have made claims; or they may not understand what is meant by "loss or damage" that does not result in a claim.

C.50 If interpreted literally, "loss or damage" could cover any occasion on which a household item is lost or damaged, but few people would interpret the question in this way. In Case 11, for example, Mrs T's young son had spilled candle wax on the carpet. A few months later she had redecorated the room and replaced the carpet. The insurer attempted to argue that her failure to mention this incident when she renewed her insurance entitled them to avoid the policy, though the ombudsman ruled that the phrase "suffered loss" could not be intended to include all damage to a home caused by young children.

[6] See http://www.backcare.org.uk/backhealth/

The FOS approach to unclear questions

C.51 The FOS does not evaluate questions in the abstract. Our survey did not include any cases where a question had been asked, but where the Ombudsman had thrown the case out at Stage 1 simply because the question was not clear. In all the cases we looked at involving an inaccurate answer, the ombudsman had proceeded to Stage 3 to evaluate the policyholder's state of mind. In other words, the cases always involved some discussion of whether the policyholder had acted honestly or reasonably in giving the answer that they did, though ombudsmen used different terms and tests to describe this process. The FOS explained that the issue of whether a question is unclear "invariably involves a discussion of the complainant's response to it".[7]

STAGE 2: INDUCEMENT

C.52 Under the rule in *Pan Atlantic*, the insurer must show that the non-disclosure or misrepresentation influenced (or "induced") them to enter the contract – though it does not necessarily have to be a decisive influence. The insurer does not have to show that, if they had known the full facts, they would not have entered the contract at all. It is enough to show that they might have charged a higher premium, or that they would have inserted other terms or exclusions into the policy.

C.53 The FOS comments that

> The burden of proving inducement will not be high in clear-cut cases. For example, if a customer fails to disclose that their house has serious cracks, we are likely to believe the insurer would not have offered them full buildings insurance.

C.54 However, in other cases it may not be clear-cut, and the FOS will usually require evidence of influence, such as a statement from the underwriters.

C.55 Thus the cases in our survey usually included a statement or other evidence from the underwriter, saying what they would have done had they known the full facts. These statements are relevant for two reasons:

(1) Insurers can only avoid a policy if they can show that they would have been influenced by the information had they known it. Thus, even if a claimant has deliberately failed to mention past claims, the insurer can only avoid the policy if they show that had they known about the past claim, they would probably have acted differently in entering into the contract. At this stage, the insurer does not necessarily have to show *what* they would have done differently.

(2) Where the non-disclosure is inadvertent, the ombudsman asks what the insurer would have done had they known the information. The insurer will usually be required to pay a claim that it would have paid under the terms of the insurance it would have offered.

[7] Private communication.

C.56 At this stage, we are only concerned with the first issue: can the insurer show they would (probably) have done something differently? We return to the second issue below.

C.57 In practice, the first issue rarely causes disputes. It is a fairly easy test for insurers to meet. In most cases, the insurer's underwriters sent a letter stating that had they known the information, they would have acted differently. The FOS told us that ombudsmen then exercise their own judgement on whether the insurer has in fact been induced: they do not rely on complainants to undertake "the burden of challenging insurance experts on insurance practice".

C.58 There were a few cases in which the ombudsman did not accept that the insurer would have written the policy on different terms or not at all if they had known the information. For example:

(1) In Case 102, the ombudsman found that the policyholders had acted recklessly in not telling the insurer that their son had been convicted of theft. They had not read page 2 of the renewal notice, which asked for such information. However, there were particular circumstances surrounding the conviction, and the policyholders had been insured with the insurer for more than 14 years, during which they had an excellent claims record. The ombudsman said the insurer had not discharged their burden of proof to show that they would not have entered into the contract on the same terms.

(2) In Case 129, the applicant failed to mention that she had been referred to a specialist for a heart murmur, and had undergone an ECG test. She later developed cancer. The tests revealed no abnormality of the heart. On this basis, the ombudsman said that the information would not have affected the underwriter's decision, and the insurer would still have issued the same policy on the same terms.

C.59 However, most cases focused on the customer's state of mind (discussed below) rather than the insurer's. If a complainant were to challenge an insurer's claim, they would need expert evidence. The FOS does not ask complainants to provide such evidence, and we did not find any cases in which the complainant had done so. This is hardly surprising, given the low levels of legal representation. The FOS regards legal representation as unnecessary and most policyholders were unrepresented. Among the 190 decisions, we found evidence that the applicant was legally represented in only 21 cases (11%).[8]

STAGE 3: EVALUATING THE CUSTOMER'S STATE OF MIND

The stated approach

C.60 The FOS state that they categorise misrepresentations in four ways: deliberate, reckless, inadvertent and innocent. They define these categories as follows:

[8] In three cases the applicant appeared to be represented by a (paid) non-lawyer such as a broker, and in one case by an unpaid adviser.

Deliberate

Customers *deliberately* mislead the insurer if they dishonestly provide information they know to be untrue or incomplete. If the dishonesty is intended to deceive the insurer into giving them an advantage to which they are not entitled, then this is also a fraud and – strictly speaking – the insurance premium does not have to be returned.

Reckless

Customers also breach their duty of good faith if they mislead the insurer by *recklessly* giving answers without caring whether those answers are true or false. An example of recklessness might be where a customer signs a blank proposal form and leaves it to be filled out by someone else. The customer has signed a declaration that *'the above answers are true to the best of my knowledge and belief'*, but does not know what those answers will be.

Inadvertent

A customer may also have acted in good faith if their non-disclosure is made *inadvertently*. These are the most difficult cases to determine and involve distinguishing between behaviour that is merely careless and that which amounts to recklessness. Both are forms of negligence.

Innocent

Customers act in good faith if their non-disclosure is made *innocently*. This may happen because the question is unclear or ambiguous, or because the relevant information is not something that they should reasonably know. In these cases, the insurer will not be able to 'avoid' the contract and (subject to the policy terms and conditions) should pay the claim in full.[9]

C.61 The FOS explain that deliberate misrepresentations are not necessarily fraudulent. Fraud involves a deception in which the policyholder attempts to gain a benefit to which they are not entitled. The applicant may deliberately withhold information because they are embarrassed about it, without thinking that it would have any affect on a claim. Thus a deliberate misrepresentation may be either fraudulent (when the insurer is entitled to keep the premium) or non-fraudulent, (when the premium must be returned). On this basis, it may be better to think of the FOS applying a five-fold classification: fraud, deliberate, reckless, inadvertent and innocent.

[9] *Ombudsman News* 46. The FOS has now provided further guidance on these issues in *Ombudsman News* (April/May 2007) Issue 61. For discussion, see paras 4.72 to 4.74.

C.62 The classification system is a complex one. It attempts to distinguish between two forms of negligence: inadvertence and recklessness. The word "reckless" is often used in a criminal context, and attempts to define it have kept the courts busy.[10] In 1993 the Law Commission distinguished between acting recklessly in respect of a circumstance (such as whether you had undergone an MRI scan) and acting recklessly in respect of a result (such as whether the insurer would act differently if they knew about it).[11] We provided the following draft statutory definition:

> A person acts "recklessly" with respect to:
>
> > (i) a circumstance, when he is aware of a risk that it exists or will exist and
> >
> > (ii) a result when he is aware of a risk that it will occur
>
> and it is unreasonable, having regard to the circumstances known to him, to take that risk.

C.63 It is not absolutely clear whether the FOS is talking about recklessness in relation to the circumstances or the result. For example, a policyholder may be aware that the question asks about "any ear disorder" and that they suffer from minor hearing loss. They may, however, fail to mention it in a proposal for life insurance because they do not think it would be of any relevance to the insurer. The misrepresentation would therefore be deliberate as to the circumstances but inadvertent as to the result (as the applicant is unaware of the risk that the insurer would think it material).

C.64 At first reading, the description the FOS gives of their approach suggests that ombudsman will look only at the applicant's state of mind in relation to the literal truth of the answer: did they give an answer knowing it to be untrue or without caring whether it was true? On this basis someone who deliberately states that they do not have a hearing loss because they didn't think the insurer had any reason to know would be classed as acting "deliberately" rather than "inadvertently". This can lead to a harsh result where the applicant dies of a cause unrelated to the hearing loss (such as leukaemia). If the mis-statement is classified as deliberate or reckless, then the insurer may avoid payment if they can show that, had they known the truth, they would have done something differently (such as exclude hearing loss). The insurer does not need to show that, had they known, they would have excluded the particular claim in question.

[10] See in particular, *R v G* (2003) 22257805 (HL), [2004] 1 AC 1034; *R v Caldwell* [1982] AC 341; *R v Cunningham* [1957] 2 QB 396.

[11] Legislating the Criminal Code: Offences against the Person and General Principles (1993) Law Com 218.

C.65 A further complication of the FOS test is that ombudsmen are forced to make subtle evaluations of the policyholder's state of mind when they were filling in a form, possibly several years earlier, and to which they may not have paid much attention to at the time. This is especially difficult where the policyholder has died (which occurred in at least 16 cases). In the absence of evidence about what risks the applicant was aware of, the burden of proof becomes an issue. The burden is clearly on the insurer to establish that a misrepresentation has been made. However, once this has been established, the ombudsman's description of the process does not make it clear whether it is up to the policyholder and their family to show that the risk was innocent or inadvertent, or up to the insurer to show that it was reckless or deliberate.

Applying the categories in practice

C.66 Given the potential problems with attempting to categorise the policyholder's state of mind, we were keen to see how the system worked in practice. In our survey there were 160 cases in which it was alleged that the policyholder had given an inaccurate answer to a question. We read through each of these decisions to see how the ombudsman had classified the behaviour

Table 5: Consumer cases where a question was asked: how did the ombudsman classify the answer?

	No.		***%***	
Innocent	22		14	
Inadvertent	14		9	
Reckless	31		19	
Deliberate	6		4	
Did not classify in this way of which:	87		54	
Policy avoided		59		68
Policy not avoided		25		29
Ombudsman upholds insurer's decision to amend policy terms/apply proportionality		3		3
All cases where question answered inaccurately	160	87	100	100

C.67 The first issue to note is that very few answers were classified as deliberately false. We found only six cases where the ombudsman said that the insured had acted deliberately in giving false information. There were none in which the complainant was said to be fraudulent. It was much more common for the ombudsman to say that the behaviour was "at least reckless".

C.68 The second point is that ombudsmen were often reluctant to use the terminology of this four-fold classification. In over half of the cases in the sample, the ombudsman did not specifically state in the decision whether they regarded the policyholder's actions as innocent, inadvertent, reckless or deliberate. In two-thirds of cases where the ombudsman failed to apply the classification, the policy was nevertheless avoided. Unfortunately, words such as "deliberate" and "reckless" have strong connotations of criminal wrongdoing. Ombudsmen are naturally reluctant to use such language to grieving relatives or terminally-ill patients. Ombudsmen told us that the four-fold classification was useful for analytical purposes, but does not necessarily represent a clear, simple way of explaining the issues to the parties.

C.69 One of the Law Commission's tasks is to ensure that legal rules are expressed as simply and straightforwardly as possible, and that the language used make sense to those most affected by it – in this case, insurers and their customers. We were therefore interested to see the form of words that ombudsman used when communicating a negative decision to the policyholder. Note that in all the cases that follow, the insurer's decision to avoid the policy was upheld.

C.70 The most used form of words was simply that the policyholder did not give the questions and answers the care and attention they required:

> Mr X did not give the questions and answers the care and attention they required. (Case 2)
>
> I remain of the view that the complainant did not give the questions asked in the proposal form, and her answers, the consideration required. (Case 61)
>
> She did not give the questions the careful attention they required and provided misleading information. (Case 71)
>
> Mr B did not give that question and his answer as written on the application, the care and attention required. (Case 84)
>
> If she had given her questions the care and attention they required she should have been able to recall at least a number of other claims. (Case 135)

C.71 In a few cases, the ombudsman applied a reasonableness test, and asked how a reasonable person would have understood the question:

> What is crucial is that Mrs Z understood, or should reasonably have understood [the question]. I am not satisfied that she gave a reasonable answer. (Case 51)

C.72 In other cases, ombudsmen merely stated that they were unable to conclude that the mis-statement was innocent or inadvertent. On this basis, it was not necessary to make a positive finding that the answer was reckless or deliberate.

> In all the circumstances I am unable to conclude that the complainant's non-disclosure was innocent or inadvertent (Case 105)

> I cannot accept that the complainant's failure to disclose the information was merely inadvertent (Case 113)
>
> I am unable to conclude that the condition of the boat was misrepresented innocently or inadvertently (Case 123)

C.73 In other cases, the ombudsman upheld the decision to avoid a policy on the basis that the information was inaccurate, without setting out a specific finding on the claimant's state of mind in their decision:

> I am satisfied that the firm asked a clear question and the complainant gave an incorrect answer (Case 9)
>
> The claimant did not disclose all his convictions when he applied for insurance (Case 78)
>
> The complainant did not answer accurately the questions asked (Case 117)
>
> [The form] was not completed fully and accurately and misled the firm (Case 119)

C.74 In Case 81, the ombudsman specifically stated that the claimant must answer accurately, even if she did not believe the question to be material:

> She had a duty to answer the questions accurately, whether she believed them to be material or not. Although… she states that she did this, I am not satisfied that this is so.

C.75 In Case 112, the ombudsman accepted that the failure to mention a problem may have been "an oversight", but commented:

> The firm cannot reasonably be expected to be held to the contract if it entered into it on the basis of wrong information which the complainant supplied as a result of insufficient care.

C.76 We should stress that these examples look only at the words the ombudsman used to justify the decision – not at the substance. We suspect that, in many of the cases outlined above, if the ombudsman had been forced to use one of the four categories, they would have labelled the misrepresentation as deliberate or at least reckless. Furthermore, some of these cases dated from 2003, when the ombudsman approach was still being refined. The words used, however, suggest that many ombudsmen expect consumers to answer questions carefully and accurately. They are prepared to apply the rigours of the law when they fail to do so even if (as discussed below) the non-disclosure may not have had a decisive effect on the whether the claim would have been paid.

STAGE 4: INADVERTENT NON-DISCLOSURE: WHAT WOULD THE INSURER HAD DONE?

C.77 The final stage of the process applies only where the non-disclosure is found to be inadvertent. Here the FOS asks what policy terms the insurer would have offered if they had been aware of all the information. In practice there are three possibilities:

(1) If the insurer would not have entered into the contact at all, then the policy is avoided.

(2) If they would have charged a higher premium, they will be ordered to pay a proportion of the claim. For example, if the ombudsman finds that the insurer would have charged twice the premium, the policyholder would receive half the claim.

(3) If the insurer would have inserted an exclusion into the policy, the ombudsman asks whether the claim would have been paid had the exclusion been present. Claims subject to the exclusion may be rejected, and other claims must be considered.

C.78 The issue arose only rarely. Only 14 out of the 160 cases (8%) were classified as inadvertent. In one case, the ombudsman found that there was no inducement: even if the insurer had known about the (negative) test, they would not have done anything differently. Out of the remaining 13 cases, the FOS applied a proportionality test in five cases. In eight cases, the FOS asked whether an exclusion would apply.

Proportionality

C.79 There has been considerable discussion of the proportionality principle, which is a feature of some civil law systems. 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" and recommended a similar approach in all non-fraudulent claims.[12]

C.80 The survey shows that proportionate outcomes are relatively rare in final decisions. In all, we found four cases where the insurer had offered a proportionate outcome. In three cases, the FOS accepted this as fair, without classifying the claimant's conduct (cases 27, 100 and 202). In the remaining case, the ombudsman upheld the complaint, and required the insurer to pay in full. In another five cases, the FOS required the insurer to pay a proportion of the claim although they initially refused. On this basis, the consumer received a proportionate outcome in only 8 out of the 190 cases in the survey (4%).

C.81 Initially, we were surprised that so few cases resulted in a proportion of the claim being paid. However, this result is only reached where two circumstances overlap. First the non-disclosure must be inadvertent (rather than innocent, when the claim will be paid in full; or reckless or deliberate, where it will not be paid at all). Secondly, it only applies where an insurer, had they known the facts, would have charged a higher premium. Again, this applies in only a minority of cases.

C.82 The five cases in which the ombudsman imposed a proportionate outcome were:

(1) V failed to disclose one of his two motoring convictions. The ombudsman decided that he was not entirely innocent, but the question could have been clearer. The insurer said, had they known of the conviction, they would have charged an additional 33% premium. On this basis, the claimant received 75% of their claim. (Case 1)

[12] NCC, Insurance Law Reform (1997) pp 26 and 55

(2) W failed to disclose an eating disorder and depression. The ombudsman said that the question was oddly worded and that W found the issue particularly difficult to talk about. She was later diagnosed with multiple sclerosis. The insurer said that their standard practice where there was evidence of depression was to increase the premium by 50%. On this basis, W received two thirds of the normal claim. (Case 23)

(3) X failed to mention a minor eye infection and underestimated the number of cigarettes she smoked. The ombudsman found that the eye infection non-disclosure was innocent. The insurer used standard rates to assess the level of smoking. The Ombudsman asked them to look at the case again, taking into account the premium they would have charged for that level of smoking. (Case 89)

(4) Y had failed to disclose that his father had died of a heart attack. He later developed Parkinson's disease. The ombudsman found that the non-disclosure was "slightly careless… but this does not amount to recklessness". The case was sent back to the insurer, for them to calculate how much they would have charged if they had known about Y's father's heart attack. (Case 138)

(5) Z failed to mention that he suffered from Crohn's disease. He later developed multiple sclerosis. The ombudsman found that had the insurer been aware of the problem they would have charged double the premium. On this basis the insurer was ordered to pay half the claim. (Case 171)

Applying an exclusion

C.83 In other cases, the insurer stated that they would have charged a similar premium but would have added an exclusion to the policy. Clearly, this helps those complainants whose claims would not be caught by the exclusion – though is of no use to those whose claims would be caught. In five cases the exclusion did not affect the claim. For example:

(1) In Case 15, an intermediary filled in the form and failed to mention the complainant's hearing loss. The complainant later died of leukaemia. The insurer admitted that if they had known of the hearing problem they would have issued the policy at the same premium, but would have excluded hearing-related problems from the cover. The ombudsman found that the non-disclosure was inadvertent, and required the insurer to re-instate the policy, subject to this exclusion. The effect was that the claim was met in full.

(2) In Case 55, the proposal form contained an extremely wide question, which, among other things, asked if the complainant had ever suffered from back pain. She did not mention her back pain following pregnancy five years earlier. She later developed (unrelated) breast cancer. The ombudsman categorised the answer as only slightly careless, and decided that had the insurer known about the backache, they would have simply have excluded back conditions from cover. They were required to reinstate the policy subject to a back exclusion, and to pay the claim for cancer.

(3) In Case 121, the ombudsman held that had the insurer known about the complainant's true state of health, they would have excluded mental illness from cover. They were still liable to pay the claim for cancer.

C.84 By contrast in Case 96, the complainant failed to mention an upcoming opthalmological referral, in a way that was classified as inadvertent. He later developed a serious eye problem. The ombudsman reinstated the policy, but subject to an exclusion for eye conditions, which meant that his claim would not be paid.

C.85 Similarly in Case 188, the claim for a brain haemorrhage was rejected, but the rest of the policy was reinstated, and the claimant was given £500 for the distress and inconvenience caused by the insurer's maladministration in avoiding the policy.

C.86 In the final case (Case 137), the insurer had asked "what is your average daily cigarette consumption". At the time, the complainant was cutting back, and smoked only 10 a day. However, subsequently the policyholder went back to smoking 35 a day. Given the lack of a clear question about normal consumption, the ombudsman allowed the complainant's claim for throat cancer, subject to the complainant paying the appropriate additional premiums.

C.87 It is worth noting, however, that in some cases had the insurer known of the risk, they would not have written the cover at all. Here it makes little difference whether the claimant acted inadvertently or recklessly, and the ombudsman does not need to classify the behaviour. For example, in Case 109, the claimant wrongly stated that he did not suffer from depression and went on to develop a thyroid disease. The ombudsman decided that the non-disclosure could not be considered innocent. There was no need to consider whether it was reckless or merely inadvertent, as in any event the insurer would not have accepted the risk had they been aware of the facts.

Evaluating what the insurer would have done

C.88 One difficulty with this approach is that it requires the ombudsman to reach a decision on what the insurer would have done had they known about the condition. Typically, the underwriters send a letter stating, for example, that had they known the information, they would not have accepted the risk. It was rare for this to be supported by reference to rating tables. The FOS told us that ombudsmen evaluated such evidence by applying their own knowledge. They cannot rely on policyholders to challenge such evidence and it would be unfair of them to do so.

C.89 One problem with relying on ombudsmen's knowledge of the industry is that insurers may vary in their approach. This is particularly true where there are niche markets, in which some insurers confine their business to particular sorts of risk. But even when policies are otherwise similar, insurers may react differently to particular risks. Within the study, for example, we found 12 cases where the policyholder had failed to disclose the fact that they had consulted a doctor for depression and/or been prescribed anti-depressant drugs. In these 12 cases the policyholder had gone on to develop a physical medical condition, such as cancer or a heart attack. Insurers differed in the evidence they gave about what they would have done had they known of the depression. In one case they said they would have charged an additional premium. In four cases they suggested that they would have excluded depression from the cover. In another case they said they would have charged a higher premium for life and critical illness cover and have excluded depression from the permanent disablement policy. However, in two cases, the insurers said they would not have accepted the case at all. There is no clear way of testing this evidence.

The effect of reckless non-disclosure

C.90 It is worth stressing that issues of proportionality or exclusions only arise where the conduct is classified as inadvertent. If the level of carelessness is more serious than this, the insurer need only show that the missing information would have influenced the terms on which they wrote the policy. The insurer does not need to show that the change in terms would have prevented the claim that would have arisen.

C.91 For example, in Case 140 the complainant had failed to mention that she had been referred to a gynaecologist for tests, for what she perceived as a minor problem. She later developed (unconnected) breast cancer. Once the ombudsman had classified her behaviour as reckless, it did not matter whether, had the insurer known of the tests, they would have excluded breast cancer from cover. In two cases a policyholder failed to mention a negative MRI scan, in a way which the ombudsman thought reckless. In Case 44, the ombudsman stated that "it is not disputed that there is no connection between Mr D's illness and the undisclosed facts", but that was not the issue. In Case 56, the insurer said that had they known the facts they would have asked for a medical report. As we understand the rules the ombudsman applies, this is sufficient to show some inducement. It is not necessary for the ombudsman to find that the medical report would have led to the insurer excluding the condition that arose.

C.92 In Case 13, the complainant failed to disclose speeding conviction, which would have resulted in additional premium of only £70. The ombudsman classified her conduct as reckless. This meant that when her car was vandalised she received nothing. The ombudsman commented that it seemed harsh that such a small additional premium should have such drastic consequences, but that the FOS considers that it can be fair and reasonable for firms to apply the strict legal remedy where a non-disclosure is reckless or deliberate.

THE OVERALL SUCCESS RATE

C.93 Across all the consumer cases in our sample, the insurer's original decision was upheld in over half the cases (57%). There was a substantial change in 38%, and a small change in 5%.

Table 6: Consumer cases: overall success rate

	No.	%
No change to insurer's decision	109	57
Substantial change to insurer's decision	72	38
Small change/goodwill payment	9	5
Total	190	100

SMALL BUSINESS CASES

C.94 As discussed above, only 7 of the 197 case in our original sample (4%) were brought by small businesses. In order to say more about the particular issues raised by small business cases, we attempted to boost this number. We therefore asked the FOS if they could locate another 30 final decisions on non-disclosure by small businesses. In the end, however, we were only able to locate another 5 small business decisions relating to non-disclosure. It appears that, for whatever reason, relatively few small businesses bring claims to the FOS about this issue.

C.95 The discussion that follows is therefore based on only 12 case. They all involved a final ombudsman decision, and were decided between March 2003 and August 2005.

C.96 Table 1 shows the type of insurance. Over half involved building or contents insurance; two cases involved professional indemnity insurance; and two involved health issues (either to protect income or a business loan). In the final case, the owner of a residential care home for the elderly had taken out insurance which, among other things, covered the policyholder against loss of registration.

Table 1: Small business cases – by type of policy

	No.
Building/contents	7
Professional indemnity	2
Income protection/permanent health	1
Loan protection	1
Care home insurance	1
Total	12

C.97 The non-disclosure related to a wide variety of different issues. Two cases involve health issues; two related to the locks or alarm system; and the two professional indemnity cases both related to pending complaints. The other cases each involved a different issue, including previous losses, the value of the property and the property's state of repair.

C.98 The value of the claim was an issue in only one case. Here the full claim was valued at £650,000, but the complainant agreed to limit their claim to £100,000.

When does the FOS apply the consumer approach?

C.99 One issue we were interested in exploring was how far the FOS applied the strict letter of the law to small business claims, and how far it tempered the rule in *Pan Atlantic* to take into account the ABI Statements or good industry practice. Technically the ABI Statement of Practice and FSA Conduct of Business Rules on non-disclosure only apply to consumer claims, but the FOS may apply similar provisions to small business cases on the grounds that it is fair and reasonable to do so.

C.100 In one case (SB3) the ombudsman explicitly stated that the policyholder would be given the same rights as a private consumer. A fish and chip shop had suffered a fire when an intruder entered the premises. The building insurer attempted to avoid the policy on the grounds that policyholder had told them that the door was fitted with a five-lever mortice lock. In fact, it was only a three-lever lock. The ombudsman took the view that the misrepresentation was innocent. Furthermore, the type of lock made no difference to the outcome as the intruder had broken through a panel in the door.

C.101 By contrast, there were four cases in the study where the ombudsman applied the letter of the law. For example:

(1) In Case SB2, the policyholder was a firm of insurance brokers. The ombudsman decided that the inequality of bargaining power often present between small businesses and insurers did not apply. Instead, the complainant's size, status and knowledge of insurance law meant that it would be appropriate to apply normal legal principles. The brokers had signed a professional indemnity policy, stating that each member of staff had been asked whether they were aware of any circumstances that might give rise to a claim. In fact, the firm had not made these enquiries. A member of staff had been issuing backdated cover notes. The brokers argued that even if they had made enquiries it would have made no difference, as they would not have found out about the cover notes. The ombudsman found that this was irrelevant: the non-disclosure was effectively a breach of warranty and had the effect of avoiding the policy.

(2) In Case 52 the ombudsman held that the policyholder was under a duty to volunteer information even though no question had been asked. The policyholder had insured a shop with a flat above it. At the time the flat had been empty, but shortly afterwards it was let to a tenant. The tenant proved unsatisfactory. The owner started possession proceedings against her, but before the court proceedings ended the tenant smoked in bed and started a serious fire. The ombudsman found that the policyholder should have realised that a prudent underwriter would want to know that the flat was occupied by an unsatisfactory tenant. In particular, the insurer should have been told that possession proceedings had been started. Even though the insurer had not asked any questions about the occupant of the flat, the policyholder should have volunteered this information.

The role of intermediaries

C.102 In eight out of the 12 cases, the complainant had raised issues about the role of the intermediary, claiming either that the intermediary failed to pass on information, or that they failed to check information with the policyholder. In all but two cases, the ombudsman rejected this argument, stating that even if the intermediary was at fault, the insurer could not be held responsible for the intermediary's mistake.

C.103 For example, in Case 14 farmers had failed to declare all the previous straw fires they had experienced. When they claimed for another fire, the insurer avoided the policy. The policyholders said they had given full details of previous losses to their insurance intermediary, who failed to pass on the information to the insurer. The ombudsman concluded that the intermediary had acted as the policyholder's agent, so any disclosure to the intermediary was irrelevant.

Classifying the policyholder's behaviour

C.104 We have already discussed the way in which the FOS classifies consumers' behaviour as innocent, inadvertent, reckless or deliberate. This classification is relevant where the FOS applies consumer principles to small business, but not where an insured is of a sufficient size and sophistication for normal insurance law to apply. Table 5 shows how the small business cases were classified.

Table 2: small business cases: how did the ombudsman classify the answer (compared to consumer claims)

	No.		**%**
Innocent	1	8	
Inadvertent	0	0	
Reckless	2	16	
Deliberate	1	8	
Did not classify in this way of which:	8	67	
Policy avoided	*6*		*75*
Policy not avoided	*2*		*25*
All cases	12	100	100

C.105 Two thirds of cases were not classified.[13] For example, in Case 190, the ombudsman simply said that it was unreasonable for the policyholder to have given the answer they did. In Case 62, the policyholder claimed to have the wrong sort of alarm. The ombudsman stated that the complainant may well have believed this to be an honest mistake, but even so it is generally the case that the policyholder must suffer the consequences of such failure.

C.106 There were no cases in the sample where the ombudsman held that a small business had behaved inadvertently; or where the insurer or ombudsman attempted to apply a proportionate outcome to a small business complaint. These are relatively rare events, and would not necessarily be represented in such a small sample.

[13] This appears higher than for consumer claims but, given the small numbers, the difference is not statistically significant.

The overall success rate

C.107 The success rate for small business cases was low. The insurer's decision was upheld in 9 out of the 12 cases (75%). Again, the difference between the small business and consumer samples is not statistically significant.

Table 3: small business cases: overall success rate

	No.	**%**
No change to insurer's decision	9	75
Substantial change to insurer's decision	3	25
Total	12	100

APPENDIX D
LIST OF MEETINGS AND RESPONSES IN RELATION TO THE ISSUES PAPERS

SEMINARS

We held or took part in seminars on our three Issues Papers, and on other aspects of the project, as follows:

Issues Paper 1: Misrepresentation and Non-Disclosure

Invited seminar at Beachcroft LLP on 21 September 2006. (Notes of this seminar are available on our website at: http://www.lawcom.gov.uk/docs/issues1_notes.pdf)

Public seminar in relation to Issues Paper 1: Misrepresentation and Non-Disclosure held at the Old Library in Lloyd's on 22 September 2006.

Issues Paper 2: Warranties

Invited seminar at Barlow Lyde and Gilbert on 27 November 2006. (Notes of this seminar are available on our website at http://www.lawcom.gov.uk/docs/issues2_notes.pdf)

Public seminar at University College London on 29 November 2006.

Seminar at Beachcroft LLP on 5 December 2006.

Issues Paper 3: Intermediaries and Pre-contract Information

Seminar with the British Insurance Law Association held at Lloyd's on 20 February 2007.

Seminar at Beachcroft LLP on 2 March 2007.

Other seminars

Seminar on Pre-contract information held at Norton Rose, 13 October 2006.

Seminar on the remedy of avoidance with WHCG LLP held at the Old Library in Lloyd's, 23 November 2006.

Seminar on Pre-contract information with Complinet,11 January 2007.

Seminar on our review of insurance contract law with the Chartered Insurance Institute at Lloyd's, 1 February 2007.

Seminar on our review of insurance contract law in Liverpool with the Liverpool Underwriters and Maritime Association, 15 March 2007.

Seminar with the London Shipping Law Centre, 17 April 2007.

Workshop on Non-Disclosure in the London Underwriting Centre with the Health Claims Forum and Association of Medical Underwriters, 3 May 2007.

Institute of Actuaries Healthcare Conference in Manchester, 10 May 2007.

Sweet & Maxwell and 20 Essex Street Insurance Law Conference, 18 May 2007.

C5 10th Annual Forum on Re-insurance Claims, 21 May 2007.

BILA Colloquium, 25 May 2007.

MEETINGS

The Association of British Insurers on 11 October 2006, 23 November 2006, 28 February 2007, 23 April 2007 and 16 May 2007.

Aspen Re on 23 November 2006 and 12 December 2006.

The Financial Ombudsman Service in relation to the Unfair Terms in Consumer Contracts Regulations 1999 on 15 January 2007.

Scottish Re, Pioneer Friendly Society, Liverpool Victoria Friendly Society, Axa, Aegon and Resolution to discuss life insurance on 15 January 2007.

The Financial Services Authority on 18 January 2007.

Professor Robert Merkin, Berwin Leighton Paisner and Which? in relation to Australian insurance law reforms on 23 January 2007.

The Life Insurance Association of Japan on 1 February 2007.

The Royal Bank of Scotland to discuss intermediaries and pre-contract information on 6 February 2007.

The Contract Certainty Group of Lloyd's on 12 February 2007.

Pinsent Masons on 12 February 2007.

GRiD 6 March 2007

Swiss Re on 19 March 2007 and 11 May 2007.

Age Concern and Help the Aged conference on "Insurance and Age", 22 March 2007.

Munich Re on 26 March 2007.

WRITTEN RESPONSES

Association of British Insurers

Association of Friendly Societies

Aviva Plc

Chris Nicoll

City of London Law Society Insurance Law Committee

Clyde & Co

Derrick G. Cole and Geoffrey H. Lloyd

Group Risk Development (GRiD)

HBOS plc

Ince & Co

International Underwriting Association

Investment & Life Assurance Group

John D Gordan III

Kendall Freeman Solicitors (responding after holding meetings with representatives of Amlin Underwriting Limited, Aspen Re, AXA UK Plc, Chubb Insurance Company of Europe, Danish Re Syndicates Ltd, Dresdner Kleinwort, General Reinsurance UK Ltd, Hiscox Underwriting Group Services, Lloyd's, Lloyd's Market Association, RBS Insurance, RJ Kiln & Co Ltd, St Paul Travelers Insurance Company Ltd, XL Services UK Ltd, Zurich Global Corporate Ltd).

Lloyd's Market Association

London Market Excess of Loss Discussion Group (LMX)

Scottish Widows Plc

Stephen Sumption Consultancy Ltd

The Royal Bank of Scotland

We are very grateful to all those who organised and took part in the seminars and meetings, and to those who provided written responses.