Reforming Insurance Contract Law

Issues Paper 7: The Insured's Post-Contract Duty of Good Faith

July 2010

The Law Commission
and
The Scottish Law Commission

INSURANCE CONTRACT LAW

Issues Paper 7

The Insured's Post-Contract Duty of Good Faith

THE LAW COMMISSIONS – HOW WE CONSULT

About the Law Commissions: The Law Commission and the Scottish Law Commission were set up by the Law Commissions Act 1965 for the purpose of promoting the reform of the law.

The Law Commissioners are: The Rt Hon Lord Justice Munby (*Chairman*), Professor Elizabeth Cooke, David Hertzell, Professor Jeremy Horder and Frances Patterson QC. The Chief Executive is Mark Ormerod CB.

The Scottish Law Commissioners are: The Hon Lord Drummond Young (*Chairman*), Laura J Dunlop QC, Professor George L Gretton, Patrick Layden QC, TD and Professor Hector L MacQueen. The Chief Executive is Malcolm McMillan.

Topic: We consider the law on fraudulent claims, and ask what remedy should be available to the insurer if a policyholder acts fraudulently. We welcome views on whether there is a need to reform the policyholder's duty of good faith, as set out in section 17 of the Marine Insurance Act 1906.

Geographical scope: England and Wales, Scotland.

Duration of the consultation: from 9 July 2010 to **11 October 2010**.

How to respond

Please send your responses either –

By email to: commercialandcommon@lawcommission.gsi.gov.uk or

By post to: Christina Sparks, Law Commission, Steel House, 11 Tothill Street, London SW1H 9LJ

Tel: 020 3334 0285 / Fax: 020 3334 0201

If you send your comments by post, it would be helpful if, where possible, you also send them to us electronically (in any commonly used format).

After the consultation: In the light of the responses, we will work towards a full Consultation Paper, which we hope to publish in 2011.

Freedom of information: We will treat all responses as public documents in accordance with the Freedom of Information Act. We may attribute comments and include a list of all respondents' names in each of our publications. If you wish to submit a confidential response, you should contact us before sending it.

PLEASE NOTE – We will disregard automatic confidentiality statements generated by an IT system.

Code of Practice: The Law Commission is a signatory to the Government's Code of Practice on Consultation, available at: http://www.berr.gov.uk/files/file47158.pdf.

Availability: You can view / download this paper free of charge from our websites at: http://www.lawcom.gov.uk/docs/issues7_duty-of-good-faith.pdf or http://www.scotlawcom.gov.uk/downloads/cpinsurance_issue7.pdf.

THE LAW COMMISSION
THE SCOTTISH LAW COMMISSION

Joint Review of Insurance Contract Law
Issues Paper 7

THE INSURED'S POST-CONTRACT DUTY OF GOOD FAITH

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THE INSURED'S POST-CONTRACT DUTY OF GOOD FAITH

SUMMARY

S.1 Insurance contracts are based on mutual duties of good faith, which apply both before and after the contract is formed. In our last paper, Issues Paper 6,[1] we considered the duties on the insurer after the contract had been formed – including the insurer's duties to investigate, assess and pay valid claims. We asked what remedies should be available to policyholders if the duty was breached.

S.2 This paper looks at the other side of the same coin. It considers policyholders' duties after the formation of the contract. In practice, the policyholder's main duty is to act honestly when making a claim. We consider the law of fraudulent claims, focusing in particular on what remedies should be available to insurers if policyholders act fraudulently.

S.3 The paper sets out our preliminary thinking. Its purpose is to promote discussion before the formal consultation process begins. We seek responses by **Monday 11 October 2010**, to the address on page 1 of the paper.

S.4 The review is limited to insurance contract law. We do not look at fraudulent third party claims, or at the criminal law.

THE DUTY OF GOOD FAITH

S.5 The duty to act in good faith is codified in section 17 of the Marine Insurance Act 1906, which 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.

S.6 In Issues Paper 6, we argued that the law was right to recognise mutual duties of good faith. The law should provide safeguards against the moral hazards of insurance – particularly that policyholders may lie, or insurers may delay. However, we thought that the duty was best seen as one of "good faith" rather than "utmost good faith". We also thought that avoidance was often not an appropriate remedy. Instead, the law should allow for more flexible and tailored remedies. Here we apply the same reasoning to the policyholder's duty to act in good faith.

S.7 The courts have held that a policyholder who lies in connection with a claim should forfeit the claim. Thus if a policyholder suffers £18,000 of legitimate loss, but then adds a fictitious claim of £2,000 for an item which never existed, the policyholder loses the whole £20,000 claim. We think this is right. Policyholders should not be able to add invented items to claims safe in the knowledge that even if the fraud is discovered they will lose nothing.

S.8 However, the law on fraudulent claims is unnecessarily confused. The main problem is that section 17 specifies only one remedy – that the insurer may avoid the contract from the start. This means that insurers could require policyholders to repay all claims made under the policy, including perfectly genuine claims which were finalised and paid before the fraud arose. The courts have struggled against such a conclusion, holding instead that a fraudulent policyholder should forfeit the fraudulent claim, leaving the rest of the contract unaffected. We think this is the right policy, but unfortunately it is incompatible with section 17.

THE DUTY NOT TO MAKE A FRAUDULENT CLAIM

S.9 Insurance fraud is relatively common. Figures from the Association of British Insurers suggest that 1.4% of claims were refused for fraud in 2008, amounting to 4.2% of the value of claims.[2] Although insurance fraud is a criminal offence, prosecutions are relatively rare, meaning that the civil law has an important part to play in deterring fraud.

What is fraud?

S.10 In Part 3 we look at how the courts have defined a fraudulent claim. Our tentative conclusion is that the courts have defined fraud in a pragmatic and sensible way. Although there is some ambiguity about the exact definition of fraud, we think this is inevitable, given that dishonesty is a broad and malleable concept, which has to be interpreted in its context. We are concerned that a statutory definition may become ossified or could have unintended consequences.

S.11 We ask consultees if they agree that the definition of fraud can be left to the common law.

Express terms

S.12 Many insurance policies include express "fraud clauses", setting out the consequences of making a fraudulent claim. The courts allow the parties to extend the remedies available for fraud, provided they do so in clear, unambiguous terms. However, in consumer contracts, such terms must be fair within the meaning of the Unfair Terms in Consumer Contracts Regulations 1999.

S.13 The law does not permit a party to exclude liability for his or her own fraud. There is some doubt, however, about whether a party may exclude liability for the fraud of their agent.

S.14 We think that the current law is broadly right. The parties should be entitled to extend liability for fraud, provided they do so in clear terms, but should not be permitted to exclude liability for fraud.

[1] Damages for Late Payment and the Insurer's Duty of Good Faith (March 2010).

[2] Association of British Insurers, General Insurance Claims Fraud (July 2009) available at http://www.abi.org.uk/Media/Releases/2009/07/40569.pdf, at p 19.

S.15 We welcome views on whether parties should be entitled to exclude or limit liability for the fraud of their agents. In practice, most insurers would be extremely reluctant to assume the risk that the insured's agent is fraudulent. However, we are not sure that the law should prevent an insurer from doing so if the parties so wish.

The remedy for fraud in the absence of an express term

S.16 Even in the absence of an express term, the courts provide insurers with a remedy for a fraudulent claim. However, the law in this area is complex, convoluted and confused.

S.17 We summarise the main cases. The duty not to make a fraudulent claim has variously been characterised as an implied term of the contract,[3] as a breach of section 17,[4] and as a stand-alone common law rule, based on public policy.[5] The House of Lords has severely criticised the idea that an insurer may avoid the contract from the start, without definitely deciding that the clear words of section 17 do not apply.[6]

S.18 Commentators differ over the effect of these cases. The law appears to be that the whole of any claim tainted by fraud is forfeited. However, previous honest claims remain enforceable, and the insurer cannot recover insurance money paid in respect of other claims. This is said to be based on a stand-alone common law rule. However, the issue is open to doubt. An insurer could argue that fraud is a breach of the insured's duty of good faith under section 17, entitling it to avoid the policy and unravel all previous and subsequent claims.

S.19 We think that the common law rule is the correct approach: a policyholder who acts fraudulently in connection with a claim should forfeit the whole claim. However, it would be wrong to deny the reality of the insurance contract as a whole, or for the fraudulent claim to affect other claims.

S.20 We tentatively conclude that there is a need for legislation to amend section 17, for three reasons:

(1) The disjuncture between the common law rule and section 17 generates unnecessary disputes and litigation.

(2) Increasingly, UK commercial law must be justified to an international audience. If the UK wishes to influence European and international developments, it must seek to develop its insurance law in a coherent, principled and fair way.

3 *Orakpo v Barclays Insurance Services Co Ltd* [1994] CLC 373.

4 *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563.

5 *Agapitos and Another v Agnew and Others (No 1) (The Aegeon)* [2002] EWCA Civ 247; [2003] QB 556.

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

(3) The rules on fraudulent claims are intended to act as a deterrent, and deterrents work best if they are clear and well-understood. Penalties, in particular, should be clearly set out in law.

S.21 In Australia, the remedy of avoidance was removed by the Insurance Contracts Act 1984. Instead, the insurer may refuse payment of the claim.

S.22 We tentatively conclude that forfeiture of the claim is the correct remedy and ask for views. In particular, we ask whether consultees agree that:

(1) The insured should forfeit the whole claim to which the fraud relates.

(2) A fraudulent claim should not affect previous, valid claims, whether or not they have been paid.

(3) A fraudulent claim should give the insurer the right to terminate the contract, but should not affect a valid claim arising between the fraud and the termination.

S.23 We also ask whether the insurer should be entitled to damages from a policyholder for the costs of investigating a fraudulent claim. There may be cases in which the insurer incurs reasonable and foreseeable costs in investigating the claim for which it is not otherwise compensated. If so, we see no reason in principle why the fraudster should not pay damages.

FRAUD BY A CO-INSURED

S.24 Difficult issues arise when two or more policyholders have taken out a single insurance policy. What should happen when one policyholder has acted fraudulently but the other has not?

S.25 The law distinguishes between *joint insurance*, taken out by two or more people to cover joint interests, and *composite insurance*, in which policyholders insure separate interests. With joint insurance, the fraud of one policyholder affects the others. With composite insurance, each policyholder is treated separately.

S.26 The problems arise where policyholders start by taking out insurance together, but later become estranged and act contrary to each other's interest. We consider cases from the USA, Canada, Australia and New Zealand where a husband and wife take out joint insurance on their home, but one spouse later attacks the other by setting fire to the home. It seems unjust to deprive the innocent victim of his or her insurance claim.

S.27 We tentatively conclude that there is a need for reform. We think that in joint insurance, where two or more people act together to insure their joint interests, there should be a presumption that any fraud committed by one party is done on behalf of all the parties.

S.28 However, it should be open to an innocent party to rebut this presumption. If the innocent party produces evidence that the fraud was not carried out on their behalf or with their knowledge, then the claim should be paid. It is important that the recovery is limited to the innocent party's particular loss, and that the guilty party should not benefit. We ask for views.

FRAUD IN GROUP INSURANCE

S.29 Group insurance is an important sector, particularly in long-term insurance. Typically, an employer takes out a policy for the benefit of employees, who are members of the group scheme. The policyholder is the employer.

S.30 As group members are not policyholders, there is some doubt whether they are caught by the obligations imposed on policyholders under insurance contract law. It is possible that a group member who includes a fraudulent element in a claim does not suffer any penalty, but would be entitled to the payment of the remaining valid claim.

S.31 We ask whether there is a need to make special provision for fraudulent claims by group members, to give insurers similar remedies to those available where a policyholder acts fraudulently.

THE DUTY OF GOOD FAITH IN OTHER CONTEXTS

S.32 We consider whether the insured's post-contract duty of good faith has any other effects, outside the context of fraudulent claims. The duty clearly applies when an insured is varying the contract or negotiating a held-covered clause. However, we think these raise issues similar to pre-contract disclosure and misrepresentation, and are best dealt with in that context. Otherwise, the effect of the insured's post-contract duty of good faith is limited.

A duty to report increases in the risk?

S.33 In many European countries, policies tend to last for several years. Policyholders are under a continuing duty to notify the insurer of factors which aggravate the risk. The Principles of European Insurance Contract Law provide the insurer with a remedy if the policyholder fails to do so, but the remedy is limited. The insurer may only refuse payment if the loss was caused by the aggravation of risk. Even if the loss was so caused, the insurer is usually required to pay a proportion of the claim, based on the premium it would have charged had it known the full circumstances. The insured also has a right to a premium reduction if there is a material reduction in the risk.

S.34 By contrast, UK policies are usually renewed annually. The insurer is expected to define the risk precisely, and to continue to cover the risk specified for the contract period. UK law does not recognise an on-going duty of disclosure in the absence of a specific contract term. Even if the contract does include a notification clause, the UK courts will interpret it restrictively. For example, there is doubt over the effect of a term requiring the policyholder to inform the insurer if premises are left unoccupied. The issue is more clearly addressed through an exclusion, by which the policy excludes unoccupied premises unless the parties agree a variation.

S.35 We tentatively conclude that the UK approach is correct. However, we would welcome views on whether there are advantages to following the approach set out in the Principles of European Contract Law.

Preserving the general duty?

S.36 We have not identified other consequences of the insured's post-contract duty of good faith, but it is open to the courts to develop the insured's post-contract duty of good faith in new and unexpected ways.

S.37 We have considered whether any codification of the duty of good faith should be exclusive (so that it covers only the specified instances) or whether it should continue to have some general, unspecified effect. Allowing a general duty might permit the courts to develop the law to meet new challenges. Alternatively, it could add to confusion and uncertainty. We would welcome comments.

S.38 A full list of questions is provided in Part 8.

PART 1
INTRODUCTION

1.1 This Issues Paper continues the joint review of insurance contract law by the Law Commission and Scottish Law Commission. In our first consultation paper,[1] we concentrated on the duty to act in good faith when applying for insurance. In particular, we examined policyholders' duties to disclose information to insurers and to answer insurers' questions honestly and carefully.

1.2 At this stage of the review, we are concentrating on claims, looking in particular at how the duty to act in good faith operates in the context of making a claim. In March 2010 we published Issues Paper 6, which focused on insurers' duties when receiving a claim.[2] We looked at insurers' duties to investigate, assess and pay valid claims and asked what remedies should be available to policyholders if this is not done.

1.3 This paper looks at the other side of the same coin: what are policyholders' duties when submitting a claim, and what remedies should be available to insurers where policyholders breach their obligations?

1.4 This paper sets out our preliminary thinking. Its purpose is to promote discussion before the formal consultation process begins.

1.5 Our tentative proposals and questions are listed in Part 8. We seek views on these issues by **Monday 11 October 2010** and would be grateful if responses could be sent:

by email to commercialandcommon@lawcommission.gsi.gov.uk;

by post to Christina Sparks, Law Commission, Steel House, 11 Tothill Street, London SW1H 9LJ (tel: 020 3334 0285); or

by fax to 020 3334 0201, marked for the attention of Christina Sparks.

THE POST-CONTRACT DUTY OF GOOD FAITH

1.6 As we explained in Issues Paper 6, insurance contracts are based on mutual good faith. We said that the nature of insurance makes this a commercial necessity. We characterised insurance as a bargain in which one party pays money to another not in return for goods or services but for a promise to pay should a particular event occur. The insurer has to be confident that the policyholder has provided a fair presentation of the risk, and has acted honestly in making a claim. Policyholders have to be confident that their claims will be considered in a fair and unbiased way. Mutual duties of good faith reinforce the parties' contractual arrangements.[3]

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

[2] Law Commission and Scottish Law Commission, Issues Paper 6: Damages for Late Payment and the Insurer's Duty of Good Faith (2010).

[3] Above, para 9.10.

1.7 The duty to act in good faith in insurance contracts was developed by the courts in the eighteenth century. It was codified in section 17 of the Marine Insurance Act 1906,[4] which 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.

1.8 Much of the case law on good faith concerns policyholders' duties to provide insurers with information before entering into insurance contracts. These are set out in sections 18 and 20 of the 1906 Act, and are said to be specific examples of the more general duty. Section 17, however, is not limited to issues which arise before the contract is agreed. It is a mutual duty which governs the way the parties behave towards each other both before and after the contract has been formed. In this paper we use the term "post-contract" to refer to those duties that arise after the contract has been formed.

1.9 The problem with section 17 is that it specifies only one remedy – namely that the insurer may avoid the contract from the start. The implication is that once a fraud is discovered, both parties should be returned to the position in which they would have been had the contract never existed. On this basis, insurers could ask policyholders to repay all claims made under the policy, including perfectly genuine claims which were finalised and paid before the fraud arose. The courts have struggled against such a conclusion – preferring instead to hold that a fraudulent policyholder should forfeit the whole of the fraudulent claim, but leaving other aspects of the contract unaffected.

1.10 The result is that the law in this area is complex, convoluted and confused. Fraudulent claims have been characterised in several different ways, including as breaches of an implied term, breaches of section 17 or breaches of a separate common law rule. The relationship between these is far from clear, and it is difficult to describe the law in this area with any degree of certainty. This is likely to lead to further litigation. We are concerned that it is not possible to justify or explain the law to an international audience. Furthermore, confusion about the penalties reduces their deterrent effect.

1.11 In Issues Paper 6 on Damages for Late Payment, we argued that it was right to see insurance contracts as based on mutual duties of good faith. We thought, however, that section 17 should be amended to remove the automatic remedy of avoidance. Instead, the law should provide flexible and appropriate remedies for breach of the duty of good faith. We think that the same applies here.

1.12 This paper does not propose any major changes to the way in which the law is applied in practice. However, we think there is a need to clarify the law in this area and remove the problems created by section 17.

[4] Although on its face, the 1906 Act only applies to marine insurance, it codifies the common law and has been held to apply to all forms of insurance.

STRUCTURE OF THIS PAPER

1.13 The paper is divided into a further seven parts.

The duty not to make a fraudulent claim: overview

1.14 In Part 2 we start by explaining that fraud is a relatively common problem. The circumstances of a claim are often known only to the insured, which gives rise to the moral hazard that an insured may lie about what has happened.

1.15 We explain that under current case law, a policyholder who submits a claim which is partly genuine and partly fraudulent stands to lose the legitimate element of the claim. However, the courts have been reluctant to permit the insurer to avoid the policy, as specified in section 17.

What is fraud?

1.16 In Part 3 we look at how the courts have defined a fraudulent claim. We consider the main elements of fraud, and some of the difficult issues that have arisen in the case law, including how to assess whether a fraud is substantial; the difference between fraud and exaggeration; and the effect of a fraudulent device. We also give a brief overview of the Financial Ombudsman Service approach.

1.17 Our tentative conclusion is that the courts have defined fraud in a pragmatic and sensible way. We ask consultees if they agree that the definition of fraud should be left to the common law.

Fraud: the appropriate remedy

1.18 In Part 4, we summarise the case law on remedies for fraud. We start by looking at express terms. Even in the absence of an express term, the courts provide insurers with a remedy for a fraudulent claim. There is, however, considerable debate about the legal basis of this remedy, and some confusion about what the remedy is. We then look briefly at the position in Australia, where the remedy of avoidance was removed by the Insurance Contracts Act 1984.

1.19 We tentatively conclude that forfeiture of the claim is the correct remedy. However, this cannot be reconciled with section 17 of the Marine Insurance Act 1906. We identify a need to clarify the law in this area.

Co-insureds and group insurance

1.20 In Part 5 we start by considering the law of co-insurance, when one insured acts fraudulently or wrongfully but the other does not. Should the innocent party be entitled to claim? We outline cases in several common law jurisdictions where a husband and wife have insured a home, which one spouse has then burnt down. The modern approach is to permit the innocent spouse to claim. We tentatively conclude that current UK law can operate unfairly.

1.21 We then look briefly at group insurance, and ask if there is a need for special provisions to cover fraud by group members,

Other aspects of the insured's post-contract duty of good faith

1.22 In Part 6 we consider whether the duty of good faith set out in section 17 imposes any other duties on policyholders after the contract has been formed.

1.23 Traditionally, UK law does not recognise any general duty on policyholders to disclose information after the contract has been agreed. The parties may include express terms, but they are interpreted restrictively. We discuss the alternative approach set out in the Principles of European Insurance Contract Law. We tentatively conclude that the UK approach is correct, but we would welcome views.

1.24 We ask whether the duty of good faith should be limited to specific instances or whether it should be left as a general duty, which the courts can develop to meet future problems.

Tentative proposals and questions

1.25 In Part 7 we discuss our proposals for reform. Our questions for consultees are listed in Part 8.

ISSUES NOT CONSIDERED

1.26 This joint review is confined to insurance contract law. This means that the paper considers only the actions of policyholders under insurance contracts. We are not looking at fraudulent claims made by third parties against both the insured and the insurer. The courts have held that as these are not claims under an insurance contract they are not governed by the duty of good faith.

1.27 In *Shah v Ul-Haq*, for example, three people claimed for personal injury against an insured driver following a road accident.[5] At trial, it was held that one claimant had not been in the car at the time of the collision, and that the other two claimants had conspired to support her fraudulent claim. The question on appeal was whether the claims of the other two people should be struck out, even if they were genuine, because of their fraud in supporting the invented claim. The Court of Appeal held that there was no general rule of law that the dishonest exaggeration of a genuine personal injury claim would result in the dismissal of the whole claim. The position was no different where the attempted fraud consisted of lying to support another claimant. Therefore, the court would not deprive the claimants of damages they were entitled to because of their attempted fraud.

1.28 This case illustrates the differences between the way that a fraudulent third party claim is treated, and the way that a claim would be treated under an insurance contract. This is one consequence of the special requirements of good faith in insurance contracts, which impose higher penalties for fraudulent behaviour than are recognised in other parts of the civil law. The issue of fraudulent third party claims raises issues about the nature of personal injury compensation which we are unable to consider in the context of this review.

[5] [2009] EWCA Civ 542; [2010] 1 WLR 616.

1.29 Even in fraudulent insurance claims, there are issues outside the scope of our review. We are not concerned with criminal penalties. In Part 4 we note, briefly, that insurance fraud is a criminal offence. In Scotland, fraud and attempted fraud are offences at common law. In England and Wales the issue is governed by the Fraud Act 2006, which was introduced following a previous Law Commission report, published in 2002.[6] We do not revisit the recommendations made in 2002. Nor do we consider the penalties imposed by the courts for false evidence or a failure to disclose in the course of litigation, which may amount to perjury or contempt of court. However, these are issues an insurer might wish to consider if it suspects fraud.

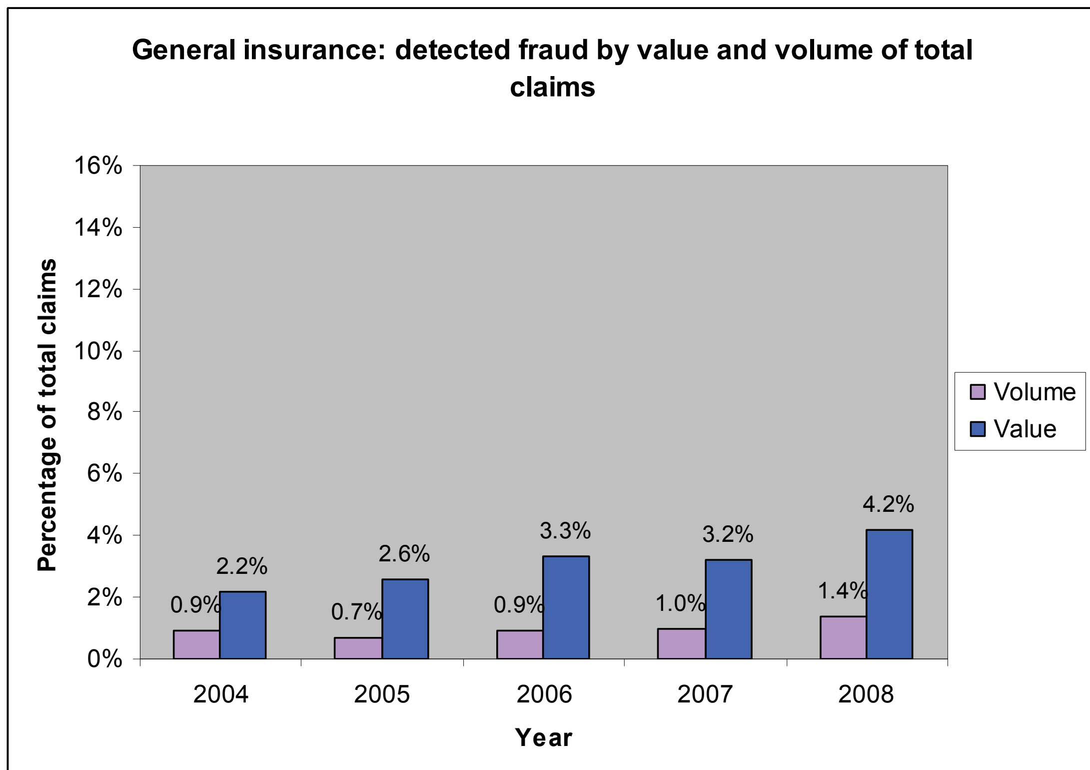
[6] Law Commission, Fraud (2002) Law Com No 276.

PART 2
THE DUTY NOT TO MAKE A FRAUDULENT CLAIM: AN OVERVIEW

THE PROBLEM OF FRAUD

2.1 Insurers are particularly vulnerable to fraud. Usually, policyholders are the only people fully aware of the circumstances surrounding a loss. This means that it is difficult for insurers to refute what they are told about a claim.

2.2 Fraudulent claims are a significant problem. The Association of British Insurers (ABI) reports that in 2008, 1.4% of claims were refused on the grounds of fraud, amounting to 107,000 claims. In terms of value, the proportion was greater, reflecting the fact that insurers put more resources into detecting fraud in larger claims. Thus detected fraud amounted to 4.2% of the value of claims, representing £730 million.[1]



2.3 As this chart shows, both the volume and value of detected fraud have increased over the last five years. The ABI explains that this is partly because firms have become better at detecting fraud. The ABI also suggests that fraud may currently be increasing as a result of the recession.

[1] Association of British Insurers, General Insurance Claims Fraud (July 2009) available at http://www.abi.org.uk/Media/Releases/2009/07/40569.pdf, at p 19. As we discuss in Part 3, where the claim includes a fraudulent element, the insurer may refuse the whole claim. As we understand these figures, they relate to the full value of the refused claim, not simply the value of the fraudulent element.

2.4 Clearly it is difficult to estimate how many fraudulent claims are not detected. The Insurance Fraud Bureau estimates that the value of undetected fraud may be more than twice the value of detected fraud, and may amount to £1.9bn a year.[2]

2.5 It is a common complaint that insurance fraud is only rarely prosecuted through the criminal justice system.[3] Kennedys comment in their guide to fraud investigation:

> Whilst the police are more interested in cases of insurance fraud, they remain constrained by limited resources and budgets. Consequently, unless a case is presented to them as, essentially, a pre-packaged conviction, they may have insufficient time or resources to assist.[4]

2.6 This means that the civil law has a particularly important part to play in combating insurance fraud.

THE NEED TO GUARD AGAINST MORAL HAZARD

2.7 If a claim is made in the absence of any genuine loss, then clearly the insurer is not required to pay the claim. A policyholder is required to prove the loss, and would not be able to do so. Similarly, if a policyholder brings about a loss then the claim would fail because a policy of insurance does not cover against the wilful misconduct of an insured.

2.8 It is generally accepted, however, that a policyholder who acts fraudulently should risk more than the non-payment of the fraudulent part of the claim. There should also be some element of penalty.[5] The point was put forcefully in 1866, in *Britton v Royal Insurance Co*:

> If the claim is fraudulent, it is defeated altogether. That is, suppose the insured made a claim for twice the amount insured and lost, thus seeking to put the office off its guard, and in the result to recover more than he is entitled to, that would be a wilful fraud, and the consequence is that he could not recover anything… .

[2] See http://www.insurancefraudbureau.org/.

[3] See, for example, the ABI's submission to the Government's fraud review, April 2006: http://www.abi.org.uk/Publications/ABI_Response_to_the_Fraud_Review_1.aspx.

[4] Crawford & Kennedys, *Fraud Investigation: A practical guide to the key issues and current law*, Autumn 2009, p 74.

[5] As we mention in para 4.2, a fraudulent policyholder may also be subject to criminal prosecution.

> The law upon such a case is in accordance with justice, and also with sound policy. The law is, that a person who has made such a fraudulent claim could not be permitted to recover at all. The contract of insurance is one of perfect good faith on both sides, and it is most important that such good faith should be maintained…. It would be most dangerous to permit parties to practise such frauds, and then, notwithstanding their falsehood and fraud, to recover the real value of the goods consumed. And if there is wilful falsehood and fraud in the claim, the insured forfeits all claim whatever upon the policy.[6]

2.9 As we shall see in Part 4, it is common for insurers to include express terms within their policies to provide a penalty for fraud. However, it is not necessary for insurers to include such terms. The law will still impose a penalty by requiring the fraudster to forfeit the claim.

2.10 The case of *Galloway v Guardian Royal Exchange (UK) Ltd*[7] illustrates what this means. The policyholder suffered a burglary, in which goods worth around £16,000 were stolen. The policyholder claimed £18,000, including £2,000 for a computer which did not exist. The Court of Appeal had no reservations in rejecting the policyholder's whole claim, including the £16,000 of real loss. As Lord Hobhouse put it in *The Star Sea*, the leading House of Lords case on post-contract good-faith:

> The logic is simple. The fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing.[8]

2.11 We think that it is right that the remedy for fraud should include some element of sanction. As we said in our 2007 consultation paper on pre-contract misrepresentations, where there is dishonesty, it is right that a penalty should be imposed, even if this puts the insurer in a better position than it would have been in had no dishonesty taken place:

> 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.[9]

2.12 We think, however, that there needs to be greater clarity about what the penalty should be.

[6] (1866) 4 F&F 905, by Willes J at p 909.

[7] [1999] Lloyd's Rep IR 209.

[8] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1; [2003] 1 AC 469, at [62].

[9] Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007), Law Commission Consultation Paper No 182; Scottish Law Commission, Discussion Paper No 134, at para 4.50.

THE REMEDY OF AVOIDANCE

2.13 The main problem is that section 17 of the Marine Insurance Act 1906 mentions only one remedy, avoidance. Section 17 provides that "if the utmost good faith be not observed by either party, the contract may be avoided by the other party".

2.14 This suggests that if the insured behaves dishonestly, the insurer should be entitled to avoid the policy from the start and seek repayment of any money paid under it (including money paid for legitimate claims). In Part 4, we outline how the courts have sought to escape this conclusion, making the case law needlessly complex. As John Lowry comments, the question "has vexed judges and commentators alike".[10]

2.15 In *The Star Sea*, Lord Hobhouse criticised the idea that avoidance is an appropriate remedy for a breach of the post-contract duty of good faith. It may be appropriate where "the want of good faith has preceded and been material to the making of the contract". But, where the want of good faith occurs later, "it becomes anomalous and disproportionate". He explained:

> The insurer is able not only to treat himself as discharged from further liability but can also undo all that has perfectly properly gone before. This cannot be reconciled with principle. [11]

In *The Star Sea*, the insurers had insured 33 vessels under a single policy. Avoiding the entire policy would have been disproportionate.[12]

2.16 Similarly, in the Scottish case of *Fargnoli v GA Bonus Plc*, Lord Penrose distinguished pre-contract fraud (where avoidance is appropriate) from post-contract fraud:

> [Pre-contract] fraud, even concealment, entirely vitiates the contract. Where consent is so undermined, there is little difficulty in saying that there never was a contract.

Where there is fraud in making a claim, however, there is "a valid binding contract" up to the date the fraudulent claim is presented to the insurer. "To avoid the policy *ab initio* would defeat that reality".[13]

ESCAPING THE EFFECT OF SECTION 17

2.17 The courts have sought to escape the conclusion that the remedy for fraudulent claim is avoidance, but at the cost of convoluted reasoning and uncertainty.

[10] J P Lowry, "Redrawing the parameters of good faith in insurance contracts", in C O'Cinneide and J Holder, *Current Legal Problems 2007: Volume 60,* at pp 338 to 407.

[11] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1; [2003] 1 AC 469 at [51].

[12] For comment on this issue, see M A Clarke, *The Law of Insurance Contracts* (4th ed 2002), at p 901, para 27-2C3.

[13] *Fargnoli v G A Bonus plc* [1997] CLC 653, at p 670.

2.18 In Part 4 we consider the various ways in which the courts have conceptualised the duty not to make a fraudulent claim. In 1994, the Court of Appeal said that the duty not to act fraudulently was an implied term of the contract.[14] However, this was criticised in *The Star Sea*.[15] Here the House of Lords criticised the remedy of avoidance, without definitively deciding whether it applied to fraudulent claims. This was left to subsequent cases.

2.19 In *The Mercandian Continent*,[16] Lord Justice Longmore attempted to reduce the scope of section 17. He held that it applied only where the fraud was material, and was sufficiently serious to permit the insurer to repudiate the contract. On the special facts of the case, these requirements were not met. However, the requirements are not onerous. It has been pointed out that in most cases, the fraud is material and would be sufficient to allow the insurer to repudiate.[17]

2.20 By contrast in *The Aegeon (No 1)*,[18] Lord Justice Mance tentatively suggested that the rule against fraudulent claims should be treated as a stand-alone common law rule, falling outside the scope of section 17. Under the common law rule, the whole of the fraudulent claim is forfeited, but the policy is not avoided.[19]

2.21 Commentators differ over the effect of these cases. *MacGillivray* suggests that there are now "two separate principles of insurance law, each of which can be invoked in defence by the insurer".[20] By contrast, Professor Clarke describes forfeiture and termination as the only remedies. He concludes that the courts will not avoid the contract for a fraudulent claim. Any previous honest claims remain enforceable, and the insurer cannot recover insurance money paid in respect of other claims.[21]

THE CURRENT STATE OF THE LAW

2.22 In Part 3 we discuss the definition of fraud, and conclude that the courts approach the issue in a pragmatic and sensible way. However, as is clear from Part 4, the law on the appropriate remedy is unnecessarily confused.

2.23 Section 17 continues to exist, and in theory it remains open to an insurer to argue that a fraudulent claim permits the insurer to avoid the policy. However, it is unlikely that a court would find for the insurer on this basis. Instead, the courts have consistently held that the appropriate remedy for fraud is forfeiture of the claim.

[14] *Orakpo v Barclays Insurance Services Co Ltd* [1994] CLC 373..

[15] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1; [2003] 1 AC 469 at [66].

[16] *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563.

[17] N Legh-Jones (ed), *MacGillivray on Insurance Law* (11th ed 2008), at para 19-065.

[18] *Agapitos and Another v Agnew and Others (No 1)* [2002] EWCA Civ 247; [2003] QB 556 at [1].

[19] Above, at [45].

[20] N Legh-Jones (ed), *MacGillivray on Insurance Law* (11th ed 2008), at p 901, para 19-055.

[21] M A Clarke, *The Law of Insurance Contracts* (looseleaf), at para 27-2C3.

2.24 This can be illustrated by two cases, one in England and one in Scotland. In *Axa General Insurance Ltd v Gottlieb,* Mr and Mrs Gottlieb claimed under a buildings insurance policy on four occasions during the policy year.[22] The insurer settled two claims in their entirety without any issue of fraud arising. It also made interim payments on the other two claims, before discovering that the policyholders had acted fraudulently in pursuing these claims. The insurer brought proceedings to recover all the payments it had made.

2.25 The Court of Appeal held that the insurer was entitled to recover all sums paid in respect of the two claims in which there was fraud. However, the two claims which had been paid in full had arisen before any fraud had occurred and were not recoverable.

2.26 *Fargnoli v GA Bonus Plc* is a Scottish decision in the Outer House of the Court of Session.[23] The pursuer, a restaurateur, made a claim in respect of a fire at his premises. The defender insurers resisted on the ground that the pursuer had caused or connived at a second, later fire at the same premises. The insurers argued that the pursuer had therefore forfeited all benefits under the policy, including the claim for the first fire. Lord Penrose rejected the insurers' argument. He suggested that "a claim tainted by fraud would be cut down as a whole".[24] He held, however, that the pursuer's first claim was a valid one made under a valid contract, and his subsequent involvement in the further fire had no effect on that position.

CONCLUSION

2.27 As we discuss in Part 7, we think these cases came to the right decision. However, as we shall see, the attempt to reconcile this policy with the words of section 17 has caused considerable confusion.

2.28 In Issues Paper 6 we looked in depth at the insurer's post-contract duties of good faith. We concluded that the law is right to recognise mutual duties of good faith. The problem with section 17, however, is that the courts have interpreted it to mean that avoidance is the only remedy available for breach of good faith. We recommended statutory reform. Avoidance should not be the only, or indeed the primary remedy for a breach of the duty of good faith. Instead, the law should provide flexible and appropriate remedies.

[22] [2005] EWCA Civ 112; [2005] 1 All ER (Comm) 445. In this case AXA had not relied "on any general principle" reflected in s 17 (see [20]). It is therefore possible that AXA might have won had it framed its claim differently.

[23] [1997] CLC 653, also reported at 1997 SCLR 12.

[24] Above, at p 670 (rejecting an earlier obiter view to the contrary by Lord Trayner in *Reid & Co v Employers' Accident & Live Stock Insurance Co* (1899) 1 F 1031, at p 1037).

2.29 We think that a similar reform is needed here. The law should state that it is a breach of the duty of good faith for the insured to make a fraudulent claim, and the appropriate remedy is forfeiture of the claim. We do not see this as a change in substance. This is already the position taken by the courts. However, it would provide a helpful simplification of the law.

PART 3
WHAT IS FRAUD?

FRAUDULENT BEHAVIOUR

3.1 Fraud can be thought of as a range of behaviours. Thus an insurance claim may be fraudulent in at least five ways. A policyholder may:

(1) submit a claim where there was no actual loss;

(2) deliberately cause the damage, and then pretend that the loss was caused by an insured event;[1]

(3) suffer some genuine loss, but then invent further losses which did not take place; [2]

(4) suffer genuine losses, but then exaggerate the value of those losses;[3]

(5) present the claim in a way that disguises the fact that the insurer has a defence to the claim.[4]

3.2 In addition, a policyholder may suffer a genuine loss which is covered by the policy, but then employ "fraudulent means or devices" to improve their prospects of recovery.[5] An example would be where a consumer genuinely suffers the theft of an expensive camera, but fakes an invoice in an attempt to prove its value.

[1] For example, *Continental Illinois National Bank & Trust of Chicago v Alliance Assurance Co Ltd (The Captain Panagos DP)* [1986] 2 Lloyd's Rep 470 (where the policyholder deliberately grounded the insured vessel and then deliberately set fire to it).

[2] For example, *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] Lloyd's Rep IR 209 (where the policyholder took advantage of a burglary to claim for a computer which he had never owned) and *Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd's Rep 682 (where, following a fire to his general store, the policyholder made a series of claims including one for non-existent stock).

[3] For example, *Baghbadrani v Commercial Union Assurance Co Plc* [2000] Lloyd's Rep IR 94 (where the policyholder operated a private school that was damaged by fire and grossly exaggerated the number of pupils expected to attend when making a claim under their business interruption cover) and *Orakpo v Barclays Insurance Services* [1995] LRLR 443 (where the policyholder claimed for loss of rent from his bedsit on the basis of full occupancy even though only three of the rooms were tenanted at the time of the loss).

[4] For example, *Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd's Rep 682 (where the policyholder deliberately concealed from insurers the fact that the local authority had levied distress for unpaid rates) and *Black King Shipping Corporation v Massie (The Litsion Pride)* [1985] 1 Lloyd's Rep 437 (where the policyholder tried to conceal the fact that they had no intention of notifying their war risk insurers that their voyage would take them into dangerous waters in breach of warranty so as to attract an additional premium).

[5] See *Agapitos and Another v Agnew and Others (No 1) (The Aegeon)* [2002] EWCA Civ 247; [2003] QB 556.

3.3 The ABI carries out regular studies to record public perceptions of insurance fraud. The studies show that moral stigma attached to these different forms of behaviour varies considerably. While at least 95% of the population view fabricating an entire claim as clearly "unacceptable", people are much more ambivalent about increasing the price of an item in an otherwise genuine claim. Over 40% viewed this as either an "acceptable" or "borderline" thing to do.[6]

THE DEFINITION OF FRAUD

3.4 The essence of fraud is making a false statement without an honest belief in its truth. The classic common law definition of civil fraud was set out in 1889 in *Derry v Peek*:

> Fraud is proved when it is shewn that a false representation has been made (1) knowingly, or (2) without belief in its truth, or (3) recklessly, careless whether it be true or false.[7]

3.5 In an insurance context, in *Goulstone v Royal Insurance Company*, Baron Pollock put the issue to the jury in the following terms: "the question is whether the claim was fraudulent, ie, whether it was wilfully false in any substantial respect".[8]

3.6 Professor Clarke identifies three elements to a fraudulent claim: the fraud must be substantial, wilful and material.[9] Below we look briefly at these elements, before considering some of the more difficult issues that arise in the case law.

The fraud must be substantial (or more than minimal)

3.7 A claim may be fraudulent even if most of it represents a real loss. However, the fraudulent element must be "not insubstantial". Thus in *Lek v Matthews* Viscount Sumner said that the word "fraud" included:

> Anything falsely claimed, that is, anything not so unsubstantial as to make the maxim de minimis applicable, and is not limited to a claim which as to the whole is false. It means claims as to particular subject-matters in respect of which a right to indemnity is asserted, not the mere amount of money claimed without regard to the particulars of the contents of the claim.[10]

[6] Association of British Insurers, General Insurance Claims Fraud (July 2009) available at http://www.abi.org.uk/Media/Releases/2009/07/40569.pdf, at p 11.

[7] *Derry v Peek* (1889) LR 14 App Cas 337, at p 375. This definition has been held to apply equally to the Scots law of fraud: see *Boyd and Forrest v Glasgow and South-Western Railway Co* 1912 SC (HL) 93; *Romanes v Garman* (1912) 2 SLT 104 and *Robinson v National Bank of Scotland* 1916 SC (HL) 154.

[8] *Goulstone v Royal Insurance Company* (1858) 1 F & F 276, by Pollock CB at p 279. See also the reference to wilfulness in *Britton v The Royal Insurance Company* (1866) 4 F & F 905, by Willes J at p 909.

[9] M A Clarke, *The Law of Insurance Contracts* (looseleaf) at para 27-2B.

[10] *Lek v Mathews* (1927) 29 Ll LR 141, at p 145.

3.8 In paragraphs 3.22 to 3.29 below, we examine how the courts have interpreted this requirement. In particular, we consider whether the issue has to be judged by the sum involved, or by looking at the fraudulent element as a proportion of the claim.

The false representation must be wilful

3.9 A false statement made innocently or carelessly is not fraudulent. It must be made deliberately or recklessly. Furthermore, there must be some element of intention. In *Wisenthal v World Auxiliary Insurance Corporation Ltd*, Mr Justice Roche directed the jury that:

> Fraud… was not mere lying. It was seeking to obtain an advantage… or to put someone else at a disadvantage by lies and deceit.[11]

3.10 As Professor Clarke puts it "the falsity must have been wilful: in some degree the falsity must have been known to and, by inference, intended by the Claimant".[12]

3.11 It is not necessary, however, for the insurer to prove that the insured actually knew the statement to be false. As Lord Herschell made clear in *Derry v Peek*, it is enough that the insured has no honest belief in its truth. A person may also act fraudulently by deliberately failing to inquire into the facts:

> If I thought that a person making a false statement had shut his eyes to the facts, or purposely abstained from inquiring into them, I should hold that honest belief was absent and that he was just as fraudulent as if he had knowingly stated that which was false.[13]

The fraud must be material

3.12 Finally, the fraud must be such that if true it would make some difference to the way the insurer dealt with the claim.[14] In *The Aegeon,* it was stated that a fraudulent device must, if believed:

> have tended to yield a not insignificant improvement in the insured's prospects of obtaining a settlement, or a better settlement, or of winning at trial.[15]

3.13 The requirement of materiality has, however, been interpreted widely. As we explore below, a fraud will be considered material even if it adds only a small proportion to the claim.

[11] *Wisenthal v World Auxiliary Insurance Corporation Ltd* (1930) 38 Ll L Rep 54, by Roche J at p 62.

[12] M A Clarke, *The Law of Insurance Contracts* (looseleaf) at para 27-2B2.

[13] *Derry v Peek* (1889) LR 14 App Cas 337, at p 376.

[14] See MacGillivray on Insurance Law (11th ed, 2008) at para 19-061.

[15] *Agapitos and Another v Agnew and Others (No 1) (The Aegeon)* [2002] EWCA Civ 247; [2003] QB 556 at [45]. See also *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563, where Longmore LJ drew an analogy with pre-contract disclosure, where the insurer may only avoid the policy if the issue is material.

3.14 It is said to be enough if a policyholder knowingly or recklessly makes a false statement to obtain the more expedient resolution of a claim which the insurer would have paid ultimately in any event. Thus quicker or easier payment is considered to be a benefit in itself. This was recognised by Mr Justice Roche in *Wisenthal* who directed the jury that:

> It would be sufficient to come within the definition of fraud if… deceit had been used to secure easier or quicker payment of the money that would have been obtained if the truth had been told.[16]

3.15 Thus in most cases the requirement of materiality will be met. It is a rare case in which a policyholder tells a lie which would not affect the way an insurer handles the claim.[17]

INTERPRETING FRAUD IN THE CASE LAW

3.16 Although the definition of fraud is easy to state, it is more difficult to apply to the varied range of behaviours that arise in practice. Here we consider the main issues which have arisen in the case law.

Fraud in support of a genuine claim

3.17 The courts have considered what should happen when a policyholder claims for an overall amount which they genuinely believe to represent their true loss, but which includes claims for items which were not lost. Does a policyholder need to have an overall fraudulent intent, or is it sufficient to be fraudulent in some particulars? The courts have held that it is sufficient to be fraudulent in some particulars.

3.18 In *Lek v Mathews*, the claimant insured his stamp collection for £44,000.[18] When the collection was stolen, Mr Lek submitted a schedule of the stamps he had lost. The insurers provided evidence that some of the listed stamps had never been issued. Others were extremely rare, and Mr Lek could not provide any evidence of how he had obtained them. The Court of Appeal held that Mr Lek was not fraudulent if he genuinely believed he had lost the amount claimed. However, this was overturned by the House of Lords.

3.19 In the Court of Appeal, Lord Justice Atkin put the arguments as follows:

[16] *Wisenthal v World Auxiliary Insurance Corporation Ltd* (1930) 38 Ll L Rep 54, by Roche J at p 62.

[17] For this reason it is sometimes doubted that materiality is a distinct element: see, for example, Rix J's comments at first instance in *Royal Boskalis Westminster NV v Mountain* [1997] LRLR 523 at p 599, where he said that the test of materiality was not separate but built into the concept of a fraudulent claim.

[18] (1926) 25 Ll L Rep 525.

> At all times Mr Lek himself thought he had a valid claim for £44,000 less an amount of £5,000… . If he retained this belief throughout the negotiations, and there appears to me no evidence to the contrary, how can he be said to have had the intent to defraud the underwriters?... . I think that Mr Lek's intention to defraud must be judged by his own actual belief in the nature of his claim.[19]

3.20 The House of Lords, however, disagreed. Viscount Sumner rejected this passage, commenting that "if a man has claimed for the loss of things which he had not got, I think it is a contradiction in terms to say that he may have honestly believed in his claim".[20] It is therefore clear that inventing items of loss is fraudulent, even if the policyholder genuinely believes that they have lost the overall sum claimed.

3.21 As we see below, the courts have distinguished between merely exaggerating the overall amount of the loss and inventing items to add to the claim. The first may be treated more leniently than the second, even though the amounts claimed may be identical. It seems that invention indicates an intention to deceive that exaggeration does not, given that opinions on value will vary.

Substantial in itself or substantial in proportion to the claim?

3.22 There has been some debate over how to assess whether an amount is substantial. Is it right to look at the amount in isolation, or should it be assessed as a proportion of the claim?

3.23 We have already mentioned *Galloway v Guardian Royal Exchange (UK) Ltd*, where the policyholder lost goods worth around £16,000 but added £2,000 for a computer which did not exist. The Court of Appeal deprived the policyholder of the whole claim. Lord Woolf MR commented:

> In determining whether or not the fraud is material so that it has that effect, one of course has, in my judgment, to look at the whole of the claim. But if you have a claim (which admittedly here is a much more substantial sum than that part which is fraudulent) where the part which is fraudulent is nonetheless in relation to £2,000 (which amounts to about ten per cent of the whole) that is an amount which is substantial and therefore an amount which taints the whole.[21]

3.24 Lord Justice Millett took a different approach, suggesting that it was not appropriate to consider the fraudulent amount as a proportion of the whole claim:

[19] *Lek v Mathews* (1926) 25 Ll L Rep 525, by Atkin LJ at pp 544 to 545.

[20] *Lek v Mathews* (1927) 29 Ll L Rep 140, by Viscount Sumner at pp 163 to 164.

[21] *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] Lloyd's Rep IR 209, by Woolf LJ at p 213.

> I reject the submission that this is to be tested by reference to the proportion of the entire claim which is represented by the fraudulent claim. That would lead to the absurd conclusion that the greater the genuine loss, the larger the fraudulent claim which may be made at the same time without penalty. In my judgment, the size of the genuine claim is irrelevant… . In my view, the right approach in such a case is to consider the fraudulent claim as if it were the only claim and then consider whether taken in isolation, the making of that claim by the insured is sufficiently serious to justify stigmatising it as a breach of his duty of good faith so as to avoid the policy.[22]

3.25 These principles were applied in *Direct Line Insurance Plc v Khan*.[23] The policyholders suffered a fire, making a legitimate claim for just over £62,000 and a fraudulent claim for rent on alternative accommodation for around £8,250. It was accepted that £8,250 was a substantial fraud, looking either at the overall amount of the fraud or at the sum as a proportion of the claim.[24] Similarly in *Baghbadrani v Commercial Union Assurance Co Plc*, the judge applied both tests. He found that a fraudulent claim of £3,000 was "not a minimal sum, either in itself or in comparison with the total material damage claim".[25]

3.26 The courts are clearly right to reject the idea that policyholders are allowed some margin of fraud, so as to increase claims by 10%, 5% or even 1%. On the other hand, the issue of whether the fraudulent element of the claim is more than minimal must be looked at in the context of the claim itself. We think it would be wrong to state that the courts should never consider the amount of the fraud as a proportion of the claim. A misrepresentation which appears substantial in the context of a £20,000 claim may be viewed differently in the context of a £2 million claim.

3.27 This is demonstrated by the case of *Tonkin v UK Insurance*.[26] The claimants' house was destroyed by fire, and they claimed over £700,000. The insurer paid some of the claim and offered reinstatement. However, the claimants and insurer were unable to agree a reinstatement scheme. Among other issues in the case, the insurer alleged that the claimants had behaved fraudulently, by claiming £2,000 for reinstating the kitchen, when the claim for a kitchen had already been paid.

3.28 His Honour Judge Peter Coulson QC held that this was "clearly and obviously an inadvertent mistake".[27] However, even if it had been deliberate it would not have been sufficiently substantial to amount to fraud:

[22] Above, by Millett LJ at p 214.

[23] QBD, 19 December 2000 (Unreported); 2000 WL 33148765 (Westlaw). The decision was upheld by the Court of Appeal in *Direct Line Insurance Plc v Khan* [2001] EWCA Civ 1794; [2002] Lloyd's Rep IR 364.

[24] Above, at p 8. See also Arden LJ in the Court of Appeal, [2001] EWCA Civ 1794; [2002] Lloyd's Rep IR 364 at [24].

[25] [2000] Lloyd's Rep IR 94 at p 111..

[26] *Tonkin v UK Insurance* [2006] EWHC 1120; [2006] 2 All ER (Comm) 550.

[27] See above at [186].

> It would be absurd if an entirely insubstantial element of a large claim, which is found to be fraudulent, could taint the entirety of that claim... I do not accept... that, effectively, any fraud, no matter how small, would be sufficient to wipe out the whole of the claimants' claim under this policy.[28]

3.29 In reaching this view, the judge focused upon the proportion the alleged fraudulent claim bore to the entire claim, which was "not more than 0.3%".[29]

Exaggeration for the purposes of negotiation

3.30 Although it is clearly fraudulent to add an item to a claim when it has not been lost, the courts have been more lenient when a claim is simply exaggerated. It may be acceptable for policyholders to start negotiations with a high claim if they know that the amount will be fully investigated and reduced. As Mr Justice Goddard explained in his direction to the jury:

> Mere exaggeration was not conclusive evidence of fraud, for a man might honestly have an exaggerated idea of the value of the stock, or suggest a high figure as a bargaining price.[30]

3.31 In *Ewer v National Employers' Mutual General Insurance Association,* Mr Justice MacKinnon considered the claim to be "preposterously extravagant".[31] The policyholder had claimed the price of new replacements, even though he probably knew he was only entitled to the value of the goods lost. However, he had not acted fraudulently because he had been open about the basis of his valuation:

> All he [the policyholder] can recover is the reasonable value of the second-hand goods that have been destroyed. The plaintiff here has put down the cost price of new things. I do not think he was doing that as in any way a fraudulent claim, but as a possible figure to start off with, as a bargaining figure. The plaintiff knew the claim would be discussed, and probably drastically criticised by the assessors.[32]

[28] See above at [178].

[29] See above, at [179]. For academic commentary on this issue, see M Clarke, *The Law of Insurance Contracts* (looseleaf) at para 27-2B1 and B Soyer, "Continuing duty of utmost good faith in insurance contracts: still alive?" [2003] Lloyd's Maritime and Commercial Law Quarterly 39 at p 46.

[30] *London Assurance v Clare* (1937) 57 Ll L Rep 254 at p 268.

[31] *Ewer v National Employers' Mutual General Insurance Association* [1937] 2 All ER 193, at p 203.

[32] Above, at p 203.

3.32 In some cases, however, exaggeration tips over the line to become fraudulent. In *Orakpo v Barclay Insurance Services Co Ltd*,[33] the policyholder claimed for storm and other damage to a large house divided into 13 bedsits. The real damage was minor, but the policyholder significantly inflated it. For example, he submitted a claim for loss of rent on the basis that all 13 bedsits were occupied, even though only three had been occupied at the time of the loss. Lord Justice Hoffmann observed that exaggerating a claim was not necessarily fraud:

> One should naturally not readily infer fraud from the fact that the insured has made a doubtful or even exaggerated claim. In cases where nothing is misrepresented or concealed, and the loss adjuster is in as good a position to form a view of the validity or value of the claim as the insured, it will be a legitimate reason that the assured was merely putting forward a starting figure for negotiation.[34]

In this case, however, the claim was largely false and Lord Justice Hoffmann was prepared to accept the trial judge's conclusion that it was fraudulent.

3.33 Lord Justice Staughton addressed the issue of exaggeration in the following way:

> Of course, some people put forward inflated claims for the purpose of negotiation, knowing that they will be cut down by an adjuster... . From time to time claims are patently exaggerated; for example, by claiming the replacement cost of chattels, when only the depreciated value is insured. In such a case, it may perhaps be said that there is in truth no false representation, since the falsity of what is stated is readily apparent. I would not condone falsehood of any kind in an insurance claim. But in any event I consider that the gross exaggeration in this case went beyond what can be condoned or overlooked. Nor was it so obviously false on its face as not to amount to a misrepresentation.[35]

3.34 This sentiment was echoed by Mr Justice Thomas in the case of *Nsubuga v Commercial Union Assurance Co Plc:*

[33] *Orakpo v Barclays Insurance Services Co Ltd* [1994] CLC 373.

[34] See above at p 383

[35] See above at p 382. For discussion of these issues, see James Davey "Unpicking the fraudulent claims jurisdiction in insurance contract law: sympathy for the devil?" *Lloyds Maritime and Commercial Law Quarterly* 223.

> One has to accept as a matter of commercial reality that people will often put forward a claim that is more than they believe they will recover. That is because they expect to engage in some form of 'horse trading' or other negotiation. It would not generally in those circumstances be right to conclude readily that someone had behaved fraudulently merely because he put forward an amount greater than that which he reasonably believed he would recover. He would have to put forward a claim that was so far exaggerated that he knew that in respect of a material part of it, there was no basis whatsoever for the claim.[36]

3.35 In summary, it appears that the insurer must prove not only that the claim was inflated but that the inflation was dishonest. The requisite mindset will not be automatically inferred from the fact of inflation. However, it may be inferred in appropriate circumstances.[37] Where a policyholder has been open about their claim and their method of valuation, and the matter is one which an insurer can evaluate without difficulty, it is unlikely that a court would infer fraudulent intent. However, if the policyholder makes assertions which cannot be readily evaluated, the claim is more likely to be classified as fraud.

Fraudulent devices

3.36 Another difficult issue is how the law should treat the use of fraudulent means and devices in support of valid claims. It is not uncommon for the insured to forge an invoice or letter to support a claim which is perfectly valid. Should the forgery lead to the forfeiture of the valid claim?

3.37 In *The Mercandian Continent*[38] a forged letter was considered not sufficiently material to constitute fraud. The case concerned liability insurance. The policyholders were ship repairers who had negligently failed to tighten engine bolts on the claimant's vessel, leading to an explosion in the engine. The owners obtained a judgment against them. When the ship repairers went into liquidation, the owners sought satisfaction directly from the insurers under the Third Parties (Rights against Insurers) Act 1930.

3.38 The insurers defended the action on the ground of the policyholders' fraud. The policyholders had provided a document to the insurers which purported to establish that Trinidad was the proper forum for the dispute. It transpired that the policyholders had forged the document under the mistaken belief that the limitation period for any claim was shorter in Trinidad. The policyholders had been overzealous on the insurers' behalf, attempting to provide the insurers with a defence which did not exist. The claimants were the intended victims of the fraud. Nevertheless, the insurers sought to avoid the policy of insurance for breach of the duty of good faith, and thus deny recovery to the claimants.

[36] *Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd's Rep 682, at p 686.

[37] This is supported by *MacGillivray* at para 19-058.

[38] *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563.

3.39 The court found against the insurers on the ground that the fraud was not material. Lord Justice Longmore drew an analogy with pre-contract good faith, where the insurer can only avoid the contract if the non-disclosure or misrepresentation was material and induced the contract. Applying the same concepts in a post-contract context, he held that the fraudulent conduct

> … must be causally relevant to the underwriters' ultimate liability, or, at least, to some defence of underwriters before it can be permitted to avoid the policy.[39]

3.40 In this case, the fraudulent letter was not relevant to the underwriters' liability, and it would be "absurdly disproportionate" to permit the insurers to avoid the policy or defeat the owners' claim.[40]

3.41 In *The Aegeon (No 1)*, Lord Justice Mance described *The Mercandian Continent* as "an unusual case", where the deceit was aimed at a third party: the case provided "no guidance" where the fraudulent device was used to promote a claim under the policy.[41] Furthermore, it was concerned only with the proper scope of section 17. It would not necessarily apply where the insurer sought forfeiture of the claim under the common law rule against fraudulent claims.

3.42 We return to the difference between a breach of the duty of good faith and the common law rule against fraud in Part 4. Here it is sufficient to note that *The Mercandian Continent* illustrates how reluctant the courts would be to deprive a third party of payment where the insured has been over-zealous in providing the insurer with a defence. However, it is not necessarily a good guide to the definition of fraud where the policyholder uses a fraudulent device to promote its own claim under the policy. The law on this is set out in *The Aegeon (No 1)*.[42]

3.43 Here the insurers refused a claim on the ground that the insured had breached a warranty by undertaking "hot works".[43] As part of a complex dispute, the insurers alleged that the insured lied about when the hot works had begun.

[39] Above at [28], adopting Mr Justice Rix's dicta in *Royal Boskalis Westminster NV v Mountain* [1997] LRLR 523 at p 597 that a post-contract breach of good faith must be ultimately legally relevant to a defence which the insurer had under the policy terms and the insurers must have been induced to change their position.

[40] See above at [43].

[41] *Agapitos and Another v Agnew and Others (No 1) (The Aegeon)* [2002] EWCA Civ 247; [2003] QB 556 at [24].

[42] See above, at [24].

[43] Hot works are processes involving a significant fire hazard, typically welding, cutting or brazing.

3.44 Lord Justice Mance held that even if a policyholder honestly believes in a claim when initially presented, it may become fraudulent if the policyholder subsequently realises it is exaggerated and continues to maintain it. Similarly, a fraud may be committed if the policyholder knows that the insurer has a defence to the claim, but lies to suppress this fact. The use of fraudulent devices intended to improve the insured's prospects of a successful claim is a sub-species of making a fraudulent claim. The fraudulent device must, however, be relevant to the claim before the insurer is afforded a remedy. To be relevant to the claim, the device must be:

> [a] lie, directly related to the claim to which the fraudulent device relates which is intended to improve the insured's prospects of obtaining a settlement or winning the case, and which would, if believed, tend, objectively, prior to any final determination at trial of the parties' rights, to yield a not insignificant improvement in the insured's prospects – whether they be prospects of obtaining a settlement, or a better settlement, or of winning at trial.[44]

3.45 In this case, however, the alleged fraud took place after litigation had started. On this basis, the Court of Appeal refused to allow the insurer to raise it at trial.

3.46 The key word, in the quote given above, is "objectively". If an insurer requests irrelevant paperwork, then the use of a forged document would not amount to fraud if it had no objective impact on the insured's prospects of success. As Lord Justice Mance put it, the question is, would it "sensibly" have "any significant impact" on the insurer or judge?[45] If so, forging an invoice or letter should be treated as a fraud. As we discuss in Part 4, it appears that a fraud will lead to forfeiture of the claim, with little distinction between fraudulent devices and fraudulent claims, provided the materiality test is met.

3.47 It also appears that the fraud must occur before the settlement has been agreed. In *Direct Line v Fox*[46] the loss was genuine. The insurers agreed a settlement figure. Mr Fox then supplied a false invoice in the context of a claim for VAT. On discovering the fraud the insurers sought the return of all monies paid out. However the court held that the fraud related to the settlement agreement, not the insurance policy. The settlement agreement was not a contract of utmost good faith. The insurers and their loss adjusters had already agreed the claim with Mr Fox and it was not possible to link the fraudulent invoice back to the original claim under the insurance policy.

Fraud and mental impairment

3.48 The requirement that fraud must be wilful raises the question of whether it can be committed by a person who suffers from a mental impairment. The courts have held that insanity or disability may remove the requisite intention in theory, though they will require strong evidence.

[44] *Agapitos and Another v Agnew and Others (No 1) (The Aegeon)* [2002] EWCA Civ 247; [2003] QB 556 at [45].

[45] See above at [38].

[46] [2009] EWHC 386 (QB); [2009] 1 All ER (Comm) 1017.

3.49 In *Markel International Insurance Company Ltd v Timothy Higgins* and *QBE Insurance (Europe) Ltd v Amalfi,*[47] the claimant attempted to argue that because he suffered from Alzheimer's disease he lacked the necessary intention to commit fraud. Although the claimant did in fact suffer from Alzheimer's disease at the time of the fraud the trial judge considered that his disability was not so significant that he could have had no intention to deceive. The finding was upheld on appeal.

3.50 In *Porter v Zurich Insurance Company*, Mr Justice Coulson stated that;

> Where a claimant seeks to recover under a policy of insurance for the consequences of his own act in setting a fire, they will need to prove, on the balance of probabilities that they were insane, within the meaning of the M'Naghten Rules, at the time of the fire.[48]

3.51 It follows that where this requirement is fulfilled, such a person might still make a valid claim. The court did not accept the insurer's arguments that allowing a claim to succeed in such circumstances would breach the duty of good faith or be contrary to public policy as Mr Porter would profit from his own illegal act. Again, however, the claimant lost on the facts.

THE BURDEN OF PROOF

3.52 The burden of proving fraud rests with the insurer. It is often said that as allegations of fraud are extremely serious, cogent proof is required to persuade a court that fraud has occurred.[49] However, a recent House of Lords case has emphasised that "there is only one civil standard of proof and that is proof that the fact in issue more probably occurred than not".[50]

3.53 In *Re H*,[51] Lord Nicholls explained that the more serious the allegation, the more improbable it is, and therefore the greater the proof needed:

> The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not. When assessing the probabilities the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability. Fraud is usually less likely than negligence....

[47] [2009] EWCA Civ 790.

[48] [2009] EWHC 376; [2009] 2 All ER (Comm) 658, at [17]. The position appears to be the same in Scots law. See *Howie v CGU Insurance Plc* [2005] CSOH 110 (unreported).

[49] This issue was considered in the *Eagle Star Insurance Co Ltd v Games Video Co (GVC) SA (The Game Boy)* [2004] EWHC 15 (Comm); [2004] 1 All E.R. (Comm) 560 at [29] and in *Tonkin v UK Insurance Ltd* [2006] EWHC 1120 at [179].

[50] *Re B* [2008] UKHL 35; [2009] 1 AC 11, by Lord Hoffmann at [13].

[51] [1996] AC 563.

> Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established. [52]

3.54 Thus although the courts may start by thinking that an innocent explanation is more likely than fraud, this does not affect the legal standard of proof. As Lady Hale emphasised in *Re B*, "the inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies".[53]

THE FOS APPROACH

3.55 Consumers whose claims are turned down on the ground of fraud have the right to complain to the Financial Ombudsman Service (FOS). In 2002, the FOS issued guidance about how it would deal with such cases.[54]

3.56 The FOS guidance stressed that insurers are required to produce concrete evidence of fraud. It is not enough that the policyholder lied in connection with some other claim, or failed to report some matters to the police.[55] The FOS accepted that if a policyholder claims for items which were not lost this amounts to fraud. However, an exaggeration is not always fraud. The FOS commented:

> The firm should not repudiate the entire claim simply because the customer has mistaken the cost of replacing the item claimed – or has an inaccurate recollection of the purchase price. To repudiate the claim, the firm must be able to show that the customer was trying to obtain more than he or she was entitled to.

3.57 Similarly, the FOS was prepared to accept that the use of a false document is not always fraud. The FOS commented:

> In some recent cases involving claims for written-off vehicles, firms appear to have asked customers to substantiate the original purchase price of their vehicles. As a result, some customers who had lost the original sales material (or perhaps purchased the car through somewhat informal routes) have sent in false documents.

[52] Above, at pp 586 to 587.

[53] [2008] UKHL 35; [2009] 1 AC 11, at [70].

[54] *Ombudsman News*, Issue 21, October 2002.

[55] In Case 21/3, for example, a couple returned home to find they had been burgled, and immediately notified the police that evening. The couple reported some items missing to the police, but then reported a longer list to the insurers the next morning. The ombudsman rejected the insurer's arguments that this indicated fraud. Rather it was entirely credible that theft victims were not aware of the full extent of their loss within a few minutes of discovering it.

> Other customers have produced false documents to try and substantiate a higher price than they actually paid. This is clearly improper, but it does not justify the firm voiding the policy. The customer's claim is for the present market price, not the original purchase price. As long as there is no doubt about ownership and no suggestion of fraud, the firm should meet such claims on the basis of normal market value.[56]

3.58 Where the false document has no objective relevance to the claim, this approach is in line with the case law, as set out in *The Aegeon (No 1)*.[57]

3.59 In 2004, the FOS issued further guidance on the subject.[58] The FOS again followed the law by stating that policyholders had a continuing duty of good faith when submitting a claim. However, the insurer's remedy is not avoidance but forfeiture: "the insurer is not obliged to pay the fraudulent claim and it can cancel the policy prospectively".[59]

3.60 The FOS illustrated this with an example. Mr H was a self-employed plumber. In January he made a claim for burglary, which was duly paid. In May, his van was broken into and his tools were stolen. The loss adjusters insisted that he provide receipts for every item. He could not find receipts, and he asked a friend to fake one for him. When the insurers discovered this, they attempted to avoid the policy and demand repayment of the previous claim.

3.61 The Ombudsman was not convinced that the forgery amounted to fraud. The policy did not cover work tools, and therefore their value was irrelevant to the claim. Even if Mr H had been guilty of fraud, only the claim would have been forfeited, and the insurer was not entitled to recover the previous payments.[60]

CONCLUSION

3.62 Our view is that this element of the law is best left to the courts to develop, and that it does not require statutory reform.

3.63 It is true that the exact definition of fraud is not always clear-cut. But we think that this arises from the nature of the issue.

[56] *Ombudsman News*, Issue 21, October 2002.

[57] *Agapitos and Another v Agnew and Others (No 1) (The Aegeon)* [2002] EWCA Civ 247; [2003] QB 556.

[58] *Ombudsman News*, Issue 41, November 2004. This guidance is illustrated by case studies on *Ombudsman News*, Issue 42, December 2004/January 2005.

[59] Above, Issue 41, p 3.

[60] *Ombudsman News*, Issue 42, December 2004/January 2005.

3.64 There are many ways in which a claim might be fraudulent, covering a variety of morally reprehensible behaviours. This makes it difficult to be precise about the exact boundary between fraud and, for example, exaggeration as part of the negotiation process. We think that it is right that the fraudulent element of a claim must be more than minimal. However, we think it would be neither possible nor desirable to attempt to define what amounts to a minimal amount – either in overall amount (say, £50) or in terms of proportion of the claim (say, 1%). Some issues are better left to the courts after examining all the circumstances.

3.65 In Part 7 we ask whether consultees agree that the definition of fraud is best left to case law, and does not need to be reformed.

PART 4
FRAUD: THE APPROPRIATE REMEDY

4.1 Although we consider the law defining fraud to be generally satisfactory, we have more concerns about the remedies. In this Part we consider what civil remedy should be available to the insurer once it is proved that the policyholder has acted fraudulently in respect of all or part of a claim.

4.2 We are not concerned with criminal sanctions. In England and Wales, if a policyholder dishonestly makes a false representation intending to make a gain, this is an offence under section 2 of the Fraud Act 2006.[1] If tried on indictment, the policyholder may be fined or imprisoned for up to 10 years. This provision is based on a previous Law Commission report,[2] and we do not revisit it here. In Scots law, the common law offence of fraud is committed by bringing about a practical result by means of a false pretence.[3] If tried in the High Court of Justiciary, the maximum sentence which may be imposed is life imprisonment or an unlimited fine.[4]

4.3 The duty not to make a fraudulent claim has been characterised in several different ways. First and foremost, fraud may be a breach of an express term of the contract. Many insurance policies include such terms, and we discuss them below. It appears that a well-drafted clause may extend the remedies available to an insurer should a policyholder act fraudulently. On the other hand, a party may not exclude liability for his or her own fraud. There remains doubt on whether it is possible for policyholders to exclude liability for their agents' fraud.

4.4 It is not necessary for policies to include specific terms dealing with fraud. Even in the absence of an express term, the courts have required fraudsters to forfeit the claim. As we discuss from paragraph 4.18 onwards, the difficulty is how this result should be conceptualised.

4.5 Finally, we look briefly at the position in Australia, where the remedy of avoidance was abolished by statute in 1984.

[1] Under s 2, the requisite intention may be "to make a *gain* for himself or another, or to cause loss to another or to expose another to a risk of loss". Under s 3, it is also an offence to dishonestly fail to disclose information which one is under a legal duty to disclose.

[2] Fraud (2002) Law Com No 276.

[3] The common law offence of attempted fraud is committed where the false pretence does not cause a practical result. See *The Laws of Scotland (Stair Memorial Encyclopaedia)*, Criminal Law (Reissue), para 364.

[4] Fraud may also be tried in the sheriff court, where the powers of sentence are restricted by statute. For the sentencing powers of the High Court of Justiciary and sheriff court, see *The Laws of Scotland (Stair Memorial Encyclopaedia)*, Criminal Procedure (2nd Reissue), paras 68 and 72.

EXPRESS CONTRACT TERMS

4.6 Many insurance policies include express "fraudulent claims clauses". These typically prescribe the insurer's remedy should the policyholder present a fraudulent claim, and they may also define what constitutes a fraudulent claim for the purposes of the clause. It has been held that since fraud clauses are commonly used in policies of insurance there is no need to bring such a term to the insured's attention specifically in order to incorporate it.[5]

4.7 The wording of such clauses varies and has developed over time.[6] In *Insurance Corporation of the Channel Islands Ltd v McHugh* the fraud clause stated:

> Fraud - If the claim be in any respect fraudulent or if any fraudulent means or devices be used by the insured or anyone acting on his behalf to obtain any benefit under this Policy or if any destruction or damage be occasioned by the wilful act or with the connivance of the insured all benefit under this Policy shall be forfeited.[7]

4.8 Mr Justice Mance held that this clause forfeited the benefit of the whole policy and was not restricted to the section to which the fraud related.[8] This dispensed with the issues in the case. However, the meaning of "forfeit all benefit" was not entirely clear. It could apply to benefits arising after the date of the fraud, or to all benefits relating to the claim. Alternatively, forfeiture could be applied retrospectively so as to undo previous claims which had already been paid. Whether the clause had retrospective effect was left open.[9]

4.9 In *Fargnoli v G A Bonus Plc,*[10] the Court of Session was required to determine whether a similarly worded clause did indeed apply retrospectively, to deny the pursuer the benefit of an earlier claim, unconnected to the alleged fraud. Lord Penrose held that it did not. The words "all benefit under this policy shall be forfeited" were ambiguous. They could mean all benefit in respect of the particular claim or all benefit in respect of the policy as a whole. He resolved the issue by applying the "contra proferentem" rule, namely that a clause should be construed against the party who puts it forward. The insurer had drafted the clause, which was conceived in its own interests. If the insurer had left room for ambiguity it should be interpreted in the interests of the insured. Therefore only the claim to which the fraud related should be forfeited.

Extending the duty not to act fraudulently

4.10 It is clear that the law permits the parties to enlarge the circumstances in which the insurer may decline a claim, and extend the insurer's remedy if a claim is fraudulent. However, such clauses must be clearly drafted.

[5] *Nsubuga v Commercial Union Assurance* [1998] 2 Lloyd's Rep 682, at p 686.

[6] For examples of the wordings of fraud clauses in different periods of time see *MacGillivray* at pp 546 to 547.

[7] *Insurance Corporation of the Channel Islands Ltd v McHugh* [1997] 1 LRLR 94, at p 98.

[8] See above, at p 135.

[9] See above at p 135.

[10] [1997] CLC 653.

4.11 A fraud clause may also be subject to statutory controls. In the case of compulsory insurance, the legislation protects a third party, even if the insured has lied to the insurer about the circumstances of the accident. Thus for compulsory motor insurance, section 151(5) of the Road Traffic Act 1988 requires an insurer to pay the third party even if the insurer has avoided or cancelled the policy as against the insured. For employers' liability insurance, the Employers' Liability (Compulsory Insurance) Regulations 1998 prohibit terms which would otherwise exclude liability for something done after the event giving rise to a claim.[11]

4.12 In consumer insurance, a fraud clause will be subjected to the Unfair Terms in Consumer Contracts Regulations 1999. The regulations require terms to be drafted in plain, intelligible language. They must also be fair. A term which is unexpectedly harsh may well be considered unfair if it is not brought to the policyholder's attention.

Can liability for fraud be excluded?

4.13 On the other hand, it appears that liability for fraud may not be excluded by a contract term. There is no direct authority on this point in relation to fraudulent claims, but the issue has arisen in connection with fraud at the pre-contract stage.[12]

4.14 In *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank*,[13] a syndicate of banks had advanced substantial sums to finance the making of feature films. In case the films did not generate sufficient revenue to repay the investment, the banks arranged insurance, through a broker, with a group of insurers. The films' earnings were insufficient and the banks claimed on the policy. The insurers refused to pay out, partly on the basis that the broker had made fraudulent misrepresentations or non-disclosures. The banks relied on a clause in the policy which stated that they would "have no liability of any nature to the insurers for any information provided by any other parties".

4.15 The House of Lords held that this clause did not protect the banks if the insurers had been induced to enter into the contract through the fraud of the banks' agents. The law, on public policy grounds, did not permit a contracting party to exclude liability for his or her own fraud. Lord Bingham explained:

[11] Reg 2(1)(a).

[12] For the position under English law, see *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank* [2003] UKHL 6; [2003] 1 CLC 358, discussed below. Similarly, parties may not, by virtue of contractual terms, exclude liability for fraud in Scots law: see *Mair v Rio Grande Rubber Estates Ltd* 1915 SC (HL) 74; *Boyd and Forrest v Glasgow and South-Western Railway Co* 1915 SC (HL) 20; and *H & J M Bennett (Potatoes) Ltd v Secretary of State for Scotland* 1988 SLT 390.

[13] [2003] UKHL 6; [2003] 1 CLC 358.

> Parties entering into a commercial contract will no doubt recognise and accept the risk of errors and omissions in the preceding negotiations, even negligent errors and omissions. But each party will assume the honesty and good faith of the other; absent such an assumption they would not deal. What is true of the principal is true of the agent, not least in a situation where, as here, the agent, if not the sire of the transaction, plays the role of a very active midwife.[14]

4.16 The court found that the general words used were insufficient to exclude liability for the agent's fraud. But the court did not decide whether it would ever be possible for a contracting party to exclude liability for their own agent's fraud, even if clear words were used. Lord Hoffmann commented:

> There is no doubt that a party cannot contract that he shall not be liable for his own fraud. But whether he can contract that he should not be liable for his agent's fraud is less clear. [Counsel] submitted that although he might be able to exclude liability for the fraud of an agent in the performance of a contract, he could not exclude the right of the other party to rescind for the fraud of an agent in inducing the conclusion of the contract. It would be contrary to public policy to allow him to enforce a contractual advantage which had been obtained by him for the fraud of his agent. I see the force of this submission… . In this case, it is sufficient to say that the question has not arisen for decision.[15]

4.17 We agree that it should be impossible for a contracting party to exclude liability for their own fraudulent behaviour. However, in Part 7 we ask whether it should be possible for two contracting parties to exclude liability for the fraud of an agent if they use clear and unambiguous words to do so.

THE REMEDY FOR FRAUD IN THE ABSENCE OF AN EXPRESS TERM

4.18 As we shall see, it is not necessary for the insurance policy to include an express term dealing with fraudulent claims. The courts will provide the insurer with a remedy in any event. The difficulty is how this rule should be characterised. It has been seen as a breach of an implied term of the policy, as breach of the obligation to act in good faith or as a breach of a common law rule based on public policy. As we shall see, judges have struggled to characterise the rule in a way which escapes the full consequences of avoidance under section 17.

An implied term of good faith

4.19 In *Orakpo v Barclays Insurance Services Co Ltd* there was no express term dealing with fraudulent claims.[16] However, the majority of the Court of Appeal held that a term similar to the commonly-used express fraud clause should be implied. The term appears to have been implied by operation of law to give effect to the obligation to act in good faith. Lord Justice Hoffmann commented:

[14] Above at [15].

[15] Above, by Lord Hoffmann at pp 386 to 387.

[16] *Orakpo v Barclays Insurance Services Co Ltd* [1994] CLC 373.

> It is true that an express term to this effect is commonly inserted into insurance policies and that there is no such term in this one. But in my view the direction to the jury by Willes J in *Britton v The Royal Insurance Co*... is sufficient authority for holding that such a term is implied by law as one which, in the absence of contrary agreement, it would be reasonable to regard as forming part of a contract of insurance.[17]

4.20 Sir Roger Parker agreed that an implied clause existed "in accordance with principle and sound authority".[18] He likened the duty not to make a fraudulent claim to the pre-contract duty to disclose, stating that the remedy for fraud was full avoidance of the contract:

> It appears to me that it is contrary to reason to allow an insurer to avoid a policy for material nondisclosure or misrepresentation on inception, but to say that, if there is subsequently a deliberate attempt by fraud to extract money from the insurer for alleged losses which had never been incurred, it is only the claim which is forfeit.[19]

4.21 Support for the existence of an implied term not to make a fraudulent claim can also be found in *Royal Boskalis Westminster*,[20] and *The Captain Panagos DP*.[21]

4.22 This aspect of the decision in *Orakpo* no longer appears to be good law, following the House of Lords' decision in *The Star Sea,*[22] which we discuss below. In that case, the policyholder's duty was characterised as based upon a rule of law, not an implied term.[23] Lord Hobhouse was especially critical of the idea that avoidance was the right remedy for a fraudulent claim, commenting that "the judgments in the *Orakpo* case cannot be treated as fully authoritative in view of the contractual analysis there adopted".[24]

[17] Orakpo v Barclays Insurance Services Co Ltd [1994] CLC 373 at p 383.

[18] Above, at p 385.

[19] Above, at p 385.

[20] *Royal Boskalis Westminster NV v Mountain* [1997] LRLR 523, at pp 593 and 597.

[21] *Continental Illinois National Bank v Alliance Assurance Co Ltd (The Captain Panagos D.P.)* [1986] 2 Lloyd's Rep 470, at p 512.

[22] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd and Others (The Star Sea)* [2001] UKHL 1; [2003] 1 AC 469.

[23] See above, by Lord Hobhouse at [62]. The common law rule against fraudulent claims is considered below at paras 4.39 – 4.46.

[24] See above at [66].

A breach of section 17?

4.23 In some cases, the insurers have based their case directly on section 17, arguing that a fraudulent claim is a breach of the insured's post-contract duty of good faith.[25]

4.24 *The Litsion Pride*[26] represents the high watermark in the operation of the duty of good faith at the claims stage. The mortgagee of a vessel insured against war risks claimed as an assignee under the policy. The insurance provided that the policyholder would be in breach of warranty if the vessel entered high risk waters such as the Persian Gulf. However, cover would continue subject to the policyholder paying an additional premium. The owners wished to avoid paying a substantial additional premium and intended to slip in and out of the dangerous waters without notifying their insurers. When The Litsion Pride was struck by an Iraqi missile the owners sought to conceal the fact that they had not intended to pay the additional premium. The insurers argued that there had been a breach of the post-contract duty of good faith.

4.25 Mr Justice Hirst found that the duty of good faith applied post-contract and at a similar level to the pre-contract duty of good faith:

> The duty of utmost good faith applied with its full vigour in relation to the giving of information of the voyage under the warranty... . The duty in the claims sphere extends to culpable misrepresentation and non-disclosure. Further than that there is no need to go on the facts of the present case, nor would it be right to do so in view of the remarkable dearth of authority… .[27]

4.26 Again, however, this can no longer be regarded as good law. In *The Star Sea*,[28] the House of Lords reduced the scope of the post-contract duty of good faith and limited the circumstances in which the insurer may avoid the policy from its inception.

[25] See, for example, *Black King Shipping Corporation v Massie (The Litsion Pride)* [1985] 1 Lloyd's Rep 437, *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd and Others (The Star Sea)* [2001] UKHL 1; [2003] 1 A.C. 469, *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563 and *Agapitos and Another v Agnew and Others (No 1) (The Aegeon)* [2002] EWCA Civ 247; [2003] QB 556 .

[26] *Black King Shipping Corporation v Massie (The Litsion Pride)* [1985] 1 Lloyd's Rep 437.

[27] See above, at p 512.

[28] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd and Others (The Star Sea)* [2001] UKHL 1; [2003] 1 A.C. 469.

Reinterpreting the post-contract duty of good faith

4.27 In *The Star Sea*[29] a vessel became a constructive total loss after a fire in the engine room. Attempts had been made to deploy carbon dioxide to extinguish the fire but were unsuccessful because they were not undertaken soon enough and there was a defect which meant that the engine room could not be fully sealed. Two vessels in the same fleet had suffered a similar fate and the policyholder had obtained a report into the circumstances of their loss. The insurers alleged that the policyholder had breached the post-contract duty of good faith by failing to disclose this report, which was relevant to a possible defence that the owners were aware that The Star Sea was unseaworthy.

4.28 The House of Lords limited the operation of good faith in the claims context in two ways. First, it held that the duty of good faith did not continue once legal proceedings had begun. Lord Hobhouse explained that once a writ was issued, the rights of the parties crystallised. Thereafter, the parties' duties were governed by the rules of court procedure, not by the contract. Court rules set out disclosure requirements and appropriate sanctions.

4.29 Secondly, the House of Lords considered that the post-contract duty of good faith had a different content to the pre-contract duty.[30] Lord Clyde talked about the difficulties of making sense of section 17. On the face of it, section 17 appears to require a high degree of openness throughout the contract, with harsh sanctions on the insured if that openness is not maintained. However, this "superficial meaning of section 17 cannot be correct".[31] One possible way out of the difficulty would be to confine section 17 to the pre-contract stage, "but that solution now appears to be past praying for".[32] All the courts could do was to adopt "a flexible construction of the concept of utmost good faith".[33]

4.30 In the claims context, the duty of good faith would only be broken if the claim was made fraudulently.[34] Lord Scott said that the duty of good faith ought to be limited:

> to a duty of honesty. If the duty derives from section 17, none the less this limitation does not, in my opinion involve a judicial re-writing of section 17. On the contrary, it would be the creation out of section 17 of a duty that could be broken notwithstanding that the assured had acted throughout in good faith that would constitute re-writing of the section. Unless the assured has acted in bad faith he cannot, in my opinion, be in breach of a duty of good faith, utmost or otherwise.[35]

[29] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd and Others (The Star Sea)* [2001] UKHL 1; [2003] 1 A.C. 469.

[30] Above, at [57] by Lord Hobhouse.

[31] Above, at [6] by Lord Clyde.

[32] Above, at [6] by Lord Clyde.

[33] Above, at [6] by Lord Clyde.

[34] See above by Lord Hobhouse at [72] and Lord Scott at [111].

[35] See above by Lord Scott at [111].

4.31 As Professor Clarke put it "when a claim is made nothing short of fraud in the presentation of the claim will amount to breach of the duty of disclosure and of good faith".[36]

4.32 However, this leaves a problem. If making a fraudulent claim is a breach of good faith, then the words of section 17 suggest that the remedy for fraud is avoidance. Lord Scott described this conclusion as "debatable", but it was not necessary to decide the point.[37] Lord Hobhouse also struggled to escape this conclusion:

> Where the application of the proposed principle would simply serve the interests of one party and do so in a disproportionate fashion, it is right to question whether the principle has been correctly formulated or is being correctly applied and it is right to question whether the codifying statute from which the right contended for is said to be drawn is being correctly construed.[38]

4.33 He pointed out that many traditional authorities do not use the language of avoidance but refer to forfeiture of "all benefit under the policy" or "all claim" upon it. He thought it right that a fraud should result in forfeiture of the claim. This was not dependent on a contract term but was "a rule of law".[39]

Limiting the right to avoid: *The Mercandian Continent*

4.34 In *The Mercandian Continent,*[40] Lord Justice Longmore reviewed the circumstances in which the duty of good faith has been applied post-contract and considered that insurers are not entitled to avoid a contract of insurance in every case of non-observance of good faith by the policyholder. It was therefore "necessary to find some principle by which it is possible to decide whether, in the event of good faith not being observed by either party, the result is that the contract can be avoided".[41] Longmore LJ concluded that:

> It must have been intended by Parliament that avoidance by reason of post-contract matters should be subject at least to the same requirements as avoidance by reason of matters pre-contract.[42]

4.35 Where insurers sought to avail themselves of the remedy of avoidance they have, therefore, to prove materiality and inducement, albeit with those concepts being adapted to recognise the fact that they are being applied in the post-contract context.

[36] M Clarke, *The Law of Insurance Contracts* (looseleaf) at para 27-2B.

[37] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd and Others (The Star Sea)* [2001] UKHL 1; [2003] 1 A.C. 469 at [110].

[38] See above at [61].

[39] See above at [62].

[40] *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563.

[41] Above, at [23]. Lord Justice Robert Walker and Mr Justice Carnwath agreed.

[42] Above, at [26].

4.36 Materiality, in this context, requires that the conduct of the assured which is relied on by the underwriters must be causally relevant to the underwriters' ultimate liability, or at least, to some defence of the underwriters before it can be permitted to avoid the policy.[43]

4.37 The requirement of inducement was addressed as follows:

> Avoidance ab initio is an even more extreme form of contractual termination than an acceptance of repudiatory conduct and, for the extreme remedy of avoidance to be available, there must, in my view, be at least the same quality of conduct as would justify the insurer in accepting the insured's conduct as a repudiation of the contract. It is only in this way that the requirement of inducement for pre-contract conduct resulting in avoidance can be made to tally with the post-contract conduct said to entitle the insurer to avoid the contract.[44]

4.38 It is unclear how far this requirement limits an insurer's ability to avoid a policy from inception. In *Orakpo v Barclays Insurance Services Co Ltd* it was said that "any fraud in making the claim goes to the root of the contract and entitles the insurer to be discharged".[45] MacGillivray suggests that "the paradigm cases of the baseless claim, the inflated claim and the suppression of a defence" would most probably pass both the materiality and inducement tests set out above.[46]

A "special common law rule" against fraudulent claims

4.39 In *The Aegeon (No 1)*, Lord Justice Mance attempted to make sense of the law on remedies for fraudulent claims following *The Star Sea*. He started by acknowledging that this was not an easy task.

> The waves of insurance litigation over the last 20 years have involved repeated examination of the scope and application of any post-contractual duty of good faith. The opacity of the relevant principles – whether originating in venerable but cryptically reasoned common law cases or enshrined, apparently immutably, in section 17 of the Marine Insurance Act 1906 – is matched only by the stringency of the sanctions assigned.[47]

[43] A*bove,* at [28], adopting Rix J's statement in *Royal Boskalis Westminster NV v Mountain* [1997] LR 523 at p 597 that a post-contractual breach of good faith must be ultimately legally relevant to a defence which the insurer had under the policy terms and the insurers must have been induced to change their position.

[44] *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563 at [26].

[45] *Orakpo v Barclays Insurance Services Co Ltd* [1994] CLC 373, by Hoffmann LJ at p 383.

[46] Ed N Legh-Jones, MacGillivray on Insurance Law (11th ed 2008), para 19-065.

[47] *Agapitos and Another v Agnew and Others (No 1) (The Aegeon)* [2002] EWCA Civ 247; [2003] QB 556 at [1].

4.40 He then acknowledged that the reasoning in *The Star Sea* had been influenced by an attempt to escape the full stringency of the sanction of avoidance. This had introduced some complexity in the law. Lord Justice Mance expressed "the hope that the House of Lords judicially or Parliament legislatively might one day look at the point again".[48]

4.41 In the current state of the law, there are only three approaches to the effect of section 17 on fraudulent claims. The courts may:

(1) accept section 17 at face value, and hold that avoidance is the remedy for a fraudulent claim;

(2) deny that avoidance is always the remedy for breach of the duty of good faith; or

(3) decide that making a fraudulent claim is not a breach of the duty of good faith, as set out in section 17.

4.42 Lord Justice Mance tentatively opted for (3), namely that making a fraudulent claim fell outside the scope of section 17. He commented:

> In the present imperfect state of the law, fettered as it is by section 17, my tentative view of an acceptable solution would be to: ...
>
> (d) to treat the common law rules governing the making of a fraudulent claim (including the use of fraudulent devices) as falling outside the scope of section 17… . On this basis no question of avoidance ab initio would arise.[49]

4.43 At first sight, this seems a surprising conclusion. It is one thing to say that the insured's post-contract duty to act in good faith covers nothing short of fraud. It is another to say that not even fraud is included. Academics and textbook writers have struggled to make sense of it.

4.44 MacGillivray takes the view that that there are "two separate principles of insurance law, each of which can be invoked in defence by the insurer".[50] On this basis, the common law rule referred to by Lord Justice Mance exists side by side with the continuing duty of utmost good faith set out in section 17, and the insurer can choose which to pursue.[51] The advantage of section 17 is that it would permit the insurer to avoid the policy, and therefore recoup money paid out on earlier, valid claims. The advantage of the common law duty is that the policyholder forfeits the whole claim (which is usually all that most insurers require) and the requirement of materiality may be less stringent.

48 See above at [13].

49 See above at [45].

50 Ed N Legh-Jones, MacGillivray on Insurance Law (11th ed 2008), para 19-055.

51 This is evident on a subsequent judgment of Lord Justice Mance in which he refers to the common law principle having a separate origin and existence to any principle which exists under section 17. See *Axa General Insurance Ltd v Gottlieb* [2005] EWCA Civ 112; [2005] 1 All ER (Comm) 445 at [20].

4.45 By contrast, Professor Clarke summarises the current state of the law of fraudulent claims by stating that the fraudulent claim fails entirely and the insurer may terminate the contract. However, as to the past, any outstanding honest claims remain enforceable, and the insurer cannot recover insurance money paid out for in respect of other claims.[52]

4.46 The case *Axa General Insurance Ltd v Gottlieb*,[53] suggests that courts are extremely loath to allow an insurer to recoup payments for other honest claims. However, the effect of section 17 was not specifically argued in that case, so there is still some uncertainty about whether avoidance would ever be granted.

No avoidance: the requirement to pay prior claims

4.47 In *Axa General Insurance Ltd v Gottlieb,* Mr and Mrs Gottlieb claimed under a buildings insurance policy on four occasions during the policy year.[54] The insurer settled two claims in their entirety without any issue of fraud arising. It also made interim payments on the other two claims, before discovering that the policyholders had acted fraudulently in pursuing these claims. The insurer brought proceedings to recover all the payments it had made.

4.48 The Court of Appeal held that the insurer was entitled to recover all sums paid in respect of the two claims in which there was fraud. However, the two claims which had been paid in full had arisen before any fraud had occurred and were not recoverable.

4.49 In *Gottlieb*, Lord Justice Mance again explained that the rule against fraudulent insurance claims was a “special common law rule”, distinct from section 17.[55] It had its own remedies, developed over the years, though in some cases judges have “to set its limits without the benefit” of binding authority.

4.50 The insurer’s primary remedy for a fraudulent claim is forfeiture of the whole claim, including any part of it which may otherwise be good. Lord Justice Mance stated that “the effect of a fraudulent claim is retrospectively to remove or bar the insured’s pre-existing cause of action” for that claim.[56] However, there was “no basis or reason” for giving the rule retrospective effect on prior separate claims which have already been settled under the same policy before any fraud occurred.

4.51 Lord Justice Mance did not reach a conclusion on whether the insurer would be obliged to pay separate claims which were still unpaid at the time of the fraud, although there seemed to be “some force in the argument” that forfeiture should be confined only to the fraudulent claim.[57]

[52] MA Clarke, The Law of Insurance Contracts (4th ed 2002), para 27-2C3, p 902.

[53] [2005] EWCA Civ 112; [2005] 1 All ER (Comm) 445.

[54] See above.

[55] See above at [31]. For commentary on this point, see A Naidoo and D Oughton, “The Confused Post-Formation Duty of Good Faith in Insurance Law: From Refinement to Fragmentation to Elimination” [2005] *Journal of Business Law* 346.

[56] See above at [26].

[57] See above at [22].

The Scots approach

4.52 The Scottish courts have reached the same result through a different route. As discussed in paragraph 2.26 above, *Fargnoli v GA Bonus Plc*[58] concerned the insurer's refusal to compensate the insured for two fires occurring at his business premises on the ground that he had caused, or connived in causing, the second fire. In this case, Lord Penrose held that the duties associated with making a claim were indeed duties of good faith. However, avoidance was not the appropriate remedy for breach of those duties.

4.53 He thought that it was helpful to understand the insurance contract as based on mutual good faith:

> Describing the contract as one of utmost good faith assists one to identify a characteristic of the relationship between the parties which appears to me properly to colour at least the material obligations express and implied which each owes the other.[59]

4.54 The insurer needed protection against the insured's fraud because at the date of making the claim the insured had exclusive control of the information on which the claim was based:

> The insured is, typically, the dominant party in terms of having available relevant information. The risk of fabrication in such circumstances is real.[60]

However, "the insurer had similarly rigorous duties in dealing with claims".[61] He raised the issue of whether an insurer would act in good faith in, for example, delaying admission of liability or advancing spurious defences.

4.55 It followed from the mutual application of the duty that avoidance could not be the remedy for all breaches of good faith, since an insured would rarely have anything to gain from avoidance. Lord Penrose concluded that a claim tainted by fraud should not have "any validity whatsoever".[62] However, fraud on one claim would not affect an earlier claim. Thus the pursuer was entitled to have his first fire claim assessed on its merits. The earlier claim would not be affected by the pursuer's alleged subsequent arson attempt.

4.56 It is regrettable that the *Fargnoli* case was not referred to in *The Star Sea*, *The Aegeon* or *Axa v Gottlieb*. We think that the decision is a helpful way to conceptualise the duties. It is right to recognise that an insurance contract is a contract of mutual good faith. Insurance involves special risks, including the risk that the insured will lie about a claim and the risk that the insurer will delay investigation or reject claims unreasonably. This is the reason why the law should provide special protection against these risks. However, as *The Star Sea* makes clear, avoidance is often not the appropriate remedy.

[58] 1997 SCLR 12; [1997] CLC 653.

[59] See above at p 670.

[60] See above at p 673.

[61] See above at p 670.

[62] See above at p 670.

The effect of fraud on subsequent claims

4.57 As we have seen, the courts have held that a fraudulent claimant is not required to forfeit a prior separate claim. The effect on claims arising after the fraud is less clear. Suppose that an insured householder invents some aspect of a water damage claim, but while the issue is being investigated, the house burns down? Does the policyholder forfeit this subsequent valid claim?

4.58 In theory, there are two possible ways of dealing with the issue:

(1) The fraud is categorised as a breach of contract, which gives the insurer the right to terminate cover. However, the policy continues to exist until termination, and any claims arising between the date of the fraud and the date of the termination must be paid.

(2) The fraud automatically brings the contract to an end, invalidating any claim which arises after the fraud but before the fraud is discovered.

4.59 There is no definitive ruling on the issue. However, the logic of the argument as set out in *The Star Sea*, *Axa General Insurance Ltd v Gottlieb* and *Fargnoli v G A Bonus plc* is clear. Fraud does not automatically bring the contract to an end. Instead it entitles the insurer to repudiate liability. The contract continues to exist until the insurer exercises its right to terminate. In *The Star Sea*, Lord Scott put it as follows:

> The presentation of a dishonest or fraudulent claim constitutes a breach of duty that entitles the insurer to repudiate any liability for the claim and, prospectively at least, to avoid any liability under the policy.[63]

4.60 This was confirmed by Lord Justice Mance in *Axa General Insurance Ltd v Gottlieb*:

> there seems to me some force in the argument that the common law rule relating to fraudulent claims should be confined to the particular claim to which any fraud relates, while the potential scope and operation of more general contractual principles might in some circumstances also require consideration.[64]

[63] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd and Others (The Star Sea)* [2001] UKHL 1; [2003] 1 A.C. 469, Lord Scott at [110].

[64] *Axa General Insurance Ltd v Gottlieb* [2005] EWCA Civ 112; [2005] 1 All ER (Comm) 445 at [22].

4.61 The same position is taken in Scotland. In *Fargnoli v G A Bonus plc*,[65] Lord Penrose held that a fraudulent claim would not void the contract from the start. Instead, it would be a repudiatory breach of contract, entitling the insurer to rescind. He explained that general contract principles apply. In other words, "material breach entitles the innocent party to rescind the contract with the result that both parties are absolved from future performance". However, "rescission does not absolve parties from primary obligations already due for performance at the time of rescission".[66]

4.62 It would appear that after termination, the policyholder is not liable to pay any future premium, but is not entitled to a refund of any premium already paid.

Are damages recoverable?

4.63 Can an insurer sue an insured for damages following a fraudulent claim, for example to cover the cost of investigating the claim? The answer would appear to be no. There is clear authority that damages cannot be recovered for a pre-contract breach of the duty to act in good faith, as the only remedy mentioned in section 17 is avoidance.[67] It would therefore seem that damages are not available for a post-contract breach of the obligation of good faith.

4.64 *London Assurance v Clare* is authority that damages in respect of the cost of investigations into a fraudulent claim are not recoverable on the basis of a breach of an implied term requiring the assured not to advance a fraudulent claim.[68]

4.65 However, it remains open to an insurer to argue that they are entitled to claim damages for deceit following a fraudulent claim.[69] In *Insurance Corporation of the Channel Islands Ltd v McHugh* allegations of deceit were pleaded by the insurers but not really pursued at trial. Mr Justice Mance dismissed the claim on the basis that it had not been argued but acknowledged that it could be arguable in principle.[70]

4.66 In Part 7 we consider whether damages ought to be available.

REFORM IN AUSTRALIA

4.67 Until 1984, Australian insurance law was largely modelled on UK law, with the Australian Marine Insurance Act 1909 reflecting the UK Marine Insurance Act 1906. In 1982, the Australian Law Reform Commission (ALRC) recommended widespread reforms.[71] On the issue of fraudulent claims, the ALRC commented:

[65] [1997] CLC 653, also reported at 1997 SCLR 12.

[66] Above, at p 662.

[67] *La Banque Financiere de la Cite v Westgate* [1988] 2 Lloyd's Rep 513.

[68] *London Assurance v Clare* (1937) 57 Ll. L. Rep. 254 by Goddard J at p 270.

[69] In *London Assurance v Clare* (1937) 57 Ll. L. Rep. 254 at p 270 Goddard J recognised that if damages had been sought for fraud in that case "there might be something to be said". In Scots law an insurer may be able to recover damages for the delict of fraud in the event of a fraudulent claim; see generally, J M Thomson, *Delictual Liability* (3rd ed 2009), para 2.10.

[70] [1997] 1 LRLR 94, at p135.

[71] ALRC, Insurance Contracts, Report No 20 (1982).

> The strict application of the doctrine of utmost good faith might conceivably result in the insurer being entitled to avoid the contract *ab initio*. If so, an insurer might be entitled to deny a prior claim untainted by fraud or to require repayment of moneys paid by it in connection with such a claim. That would not be acceptable. A breach of the duty of utmost good faith in connection with a claim should only affect the claim in question.[72]

4.68 This recommendation was introduced by section 56(1) of the Insurance Contracts Act 1984, which states that if a claim is made fraudulently, "the insurer may not avoid the contract but may refuse payment of the claim". The Act does not define a fraudulent claim.

Discretion for "insignificant" frauds

4.69 More controversially, the ALRC also recommended that the insured who has committed only a minor fraud should be protected against disproportionate harm. Section 56(2) of the 1984 Act states:

> … the court may, if only a minimal or insignificant part of the claim is made fraudulently and non-payment of the remainder of the claim would be harsh and unfair, order the insurer to pay, in relation to the claim, such amount (if any) as is just and equitable in the circumstances.

4.70 Section 56(3) provides that in exercising this discretion the court shall have regard to the need to deter fraudulent conduct in relation to insurance, but may also have regard to any other relevant matter.

4.71 In recommending this approach, the ALRC suggested that it was already current practice: a claim for $3,000 lost baggage would usually be met even if a fraudulent claim for a camera worth $200 was included. However, this was played down in the Explanatory Memorandum accompanying the Act, which referred to fraud of $50 in a claim of $100,000. Professor Merkin suggests that in England this might not be treated as fraud at all.[73]

4.72 The courts have confined the operation of section 56(2) to cases in which there is a claim for a separate divisible loss. It has been held that a false statement about how the loss happened cannot be described as relating only to "a minimal or insignificant part of the claim".[74] Assuming there is a severable loss, how much is regarded as "insignificant"? In *Entwells Pty Ltd v National and General Insurance Co Ltd* it was held that the exaggeration of a claim of between A$222,589 and A$528,000 by A$27,000 was not large enough to taint the entirety of the claim.[75]

[72] Above, para 243.

[73] See R Merkin, *Reforming Insurance Contract 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* (2007), at para 6.10 (available at http://www.lawcom.gov.uk/insurance_contract.htm).

[74] *Gugliotti v Commercial Union Assurance Co of Australia* (1992) 7 ANZ Ins Cas 61-104; *Tiep Thi To v AAMI Ltd* (2001) 161 FLR 61.

[75] (1991) 6 WAR 68.

4.73 Professor Merkin notes that the *Entwells* decision has not been welcomed. He comments that the discretion conferred upon the courts by section 56(2) is likely to give the wrong message.[76] We agree. We are concerned that it might be seen to encourage policyholders to commit minor frauds in the expectation that such conduct would not affect the legitimate element of the claim.

Cancellation for the future

4.74 Where the insured has made a fraudulent claim, the 1984 Act provides that the insurer may cancel both the contract and any other policy in operation at the same time.[77] The logic is that insurers cannot be expected to continue a contractual relationship with a fraudulent policyholder.

4.75 The Act does not expressly address the effect of a fraudulent claim on later claims. However, since cancellation of the policy is only possible by giving 14 days' notice in accordance with the procedure set out in section 59, it appears that all losses which occur up to the date of cancellation are payable.

CONCLUSION

4.76 UK law on remedies for fraudulent claims is unduly convoluted. The problem stems from the way in which Parliament partly codified the law in 1906. This has unduly constrained the development of case law. As Professor Thomas comments:

> The traditional elasticity of the common law, with its ability to attribute just solutions to individual disputes, has been constrained by the manner in which the principle of good faith has been codified by the Marine Insurance Act 1906, section 17…. There can be little doubt that, had the remedy for breach of good faith been codified more flexibly, the contours of contemporary law relating to fraudulent claims would be very different and much clearer.[78]

4.77 James Davey agrees. He criticises the "one-off" codification of marine insurance law undertaken in 1906: "rules that were not yet fully developed were frozen *in utero*".[79]

4.78 We think that the courts have generally reached the right decisions on the facts before them, but at the cost of conceptual coherence. As Lord Justice Aikens put it in a talk to the British Insurance Law Association:

[76] R Merkin, *Reforming Insurance Contract Law: Is There A Case for Reverse Transportation?* (2007), at para 6.11.

[77] See s 60(1)(e).

[78] D Rhidian Thomas, "Fraudulent insurance claims: definition, consequences and limitations" (2009) *Lloyd's Maritime and Commercial Law Quarterly* 485 at 515.

[79] James Davey, "Unpicking the fraudulent claims jurisdiction in insurance contract law: sympathy for the devil?" (2006) *Lloyd's Maritime and Commercial Law Quarterly* 223. See also J.P Lowry, "Redrawing the parameters of good faith in insurance contracts" In: C O'Cinneide and J Holder, *Current Legal Problems 2007: Volume 60* pp 338-407.

> If the law stays as it is, the relationship between the common law rules relating to fraudulent claims and devices and the duty under section 17 and the consequences of breach will remain opaque and, in my view, logically irreconcilable.[80]

Although he did not believe in "reform for the sake of tidiness", he conceded "with great reluctance" that the Law Commission should consider these issues.

4.79 We fear that the complexity of the law has generated unnecessary disputes and litigation. We think that the law would also fulfil its role as a deterrent more successfully if it were clearer. As Mr Justice Jackson put it in *Direct Line Insurance v Khan*:

> It is particularly important at the present time that this rule of law is understood by everyone who may have insurance claims. If policyholders suffer misfortune and have valid claims, they should make those claims in an honest fashion. If policyholders seek to top up their honest claims by adding bogus claims, they are at peril of losing everything.[81]

4.80 The complexity also makes it difficult to explain or justify UK law to an international business community, or to resist calls to harmonise the law along civil law lines. The European Commission has called for consideration to be given to developing common rules on insurance contract law.[82] A working party has drafted Principles of European Insurance Contract Law and submitted them to the European Commission as a Draft Common Frame of Reference.[83] The intention is that they should form the model for an optional instrument, which the parties could choose to use to govern their contracts. These Principles frame the issue of fraudulent claims in a different way, as part of a duty to co-operate.[84] If the UK wishes to retain its influence in insurance contract law, it must seek to develop its law in a coherent, principled and fair way.

[80] Lord Justice Aikens, "The post-contract duty of good faith in insurance contracts: is there a problem that needs a solution?", speech to BILA 8 February 2010.

[81] QBD, 19 December 2000 (Unreported); 2000 WL 33148765 (Westlaw).

[82] See the Stockholm Programme, 10 June 2009 (COM (2009) 262 Final) para 3.4.2.

[83] Principles of European Insurance Contract Law, ed J Basedow and others, Sellier European Law Publishers, Munich, October 2009.

[84] Art 6:102 requires the insured to respond to the insurer's reasonable requests for information about the insured event and for documentary and other evidence. If this is breached "with intent to cause prejudice or recklessly and with knowledge that such prejudice would probably result" then the insurer is not obliged to pay the insurance money.

Article 9:101 covers deliberate loss: the insured is not entitled to an indemnity "to the extent that the loss was caused by an act or omission on his part with intent to cause the loss or recklessly and with knowledge that the loss would probably result".

4.81 For these reasons, we think it would be helpful to reform section 17. We think it is right that the parties should have mutual duties of good faith during the currency of an insurance contract. However, we see this as a duty of good faith (to act honestly and without fraud) rather than of "utmost" good faith. We do not think it is right that avoidance should be the only remedy. Instead, the legislation should specify appropriate remedies for specific circumstances.

4.82 Our tentative conclusion is that the main remedy for a fraudulent claim should be forfeiture of the claim. This is well established and accepted. It is also the reform introduced by section 56(1) of the Australian Insurance Contracts Act 1984.

4.83 In Part 7 we discuss the issue in more depth, considering (for example) the effect of a fraud on future claims and whether it is appropriate to provide damages.

PART 5
CO-INSUREDS AND GROUP INSURANCE

5.1 In this Part, we look first at the position of co-insureds and then at fraud by beneficiaries under group insurance.

CO-INSUREDS: THE EFFECT OF ONE PERSON'S FRAUD ON THE OTHER

5.2 Here we consider the situation where two or more policyholders are insured under the same policy. How far should fraud or deliberate destructive acts by one policyholder affect the claims of the other policyholder?

5.3 Where two or more people take out insurance jointly to protect their joint property,[1] the law will treat them as acting together. Thus a fraud by one party will lead to forfeiture of the other party's claim. This seems legitimate where the parties are still acting jointly at the time of the fraud, but can be extremely harsh where the parties have become estranged.

5.4 A scenario that has arisen in several common law jurisdictions is where a husband and wife go through an acrimonious separation: one spouse acts violently against the other by, for example, burning down the matrimonial home. Should the victim forfeit his or her insurance claim? The courts have attempted to do justice to the innocent victim, but at some cost to the logic of the law.

5.5 Here we start by setting out the position under the present law. We then look briefly at how other common law jurisdictions have addressed the issue before considering whether there is a need for reform.

Current law

Summary

5.6 The courts start by asking whether the fraudster made the claim on behalf of the others. If so, the law is clear: any fraud by an agent is attributed to the principal. Thus "innocent" policyholders will suffer the consequences of their agent's fraud, even if they are unaware of it.

5.7 If the fraudster did not act as agent for the innocent policyholder, the next question is whether the insurance policy was "joint" or "composite". In a joint policy, all policyholders stand or fall together. However, many policies are "composite". Here each policyholder's right is regarded as independent and is not affected by the fraud.

Fraud by an agent

5.8 It is a basic rule of agency law that where one person acts as agent for another, any fraud by the agent affects the principal.

[1] The equivalent term in Scots law is common property; joint property refers only to property held by, for example, trustees or unincorporated associations. See K G C Reid, *The Law of Property in Scotland* (1996), para 536.

5.9 In an insurance context, this is illustrated by *The Litsion Pride*.[2] The claimant was the mortgagee of the vessel and the assignee of the policy, and innocent of any fraud committed by the policyholder's brokers. Mr Justice Hirst held that the brokers represented the insured owners when presenting a claim so any fraud by the brokers was attributable to the policyholders, and therefore affected the assignees.

5.10 The Court of Appeal followed this approach in *Direct Line Insurance Plc v Khan*.[3] In that case it was held that a husband had put forward a fraudulent claim as an agent for his wife as well as himself. As a result, the innocent wife was "bound by the consequences of [the husband's] fraudulent actions" and her claim against the insurer was forfeited along with his.[4]

Distinguishing between joint and composite insurance

5.11 Whether an insurance policy is joint or composite depends on the correct construction of the policy. The distinction depends mainly upon whether the co-insureds are to be treated as having a single interest or separate interests in the property insured.[5] Thus:

(1) If both parties own the property jointly, it is likely that the policy will be construed as creating joint obligations.

(2) Where co-insureds have different interests or rights to the property, it is likely that the policy will be construed as composite.

5.12 Take the example of household contents insurance. If a husband and wife insure their joint possessions, this is likely to be construed as joint insurance. However, if two flat sharers each own different household possessions, a single policy taken out on both sets of possessions is considered to be composite.

2 *Black King Shipping Corporation and Wayang (Panama) SA v Mark Ranald Massie ("The Litsion Pride")* [1985] 1 Lloyd's Rep 437. *The Litsion Pride* was overruled by *The Star Sea* [2001] UKHL 1; [2003] 1 AC 469 on other grounds.

3 [2001] EWCA Civ 1794; [2002] Lloyd's Rep IR 364.

4 Above, by Lady Justice Arden at [31]. See also P MacDonald Eggers, S Picken and P Foss, *Good Faith and Insurance Contracts* (2nd ed 2004) at pp 273 to 274.

5 The classic exposition of the difference was given by Sir Wilfred Greene MR in *General Accident Fire & Life Assurance Corp Ltd v Midland Bank Ltd* [1940] 2 KB 388, at p 405:

> If A and B are joint owners of property… an undertaking to indemnify them jointly is a true contract of indemnity in respect of a joint loss which they have jointly suffered. Again, there can be no objection to combining in one insurance a number of persons having different interests in the subject-matter of the insurance, but I find myself unable to see how an insurance of that character can be called a joint insurance.

5.13 The nature of the subject-matter does not necessarily overwhelm the clear words of the policy. It is theoretically possible for co-insureds with a joint insurable interest to obtain composite cover,[6] or vice versa. However, we have not found any cases in which the wording is sufficiently plain and unambiguous to make insurance on different interests joint.

5.14 The courts have found the following instances of co-insurance to be composite by their nature: mortgagor and mortgagee,[7] landlord and tenant,[8] contractor and sub-contractor under a construction risk policy,[9] companies in the same group,[10] and a company and its directors.[11]

5.15 It is also common for a building site to be insured under a single policy to cover all the contractors and subcontractors. It is said that each co-insured insures a "pervasive interest" in the whole. In *Petrofina (UK) Ltd v Maghanload*,[12] Mr Justice Lloyd explained why such "pervasive" insurance was important:

> In the case of a building contract, where numerous different sub-contractors may be engaged, there can be no doubt about the convenience from everybody's point of view, including, I would think, the insurers, of allowing the head contractor to take out a single policy covering the whole risk, that is to say covering all contractors in respect of loss or of damage to the entire contract works. Otherwise each contractor would be compelled to take out his own separate policy. This would mean, at the very least, extra paperwork; at worst it could lead to overlapping claims and cross-claims in the event of an accident.[13]

This sort of insurance has also been categorised as composite.[14]

[6] It seems implicit in the decision of the Court of Appeal in *Direct Line Insurance Plc v Khan* [2001] EWCA Civ 1794; [2002] Lloyd's Rep IR 364 that joint tenants could insure compositely if they wanted to. This would also be consistent with the general law of joint obligations.

[7] *P Samuel & Co Ltd v Dumas* [1924] AC 431 and *Woolcott v Sun Alliance* [1978] 1 Lloyd's Rep 629.

[8] *General Accident Fire and Life Assurance Corporation v Midland Bank Ltd* [1940] 2 KB 388.

[9] *State of the Netherlands v Youell and Hayward* [1997] 2 Lloyd's Rep 440.

[10] *New Hampshire Ins Co v MGN Ltd* [1997] LRLR 24.

[11] *Arab Bank Plc v Zurich Insurance Co* [1999] 1 Lloyd's Rep 262.

[12] [1984] QB 127.

[13] Above, at p 136. For more detail on pervasive interests, see *State of Netherlands v Youell and Hayward* [1997] 2 Lloyd's Rep 440; [1997] CLC 938 and M A Clarke, *The Law of Insurance Contracts* (4th ed 2002) at 27-2C6.

[14] *State of the Netherlands v Youell and Hayward* [1997] 2 Lloyd's Rep 440, by Rix J at p 450.

The effect of fraud in composite insurance

5.16 Under a composite policy, the obligations are said to be "several"; that is, treated separately. Thus one co-insured will not be affected by another co-insured's fraud. As Lord Sumner put it, when dealing with a case of wilful misconduct in *P Samuel & Co Ltd v Dumas*:

> … 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?[15]

5.17 Lord Justice Staughton relied on this passage when commenting that where "there are separate interests one insured is not affected by misconduct of another" in *New Hampshire v MGN*.[16] In *Arab Bank Plc v Zurich Insurance Co,* Mr Justice Rix explained 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 under a composite policy.[17]

The effect of fraud in joint insurance

5.18 For joint policies, the courts have in the past taken the firm approach that, because there is a single insurance contract, a fraudulent claim by one of the insureds will be attributable to the innocent insured(s) as well.[18] As Viscount Cave said in *P Samuel & Co Ltd v Dumas*, when "two persons are jointly insured… the misconduct of one is sufficient to contaminate the whole insurance".[19]

5.19 Professor Clarke argues that this approach to joint insurance produces "in some cases an injustice bordering on the absurd, particularly if the effect is a bar to recovery by an innocent insured, when the arson appears to have been an act of retribution against the innocent insured".[20] He points out that several other common law countries view this as the "old approach" and have developed a "modern approach" instead.[21] Below we give a brief summary of how the issue has been dealt with in other jurisdictions, before considering how far the UK courts might be prepared to follow a similar approach.

5.20 We concentrate on common law jurisdictions. The Principles of European Insurance Contract Law suggest that the approach in other European jurisdictions may be similar. Article 11.103 states that:

[15] *P Samuel & Co Ltd v Dumas* [1924] AC 431, by Lord Sumner at p 469.

[16] *New Hampshire Ins Co v MGN Ltd* [1997] LRLR 24 at p 57.

[17] *Arab Bank Plc v Zurich Insurance Co* [1999] 1 Lloyd's Rep 262, at p 277.

[18] See M Clarke, *The Law of Insurance Contracts* (4th ed 2002) at para 27-2C6.

[19] [1924] AC 431, at p 445.

[20] M Clarke, *The Law of Insurance Contracts* (4th ed 2002) at para 27-2C6.

[21] Above.

> Breach of duty by one insured shall not adversely affect the rights of other persons insured under the same insurance contract, unless the risk is jointly insured.

However, we have not been able to gain information about how this would be applied in practice.

The approach in other common law jurisdictions

The United States

5.21 In the US, the courts in several jurisdictions have ceased to follow the old rule and have taken what has become known as the "modern approach".

5.22 Cases applying the "old rule" focused on how the property was owned. Where property ownership was regarded as joint, the insurance contract was presumed to be joint as well. *Klemens v Badger Mutual Insurance Co of Milwaukee* is a typical example.[22] It involved a married couple whose home was intentionally set ablaze by the husband. The Supreme Court of Wisconsin held that since the insurance policy was written in the names of the husband and wife, they had a joint obligation to comply with the terms of the policy (that is, to save and preserve the property). Accordingly, the husband's failure to comply with the obligation prevented the innocent wife from claiming under the insurance policy.[23]

5.23 During the late twentieth century, however, there was a growing recognition that this produced harsh and inequitable results. As a result, many courts adopted a "modern approach". In *Hedtcke v Sentry Insurance Co*,[24] for example, the Supreme Court of Wisconsin expressly overruled the "old rule" on the grounds that it "punishes the innocent victim", contrary to "basic notions of fair play and justice":

> An absolute bar to recovery by an innocent insured is particularly harsh in a case in which the arson appears to be retribution against the innocent insured. Having lost the property, the innocent insured is victimised once again by the denial of the proceeds forthcoming under the fire insurance policy.[25]

5.24 The court held that, in the absence of a clear intention that the obligations created were joint, the policy would be construed as creating several obligations. An innocent insured would not therefore be barred from recovery by virtue of another insured's intentional damage to the insured property.

[22] (1959) 8 Wis 2d 565, 99 NW 2d 865.

[23] Above. The court followed the earlier case of *Bellman v Home Insurance Co* (1922) 178 Wis 349, 189 NW 1028.

[24] *Hedtcke v Sentry Insurance Co* (1982) 109 Wis 2d 461, 326 NW 2d 727 (Wis).

[25] Above, at p 740.

5.25 The Supreme Court of Wisconsin acknowledged the public policy concern to prevent wrongdoers from benefiting from their wrongdoing. Thus it was important "to guard against the possibility that the arsonist might receive financial benefit as a result of the arson".[26] This could be done by denying recovery to the arsonist, while allowing the innocent insured to recover a pro rata share of the insurance proceeds, according to his or her interest in the property.

Other countries

5.26 The "modern approach" has now been followed in cases in Canada,[27] Australia[28] and New Zealand.[29]

5.27 For example, in the Canadian case, *Higgins v Orion Insurance Co Ltd*, the Ontario Court of Appeal firmly rejected the "old rule" in cases of this kind:

> To deny recovery to an innocent partner because of the guilt of a co-partner is in reality to impute that guilt to the innocent party and to punish him vicariously for the crime of the co-partner. Such a result is repugnant to a sense of fair play and to our fundamental notions of justice.[30]

5.28 The court held that the starting position is that the policy is composite. The parties must therefore use plain unambiguous language if they intend it to be joint. However, the court recognised that "there remains a public policy concern that a wrongdoer should not be allowed to benefit from his own wrongdoing" and suggested that:

> A court must take care to prevent the guilty from reaping a financial reward from the arson. For that reason it should ascertain in each case whether the arsonist will benefit by the recovery and fashion its judgment to guard against such a result.[31]

[26] Above at p 740.

[27] *Higgins v Orion Insurance Co Ltd* (1985) 17 DLR (4th) 90.

[28] *Holmes v GRE Insurance Ltd* (1989) 5 ANZ Insurance Cases 60 – 894.

[29] *Maulder v National Insurance Company of New Zealand Ltd* [1993] 2 NZLR 351.

[30] *Higgins v Orion Insurance Co Ltd* (1985) 17 DLR (4th) 90, per Robins JA, delivering the judgment of the court, at pp 110 to 111. The passage refers to *Hedtcke v Sentry Insurance Co* (1982) 109 Wis 2d 461, 326 NW 2d 727 (Wis).

[31] *Higgins v Orion Insurance Co Ltd* (1985) 17 DLR (4th) 90, by Robins JA, delivering the judgment of the court, at p 111.

5.29 In the Australian case of *Holmes v GRE,*[32] Mr and Mrs Holmes ran a general store with a residence above it. Mr Holmes set fire to the premises, but Mrs Holmes was permitted to recover on the basis that the policy was a composite policy. The Supreme Court of Tasmania commented that "such a construction accords with the social reality of the situation and with the modern approach to construction of insurance contracts of this kind".[33] The court emphasised that Mrs Holmes had not known of her husband's intention to burn down the premises, and had not even been aware of his whereabouts at the time of the fire.

5.30 The New Zealand case of *Maulder v National Insurance* came to a similar conclusion.[34] Mr Maulder set fire to the matrimonial home deliberately. The ensuing fire destroyed the property and killed him. Mrs Maulder claimed on the couple's insurance policy but the insurers declined her claim on the basis that her co-insured had deliberately brought about the loss.

5.31 Eichelbaum CJ considered many of the relevant cases in the US, Canada, and Australia. Of the US jurisprudence, he said:

> I do not espouse the concept developed in the United States Courts that a policy should be interpreted according to the insured's reasonable perception of it.[35]

5.32 Despite this, however, he favoured the "modern approach" that the contract should be construed as composite rather than joint. Mrs Maulder was therefore entitled to recover her half-share in the destroyed property.[36] The judge pointed out that social realities had developed since the old rule was applied:

> Relationships alter rapidly; by the time of the loss the parties may have separated. The manner in which legal title is held masks the rights arising on separation. Insurers must be taken to know that the ostensible categorisation of property as joint is meaningless… . Against this background, an insurer seeking to impose joint obligations on the insured must use clear language.[37]

5.33 He went on to observe that the problem was a common one:

[32] *Holmes v GRE Insurance Ltd* [1988] TASSc 14; (1988) Tas R 147.

[33] Above, at [11].

[34] *Maulder v National Insurance Company of New Zealand Ltd* [1993] 2 NZLR 351.

[35] Above, at p 358.

[36] Mrs Maulder in fact argued that she had been beneficially entitled to the entire property, because her husband had regarded the house and contents as hers. By disregarding the nature of the insured's interest in the property when determining a policy's meaning and effect, the court held that the extent of her beneficial entitlement had no relevance to the interpretation of her insurance contract. Thus the court limited Mrs Maulder's recovery to half of the property's value. No trust in respect of her husband's share could be inferred or imposed in her favour.

[37] Above, at p 359.

> That the possibility of one spouse or partner deliberately destroying insured property is not fanciful is demonstrated by the stream of cases which have reached the law reports overseas. Insurance which does not cover the innocent spouse against that eventuality has a significant gap.[38]

5.34 It would therefore seem that courts in the United States, Canada, Australia and New Zealand are prepared to follow the "modern approach". Thus insurance on a family home is construed as a composite policy in the absence of unmistakable contractual words to say that it is a joint policy. We do not know how many policies now include clear joint policy provisions.

How far would courts in the UK follow the "modern approach"?

5.35 It is not yet clear to what extent the courts in England and Scotland will follow this "modern" common law jurisprudence. The question almost arose in *Direct Line Insurance Plc v Khan*,[39] where Mrs Khan claimed for property damage even though Mr Khan had made a fraudulent claim under a joint insurance policy. The Court of Appeal found that Mr Khan acted as Mrs Khan's agent when he made the fraudulent claim and, consequently, his fraudulent behaviour was attributed to her. The court did not have to address whether Mrs Khan would be entitled to her share if she had made a separate claim, but the insurer had denied her recovery on the ground that she was a joint policyholder.

5.36 Lady Justice Arden explained that "the court was prepared to assume, without of course deciding it, that the policy was a separate policy in respect of Mrs Khan's interest".[40] Similarly, the Vice-Chancellor said:

> If one strips away the complication of whether the policy is joint or composite and assumes that the wife was the only policyholder and that the property insured was vested in her alone, one is left with the case of a fraudulent claim by an agent… . Vis-à-vis the insurer, the claim is the act of the insured and, being fraudulently made, entitles the insurer to repudiate any liability to the insured.[41]

5.37 However, the joint insurance issue had apparently been mentioned, albeit briefly, by Lord Justice Mance at an earlier hearing when he granted Mrs Khan leave to appeal. In Lady Justice Arden's judgment in that subsequent appeal, she referred to Lord Justice Mance's earlier views:

> [Lord Justice Mance] said that it was arguable that the policy was a several one rather than a joint one with the result that it covered their separate interests with no joint element. In that situation Mrs Khan would not be disabled from recovering under the policy in respect of her own loss merely because Mr Khan has put forward a fraudulent claim in respect of his own loss.

[38] *Maulder v National Insurance Company of New Zealand Ltd* [1993] 2 NZLR 351, at p 359.

[39] *Direct Line Insurance Plc v Khan* [2001] EWCA Civ 1794; [2002] Lloyd's Rep IR 364.

[40] Above, at [14].

[41] Above, at [45].

> [Lord Justice Mance] also noted that it was arguable that even if the policy was a joint one, the law might be developed in such a way that the position of the non-fraudulent policyholder was not affected.[42]

5.38 It therefore remains open for a court to adopt the "modern approach" regarding the effect of a fraudulent claim on an innocent co-insured, even with respect to joint insurance.

The Davitt case

5.39 The English and Scottish courts have not yet been faced with a case in which a husband and wife took out joint insurance on their joint property, but one then committed an act against the interests of the other, such as burning down the matrimonial home.

5.40 However, *Davitt v Titcumb*[43] raises some of the same issues. A and B purchased a house as tenants in common and effected life insurance to cover their mortgage in the event of either dying. In time, this insurance was assigned to the mortgage lender. When B murdered A, the lender claimed on the policy of insurance.

5.41 In theory, it might have been open to the insurer not to pay the lender in these circumstances. If the insurer had been able to establish that the insurance was a joint policy on A and B's joint lives, to cover a joint debt, then under the traditional approach, A's claim would be forfeited as a result of B's wrongful act. The lender's rights, as assignee, would be no greater than the rights of either A or B.

5.42 The insurers did not, however, attempt to run such an unattractive argument. Instead, the insurers paid the lender, who applied the funds received to the outstanding mortgage. The case concerned whether B could share in any proceeds following the sale of the property. Mr Justice Scott held that since B was unable to claim on the insurance by virtue of his wrongdoing, the mortgagee was entitled to claim on the insurance only in its capacity as an assignee of A's contract of insurance. A's estate had, therefore, paid the jointly owed mortgage and was entitled to a contribution from B. A's estate was entitled to take B's proceeds of the sale as such a contribution.

5.43 Professor Clarke notes this case as an example of the courts' concerns about "cross-infection": in other words, the courts will strive to prevent any recovery by the innocent policyholder from benefiting the guilty one.[44]

5.44 Where the guilty co-insured would benefit from an innocent co-insured's claim then that claim may be barred. In *State of Netherlands v Youell and Hayward*, Mr Justice Rix commented that even under a composite policy, an innocent policyholder should be prevented from claiming if the effect would be to benefit a guilty one:

[42] Above, at [8] and [9].

[43] [1990] Ch 110.

[44] M Clarke, *The Law of Insurance Contracts* (looseleaf), p 27-35 at para 27-2C6.

> … a claim upon a pervasive interest by an entirely innocent assured may well be affected by defences available to insurers by reason of the wilful misconduct of a co-assured… . The innocent party cannot recover for the guilty where the guilty could not recover directly for himself.[45]

Conclusion

5.45 Courts in other common law jurisdictions are rightly sympathetic to an innocent co-insured who has suffered from the wrongful act of a co-insured. It seems arbitrary and wrong that a spouse or cohabitant who has suffered an arson attack by a former partner should also forfeit his or her insurance claim. We can understand why the courts in several different common law jurisdictions have applied the "modern approach" to such difficult cases.

5.46 As a matter of law, however, whether a policy is joint or composite depends on the construction of the policy. It must therefore be judged in the light of circumstances at the time the contract is formed. It cannot be influenced by later events. The "modern approach" works backwards. The courts decide what result they wish to reach in the circumstances, and they then characterise the policy as joint or composite accordingly. We do not think this is entirely satisfactory.

5.47 If a husband and wife, or other partners, take out joint insurance and one party lies on the application form, then the insurer's remedy against the dishonest party applies against the other. In our consultation paper we said that in the context of pre-contract information, this was 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.[46]

We did not propose reform.

5.48 The problem is that two people may act together in taking out insurance, but may act separately at the time of the deliberate destructive act or fraudulent claim. If, for example, a wife asks her husband to take out insurance on their home we think it is fair to hold her responsible for the husband's lie on the application form. It would be unfair, however, to hold her responsible for her husband's arson or wilful fire-raising several months later, especially where this constituted an attempt on her life.

[45] *State of the Netherlands v Youell and Hayward* [1997] 2 Lloyd's Rep 440, by Rix J at pp 450 to 451.

[46] Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134 at para 6.51.

5.49 We tentatively conclude that the matter should be subject to statutory reform. In Part 7 we argue that in joint insurance, where two or more people act together to insure their joint interests, there should be a presumption that any fraud committed by one party is done on behalf of all the parties. The starting point is that all the policyholders forfeit their claims. However, it should be open to an innocent party to rebut this presumption. If a policyholder can produce evidence that the fraud or wrongful act was not carried out on their behalf, or with their knowledge then the innocent party's claim is not forfeited and should be paid. However, we endorse the statement in *Higgins v Orion Insurance Co Ltd*, that the court must take care to prevent the guilty party form reaping a financial reward from their misconduct.[47]

5.50 In Part 7 we ask consultees whether they agree that there is a need for statutory reform to protect a joint insured who can prove that any fraud or wrongful act was not carried out on their behalf or with their knowledge.

GROUP INSURANCE

5.51 As we explained in our 2007 consultation paper, group insurance is an important sector of the market, especially for long-term insurance.[48] Despite the prevalence of group insurance, the law applying to such schemes is under-developed.

5.52 Under a group scheme, the insured (typically an employer) takes out a policy for the benefit of the members of the group scheme (typically employees). However, the individual members are not party to the policy of insurance. The payments are usually discretionary, and the members do not have any enforceable right to them.

5.53 As the members are not policyholders, the legal obligations applying to policyholders under insurance contracts do not apply to them. Thus the members do not have a duty of disclosure. Similarly, members are not caught by post-contract duties of good faith.

5.54 Clearly, if the insured makes a fraudulent claim, then the normal rules apply. However, fraud by group members is more problematic. We have considered the remedies available to an insurer if a group member adds fraudulent elements of loss to an otherwise valid claim. Does the insurer have to pay the valid elements of the claim, or does the common law rule of forfeiture apply? Our initial conclusion is that the common law rule requiring claims to be forfeited only applies to policyholders. It would not apply to group members. Clearly, if payments were discretionary, the insurer could exercise any discretion it may have not to pay. But insurers do not have any clear legal protection in such circumstances.

[47] (1985) 17 DLR (4th) 90. See para 5.28 above.

[48] For a discussion of how group insurance works, see Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134 at paras 6.3 to 6.41.

5.55 In our draft Bill on misrepresentation in consumer insurance,[49] we made special provisions for misrepresentation by group members. Essentially, a misrepresentation made by a group member is treated as if the group member were a party to the contract. In Part 7 we ask whether similar provisions might be needed in this context.

[49] See Draft Consumer Insurance (Disclosure and Representations) Bill, Appendix A of Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (2009) Law Com No 319; Scot Law Com No 219.

PART 6
OTHER ASPECTS

INTRODUCTION

6.1 In this Part, we consider whether there are any aspects of the insured's post-contract duty of good faith, other than those which relate to fraudulent claims.

6.2 This is a difficult issue. We know from *The Star Sea* that any post-contract duties of good faith are limited. There is no general duty on the insured to disclose facts occurring after the risk is accepted.[1] Furthermore, the parties' duties cease once litigation commences, at least with regard to a duty to disclose information. However, it is not necessarily clear what actions are covered by the duty of good faith. Lord Clyde stressed that the duty was "not an absolute" and varies according to context.[2] Lord Hobhouse commented that compared with pre-contract obligations, the criterion "becomes more elusive".[3]

6.3 In this Part we consider possible obligations on the insured which give rise to a duty of good faith. We then ask about how the duty of good faith should be enshrined in legislation. Should the duty be confined to specific instances, such as the duty not to make a fraudulent claim, or should it continue to have some general but unspecified effect?

SIX POSSIBLE CATEGORIES

6.4 In *The Mercandian Continent*,[4] Lord Justice Longmore outlined six scenarios in which case law suggested that a post-contract duty of good faith may apply:[5]

(1) Where the insured makes a claim under the policy.

(2) Where the insured or the insurer seeks variation to the contractual risk.

(3) At the time when an insured seeks renewal of the policy. However, Lord Justice Longmore pointed out that if the breach takes place during the currency of the earlier contract, it is never suggested that the earlier contract is avoided as well as the renewal.[6]

(4) Where the insured seeks to invoke a "held covered" clause.

[1] This is supported by a long line of authority: see *Kausar v Eagle Star Insurance Co Ltd* [2000] Lloyd's Rep 154; *Pim v Reid* (1843) 6 M & G 1; *Baxendale v Harvey* (1859) H & N 449; *Lishman v Northern Maritime Ins Co* (1874-75) LR 10 CP 179; and *Niger Co Ltd v Guardian Assurance Co Ltd* (1922) 13 Ll L Rep 75 in which Lord Sumner said that the continuing duty of disclosure "would turn what is an indispensable shield for the Underwriter into an engine of oppression against the assured".

[2] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1; [2003] 1 AC 469, at [7].

[3] Above at [54].

[4] *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563.

[5] Above, at pp 571-2.

[6] Above at p 571.

(5) When the insured is bound to provide information to the insurer by virtue of an express or implied contract term.

(6) Under liability policies where liability insurers take over the defence of a claim. However, here the duty is mainly on the insurer. The insurer is obliged to conduct the defence in good faith, rather than run up excessive costs so as to exceed the policy limit to the detriment of the insured.[7]

6.5 Out of these six possible categories, three are not relevant to the current discussion. We have already addressed (1), good faith in the context of a claim. As for (3), a renewal is considered to be a new contract, which means that any duty which arises before a renewal is a pre-contract duty. Finally (6) principally concerns the insurer's duty of good faith.

6.6 This leaves two categories which we see as analogous to pre-contract disclosure: (2) variations and (4) held-covered clauses. We address these briefly below.

6.7 The most difficult issue on the list is (5) – contractual provisions for the insured to provide the insurer with information. We discuss this in more detail.

VARIATION

6.8 When an insured seeks to vary the contract, a duty of good faith arises. However, as stated in *Lishman v Northern Maritime*[8] and affirmed by Longmore LJ in *The Mercandian Continent*, the variation is similar to a new contract. This means that the duty of good faith should be analogous to the duty which arises pre-contract.

6.9 We discussed variations in consumer contracts in our 2009 report, Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation.[9] We noted that there were very few cases concerning variations, either before the courts or the Financial Ombudsman Service. However, the courts seem to have settled on the view that if the policyholder made a misrepresentation in relation to a variation, only the variation, rather than the entire policy, may be treated as if it does not exist.[10]

[7] See *Cox v Bankside* [1995] 2 Lloyd's Rep 437 at p 462.

[8] (1875) LR 10 CP 179.

[9] See Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (2009) Law Com No 319; Scot Law Com No 219.

[10] See Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (2009) Law Com No 319; Scot Law Com No 219. This view was taken by Leggatt LJ in *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [1997] 1 Lloyd's Rep 360 and by Longmore LJ in *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563 and *Limit No 2 Ltd v Axa Versicherung AG* [2008] EWCA Civ 1231, [2008] 2 CLC 673.

6.10 In our report, Pre-Contract Disclosure and Misrepresentation in Consumer Insurance, we recommended that where a qualifying misrepresentation is made in relation to a variation, the remedy should depend on whether the variation can reasonably be treated separately from the insurance policy as a whole. Where the variation can be separated, we recommended that the remedy should only apply to the subject-matter of the variation. However, in cases where the variation went to the heart of the policy, such that it could not be separated, we recommended that the remedy should apply to the whole policy.[11]

6.11 Our view is that any proposals to reform the duties when varying a contract should be dealt with in the context of reforming pre-contract duties of disclosure. We do not discuss this further in this paper.

HELD-COVERED CLAUSES

6.12 Held-covered clauses are used in marine insurance to continue cover, despite a breach of warranty by the insured, provided that certain requirements are met. Such clauses are usually drafted subject to two conditions: that immediate notice be given to the insurer and that any variation in conditions or additional premium be agreed. As was held in *Overseas Commodities Ltd v Style*,[12] the insured is required to observe the duty of good faith in giving notice.

6.13 Several decisions, however, support the view that the additional cover provided under held-covered clauses is a variation in the contract that creates a distinct agreement.[13] Cases also suggest that breach of the duty of good faith does not result in avoidance of the entire policy, but affects only the variation.[14]

6.14 Our tentative view is that when an insured invokes a held-covered clause, the contract is varied. Thus any duty of good faith which arises in invoking a held-covered clause, is the same as arises upon variation. Again, the matter is best considered in the context of reforming pre-contract duties.

TERMS REQUIRING THE INSURED TO PROVIDE INFORMATION

6.15 In many European countries, it is common for the insured to be obliged to notify the insurer of any aggravation of the risk. The Principles of European Insurance Contact Law (PEICL) provide a special regime for dealing with such clauses. Article 4.202 specifies that, in the event of breach of the duty of notification, the insurer may only refuse to pay for subsequent loss if “the loss was caused by the aggravation of risk”. Other losses resulting from events within the scope of the cover remain payable.

[11] See draft Consumer Insurance (Disclosure and Representations) Bill Sch 1, paras 10 to 12 in Appendix A of the above report.

[12] [1958] 1 Lloyd’s Rep 546, affirmed in *Liberian Insurance Agency Inc v Mosse* [1977] 2 Lloyd’s Rep 560.

[13] *Iron Trades Mutual Insurance Co Ltd v Comphanhia de Seguros Imperio* (1990) Unreported (QB) and *The Star Sea* [1997] 1 Lloyd’s Rep 360 at 370 by Leggatt LJ.

[14] In *K/S Merc-Scandia XXXXII v Certain Lloyd’s Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd’s Rep 563, Longmore LJ comments, at p 571 "although it is settled that good faith must be observed, it is never suggested that lack of good faith in relation to a matter held covered by the policy avoids the whole contract of insurance". See also the Court of Appeal's judgment in *The Star Sea* [1997] 1 Lloyd's Rep 360, p 370. For discussion on this point see B Soyer, *Warranties in Marine Insurance* (2nd ed 2006) p 164.

6.16 Even if a loss is caused by the aggravation, the insurer may still be liable for a proportion of the claim. Article 4.203 provides that:

> …no insurance money shall be payable if the insurer would not have insured the aggravated risk at all. If, however, the insurer would have insured the aggravated risk at a higher premium or on different terms, the insurance money shall be payable proportionately or in accordance with such terms.

6.17 PEICL also includes provisions on the reduction of risk. Under Article 4.301, if there is "a material reduction of risk", the policyholder is entitled to request a proportionate reduction of the premium. If the parties fail to agree a reduction within a month, the policyholder may terminate the contract within two months of the request.

6.18 The reason why these clauses are frequently used in civil law jurisdictions is that insurance contracts tend to last for a longer period than one year. By contrast, the UK approach is to expect an insurer to define the risk precisely every year, adding in appropriate exclusions for those risks it does not wish to insure. At the end of the year, the policy is renewed. At this point, a new duty of disclosure arises, and the insurer is expected to ask about any alterations to the risk before issuing a new contract.

6.19 This reliance on annual policies and precisely defined risks means that the courts have been puzzled by clauses requiring notification of alterations in the risk. The courts have found such clauses difficult to interpret and they have taken a restrictive approach.

6.20 The clauses tend to be of two types: general clauses requiring the policyholder to notify the insurer of any increase in the risk, and more specific clauses, asking for prescribed information. Below we consider each in turn.

General duties to notify an increase in the risk

6.21 Some policies include terms requiring the insured to tell the insurer about any circumstances which lead to an increase in the risk.

6.22 In *Hussain v Brown (No 2),*[15] for example, the policy included a clause requiring the policyholder to inform the insurers of any alteration likely to increase the risk. The insurers were then entitled to terminate the contract on notice, or require a reasonable increase in the premium. When the policyholder suffered fire damage to the insured premises, the insurer refused to pay on the ground that the premises were unoccupied. Although this increased the risk, the policyholder had not notified the insurers of the fact.

[15] (1996) unreported. The case is discussed in Insurance Law Monthly, (1997) 9 ILM 4.

6.23 The insurers argued that, following *The Litsion Pride*,[16] the insured is under a post-contract duty of full disclosure whenever the insured is required to give information to the insurer. The judge accepted that this was correct, but said that in this case, the duty had been replaced by the contract term. The clause was an exhaustive statement of the claimant's obligations, and if the insurer wished to preserve a continuing duty of utmost good faith, it should do so expressly.

6.24 The judge found that the clause had been breached, and this amounted to a breach of contract giving rise to a claim for damages. If the insurer had been informed, it would have insisted on an inspection, the implementation of the findings of which would have had a 50:50 chance of preventing the fire. On this basis, the claim was reduced by 50%. This outcome looks a little like the proportionate remedy specified in PEICL. However, in the light of the more recent decision of the Court of Appeal (discussed below), it is doubtful if it is good law.

6.25 In *Kausar v Eagle Star Insurance Co Ltd,*[17] the Court of Appeal interpreted a notification clause extremely narrowly. Here the clause stated:

> You must tell us of any change of circumstances after the start of the insurance which increases the risk of injury or damage. You will not be insured under the policy until we have agreed in writing to accept the increased risk.

6.26 Lord Justice Staunton pointed out that the insurers could not mean that the insured had to keep the insurer updated on all aspects of the risk:

> On its plain wording the meaning would appear to be that, if there is a change of circumstances during the currency of the policy which increases the chance of injury or damage, all cover will cease until the insurers have agreed in writing to accept the increased risk; that consequence follows whether or not the insured tells the insurers of the change of circumstances, and whether or not a reasonable time has elapsed since the change. The appearance of a hurricane on the weather forecast, or of a fire spreading down the street, would bring cover to an end. That cannot be right; or at least if it was intended the parties should have made it abundantly clear.

6.27 Thus the clause would have effect only in extreme circumstances. As Lord Justice Saville put it:

[16] *Black King Shipping Corp v Massie (The Litsion Pride)* [1985] 1 Lloyd's Rep 437. For an account of this case see paras 4.24 – 4.26.

[17] *Kausar v Eagle Star Insurance Co Ltd* [2000] Lloyd's Rep 154. Also see, for example, *Pim v Reid* (1843) 6 M & G 1; *Baxendale v Harvey* (1859) H & N 449; *Lishman v Northern Maritime Ins. Co* (1874-5) LR 10 CP 179 and *Niger Co Ltd v Guardian Assurance Co Ltd* (1922) 13 Ll L Rep 75.

> All that this Condition does is to state the position as it would exist anyway as a matter of common law, namely that without the further agreement of the insurer, there would be no cover where the circumstances had so changed that it could properly be said by the insurers that the new situation was something which, on the true construction of the policy, they had not agreed to cover. The mere fact that the chances of an insured peril operating increase during the period of the cover would not, save possibly in the most extreme of circumstances, enable the insurers properly to say this, since the insurance bargain is one where, in return for the premium, they take upon themselves the risk that an insured peril will operate.[18]

6.28 Following *The Star Sea*,[19] there is some doubt about whether a duty of good faith affects such terms. Even if it does, it is unlikely that the courts would allow the insurer to avoid the contract if the term is breached. As Lord Justice Longmore stated in *The Mercandian Continent,* damages would normally be the appropriate remedy:

> To the extent that *Alfred McAlpine Plc v BAI Insurance (Run Off) Ltd* [2000] 1 Lloyd's Rep 437 accepts that giving of information attracts obligations of good faith, it does not support a remedy of avoidance in the absence of prejudice to underwriters in connection with their ultimate liability for the claim.[20]

Clauses requiring specific information

6.29 Policies also include clauses asking for specific types of information. Such clauses are relatively common in consumer policies, but we have been told that there is widespread confusion about their effect.

6.30 This is an example from a consumer car insurance policy:

> You must tell us what modifications you intend to make and obtain our agreement *prior* to making them….
>
> If you do not tell us about any relevant modifications, we may:
>
> - reject or reduce your claim
>
> - treat the policy as void (ie as though it never existed).

6.31 As long as such clauses are brought to the consumer's attention, it may be fair to expect a consumer to provide the information. The difficulty is in interpreting the effect of such a clause and the insurer's remedy if it is not complied with.

[18] Above at p 159.

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

[20] *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275; [2001] 2 Lloyd's Rep 563 at p 571.

6.32 The easiest way of interpreting such a clause is as an exclusion. Effectively, what the insurer is saying is that the insurance does not cover a modified car, unless the modifications have been agreed by the insurer. On this basis, if a modified car is stolen, the insurer is not liable. Take a case, however, in which the consumer puts alloy wheels on the car in June without informing the insurer. The consumer then removes them in July, and the car is stolen in August. If the term defines the risk, the insurer must pay for the loss, as the car was not modified at the time of the theft.

6.33 An alternative way of viewing the clause is as a warranty. Under section 33 of the Marine Insurance Act 1906, this would discharge the insurer from liability from the date of the breach. This means that the insurer would have no liability after the car was modified in June, and could refuse all further claims. However, under Financial Service Authority Rules, in consumer contracts, insurers would not be permitted to rely on such a breach of warranty unless the circumstances of the claim were connected with the breach.[21] Similarly, the Financial Ombudsman Service (FOS) would not permit the insurer to refuse the claim unless there was some connection between the modification and the claim.

6.34 The third approach, following *The Litsion Pride*,[22] would be to view this as an information obligation, giving rise to a duty of good faith. On one possible reading this would mean that on discovering the modifications, the insurer could avoid the policy from the start, invalidating all claims, including those paid before the modifications were made. This appears to be the view taken by the insurer when it claims to be able to treat the policy as if it never existed.

6.35 The problem is that avoiding the policy would give an insurer an even more powerful remedy than that produced by a breach of warranty, permitting the insurer to recoup claims arising before the breach and which have no possible connection with the breach. This seems to contravene the spirit (if not the letter) of the Financial Services Authority Rules, and would be prevented by the FOS. We think the courts would also be unlikely to permit an insurer to avoid the policy in this way.

6.36 We have also been told of problems concerning terms which require consumers to notify the insurer of convictions during the policy period. It is not always clear what right the insurer has when convictions are notified. If insurers wish to reserve the right to cancel insurance if policyholders are convicted, this would need to be spelled out in clear terms.

[21] ICOBS 7.3.6.

[22] *Black King Shipping Corp v Massie (The Litsion Pride)* [1985] 1 Lloyd's Rep 437.

The FOS approach

6.37 The Financial Ombudsman Service (FOS) gives only limited effect to information clauses. It argues that in most cases, if the policyholder's circumstances change during the term of the policy, that is generally just part of the risk the firm agreed to take on.[23] Clauses requiring policyholders to tell insurers about changes in their circumstances may well not be fair and reasonable, particularly if they were not highlighted when the policy was sold:

> Firms cannot normally expect customers to recognise relevant facts and to inform them of these facts – voluntarily – as and when they arise. By varying a contract after it has been agreed, the firm arguably creates a *"*significant imbalance in the parties' rights and obligations*"*, as defined under the Unfair Terms in Consumer Contracts Regulations 1999*.*[24]

6.38 One example is where travel insurance policies include terms requiring policyholders to inform insurers about any change in their medical conditions. This is an example:

> If your health changes between the date the policy was bought and the date of travel, you should advise us as soon as possible. We will advise you what cover we are able to provide after the date of diagnosis.

6.39 In one case a policyholder was forced to cancel his planned trip when his mother was told her cancer was terminal. The insurer argued that the insured should have notified them as soon as cancer was diagnosed: the policy imposed an on-going duty of disclosure, and this was a relevant matter. The FOS disagreed. The issue had arisen only after the policy was taken out. If interpreted literally, the clause would effectively relieve the insurer of any obligation to pay health-related claims.

6.40 In another case, a policyholder's claim for fire damage to her home was refused because she did not tell her insurer when she moved abroad for six months and left her home unoccupied. The insurers insisted that this had changed the nature of the risk. The FOS disagreed and held that she had no duty to notify the insurers that the house was unoccupied.

6.41 The FOS considers that it is only reasonable for an insurer to vary the terms of an insurance policy after it is bought when the nature of the risk changes so fundamentally that the subject matter of the insurance is completely different.

Terms requiring information from the insured: conclusion

6.42 There are two possible approaches to clauses requiring policyholders to tell the insurers about alterations of the risk during the currency of an insurance policy.

[23] Ombudsman News, April 2004, Issue 36.

[24] Ombudsman News, April 2004, Issue 36.

6.43 The first would be to take the approach set out in PEICL, and view notification clauses as a helpful way of regulating the insurance bargain. This may raise issues of good faith, and require specified remedies. We note that under PEICL the remedies available to an insurer are specified and limited. In the example given in paragraph 6.30, the insurer could refuse to pay for the theft of a modified car only if an unmodified car would not have been stolen. And even if this were shown, the insurer might still be liable for a proportion of the loss if, had it known of the modifications, it would have continued to insure the car for an increase in premium. Furthermore, policyholders may request reductions if the risk decreases. These detailed provisions prevent notification of risk terms from becoming instruments of oppression.

6.44 The alternative would be to take the more traditional UK approach, and expect insurers to specify risks precisely for the duration of the insurance. On this basis, it is open to an insurer to exclude modified cars, unless the modifications have been agreed. However, if the insurer does not exclude this risk, it would be expected to cover it, despite a clause requiring notification of alterations in the risk. This is the approach taken by the FOS and by the Court of Appeal in *Kausar v Eagle Star Insurance Co Ltd*.[25]

6.45 Our tentative conclusion is that in a market based on annual renewals there is no need for the parties to continue to bargain over changes in the risk. As we said in our 2007 Consultation Paper, for annual policies, a continuing duty to disclose with concomitant rights of adjustment, is not needed: "on renewals the insured will normally be asked what has changed since last year".[26] Notification clauses could introduce unwanted uncertainty as it is often unclear what must be notified.

6.46 We think that the courts are right to construe general notification clauses restrictively. When entering into an insurance contract, the onus is on the insurer to define the risk it is covering. If the risk falls within the policy, it should be covered. Insurance against storm damage is not discharged if hurricanes are forecast; nor does life insurance become void if, during the currency of the contract, the policyholder develops terminal cancer. An insurer may decide not to cover certain risks. It may, for example, decide not to insure unoccupied premises. If so, it should say so explicitly.

6.47 On this basis, most clauses requiring the insured to notify specific changes should be written as exclusions: "we will not cover this risk unless you tell us and we agree". This would suggest that they should be dealt with like any other exclusion, and the duty of good faith has no particular relevance to them. However, in Part 7 we welcome views on this issue.

[25] *Kausar v Eagle Star Insurance Co Ltd* [2000] Lloyd's Rep 154. Also see, for example, *Pim v Reid* (1843) 6 M & G 1; *Baxendale v Harvey* (1859) H & N 449; *Lishman v Northern Maritime Ins. Co* (1874-75) LR 10 CP 179 and *Niger Co Ltd v Guardian Assurance Co Ltd* (1922) 13 Ll L Rep 75.

[26] Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134, at para 4.151.

PRESERVING THE GENERAL DUTY?

6.48 The final question is whether the insured's post-contract duty of good faith should have any other effects, outside the various instances we have listed. We have not identified any other effects, but it is difficult to be sure. It is always open to the courts to develop the insured's post-contract duty of good faith in new and unexpected ways.

6.49 We have considered whether any codification of the duty of good faith should be exclusive (so that it covers only the specified instances) or whether it should continue to have some general, unspecified effect. Allowing a general duty might permit the courts to develop the law to meet new challenges. Alternatively, it could add to confusion and uncertainty. We have no decided view on this issue and in Part 7 we welcome comments on it.

PART 7
PROPOSALS FOR REFORM

7.1 In Parts 4 and 5 we identify a need to clarify the law on the effect of a fraudulent claim. We tentatively suggest that it would be helpful to reform section 17 of the Marine Insurance Act 1906, so that it more accurately reflects the position at common law. In this Part we outline what such a reform might look like.

EMBEDDING CURRENT LAW AND PRACTICE WITHIN LEGISLATION

7.2 We do not see our suggested reforms as changing current practice. Rather our aim is to clarify the position which the courts already appear to have reached; namely that an insured who commits fraud forfeits the whole claim to which the fraud relates.

7.3 Lord Justice Aikens has warned against "reform for the sake of tidiness".[1] We agree. However there are three reasons why it would be desirable to remove the problems created by section 17 in its present form:

(1) The disjuncture between the common law rule and section 17 generates unnecessary disputes and litigation;

(2) Increasingly, commercial law in the UK must be justified to an international audience. The UK must seek to develop insurance law in a coherent, principled and fair way if it wishes to influence wider European and international activity in the area.

(3) The rules on fraudulent claims are intended to act as a deterrent, and deterrents work best if they are clear and well understood. Penalties, in particular, should be clearly set out in law.

7.4 **Do consultees agree that the law on the remedies available for fraudulent claims is unnecessarily complex?**

7.5 **Would it be helpful to introduce legislation to clarify the insurer's remedy for a fraudulent claim?**

A MUTUAL DUTY OF GOOD FAITH

7.6 In March 2010, we published Issues Paper 6 on damages for late payment and the insurer's duty of good faith. We argued that the law was right to recognise mutual duties of good faith. Put simply, good faith is a commercial necessity in insurance. One party pays money to another not for goods or services but for a future promise. This creates moral hazards. An insurer is particularly vulnerable if the policyholder lies about the risk or the claim. Conversely, the policyholder is vulnerable if the insurer delays or refuses payment for no valid reason. It is therefore important that the law provides safeguards against these hazards.

[1] Lord Justice Aikens, "The post-contract duty of good faith in insurance contracts: is there a problem that needs a solution?", speech to BILA 8 February 2010.

7.7 At the pre-contract stage, if the insured deliberately or recklessly misrepresents the risk, we think it is right that the insurer should be entitled to avoid the policy. As we said in our 2009 Report, avoidance may over-compensate the insurer for the loss it has suffered. However, it is appropriate to include a penal element to show society's disapproval of this behaviour and to deter wrongdoing.[2]

7.8 Similarly, if a policyholder lies about elements of a claim it is right that the law should provide a penalty. In other types of contract, if a party makes a claim which is partly valid and partly dishonest, it may be appropriate to allow the claimant the valid part of the claim. In insurance contracts, however, the moral hazard inherent in the bargain means that the law should include a penal element.

7.9 On the other hand, avoidance would not be the appropriate remedy. Avoidance pretends that an existing contract, which may have operated legitimately and honestly for some time, never existed.

PREVIOUS PROPOSALS

7.10 In Issues Paper 6, we argued that there was also a need for safeguards where the insurer deliberately delays investigating a valid claim, or rejects a valid claim for no good reason, or accepts that a claim is valid but neglects to pay it. We tentatively proposed to amend section 17. In so far as section 17 represents a codification of the common law, it would also be necessary to reform its common law underpinning. We argued that legislation should continue to say that an insurance contract is a contract based upon mutual duties of good faith. However, the law should provide flexible and appropriate remedies for breach of this duty by either party.

7.11 We made the following tentative proposals on how this should be done:

(1) The duty should be one of good faith, rather than "utmost" good faith.

(2) The duty should be non-excludable.

(3) At present, the 1906 Act sets out a general duty of good faith, followed by specific instances of how the duty applies. We suggested retaining this structure, but adding in other specific examples of how the duty operates post-contractually. This should include a duty on the insurer to investigate and assess claims fairly and, once a claim is assessed as valid, to pay it within a reasonable time.

(4) For each specific breach, the legislation should specify an appropriate remedy. Avoidance should be the remedy only in appropriate cases.

(5) Where the insured suffers foreseeable loss as a result of the insurer's breaches of the duty of good faith, damages should be available to compensate the insured.

[2] Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (2009) Law Com No 319; Scot Law Com No 219 at paras 4.19 and 4.20.

7.12 This paper is the other side of the same coin. We therefore make similar tentative proposals. We think there should be a non-excludable duty of good faith on both insurer and insured. The legislation should specify that this includes a duty on the insured not to make a fraudulent claim. The Act should then specify the appropriate remedy for breach of the duty, namely forfeiture of the claim.

7.13 Below we look at these elements in more detail.

An insurance contract is based on mutual duties of good faith

7.14 We tentatively propose to amend section 17 and any common law which it codifies. We think that any new Insurance Act should specify that the parties to an insurance contract owe each other mutual duties of good faith.

7.15 We prefer the phrase "good faith" rather than "utmost good faith". As Lord Clyde and Lord Hobhouse pointed out in *The Star Sea*,[3] the word "utmost" was not included in the original formulation of the duty. The word may be confusing in a post-contract context, where the parties are only required to behave honestly. After the contract has been agreed, the parties are no longer under a positive duty to reveal new information, unless the contract provides for it. Instead, they must undertake their contractual obligations in good faith. The duty of good faith applies only where the parties are required to act: if so the actions must be undertaken honestly.

7.16 **Do consultees agree that an insurance contract should be based on mutual duties of good faith?**

The duty may be extended, but not reduced

7.17 At present, it is common for the parties to agree a "fraud clause", specifying that the policyholder should not act fraudulently in relation to a claim, and setting out the remedies available to the insurer if fraud is committed.

7.18 We think that the parties should continue to be free to set their own rules in this way. However, as is already the case under the current law, any clause which grants the insurer greater remedies than the general law must be clearly drafted to achieve this effect. For example, if a clause goes further than merely requiring forfeiture of the claim and permits the insurer to avoid the policy completely, this must be stated unambiguously. Any ambiguity should be resolved against the interests of the party who puts the clause forward, as Lord Penrose held in *Fargnoli v G A Bonus Plc*.[4]

[3] *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1; [2003] 1 AC 469, at p 499 at [5] and [44].

[4] *Fargnoli v G A Bonus plc* 1997 SCLR 12; [1997] CLC 653 at p 681.

7.19 An express fraud clause may also be subject to statutory controls.[5] In consumer contracts, the Unfair Terms in Consumer Contracts Regulations 1999 require that the term is fair. If a clause imposes unexpectedly severe penalties on the insured, this must be brought clearly to the policyholder's attention.

7.20 In Issues Paper 6, we argued that the duty of good faith may not be excluded by a contract term. In other words, the parties are not entitled to agree that the insurer may act unfairly, or that the insured may act fraudulently. We propose to retain the law that a party should not be entitled to exclude liability for his or her own fraud.[6]

7.21 In some cases, however, the law holds a party liable for the fraud of another, such as a broker or joint policyholder. In these cases, we think there is a case for permitting the parties to exclude such liability. Broker fraud is a risk which exists independently of the parties, which suggests that the parties should be free to allocate the risk as they think fit. We can understand that most insurers would be very reluctant to assume the risk that the insured's agent is fraudulent. However, we are not sure that the law should prevent an insurer from doing so if the parties so wish.

7.22 **Do consultees agree that we should retain the current law that:**

(1) **the remedies for fraud may be extended by a clear, unambiguous express term, but**

(2) **a party may not exclude liability for his or her own fraud?**

7.23 **Do consultees agree that the parties should be entitled to exclude liability for the fraud of their agents, if they so wish?**

The insured is under a duty not to make a fraudulent claim

7.24 As we have explained, the main duty of good faith on an insured after a contract has been formed is not to make a fraudulent claim. We do not think it should be necessary for the parties to include an express term not to make a fraudulent claim. Instead, this is a legal duty in all insurance contracts.

7.25 To bring clarity to the law, we think that the new statute should set out the duty not make a fraudulent claim as a particular instance of the duty to act in good faith. The statute should then specify the appropriate remedy.

7.26 As we explain in Part 3, our current view is that we should not attempt to define fraud. Instead the definition of fraud should be left to the courts to develop.

7.27 **Do consultees agree that:**

[5] For compulsory insurance there are specific statutory controls to prevent an insurer from avoiding liability. For third party motor insurance, the Road Traffic Act 1988, s 151(5), requires an insurer to pay the third party even if the insurer has avoided or cancelled the policy as against the insured. For employers' liability insurance, reg 2 of the Employers' Liability (Compulsory Insurance) Regulations prohibits terms which would otherwise exclude liability for something done after the event giving rise to a claim.

[6] For an account of the current law, see paras 4.13 – 4.17.

(1) **policyholders should be under a statutory duty not to make a fraudulent claim;**

(2) **the definition of fraud should be left to the courts?**

The main remedy for fraud is forfeiture of the claim

7.28 As we outline in Part 4, the current law appears to be that an insured who commits fraud forfeits the whole claim to which the fraud relates, including any interim payments already made on the claim. The insured does not forfeit any other claims previously paid under the policy. Our view of the current case law is that the insurer also has to pay any outstanding previous claims.[7]

7.29 Our tentative view is that this is appropriate. It is a well-established practical solution to the issue, which has been applied many times over the last 150 years. It imposes a penalty on the insured without denying the reality of an insurance contract, which may have worked well in the past.

7.30 Of course, the penalty may be arbitrary. An insured who presents an entirely fictitious claim loses nothing (except a claim which never existed). By contrast, an insured who acts less dishonestly by claiming only for a small additional, non-existent, item of loss may forfeit a large amount. For example, an insured who falsely claims for the theft of a car loses nothing. An insured whose £15,000 car is stolen, but who also claims £500 for the loss of a non-existent satellite-navigation system, loses £15,000.

7.31 One possible answer is that the first case should be dealt with primarily under the criminal law. Inventing a loss of this type is a major fraud. As the ABI surveys show, over 95% of the population regard such behaviour as unacceptable.[8] With appropriate evidence, a jury will convict, and a sentence of an unlimited fine and up to 10 years imprisonment may be imposed.[9]

7.32 The second case, however, is more common and presents more of a problem for insurers. People feel much more ambivalent about such frauds, with up to two in five of the population regarding this type of behaviour as acceptable or borderline. Prosecution may not be appropriate and a jury may be unwilling to regard the matter as criminal. In practice, insurers rely on the civil law to deter this behaviour and protect them against the moral hazard. We therefore think that it is appropriate for the civil law to provide a penalty in this type of case.

7.33 **Do consultees agree that an insured who makes a fraudulent claim should forfeit the whole claim to which the fraud relates?**

[7] See *Fargnoli v G A Bonus plc* [1997] CLC 653 and MA Clarke (looseleaf) para 27-2C3. In *AXA v Gottlieb* [2005] EWCA Civ 112; [2005] 1 All ER (Comm) 445, the point was left open: see [22]. However, the argument that the appropriate remedy was forfeiture of the fraudulent claim suggests strongly that outstanding previous claims must be paid.

[8] Association of British Insurers, General Insurance Claims Fraud (July 2009) available at http://www.abi.org.uk/Media/Releases/2009/07/40569.pdf, at p 11.

[9] As noted in para 4.2 above, the maximum sentence which may be imposed by a Scottish court is life imprisonment or an unlimited fine.

A fraud should not affect previous valid claims

7.34 Under the current case law in both England and Scotland,[10] it appears that a fraudulent claim does not invalidate previous, legitimate claims, whether or not they have been paid. The courts have been unwilling to undo previous legitimate transactions. As Lord Penrose put it, the penalty should "not extend beyond the offence to deprive persons of innocent benefits, or benefits otherwise free from the taint of fraud".[11] We think this is correct.

7.35 **Do consultees agree that a fraudulent claim should not affect previous claims, whether or not they have been paid?**

Fraud gives the insurer the right to terminate the contract

7.36 The current law appears to be that a fraudulent claim gives the insurer the right to terminate the contract. Following termination, the insurer is not liable for future claims. The policyholder is not liable to pay future premiums, but the insurer may retain any premiums already paid. However, if a valid claim arises between the fraud and the termination, the insurer is obliged to pay it.

7.37 This outcome is in line with general contract principles and we think it is correct.

7.38 **Do consultees agree that a fraudulent claim should give the insurer the right to terminate the contract, but should not affect a valid claim arising between the fraud and the termination?**

Should an insurer be entitled to damages?

7.39 Under current law, damages may not be recovered for a breach of the duty to act in good faith.[12] It remains open to an insurer to argue that they are entitled to claim damages for deceit following a fraudulent claim, but we have not found a case in which this has been done.[13]

7.40 This raises a difficult policy issue. If an insurer incurs the cost of investigating a fraudulent claim, should the fraudster be liable for those costs? This has not proved to be a major issue in the case law. The costs of investigating claims are rarely substantial, and tend to be lower than the savings which accrue from not paying the legitimate element of a fraudulent claim. Take an example where a consumer makes a claim for £20,000, of which £18,000 is legitimate and £2,000 is fictitious. If the insurer spends £1,000 in investigating the claim, this is more than compensated by the insurer's saving in not paying £18,000.

[10] *Fargnoli v G A Bonus plc* [1997] CLC 653 and *AXA v Gottlieb* [2005] EWCA Civ 112; [2005] 1 All ER (Comm) 445. See discussion in Part 4.

[11] *Fargnoli v G A Bonus plc* [1997] CLC 653 at p 678.

[12] See *La Banque Financiere de la Cite v Westgate* [1988] 2 Lloyd's Rep 513 and *London Assurance v Clare* (1937) 57 Ll. L. Rep. 254.

[13] In *London Assurance v Clare* (1937) 57 Ll. L. Rep. 254 at p 270 Goddard J recognised that if damages had been sought for fraud in that case "there might be something to be said".

7.41 There may, however, be cases in which the insurer incurs reasonable and foreseeable costs in investigating the claim for which it is not otherwise compensated. We see no reason in principle why the fraudster should not pay damages in these circumstances. Take an example in which a policyholder commits arson, making a totally fraudulent claim for £100,000, which the insurer investigates at a cost of £10,000. We see no reason why the arsonist should not be liable to the insurer for £10,000, provided that these costs were foreseeable, reasonable and not otherwise compensated.

7.42 **Do consultees think that an insurer should be entitled to claim damages for the reasonable and foreseeable costs of investigating a fraudulent claim?**

7.43 **Should damages be available only where such costs are not recouped from the insurer's saving in retaining the legitimate element of the claim?**

FRAUD BY A CO-INSURED

7.44 In Part 5 we summarised the existing law in this area. The law distinguishes between joint insurance, taken out by two or more people to cover joint interests, and composite insurance, in which policyholders insure separate and several interests. For joint insurance, the fraud of one policyholder affects the others. With composite insurance, each policyholder is treated separately.

7.45 The problems come where policyholders start by taking out insurance together, but later become estranged and act contrary to each other's interest. An example which has arisen in several jurisdictions is where a husband and wife take out joint insurance on their home, but later fall out. If one spouse attacks the other by setting light to the home, it seems unjust to deprive the innocent victim of his or her insurance claim.

7.46 We tentatively conclude that the matter should be subject to statutory reform. In Part 5 we argued that in joint insurance, where two or more people act together to insure their joint interests, there should be a presumption that any fraud committed by one party is done on behalf of all the parties. However, it should be open to an innocent party to rebut this presumption. If the innocent party produces evidence that the fraud was not carried out on their behalf or with their knowledge, then the claim should be paid. It is important that the recovery is limited to the innocent party's particular loss, and that the guilty party should not benefit. For example, in a case in which one spouse damages a joint home, any recovery would be limited to the innocent spouse's share of that home.

7.47 **Do consultees agree that if a joint policyholder provides evidence that the fraud was not carried out on their behalf or with their knowledge, the innocent policyholder's share of the claim should be paid?**

7.48 **Should the legislation provide that the recovery will be limited to the innocent insured's own interest, and will only be payable if the guilty insured would not benefit from any recovery?**

FRAUD IN GROUP INSURANCE

7.49 In Part 5 we consider the remedies available to an insurer if a group member makes a fraudulent claim under group scheme. As group members are not policyholders, there is some doubt whether they are caught by the obligations imposed on policyholders under insurance contract law. We ask whether any future legislation needs to address this issue specifically.

7.50 **Is there a need to make special provision for fraudulent claims by group members, to give insurers similar remedies to those available where a policyholder acts fraudulently?**

OTHER ASPECTS OF THE INSURED'S POST-CONTRACT DUTY OF GOOD FAITH

7.51 In Part 6 we discuss other possible applications for the insured's post-contract duty of good faith. The duty clearly applies to variations and held-covered clauses, but we see these as analogous to the pre-contract duty, and think it should be considered in that context. Our draft Bill on disclosure and representations in consumer insurance makes specific provisions for misrepresentations made before variations to the contract.[14]

Clauses requiring the insured to report increases in the risk

7.52 Part 6 also considers terms requiring the insured to notify the insurer of increases in the risk. Although these are commonly used in civil law countries, the UK approach has been to interpret them restrictively. In an annual policy, the insurer is expected to define the risk precisely, and to continue to cover the risk specified for the contract period. Thus if an insurer wishes to protect itself against, for example, premises being left unoccupied, the normal approach would be to exclude unoccupied premises from cover, unless the insurer agrees a variation in the policy terms.

7.53 We tentatively conclude that this is the correct approach. However, we would welcome views on whether there are advantages to following the approach set out in the Principles of European Insurance Contract Law, which is to permit such clauses but to provide a restricted remedy if they are breached.

7.54 **Do consultees agree that clauses requiring the insured to notify the insurer about any increases in the risk should be interpreted restrictively?**

7.55 **Do consultees agree that the duty of good faith has no particular application to such clauses?**

7.56 **Do consultees see any advantages in legislating for such clauses along the lines set out in the Principles of European Insurance Contract Law?**

[14] See draft Consumer Insurance (Disclosure and Representations) Bill Sch 1, paras 10 to 12 in Appendix A of Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (2009) Law Com No 319; Scot Law Com No 219.

PRESERVING THE GENERAL DUTY?

7.57 The final question is whether the insured's post-contract duty of good faith should have any other effects, outside the various instances we have listed. We have not identified other effects, but it is open to the courts to develop the insured's post-contract duty of good faith in new and unexpected ways.

7.58 We have considered whether any codification of the duty of good faith should be exclusive (so that it covers only the specified instances) or whether it should continue to have some general, unspecified effect. Allowing a general duty might permit the courts to develop the law to meet new challenges. Alternatively, it could add to confusion and uncertainty. We have no decided view on this issue and welcome comments on it.

7.59 **Should the insured's duty of good faith be confined to the duty not to make a fraudulent claim, or should it continue to have some general but unspecified effect?**

PART 8
LIST OF CONSULTATION QUESTIONS

We ask for comments on and responses to the following questions:

GENERAL

8.1 Is the law on the remedies available for fraudulent claims unnecessarily complex? (Paragraph 7.4)

8.2 Would it be helpful to introduce legislation to clarify the insurer's remedy for a fraudulent claim? (Paragraph 7.5)

8.3 Should an insurance contract be based on mutual duties of good faith? (Paragraph 7.16)

EXPRESS TERMS

8.4 Should we retain the current law that:

(1) the remedies for fraud may be extended by a clear, unambiguous express term, but

(2) a party may not exclude liability for his or her own fraud? (Paragraph 7.22)

8.5 Should the parties be entitled to exclude liability for the fraud of their agents, if they so wish? (Paragraph 7.23)

WHERE THERE IS NO EXPRESS TERM

The duty

8.6 Should policyholders be under a statutory duty not to make a fraudulent claim? (Paragraph 7.27)

8.7 Should the definition of fraud be left to the courts? (Paragraph 7.27)

The remedies

8.8 Should an insured who makes a fraudulent claim forfeit the whole of the claim to which the fraud relates? (Paragraph 7.33)

8.9 Should a fraudulent claim have no effect on previous claims, whether or not they have been paid? (Paragraph 7.35)

8.10 Should a fraudulent claim give the insurer the right to terminate the contract, but have no effect on a valid claim arising between the fraud and the termination? (Paragraph 7.38)

8.11 Should an insurer be entitled to claim damages for the reasonable and foreseeable cost of investigating a fraudulent claim? (Paragraph 7.42)

8.12 Should damages be available only where such costs are not recouped from the insurer's saving in retaining the legitimate element of the claim? (Paragraph 7.43)

FRAUD BY A CO-INSURED

8.13 If a joint policyholder provides evidence that the fraud was not carried out on their behalf or with their knowledge, should the innocent policyholder's share of the claim be paid? (Paragraph 7.47)

8.14 Should the legislation provide that the recovery will be limited to the innocent insured's own interest, and will only be payable if the guilty insured would not benefit from any recovery? (Paragraph 7.48)

FRAUD IN GROUP INSURANCE

8.15 Is there a need to make special provision for fraudulent claims by group members, to give insurers similar remedies to those available where a policyholder acts fraudulently? (Paragraph 7.50)

OTHER ASPECTS OF THE INSURED'S POST-CONTRACT DUTY OF GOOD FAITH

8.16 Should clauses requiring the insured to notify the insurer about any increases in the risk be interpreted restrictively? (Paragraph 7.54)

8.17 Should the duty of good faith have no particular application to such clauses? (Paragraph 7.55)

8.18 Are there any advantages in legislating for such clauses along the lines set out in the Principles of European Insurance Contract Law? (Paragraph 7.56)

8.19 Should an insured's duty of good faith be confined to the duty not to make a fraudulent claim, or should it continue to have some general but unspecified effect? (Paragraph 7.59)