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## **Insurance Contract Law Issues Paper 1 Misrepresentation and Non-Disclosure**

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**This paper should not be quoted as representing the fixed policy of either Commission.**

**The paper has been drafted by the teams working on the insurance contract law review at the English and Scottish Law Commissions and is intended simply to promote discussion before the formal consultation process begins. It has not been subject to formal scrutiny by Commissioners.**

**September 2006**

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# **PART 1: SUMMARY**

## **PURPOSE AND CONTENT**

- 1.1 The teams working on the insurance contract law review at the English and Scottish Law Commissions intend to issue jointly a short series of Issues Papers. These papers are not subject to formal scrutiny by Commissioners and their contents should not be quoted as representing the views of either Commission.
- 1.2 Our intention is that these Issues Papers will promote discussion of some of the main matters within the review, and give a focus for debate at seminars that we are holding. This paper, the first in the series, looks at misrepresentation and non-disclosure by the insured. It also considers basis of the contract clauses, which could currently be used to avoid our proposals.
- 1.3 We consider the position of consumers before we consider that of businesses. This is partly because the law is regarded as having the potential for particular harshness in the consumer context, partly because statutory regulation and an Ombudsman scheme apply to consumer insurance and partly because where consumers are concerned alternative approaches to dealing with non-disclosure and misrepresentation have already been tried and tested. We then move on to assess the extent to which rules which are suitable for consumers could also be suitable for businesses. Finally we consider how small businesses should be treated and, if necessary, defined.

## **TENTATIVE CONCLUSIONS AND PROPOSALS**

- 1.4 No fixed decisions have been reached. Here we list our tentative conclusions and proposals. These will be reviewed in the light of submissions we receive and discussions at the planned seminars. In areas where we have not yet formulated a tentative view, we ask questions.

### **Consumers**

- 1.5 We conclude that the time has come to state clearly what rights and obligations a consumer insured should have. We believe strongly that a new statute should replace the current patchwork by a single system that is coherent and clear, and that is fair in that it meets the reasonable expectations of both consumers and insurers. (para 5.25)
- 1.6 We tentatively propose that:
  - (1) It should not be possible to contract out of the new rules governing consumer insurance except in favour of the consumer. (para 6.3)
  - (2) Insurers should only be entitled to a remedy for an insured's non-disclosure or misrepresentation in so far as this is material, as defined below. The same test should apply to misrepresentation and non-disclosure.
  - (3) First, the actual insurer must show inducement, in that had it known the true facts it would not have entered into the same contract on the same terms or at all.

- (4) Additionally, the insurer must show either
- (i) that the proposer appreciated that the fact in question would have that significance;<sup>1</sup> or, if not,
  - (ii) that a reasonable insured in the circumstances would have appreciated its significance.<sup>2</sup>
- (5) In assessing what a reasonable insured would appreciate, the courts should take into account the type of policy, the way the policy was advertised and sold, and the normal characteristics of consumers in the market. However, they would not look at individual circumstances, known only to the insured.

1.7 We ask whether the test should also take into account any particular characteristics or circumstances affecting the insured, so far as these were known to the insurer. (paras 6.30-6.32)

1.8 We tentatively propose that:

- (1) Insurers should be allowed to avoid policies where the insured has acted fraudulently at the pre-contractual stage, that is, if the insured:
  - (a) knew that the statement was untrue (or realised that it might be not be true and did not care); and
  - (b) knew that the statement was material to the insurer (or realised that it might be material and did not care whether it was or not). (para 6.39)
- (2) If the consumer insured had reasonable grounds for believing the truth of what they said, or was not negligent in other ways (such as in failing to answer a question), the insurer should have no remedy for misrepresentation or non-disclosure. (para 6.50)

1.9 If the consumer proposer has made a negligent misrepresentation, the court should apply a proportionate remedy by asking what the insurer would have done had it known the true facts. In particular:

- (a) Where an insurer would have excluded a particular type of claim, the insurer should not be obliged to pay claims that would fall within the exclusion;
- (b) Where an insurer would have declined the risk altogether, the claim may be refused;

<sup>1</sup> At the seminar on 21 September 2006, it was pointed out that this formulation is confusing. We meant that it must be shown that the proposer appreciated that the fact in question would be *relevant* to the insurer (in the sense that it would have an effect on the insurer's mind in assessing the risk) - not necessarily that it would have a decisive influence on the insurer.

<sup>2</sup> By this we mean that a reasonable insured would have appreciated that the fact would be relevant to the insurer (in the sense set out above), not necessarily that it would be decisive.

- (c) Where an insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium. (para 6.79)

1.10 There are three further issues on which we would welcome advice:

- (1) Is there a case for granting the courts or ombudsman some discretion to prevent avoidance where the insurer would have declined the risk but the policyholder's fault is minor, and other insurers would have accepted the risk at a higher premium? This may also apply where the misrepresented fact is unrelated to the claim.
- (2) Should insurers be entitled to avoid policies for the future in all cases, or only where they would have declined the risk?
- (3) Is it desirable to give greater protection to third parties in the event of misrepresentation by a policyholder? (para 6.81)

1.11 Our tentative proposal is that in the consumer market, insurers should ask consumers clear questions about any matter that is material to them and that, if they do not ask questions on a particular point, the insurer should be regarded as having waived its right to such information. (para 6.89)

1.12 Our tentative view is that:

- (1) General questions should be permitted, but that the court should ask whether a reasonable consumer would understand that this question was asking about this particular information. (para 6.97)
- (2) An insurer should have no right to rely on non-fraudulent misrepresentations made at renewal in response to such a question, unless the policyholder was supplied with copies of any information previously provided to the insurer. (para 6.101)
- (3) "Basis of the contract" clauses, whether in the proposal form or the contract itself, should be ineffective to make all the answers given by the insured into warranties. (This is without prejudice to the decision whether or not to permit specific warranties of existing fact contained within the contract.) (para 6.104)

1.13 We tentatively propose that:

- (1) An insurer should not be allowed to rely on a failure to disclose or a misrepresentation because of an incomplete answer, if the insured reasonably thought that the insurer would investigate and verify the matter. (para 6.112)
- (2) An insurer should be treated as knowing information contained in its own files, provided that the information was reasonably identifiable. (para 6.115)

- (3) An insurer who has indicated that it may obtain information from a third party (by, for example, asking the insured for consent to obtain it) should not be allowed to rely on a non-fraudulent misrepresentation (or failure to disclose) if the insured reasonably thought the insurer would check with the third party. (para 6.117)
- 1.14 We tentatively propose that insurers should be precluded from relying on a non-disclosure or misrepresentation when a question in a proposal form that requires an answer has not been answered or has an obviously incomplete answer. (para 6.125)
- 1.15 We ask whether in consumer life assurance the insurer should be prevented from relying on any non-fraudulent misrepresentation after the policy has been in force for three years. (para 6.129)

### **Businesses**

- 1.16 We tentatively propose that:
- (1) The law affecting business insurance should be changed to give the insured certain additional rights, but that the rules should in general not be mandatory. (para 7.38)
  - (2) The duty of disclosure should continue to apply to business insurance contracts in general. (para 7.45)
  - (3) A reasonable insured test of materiality should apply to all business insurance. (para 7.59)
  - (4) There is no case for restricting the insurer's right to avoid the policy (and therefore to refuse to pay any claim) where a business insured has behaved fraudulently. (para 7.62)
  - (5) When a business insured has acted without negligence in making an incorrect statement or in other ways (such as failing to answer a question), the insurer should have no right to avoid the policy or to refuse to pay a claim under it on that ground. (para 7.66)
- 1.17 We ask:
- (1) whether the remedy for negligent misrepresentation should be proportionate, in that it should aim to put the insurer into the position it would have been in had it known the true circumstances. (para 7.71)
  - (2) Whether the insured should have to show that it did not know what a person in its position would be expected to know, or alternatively that it did not know why an inaccurate response to a clear question was material. (para 7.75)
  - (3) Whether where the insurer would have declined the risk, but the policyholder's fault is minor and other insurers would have accepted the risk at a higher premium, the court should have a discretion to apply a proportionality solution. (para 7.78)

1.18 We tentatively propose:

- (1) That negligent misrepresentation or non-disclosure should be a ground on which the insurer may cancel the policy after reasonable notice, without prejudice to claims that have arisen or arise within the notice period. (para 7.80)
- (2) That there should be a mandatory rule that incorrect answers would not give rise to a remedy for breach of warranty unless there was a term to that effect in the contract itself, rather than merely a “basis of the contract” clause in the proposal form. (para 7.83)
- (3) That our earlier proposals for business insurance should apply to MAT. (para 7.87)

1.19 Our tentative conclusion is that we should not extend the existing rights of third parties where there is negligent misrepresentation by the policyholder, but we welcome views on this issue. (para 7.92)

1.20 We ask if there is any reason not to apply our earlier proposals for business insurance to reinsurance. (para 7.95)

#### **Small businesses**

1.21 We ask:

- (1) To what extent small businesses should be treated in the same way as consumers. (para 7.104)
- (2) How small businesses should be defined for this purpose. (para 7.105)

#### **CONSULTATION PAPER**

1.22 We would very much value your views on these issues. The comments we receive will be taken into account as we draft our formal proposals, which will be published in a Consultation Paper in summer 2007.

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# PART 1: INTRODUCTION

## BACKGROUND

- 1.1 The English and Scottish Law Commissions are conducting a joint review of insurance contract law. This review covers both general and long-term insurance, and both commercial and consumer policies.
- 1.2 It is intended that any reforms we recommend will result in the same law applying to England and Wales and to Scotland. Insurance contract law is broadly similar in the two jurisdictions. However, there are important differences. For example, Scots law provides a different test of materiality for life insurance, looking at the issue from the point of view of a reasonable insured, rather than that of the “prudent underwriter”.<sup>1</sup>
- 1.3 In January 2006 we issued a Scoping Paper, explaining that the review would examine the law of misrepresentation, non-disclosure and breach of warranty.<sup>2</sup> We asked whether any other topics also needed to be considered. In the light of the responses received, we will be reviewing most of the areas referred to in the Scoping Paper. A paper setting out our decisions on scope and including extracts from the responses we received is available on our websites.<sup>3</sup>
- 1.4 We intend to publish a first formal consultation paper in summer 2007. Before then, we are developing our ideas through a short series of issues papers. This is the first such paper, dealing with misrepresentation and non-disclosure by the insured. It also deals briefly with “basis of the contract” clauses. The next paper will consider these in more detail, and also with specific warranties of existing facts and warranties as to the future. We regard these issues as being at the very heart of the review.
- 1.5 Some questions will be considered at a later stage. These include the insurer’s duty of good faith; the way that the law treats non-disclosure by one party in joint policies; and how to deal with disclosures to an intermediary that have not been communicated to the insurer. They are relevant to this topic but considerations of space and time preclude covering them in this paper.

<sup>1</sup> See paras 2.22 to 2.23 below.

<sup>2</sup> Insurance Contract Law, A Joint Scoping Paper (January 2006).

<sup>3</sup> We were pleased to receive 118 responses to the Scoping Paper. In August 2006 we published on our websites brief extracts from a selection of these responses and announced our decisions on scope.

## **STATUS OF ISSUES PAPERS**

- 1.6 This paper has been drafted by the teams working on the project at the English and Scottish Law Commissions. It has not been subject to formal scrutiny by Commissioners and does not represent fixed policy. This paper, together with subsequent papers, is simply intended to promote discussion before the formal consultation process begins. It should not be quoted as representing the views of either Commission.
- 1.7 Our final report will be accompanied by an impact assessment of any recommendations we make. We do not intend to include such an assessment in any of our issues papers, given that such papers merely indicate our provisional thoughts. Nevertheless, we would be interested to hear views on the practical implications of the changes we are suggesting.

## **PREVIOUS REPORTS**

- 1.8 Insurance law has been widely criticised by the judiciary, by practitioners, by academics and others. There have been reports calling for reform since 1957.<sup>4</sup> In our early work we have found three reports to be of particular assistance.
- 1.9 In 1980 the English Law Commission published a report in which it considered two aspects of insurance law - non-disclosure and breach of warranty. It concluded that:
- The law relating to non-disclosure and breach of warranty is undoubtedly in need of reform, and this reform has been too long delayed.<sup>5</sup>
- 1.10 We have found this report valuable, and consider its recommendations further in Part 3 below. However, the 1980 report was more limited in scope than the review we are now conducting. In particular:
- (1) It did not consider Scots law.
  - (2) It was limited to non-disclosure, misrepresentation and breach of warranty. By contrast, our current review will be considering a wider range of topics.<sup>6</sup>
  - (3) It excluded Marine, Aviation and Transport ("MAT") insurance from its recommendations. We are including them in the scope of our review.
  - (4) It only considered misrepresentation and non-disclosure by the insured. We will also be looking at misrepresentation and non-disclosure by the insurer, though these areas will be dealt with in a later issues paper.

<sup>4</sup> Conditions and Exceptions in Insurance, Fifth Report of the Law Reform Committee (1957) Cmnd 62.

<sup>5</sup> Insurance Law, Non-disclosure and Breach of Warranty (1980) Law Com No 104, para 1.21(a), p10.

<sup>6</sup> See *Analysis of Responses and Decisions on Scope* on our website address.

- 1.11 Furthermore, some parts of the 1980 report are now dated. For example, the report preceded the opening of the Insurance Ombudsman Bureau (“IOB”) in March 1981. We have looked carefully at how the Financial Ombudsman Service (“FOS”) — successor to the IOB — approaches these issues, and have tried to reflect the best elements of ombudsman practice into our proposals.
- 1.12 In 1997 the National Consumer Council investigated the operation of the law and self-regulation to identify what it termed “areas where consumers are manifestly still at risk”. It said:
- We conclude that the only effective solution to some of the serious problems encountered by consumers when it comes to buying personal insurance is legislative reform.<sup>7</sup>
- 1.13 In 2002 the British Insurance Law Association examined those areas of law which it felt were causing concern in the insurance market and in insurance disputes. Its report, which has been described by Lord Justice Longmore as “balanced and impressive”,<sup>8</sup> stated:
- We are satisfied that there is a need for reform.<sup>9</sup>
- 1.14 These three reports present a compelling case for a review and offer a range of potential solutions that are worth considering.
- 1.15 We have also been influenced by the different legal rules applied in other jurisdictions and the reforms introduced in Australia and France. The legal rules relating to non-disclosure and misrepresentation in some of these jurisdictions are summarised in Appendix F.

## **CONTENTS**

- 1.16 The remainder of this paper is split into the following parts:
- (1) In Part 2 we set out the current law.
  - (2) In Part 3 we look at how the strict legal rules have been supplemented by Statements of Practice issued by the Association of British Insurers (“ABI”), Rules issued by the Financial Services Authority (“FSA”) and guidance issued by the FOS. We also consider some of the reports that have been published criticising the law.
  - (3) In Part 4 we consider the current position of consumers – taking into account both the law and the measures described in Part 3.

<sup>7</sup> National Consumer Council, *Insurance Law Reform: the consumer case for review of insurance law* (May 1997) p5.

<sup>8</sup> *North Star Shipping Ltd v Sphere Drake Insurance plc* [2006] EWCA Civ 378, [2006] 2 Lloyd’s Rep 183 at [54].

<sup>9</sup> British Insurance Law Association, *Insurance Contract Law Reform* (September 2002) p1, para 5.

- (4) In Part 5 we set out the case for reforming insurance contract law as it applies to consumers.
- (5) In Part 6 we give tentative proposals for the reform of insurance contract law as it applies to consumers.
- (6) In Part 7 we set out the case for reforming insurance contract law as it applies to businesses and give our tentative proposals.

1.17 These parts are followed by six appendices:

- (1) In Appendix A, we outline how misrepresentation is dealt with under the general law of contract – first in England and Wales, and secondly in Scotland.
- (2) Appendix B contains copies of the ABI Statement of Long-Term Insurance Practice and the now repealed ABI Statement of General Insurance Practice.
- (3) Appendix C contains a brief commentary on the relevant provisions of the ABI Statements.
- (4) Appendix D contains guidance from the ABI entitled Application Form Design for Life and Health Protection Insurances.
- (5) Appendix E contains extracts from the FSA Conduct of Business and Insurance Conduct of Business Sourcebooks.
- (6) Appendix F contains a brief commentary on the relevant Rules within those Sourcebooks.
- (7) Appendix G deals with comparative law. It summarises how the issues of misrepresentation and non-disclosure are dealt with in Australia, New York, France and Norway.

## PART 2: THE CURRENT LAW

- 2.1 In this Part we describe the current law. First we explain that insurance contracts are regarded as having a special status, in that the parties are expected to act “with utmost good faith”. Then we look at the law of misrepresentation followed by the duty to disclose.

### UTMOST GOOD FAITH

- 2.2 An insurance policy is one of a small number of types of contract that are *uberrimae fides* - of the utmost good faith.<sup>1</sup>
- 2.3 For the purposes of this paper, we are interested solely in the impact of the duty at the pre-contractual stage, that is, before the contract has been formally concluded. As in law each renewal is a separate contract, the duty of disclosure also arises each time an insurance policy is renewed. We will consider the post-contractual duty of good faith in a later paper.

### The common law

- 2.4 At the pre-contractual stage, the effect of the duty of utmost good faith is that each party has obligations:
- (1) To refrain from misrepresenting material facts, and
  - (2) To disclose material facts even if no question is asked.
- 2.5 In contrast, ordinary commercial contracts start from the premise of *caveat emptor* – let the buyer beware.<sup>2</sup> A party to a contract *caveat emptor* must not misrepresent facts, but is under no obligation to disclose facts about which it is not asked.

### Reciprocity

- 2.6 The duty of utmost good faith lies on each party to a policy of insurance. Lord Mansfield's judgment in *Carter v Boehm* is the clearest early statement that the duty is reciprocal:

<sup>1</sup> Other such contracts include “contracts to subscribe for shares in a company, family settlements, contracts for the sale of land, contracts for suretyship and partnerships.” *Chitty on Contracts* (29<sup>th</sup> ed 2004) para 6-139).

<sup>2</sup> Though they are often subject to implied terms, such as those set out in the Sale of Goods Act 1979, ss 13, 14 and 15, which may have the indirect effect of requiring that the seller disclose defects.

Good faith forbids either party, by concealing what he privately knows to draw the other into a bargain from his ignorance of the fact, and his believing the contrary.<sup>3</sup>

- 2.7 However, in the past, the information relevant to the assessment of a risk has most commonly been in the knowledge of the applicant for insurance. This was recognised by Lord Mansfield:

Insurance is a contract upon speculation. The special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only: the underwriter trusts to his representation, and proceeds upon confidence that he does not keep back any circumstance in his knowledge, to mislead the underwriter into a belief that the circumstance does not exist, and to induce him to estimate the risque, as if it did not exist.<sup>4</sup>

- 2.8 The result has been that the duty has developed unevenly, so that it lies significantly more heavily on the applicant for insurance than on the insurer. This paper deals only with the duty on the insured. The duty on the insurer will be dealt with in a later paper.
- 2.9 Lord Mansfield's comments date from 1766, when insurers had access to fewer sources of information and when communications were very much slower than today. In some respects the balance of knowledge between insured and underwriter has changed markedly in the last 250 years.

### **Remedy for breach**

- 2.10 As a matter of law, a breach of the pre-contractual duty of utmost good faith will give the other party the right to avoid the policy "ab initio". This right must be exercised within a reasonable period after discovery of the breach. Until such time as the policy is avoided, it is valid and binding. On avoidance it is set aside as from outset – in other words, it is treated as if it never existed. This is so regardless of whether the breach was fraudulent, negligent or entirely innocent. Many allegations of a breach arise after a claim has been made. If a policy is avoided, any such claim may be rejected and any payments already made to the policyholder can be recovered.

### **The Marine Insurance Act 1906**

- 2.11 The Marine Insurance Act 1906 ("MIA 1906") partially codified the common law. Though strictly concerned only with marine insurance, many of its provisions are presumed to be equally applicable to other types of insurance:

<sup>3</sup> *Carter v Boehm* (1766) 3 Burr 1905, 1910. The doctrine of utmost good faith also applies in Scots law: see *Stewart v Morison* (1779) M 7080, 7081 and *The Spathari* 1924 SC 182, 196 (affd 1925 SC (HL) 6).

<sup>4</sup> *Carter v Boehm* (1766) 3 Burr 1905, 1909.

Although the issues arise under a policy of non-marine insurance it is convenient to state them by reference to the Marine Insurance Act 1906 since it has been accepted in argument, and is indeed laid down in several authorities, that in relevant respects the common law relating to the two types of insurance is the same, and that the Act embodies a partial codification of the common law.<sup>5</sup>

- 2.12 Section 17 of the MIA 1906 confirms that the duty of utmost good faith applies to both parties, and indicates the consequences of breach:

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.

### **MISREPRESENTATION**

- 2.13 Misrepresentation and non-disclosure are often pleaded and considered together. The law of non-disclosure has tended to dominate, with relatively little attention being applied to misrepresentation in an insurance context:

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

- 2.14 The difference between the two has been described as follows:

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

<sup>5</sup> *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] AC 501, 518, by Lord Mustill.

<sup>6</sup> J Birds & N J Hird, *Birds' Modern Insurance Law* (6<sup>th</sup> ed 2004) p 101.

<sup>7</sup> *Zurich General Accident and Liability Insurance Co v Leven* 1940 SC 406, 415, by Lord President Normand.



- 2.15 The practical significance of this distinction, as illustrated by the *Zurich General Accident* case,<sup>8</sup> is that misrepresentation of a material fact will afford grounds for avoidance of the policy whether or not the proposer was aware that it was incorrect, whereas avoidance for non-disclosure will be restricted to facts of which the proposer was aware and which they ought to have realised the insurer would regard as material.
- 2.16 In the consumer area, most insurers ask set questions. The cases brought before the Financial Ombudsman Service usually involve an inaccurate answer to one or more of those questions. Non-disclosure thus has come to assume a residual function. Below we consider whether it should still apply to consumer insurance. We therefore start by setting out the law of misrepresentation, before considering the law of non-disclosure.
- 2.17 We begin by outlining the rules relating to misrepresentation under insurance contract law and then consider misrepresentation under general contract law.

### **Misrepresentation in insurance contract law**

#### **The obligation not to misrepresent material facts**

- 2.18 As an aspect of the common law duty of utmost good faith, the potential parties to a policy of insurance are under an obligation not to misrepresent facts that are material to the insurer's decision whether or not to accept the risk. Above, we point out that this obligation, whilst reciprocal, lies more heavily on the applicant for insurance. This emphasis is reflected in section 20(1) of the MIA 1906 which deals only with the obligation of applicants:

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

#### **The test of materiality**

- 2.19 It might be thought that when a proposal form asks a question, the answer would always be material and, if it were inaccurate, would amount to a misrepresentation. However this is often not so. Many questions are asked in rather general terms and it is difficult to know the full extent of what is wanted. For example, an insured who is asked if they have had medical tests for illness may not interpret this as referring to routine tests (e.g. blood pressure checks) or even to non-routine tests that were completely negative. The answer may be inaccurate or incomplete, but if the insurer is to have a remedy for misrepresentation the inaccuracy or incompleteness must also be material. The test of materiality is set out in Section 20(2) of the MIA 1906:

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

<sup>8</sup> Above.

2.20 Until 1994, there were two further vital questions relating to the interpretation of the section 20(2) test:

- (1) Does "would influence the judgment" require that the influence would be decisive? There are no doubt many matters of which an insurer would wish to be aware. Some will be decisive in the decision-making process - for example, a prior conviction for insurance fraud may of itself lead an insurer to decline an application. Others will not be decisive but may, taken with other factors, affect an insurer's assessment of the risk.
- (2) When is the remedy of avoidance available? In particular, can an insurer avoid a policy if it was not induced to enter into it by the misrepresentation?

2.21 For English law, these questions were answered in the landmark case of *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*.<sup>9</sup> The House of Lords decided that:

- (1) A material circumstance is one that would have an effect on the mind of the prudent insurer in assessing the risk and it is not necessary that it would have a decisive effect on the insurer's acceptance of the risk or on the amount of premium charged.
- (2) Before an insurer may avoid a contract for misrepresentation of a material circumstance it has to show that it was induced by the misrepresentation to enter into the policy on the relevant terms.

2.22 In Scots law, the *Pan Atlantic* test of materiality applies other than for life insurance.<sup>10</sup> Materiality in the case of life assurance is judged by the "reasonable assured" test, set out in *Life Association of Scotland v Foster*.<sup>11</sup> Lord President Inglis described the insured's duty as follows:<sup>12</sup>

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

2.23 In *Cuthbertson v Friends' Provident Life Office*,<sup>13</sup> Lord Eassie observed that the *Foster* test has two elements:

<sup>9</sup> [1995] AC 501. The case mainly concerns non-disclosure, but the tests apply equally to misrepresentation.

<sup>10</sup> *Hooper v Royal London General Insurance Co Ltd* 1993 SC 242.

<sup>11</sup> (1873) 11 M 351.

<sup>12</sup> Above at 359.

<sup>13</sup> [2006] CSOH 74; 2006 SLT 567. The case concerned critical illness cover. It was common ground between the parties, and accepted by the court, that the test applicable to life assurance also fell to be applied to critical illness cover.

- (1) For any fact to be material, it must be material in the view of the reasonable underwriter - "If the fact were regarded by such an underwriter as of no significance, *cadit quaestio*<sup>14</sup>."
- (2) Additionally, the insurer must show that either:
  - (a) "The proposer appreciated that the fact in question would have had that significance", or, assuming that the proposer did not have that appreciation,
  - (b) "A reasonable person making the proposal and possessed with the factual knowledge possessed by the actual proposer would think that fact to be material to the insurer".

2.24 Given that the obligation lies primarily on the proposer, it seems preferable to look at the issue from the point of view of a reasonable person making the proposal. We return to this point in Part 6.

### **Unusual views, niche markets and affinity schemes**

- 2.25 There is an aspect of both the *Pan Atlantic* and the *Cuthbertson* tests which is uncertain and which may operate against the interests of the insurer. Where an insurer asks a clear question it seems reasonable that it should expect the prospective policyholder to take adequate care to answer correctly, and that a suitable remedy should be available where there is a failure to do so. However, the first limbs of the *Pan Atlantic* and *Cuthbertson* tests are objective. What happens, therefore, when the clear question relates to a matter material to this particular insurer but which would be irrelevant to any other insurer?
- 2.26 An underwriter may, for example, take a different attitude to the rest of the market in assessing a particular type of risk based on experience, difference of opinion or a desire to carve out a niche market. The issue may also arise with affinity schemes. An insurer may, for example, offer a special deal on household insurance to members of a particular union. For the rest of the market, membership of that union is irrelevant to the assessment of the risk. However the insurer in question will ask a specific question which will determine whether wider cover and a lower premium are granted.
- 2.27 If a wrong answer is given by an applicant for insurance, and no fraud is involved, will the insurer have a remedy? The question relates to facts that are not material under the first limbs of the *Pan Atlantic* and *Cuthbertson* tests or under section 20(2) of the Marine Insurance Act 1906. If the courts were to apply these tests strictly, there is no actionable misrepresentation even though the wrong answer may induce the contract.
- 2.28 A partial answer may be that it will be necessary to consider some characteristics of the actual insurer to establish what a reasonably prudent insurer would regard as material:

<sup>14</sup> "The question falls" - that is, the fact is sufficient to settle the matter.

For example, in the case of a proposed motor insurance, it would surely be appropriate to ask what the reasonably prudent motor insurer would regard as material. It struck me that there may be other characteristics of the particular insurer which might be relevant. So here, it seems to me that it might be relevant to ask whether a speeding conviction would be material to the reasonably prudent insurer with a 'points' system of underwriting.<sup>15</sup>

### **Belief or fact?**

- 2.29 A statement of opinion or belief is not in itself a statement of fact. However, the person expressing the opinion or belief impliedly represents that they genuinely believe it to be true. If they express it dishonestly, they therefore make a fraudulent misrepresentation. Section 20(3) of the MIA 1906 provides:

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

- 2.30 In general contract law the courts have often held that there is not only a representation that the opinion or belief is honestly held but also that it is based on reasonable grounds.<sup>16</sup> Insurance law differs in that there is no representation that there are reasonable grounds for the opinion or belief. The absence of this requirement derives from section 20(5) of the MIA 1906:

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

- 2.31 An illustration of this principle is to be found in *Economides v Commercial Union Assurance Co.*<sup>17</sup> A 21 year old man undervalued the contents of his flat after his parents moved in with him. As his statements on this issue were found to be a matter of opinion rather than fact, it was sufficient that they were held in good faith. It was not necessary that they should be based on reasonable grounds.

### **The remedies for misrepresentation under the MIA 1906**

- 2.32 Under the MIA 1906 the remedy for misrepresentation is avoidance. An insurer may avoid a policy regardless of whether the misrepresentation by the consumer was fraudulent, negligent or entirely innocent. Avoidance normally requires restitution: the parties must be restored to the positions they were in prior to the contract being made. This has two important elements:

- (1) The insurer may reject any claim that has been made, and recover any claims payments already made.
- (2) In most cases, the policyholder may demand the return of the premium paid.

<sup>15</sup> *Drake Insurance v Provident Insurance* [2003] EWCA Civ 1834, [2004] QB 601 at [140] to [141], by Clarke LJ.

<sup>16</sup> *Brown v Raphael* [1958] Ch 636.

There is an exception to (2) in the case of fraudulent misrepresentation. For marine insurance the matter is dealt with by section 84(3)(a) of the MIA 1906, which states:

Where the policy is void, or is avoided by the insurer as from the commencement of the risk, the premium is returnable, provided that there has been no fraud or illegality on the part of the assured...

- 2.33 For non-marine insurance, the point is not wholly clear, and depends on general principles of contract law.<sup>18</sup>

### **Misrepresentation in general contract law**

- 2.34 The insurer's rights under the MIA 1906 are, at least in principle, supplemented by and qualified by the general law of misrepresentation. The law in this area is particularly complex, and is set in more detail in Appendix A. Here we deal only with three points: the availability of damages; restrictions on the right to avoid (or "rescind") a contract that has been entered as the result of a misrepresentation; and whether the general law provides the only remedy for misrepresentations that are not material to the risk.

### **The right to damages**

- 2.35 In both jurisdictions the victim of a fraudulent misrepresentation is entitled to claim damages. A misrepresenter commits the tort of deceit in English law or entitles the other party to reparation in Scots law if they make a material statement (which causes loss) that they know is not true, or if they know the statement may or may not be true and make it nonetheless.<sup>19</sup>
- 2.36 In each jurisdiction there is now also, in effect, liability in damages created by statute for negligent misrepresentation by one of the parties to the contract.<sup>20</sup> In England and Wales, a party who makes a non-fraudulent misrepresentation will nonetheless be liable in damages "as if he were fraudulent" unless they prove that they had reasonable ground to believe, and did believe up to the time the contract was made, that the facts represented were true.<sup>21</sup> In Scotland, the statute appears to create liability for negligent misrepresentation without resorting to the English "fiction of fraud".<sup>22</sup>

<sup>17</sup> [1998] QB 587.

<sup>18</sup> See *Berg v Sadler & Moore* [1937] 2 KB 158 and *Clough v London and North Western Railway Co* (1971-72) LR 7 Ex 26.

<sup>19</sup> *Derry v Peek* (1889) LR 14 App Cas 337. See further below, paras 6.36 and A.26.

<sup>20</sup> There may also be liability for negligent misrepresentation at common law, including where the misrepresentation is made by a person who is not party to the contract. However, in the light of the statutory provisions, negligence in common law is of no relevance in this context.

<sup>21</sup> Misrepresentation Act 1967, s 2(1).

<sup>22</sup> Law Reform (Miscellaneous Provisions) (Scotland) Act 1985, s 10(1). For some of the difficulties caused by the "fiction of fraud" see below, para A.19.

2.37 In principle, therefore, an insurer that has suffered a loss as the result of a fraudulent or negligent misrepresentation can recover damages. However a leading authority on English insurance writes that there are no known cases in which an insurer has claimed damages from an insured.<sup>23</sup> This is perhaps not surprising, even in cases of fraud. The main potential loss to the insurer will normally be prevented by avoidance of the policy, and if there has been fraud the insurer's right to retain the premium will probably cancel out any further loss.

### **Restrictions on the right to rescind**

2.38 In England and Wales, section 2(2) of the Misrepresentation Act 1967 gives the court a discretion to refuse to permit rescission for non-fraudulent misrepresentation.<sup>24</sup> It must then award damages in lieu of rescission.<sup>25</sup> In principle this might be applied to an insurance case, but it has been held that it should not normally be applied to commercial insurance.<sup>26</sup> It is unclear whether it might apply to consumer cases, and we have not found a case in which the point has been taken.

### **Misrepresentations that are not relevant to the risk**

2.39 There has been a recent suggestion - without a decision being reached - that a fact is not material unless it goes to the risk insured:<sup>27</sup>

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

<sup>23</sup> M Clarke, *The Law of Insurance Contracts* (4<sup>th</sup> ed, 2002) 23-15.

<sup>24</sup> There is no equivalent provision in Scots law.

<sup>25</sup> The measure of damages is obscure. See paras A23 to A24 below.

<sup>26</sup> *Highland Insurance Co v Continental Insurance Co* [1987] 1 Lloyd's Rep 109, 118.

<sup>27</sup> *North Star Shipping Ltd v Sphere Drake Insurance plc* [2006] EWCA Civ 378, [2006] 2 Lloyd's Rep 183, at [50].

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

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

## **NON-DISCLOSURE**

- 2.40 As an aspect of the common law duty of utmost good faith, the potential parties to a policy of insurance are under an obligation to disclose all material facts, subject to the exceptions discussed below. There is no obligation in insurance contract law for insurers to ask any questions at all at the time of an application or renewal.
- 2.41 It may come as a surprise to many policyholders – particularly consumers - that they are expected to disclose information about which they have not been asked. In our Scoping Paper we quoted Professor Malcolm Clarke’s criticism of the current position:

Applicants in England may complete the form with scrupulous care, but still find that there was something else material to prudent insurers which, apparently, the particular insurer did not think to ask about but which, nonetheless, the applicant was expected to think of and disclose.<sup>31</sup>

### **The obligation to disclose material facts**

- 2.42 Section 18(1) of the MIA 1906 expresses the obligation on applicants in the following terms:

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

It is only business policyholders who are deemed to know every circumstance which in the ordinary course of business ought to be known by them. We discuss this point further in Part 6.<sup>32</sup>

<sup>29</sup> *The Dora* [1989] 1 Lloyd’s Rep 69.

<sup>30</sup> See MIA s 18(2) (para 2.43 below) and s 20(2) (para 2.19 above).

<sup>31</sup> MA Clarke, *Policies and Perceptions of Insurance Law in the Twenty-first Century* (2005) p 103.

<sup>32</sup> See para 6.46 below.

### **The test of materiality**

2.43 The test of materiality is set out in Section 18(2) of the MIA 1906:

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

2.44 This is the same test as found in Section 20(2) of the MIA 1906, and the points made earlier in relation to misrepresentation are therefore applicable.

### **Exceptions**

2.45 There are four categories of exception to the general duty of disclosure:

- (1) Facts which reduce the risk. It may not, of course, always be clear-cut whether a risk is reduced. A sprinkler system, for example, may reduce losses by fire. However, false activation of the system may cause damage which would otherwise not have occurred.
- (2) Facts which the insurer knows or is presumed to know.
- (3) Facts which are common knowledge.
- (4) Facts of which the insurer has waived disclosure.

### **Remedies**

#### **Avoidance**

2.46 As with misrepresentation, the remedy for non-disclosure is that the insurer may avoid the contract.

#### **Damages**

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

Once it is accepted that the principle of the utmost good faith imposes meaningful reciprocal duties, owed to the insurers and vice versa, it seems anomalous that there should be no claim for damages for breach of those duties in a case where that is the only remedy.<sup>33</sup>

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

<sup>33</sup> [1987] 2 WLR 1300, 1332, by Steyn J.



We think the clear inference from the Act of 1906 is that Parliament did not contemplate that a breach of the obligation would give rise to a claim for damages in the case of such contracts. Otherwise it would surely have said so. It is not suggested that a remedy is available in the case of non-marine policies which would not be available in the case of marine policies.<sup>34</sup>

Despite some contrary suggestions,<sup>35</sup> it seems to be accepted as settled law in England and Wales that even deliberate non-disclosure does not give rise to liability in damages, as deceit or fraud requires a positive misrepresentation.<sup>36</sup>

## **RENEWALS**

- 2.48 With the exception of some types of life insurance, most insurance policies have a fixed term. Typically this is one year, at the end of which the policy falls due for renewal. Although the process is referred to as "renewal" the legal position is clear - a new contract is formed. The law of misrepresentation and non-disclosure therefore applies to renewals in the same way as it applies to fresh applications for insurance.
- 2.49 At renewal, however, there may be an additional potential pitfall for a policyholder. Rather than - or in addition to - specific questions, an insurer may simply ask whether there has been any change in material circumstances. To be certain of answering this question accurately, a policyholder should review all the information previously submitted to the insurer. Unfortunately the policyholder will not usually have been given a copy of the original proposal form, and in many cases will not have retained copies of information submitted at subsequent renewals.

## **BASIS OF THE CONTRACT CLAUSES**

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

<sup>34</sup> [1990] 1 QB 665, 781, by Slade LJ.

<sup>35</sup> *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank* [2001] E.W.C.A. Civ. 1250; [2001] 2 Lloyd's Rep. 483 at [48], [164] and [168]; see also *Conlon v Simms* [2006] E.W.H.C. 401 (Ch.); [2006] 2 All E.R. 1024 (partnership).

<sup>36</sup> *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank* [2003] U.K.H.L. 6; [2003] 1 All E.R. (Comm) 349 at [75] ("nondisclosure (whether dishonest or otherwise) does not as such give rise to a claim in damages"); *Manifest Shipping Co v Uni-Polaris Insurance Co, The Star Sea* [2001] U.K.H.L. 1; [2003] 1 A.C.469, at [46].

- 2.51 Such clauses elevate the answers in proposal forms to contractual warranties, even if the terms are not to be found in the contract itself. This means that in effect an insurer may avoid liability for an inaccurate representation, even if it was not material. For example, in *Dawsons Ltd v Bonnin*,<sup>37</sup> the insured was asked where their lorry was garaged. They inadvertently gave the firm's place of business in central Glasgow, though the lorry was usually kept in the outskirts. This did not increase the risk, and arguably decreased it. However, when the lorry was destroyed by fire, the insurers were allowed to treat the policy as terminated by the breach of warranty, even though the misrepresentation was immaterial.
- 2.52 Although the effect of basis of the contract clauses has been confirmed as recently as 1996,<sup>38</sup> there has been widespread criticism of their use.<sup>39</sup> In 1997, the National Consumer Council described them as "completely unfair".<sup>40</sup> We understand that they have been outlawed in Australia and New Zealand. For example, section 24 of the Australian Insurance Contracts Act 1984 provides that a statement by the insured about the existence of a current state of affairs should take effect only as a representation, not as a warranty. A provision along similar lines may be needed to prevent evasion of our other proposals.
- 2.53 Our present view is that an insurer should not be able to rely on a simple basis of the contract clause to give it rights that it would not have under the law of misrepresentation or non-disclosure. We note with interest that the Statement of General Insurance Practice effectively prohibited the use of basis of the contract clauses in consumer insurances.<sup>41</sup> However, we intend to address the matter more fully in our second issues paper, which will be on warranties.

<sup>37</sup> [1922] 2 AC 413.

<sup>38</sup> *Unipac (Scotland) Ltd v Aegon Insurance* [1996] SLT 1197.

<sup>39</sup> See, for example, the 1980 report para 7.2 and *Joel v Law Union and Crown Insurance Co* [1908] 2 KB 863, 885; *Glicksman v Lancashire and General Assurance Co* [1927] AC 139, 144 to 145; *Mackay v London General Insurance Co* [1935] Lloyd's Law Reports 201 and Lord Russell's comments in *Provincial Insurance v Morgan* [1933] AC 240, 250.

<sup>40</sup> NCC, *Insurance Law Reform*, May 1997, p 28.

<sup>41</sup> See Appendix B below.

## **PART 3**

# **PREVIOUS REPORTS, SELF-REGULATION AND STATUTORY REGULATION**

- 3.1 In this Part we provide an overview of some of the more important measures of self-regulation and statutory regulation introduced in recent years. We do so because we believe that some knowledge of these developments is vital to understanding the current position of consumers, which we discuss later. Given this limited purpose we have not attempted to provide a full history, and indeed we have omitted some measures altogether.<sup>1</sup>
- 3.2 This is also a convenient point to consider some of the previous reports which called for reform, and to outline the recommendations they have made in respect of consumers and businesses.

### **ENGLISH LAW REFORM COMMITTEE REPORT 1957**

- 3.3 Insurance contract law was considered by the Law Reform Committee in 1957.<sup>2</sup> The Committee did not make formal recommendations, but suggested three reforming provisions it felt could be enacted without legal difficulties:
- (1) For the purposes of a contract of insurance no fact should be deemed material unless it would have been considered material by a reasonable insured.
  - (2) An insurer should not be able to rely on misrepresentation if the insured could prove that the statement was true to the best of the insured's knowledge and belief.
  - (3) An intermediary who arranged a contract of insurance should be deemed for the purposes of the formation of the contract, to be the agent of the insurer. Consequently anything disclosed to the intermediary would be deemed disclosed to the insurer.

These suggestions were not implemented.

- 3.4 A similar report by the Law Reform Committee for Scotland made no proposals for reform,<sup>3</sup> concluding that there was "...no demand in Scotland for any alteration in the law with regard to the subject of our remit".<sup>4</sup>

<sup>1</sup> For example, the Insurance Brokers Registration Council.

<sup>2</sup> Fifth Report of the Law Reform Committee (1957) Cmnd 62.

<sup>3</sup> Fourth Report of the Law Reform Committee for Scotland (1957) Cmnd 330.

<sup>4</sup> Above at para 25.

## THE STATEMENTS OF PRACTICE 1977

- 3.5 In 1977 the British Insurance Association (predecessor to the ABI) and Lloyd's issued a Statement of General Insurance Practice ("SGIP"). This was followed later in the same year by a Statement of Long-Term Insurance Practice ("SLIP") issued by the Life Offices' Association (now part of the ABI) and the Associated Scottish Life Offices.
- 3.6 It appears that these Statements were introduced as part of an agreement with the Government, under which insurance contracts were exempted from key provisions of the Unfair Contract Terms Act 1977.<sup>5</sup> We are told that the title "Statement" was chosen in preference to "Code" to make it clear that in the industry's view the provisions merely confirmed current practice.
- 3.7 It was intended that the Statements would address some of the harsher aspects of the law for consumers. Both Statements required proposal forms to contain warnings regarding the duty of disclosure and the consequences of any breach. In addition, insurers were required to ask clear questions about matters which were generally found to be material.
- 3.8 The Statements did not directly change the test of materiality. Nor did they explicitly refer to avoidance. They did, however, restrict the right of an insurer to repudiate liability for a claim – and such repudiation could only take place after the policy had been avoided. The Statements did not address the situation where no claim had been made. Whilst many allegations of misrepresentation or non-disclosure are undoubtedly raised after a claim, these issues can arise in other circumstances.
- 3.9 SGIP provided that in cases of fraud, deception or negligence, an insurer's right to repudiate a claim remained unchanged. Otherwise - presumably in cases where a misrepresentation or non-disclosure was innocent - insurers should not:
- unreasonably repudiate liability to indemnify a policyholder:-
- on the grounds of non-disclosure or misrepresentation of a material fact where knowledge of the fact would not materially have influenced the insurer's judgment in the acceptance or assessment of the insurance.
- 3.10 This effectively anticipated the *Pan Atlantic* decision by requiring actual inducement.
- 3.11 SLIP was less clear:

<sup>5</sup> Unfair Contract Terms Act 1977, schedule 1, para 1(2)(1)(a).

An insurer will not unreasonably reject a claim. (However, fraud or deception will, and negligence or non-disclosure or misrepresentation of a material fact may, result in adjustment or constitute grounds for rejection). In particular, an insurer will not reject a claim on grounds of non-disclosure or misrepresentation of a matter that was outside the knowledge of the proposer.

- 3.12 The word "or" between negligence and non-disclosure suggests that these are separate grounds for rejection of a claim. If this is correct, the only obligation on the insurer in respect of misrepresentation or non-disclosure is not to "unreasonably" reject a claim.
- 3.13 The weak nature of the protections offered by the Statements led one academic to describe them as "a rather pointless exercise".<sup>6</sup>
- 3.14 Detailed criticisms of the Statements were also made in the English Law Commission's Report of 1980.<sup>7</sup>

#### **ENGLISH LAW COMMISSION REPORT 1980**

- 3.15 In 1975, a draft European Directive called for the harmonisation of the essential provisions of insurance contract law. By 1978 there was a separate draft Directive modelled on French law and aimed at achieving a measure of harmonisation. In 1978, against this background, the Lord Chancellor referred insurance contract law to the Commission.

#### **The central problem**

- 3.16 The report concluded that the current duty of disclosure is far too stringent. It argued that a duty of disclosure based on what a "prudent insurer" thinks is material is inherently unreasonable:

It requires every insured to disclose any fact which a prudent insurer would consider to be material, and entitles the insurer to repudiate the policy and to reject any claim in the event of any breach of this duty. However, an honest and reasonable insured may be quite unaware of the existence and extent of this duty, and even if he is aware of it, he may have great difficulty in forming any view as to what facts a prudent insurer would consider to be material."<sup>8</sup>

- 3.17 As a result, a policyholder may act honestly and reasonably and still find that the insurer is entitled to avoid the policy. Furthermore, the duty of disclosure can operate as a trap in relation to proposal and renewal forms. A reasonable insured may think that it is sufficient to answer the questions presented, and find that they are later deprived of the cover they thought they had bought.

<sup>6</sup> See J. Birds, "The Statement of Insurance Practice — A Measure of Regulation of the Insurance Contract" (1977) 40 *Modern Law Review* 677.

<sup>7</sup> Insurance Law Non-Disclosure and Breach of Warranty (1980) Law Com No 104, paras 3.24 to 3.30.

<sup>8</sup> Above at para 9.3(i).

### **Voluntary measures unsatisfactory**

3.18 The insurance industry did not attempt to defend the law in its present form. Instead, they argued that any faults had been cured through the 1977 Statements of Practice. However, the Law Commission thought that the statements “are themselves evidence that the law is unsatisfactory and needs to be changed”.<sup>9</sup> It gave three reasons:

- (1) The Statements left insurers as the sole judge of whether rejection of a claim was reasonable.
- (2) The Statements did not have the force of law and, indeed, the liquidator of an insurance company would be bound to disregard them.
- (3) The Statements were restricted to policyholders effecting policies in their private capacity - but the mischiefs in the law also affected businesses.

3.19 The Commission was particularly scathing about the suggestion that insurers should have discretion “to repudiate a policy on technical grounds if they suspect fraud but are unable to prove it”.<sup>10</sup> This placed insurers in the position of judge in their own cause.

### **Modifying the duty of disclosure**

3.20 The Commission considered that the duty of disclosure should be modified rather than abolished. It thought that insurers still relied on information volunteered by policyholders. Without it, insurers would be less able to differentiate between good and bad quality risks, leading to higher premiums for honest and reasonable policyholders.

3.21 This approach applied to both consumers and businesses. The Commission thought that abolition would enable “sharp practice” by consumers.<sup>11</sup> It would also hamper the granting of temporary cover prior to a proposal form being completed. Indeed, any division between consumers and business was thought by the Commission to be artificial; it felt the dividing line should really be between “professionals” and “non-professionals”. Special rules for consumers would lead to complex law, as there would then be three categories:

- (1) Consumers.
- (2) Businesses.
- (3) Marine, Aviation and Transport risks.

<sup>9</sup> Above at para 3.28.

<sup>10</sup> Above at para 6.10, when it made this explicit condemnation of the provisions on warranties.

<sup>11</sup> Above at paras 4.34 to 4.42 and 10.8.

So far as businesses were concerned, most other systems of law imposed such a duty and abolition might cause the British insurance industry to lose international competitiveness. Instead, the Commission attempted to draw a better balance between the interests of the insurer and those of the policyholder.

#### **A reasonable insured test**

3.22 The Commission recommended that an applicant for insurance should only be required to disclose those facts that a reasonable person in the position of the applicant would disclose. Thus an applicant for insurance would be obliged to disclose a fact only if:

- (1) It is material in the sense that it would influence a prudent insurer in deciding whether to offer cover against the proposed risk and, if so, at what premium and on what terms; and
- (2) It is either known to the applicant or it is one which the applicant can be assumed to know. For this purpose the applicant should be assumed to know a material fact if it would have been ascertainable by reasonable enquiry and if a reasonable person applying for the insurance in question would have ascertained it; and
- (3) It is one which a reasonable person in the position of the applicant would disclose to the insurer, having regard to the nature and extent of the insurance cover which is sought and the circumstances in which it is sought.<sup>12</sup>

3.23 The final limb allows the court to make a distinction between, say, a small business and a large business with in-house insurance expertise. However, it was not intended that an individual's personal characteristics would be considered.

3.24 Regard should be had to the nature and extent of the insurance cover sought. A reasonable person might not disclose facts relevant to health when applying for a household policy, and a lesser degree of disclosure might be expected from those applying for mere temporary cover. The circumstances in which cover is sought should be considered. An application by telephone might be treated differently to an application made on paper.

#### **Only reasonable enquiries**

3.25 It was felt that a policyholder should be required to make reasonable enquiries, but not to undertake elaborate investigations. The Commission recommended that even if an answer on a proposal form proved to be inaccurate, a policyholder should be regarded as having met the duty of disclosure if two conditions were satisfied:

<sup>12</sup> Above at paras 4.43 to 4.53 and 10.9.

- (1) The policyholder, before answering, had carried out enquiries that were reasonable having regard to the subject matter of the question and the nature and extent of the cover sought.
- (2) The answer was correct to the policyholder's best knowledge and belief.

In such circumstances, it was also recommended that the insurer should not be entitled to pursue an alternative remedy for misrepresentation.<sup>13</sup>

### **Proposal and renewal forms**

- 3.26 The Commission recommended that proposal forms should contain clear, explicit and prominent warnings about the standard of answers required, the duty to volunteer information and the consequences of failing to meet these obligations.<sup>14</sup> A copy of the completed proposal form should be provided to a policyholder after completion or as soon after as is reasonably practicable.<sup>15</sup>
- 3.27 In the event of a failure to meet these requirements, an insurer would be unable to rely on any non-disclosure by the policyholder — subject to the court having a discretion to allow the insurer to rely on the non-disclosure if the failure caused no prejudice to the policyholder.
- 3.28 The Commission further recommended that if a policy had been initiated by the completion of a proposal form the insurer should only have a remedy for non-disclosure at renewal if it had taken the following steps:
  - (1) Supplied the policyholder with copies of any information that the policyholder had previously submitted to the insurer.
  - (2) Warned the policyholder of the importance of retaining such copies.
  - (3) Warned the policyholder of the duty to volunteer information and the consequences of failing to meet this obligation.
- 3.29 For policies not initiated by proposal form, only the third step was required.

### **Anti-avoidance**

- 3.30 The Commission recommended measures to prevent insurers from avoiding the reforms.
- 3.31 First, it thought that where a policyholder's failure to provide an insurer with information amounts to both a non-disclosure and a non-fraudulent misrepresentation, an insurer's rights would be limited to those — if any — available for non-disclosure.<sup>16</sup>

<sup>13</sup> Above at paras 4.61 to 4.62 and 8.5.

<sup>14</sup> Above at para 10.14.

<sup>15</sup> Above at para 10.15.

<sup>16</sup> Above at para 8.5.



- 3.32 Secondly, it recommended measures to curb the use of “basis of the contract” clauses.<sup>17</sup> The Commission recommended that such clauses should be ineffective insofar as they seek to create warranties as to past or present fact.

### **Rejected options**

- 3.33 The English Law Commission specifically rejected two further options for reform.

### **No requirement for a causal link**

- 3.34 The Commission rejected the idea that the insurer would be required to show a link between a non-disclosure and any loss that had occurred.<sup>18</sup> It argued that an insurer assesses a risk at a fixed point - the time at which an application for insurance is considered. A non-disclosure may cause it to offer cover which it would not otherwise have granted, or where a different premium or different terms would have been applied. It would be wrong to hold an insurer to such a contract. Furthermore, where the non-disclosure relates to moral hazard, such as the applicant's claims record or criminal convictions, it would be rare that a link can be shown with any loss that occurs. It seems unfair that the insurer has no remedy when the applicant has acted unreasonably.

### **The “all or nothing” rule maintained**

- 3.35 The Commission concluded that there should not be a remedy based on the proportionality principle.<sup>19</sup> It specifically rejected the idea that claims should be reduced to reflect the ratio between the premium paid and the premium that should have been paid. In many cases it would be difficult to establish what premium should have been charged. Furthermore, the insurer may not necessarily have charged a higher premium: it may have declined the risk altogether or imposed additional warranties, exclusion clauses, or excesses. In such cases a reduction in the claim paid would become arbitrary.

### **THE INSURANCE OMBUDSMAN BUREAU 1981**

- 3.36 The Insurance Ombudsman Bureau ("IOB") was the first private-sector ombudsman scheme in the UK, and the first complaints-handling service formally to use the title "ombudsman". It was established on a voluntary basis by three insurers and commenced operations in March 1981. The IOB investigated complaints against insurers and was able to make awards which, if accepted by the complainant, were binding on an insurer to a limit of £100,000. Until 1994, it could consider complaints relating to general or life insurance.
- 3.37 The ombudsman concept met with enthusiasm from the public. Further insurers joined until almost all were members.

<sup>17</sup> Above at paras 7.8 to 7.11

<sup>18</sup> Above at paras 4.89 to 4.97 and 10.30.

<sup>19</sup> Above at paras 4.4 to 4.17 and 10.6.

## **THE STATEMENTS OF PRACTICE 1986**

- 3.38 The 1980 report was never implemented. Instead, the industry reached agreement with the Government that the Statements of Practice would be strengthened in place of law reform.
- 3.39 On 31 October 1980 the Department of Trade and Industry circulated a consultation paper seeking views on the English Law Commission's 1980 report. The responses indicated a division of opinion between consumers and others who wished to see reform, and insurers who argued that there was no need for radical or urgent change.
- 3.40 In 1984 the DTI put forward a Bill based on the 1980 report but limited to consumers. However, this was subsequently abandoned and on 20 December 1984 the Secretary of State made the following announcement:
- I am embarking on discussions with the insurance industry to see whether changes to their statements of insurance practice can be made to deal with problems in those areas. I shall review whether legislation is appropriate and feasible in the light of whatever changes may be agreed.
- 3.41 On 21 February 1986, the Secretary of State confirmed that the DTI had accepted changes in the Statements as an alternative to law reform:
- The insurers have informed me that they are willing to strengthen the non-life and long-term statements of insurance practice on certain aspects proposed by the Department.... I am well aware of the arguments, advanced amongst others by the representatives of consumers, in favour of legislation on non-disclosure and breach of warranty. But I consider that on balance the case for legislation is outweighed by the advantages of self-regulation so long as this is effective.
- 3.42 The 1986 version of SGIP remained in force until 14 January 2005. It was then withdrawn with the introduction of statutory conduct of business regulation for general insurance. However, it continues to be taken into account by the Financial Ombudsman Service as an indicator of good practice.<sup>20</sup> SLIP remains in force – see paragraph 3.72. Both Statements are reproduced in Appendix B to this paper.

<sup>20</sup> Ombudsman News 39.

## **FINANCIAL SERVICES ACT 1986**

### **LAUTRO and FIMBRA**

- 3.43 Regulation of the conduct of investment business was introduced in 1988 under the Financial Services Act 1986. It was a two-tier system, with a statutory regulator - the Securities and Investments Board - overseeing self-regulating organisations and recognised professional bodies. The two self-regulating organisations for insurance were the Life Assurance and Unit Trust Regulatory Organisation ("LAUTRO") and the Financial Intermediaries, Managers and Brokers Association ("FIMBRA"). LAUTRO appointed IOB to act as its primary complaints-handling mechanism. For most of the time FIMBRA operated, it offered an arbitration scheme.

### **PIA**

- 3.44 In 1994 LAUTRO and FIMBRA were replaced by a single self-regulating organisation - the Personal Investment Authority ("PIA"). The PIA established its own Ombudsman, leading the IOB to lose jurisdiction over life insurance.

## **NATIONAL CONSUMER COUNCIL REPORT 1997**

- 3.45 In 1997 the National Consumer Council ("NCC") published a report written by Professor John Birds, then of Sheffield University, which considered the impact of insurance law on consumers:

Almost every household in the country regularly buys personal insurance of one kind and another, to safeguard the value of their personal belongings, home, income, health, travel and so on, in case of crime, accident or other disaster. And every time they buy – or renew – a policy, the transaction is governed by law that has remained largely unchanged for hundreds of years. Large parts of that law, it is widely acknowledged, are heavily biased against the interests of consumers.

- 3.46 The NCC took into account the 1986 Statements of Practice but concluded that there were still areas "where consumers are manifestly still at risk". It recommended reform in a range of areas:

We conclude that the only effective solution to some of the serious problems encountered by consumers when it comes to buying personal insurance is legislative reform.

- 3.47 With regard to misrepresentation and non-disclosure, the NCC made a series of recommendations.

### **The test of materiality**

- 3.48 The NCC recommended that a consumer should be required to disclose those facts within the consumer's knowledge which either the consumer knows to be relevant to the insurer's decision or which a reasonable person in the circumstances could be expected to know to be relevant.
- 3.49 It also recommended that an untrue statement should not be treated as a misrepresentation if the applicant honestly believed it to be true.

### **Remedies**

- 3.50 The NCC recommended that avoidance should continue to be available as a remedy for fraudulent misrepresentation or non-disclosure.
- 3.51 For other cases, the rights of the insurer would depend on the action the insurer would have taken had it known of the true facts:
- (1) If the insurer would have declined to offer cover, it should be entitled to avoid the policy.
  - (2) If the insurer would have offered cover, it should retain liability under the policy but should be entitled to deduct the extra premium it would have charged had there been no non-disclosure or misrepresentation.

### **GENERAL INSURANCE STANDARDS COUNCIL**

- 3.52 In July 2000, a voluntary regulator was established for general insurance. Membership was open to insurers and intermediaries. Regulation was based on two codes - the GISC Private Customer Code for consumer insurances and the GISC Commercial Code for business insurances.

### **THE PAT SAXTON MEMORIAL LECTURE 2001**

- 3.53 In March 2001 Lord Justice Longmore gave the Pat Saxton Memorial Lecture. He took the opportunity to propose a new Insurance Contracts Act, dealing with, amongst other issues, misrepresentation and non-disclosure. He made a number of suggestions for reform.

### **Test of materiality**

- 3.54 Lord Justice Longmore identified a number of possible formulations for the test of materiality, and expressed support for a formulation that depends on what the reasonable insured would think was material. He has since said judicially:

Is it not time that the law was changed at least to the extent that an insured's disclosure obligation should be to disclose matters which the insured knows are relevant to the insurer's decision to accept the risk or which a reasonable assured could be expected to know are relevant to that decision.<sup>21</sup>

### **Remedies**

- 3.55 He suggested that the courts might be given a discretion to adjust the respective responsibilities of insured and insurer instead of allowing avoidance:

<sup>21</sup> *North Star Shipping Ltd v Sphere Drake Insurance plc* [2006] EWCA Civ 378, [2006] 2 Lloyd's Rep 183, at [53].

It would, of course, lead to some uncertainty but that, after all, was a reason against the introduction of the concept of contributory negligence which, in the event, is a concept that has worn the test of time very well. In these days when the incidence of costs in litigation may depend on well or ill informed guesses made by the litigant, at the time they are obliged to serve pre action protocols, uncertainty is endemic, yet the court, and litigants, are quite good at getting used to it. Moreover, the Insurance Ombudsman Bureau apparently uses its discretion on occasion to apportion the loss and appears to have no difficulty with the concept.

## **THE FINANCIAL SERVICES AND MARKETS ACT 2000**

### **COB**

- 3.56 One of the earliest acts of the Labour government formed in May 1997 was an announcement that it intended to introduce statutory regulation for the financial services industry with a single regulator – the Financial Services Authority (“FSA”). This new system was introduced in 2001 under the Financial Services and Markets Act 2000 (“FiSMA”)
- 3.57 The FSA sets out its Rules for regulated firms in its Handbook. With effect from 1 December 2001 the FSA took responsibility for conduct of business regulation of investment insurance. The relevant Rules are to be found in the Conduct of Business (“COB”) sourcebook.
- 3.58 On 13 July 2005, the FSA announced that it would be simplifying the COB regime to make it “easier to understand, comply with, enforce and amend”<sup>22</sup>. It is anticipated that a revised structure for the COB sourcebook will be introduced in November 2007 at the same time as the Markets in Financial Instruments Directive (“MiFID”) is implemented.

### **Financial Ombudsman Service**

- 3.59 When this new system was being designed, it was decided that there should be a single complaints-handling body — the Financial Ombudsman Service.
- 3.60 The Financial Ombudsman Service (“FOS”) therefore replaced eight existing dispute-resolution mechanisms, including the Insurance Ombudsman Bureau and the Personal Investment Authority Ombudsman. It was established under Part 16 and Schedule 17 of FiSMA. In addition, Rules relating to the FOS can be found in the *Dispute Resolution: Complaints* sourcebook (“DISP”) within the FSA Handbook. Although the FOS has both a compulsory and a voluntary jurisdiction, it is the former that is of primary importance for current purposes.

<sup>22</sup> FSA/PN079/2005.

3.61 Provided that certain preliminary conditions are met, the FOS can consider complaints against insurers and intermediaries. Both complainant and the complaint must be within the scope of the scheme, and the complaint must be brought within the relevant time limits and not subject to dismissal without consideration of its merits. Complaints may be referred to the FOS by private individuals, and by sole traders and small businesses with a turnover of less than £1 million.

3.62 Chapter 1 of DISP contains rules relating to the internal handling of complaints by firms:

The purpose of this chapter is to set out the rules relating to the internal handling of complaints by firms, including the procedures which a firm must put in place; the time limits within which a firm must deal with a complaint; the referral of complaints, the records of a complaint which a firm must make and retain; and the requirements on a firm to report information about complaints to the FSA. This is to ensure that complaints are handled fairly, effectively and promptly, and resolved at the earliest possible opportunity, minimising the number of unresolved complaints which need to be referred to the Financial Ombudsman Service.

#### **BRITISH INSURANCE LAW ASSOCIATION REPORT 2002**

3.63 In 2002 the British Insurance Law Association ("BILA") submitted a report to the English Law Commission in which it recommended reform of various aspects of insurance contract law.

3.64 This report is of particular interest in that it was drafted by a sub-committee whose members included insurance practitioners as well as academics and lawyers. The introduction to the report indicated clearly that the state of the law was now a matter of concern to the market:

This Sub-Committee was formed in January 2001 to examine areas of insurance law causing concern in the insurance market and in insurance disputes, and to make recommendations to the Law Commission as to the desirability of drafting a new Insurance Contracts Act in respect of Marine and Non-Marine Insurance and/or other reforms to current legislation.

3.65 BILA made recommendations affecting both the test of materiality and the remedies available to insurers.

#### **The test of materiality**

3.66 BILA recommended that the test of materiality should be amended so that an applicant for insurance would be obliged to disclose those matters which a reasonable insured would have considered material to a prudent insurer.

#### **Remedies**

3.67 BILA recommended that avoidance should continue to be available as a remedy for fraudulent or reckless misrepresentation or non-disclosure. In addition, the insurer would have the right to retain the premium paid.

3.68 Where a misrepresentation was innocent or negligent, BILA recommended a response depending on the action an insurer would have taken had it known of the true facts:

- (1) If the insurer would have declined to offer cover, it could avoid the policy but would be obliged to return the premium.
- (2) If the insurer would have offered cover on different terms, it could not avoid the policy but:
  - (a) would not be liable for any loss proximately caused by the fact that was misrepresented or not disclosed, and
  - (b) could vary its liability to reflect any variation in premium deductible or excess that would have been imposed had it known of the true facts.

#### **ICOB 2005**

3.69 On 14 January 2005, the FSA took over responsibility for conduct of business regulation of general insurance. The Rules for "pure protection insurance" are contained in the Insurance Conduct of Business ("ICOB") sourcebook. On the same date, the GISC was closed and SGIP was withdrawn.

3.70 The FSA is currently conducting a post-implementation effectiveness review of ICOB. Its objectives have been described by Mr Dan Waters, Director of Retail Policy at the FSA in the following terms:

Effectiveness reviews are part of the FSA's approach seeking to ensure that its interventions in the market make a real and beneficial difference in practice. We are seeking to introduce more principles-based regulation and simplification across the FSA Handbook as a whole in the context of our Better Regulation agenda. And the GI effectiveness review presents a good and timely opportunity to look at ICOB in fine detail from the viewpoint of restricting prescription to the point where it is only demonstrably necessary to meet our consumer protection objective.

3.71 A report from the FSA is anticipated in the first quarter of 2007.

#### **APPLICATION FORM DESIGN – GUIDANCE FROM THE ABI 2006**

3.72 In February 2006, the ABI issued guidance to its members on the design and wording of proposal forms for life and health insurance. This guidance, entitled *Application Form Design for Life and Health Protection Insurances* ("AFD") was aimed at ensuring that all relevant information is disclosed at the application stage:

Although not all non-disclosure arises because of faults in proposal forms, insurers should do as much as they can to ensure that the questions they ask are clear and unambiguous. Doing so assists the applicant in their understanding of what is being asked of them. Thus when completing a proposal form, they should have confidence they are giving all the necessary correct and relevant information. This will also reduce the burden on salespersons in explaining or interpreting how questions should be responded to.

SLIP is now an addendum to the AFD, which is reproduced in Appendix D.

- 3.73 The AFD has provisions relating to some of the problems that we identify in Part 6. It should, however, be noted at this stage that the AFD specifically states that its provisions are not binding on insurers except where they represent the law or the requirements of the Statements of Practice:

In order to allow flexibility and to preserve competition between Insurers, the recommendations are not in any way prescriptive to ABI members, other than where existing legislation or Statements of Best Practice are applicable.

## **CONCLUSION**

### **The general law**

- 3.74 Despite these various reports the law remains essentially unchanged and open to the same criticisms. The decision in *Pan Atlantic* made it clear that the insurer must show inducement, but the test of materiality is still based on whether a fact would have an effect on the mind of a prudent underwriter. Many policyholders will be unaware of the true extent of this onerous obligation, and few will be able to place themselves in the mind of a prudent underwriter. The weight of opinion in the reports we have discussed is clearly in favour of a move to a test based in some way on the reasonable insured, irrespective of whether the insured is a consumer or a business.
- 3.75 We need to review the law applying to insurance contracts of all types. However we need to distinguish between various types of policyholder.

### **Consumer insurance**

- 3.76 The result of the Statements of Practice, the COB and ICOB Rules and above all the FOS scheme mean that consumer insurance is subject to an additional set of rules that should go some way to improving the consumer's position so far as misrepresentation or non-disclosure is concerned. For this reason we deal with consumers and businesses separately.
- 3.77 There are also reasons of substance that may make it sensible to treat consumer insurance separately. Consumers might be thought to deserve more favourable treatment under the law than, say, large businesses because:
- (1) Consumers will almost always contract on standard policy terms which they lack the bargaining power to alter.



- (2) Consumers are unlikely to have access to the level of expert advice which will be available to large businesses - whether in-house or externally.
- (3) Consumers are typically less able to understand the technicalities of insurance contract law - particularly if it does not meet their reasonable expectations. Indeed, as the FOS has pointed out to us, consumers may not even be aware that there is an issue of law to be considered:

There are two problems for consumers; firstly they do not know that there are issues of insurance contract law and secondly, in the unlikely event that they do, they are less likely to understand them than a business advised by its broker or in house specialists.

This problem is compounded by the fact that expert broker or intermediary advice is hard to find for consumers and there is little understanding of the need to obtain this given the ignorance of the pitfalls in insurance contract law. In this regard it is important to bear in mind that the reasonable expectations of the consumer may well be based upon their expectation of the law in relation to all, or nearly all, other consumer transactions that they may enter into. Applying for an insurance contract may be the only transaction to acquire goods or services that they enter into in any year in which they are expected in law to assume duties and responsibilities that are not known or explained to them and, where they are not required to seek expert assistance for their own benefit.

- 3.78 We describe the statements of practice and the FSA and the FOS schemes in more detail in Part 4. In Part 5 we consider the case for reform for consumer insurance. We set out our proposals for consumers in detail in Part 6. In some areas we suggest that the 1980 report did not go far enough, and we identify some gaps in COB, ICOB and the FOS scheme.
- 3.79 Within consumer insurance we need to distinguish general insurance from long-term insurance. A special rule on long-term insurance needs to be considered.<sup>23</sup>

### **Business insurance**

- 3.80 We turn to the case for reform for businesses in Part 7. We consider in particular the extent to which the needs and circumstances of businesses genuinely differ from those of consumers. Our conclusion is that in some respects the differences are genuine, in others the two classes of policyholder should be treated in the same way.

<sup>23</sup> See paras 6.126 to 6.129 below.

3.81 We need to consider how any changes should affect reinsurance, and also whether marine, aviation and transport insurance need different treatment.

**Small businesses**

3.82 We shall see that small businesses can also take advantage of the FOS scheme.<sup>24</sup> At the end of Part 7 we consider whether they should be treated in the same way as other businesses, like consumers or in some other way.

<sup>24</sup> See below, para 4.17.

## **PART 4**

# **CONSUMERS – THE CURRENT POSITION**

### **INTRODUCTION**

- 4.1 In this Part of the paper we look at how the strict legal rights of the consumer are supplemented by three measures - the Statements of Practice issued by the Association of British Insurers ("ABI"), regulation by the Financial Services Authority ("FSA") and the dispute resolution service of the Financial Ombudsman Service ("FOS").

### **THE ABI STATEMENTS OF PRACTICE**

- 4.2 In Appendix B we reproduce the Statement of General Practice Insurance Practice ("SGIP") and the Statement of Long-Term Insurance Practice ("SLIP") issued by the ABI.
- 4.3 The Statements address the problem of non-disclosure in three ways:
- (1) It states that each proposal form should include a prominent warning, drawing attention to the consequences of failing to disclose material facts, and explaining that material facts are those which "an insurer would regard as likely to influence the acceptance and assessment of the proposal". Applicants must be warned that if they are in any doubt about whether facts are material, they should disclose them.
  - (2) SGIP states that "those matters which are generally found to be material should be the subject of clear questions". However SGIP provides no sanction if this rule is not observed.
  - (3) Under SGIP, insurers undertake not to repudiate liability on grounds of non-disclosure of a material fact which a policyholder could not reasonably be expected to have disclosed. This effectively limits consumers' duty to volunteer information to facts which "a policyholder could reasonably be expected to disclose".
- 4.4 As far as misrepresentation is concerned, insurers undertake not to repudiate liability on grounds of misrepresentation unless it is a deliberate or negligent misrepresentation of a material fact.
- 4.5 We have found the Statements of Practice to be a useful indicator of what is accepted by the industry to be good practice. However, we believe that they are limited in their practical impact for the following reasons:
- (1) Few consumers are likely to be aware of the existence of SGIP or SLIP.
  - (2) SGIP was withdrawn on 14 January 2005 (though it may still be applied by the FOS).

- (3) The relevant provisions of SGIP and SLIP are limited in their effect and are not legally binding. They are enforced by the FOS but at that stage the question is whether they add anything to the general obligation on the FOS to reach a decision that is "fair and reasonable in all the circumstances".
- 4.6 We discuss those provisions of the Statements relating to misrepresentation and non-disclosure in more detail in Appendix C.

## **THE FINANCIAL SERVICES AUTHORITY**

- 4.7 There are several ways in which the FSA influences the approach taken by insurers to misrepresentation and non-disclosure. Most importantly, it has issued specific Rules in this area. In addition, it publishes high level principles and conducts initiatives such as *Treating Customers Fairly* ("TCF").

### **The Rules**

- 4.8 In Appendix D we reproduce certain Rules from COB and ICOB, including those which relate specifically to misrepresentation and non-disclosure. We discuss these Rules in Appendix E.
- 4.9 It should be noted that where there are breaches of the Rules there are two potentially significant consequences under the Financial Services and Markets Act 2000. First an affected policyholder may bring a claim against a regulated firm for breach of statutory duty.<sup>1</sup> Secondly, the FSA may take disciplinary action against the firm and has the power, for example, to impose a fine<sup>2</sup>
- 4.10 These are important provisions which will undoubtedly be invaluable in certain circumstances. However, for the following reasons we rather doubt that they are of significance in most day-to-day cases:
- (1) The specific Rules on misrepresentation and non-disclosure are largely based on the provisions of SGIP, and are subject to similar limitations on their effect.
  - (2) The vast majority of consumers will pursue disputes through the FOS rather than through the courts.<sup>3</sup> A right to bring an action for breach of statutory duty is unlikely to add anything to a consumer's right to receive a decision that is "fair and reasonable in all the circumstances". Serious disciplinary action is unlikely in what appear to be one-off cases. Relatively few consumers will complain to the FSA about matters of misrepresentation or non-disclosure. We understand that those who do are most likely to be advised to pursue the matter through the FOS.

<sup>1</sup> Financial Services and Markets Act 2000, s150.

<sup>2</sup> Financial Services and Markets Act 2000, s66.

<sup>3</sup> An exception might be, for example, if the amount in dispute exceeded £100,000 - see para 5.19.

## **FSA Principles and Treating Customers Fairly**

- 4.11 The FSA publishes eleven high level "Principles for Businesses", to be found in the PRIN Sourcebook of the Handbook. These are part of a move away from prescriptive Rules to principles-based regulation. Perhaps most importantly in the areas of misrepresentation and non-disclosure is Principle 6:

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

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

Good TCF examples we have seen include...

1. Firms stressing the importance of full disclosure by customers when completing a critical illness application. One firm included a case study for customers explaining the implications of non-disclosure.

2. A firm does full medical underwriting at the time of application to ensure both the firm and the customer are clear about the basis on which the cover is being provided.

Examples of poor practice include...

3. Firms who provide little training to their distributors in issues such as application forms where technical medical questions can be asked and where the consequences of non-disclosure can be significant.

- 4.13 We believe that TCF is a valuable initiative which is influencing attitudes within the insurance industry. However, it was never intended to be a substitute for law reform and we do not think that it can be treated as such. The state of the law on misrepresentation and non-disclosure is such that swifter, more radical, and more consistent change is required.

## **THE FINANCIAL OMBUDSMAN SERVICE**

- 4.14 Very few consumer insurance disputes are now considered by the courts. Instead, most complainants opt to use the service offered by the FOS. In its last year of operation, the FOS received 14,270 insurance-related cases. This figure excludes a large number of complaints that the FOS received relating to investment contracts.

### **Research project**

- 4.15 When we commenced our review of insurance contract law we were struck by comments made by Lord Justice Longmore. He suggested that if we were to conduct such a review “the records of the Ombudsman Bureau will be an early port of call”.<sup>4</sup>
- 4.16 With the kind co-operation of the FOS we have therefore conducted a research project to assist our understanding of the experience of consumers. We reviewed around 200 cases that had been considered by the FOS and which involved allegations of misrepresentation or non-disclosure. Our findings will be published in a separate paper.
- 4.17 The sample included 12 small business cases. The FOS sees a relatively small number of such cases, possibly because insurers are under no obligation to bring the existence of the scheme to the attention of small business policyholders. We address the position of small businesses in Part 7 below.
- 4.18 From the work we have conducted we have no doubt that the FOS currently provides consumers with their best chance of achieving a fair result in cases where misrepresentation or non-disclosure is alleged. Its obligation to reach a decision that is “fair and reasonable in all the circumstances” enables it to set aside the strict law and to explore other solutions. We set out below in some detail the approach taken by the FOS and acknowledge here the significant influence its guidance has had on our thinking.
- 4.19 This is not to say that the FOS is a satisfactory alternative to law reform. We are entirely satisfied that it is not, for the reasons we will discuss in Part 5.

### **The FOS approach to complaints**

- 4.20 The FOS seeks wherever possible to settle complaints by mediation. Should this prove impracticable, the case will be investigated and a view reached by an adjudicator. If either party remains dissatisfied, an appeal may be made to an Ombudsman. An Ombudsman has the power to make awards of up to £100,000 against an insurer, or instruct it to take specified steps, the cost of which should not exceed that limit.
- 4.21 Compulsory jurisdiction complaints are determined “by reference to what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case”.<sup>5</sup> As explained above, this means that the FOS is not bound by the strict law. A case study illustrates the difference that this can make:

<sup>4</sup> “An Insurance Contracts Act For A New Century?“, The Pat Saxton Memorial Lecture organised by the British Insurance Law Association (5 May 2001) para 40.

<sup>5</sup> Financial Services and Markets Act 2000, s228(2).

### Case study 1<sup>6</sup>

Mr M made a claim under his household policy for possessions stolen after burglars gained access to his home by kicking in a panel in the back door. The insurer accepted the claim, and had the door replaced by one of its approved contractors. At the next renewal of the policy, Mr M completed a questionnaire for the insurer in which he confirmed that external doors had “a mortise deadlock and security bolts or a key-operated locking system”.

Shortly after the policy was renewed, Mr M suffered a second burglary when entry was again gained by kicking in a rear door panel. The insurer discovered that the door did not have security bolts or a key-operated locking system. As a matter of law, the insurer was entitled to avoid the policy on the basis of the misrepresentation. It refused to pay Mr M's claim.

The FOS instructed the insurer to meet the claim. It gave three reasons:

1. Mr M had assumed the insurer would have had a door installed that met its own requirements. It was careless of him not to have checked this, but he had not deliberately or recklessly supplied an incorrect answer.
2. There was no link between the misrepresentation and the loss that occurred - the burglars had entered the house by kicking in the door panel.
3. If Mr M had answered the question correctly, the firm would have allowed him time to change the locks. The burglary occurred within this timescale.

### **Misrepresentation and non-disclosure**

4.22 As already indicated, the FOS enforces SLIP and takes note of SGIP. It also enforces COB and ICOB. However, to meet its obligation to reach a fair and reasonable decision in cases of misrepresentation and non-disclosure, the FOS has found it necessary to go significantly further than these measures.

4.23 The FOS approach to misrepresentation and non-disclosure is explained in a series of case studies and guidance notes in *Ombudsman News*. In *Ombudsman News Issue 46* the FOS indicated that in cases where misrepresentation or non-disclosure is alleged, it asks two questions:

- (1) When the customer sought insurance, did the insurer ask a clear question about the matter which is now under dispute?
- (2) Did the answer to that clear question induce the insurer; that is, did it influence the insurer's decision to enter into the contract at all, or to do so under terms and conditions that it otherwise would not have accepted?

<sup>6</sup> Ombudsman News 48.

- 4.24 Should the answer to either question be "No", the FOS will not support an insurer in avoiding the policy. Since a question is required before a policy can be avoided, this seems effectively to remove the duty of disclosure.
- 4.25 If the answer to both questions is "Yes", the FOS determines the dispute by consideration of the state of mind of the policyholder at the time any misrepresentation or non-disclosure occurred. The FOS has established four categories:

**Deliberate**

Customers *deliberately* mislead the insurer if they dishonestly provide information they know to be untrue or incomplete. If the dishonesty is intended to deceive the insurer into giving them an advantage to which they are not entitled, then this is also a fraud and – strictly speaking – the insurance premium does not have to be returned.

**Reckless**

Customers also breach their duty of good faith if they mislead the insurer by *recklessly* giving answers without caring whether those answers are true or false. An example of recklessness might be where a customer signs a blank proposal form and leaves it to be filled out by someone else. The customer has signed a declaration that *'the above answers are true to the best of my knowledge and belief'*, but does not know what those answers will be.

**Inadvertent**

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

**Innocent**

Customers act in good faith if their non-disclosure is made *innocently*. This may happen because the question is unclear or ambiguous, or because the relevant information is not something that they should reasonably know. In these cases, the insurer will not be able to 'avoid' the contract and (subject to the policy terms and conditions) should pay the claim in full.<sup>7</sup>

- 4.26 There are significant differences between this categorisation and the traditional legal analysis. Lawyers would regard both the deliberate and the reckless categories as being fraud, and the inadvertent category as being negligence. Only the innocent category is common to both approaches.

<sup>7</sup> Ombudsman News 46.



- 4.27 However, the cases we saw in our research project left us with the clear impression that the FOS takes a wider view of recklessness than might be suggested by the definition quoted above. In practice the FOS distinguishes between two forms of negligence - serious negligence which it treats as recklessness and minor negligence which it treats as inadvertence. This distinction allows the FOS to reach a fair and reasonable result in cases of mere carelessness, where avoidance would seem an excessive remedy.

#### **Deliberate or reckless**

- 4.28 Where a misrepresentation or non-disclosure is deliberate or reckless, the FOS allows an insurer to avoid the policy and to refuse to pay any claim.

#### **Case study 2<sup>8</sup>**

Mr W notified his household insurer that cracks had developed in the walls of his home. Investigations indicated that the cracks resulted from subsidence. At the time Mr W took out the policy, he had informed the insurer that the property had never been affected by movement of any kind, including subsidence, heave, landslip or settlement.

In fact, when Mr W purchased the property the surveyor had reported that:

*The property is affected by structural movement evident in severe cracking to the gable elevation. This appears significant and likely to be progressive.*

The insurer avoided the policy on the basis of the misrepresentation by Mr W. It declined to pay the subsidence claim.

The FOS concluded that the question regarding movement was clear, and that Mr W's reply had not fairly represented the true picture. It supported the insurer in its decision to avoid the policy.

- 4.29 Other than where there is clear evidence of fraud, the FOS requires an insurer to refund the premiums if it avoids a policy.

#### **Inadvertent**

- 4.30 Potentially the most difficult category is that of inadvertent misrepresentation. The attempt to distinguish between different forms of negligence can introduce considerable complexity into the analysis. During our research project we encountered many different factual situations in the cases referred to the FOS. It was on occasion hard to predict how a case fitted into the FOS categories. For example, consumers may:

<sup>8</sup> Ombudsman News 25.

- (1) fail to read the question (either reasonably if the form is badly set out, or negligently);
- (2) fail to understand the question (because the question is unclear, or they had limited knowledge of such matters, or they acted negligently);
- (3) understand the question, but have no way of knowing the answer;
- (4) understand the question, and think they know the answer, but give an inaccurate reply (either innocently, or without conducting proper checks, or deliberately);
- (5) understand the question, but fail to take enough care with the reply because they didn't realise it mattered.

4.31 Nevertheless, as we will see below distinguishing between serious negligence and minor negligence allows the FOS to take a more graduated approach than, say, ICOB, which specifically permits insurers to apply the full remedy of avoidance to all negligent misrepresentations.

### **Innocent**

4.32 In cases of innocent misrepresentation or non-disclosure, the insurer is not permitted to avoid the policy, and will be required to meet any claim in full.

#### **Case study 3<sup>9</sup>**

Mrs B claimed under her motor insurance policy when her son, a named driver, was involved in an accident. On the claim form she disclosed that she had "access" to another car. The insurer pointed out that when she had applied for the policy, two years earlier, she had declared that she did not have the "use" of another car. Had it been aware of the true position it would have increased the premium. On the basis of the apparent misrepresentation the insurer cancelled the policy, rejected the claim and denied liability for damage to the third party vehicle.

The FOS was not satisfied that asking Mrs B if she had "use of another car" was a clear question. Mrs B had interpreted it as asking whether she wanted the policy to cover more than one car. The FOS therefore instructed the insurer to deal with the claim and pay Mrs B a further £200 compensation for its mishandling of the matter.

4.33 One curious feature of the FOS approach is that it appears to disregard the issue of materiality. The FOS looks to see whether a clear question about the matter was asked - not whether the matter was material. However, the FOS has confirmed to us that it would not allow avoidance for a non-material misrepresentation.

<sup>9</sup> Ombudsman News 7.

4.34 In Ombudsman News Issue 27, the FOS stated:

We may consider whether the firm gave any warning about the consequences of giving false or incomplete information, and how clear such a warning was.

4.35 Presumably the lack of such warnings might, in some cases, be enough to tip the scales and lead the FOS to conclude that a misrepresentation was, say, inadvertent rather than reckless.

**A graduated approach to remedies in cases of “inadvertence”**

4.36 In cases of what it terms inadvertence, the FOS considers the terms the insurer would have offered had it been aware of the true position. This could lead to a number of outcomes. For example:

- (1) If the insurer would have refused the application for insurance, it will be allowed to avoid the policy and refuse to pay any claim.
- (2) If the insurer would have applied an exclusion to the cover, the policy will be rewritten to include this term. In some cases this will entitle the insurer to refuse to pay any claim that has arisen.
- (3) If the insurer would have simply charged a higher premium, a proportionate settlement of any claim may be appropriate. In its simplest form this might mean that a policyholder who has only paid, say, 60% of the correct premium only gets 60% of the claim paid.

Case study 4<sup>10</sup>

Mrs A claimed under her motor policy when her car was stolen. The insurer discovered that she had not declared four convictions for speeding. These were relatively minor matters, and if disclosed would have led to a premium loading of 12% initially, reducing to 5% for the second year of cover. The insurer exercised its legal right to avoid her policy and decline the theft claim.

The FOS considered that the question asked by the insurer about convictions was clear. However, it felt that the non-disclosure by Mrs A was an oversight. It concluded that a fair and reasonable settlement would be for the insurer to meet the claim on a proportional basis. The insurer agreed to pay Mrs A 85% of the value of her claim.

<sup>10</sup> Ombudsman News 25.

## **RENEWALS**

- 4.37 The FOS generally expects an insurer to ask clear questions if it wishes to obtain information from a policyholder at renewal. It points out that asking simply whether anything has changed is unlikely to produce reliable results unless the policyholder is provided with copies of the original information:

Customers cannot be expected to remember all the details of information they provided perhaps several years earlier. So if firms ask them general questions such as 'has anything changed in the information we asked for in your proposal form?' when they are renewing a policy, the responses are unlikely to be reliable...

If a firm wants policyholders to check and re-confirm all the information they provided originally, then it is good practice for the firm to send them a copy of that information, or to ask all the questions afresh. A firm that does not follow good practice may not be able to use a customer's failure to provide information as a reason to decline a claim.<sup>11</sup>

## **CONCLUSION**

- 4.38 Where misrepresentation or non-disclosure is alleged, the ABI Statements and FSA Rules may be of assistance to a well-informed consumer. However, we have no doubt that it is the FOS which ultimately offers the consumer the most valuable protection. In particular, it addresses the harshness of the law in three important ways:

- (1) The FOS treats consumers as if there is no residual duty of disclosure. Neither the Statements nor the Rules have this effect.
- (2) The FOS will require an insurer to settle claims on a proportionate basis where there has been "inadvertent" misrepresentation and the insurer, had it been aware of the truth, would simply have accepted the application at an increased premium. In contrast, both Statements and Rules allow avoidance for "negligent" misrepresentation.
- (3) The FOS does not offer an insurer any remedy in cases of innocent misrepresentation. It appears to take this line regardless whether there has been a claim or not - whereas corresponding provisions in the Statements and Rules only apply where a claim has been made.

<sup>11</sup> Ombudsman News 23.

# **PART 5**

## **CONSUMER INSURANCE – THE CASE FOR LAW REFORM**

### **INTRODUCTION**

#### **Fairness and reasonable expectations**

- 5.1 The Law Commission's 1980 report and the others that followed it identified a number of ways in which the law is unfair. It is not suggested that insureds are being cheated; the market for insurance is highly competitive and no doubt they get value for money. What seems unfair about the law is that it defeats the reasonable expectations of consumers. Insurance is intended to be an effective risk-transfer mechanism, bringing peace of mind to the purchaser. The consumer exchanges the risk of a loss of unknown amount for the payment of a known premium. This process performs a valuable function in enabling consumers to plan their financial affairs prudently.
- 5.2 Where claims are not met, the transfer of risk fails, and the peace of mind has proved to be illusory. In some cases, the results can be devastating for consumers. For example, in our study of FOS cases we were struck by the large number of complaints we saw relating to critical illness policies. Consumers who were already suffering from their own serious ill-health, or that of a family member, were faced with the added stress of having a claim declined. The problem is not restricted to critical illness policies. We found evidence of many different types of policy being avoided in circumstances where this approach seemed unduly harsh.
- 5.3 It seems correct to allow a policy to be avoided where the policyholder has behaved fraudulently when taking it out.<sup>1</sup> However, as the FOS said in its response to our Scoping Paper:

Only a relatively small proportion of policyholders who have failed to disclose relevant information are found to have done so with any dishonest intent.

We are chiefly concerned with those who were not fraudulent. It is arguable that they deserve better protection than the law currently provides – and that (were they aware of the problem) consumer insureds generally would want that better protection even at the price of slightly increased premiums.

<sup>1</sup> Though see para 6.40 below, where we note that legislation in Australia gives the court a discretion even in the case of fraud.

### **Confidence in the market place**

- 5.4 It is not just the individual insured with whom we need to be concerned. Where insurance fails to meet reasonable expectations, confidence in the market can be undermined. Dissatisfied consumers spread the word, and those who have had an insurance claim rejected frequently have a deep sense of grievance.
- 5.5 We are concerned that the bad press from which insurers sometimes suffer must inevitably deter consumers from purchasing insurance when it would be in their best interests to do so. It is clear from the comments we have received that some insurers share this concern.

### **ARE THE FOS AND THE FSA RULES A SUBSTITUTE FOR LAW REFORM?**

- 5.6 In Part 4 we showed that whilst the Statements of Practice, the COB and ICOB Rules may assist consumers in cases of misrepresentation or non-disclosure, it is the FOS scheme that offers the most effective remedy. We now turn to assess whether the FOS and the FSA Rules are an adequate substitute for law reform.
- 5.7 From a complainant's perspective, the FOS offers many advantages over the alternative of court action:
- (1) Compulsory jurisdiction complaints are determined by reference to what is "fair and reasonable in all the circumstances of the case".
  - (2) The service is free to complainants.
  - (3) The FOS can provide remedies not available through the courts. For example, it may instruct an insurer to reinstate a policy, or to rewrite it on different terms.
  - (4) An application to the FOS is a "no lose" option for complainants. If a complainant accepts the ombudsman's decision it becomes binding on both insurer and complainant. However, the complainant is free to reject the decision and pursue the matter through the courts.
  - (5) The FOS processes are intended to be relatively rapid.
  - (6) The FOS has an inquisitorial process. Once a case is accepted for investigation, the FOS will carry out its own investigations rather than merely relying on the arguments presented by the parties.
  - (7) The FOS has introduced several initiatives to make its service more accessible to complainants. It maintains an informative website and a range of publications. Last year it demonstrated that it was capable of conducting "correspondence in Arabic, phone calls in Tagalog and emails in Urdu".<sup>2</sup>
  - (8) The processes operated by the FOS are intended to be informal and friendly. There is no need for a complainant to be represented.

<sup>2</sup> Financial Ombudsman Service, *Annual Review 1 April 2005 to 31 March 2006*, p49.

- (9) The FOS has more experience than the courts in dealing with the types of insurance dispute within its jurisdiction. Importantly, it may also be more aware of current issues within the insurance industry, and have a better understanding of the problems typically faced by complainants.
  - (10) The FOS is not bound by the rules that would apply in court proceedings. It may exclude evidence that would be admitted in court, and admit evidence that would be excluded.
  - (11) The FOS will take into account the provisions of both ABI Statements. Even though SGIP has been withdrawn, the FOS treats it as an indicator of good practice.
- 5.8 Similarly, the COB and ICOB Rules potentially offer consumers greater protection than the strict law.
- 5.9 However, we do not consider that the FOS and the FSA Rules, separately or together, are a satisfactory alternative to law reform for consumers. We have two main groups of concerns. The first group are about substance: do the FOS and FSA Rules in fact protect consumers fully, or is it necessary to change the law? The second group are about the current state of “the law as a whole”, i.e. the general rules plus the FOS and FSA Rules.

#### **The FOS cannot in practice protect all consumers**

- 5.10 As to the substance, we think there are probably still serious gaps in coverage. On the one hand, our research and concerns expressed to us by the industry itself suggest that there are some insurers who are still refusing to pay claims and avoiding policies when that is not consistent with the Statements of Practice or would not be permitted by the FOS. Given the obscurity of the statements, FSA Rules and the detail of the FOS approach, many insurers simply decide cases on the basis of the strict law. Our survey of ombudsman cases showed that many insurers did in fact apply the law in this way. This penalises the many consumer and small businesses who do not take their cases to the FOS. On the other hand, it suggests that not every case is being dealt with or prevented by the FOS. If consumers go to the FOS, their case will be dealt with in a way that is helpful, fair and (subject to the gaps we identify below<sup>3</sup>) meets reasonable expectations. However, the consumer must get to the FOS. It is no criticism of the scheme to say that it does not reach everyone. Among the applicants to the FOS, some groups are under-represented.
- 5.11 So our first concern is simply that there are still claims being dealt with under the strict law and that by no means all cases will get to the FOS. It is likely that there are consumer insureds whose claims are not being paid when generally accepted good practice and the FOS guidance suggest that they should be.

<sup>3</sup> See paras 5.19 to 5.22 below.

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

### **FSA Rules are unlikely to achieve protection either**

- 5.13 In principle, the COB and ICOB Rules should prevent insurers from turning down claims when the consumer has acted reasonably. Again, however, we doubt whether all insurers will always follow the COB and ICOB all the time. The gap between them and the law is an invitation to make mistakes.
- 5.14 There is a further problem that the FSA Rules are less demanding than the FOS. For example, as we saw earlier, ICOB merely requires that the consumer be warned about the duty to disclose.<sup>4</sup> The FOS effectively dispenses with it: if the insurer wants a piece of information, it should ask for it.<sup>5</sup> Another example is that COB and ICOB Rules permit the insurer to avoid the policy if the consumer's misrepresentation or non-disclosure was careless,<sup>6</sup> whereas the FOS requires payment of a proportionate part of the claim.<sup>7</sup> Not only do these differences invite further confusion but they mean that the FSA Rules will not protect the consumer fully.
- 5.15 Further, although in principle a breach of the COB or ICOB Rules may lead to the insurer being liable for breach of statutory duty,<sup>8</sup> we doubt the practical efficacy of this remedy save when a very large sum is at stake.

### **Clarity and accessibility**

- 5.16 Turning now to the state of "the law as a whole", we have equally serious concerns. The first is simply that the present position is increasingly incoherent. There is a growing gulf between unsatisfactory law on the one hand and the patchwork of Statements of Practice, FSA Rules and guidance from the FOS on the other. In some cases, the different elements of this patchwork may each give different and conflicting results to a question.
- 5.17 Take, for example, a basic issue: is an insurer required to ask an applicant for insurance any questions?

- (1) The law provides that an insurer is not obliged to ask an applicant for insurance any questions. It can simply rely on the duty of disclosure by which the applicant is bound.

<sup>4</sup> ICOB 4.3.2. See Appendix E below.

<sup>5</sup> See para 4.23 above.

<sup>6</sup> See Appendix F below.

<sup>7</sup> See para 4.36 above.

<sup>8</sup> Financial Services and Markets Act 2000, s150.



- (2) Both SGIP and SLIP do require the insurer ask questions about matters “generally found to be material”. However, no sanction is provided if this requirement is breached.
  - (3) Neither ICOB nor COB contain specific Rules requiring the asking of questions, though an insurer may need to ask questions to meet its other obligations under the Rules.
  - (4) The FOS does not explicitly require questions to be asked. However, that is the practical effect since it will not allow an insurer to avoid a policy for non-disclosure as opposed to misrepresentation.
- 5.18 The existence of these conflicting sources of law and practice make it unnecessarily difficult for insurers and policyholders to establish their respective rights. The multiple layers of regulation, and to some extent the lack of precision in the rules of each layer, cause serious and quite unnecessary confusion. We believe that the situation has reached a stage where it can only be resolved by law reform.

#### **Denial of a remedy in court**

- 5.19 We think that the FOS provides an extremely valuable service. However, we do not think that it should be the only way in which consumers can secure justice. We believe it is unacceptable that if the courts are asked to resolve a consumer case they may be required to apply unfair and archaic legal rules. Whilst we accept that most consumer cases will be resolved through the FOS, there are circumstances in which a consumer may reasonably choose to pursue a dispute through the courts. For example:

- (1) The amount of the dispute may exceed £100,000, the limit on binding awards that can be made by the FOS (non-binding recommendations can be made for any sum in excess of £100,000).
- (2) The FOS may have declined to deal with the case - on any one of eighteen grounds listed in Rule 3.3 of the DISP Sourcebook of the FSA Handbook. We are told by the FOS that the Rule has a significant impact:

One of the principal reasons that we decline to look at a case is that we regard it as more suitable for a decision in the courts. This is frequently the case where the assessment of the evidence requires cross-examination of third parties. This creates a whole category of cases to which our process is unsuited.

In declining to consider such cases, due perhaps to their reliance on the evidence of a third party (which may include a broker or intermediary or the departed salesman or representative of a firm), we must accept that, in relation to non-disclosure, the effect of a referral to the courts is that the case will be decided upon an entirely different basis.

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

- (3) The consumer may have rejected a decision from the FOS in the hope of obtaining a more favourable result by litigation.

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

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

5.21 Furthermore the FOS is conscious that the current position may bring positive benefits to insurers with lower standards:

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

#### **The “effective law” is discretionary**

5.22 We believe that it is undesirable that the FOS is routinely obliged to replace the most fundamental principles of insurance contract law with its own approach. There are two obvious objections to this position:

- (1) The FOS may develop its approach without public debate or wide consultation.
- (2) As the FOS is able to change its approach at will, there is a continuing degree of uncertainty.

#### **The risk of legal challenge**

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

#### **CONCLUSION: AN INCOHERENT AND FLAWED SYSTEM**

5.24 The present system is unsatisfactory in four ways:

- (1) *It fails to prevent some insurers avoiding policies inappropriately.* Insurers may repudiate claims for negligent mis-statements that have nothing to do with the claim in issue.
- (2) *It is inaccessible and obscure.* To understand how the current law works, insurers and consumer advisers need to work through multiple layers of law, self-regulation, regulation and ombudsman case law. Not only do the rules differ but the meaning of some of the individual rules, and thus the differences intended, are unclear. It is hardly surprising that insurers often do not understand the rules that govern this area, and attempt to avoid policies inappropriately.
- (3) *Consumers are deprived of a genuine choice between the FOS and the courts.* Except in limited circumstances (see paragraph 5.19 above), no well-advised consumer would choose to take a case to court, because a court would be forced to apply the full rigour of the law.
- (4) *It requires the FOS to exercise undue discretion.* Instead of using its discretion to supplement the law, the FOS has been required to develop its approach almost from first principles. The FSA Rules provide little assistance – the FOS has confirmed to us that COB and ICOB “do not and are not intended to deal with anything like the breadth and extent of disputes that arise in insurance policies”.

**5.25 We conclude that the time has come to state clearly what rights and obligations a consumer insured should have. We believe strongly that a new statute should replace the current patchwork by a single system that is coherent and clear, and that is fair in that it meets the reasonable expectations of both consumers and insurers.**

## PART 6: CONSUMERS – OUR PROPOSALS IN DETAIL

### INTRODUCTION

- 6.1 We think there is a strong case for reform of consumer insurance contract law. In our view, a new statute should:
- (1) redefine what is and what is not a material fact in terms of what the reasonable consumer will think is material;
  - (2) provide that avoidance is appropriate only to fraud, and clarify what amounts to fraud for these purposes;
  - (3) exclude a remedy to the insurer where the consumer has acted innocently but not negligently;
  - (4) clarify the remedies that should be applied in cases of negligent misrepresentation;
  - (5) abolish the requirement that consumers should volunteer information.
- 6.2 In addition, “basis of the contract” clauses should be rendered ineffective. This would prevent insurers from evading the scheme by converting the answers in proposal forms into contractual warranties.
- 6.3 The new law should be mandatory – it should not be possible for the parties to contract out of it to the detriment of the consumer. We have reached this conclusion for the same reasons that lead us to believe that consumers should be treated differently from businesses.<sup>1</sup> In particular, consumers are unlikely to have the knowledge or bargaining power to allow for meaningful negotiations with insurers. There is therefore a real risk that contracting-out would be imposed upon them. **We tentatively propose that it should not be possible to contract out of the new rules governing consumer insurance except in favour of the consumer.**
- 6.4 Below we set out tentative proposals on these issues. The fact that most consumer proposal forms now ask detailed questions means that misrepresentation is now of greater relevance than non-disclosure, which has become almost a residual issue. We therefore consider first materiality in the context of misrepresentation, and the remedies for misrepresentation, before we discuss whether there should be a duty of disclosure on consumer insureds.

<sup>1</sup> Above, para 3.77.

- 6.5 We note at the outset that there is some overlap between these various issues. If, for example, there is to be no remedy for an innocent misrepresentation by the consumer, it may be that there is no need for a separate rule on materiality. A consumer who reasonably thought that any incompleteness or inaccuracy in his answer was not material might simply be treated as making only an innocent misrepresentation. However, there may be cases in which the two do not overlap and for purposes of the discussion we treat them separately.
- 6.6 We have found the general law of misrepresentation, and in particular the Misrepresentation Act 1967, of little assistance in developing our proposals. The right to damages for negligent misrepresentation conferred by section 2(1), and the power of the court under section 2(2) to refuse to permit rescission and to award damages in lieu, were designed for contracts such as sale. They cannot readily be applied to the very different risks and rewards of insurance contracts. In insurance contracts, risks are spread across a pool of contracts, so it may be inappropriate to look only at the atypical contract where a claim has arisen. For example, where an insurer would have charged a higher premium it may not be appropriate to compensate the insurer by awarding it damages equivalent to the difference between the premium paid and the premium it would have charged had it known the truth. This does not compensate the insurer for the lower premium it has received in cases where no claim has been made. It makes more sense to reduce the insured's claim proportionally. We therefore think that insurance contracts continue to require principles of misrepresentation specific to them.
- 6.7 At the end of this Part we consider a number of additional issues related to misrepresentation and non-disclosure which were not covered by the 1980 Report or the FSA and the FOS schemes.

#### **THE TEST OF MATERIALITY**

- 6.8 In our view, the test of materiality requires reform as it applies to consumer insurance.<sup>2</sup> The matter should be looked at primarily from the point of view of the person on whom the duty falls: that is, a reasonable insured. The re-formulation should apply to cases of misrepresentation and — if it were to be decided that a duty of disclosure should be retained in consumer cases — to non-disclosure.
- 6.9 It should be noted that in some jurisdictions, e.g. France and Norway, in the field of general consumer insurance, less emphasis is put on materiality. In both these jurisdictions, misrepresentation is the prominent, or in the case of France, the only cause of action. The test is simply that the questions posed be answered truthfully (in France) and completely and exhaustively (Norway). However, we think that a materiality test is important for both misrepresentation and non-disclosure, in order to try to give some certainty as to what is or is not required on the insured.

<sup>2</sup> On business insurance see para 7.59 below..

### Alternative formulations

6.10 We believe that the test of materiality should be considered from the point of view of the reasonable consumer. The question is how to formulate the rule. Several proposals have been made along these lines. Below we consider various formulations and the issues they raise.

6.11 In 1957, the Law Reform Committee formulated a new definition of materiality, stating that

for the purposes of any contract of insurance no fact should be deemed material unless it would have been considered material by a reasonable insured.<sup>3</sup>

6.12 In 1980, the English Law Commission supported a similar policy outcome, though the structure of their formulation was different. It recommended that the definition of a material fact "should remain substantially the same as in the present law". However, an insured's duty of disclosure should be limited to a fact which:

- (1) is material to the risk
- (2) is either known to the applicant or is one which he can be assumed to know, and
- (3) is one which a reasonable man in the position of the applicant would disclose to his insurers, having regard to the nature and extent of the insurance cover which is sought and the circumstances in which it is sought.

6.13 More recently, in *Cuthbertson v Friends' Provident Life Office*, Lord Eassie set out the test that applies to life insurance in Scotland:

- (1) For any fact to be material, it must be material in the view of the reasonable underwriter - "If the fact were regarded by such an underwriter as of no significance, *cadit quaestio*."
- (2) Additionally, the insurer must show that either:
  - (a) "The proposer appreciated that the fact in question would have had that significance", or, assuming the proposer did not have that appreciation,
  - (b) "A reasonable person making the proposal and possessed with the factual knowledge possessed by the actual proposer would think that fact to be material to the insurer".

<sup>3</sup> Fifth Report of the Law Reform Committee (1957) Cmnd 62, para 14.

### **Discussion of these formulations**

- 6.14 All these proposals share a common policy purpose, namely to limit the insured's duty of disclosure to facts which a reasonable insured would think relevant. However, when one looks at the three formulations in depth, several issues emerge.

### **Subjective and objective formulations**

- 6.15 In Australia, as the Insurance Contracts Act 1984 was passing through the Commonwealth Parliament, there was considerable debate over how far a reasonable insured test should take into account the circumstances of the particular policyholder in question. A draft which originally looked at what "a person in the circumstances of the insured could reasonably be expected to know" was changed to reflect what "a reasonable person in the circumstances could be expected to know".
- 6.16 Although the words seem similar, they represent different tests. The first looks at the particular idiosyncrasies of the insured, taking into account (for example) their age, education, and knowledge of English. The second sets up a more objective standard. For example, a "reasonable insured" may know that if an insurer has asked about signs of subsidence it will wish to know about a lengthening crack over the front door. However, a policyholder who has just been bereaved and always left home maintenance to their spouse may quite reasonably not realise the significance of such damage.
- 6.17 There is a difficult policy balance here. The insurer cannot be expected to know about every idiosyncrasy of every insured. It cannot know that the person completing the form has suffered bereavement, or understands very little about house maintenance or medical terms. On the other hand, it seems harsh to penalise a policyholder for falling below some objective standard, when this was quite reasonable given their particular circumstances.
- 6.18 In deciding what a reasonable insured would know, we think the courts should take into account all the circumstances known to the insurer, including the type of policy, the way the policy was advertised and sold, and the normal characteristics of those sort of policyholders. We think it important that the standard is not set too high. It should be assessed from the point of view of ordinary, normal, fallible people – not some idealised perfection.
- 6.19 To take an extreme example, we have been told that there has been at least one scheme to sell insurance by text message. The constraints of this medium may significantly affect what may be expected from applicants.
- 6.20 What we find more difficult is whether the test should take into account facts which the insurer would not necessarily have known about, such as the insured's stressful family circumstances or lack of education. This was the effect of the first Australian draft.

- 6.21 We think that it may be possible to achieve a workable compromise. The insurer cannot be expected to make allowances for particular characteristics of which it does not know. If however the insurer actually knows of the particular problems faced by the insured – for example, the proposal is made over the phone and it is evident that the proposer speaks very little English, or if the insured explains that she knows nothing about medical terms and asks for help – the reasonableness of the insured’s understanding of what they were being asked for should be judged accordingly. That fits with the notion of “know your customer”. In discussions the FOS supported this approach:

In so far as factors of age, infirmity, limited mental capacity, poor command of language or limited literacy are known to the insurer then there would seem to be a strong public policy argument for the law not permitting the insurer to simply ignore these characteristics of their customers.

#### **The nature of the evidence**

- 6.22 At present, the issue of what is material to a “prudent underwriter” is often determined by expert evidence from the industry. In 1980, the Law Commission saw the prominence granted to insurers’ evidence as a serious criticism of the current law.
- 6.23 Under our proposed reform, the actual insurer in question will need to start by showing that the issue was material to them, in that if they had known the truth they would not have entered into the same contract on the same terms.
- 6.24 In Part 7, we discuss the sort of evidence that may be given in business cases about what might be expected of a reasonable insured. In consumer cases, one advantage of the proposed reform is that there would be less need for expert evidence. Instead, judges should be able to draw on their own understanding to ask how a reasonable consumer would regard the matter. There would only be a need for expert evidence in specialist markets, where it might be provided by a range of experienced professionals, including insureds, brokers or underwriters.
- 6.25 An alternative approach would be to follow up the idea that materiality should be judged by what the insurer knows about the particular consumer. Such knowledge may allow the insurer to judge the extent to which the consumer will understand what information is required. A revised test of materiality might therefore ask whether a reasonable insurer with the same knowledge of the client as the actual insurer would expect the consumer to understand that a particular matter was relevant. That would once more be a question on which the court might hear evidence from underwriters and brokers.



### **The position of a niche insurer**

- 6.26 A further criticism of the present test of materiality is that in some circumstances it may prove unfair to an innovative insurer. As discussed above,<sup>4</sup> some insurers may wish to develop niche markets, by asking questions that seem irrelevant to the generality of insurers. For example, an insurer may assess risk on the basis that all their policyholders are members of a particular profession or union. This means that a question about occupation may be material to them, even if it is irrelevant to most prudent underwriters. The insurer may ask a clear question, which succeeds in communicating the importance of the question to a reasonable policyholder. However, if the policyholder gives a negligent answer, the insurer may be without a remedy. As we pointed out earlier, it is possible that it will fail the first limb of the *Pan Atlantic* test because the representation would not influence the judgement of the hypothetical prudent insurer, as required by section 20(2) of the Marine Insurance Act 1906. This point, implicit within the 1980 test, is made explicit in *Cuthbertson*.
- 6.27 The law of New York favours the niche insurer with its test of materiality. The test is concerned solely with the effect the non-disclosure or misrepresentation has on that particular insurer. This test clearly favours the insurer as it is coupled with the fact that even a slight change in the resulting contract can lead to the harshest of remedies. However, it is recognised that the principle of measuring materiality with reference to the specific insurer in question has its merits.
- 6.28 We wonder whether in such circumstances insurers require greater protection than they currently receive under section 20(2) of 1906 Act. One possible approach which might provide such protection would be to define a fact as material if it is material to the particular insurer, and a reasonable insured would understand it to be material to that insurer, even if other underwriters would not regard it as such.
- 6.29 This would suggest a two-part test. Initially, the actual insurer would need to prove that the issue was material to them, in that had it known the true facts it would not have entered into the same contract on the same terms. This is no different to the current law's requirement that the insurer prove inducement. Once this had been established, the focus would then shift to the insured. As with *Cuthbertson*, if "the proposer appreciated that the fact in question would have had that significance", that would be the end of the matter. Otherwise the court has to ask what a reasonable insured would have understood to be material in the circumstances, given the nature of the policy, the way that it was sold and the questions that were asked (or whatever variant of the "reasonable insured" test is adopted).<sup>5</sup>

<sup>4</sup> See above, paras 2.25 to 2.28.

<sup>5</sup> See above, paras 3.22 to 3.24..

## Conclusion

**6.30 Our tentative proposal is that insurers should only be entitled to a remedy for an insured's non-disclosure or misrepresentation in so far as this is material, as defined below. The same test should apply to misrepresentation and non-disclosure.**

**(1) First, the actual insurer must show inducement, in that had it known the true facts it would not have entered into the same contract on the same terms or at all.**

**(2) Additionally, the insurer must show either**

**(a) that the proposer appreciated that the fact in question would have that significance;<sup>6</sup> or, if not,**

**(b) that a reasonable insured in the circumstances would have appreciated its significance.<sup>7</sup>**

**6.31 In assessing what a reasonable insured would appreciate, the courts should take into account the type of policy, the way the policy was advertised and sold, and the normal characteristics of consumers in the market.**

**6.32 We ask whether the test should also take into account any particular characteristics or circumstances affecting the insured, so far as these were known to the insurer. However, they would not look at individual circumstances, known only to the insured.**

**6.33 We see this new test (in whichever formulation) as having two advantages. First, it will provide a fairer balance of rights between insurers and insured, by asking what the proposer did or should have appreciated in the circumstances. Secondly, it will provide greater protection to innovative insurers, who rely on matters that most underwriters in the market do not rely on.**

<sup>6</sup> At the seminar on 21 September 2006, it was pointed out that this formulation is confusing. We meant that it must be shown that the proposer appreciated that the fact in question would be *relevant* to the insurer (in the sense that it would have an effect on the insurer's mind in assessing the risk) - not necessarily that it would have a decisive influence on the insurer.

<sup>7</sup> By this we mean that a reasonable insured would have appreciated that the fact would be relevant to the insurer (in the sense set out above), not necessarily that it would be decisive.

## REMEDIES

6.34 In our view the remedy available should differ according to the state of mind or conduct of the insured. This is in line with other jurisdictions. Below we distinguish between behaviour that is fraudulent, innocent but negligent and innocent without negligence. Avoidance is appropriate where the insured has behaved fraudulently. Where the insured has behaved both innocently and reasonably, we think that insurers should take policyholders as they find them. In the mid-range cases, where the insured has behaved carelessly or negligently, the law should as far as possible put the parties into the position in which they would have been had the facts been stated correctly. Depending on the circumstances, this could mean that the claim may be rejected or that it should be paid in part.

### Fraudulent conduct

6.35 Where an insured has behaved fraudulently, it is right that a high penalty should be imposed, even to the extent of over-compensating the insurer for the loss they have suffered. As Lord Steyn put it, a generous measure of damages indicates that the defendant is morally reprehensible and it aims to deter wrongdoing.<sup>8</sup> However, if the law is to impose a penalty of this type, the category must be defined carefully so that it includes only those who are morally blameworthy.

6.36 The standard definition of fraud, as set out in *Derry v Peek*, is that the representor must either know that the statement is false or have “no care whether it is true or false”.<sup>9</sup> Lord Bramwell was careful to distinguish a lack of interest in whether the statement is true (which is reckless) from “a lack of reasonable ground for believing it to be true” (which is merely negligent).

6.37 For present purposes we also think that the insured must know both that the information it gives is inaccurate (or realise that it may be inaccurate and not care) and that the issue is material (or realise that it may be material and not care). We have come across many cases where a policyholder knew that an answer was not strictly accurate, but thought that the answer was irrelevant. For example, we were told about a motorist who filled in a proposal form that asked whether his family owned another car. He thought it was a marketing question. He was happy with the insurance arrangements on the other car, and did not want to be sent junk mail about it. He therefore answered no. If he had been wrong about the significance of the question, he may have acted carelessly or even foolishly, but we do not think this behaviour carries the moral blameworthiness necessary to be classified as fraud.

<sup>8</sup> *Smith New Court Securities Ltd v Citibank* [1997] AC 254, 280.

<sup>9</sup> (1889) LR 14 App Cas 337.

6.38 Our survey of ombudsman cases also revealed cases where policyholders failed to tell insurers about what they perceived as minor medical matters because they did not think they mattered. We came across several cases where people had said they had not suffered from stress, anxiety or depression when their medical notes revealed otherwise. For example, one woman had taken time off work for stress, but saw this as related to her matrimonial problems rather than her health. She said that she did not think that it was a medical issue relevant to her application for life insurance. If this were true, she may have been seriously mistaken and negligent, but she was not acting fraudulently.

**6.39 We tentatively propose that insurers should be allowed to avoid policies where the insured has acted fraudulently at the pre-contractual stage, that is, if the insured:**

- (1) knew that the statement was untrue (or realised that it might be not be true and did not care); and**
- (2) knew that the statement was material to the insurer (or realised that it might be material and did not care whether it was or not).**

6.40 We note that the Australian Law Reform Commission also recommended that insurers should retain the right to avoid a policy for fraud. However, they thought that in some circumstances avoidance could be seriously disproportionate to the harm suffered by the insurer. They therefore recommended that courts should have a discretion not to avoid, but instead adjust the rights of the parties, having regard to all relevant facts, including the need to deter fraudulent behaviour.<sup>10</sup> In our view, this recommendation is excessively lenient on fraudulent behaviour, and we do not recommend introducing such a provision in Britain.

6.41 Other than the Australian provision mentioned above, the jurisdictions examined have unanimously treated fraudulent behaviour harshly.

#### **Innocent conduct**

6.42 We have already indicated that a claim should not be defeated because of an inaccurate answer or a failure to disclose information if the consumer honestly and reasonably thought that the information stated inaccurately or not disclosed was not material. The same approach should apply when the consumer knows or should know that the information is material but is innocent in other ways. Thus when the insured makes an incorrect statement of fact which is clearly material but does so without any negligence – for example, because they were merely passing on information given them by their surveyor and therefore they had reasonable grounds for believing what they said to be true – we think that insurer should not be entitled to avoid the policy or refuse to pay the claim.

<sup>10</sup> See now Insurance Contract Law Act 1984 s 31; below, Appendix G para D.9.40.

- 6.43 It should be noted that in France and Australia the need to consider innocence is dispensed with. These jurisdictions define the offences such that without actual knowledge of the information allegedly not disclosed or misrepresented, there is no claim.

#### **Comparisons to statements of opinion**

- 6.44 The law already goes some way to protect those who act innocently. As we have seen, for the purposes of misrepresentation, the Marine Insurance Act 1906 makes a distinction between facts and opinions. Where the misrepresentation is deemed to be one of fact, an insurer may avoid for any material inaccuracy, even if the policyholder had no way of knowing that what they said was untrue. However, where it is deemed a matter of opinion, then the insurer is without a remedy unless it can prove that the policyholder acted in bad faith.<sup>11</sup> The policy may not be avoided because the insured had no reasonable grounds for their belief. So a statement of opinion which is honestly held is not treated as a misrepresentation, and a statement of fact that is clearly about something not within the insured's knowledge is often treated as one of opinion.<sup>12</sup>
- 6.45 The ABI Statement of General Insurance Practice ("SGIP") also considered that it should be sufficient for a consumer to fill in the form according to their own knowledge and belief. The first paragraph states:

The declaration at the foot of the proposal form should be restricted to completion according to the proposer's knowledge and belief.

The clear implication is that statements about matters which the insured cannot know should not give rise to a remedy. The insured is treated as acting innocently and the insurer should not be entitled to avoid the policy and reject the claim.

<sup>11</sup> See Marine Insurance Act 1906 s 20(5) and *Economides v Commercial Union Assurance plc* [1998] QB 587.

<sup>12</sup> For example in *Joel v Law Union & Crown Insurance Co* [1908] 2 KB 863, a statement about the insured's health was considered a matter of opinion. However, in *Godfrey v Britannic Assurance Co Ltd* [1963] 2 Lloyd's Rep 515, a visit to a specialist was regarded as a question of fact, even though the insured did not know that anything was seriously wrong.

6.46 The law on non-disclosure is different. The starting principle is that one need only disclose what one knows. However, under section 18(1) of the Marine Insurance Act 1906, the insured is “deemed to know every circumstance which, in the ordinary course of business, ought to be known by him”. This means that where an insured fails to mention something they ought to know, an insurer may succeed in an action for non-disclosure, even though it would fail under misrepresentation on the grounds the opinion was genuine. But this would only happen in business cases. In *Economides*, the phrase “in the ordinary course of business” was interpreted literally as applying only to business insured rather than consumers.<sup>13</sup> Thus an undervaluation of the property insured, some of which belonged to the proposer’s parents, was treated as a mere statement of opinion.<sup>14</sup> So again the law acts to protect the “innocent” consumer insured.

#### **Innocent misrepresentations of fact**

6.47 In contrast, if the insured makes what is clearly a misrepresentation of fact but does so without negligence, the current position is that as a matter of strict law the policy may be avoided. The SGIP, ICOB and the FOS guidance all temper the law in this area.

6.48 In our view, the insurer should have no remedy for misrepresentation or a non-disclosure if the insured had reasonable grounds for believing the truth of what they said. We think this is uncontroversial. It reflects accepted industry practice, FSA regulation, and current FOS decisions. It also aligns more closely the current tests for misrepresented facts and incorrect opinions.

#### **Other forms of innocent behaviour**

6.49 Earlier we pointed out that a consumer insured may make other kinds of “innocent” mistake. For example, if the proposal form is set out poorly, they might simply miss a question altogether. That might result in them failing to disclose a fact or, depending on the wording of the question, in them “making a statement”, that is clearly material and about which they know the truth.<sup>15</sup> Nonetheless, if they took reasonable care and were misled by the form, they are innocent and should be treated as such. This is, we believe, already the position under the Statements of Practice, the FOS scheme, and under the COB and ICOB Rules. The law should be the same.

<sup>13</sup> [1998] QB 587, 601, by Simon Brown LJ.

<sup>14</sup> Given that the distinction between a fact and an opinion is often a fine one, we do not think that this is satisfactory. It is too harsh to policyholders to require them to accurately describe facts they have no way of knowing, and it leaves insurers without a remedy when policyholders give quite unreasonable statements of opinion. We think there is a need to simplify the law by bringing the doctrines of misrepresentation and non-disclosure into alignment.

<sup>15</sup> See for example *Roberts v Avon Insurance Company Limited*, in which the applicant had been asked to complete the following declaration which contained a blank space: “I have suffered no other similar loss, except...”.

- 6.50 We tentatively propose that if the consumer insured had reasonable grounds for believing the truth of what they said, or was not negligent in other ways (such as in failing to answer a question), the insurer should have no remedy for misrepresentation or non-disclosure.**

### **Negligent conduct**

- 6.51 Within behaviour that is innocent rather than fraudulent, there lies a broad swathe of negligent conduct – where the policyholder failed to take sufficient care to understand what the insurer wanted to know or to check their facts. Here we think the law should aim to provide a proportionate remedy which, as far as possible, aims to compensate the insurer for the loss it has suffered.
- 6.52 We have noted that the FOS regularly applies proportionate remedies for mere inadvertence – where the consumer did not act deliberately, but failed to mention something they should have known.
- 6.53 We are not proposing to follow the FOS in distinguishing between different types of negligent behaviour, by (for example) classifying “recklessness” separately from “mere inadvertence”. We consider this overly complex. Words such as “reckless” can be used in several different ways, and have proved difficult to apply in this context. But we do think that where there was negligence, the insurer should not have an automatic right to avoid. This is in line with other jurisdictions.
- 6.54 We do not see a need to define negligent conduct. Misrepresentations will be treated as negligent if they are not fraudulent but were made without exercise of reasonable care.

### **A proportionate remedy**

- 6.55 Where a non-disclosure or misrepresentation has been negligent (rather than fraudulent) the law should aim to place the insured in the position they would have been had they known the true facts, but no better. This means that:
- (1) The court should ask what terms the insurer would have offered had the misrepresentation or non-disclosure not occurred. If a claim has already arisen, it may be that it would be excluded under the terms that would have been agreed, or in an extreme case it may be that a policy would not have been offered at all. In such a case the insurer should not have to meet the claim.
  - (2) If the insurer would have demanded an increase in premium and a claim has arisen, proportionality should be applied. In other words, if the misrepresentation or non-disclosure led to the consumer only paying 50% of the correct premium, the insurer should only have to pay 50% of the claim.
- 6.56 Proportionality has long been used in French law where the insured’s bad faith has not been proved. Under Article L113-9 of the *Code des Assurances*, where a misrepresentation is discovered after a loss has occurred:

the compensation shall be reduced in proportion to the rate of the premiums paid in relation to the rate of premiums that would be owed if the risks had been truthfully and exhaustively declared.

- 6.57 In 1980, the Law Commission rejected proportionality as an option on two main grounds. The first is that an insurer may react to information in a variety of ways: by declining the risk altogether; by imposing additional warranties; by imposing an exclusion clause; or by increasing the “excess” which the insured must bear. The Commission thought that the proportionality principle was only really useful where the insurer would have charged a higher premium.
- 6.58 Secondly, the Commission thought that it would be too difficult to calculate how much the premium would have been in hypothetical circumstances. It argued that tables of tariffs would only be able to assist in straightforward (but unusual) circumstances, where, for example, a life assurance proposer had mis-stated their age.

However, in the usual case where the undisclosed fact is qualitative rather than quantitative in nature – for example, failure to disclose a gastric complaint in an application for life assurance, or non-disclosure of a previous motoring conviction in an application for motor insurance – tables of tariffs will almost certainly be unable to assist, and disputes would proliferate into litigation with the inevitability of conflicting expert evidence about what the notional premium should be.<sup>16</sup>

The Commission argued that in France judges often determined a fair deduction as a matter of fact and discretion, rather than arithmetical precision.

- 6.59 We think the 1980 report exaggerated these difficulties. As the National Consumer Council pointed out, the Insurance Ombudsman Bureau applied proportionality, and its current successor, the FOS also does so. We found cases in FOS files where they had no trouble in dealing with an exclusion that would have been added, or in working out the effect on a premium of an additional motoring conviction. The approach appears to have gained acceptance from the industry<sup>17</sup>, and we note that it also has the support of the British Insurance Law Association.
- 6.60 However, it is necessary to think through the effect of various scenarios on the remedy available.

<sup>16</sup> Insurance Law Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 4.8.

<sup>17</sup> NCC, *Insurance Law Reform* (May 1997) p 26.



## **Exclusions**

- 6.61 In our survey of FOS files, it was relatively common for insurers to state that had they known about the insured's health problems, they would have excluded a particular condition from cover. The question then becomes - what effect would the exclusion have on the claim that has arisen? In several cases, the exclusion did not affect the claim. For example, a claimant who failed to mention her hearing loss later died of leukaemia. The insurer stated that had they known of the hearing problem they would have excluded hearing-related problems from the cover. Rightly, the insurer was ordered to meet the claim for leukaemia in full. Similarly, a woman who failed to mention back pain following pregnancy later developed (unrelated) breast cancer. The insurer was required to reinstate the policy subject to a back exclusion, and to pay the claim for cancer.
- 6.62 In other cases, a claim may fall within the terms of the exclusion. For example, a complainant who failed to mention an upcoming ophthalmological referral later developed a serious eye problem. The FOS instructed the insurer to reinstate the policy, but subject to an exclusion for eye conditions. This meant that the claim was not covered.
- 6.63 In some cases this result may appear harsh on a policyholder who has made a momentary lapse of judgement, and who is deprived of a large claim. However, it is a fair result from the insurer's point of view. And, from the insured's point of view, it is fairer than the current law, which avoids all claims under the policy, whether affected by the non-disclosure or not.

## **Warranties and excesses**

- 6.64 We did not find any cases where insurers argued that they would have imposed an additional warranty or excess. However, in principle, we see no reason why they could not be dealt with in the same way. The court or ombudsman should ask what the effect would be if the policy were re-written to include the new terms. If a claim satisfies the new terms, it must be paid.

## **An additional premium**

- 6.65 Proportionality works best when there is clear evidence of what the premium would have been. We accept that in some commercial cases the evidence may be disputed, and that precision may not be possible. Instead, the judge will have to work out what seems a reasonable premium given the evidence available.
- 6.66 French commentators admit that there are many cases where the court is unable to put an accurate percentage on the reduction, and the decision has "an element of arbitrariness".<sup>18</sup> However, it is still the best way of redressing the balance between the parties, which has been upset by the false statement,

<sup>18</sup> Lambert-Faivre.

6.67 In our view, it is preferable to allow judges to aim imprecisely at the correct figure, than to apply precisely the wrong one (as where a policy is avoided altogether for a small increase in the premium). There are many occasions in which the courts are forced to place arbitrary figures on the level of damages, particularly in personal injury cases. The level of imprecision involved here would appear to fall within acceptable limits.

### **Declining the risk**

6.68 If the insurer would have declined the risk altogether, the starting point must be that they should not have to meet the claim. In principle, we think it is right to hold insurers to a contract that they would have entered into had they known the true facts, but wrong to force them to abide by a contract they would not have assented to.

6.69 This is fair where all reasonable insurers would have declined the risk because they were concerned about the loss that has in fact occurred. However, difficult cases may arise. One is where this insurer would have declined the risk but other insurers would have accepted it (subject to an increase of premium). It is difficult to know what should happen where the particular insurer would have declined the risk completely, but several other insurers would have accepted it for only a moderate increase in premium.

6.70 There is also potential for injustice where the loss is unconnected to the risk: where, for example, a proposer failed to mention high blood pressure and was killed in an accident at work.

6.71 In France, the judge at first instance may decide on a fair reduction in these circumstances as a matter of fact and discretion.

6.72 We would welcome views about whether the courts or the FOS should also have a discretion to mitigate the harsh effects of avoidance in some cases. Such a discretion could be used where the policyholder's negligence was minor, and where the insurer has not suffered substantive prejudice (or where any prejudice that it has suffered could be adequately compensated by a reduction in the claim).

### **Effect on future cover**

6.73 The foregoing discussion concentrates on claims that have already arisen. We need to consider whether the insurer should also be obliged to remain on cover. Current law allows the claim to be refused because the insurer can avoid the policy as a whole. For inadvertent misrepresentation, current ombudsman practice is to require that the cover continues on amended terms.

6.74 We think, on balance, that where the risk would have been declined altogether had the negligent misrepresentation not occurred, the insurer should remain entitled to avoid the policy.

- 6.75 In other cases, the insurer should offer to remain on cover on the terms it would have granted had the negligent misrepresentation not occurred. If a higher premium would have been charged, a pro rata additional premium may be charged to cover the remaining term of the contract. The policyholder should be given the choice of accepting these new terms or cancelling the policy.
- 6.76 Most consumer policies include a cancellation clause – enabling an insurer simply to cancel the policy after paying the claim. It is likely that consumers will be asked in future applications for insurance whether they have had policies cancelled in the past. The cancellation may blight their ability to gain cover. Alternatively, an insurer may choose not to continue on cover at the next renewal date, with similar consequences. We would be concerned if insurers exercised their cancellation rights or their rights at renewal to avoid our proposals in paragraph 6.75 and we invite views on these points.

#### **The position of third parties**

- 6.77 It has been suggested to us that a proportionate remedy may be inappropriate where a claim has been made in respect of a liability the policyholder has incurred to a third party. The argument is that it seems unfortunate if a third party's ability to recover from a policyholder is adversely affected by the policyholder's misrepresentations to the insurer.
- 6.78 We discuss the position of third parties in the context of business insurance in paragraphs 7.88 to 7.92. Our tentative conclusion is the same for consumer insurance - that we should not extend the existing rights of third parties. However we welcome views on this issue.

#### **Tentative proposals**

- 6.79 **Our tentative proposal is that, in consumer cases, where the proposer has made a negligent misrepresentation, the court should apply a proportionate remedy by asking what the insurer would have done had it known the true facts. In particular:**
- (1) **Where an insurer would have excluded a particular type of claim, the insurer should not be obliged to pay claims that would fall within the exclusion;**
  - (2) **Where an insurer would have declined the risk altogether, the claim may be refused;**
  - (3) **Where an insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium.**
- 6.80 We believe that these proposals will still leave the consumer with a strong incentive to give accurate information.
- 6.81 **There are three further issues on which we would welcome advice:**

- (1) Is there a case for granting the courts or ombudsman some discretion to prevent avoidance where the insurer would have declined the risk but the policyholder's fault is minor, and other insurers would have accepted the risk at a higher premium? This may also apply where the misrepresented fact is unrelated to the claim.
- (2) Should insurers be entitled to avoid policies for the future in all cases, or only where they would have declined the risk?
- (3) Is it desirable to give greater protection to third parties in the event of misrepresentation by a policyholder?

### **THE RESIDUAL DUTY OF DISCLOSURE: SHOULD CONSUMERS BE REQUIRED TO VOLUNTEER INFORMATION?**

6.82 It is now generally accepted good practice that in consumer insurance, an insurer should ask questions about any material facts it wishes to know. This was set out clearly in the Statements of Insurance Practice. For long-term insurance

Those matters which insurers have commonly found to be material should be the subject of clear questions in proposal forms.<sup>19</sup>

For general consumer insurance, the provision is similar:

Those matters which insurers have found generally to be material will be the subject of clear questions in proposals forms.<sup>20</sup>

We saw earlier that the FOS enforces these provisions by refusing to avoid a policy for a non-disclosure where no question was asked. In considering a consumer non-disclosure case, the ombudsman will start by asking whether the insurer has provided evidence that it asked a clear question, to which it received an inaccurate response.

6.83 Here we consider whether to bring the law into line with industry practice and ombudsman guidance by requiring insurers to ask consumers clear questions about any matter that is material to them. If no question is asked, the insurer would be regarded as having waived its right to such information.<sup>21</sup> Another way of looking at the same issue would be to abolish consumers' residual duty of disclosure. Consumers would only be required to answer accurately the questions they were asked. This is the approach taken in France following amendments made in 1990.

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

<sup>19</sup> ABI, Long Term Insurance: Statement of Normal Practice, 1(c).

<sup>20</sup> ABI, Statement of General Insurance Practice.

<sup>21</sup> See paragraph 2.45(4) above.

- (1) Abolition would enable “sharp practice” by consumers. For example, a consumer should not apply for house insurance without disclosing that they had received a threat to burn their house down.
- (2) Without a duty of disclosure, it would be difficult to grant temporary cover before a proposal form was completed.
- (3) The division between consumers and businesses is artificial; the dividing line should really be between “professionals” and “non-professionals”. Special rules for consumers would lead to complex law, as there would then be three categories:
  - (a) Consumers.
  - (b) Businesses.
  - (c) Marine, Aviation and Transport risks (“MAT”).

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

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

6.86 The FOS takes the approach that consumers do not need to volunteer information. Interestingly, we found a case very similar to the one noted in the 1980 report. The complainant’s daughter had split up from her partner, who made various threats against the family. The complainant then decided to take out contents insurance (after five years without it). She was not asked if she had received threats, and she did not mention them. The household was later burgled. The insurer suspected that the ex-partner had been involved and they attempted to avoid the policy on the grounds that they should have been told about the threats. The Ombudsman decided that as no question has been asked, the insurer could not require the matter to be disclosed. They should pay the claim.

6.87 Our tentative view is that in consumer cases the duty to disclose is no longer needed. It would lead to greater complexity to leave differences between the approach taken by the FOS and the rules required by law in the same case. We think the law should now be brought into line with the FOS guidelines.

6.88 Given existing practice, we believe this proposal will be uncontroversial. It has the following advantages:

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

- (2) It nevertheless leaves insurers free to ask whatever questions they wish, or indeed to choose to ask no questions at all.
- (3) It gives applicants for insurance a clear indication of the information that is required from them.
- (4) It simplifies the law by bringing substantive law into line with best practice and the FOS guidelines.

**6.89 Our tentative proposal is that in the consumer market, insurers should ask consumers clear questions about any matter that is material to them and that, if they do not ask questions on a particular point, the insurer should be regarded as having waived its right to such information.**

#### **Preventing general questions**

6.90 There is a difficult issue about general questions, along the lines of “is there anything else we would want to know?”

6.91 As we have seen, proposal forms already include some extremely wide questions. Some of these seem to represent simply bad practice. The following is an example taken from the FOS study, which not only asks the proposer whether they have ever been ill, but also whether they have “a tendency” to be ill.

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

6.92 The French have a provision which effectively codifies the position reached through case law. Article L 112-3 para 2 provides that if an insurer asks a question expressed in “general terms”, it cannot complain when it receives a vague response. Its effect is to discourage insurers from asking vague, open-ended questions as it could leave them without recourse when a misrepresentation is made.

6.93 We see that general questions can have a useful function, particularly if there is no general duty on a consumer insured to disclose material facts that it might never occur to the insurer to ask about – such as the threat to burn down the house. The general question avoids at least the first criticism of the duty to disclose made by the 1980 report, that the consumer may not realise they have such a duty. To that extent, a general question can perform the same function as a warning to the consumer that they have such a duty, as envisaged by the SGIP. The problem with them, however, is that the consumer may be left in doubt as to what is wanted. If they think of something and are in doubt about its materiality, they can ask; but they may never even think of it despite the general question.

6.94 There are two ways of dealing with such questions. The first would be for the court to strike them out, on the ground that unless a question meets a minimum level of precision it should be disregarded. The second would be to permit them but for the court to ask whether a reasonable consumer would understand that this question was asking about this particular information.

- 6.95 For example, taking the question above, it is extremely unclear whether a consumer is expected to mention the ingrowing toenail removed 5 years ago. However, most consumers would realise that they should mention their recent cancer diagnosis. The first approach would strike out the question altogether, with the result that consumers would no longer be required to mention any health issues (including the cancer). The second would absolve a consumer of the requirement to mention the toenail (on the grounds that the insurer did not make this sufficiently clear) but would still require the cancer to be mentioned.
- 6.96 Striking out unclear questions would concentrate insurers' minds on the need to ask for information in a clear, sensible way, but it could lead to surprising decisions in some circumstances. The second approach would do justice in the individual case but does not give insurers such an incentive to clarify their questions. It would also avoid the great difficulty of defining what amounts to a general question for this purpose.
- 6.97 Our tentative view is that general questions should be permitted, but that the court should ask whether a reasonable consumer would understand that this question was asking about this particular information.**

#### **RENEWALS**

- 6.98 Our tentative proposals on misrepresentation and non-disclosure will apply to renewals of policies as much as to new applications. If an insurer requires information from the policyholder at renewal it will therefore need to ask a clear question. Under our proposals there will be no residual duty of disclosure.
- 6.99 In Part 2 we identified one potential pitfall peculiar to renewals – the question which simply asks the policyholder whether there has been any change in circumstances.<sup>22</sup> If the policyholder has not retained or been given a copy of any information previously supplied to the insurer, it may be hard to answer such a question accurately.
- 6.100 We agree with the FOS that good practice dictates that such questions should be accompanied by copies of all the information previously provided to the insurer. However, we would go further and ask whether, for consumer insurances, insurers should lose their rights to rely on non-fraudulent misrepresentations made in response to such questions unless such copies have been provided. In practice we anticipate that the copies could be provided in one of two ways – either as paper or electronic duplicates of the original documents, or as paper or electronic output of data stored on an insurer's computer systems, having been extracted from the original documents.
- 6.101 Our tentative view is that in consumer insurance an insurer should have no right to rely on non-fraudulent misrepresentations made at renewal in response to such a question, unless the policyholder was supplied with copies of any information previously provided to the insurer.**

<sup>22</sup> See para 2.49 above.

## **MID-TERM ADJUSTMENTS**

- 6.102 The duty of disclosure arises again if there is a mid-term adjustment to a policy — for example, where the policyholder requests an increase to the sum insured. Some policies may also seek to impose a continuing duty of disclosure by contractual term. We intend to deal with these matters in a later paper on post-contractual good faith.

## **BASIS OF THE CONTRACT CLAUSES**

- 6.103 If the law of non-disclosure is reformed, it will also be necessary to consider “basis of the contract” clauses. Without controls on how basis of the contract clauses are used, insurers would be able to evade the reforms we are proposing. We note that SGIP barred the use of basis of the contract clauses in consumer policies, and our present view is that this is a sensible approach. However, we intend to discuss the matter in more detail in our next issues paper.
- 6.104 Our tentative view is that in consumer insurance “basis of the contract” clauses, whether in the proposal form or the contract itself, should be ineffective to make all the answers given by the insured into warranties. (This is without prejudice to the decision whether or not to permit specific warranties of existing fact contained within the contract.)**

## **OTHER ISSUES**

### **Material available to insurers**

- 6.105 In many cases information which is relevant to an insurance application or renewal will be held by the insurer or be readily available to it. In this section we consider the extent to which insurers should retain their rights in respect of misrepresentation if they fail to make their own enquiries. The FOS has put the point to us in the following terms:

There are issues of good faith in the practice of declining to seek information at the application stage of an insurance policy in the full knowledge that this information will be sought in the event of a claim. The effect of such practice is that information that is supposed to be provided in order for the underwriter to assess the risk and to decide upon the terms of the policy is only in fact being requested from the insured in order to see if the claim can be rejected. We have identified three types of situation where these issues arise – where data is readily available to an insurer, where data is held in the insurer’s own files and where the insurer has obtained consent from the policyholder to obtain the data but has not done so.

- 6.106 Our tentative proposals apply only to those cases where the misrepresentation by the insured was non-fraudulent.

### **Data readily available to insurers**

- 6.107 The National Consumer Council has argued that law established in respect of contracts between merchants in the eighteenth century is not necessarily appropriate to consumer contracts in the modern environment. In particular, it is clear that the balance of knowledge has changed:



It is generally accepted, too, that the balance between insurance seller and insurance consumer has altered since 1766, to put the seller in a far stronger position when it comes to assessing risk. The sophisticated data available to insurance companies through the Association of British Insurers and their own company intelligence is not available to individual consumers.<sup>23</sup>

6.108 As the NCC has noted, insurers may have access to relevant information through various databases. Again there is no general obligation on insurers to check these databases at the time of an application, mid-term adjustment or renewal.

6.109 One example is the Claims and Underwriting Exchange "CUE", which is a database of incidents reported to subscribing insurers and which may provide a more accurate record of past claims and losses than policyholders can give from memory.<sup>24</sup> Another example is information about flood risks. We think it may not be unreasonable for a consumer to assume that the insurer will be well-informed of the known risk in the particular area.<sup>25</sup>

6.110 In discussions a number of points have been made to us about the use of such databases:

- (1) The information obtained will not necessarily be complete, up-to-date or accurate. CUE, for example, relies on other insurers submitting accurate information in a prompt manner.
- (2) There is typically a cost in searching such databases – both in terms of the time involved and any access charge that is payable. This cost is likely to be passed on to policyholders.
- (3) Subscription to any given database is not compulsory. If subscribers could be penalised for failing to carry out searches, one respondent asked: "Would this lead to different standards being applied to insurers that subscribed to such databases and those that do not?".
- (4) Some of the databases are subject to significant restrictions. CUE, for example, only covers certain classes of insurance.

<sup>23</sup> National Consumer Council, *Insurance Law Reform: the consumer case for review of insurance law* (May 1997).

<sup>24</sup> One insurer has since told us that the charge to it for a CUE is £2 at application stage, but only £1 at claims stage. We are not aware of the reasons for this differential and it may be justifiable in terms of the costs of operating the database. However it seems to be unfortunate in that it gives a further economic incentive to defer enquiries from the underwriting process to the claims stage. Another insurer has informed us that the charge reduces if larger numbers of searches are conducted, and that it pays less than the figures above.

<sup>25</sup> In fact the insurer will need this information to ensure it complies with the ABI commitment on flood cover - <http://www.defra.gov.uk/corporate/ministers/statements/em051111.htm>

- 6.111 Nevertheless the fact remains that some insurers are avoiding policies and rejecting claims on the basis of facts which could have been readily established at outset. In his Pat Saxton Memorial Lecture, Lord Justice Longmore suggested a test that we think may be appropriate:

whether the undisclosed matter was a matter which a reasonable insured would realise was within the knowledge only of himself (or those for whom he is responsible) rather than a matter which could have been independently investigated and verified by insurers.

This addresses non-disclosure but the same principle should apply to incomplete answers in response to questions, if the insured reasonably thought that the insurer would investigate and verify the matter.

- 6.112 We tentatively propose that an insurer should not be allowed to rely on a failure to disclose or a misrepresentation because of an incomplete answer, if the insured reasonably thought that the insurer would investigate and verify the matter.**

#### **Data in the insurer's own files**

- 6.113 Insurers may hold relevant information in their records - for example, information relating to another policy held by the same consumer. However, there is currently no general obligation on them to carry out searches at application or renewal if they have no reason to believe anything material might be found. Professor Clarke has suggested that other jurisdictions have a better rule:

In the United States and in Canada, if insurers fail to look in their data files, they are deemed to have waived disclosure of the information which the files contain. So should it be in England today.<sup>26</sup>

- 6.114 We appreciate that there are practical difficulties which may face an insurer. Information may be held in different forms – paper files, microfiche, computer records, and so on. It may be held across different sites, and by different companies within the same group. Nevertheless, if the information was reasonably identifiable we believe that the insurer should not retain its rights in misrepresentation if it has failed to make the necessary enquiries.

- 6.115 We tentatively propose that an insurer should be treated as knowing information contained in its own files, provided that the information was reasonably identifiable.**

<sup>26</sup> MA Clarke

### **Data insurer has asked permission to obtain**

- 6.116 The problem is compounded if the insurer chooses not to obtain information from a third party after obtaining a consumer's consent to do so. The consumer is very likely to assume that this information will be obtained by the insurer from the third party and thus that the consumer does not need to disclose it themselves. For example, a life insurance application form may authorise an insurer to obtain medical details from the consumer's general practitioner, but there is no obligation on the insurer to make use of this authorisation. In 1993, Dr Julian Farrand, then Insurance Ombudsman, drew attention to the confusion this can cause:

...the reasonable expectation of the ordinary policyholder for life assurance would surely be that, where the details of a doctor are asked for, he would be approached by the assurer and would supply all relevant details before the proposal could be accepted... Indeed, many people wonder why assurers ask for such details if they only intend to use them if a claim is made. By underwriting the risk without carrying out full enquiries at the underwriting stage, the assurer lulls the policyholder into a false sense of security that he has cover when the reality is that he has none because as soon as a claim is made, the assurer will write to his doctor and discover the information then said to be material. If it is that material, it should have been investigated earlier and the risk declined or a higher premium charged, or cover restricted.<sup>27</sup>

- 6.117 We tentatively propose that an insurer who has indicated that it may obtain information from a third party (by for example asking the insured for consent to obtain it) should not be allowed to rely on a non-fraudulent misrepresentation (or failure to disclose) if the insured reasonably thought that the insurer would check with the third party.**

- 6.118 We note with interest that the Application Form Design for Life and Health Protection Insurances ("AFD") suggests two optional warnings that may be included on application forms:

PLEASE DO NOT ASSUME THAT WE WILL WRITE TO YOUR DOCTOR, IT REMAINS YOUR RESPONSIBILITY TO COMPLETE THE APPLICATION FORM PROPERLY.

YOU CANNOT ASSUME THAT YOUR DOCTOR WILL PROVIDE THE INFORMATION WE NEED. IT REMAINS YOUR RESPONSIBILITY TO COMPLETE THE APPLICATION FORM PROPERLY.<sup>28</sup>

- 6.119 Even where these warnings are used, there are likely to be situations where a policyholder reasonably thinks that the insurer will have contacted their doctor.

<sup>27</sup> The Insurance Ombudsman Annual Report 1993, paras 6.52 to 6.53.

<sup>28</sup> See Appendix D.

### **Failure to follow up incomplete or inconsistent answers**

6.120 On occasion an applicant for insurance will either fail to answer a question or give an answer which is incomplete or inconsistent. The issue then arises – if the insurer fails to make further enquiries, has it waived its right to disclosure of the missing information?

6.121 In some cases, failure to answer a question may to a reasonable person appear to be an answer in itself. In *Roberts v Avon Insurance Company Limited*<sup>29</sup> the applicant was asked to complete the following declaration which contained a blank space:

I have suffered no similar loss, except...

It was held that a failure to fill in the blank space was in itself a definitive answer that there had been no similar losses. There could be no question of the insurer having waived disclosure of the relevant information.

6.122 Where an answer is incomplete, the issue is whether the incompleteness should have been apparent. If it should have been apparent then the insurer may have waived its right to disclosure if it makes no further enquiries.

6.123 An applicant may give answers which seem to conflict. For example, in *Winter v Irish Life Assurance plc*,<sup>30</sup> the consumer stated incorrectly that she was suffering from no illness, but disclosed that as a child she had suffered from meconium ileus – a precursor to cystic fibrosis. It was held that the insurer was not obliged to investigate the potential conflict between these answers.

6.124 Australia has a provision which precludes an insurer from raising an allegation of non-disclosure or misrepresentation when a question in a proposal form has not been answered or has an obviously incomplete answer.<sup>31</sup> The onus is on the insurer to follow up such a form as soon as it is received. We think a similar rule might usefully be introduced here.

**6.125 We tentatively propose that insurers should be precluded from relying on a non-disclosure or misrepresentation when a question in a proposal form that requires an answer has not been answered or has an obviously incomplete answer.**

<sup>29</sup> [1956] 2 Lloyd's Rep 240.

<sup>30</sup> [1995] 2 Lloyd's Rep 274.

<sup>31</sup> Insurance Contract Law Act 1984, s 21(3).

### **A cut-off period**

- 6.126 This option is relevant to long-term insurance business. There is a particular risk if the policy can be avoided when the claim is made since the insured may well have relied on the policy to provide essential financial protection for innocent third party dependants. Moreover, by that stage it may be very hard for the insured or their dependants to prove what was or was not said at the time the proposal was completed. Should the insurer be able to raise issues of misrepresentation that it could have raised when or soon after the policy was taken out? It is worth canvassing a 'cut-off' period for defences other than fraud. In essence, the insurer would be prevented from relying on any misrepresentation or non-disclosure at the application stage once the policy had been in force for a set number of years - say 3 or 5. The attraction of such a provision is that insurers would be encouraged to find out all they need to know as early as possible.
- 6.127 This is the approach taken in New Zealand. Under section 4 of the Insurance Law Reform Act 1977, life insurers may not avoid for a misrepresentation unless the statement, was substantially incorrect; material; and
- Was made either—
- (i) Fraudulently; or
  - (ii) Within the period of 3 years immediately preceding the date on which the policy is sought to be avoided or the date of the death of the life insured, whichever is the earlier.
- 6.128 One option would be to apply a similar rule to consumer life insurance, and we would welcome views on its advantages and disadvantages.
- 6.129 We ask whether in consumer life assurance the insurer should be prevented from relying on any non-fraudulent misrepresentation after the policy has been in force for three years.**

# PART 7: BUSINESS INSURANCE CONTRACTS

## INTRODUCTION

- 7.1 The 1980 Report took the view that the problems with insurance law are not confined to the consumer market. The BILA Report and Lord Justice Longmore's lecture were also concerned to see reform of the law governing business insurance. In this Part we discuss whether there is a need to reform the law as it applies to insurance taken out by businesses. We start by considering insurance for business generally. At the end of the Part we consider, in turn, Marine Aviation and Transport insurance ("MAT"), reinsurance and insurance for small businesses.
- 7.2 The principal question must be whether the four major changes that we have tentatively put forward for consumer insurance should apply to business insurance also. It would obviously be simpler, and would avoid awkward "boundary disputes", if the same rules were applied to all types of insurance. However we recognise that differences in the markets may make this impractical or undesirable; or that the practical importance of the issues we deal with may be so slight that reform of business insurance contract law is simply "not worth the candle."
- 7.3 It should be noted that the jurisdictions examined for the paper treat businesses the same as consumers. Any differences apply as between marine and non-marine insurance, in the case of France, Australia and New York. The jurisdictions also differentiate between normal insurance and reinsurance.
- 7.4 We would welcome views from all sides of industry on whether the issues we identify below cause problems in practice. We also want to know if they have an impact on the market – and in particular whether they have a positive or negative impact on the competitiveness of insurance policies written under English or Scots law.

## GENERAL ISSUES

- 7.5 We begin with some general points before we turn to the individual points.

### **Most businesses are not insurance experts**

- 7.6 Although almost all businesses need to buy insurance, for most it is ancillary to their main trade. As the 1980 report said:

There are certain mischiefs in the law of non-disclosure which apply equally whether the insured is a consumer or a businessman who is not constantly concerned in his business activities with the insurance market. Neither consumers nor ordinary businessmen who are not in the insurance market have the knowledge or experience to identify all facts which may be material to insurers. Both are therefore to this extent in need of protection and both may properly be regarded as consumers vis-à-vis insurers.<sup>1</sup>

- 7.7 The British Insurance Law Association also stressed this point: “a tradesman insuring his business is in as much need of protection as when he is insuring his home”. Lord Justice Longmore argued that the fact the insurance industry accepts that the strict law needs to be modified for consumers suggests strongly that it should also be modified for businesses:

How can it be right that a lawyer insuring his home and household possession can rely on the more relaxed test of non-disclosure under the Statements of Practice, but the small trader, eg the garage owner or the fishmonger insuring his premises, cannot?<sup>2</sup>

- 7.8 In 1980, the English Law Commission pointed to harsh cases involving small businesses, especially where the non-disclosed issue related to moral hazard. For example, in *Locker & Woolf Ltd v Western Australian Insurance Co*, a fire claim was rejected on the grounds that the applicant had not revealed that the partnership had previously been refused motor cover.<sup>3</sup> We do not think that many people running non-insurance businesses would understand the full extent of the duty of disclosure that the law requires. They are unlikely to understand, for example, that they must volunteer information about criminal offences their employees have committed,<sup>4</sup> or any previous rejection for insurance.

#### **Brokers or in-house expertise**

- 7.9 That said, many applicants will be advised by brokers, and some may have specialist staff. This is sometimes also true for consumers, but with business insurance it is much more common.
- 7.10 In our Scoping Paper we drew attention to the type of problem that can arise where an applicant for insurance discloses material facts to an intermediary and the intermediary fails to pass on that information to the insurer. We intend to address this issue in a later paper – it does not form part of current discussions.

<sup>1</sup> Insurance Law, Non-disclosure and Breach of Warranty (1980) Law Com No 104, para 4.36.

<sup>2</sup> “An Insurance Contracts Act for a new Century?”, Pat Saxton Memorial Lecture, 5 March 2001 (set out in Appendix A of BILA, Insurance Contract Law Reform (2002)) para 42.

<sup>3</sup> See Law Com No 104, para 3.22 and Working Paper No 83, para 28.

<sup>4</sup> See for example, *Roselodge v Castle* [1966] 2 Lloyd’s Rep 113, where a theft policy was avoided because the owner did not disclose that his sales manager had been convicted of smuggling diamonds.

- 7.11 More generally we do not think that the involvement of an intermediary should affect the test of materiality, though it may affect the standard of disclosure that can be expected from an insured. We deal with this point in paragraph 7.52.

### **Supporting trust and confidence in the market**

- 7.12 Even for large commercial risks, the insurance market is built on trust and generally accepted standards of market practice. We are concerned that the law undercuts rather than supports accepted market practice.
- 7.13 Let us take the example of avoidance. Avoidance is an appropriate remedy for conduct involving some form of dishonesty, but the law allows it to be used where an insured has acted innocently or inadvertently in making an untrue statement or failing to disclose a fact that is known to be material.
- 7.14 Insurance solicitors dealing with high value claims justify the current law on the ground that it is necessary to prevent sharp dealing. As one solicitor put it:

Time and again [non-disclosure] isn't inadvertent. A commercial decision has been made: this will not be insured if we tell the whole truth. And in those circumstances the sanction [of avoidance] should remain.

- 7.15 It is often said that the full remedy of avoidance will only be applied if there is some element of fraud or dishonesty. We were told that good market practice is that an insurer will honour an insurance contract unless there is some element of dishonesty on the part of the insured.

I always advise my clients that if they get a whiff of non-disclosure or misrepresentation, basically the panel or court has to think there is a bit of a stitch-up here. You don't really avoid for technical non-disclosure.

- 7.16 However, if the law permits insurers to avoid for purely technical non-disclosure, it is inevitable that some insurers will take the point. When we asked one firm whether insurers would ever attempt to avoid a policy for an innocent non-disclosure, this is the answer we received:

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

- 7.17 When we asked whether that particular firm would attempt to avoid for an innocent non-disclosure, we were told that they would if instructed to:

That is the current law, so we would, yes... We wouldn't really have a choice.



- 7.18 If the insured had indeed acted fraudulently, we need have little sympathy. However, if the law provides insurers with a strong financial incentive to attempt to avoid even where there was no fraud, it is inevitable that some insurers in some circumstances will use the weapon they have been given. This has the potential to undercut more ethical insurers and to undermine confidence in the UK market. It can contribute to the perception that the law in this country is unduly insurer-friendly.

### **The insurer is judge and jury**

- 7.19 A particular complaint is that while reputable insurers will not avoid for innocent misrepresentation or non-disclosure, they may do so if they suspect fraud, even if they cannot prove it. This effectively allows them to be “judge and jury in their own cause”. In other contexts the courts have roundly condemned provisions that, in effect, oust their jurisdiction.<sup>5</sup>

### **All or nothing remedies**

- 7.20 Under the current law, an insurer may avoid whenever it can show that, had it known the information, it would only have altered a single term of the contract, a term which need not have any connection with the disputed claim. Moreover, the current law, does not permit half measures. An insurer cannot pay a claim and avoid for the future, or accept liability for a proportion of the claim. It must either seek to avoid completely, or waive all rights to a remedy. As one solicitor put it:

There are avoidance cases where... you have to say to the [insurer] client, I'm sorry, you've got one remedy, and the client may say – ‘that's very heavy – we don't particularly want to go that far’... If they don't, they lose the remedy completely. So it's pay or avoid... It means [the insurers] have to avoid or abandon their right. And they have shareholders and people.

- 7.21 Even in cases where it seems right to allow an insurer some remedy, avoidance can appear to be excessively harsh. Lord Justice Longmore makes this point, quoting *Kausar v Eagle Star*.

Avoidance for non-disclosure is a drastic remedy. It enables the insurer to disclaim liability after, and not before, he has discovered that the risk turns out to be a bad one; it leaves the insurer without the protection which he thought he had contracted and paid for... I do consider that there should be some restraint in the operation of the doctrine.<sup>6</sup>

<sup>5</sup> See *George Mitchell (Chesterhall) Ltd v Finney Lock Seeds Ltd*.

<sup>6</sup> [1997] CLC 129, per Staughton LJ.

- 7.22 In practice, of course, most cases are resolved through some sort of settlement. The insurer alleges non-disclosure and misrepresentation; the insured denies that the fact is material, or pleads that it was a mere expectation or belief, held in good faith. After some horse-trading, a settlement is reached. Lawyers acting for insurers worried that if the law was changed to provide proportional remedies the insurer would have to start by offering more, and would end up paying more:

Instead of going into negotiations saying we are paying nothing and end up paying half, we would say we would pay a third and end up paying two thirds.

Inevitably, most cases will be resolved through bargaining conducted in the shadow of the legal rules. Our concern is that the current legal rules have little connection to fairness or market expectations, but instead provide insurers with a weapon that can be wielded simply to reduce the size of a settlement.

### **Pooling of risks**

- 7.23 It is frequently said that the law is too much in favour of the insurer, and that it needs to be re-balanced in favour of the insured. We think that the question of balance between insurer and insured is one that must be approached with great care.
- 7.24 In our view the question is not really whether the law favours one or other party too much. It is whether the rules that will be applied when the parties have not made a different agreement (for example, have not agreed that the insurer may not avoid for innocent misrepresentation) represent a fair or efficient balance. To put it another way, had both parties known of the potential issue in advance, what would they have agreed?
- 7.25 To the best of our knowledge, the insurance market is fully competitive in terms of price. Putting it simply, the insured gets what it pays for. If the law is to be changed so as to give the insured more rights - for example, by preventing the insurer from avoiding the contract on the ground of an innocent misrepresentation or non-disclosure, there will be a marginal increase in the cost of policies, since insurers will now be obliged to pay out on some policies that under the old law they might have avoided. However, whether the market is less competitive depends on the preferences of insureds. If it is true that insurers will normally pay in such a case unless there is a suggestion of fraud, and that fraud is rare, the increase is likely to be low. While some insureds may prefer to pay slightly less and take the risk that their policy is avoided because of a purely innocent, non-negligent misrepresentation on their part, others may prefer to pay a slightly higher premium to have this risk transferred to the pool of risks covered by the insurer.

### **The parties are free to agree what they want**

- 7.26 An argument often made against reform is that it is unnecessary because the current law is not compulsory; if insureds don't like it, they can ask for better terms in their policy. In other words, the market will take care of any problem without the need for reform.

- 7.27 No doubt there are insureds who are sufficiently sophisticated to study very carefully the terms offered by potential insurers and who bargain for changes in their favour. It is quite clear from the cases and from the many sad histories supplied to us that there are large numbers of business insureds who do not. They may have no expertise in insurance law and may simply not be able to understand the effect of the policy offered. They may not be able to afford expert advice or may rationally take the view that the chances of a problem occurring are low enough that it is not worthwhile to spend time or money doing so. If they are not important customers, then even if they are aware of the difficulties they may be unable to persuade the insurer to write a special policy just for them. That is a quite understandable reaction on the part of the insurer, since for many types of relatively low-value insurance, writing and administering policies on different terms may be uneconomic. But whatever the reason, if the insured would in fact have been willing to pay a sufficient additional premium to cover the cost of the improvement in cover plus the regular profit element, there is a form of market failure – the terms of the contract are inefficient.
- 7.28 Thus the question is whether the rules for business insurance can be made to correspond more closely to what insureds want – and, given the generally high standards of the vast majority of insurers, insureds probably think that they are getting when they buy insurance in the UK market.

#### **Mandatory or default rules**

- 7.29 The rules we have proposed for consumer insurance would be mandatory rules to the extent that the parties would not be free to vary them in favour of the insurer.<sup>7</sup> We need to consider whether whatever rules are thought appropriate for business insurance should be similarly mandatory, should be merely default rules that the parties are free to vary or should be semi-mandatory in the sense that they can be varied provided that the change from the default rules is “fair”. (That is the test applied to consumer contracts in general, though not to the ‘core terms’, under Unfair Terms in Consumer Contracts Regulations 1999.)
- 7.30 In general terms we do not favour mandatory rules for business insurance contracts. We think it is important to preserve freedom of contract unless there is a very good reason to depart from it. Nor do we favour applying a fairness test, except perhaps for insurance contracts with small businesses.<sup>8</sup> The reason is quite simply the uncertainty that such controls can create. Thus we think that for business insurance contracts in general, any proposed rules should be default rules that can be disapplied by contrary agreement.
- 7.31 It may be argued that this will defeat the object of reform; insurers will simply write their contracts to reflect the old law. Most insurance contracts are on standard terms; all we would be achieving would be an alteration in the standard terms.

<sup>7</sup> See para 6.3 above.

<sup>8</sup> See paras 7.96 to 7.105 below.

- 7.32 We do not think that this is true, nor that, if it were, it would necessarily follow that reform is pointless. First, we think most insurers would be reluctant to reduce the rights of the insured from the legal norm without discussing the matter expressly with the insured. Most insurers are rightly proud of their reputation and it would do their reputation no good at all to be found to have taken away the insured's "new rights" by means of a standard term that was not expressly agreed by the parties. And of course if the parties do freely agree to revert to the position under the old law, there can be no objection. That is what freedom of contract means.
- 7.33 Secondly, having to insert special terms to revert to the previous position at least gives the insured a chance to discover what is happening by reading the terms. If they object, they can then try to bargain for something better. Indeed, we hope that the publicity that would inevitably surround any change in the law of insurance would positively encourage insureds to ask insurers: are my rights under the new Insurance Act fully protected?
- 7.34 Lastly, insurers may be reluctant to try to reduce the insured's rights by means of standard clauses for fear that they may not work. It has to be remembered that the courts will interpret the terms of the insurance contract, when there is doubt, in favour of the insured (under the *contra proferentem* rule) but they will do so against the background of the existing law. In other words, if a provision merely leaves in place the insurer's current rights, it is unlikely to be given a narrow interpretation. But were the law to be changed to give the insured more rights, a clause excluding those rights would probably be read narrowly. The insurer would have to use very clear words. We do not think this would be inappropriate. The parties should be free to agree what they want but insureds should be left in no doubt where they stand.

#### **Keeping UK law competitive**

- 7.35 The insurance industry makes a significant contribution to the invisible earnings of the UK. However, we have been told that in recent years the London market in particular has lost a large amount of international business, and that this has been partly as a result of the state of insurance contract law. It has been suggested that from the perspective of brokers or policyholders, other jurisdictions provide a more attractive legal regime. Bermuda, France and Norway are amongst the countries mentioned.
- 7.36 To date, definitive figures on the loss of business have proved elusive. Furthermore, one observer suggested that the loss was a positive development:
- Yes, we've lost 40% of the business - but it was the 40% we wanted to lose!
- 7.37 Nevertheless, we would like to explore how reforms in the law might support the UK insurance industry and therefore invite views on this issue.
- 7.38 It is our tentative proposal that the law affecting business insurance should be changed to give the insured certain additional rights, but that the rules should in general not be mandatory.**

## **NON-DISCLOSURE**

- 7.39 In Part 6 we tentatively proposed that consumers should no longer have a residual duty of disclosure.<sup>9</sup> Rather, insurers should have to ask for the information they need. They should be entitled to ask questions in general terms (“Are there any other facts that we ought to know?”) but the answers given should be judged by what the reasonable consumer would think was being asked about. Thus if the consumer reasonably thought that a fact they did not reveal was not material, the insurer would have no remedy.
- 7.40 Should the same apply to business insurance? Although there is no such duty in several of the jurisdictions that compete with the UK (such as New York), our tentative view is that it would not be right to abolish the residual duty of disclosure for businesses. There are two reasons for this.
- 7.41 First, the duty of disclosure has become part of the way the UK business insurance market works. For many business policies, there is no proposal form. Instead the broker presents the risk, and the underwriter relies on the broker and client to present that risk honestly. It would be possible to distinguish insurance that was preceded by a proposal form (whether a paper form or on a website) and insurance where there was no such form, and require disclosure only in the latter. However we would prefer, if possible, not to set arbitrary boundaries between types of insurance. These always cause problems in marginal cases.
- 7.42 Secondly, we think that business insurance in general is probably subject to a much greater variety of risks than is consumer insurance. That would make it much harder for the insurer to ask questions about all the relevant risks.
- 7.43 Thirdly, while not all business insurance is done through intermediaries who can advise as to what is required, a far greater proportion of it is. This means that the risk of an insured not realising that it has a general duty to disclose is reduced.
- 7.44 We still think that it would be appropriate to expect insurers, as a matter of good practice, to warn insureds about the duty to disclose when it is reasonable to think that the insured may not be aware of the need, particularly on renewal. This might well be the case with many kinds of business insurance written on an annual basis. But we doubt it is necessary to provide a legal remedy, such as preventing the insurer from avoiding, for failure to do so.
- 7.45 We tentatively propose that the duty of disclosure should continue to apply to business insurance contracts in general.**

<sup>9</sup> See paragraph 6.89 above.

## **REDEFINING MATERIALITY**

### **Different degrees of sophistication**

- 7.46 In 1980, the Law Commission recommended reform not just for consumers but for all insureds outside the marine, aviation and transport markets. Although the gap between what an underwriter understands to be material and what a policyholder understands to be material is greatest for consumers, the injustice is not confined to consumer policies. Small and medium businesses may also have little understanding of insurance, and in some cases will be less protected than are consumers. As we have seen, small businesses make relatively little use of the Financial Ombudsman Scheme. Even if a small business does use the scheme, the Statements of Practice will not necessarily be applied; so only some will be granted consumer-style protection. Medium businesses with a turnover of £1 million or more do not have the right to use an ombudsman at all.

### **Over-disclosure**

- 7.47 There is even an argument that the current law operates against the interests of insurers in that they get too much information when the insured is sophisticated. The duty of disclosure is so wide and, to many insureds, so imprecise that an insured may conclude that the safest option is to give the insurer all the information it is able to gather. We have been told that applicants often provide insurers with more information than they are able to process. As one experienced insurance lawyer put it:

We are now at the stage where commercial brokers are tending to walk into underwriters with three CDs and tell them, 'it's all in there'.

- 7.48 We were told, for example, about a South American highways authority that provided the insurer with a survey report on each road, in Spanish: "It took us 2 weeks to get it translated". With the development of information technology, the problem is likely to increase.
- 7.49 To some extent, if the parties have the ability to transmit large quantities of information, they will. However, we think that a narrower test of what is material just might do less to encourage the present tendency to inundate the insurer with information.

### **Modify the duty**

- 7.50 Our tentative view is that the ambit of the duty of disclosure should be modified in business cases, to include only what a reasonable insured in the circumstances would understand to be material to the underwriter in question. We think this test is sufficiently flexible to adapt to the many different circumstances in which insurance is used and sold. The same test should apply in cases of misrepresentation.

7.51 In many insurance markets, in particular where both parties are knowledgeable about insurance and what is likely to be relevant, the effect of this change would be minimal. One advantage of a “reasonable insured test” is that it is flexible enough to cope with a variety of policyholders. In the more sophisticated markets, where both insurers and insured are professionally represented, we would expect almost no difference between what a reasonable insurer and a reasonable insured would regard as material. Here the two tests are effectively synonymous. As the gap between the two sides grows, so does the effect of the reform. A reasonable insured test has the advantage that it does not require legislators to define arbitrary lines by, for example, distinguishing businesses by their size or level of sophistication. As the British Insurance Law Association put it in their 2002 report, the test

would enable the court to differentiate between the duty of a large industrial company with a professional insurance department, as compared with a small company on an industrial estate where the insured’s knowledge of insurance law may well be very limited.<sup>10</sup>

7.52 In assessing what a reasonable insured in the circumstances would understand to be material to the underwriter in question, a court could also take into account whether the policyholder had received professional advice from an intermediary.

#### **The nature of the evidence**

7.53 We have been told that there are advantages in the present “prudent underwriter” test, because the issue of what underwriters think is material may be determined by expert evidence from the industry. Solicitors acting for insurers can locate expert underwriters and ask them to give evidence in court. They expressed concern that a reasonable insured test was inherently uncertain. In the absence of any recognised “reasonable insureds” to give evidence, they thought it would merely invite the judge to substitute his or her own opinion for that of the industry.

7.54 In 1980, the Law Commission saw the prominence granted to insurers’ evidence as a serious criticism of the current law:

<sup>10</sup> BILA, *Insurance Contract Law Reform* (2002), para 12.

Such evidence will usually be readily available to the insurers, who will have no difficulty in selecting appropriate witnesses. However the insured will often be at a considerable disadvantage in finding expert witnesses prepared to challenge those of the insurer and the position of such witnesses is often invidious. Some judicial doubt has also been cast on the cogency of such evidence.<sup>11</sup>

- 7.55 Under our proposed reform, the actual insurer in question will need to start by showing that the issue was material to them, in that if they had known the truth they would not have entered into the same contract on the same terms.
- 7.56 The judge or arbitrator would then need to determine what the reasonable insured would have understood to be material in the circumstances. We expect that in many cases involving small businesses, judges would indeed draw on their own understanding to ask how a reasonable small business would regard the matter. However, in more specialist markets, there will still be a need for expert evidence. Where the parties are relying on established practice in the market, we anticipate that this evidence may be given by a range of experienced professionals, including insureds, brokers or underwriters.
- 7.57 Thus for generalist markets, judges could be expected to draw on their own understanding of what a reasonable small business would understand to be material. For specialist markets, evidence about what is reasonable may be given by a range of experienced professionals.
- 7.58 An alternative would be to take up a suggestion we made in relation to consumer insurance. This is that a revised test of materiality might ask whether a reasonable insurer with the same knowledge of the client would expect the insured to understand that a particular matter was relevant. That would once more be a question on which the court might hear evidence from underwriters and brokers.

#### **Conclusion on materiality**

- 7.59 We tentatively propose that a reasonable insured test of materiality should apply to all business insurance.**

<sup>11</sup> para 3.21. For judicial criticism of insurers' evidence, see *Roselodge Ltd v Castle* [1966] 2 Lloyd's Rep 113, at p 132. The judge dismissed the evidence of three expert underwriters on the grounds they were far from objective: "they were anxious to defeat the claim if it could be legitimately defeated". In *Reynolds v Phoenix Assurance Co*, the judge also disbelieved the insurers' witnesses' claims that evidence of a previous conviction was material by pointing out how rarely any insurer was actually told about such convictions: [1978] 2 Lloyd's Rep 440, at p 460. See also J Birds and N Hind, *Birds Modern Insurance Law* (6<sup>th</sup> ed, 2004), p 116.



7.60 This would be a default rather than a mandatory rule of law. In other words, the parties will be free to agree a different test by means of an explicit term in the contract.<sup>12</sup> However, the need to obtain agreement to a different test will, we hope, serve the useful purpose of alerting a prospective policyholder to the importance of the issue. It will then, of course, then be open to that prospective policyholder to ask the insurer to explain exactly what information is required.

### **DISTINGUISHING BETWEEN FRAUDULENT, INNOCENT AND NEGLIGENT CONDUCT**

7.61 In Part 6 we distinguish between behaviour that is fraudulent, innocent but negligent, and innocent without negligence. We tentatively conclude that for consumer insurance, avoidance is appropriate where the insured has behaved fraudulently. Where the insured has behaved innocently and reasonably, insurers should take policyholders as they find them. Where the insured has behaved negligently, the law should as far as possible put the parties into the position they would have been in had the facts been stated correctly.

7.62 Here we consider whether the same rules should be applied to businesses, or whether there are reasons to treat business insurance differently. **We think that there is no case for restricting the insurer's right to avoid the policy (and therefore to refuse to pay any claim) where a business insured has behaved fraudulently.** Below we discuss three more difficult issues:

- (1) Should the insurer be entitled to a remedy where the insured has behaved innocently and not negligently?
- (2) Where the insured has behaved negligently but not fraudulently, should the insurer be granted a proportionate remedy?
- (3) Where should the balance of proving fraud lie?

7.63 If a proportionate remedy is to be applied, we then consider two ancillary issues: how should the law treat cases where the insurer should have declined the risk; and what rights should an insurer have to avoid in the future.

### **Innocent misrepresentation or non-disclosure**

7.64 The first question is whether there should continue to be a legal right to avoid for innocent non-negligent misrepresentation or non-disclosure. We have already discussed this in relation to the general issues of trust in the market and the pooling of risks, and it seems unnecessary to repeat what was said there. The basic question is whether in general insureds would prefer to pay the slight increase in premiums that might be involved as the price for knowing that no policy can be avoided for non-negligent misrepresentation by the insured.

<sup>12</sup> A "basis of the contract" clause should not be effective for this purpose. See below paras 7.81 to 7.83 below.

- 7.65 We have considered where the burden of proof should lie. We think that the information available to the insured when it made the misrepresentation or failed to make the disclosure will normally be a matter largely within its own knowledge. We think it is useful to draw the analogy with Misrepresentation Act 1967, section 2(1), and place the burden of disproving fraud or negligence on the insured. The Act provides (in effect) that when a misrepresentation has been made, the misrepresentee can recover damages for any resulting loss unless the misrepresenter can prove that, up until the time the contract was made, it had reasonable grounds to believe and did believe that the statement it made was true.
- 7.66 We tentatively propose that when a business insured has acted without negligence in making an incorrect statement or in other ways (such as failing to answer a question), the insurer should have no right to avoid the policy or to refuse to pay a claim under it on that ground.**

**Negligence: a proportionate remedy?**

- 7.67 In Part 6 we reach the tentative conclusion that where a consumer proposer has made a negligent misrepresentation, the court should apply a proportionate remedy by asking what the insurer would have done had it known the true facts. In particular:
- (1) where an insurer would have excluded a particular type of claim, the insurer should not be obliged to pay claims that would not fall within the exclusion;
  - (2) where an insurer would have declined the risk altogether, the claim may be refused;
  - (3) where an insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium.
- 7.68 Many insurance lawyers accept the theory behind these proposals. The main concern is how the issues would be determined in practice. Solicitors expressed concern that each side would bring experts to contradict what the other side said:
- Each side will have an expert each, which will say the opposite of the other. It's not as if they all have rating books and tariffs... In France, for example, there are fixed tariffs.
- What would actually happen at the box is that we would propose a premium, and the broker would say, 'Oh, that's a bit steep. Charlie down the road does it for half that.' And they would end up with a number without any science at all.
- 7.69 The problems are likely to be greater in relation to business insurance than they would be for consumer insurance. But we do not see them as insuperable. However unscientific the negotiations may be, they would be a more accurate assessment of the loss involved than the current law, which permits unscrupulous insurers to wield a dominant weapon.

7.70 A more difficult question is whether in business insurance, where the average insured is far more likely to be aware of what it should be doing, it is desirable to create stronger incentives. This was the reason given for refusing to apply the discretion to refuse rescission under Misrepresentation Act 1967 section 2(2) to contracts of insurance.<sup>13</sup> If business insureds know that if they make a careless mistake they will not recover anything under the policy, they would have a stronger incentive to be careful. Conversely, insureds may be willing to carry the small increase in premiums necessary to cover the cost of “innocent mistakes” as one of the pooled risks, but may feel very differently about sharing the costs of other people’s negligence.

**7.71 We welcome views on whether the remedy for negligent misrepresentation should be proportionate, in that it should aim to put the insurer into the position it would have been in had it known the true circumstances.**

### **Proving fraud**

7.72 We are conscious that this approach would mean that the insurer would only have an incontestable right to avoid the policy and refuse to pay the claim if it could prove fraud, and that fraud is hard to prove. Where the insured is a company, in particular, it can be extremely difficult to pin down who knew what at which stage, or to impute knowledge to the controlling mind of the organisation. We do not wish to give an advantage to organisations that fail to investigate safety issues properly, or where the directors isolate themselves from matters they should have known about.

7.73 We think that these concerns could be eased by two presumptions:

- (1) that an insured knew what a person in their position would be expected to know; and
- (2) that if the insurer asked a clear question about the matter, the insured knew that any inaccuracy in their answer was material.

7.74 The first presumption is similar to section 18(1) of the Marine Insurance Act 1906, whereby the insured is “deemed to know every circumstance which, in the ordinary course of business, ought to be known by him”. Unlike section 18(1), however, it would be rebuttable. The insured would be able to bring evidence that they did not know the facts, even though they should. However, the burden of proving this would be on the insured. Similarly, if the insured did not think a question was material, it would have to show why not.

**7.75 We ask whether the insured should have to show that it did not know what a person in its position would be expected to know, or alternatively that it did not know why an inaccurate response to a clear question was material.**

<sup>13</sup> See para A24 below.

### **Further issues**

- 7.76 If it is decided that proportionality should be applied where appropriate, two further questions arise.

### **Cases where another insurer would have accepted the risk**

- 7.77 For consumers we also asked whether the courts should have an additional discretion. We suggested this may apply where the insurer would have declined the risk, but the policyholder's fault is minor, and other insurers would have accepted the risk at a higher premium. This may also apply where the misrepresented fact is unrelated to the claim. On balance, we think that such a discretion is more appropriate to consumers than to businesses, but we would welcome advice on the issue.

- 7.78 We ask whether where the insurer would have declined the risk, but the policyholder's fault is minor and other insurers would have accepted the risk at a higher premium, the court should have a discretion to apply a proportionality solution.**

### **Avoidance for the future**

- 7.79 We also asked whether insurers should be entitled to cancel policies for the future in all cases, or only where they would have declined the risk. We noted that the FOS would sometimes require insurers to amend the terms of a policy, and abide by it in the future. Again, we think this may be appropriate only in consumer cases. Our starting point in business cases is that where the insured has made a negligent misrepresentation or non-disclosure, even if the insurer should have to pay a proportion of the claim in question, it should be entitled to cancel the policy for the future. We would expect the insurer to give reasonable notice and return a proportionate part of the premium.

- 7.80 We tentatively propose that negligent misrepresentation or non-disclosure should be a ground on which the insurer may cancel the policy after reasonable notice, without prejudice to claims that have arisen or arise within the notice period.**

### **BASIS OF THE CONTRACT CLAUSES**

- 7.81 In Part 6 we propose to abolish basis of the contract clauses in consumer cases. These have been criticised for many years and their use has been outlawed in Australia and New Zealand. We think we would need to enact something along similar lines to prevent evasion of our other proposals.

- 7.82 We think that basis of the contract clauses should be abolished in business contracts, for the same reasons. There would need at least to be a provision that incorrect answers would not give rise to a remedy for breach of warranty unless there was a term to that effect in the contract itself, rather than merely a "basis of the contract" clause in the proposal form. This is a rule that would have to be mandatory, otherwise the mere insertion of a basis of the contract clause might be taken as a 'contracting out' from all the rules proposed in this section.

- 7.83 We tentatively propose that there should be a mandatory rule that incorrect answers would not give rise to a remedy for breach of warranty unless there was a term to that effect in the contract itself, rather than merely a “basis of the contract” clause in the proposal form.**

#### **MARINE, AVIATION AND TRANSPORT INSURANCE**

- 7.84 The 1980 report excluded MAT insurance from the scope of its reforms. It argued that the people working in this market were generally professionals “who could reasonably be expected to be aware of the niceties of insurance law”.<sup>14</sup> The law was certain and understood, and worked satisfactorily.

- 7.85 However, the Commission accepted that the line between MAT and other insurance was not a clear one, and that some individuals with pleasure craft did need additional protection. The Commission expressed unease with the definitions of MAT used in previous regulations, and suggested some omissions. It also proposed that the Secretary of State should be empowered to vary the definition by regulation.

- 7.86 Here we are not minded to make a distinction between MAT and other forms of insurance, for three reasons.

- (1) We are told MAT is no longer regarded as such a separate and distinct form of insurance.
- (2) It would be overly complex to require lawyers to apply one law to (for example) major constructions, and quite a different law to ships.
- (3) The boundary between MAT and other insurance is extremely difficult to draft. We would not only need to extend protection to consumers who own pleasure craft but also many small leisure businesses and fishermen. The result would be complex regulations, with arbitrary dividing lines.
- (4) The difference between full avoidance and a proportional remedy is greatest in the very largest claims, where several million pounds may be at stake. With such large claims, the result of insurance litigation is likely to affect the solvency of the firm, and therefore have knock on consequences not only for shareholders but also for creditors, employees and third party claimants. Even in large sophisticated businesses, information does not always get passed on in the way it should, and the consequences may be borne by people who are not sophisticated at all. There is still a need for the law to reflect accepted notions of fairness and good market practice.

- 7.87 We tentatively propose that our earlier proposals for business insurance should apply to MAT.**

<sup>14</sup> Law Com No 104, para 2.8.

### THIRD-PARTY CLAIMS

- 7.88 It has been suggested to us that proportionality produces an unsatisfactory result where the claim in question relates to the policyholder's liability to a third party. The point in question is whether it is desirable that the rights of a third party are affected by the acts or omissions of the policyholder.
- 7.89 Under the Road Traffic Act 1988 an insurer is obliged to meet third-party claims in motor insurance cases, even where a policy has been avoided for misrepresentation or non-disclosure by the policyholder.<sup>15</sup> For most lines of business there is no such protection - the third party will have rights only against the policyholder.
- 7.90 If the policyholder is insolvent, the third party can bring a claim direct against the insurer under the Third Parties (Rights against Insurers) Act 1930.<sup>16</sup> However, defences such as misrepresentation or non-disclosure which are available to the insurer against the policyholder can, however, also be used against a third party.<sup>17</sup>
- 7.91 We can see that there may be arguments for giving third parties Road Traffic Act style protection – particularly where insurance is compulsory under statute, contract or professional rules. For example, a professional may be obliged to effect professional indemnity insurance. Such insurance is intended to provide compensation for third parties - clients affected by the professional's negligence. However, we suspect that even in such cases the matter is best left to the relevant professional body. It can decide first whether such insurance should be compulsory and second the terms on which it should be written, which might include modifying the rights of an insurer to rely on misrepresentation or non-disclosure. In doing so, it can take into account the availability or otherwise of such cover in the insurance market.
- 7.92 Our tentative conclusion, therefore, is that we should not extend the existing rights of third parties, but we welcome views on this issue.**

### REINSURANCE

- 7.93 Our starting point is the principle that the same rules should apply to reinsurance as to insurance unless a good case is made for distinguishing between the two.
- 7.94 We recognise that there are important practical differences between the ways in which insurance and reinsurance are conducted. A member of our Advisory Panel suggested that three matters in particular should be considered:
- (1) Much reinsurance is placed under obligatory treaties. If a risk falls within the terms agreed, the insurer is obliged to place it under the treaty and the reinsurer is bound to accept it. Disclosure of the details of individual risks is not typically required.

<sup>15</sup> Road Traffic Act section 151.

<sup>16</sup> Law Com No 152, Scot Law Com No 104.

<sup>17</sup> *The Fanti* [1991] 2 AC 1.

- (2) Facultative business coming in to the London market from abroad is frequently written on a fronting basis, so that the local insurer is simply the conduit for passing the risk to reinsurers. In that situation, the majority of material facts will relate not to the reinsurance itself but to the underlying risk - which will have been written under a contract governed by a foreign law with its own disclosure rules.
- (3) The parties entering into reinsurance agreements are both conducting insurance as a business and may be assumed to have a level of knowledge significantly greater than that of the typical policyholder.

**7.95 Nevertheless we ask if there is any reason not to apply our earlier proposals for business insurance to reinsurance.**

**SMALL BUSINESSES**

- 7.96 As we explained earlier, our tentative view is that the residual duty of disclosure should be abolished in consumer cases but retained in business cases. This leaves the question of whether small businesses should be treated as consumers or in the same way as larger businesses? Should a small and unsophisticated business be required to volunteer information to an insurer? Should a proportionate remedy apply in cases of negligent misrepresentation?

**The position of small businesses under the FOS scheme**

- 7.97 At present, the FOS makes a distinction between small businesses based on its assessment of the sophistication of the business in question. The most vulnerable businesses will be treated as consumers, while others will not. For example, in our survey a fish and chip shop was treated in the same way as a consumer, while an insurance broker was not. We found some cases where small businesses had been expected to volunteer information in the absence of questions. For example, the FOS held that a landlord should have revealed that his tenant was unsatisfactory even though the proposal form did not ask about this.

**Options for reform**

- 7.98 In the joint Law Commissions' report on Unfair Contract Terms, we recommended that businesses with nine or fewer employees were often particularly vulnerable and required specific protection against unfair contract terms. We have considered whether micro businesses are also vulnerable in applying for insurance. Should they be treated as consumers and only required to answer the questions asked?
- 7.99 The problem with this approach is that some firms may have very few employees but be highly sophisticated. In the context of Unfair Contract Terms, we were told that in the capital markets it was common to use special purpose vehicles to conduct extremely complex deals. We developed several additional tests to exclude such companies, including a provision imposing a value limit on the contracts that could be reviewed and (on the grounds that they are already regulated) excluding all financial services contracts.

- 7.100 The same issues arise in insurance. A ship, for example, may be owned by a one-ship company, and be managed using agents rather than employees. Obviously it may not be appropriate to say that an insurance contract affecting the vessel should not be subject to control because it is a financial services contract –that would beg the question of this review. But otherwise similar exemptions may be needed. So in defining a small business, it would be necessary to look at the turnover and assets of the business, either instead of or as well as the number of employees. Any definition would also need to be based on factors that are transparent to an insurer. An insurer would need to know, for example, how the definition applied to an overseas entity that may be no more than a shell for a particular purpose.
- 7.101 There are two possible approaches. The first is to retain the duty of disclosure for small businesses, but only to the degree that would be reasonable in the circumstances (applying the test of materiality discussed earlier). We think this would enable the FOS to continue to take the approach it currently takes, by deciding that some small businesses are so similar to consumers that they should not be expected to volunteer information. It should also be possible for court to reach the same result, considering all the circumstances of the case.
- 7.102 The alternative would be to consider more sophisticated definitions of small businesses. We were particularly interested in the Norwegian approach, which disapplies the consumer regime when one of five criteria are satisfied:
- (a) when the insurance relates to undertakings which at the time of concluding the contract, or at subsequent renewals, meet a minimum of two of the following requirements:
    - (1) the number of employees exceeds 250
    - (2) the sales earnings are a minimum of NOK 100 million according to the most recent annual accounts
    - (3) assets according to the most recent balance sheet are a minimum of NOK 50 million
  - (b) when the business takes place mostly abroad
  - (c) when the insurance relates to a ship under duty to register, cf. section 11 of the Maritime Act, or to installations as stated in section 33, subsection one, and sections 39 and 507 of the Maritime Act,
  - (d) when the insurance relates to aircraft, or
  - (e) when the insurance relates to goods in international transit, including transportation to and from the Norwegian Continental Shelf.<sup>18</sup>

<sup>18</sup> Norwegian Insurance Law Act of 16<sup>th</sup> June 1989, ss 1 to 3.



- 7.103 Using this sort of definition would ensure that foreign businesses and those taking out marine and aviation insurance would still be required to volunteer information. For domestic risks, the definition considers employees, turnover and assets. However, the test is complex, and brings back issues of how to define MAT, for example, that we had hoped to avoid.
- 7.104 We ask to what extent small businesses should be treated in the same way as consumers.**
- 7.105 We ask how small businesses should be defined for this purpose.**

# APPENDIX A

## MISREPRESENTATION IN GENERAL CONTRACT LAW

### ENGLISH LAW

#### The elements of misrepresentation

- A.1 An actionable misrepresentation in general contract law requires
- (1) An unambiguous false statement of existing fact or law.
  - (2) Made to the innocent party.
  - (3) That induces the innocent party to enter the contract.
- A.2 Once these elements are established, the innocent party can, subject to certain bars, set the contract aside, or in certain circumstances be awarded damages.

#### Materiality and inducement

- A.3 In the past there was a further element - a misrepresentation had to be material as well as inducing the contract. The test of materiality was whether the statement would have affected the judgement of a reasonable man in deciding whether or not to enter into the contract on those terms.
- A.4 It is, however, no longer clear whether a requirement of materiality applies. Certainly it does not where the misrepresentation is fraudulent<sup>1</sup> or where the representor knows or ought to know that the party to whom the statement is addressed will act on it.<sup>2</sup>
- A.5 Has the requirement of materiality merged with the requirement of inducement? Chitty on Contracts takes the view that if a statement is not material in the sense set out above, a representee is likely to have difficulty in satisfying the court that they were in fact influenced by it.<sup>3</sup> However, Chitty goes on to state that there is no clear authority denying relief to a representee who has in fact been influenced by the statement which was held not to have influenced the reasonable man. This last point was directed at the cases of *Museprime Properties Ltd v Adhill Properties Ltd*<sup>4</sup> and *Goff v Gauthier*.

<sup>1</sup> *Smith v Kay* (1859) 7 HL Cas 750.

<sup>2</sup> *Goff v Gauthier* (1991) 62 P&CR 388 and in Australia: *Nicholas v Thompson* [1924] V L R 554.

<sup>3</sup> Chitty on Contracts (29<sup>th</sup> ed) para 6-036.

<sup>4</sup> *Museprime Properties Ltd v Adhill Properties Ltd* [1990] 2 EGLR.

- A.6 In those cases the view was taken that if the statement would not have influenced the reasonable man the burden of proving that it did induce the contract was on the representee. However, if the statement could be seen to affect the judgment of the reasonable man there would be an inference of inducement. Chitty argues that in these cases the question being asked is not whether the statement is material but whether reliance on the statement in these cases was reasonable.
- A.7 The case of *Edgington v Fitzmaurice* held that the misrepresentation need not be the sole inducement, it is enough that it is simply an inducement. This “but for” causation is not required, however, for instances of fraud. Here rescission (not damages) will be granted if the statement is shown to have been materially influential on the mind of the representee even if the representee would have entered into the contract without the influence of the statement. The policy behind this so-called “fraud rule” is to deter fraudulent behaviour and has the effect of reversing the burden of proof.

### **The types of misrepresentation**

- A.8 For the purposes of remedies there are four different categories of misrepresentation: fraudulent; negligent; negligent as per the Misrepresentation Act 1967; and innocent.

### **Fraudulent misrepresentation**

- A.9 Fraudulent misrepresentation is actioned by the tort of deceit. In the case of *Derry v Peek*<sup>5</sup> the House of Lords set out the requirements of such an action. There must be proof of fraud, and as Lord Herschell stated “nothing short of that will suffice”. However, fraud bears a wider meaning than its common usage. *Derry v Peek* laid out the test as follows:

..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....To prevent a false statement being fraudulent, there must, I think, always be an honest belief in its truth...Thirdly, if fraud be proved, the motive of the person guilty of it is immaterial.<sup>6</sup>

<sup>5</sup> Derry v Peek [1889] LR 14 App Cas 337

<sup>6</sup> Above by Lord Herschell.

### **Negligent misstatement – common law**

- A.10 Negligent misstatements are actioned by the tort of negligence. These are different to misrepresentations in that the remedy available is in damages (as will be seen below) rather than rescission. To bring such an action there must be a “special relationship”, a requirement first identified in the case of *Hedley Byrne v Heller*.<sup>7</sup> Whether the insurer/insured relationship is “special relationship” for these purposes will depend on the circumstances.<sup>8</sup>

### **Negligent misrepresentation – Misrepresentation Act 1967 s2(1)**

- A.11 Section 2(1) of the 1967 Act provides a remedy for negligent misrepresentation which is not reliant on the *Hedley Byrne* line of authority. There are said to be three advantages of pleading under this provision as opposed to the common law negligent misstatement action. First, there is no requirement of a “special relationship”. Secondly, under section 2(1) in order to escape liability the representor must show that they had reasonable grounds to believe and did believe up to the time that the contract was made that the facts represented were true. This differs from the common law approach where the burden is on the representee to show that the representor was negligent. The third advantage is the measure of damages recoverable, which is discussed below.

### **Innocent misrepresentation**

- A.12 An innocent misrepresentation is a representation which is neither fraudulent nor negligent.

### **Remedies for Misrepresentation**

#### **Rescission**

- A.13 This is the principal remedy for misrepresentation. The contract is set aside and the parties are restored to the position they were in before the contract existed. Neither party should be unjustly enriched at the expense of the other. The availability of rescission is, however, subject to section 2(2) of the Misrepresentation Act 1967 which, for all types of misrepresentation other than fraudulent allows the court to order damages in its place.

<sup>7</sup> *Hedley Byrne v Heller* [1964] AC 465.

<sup>8</sup> See *Banque Keyser v Skandia* [1989] and *Esso Petroleum Co Ltd v Mardon* [1976] QB 801.

## Damages

### DAMAGES FOR FRAUDULENT MISREPRESENTATION

- A.14 Where the representee can show that the representor acted fraudulently or recklessly,<sup>9</sup> they are entitled to damages based on the assumption that they would not have entered the contract but for the misrepresentation.<sup>10</sup> The measure of damages is thus all the losses that the representee incurs as a result of entering the contract.

### DAMAGES FOR NEGLIGENT MISREPRESENTATION

- A.15 By contrast, where an action is based in negligence, the measure of damages is lower. In *South Australia Asset Management Corp v York Montague Ltd*,<sup>11</sup> the House of Lords held that it does not include all the losses that flow from a later fall in value. Instead the damages were capped by the difference between the over-valuation and the true valuation.<sup>12</sup>
- A.16 It is difficult to know what would be the appropriate measure of damages where had they known the truth, the insurer would have taken the same risk, but would have charged a higher premium. In non-insurance cases, the answer is fairly simple. The appropriate measure is the difference between the price charged and the price the representee would have charged without the misrepresentation. This would not, however, offer an appropriate level of protection to insurers because it looks only at the one contract after a claim has arisen. It ignores the effect on a pool of similar contracts. It would be more appropriate to reduce the claim proportionally, so that if, for example, a policyholder has only paid two thirds of the appropriate premium they should receive only two thirds of the claim.

### DAMAGES UNDER SECTION 2(1) OF THE MISREPRESENTATION ACT 1967

- A.17 Section 2(1) states:

Where a person has entered into a contract after a misrepresentation has been made to him by another party thereto and as a result thereof he has suffered loss, then, if the person making the misrepresentation would be liable to damages in respect thereof had the misrepresentation been made fraudulently, that person shall be so liable notwithstanding that the misrepresentation was not made fraudulently, unless he proves that he had reasonable ground to believe and did believe up to the time the contract was made the facts represented were true.

<sup>9</sup> *Derry v Peek* (1889) LR 14 App Cas 337.

<sup>10</sup> *Downs v Chappell* [1997] 1 WLR 426.

<sup>11</sup> *South Australia Asset Management Corp v York Montague Ltd* [1997] AC 191.

<sup>12</sup> For further details, see Chitty on Contracts (29<sup>th</sup> ed) Chapter 26.

- A.18 In *Royscot Trust v Rogerson*,<sup>13</sup> the Court of Appeal held that the phrase “so liable” meant not only that a negligent representor would be liable in the same circumstances as a fraudulent representor, but would be liable to the same extent. In other words, the measure of damages under the Act was the one appropriate to fraud cases – not negligence.
- A.19 This so called “fiction of fraud” has been subjected to severe academic criticism.<sup>14</sup> In *Smith New Court Securities*, Lord Steyn stated that the justification for requiring such a generous measure of damages from a fraudster is based on moral considerations.<sup>15</sup> The measure of damages indicates that the defendant is morally reprehensible and it aims to deter wrongdoing. It makes little sense to impose a similar measure against a defendant who has been merely negligent.
- A.20 There is as yet no House of Lords authority on the point. In *Smith*, Lord Steyn merely noted the criticism made of *Royscot* and expressed no concluded view on its correctness.<sup>16</sup> There are few cases in which claimants have attempted to argue that damages should reflect a mere fiction of fraud under section 2(1),<sup>17</sup> and we have found none in which they have attempted to argue such a case against a consumer.

#### DAMAGES UNDER SECTION 2(2) OF THE MISREPRESENTATION ACT 1967

- A.21 Section 2(2) states:

Where a person has entered into a contract after a misrepresentation has been made to him otherwise than fraudulently, and he would be entitled, by reason of the misrepresentation, to rescind the contract, then, if it is claimed, in any proceedings arising out of the contract, that the contract ought to be or has been rescinded, the court or arbitrator may declare the contract subsisting and award damages in lieu of rescission, if of opinion that it would be equitable to do so, having regard to the nature of the misrepresentation and the loss that would be caused by it if the contract were upheld, as well as to the loss that rescission would cause to the other party

- A.22 In other words, where a representee seeks rescission of a contract based on a non-fraudulent misrepresentation, the court has a discretion to award damages in lieu of rescission. The court must consider the loss both to the representor and to the representee, and reach an equitable decision.

<sup>13</sup> *Royscot Trust v Rogerson* [1991] 2 QB 297.

<sup>14</sup> See R. Hooley, “Damages and the Misrepresentation Act 1967” (1991) 107 *Law Quarterly Review* 597.

<sup>15</sup> *Smith New Court Securities v Scrimgeour Vickers* [1997] AC 254, at p 280.

<sup>16</sup> Above, at p 282.

<sup>17</sup> In *Avon Insurance v Swire Fraser* [2000] Lloyd’s Rep IR 535, an insurance company argued that they should receive fraudulent damages against a (possibly) negligent broker. Mr Justice Rix (as he then was) did not appear sympathetic to this argument, commenting that the law had developed piece-meal and should be read in its context (para 20). In the event, he held that there had been no inducement, so the issue did not arise.

- A.23 The measure of damages is uncertain, but is not intended to put the misrepresentee in the same position as it would have been in had the contract been rescinded.<sup>18</sup>
- A.24 It has been held that section 2(2) is inappropriate in commercial insurance cases.<sup>19</sup> It is unclear whether it might provide an alternative to avoidance in consumer claims - and we have not been able to find a case in which the point has been raised. If the remedy were to be applied to insurance contracts, many difficult issues would arise about the appropriate measure of damages. It is difficult to apply case law developed in the context of property purchase to a very different context.

## **SCOTS LAW**

### **The elements of misrepresentation**

- A.25 A party to a contract who founds on misrepresentation must establish the following elements:
- (1) There must have been a misrepresentation of fact (including a statement as to future intention) rather than of opinion;
  - (2) The representation must have been made by the contracting party or by someone acting on his behalf;
  - (3) The representation must have induced the contract.

Fraudulent concealment is also actionable where the party concealing was under a duty to disclose.

### **The types of misrepresentation**

#### *Fraudulent misrepresentation*

- A.26 Fraudulent misrepresentation is regarded by Scots law as a particular type – probably the most common in a contractual context – of fraud generally. The tainting of a transaction by fraud entitles the innocent party to recover loss sustained as a consequence of entering into it. The test for proving fraud set out by Lord Herschell in *Derry v Peek* (see above) has been adopted by Scots law.<sup>20</sup>

<sup>18</sup> *William Sindall v Cambridgeshire County Council* [1994] 1 WLR 1016, at p 1037.

<sup>19</sup> *Highland Insurance Co v Continental Insurance Co* [1987] 1 Lloyd's Rep 109, 118.

<sup>20</sup> *Boyd & Forrest v Glasgow & South Western Railway Co* 1912 SC (HL) 93; *Robinson v National Bank of Scotland* 1916 SC (HL) 154.

### *Innocent misrepresentation*

- A.27 Innocent, i.e. non-fraudulent, misrepresentation is a ground of challenge of a contract provided that the representee is induced to enter into the contract by the representation and would not have entered into it but for the representation.<sup>21</sup> The misrepresentation need not be negligent, but it must relate to something which, viewing the matter objectively, is sufficiently important to have induced the representee to contract.
- A.28 At the time when the concept of error induced by non-fraudulent misrepresentation was introduced into Scots law, no distinction was drawn between negligent and non-negligent representations. This remains the case except in relation to the availability of damages as a remedy (see below).

### **Remedies for misrepresentation**

#### *Rescission*

- A.29 A party who has been induced to enter into a contract by a misrepresentation by the other party is entitled to rescind the contract. There is no equivalent in Scots law of the power of the court in England and Wales under the Misrepresentation Act 1967, section 2(2) to order the payment of damages in place of rescission.

#### *Damages*

- A.30 At common law, damages were available only where the misrepresentation was fraudulent. The innocent party could, at his option, rescind the contract and also claim damages or, alternatively, claim damages without rescission.<sup>22</sup> Where, however, fraud could not be proved, the representee's only remedy was rescission.<sup>23</sup>
- A.31 An entitlement to damages in the case of negligent misrepresentation was introduced by the Law Reform (Miscellaneous Provisions) (Scotland) Act 1985. Section 10(1) provides as follows:

A party to a contract who has been induced to enter into it by negligent misrepresentation made by or on behalf of another party to the contract shall not be disentitled, by reason only that the misrepresentation is not fraudulent, from recovering damages from the other party in respect of any loss or damage he has suffered as a result of the misrepresentation, and any rule of law that such damages cannot be recovered unless fraud is proved shall cease to have effect.

<sup>21</sup> *Menzies v Menzies* (1893) 20R 108, following the House of Lords' decision in the English case of *Adam v Newbigging* (1888) LR 13 App Cas 308.

<sup>22</sup> *Bryson & Co Ltd v Bryson* 1916 1 SLT 361; *Smith v Sim* 1954 SC 357.

<sup>23</sup> For a discussion, see the Scottish Law Commission's *Report on Negligent Misrepresentation*, Scot Law Com No 92 (1985).



- A.32 Section 10(1) applies only to misrepresentations made by a party to the contract. A negligent misrepresentation made by some other person may be actionable under the *Hedley Byrne* principle. Where a misrepresentation by one party induces the other party to contract but is neither fraudulent nor negligent, the only remedy available to the other party remains rescission.
- A.33 The measure of damages in the case of both fraudulent and negligent misrepresentation is the usual measure for delictual damages: i.e. (subject to issues of remoteness) to put the claimant in the position in which they would have been if the representation had not been made.

# APPENDIX B

## ABI STATEMENTS OF PRACTICE 1986

### ABI STATEMENT OF GENERAL INSURANCE PRACTICE

The following Statement of normal insurance practice applies to general insurances of policyholders resident in the UK and insured in their private capacity only.

#### **Proposal Forms**

- (a) The declaration at the foot of the proposal form should be restricted to completion according to the proposer's knowledge and belief.
- (b) Neither the proposal form nor the policy shall contain any provision converting the statements as to past or present fact in the proposal form into warranties. But insurers may require specific warranties about matters which are material to the risk.
- (c) If not included in the declaration, prominently displayed on the proposal form should be a statement:-
  - (i) drawing the attention of the proposer to the consequences of the failure to disclose all material facts, explained as those facts an insurer would regard as likely to influence the acceptance and assessment of the proposal;
  - (ii) warning that if the proposer is in any doubt about facts considered material, he should disclose them.
- (d) Those matters which insurers have found generally to be material will be the subject of clear questions in proposals forms.
- (e) So far as is practicable, insurers will avoid asking questions which would require expert knowledge beyond that which the proposer could reasonably be expected to possess or obtain or which would require a value judgement on the part of the proposer.
- (f) Unless the prospectus or the proposal form contains full details of the standard cover offered, and whether or not it contains an outline of that cover, the proposal form shall include a prominent statement that a specimen copy of the policy form is available on request.
- (g) Proposal forms shall contain a prominent warning that the proposer should keep a record (including copies of letters) of all information supplied to the insurer for the purpose of entering into the contract.
- (h) The proposal form shall contain a prominent statement that a copy of the completed form:-
  - (i) is automatically provided for retention at the time of completion; or
  - (ii) will be supplied as part of the insurer's normal practice; or
  - (iii) will be supplied on request within a period of three months after its completion.
- (i) An insurer shall not raise an issue under the proposal form, unless the policyholder is provided with a copy of the completed form.

#### **Claims**

- (a) Under the conditions regarding notification of a claim, the policyholder shall not be asked to do more than report a claim and subsequent developments as soon as reasonably possible except in the case of legal processes and claims which a third party requires the policyholder to notify within a fixed time where immediate advice may be required.

- (b) An insurer will not repudiate liability to indemnify a policyholder:-
- (i) on grounds of non-disclosure of a material fact which a policyholder could not reasonably be expected to have disclosed;
  - (ii) on grounds of misrepresentation unless it is a deliberate or negligent misrepresentation of a material fact;
  - (iii) on grounds of a breach of warranty or condition where the circumstances of the loss are unconnected with the breach unless fraud is involved.

Paragraph 2 (b) above does not apply to Marine and Aviation policies.

- (c) Liability under the policy having been established and the amount payable by the insurer agreed, payment will be made without avoidable delay.

#### **Renewals**

- (a) Renewal notices shall contain a warning about the duty of disclosure including the necessity to advise changes affecting the policy which have occurred since the policy inception or last renewal date, whichever was the later.
- (b) Renewal notices shall contain a warning that the proposer should keep a record (including copies of letters) of all information supplied to the insurer for the purpose of renewal of the contract.

#### **Commencement**

Any changes to insurance documents will be made as and when they need to be reprinted, but the Statement will apply in the meantime.

#### **Policy Documents**

Insurers will continue to develop clearer and more explicit proposal forms and policy documents whilst bearing in mind the legal nature of insurance contracts.

#### **Disputes**

The provisions of the Statement shall be taken into account in arbitration and any other referral procedures which may apply in the event of disputes between policyholders and insurers relating to matters dealt with in the Statement.

### **ABI STATEMENT OF LONG-TERM INSURANCE PRACTICE**

The following Statement of normal insurance practice applies to policies of long-term insurance effected in the UK in a private capacity by individuals resident in the UK. Nothing in this statement should be interpreted as conflicting with or overriding the rules of LAUTRO in respect of long-term insurance policies which are treated as investments for the purposes of the Financial Services Act 1986.

#### **1. PROPOSAL FORMS**

- a. If the proposal form calls for the disclosure of material facts a statement should be included in the declaration, or prominently displayed elsewhere on the form or in the document of which it forms part:-
  - i. drawing attention to the consequences of failure to disclose all material facts and explaining that these are facts that an insurer would regard as likely to influence the assessment and acceptance of a proposal;
  - ii. warning that if the signatory is in any doubt about whether certain facts are material, these facts should be disclosed.
- b. Neither the proposal nor the policy shall contain any provision converting the statements as to past or present fact in the proposal form into warranties

except where the warranty relates to a statement of fact concerning the life to be assured under a life of another policy. Insurers, may, however, require specific warranties about matters which are material to the risk.

- c. Those matters which insurers have commonly found to be material should be the subject to clear questions in proposal forms.
- d. Insurers should avoid asking questions which would require knowledge beyond that which the signatory could reasonably be expected to possess.
- e. The proposal form or a supporting document should include a statement that a copy of the policy form or of the policy conditions is available on request.
- f. The proposal form or a supporting document should include a statement that a copy of the completed proposal form is available on request.

## **2. POLICIES AND ACCOMPANYING DOCUMENTS**

- a. Insurers will continue to develop clearer and more explicit proposal forms and policy documents whilst bearing in mind the legal nature of insurance contracts.
- b. Life assurance policies or accompanying documents should indicate:-
  - i. the circumstances in which interest would accrue after the assurance has matured; and
  - ii. whether or not there are rights to surrender values in the contract and, if so, what those rights are.

(Note: The appropriate sales literature should endeavour to impress on proposers that a whole life or endowment assurance is intended to be a long-term contract and that surrender values, especially in the early years, are frequently less than the total premiums paid.)

## **3. CLAIMS**

- a. An insurer will not unreasonably reject a claim. In particular, an insurer will not reject a claim or invalidate a policy on grounds of non-disclosure or misrepresentation of a fact unless:
  - i. it is a material fact; and
  - ii. it is a fact within the knowledge of the proposer; and
  - iii. it is a fact which the proposer could reasonably be expected to disclose.

(It should be noted that fraud or deception will, and reckless or negligent nondisclosure or misrepresentation of a material fact may, constitute grounds for rejection of a claim.)
- b. Except where fraud is involved, an insurer will not reject a claim or invalidate a policy on grounds of a breach of warranty unless the circumstances of the claim are connected with the breach and unless:
  - i. the warranty relates to a statement of fact concerning the life to be assured under a life of another policy and that statement would have constituted grounds for rejection of a claim by the insurer under 3(a) above if it had been made by the life to be assured under an own life policy or
  - ii. the warranty was created in relation to specific matters material to the risk and it was drawn to the proposer's attention at or before the making of the contract.
- c. Under any conditions regarding a time limit for notification of a claim, the claimant will not be asked to do more than report a claim and subsequent developments as soon as reasonably possible.

- d. Payment of claims will be made without avoidable delay once the insured event has been proved and the entitlement of the claimant to receive payment has been established.
- e. When the payment of a claim is delayed more than two months, the insurer will pay interest on the cash sum due, or make an equivalent adjustment to the sum, unless the amount of such interest would be trivial. The two month period will run from the date of the happening of the insured event (ie death or maturity) or, in the case of a unit linked policy, from the date on which the unit linking ceased, if later. Interest will be calculated at a relevant market rate from the end of the two month period until the actual date of payment.

#### **4. DISPUTES**

The provisions of the Statement shall be taken into account in arbitration and any other referral procedures which may apply in the event of disputes between policyholders and insurers relating to matters dealt with in the Statement.

#### **5. COMMENCEMENT**

Any changes to insurance documents will be made as and when they need to be reprinted, but the Statement will apply in the meantime.

Note Regarding Industrial Assurance Policyholders

Policies effected by industrial assurance policyholders are included amongst the policies to which the above Statement of Long-Term Insurance Practice applies. Those policyholders also enjoy the additional protection conferred upon them by the Industrial Assurance Acts 1923 to 1969 and Regulations issued thereunder. These Acts give the Industrial Assurance Commissioner wide powers to cover inter alia the following aspects:-

- a. Completion of proposal forms.
- b. Issue and maintenance of Premium Receipt Books.
- c. Notification in Premium Receipt Books of certain statutory rights of a policyholder including rights to:-
  - i. an arrears notice before forfeiture,
  - ii. free policies and surrender values for certain categories of policies,
  - iii. relief from forfeiture of benefit under a policy on health grounds unless the proposer has made an untrue statement of knowledge and belief as to the assured's health.
  - iv. reference to the Commissioner as arbitrator in disputes between the policyholder and the company or society.

The offices transacting industry assurance business have further agreed that any premium (or deposit) paid on completion of the proposal form will be returned to the proposer if, on issue, the policy document is rejected by him or her.

# **APPENDIX C**

## **THE ABI STATEMENTS, MISREPRESENTATION AND NON-DISCLOSURE**

### **Overview**

- C.1 In Part 3 we explained how the Statements came to be amended in 1986 in place of law reform. The Statements apply only to policyholders resident in the UK and insuring in a private capacity - in other words, consumers.<sup>1</sup> As the names suggest, SGIP deals with general insurances such as household or motor policies, and SLIP addresses long-term insurance such as endowment or term assurance policies.
- C.2 Despite the criticisms of the test of materiality contained in the 1980 report, the Statements do not address this issue directly. Instead SGIP seeks to restrict an insurer's right to repudiate liability for claims following a pre-contractual misrepresentation or non-disclosure. Rather oddly, avoidance is not mentioned at any point, even though in these circumstances avoidance is a necessary precursor to repudiation. This approach means that SGIP simply fails to deal with those cases where misrepresentation and non-disclosure come to light when there has been no claim. In contrast, SLIP does refer to avoidance, specifically restricting the right of an insurer to "reject a claim or invalidate a policy".
- C.3 Both Statements contain general requirements relating to the content of proposal forms and renewal forms.

### **Restrictions on the right to avoid a policy**

- C.4 Under the Statements, the right to avoid a policy depends on the state of mind of the applicant at the time of the misrepresentation or non-disclosure.

### **Innocent misrepresentation or non-disclosure**

- C.5 The relevant provision in SGIP applies only in cases of non-disclosure and where a claim has occurred. It permits an insurer to repudiate liability (which it can only do by avoiding the policy) if the fact is one which the applicant could reasonably have been expected to disclose. This is essentially aimed at barring avoidance where the applicant acted innocently. In contrast, SLIP applies to both misrepresentation and non-disclosure, and regardless of whether a claim has been made. It bars avoidance unless the material fact in question was known by the applicant, and is one that the applicant could reasonably be expected to disclose.

<sup>1</sup> Though the FOS has indicated that where appropriate it will take note of SGIP when dealing with small business cases.

### **Negligent misrepresentation or non-disclosure**

- C.6 SGIP refers only to cases of misrepresentation where a claim has occurred. It permits an insurer to repudiate liability - which it can do only by first avoiding the policy. SLIP states that negligent misrepresentation or non-disclosure may constitute grounds to avoid a policy and reject a claim.

### **Fraudulent misrepresentation or non-disclosure**

- C.7 Fraudulent misrepresentation and non-disclosure are not dealt with in SGIP. SLIP refers to “fraud or deception” in a note to the provision relating to misrepresentation and non-disclosure. It is not clear whether this relates to fraud and deception in the making of a claim generally, or specifically to pre-contractual misrepresentation and non-disclosure. Reckless misrepresentation - which can in law amount to fraud - may constitute grounds for rejection of a claim, as may reckless non-disclosure. Again, rejection would require first avoiding the policy.

### **A requirement to ask questions**

- C.8 SGIP states that those matters which insurers have commonly found to be material should be the subject of clear questions in proposal forms. A similar provision is contained in SLIP.

### **Questions which require expert knowledge to answer should be avoided**

- C.9 Under SLIP insurers should avoid asking questions which would require knowledge beyond that which the applicant could reasonably be expected to possess. The corresponding provision in SGIP potentially required more from the applicant in one respect – it allowed insurers to ask questions that required knowledge the applicant could reasonably be expected to obtain. However it also obliged insurers to avoid questions which would require a value judgement on the part of the applicant.

### **Knowledge and belief**

- C.10 SGIP provided that the declaration at the foot of a proposal form should be restricted to completion according to “the proposer’s knowledge and belief”. There is no equivalent provision in SLIP.

### **Consumers must be alerted to the duty of disclosure and the consequences of breach**

- C.11 In cases where disclosure is required, SLIP obliges insurers to explain on proposal forms that material facts are those “likely to influence the assessment and acceptance of a proposal” and to warn of the consequences of non-disclosure. Consumers should be warned that if there is any doubt about whether certain facts are material, they should be disclosed. The explanation and warnings should be “prominently displayed”. A similar requirement was contained in SGIP.

### **Renewals**

- C.12 Under SLIP, there are no provisions relating to renewals, since such policies are not typically subject to renewal. SGIP requires renewal notices to contain a warning about the duty of disclosure and the need to inform the insurer of changes affecting the policy.

### **Criticisms of the statements**

- C.13 From outset, the Statements have been open to criticism:
- (1) They are not legally binding.
  - (2) They are limited in their content. For example, no attempt is made to modify the much-criticised test of materiality.
  - (3) They leave a substantial degree of discretion with insurers. For example, insurers should avoid asking questions which would require expert knowledge, but only "so far as is practicable".
  - (4) They only protect consumers, not businesses.
  - (5) There was no independent input into their drafting - they were produced by industry trade associations.
  - (6) There is no sanction for breach of the Statements.
  - (7) Not all insurers are members of the ABI.
  - (8) It is likely that the vast majority of consumers are unaware that the Statements exist.



# **APPENDIX D APPLICATION FORM DESIGN FOR LIFE AND HEALTH PROTECTION INSURANCES**

**Application Form Design for Life and Health Protection Insurances**  
Guidance from the Association of British Insurers

February 2006

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**Data Protection Act**  
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## INTRODUCTION

- 1.1 The design and wording of proposal forms must meet the needs and circumstances of all interested parties, including applicants, insurers, and salespersons. With the wide ranging coverage now offered in the Life and Health Insurance protection market, it is vital that proposal form design keeps contemporary with such developments to ensure their success.
- 1.2 The reliability of the information that can be obtained from a proposal form in order to accurately assess risk is paramount. In addition, there are also commercial and legislative considerations that need inclusion, as well as those related to a variety of other published material from the ABI.
- 1.3 This document has been produced drawing on the experiences of many technicians in the industry and takes into account comments from the Financial Ombudsman's Service.
- 1.4 This guidance highlights best practice to improve the design of proposal forms. Common examples of good and bad structure and content of proposal forms are outlined. This guidance does not cover group policies.
- 1.5 ***In order to allow flexibility and to preserve competition between Insurers, the recommendations are not in any way prescriptive to ABI members, other than where existing legislation or Statements of Best Practice are applicable.***

### Concerns in connection with non-disclosure

- 2.1 The main reason for the production of this guidance is the continuing problems associated with non-disclosure that each year result in:
  - a. applicants purchasing policies which do not pay out when they expect them to;
  - b. unnecessary claims disputes;
  - c. un-priced for claims putting premiums up;
  - d. fraudulent claims.
- 2.2 One of the reasons people fail to disclose can be because of inadequacies in proposal form design. Potentially the rewards of reducing non-disclosure seen in the industry are very significant. In particular:
  - a. minimising disadvantage to diligent customers;
  - b. insurers can assess larger volumes of business, without the necessity to obtain costly medical evidence;
  - c. applications can be processed more quickly and efficiently with better take up rates and less risk of early cancellation;
  - d. reduced reputational risks arising from costly claims disputes;
  - e. claims pay out when expected – more satisfied customers;
  - f. ultimately, cost savings can benefit the consumer in the form of reduced premiums.

- 2.3 Although not all non-disclosure arises because of faults in proposal forms, insurers should do as much as they can to ensure that the questions they ask are clear and unambiguous. Doing so assists the applicant in their understanding of what is being asked of them. Thus when completing a proposal form, they should have confidence they are giving all the necessary correct and relevant information. This will also reduce the burden on salespersons in explaining or interpreting how questions should be responded to.

## INSURANCE CONTRACTS AND MATERIAL FACTS

- 3.1 Insurance contracts are founded on the principles of *Uberrima Fides* or “utmost good faith”. This places an obligation on a person applying for insurance cover to advise the other party (the insurance company) of any matter that he or she believes will affect the likelihood of the insured event happening.
- 3.2 As mentioned in more detail below, the Statement of Long term Insurance Practice (SoLTIP) and FSA rules require companies to ask questions about matters which have commonly been found to be material. A material fact can be regarded as any fact that may affect the risk of the insured event happening. Such material facts may have an effect on the price for the insurance cover.
- 3.3 Issues that are commonly material, include:
- Age and sex of the applicant;
  - Lifestyle issues (smoking, alcohol consumption, use of drugs);
  - Occupation;
  - Participation in hazardous sports or activities;
  - Residence overseas in the past or in the future;
  - Personal medical history;
  - Current medical condition;
  - Family medical history.

### **The Statement of Long Term Insurance Practice (SoLTIP)**

- 4.1 SoLTIP was issued by the ABI and derives from insurance companies earlier exemption to contract law. Insurance contracts are, however, now covered by the Unfair Terms in Consumer Contracts Regulations 1999. Nevertheless SoLTIP still stands and is used by the FOS in adjudicating claims disputes. From 2005 part of it was incorporated into the FSA rules. **The full Statement is attached at Annex A. Only the highlighted section has been moved into the FSA rules ( 1 ICOB 7 para 7.3.6)** The SoLTIP wording relevant to application forms is:
- a if the proposal form asks for the disclosure of material facts, a statement should be included in the declaration or prominently displayed elsewhere on the form or in the document of which it forms part: -

- i. drawing attention to the consequences of failure to disclose all material facts and explaining that these are facts that an insurer would regard as likely to influence the assessment and acceptance of a proposal;
  - ii. warning that if a signatory is in any doubt about whether certain facts are material, these facts should be disclosed.
- b. neither the proposal form nor the policy shall contain any provision converting the statements as to past or present fact in the proposal form into warranties except where the warranty relates to a statement of fact concerning the life to be assured under a life of another policy. Insurers, may, however, require specific warranties about matters, which are material to the risk.
  - c. those matters, which insurers have commonly found to be material, should be the subject of clear questions in proposal forms.
  - d. insurers should avoid asking questions, which would require knowledge beyond that which the signatory could reasonably be expected to possess.
  - e. the proposal form or a supporting document should include a statement that a copy of the policy form or of the policy conditions is available on request.

Note: To expand upon the provisions as outlined above, questions should be designed to encourage applicants to disclose as much relevant information as possible and should not ask the applicant to judge whether something is relevant or irrelevant. If some condition is considered minor and not relevant, it should be specified (e.g. influenza). An exhaustive list of conditions does not need to be included.

4.2 There is additional law which can impact on application forms, in particular, the Data Protection Act, the Access to Medical Records Act, the Disability Discrimination Act, the Gender Recognition Act 2004, and the Privacy and Electronic Communication Regulations 2003. Annex B summarises some of the most relevant aspects. In addition insurers should take account of the Genetics moratorium and Code of Practice, and the Statement of Best Practice on HIV. Companies should also seek their own independent legal advice if necessary.

## **PRACTICAL IMPLICATIONS**

### **Clearly defining sections and headings**

- 5.1 The different sections contained within the proposal form should be clearly identifiable with use of appropriate headings using distinctive title headings. Such as *Plan/Policy/Benefit Details, Cover Required, Mortgage/Loan Details (where applicable) etc.*
- 5.2 Usually there should be a clear distinction between personal and medical details with questions about each category asked together, rather than being integrated. This makes it easier for the applicant to complete these important sections. Questions relating to these sections, should be divided up (not necessarily in this order) as follows:

- a. **Personal Details** – including name, title, address, sex, date of birth, marital status, contact details and occupational details. In addition, questions relating to hazardous pastimes and pursuits, aviation, existing or other proposed health protection insurance cover, previous adverse terms (i.e. if they have received adverse terms or have been refused acceptance), residence and travel.
- b. **Medical Questions** – doctor’s details, smoking and drinking habits, height and weight details, personal medical history, family medical history.

- 5.3 Whilst some of these questions might overlap somewhat between what is personal and medical information e.g. doctors details, smoking and drinking habits etc, it is important that the personal medical history questions are very obviously separated from other sections where at all possible. This helps to draw attention to this vital part of the proposal form and should assist in the consistency of the responses given.
- 5.4 Where appropriate, sufficient space should be provided for the applicant to answer each of the questions appropriately.

### **Clarity of the questions asked**

#### **6.1 Easy to Understand**

Questions should be asked with particular attention to “plain English”, making them easy to understand and unambiguous. Where possible the use of technical medical terminology should be avoided e.g. use the term “high blood pressure” rather than hypertension.

#### **6.2 Highlighting important text**

Important words or phrases should be highlighted in some way such as underlining or making the relevant text bold.

#### **6.3 Long questions**

Long questions with multiple parts that include a wide variety of different medical conditions or other factors should be avoided.

### **Example**

*“Have you ever suffered from heart attack, cancer, stroke, kidney disease etc...”*

#### **6.4 Judgemental questions**

Questions should avoid asking the applicant to make any judgement on the severity of medical conditions or symptoms i.e. being minor or serious. Rather this information should be gained through the appropriate questions being asked.

## 6.5 **Wide-ranging “trawling” type questions**

Questions should be avoided that are so wide ranging that it would be difficult for practically anyone to truthfully answer them negatively.

### **Examples**

*“Have you ever suffered with back pain?”*

*“Have you ever seen a doctor?”*

## 6.6 **Unreasonable time period (sometimes referred to as “memory test” questions)**

Questions that begin with the prefix of “Have you ever had etc.” should only be used when referring to very serious conditions where the life assured can reasonably be expected to remember them. Therefore, this type of question could be used for conditions such as “cancer” or “heart attack”. However, it is not useful when enquiring about “stomach complaints” or “back pains”, where to truthfully answer these questions would be virtually impossible and result in much useless disclosure from an underwriting perspective.

An appropriate period of time could be applied to the other conditions which are likely to be of underwriting significance when recent but become less so with the passage of time.

## 6.7 **Grouping questions together**

Questions should ideally put related conditions together, such as disorders of the heart, conditions related to cancer risks and so on. A reply should be sought following each individual question, rather than having one response area relating to a number of different questions.

## 6.8 **Specificity and order of medical conditions and symptoms**

Questions should be specific and concise. Where this is achieved, the order in which they are asked is likely to be less relevant than when long questions are asked.

## 6.9 **Other separate questions**

In addition to specific questions relating to medical conditions and symptoms, there should be separate questions such as:

- Any treatment currently being taken by the applicant;
- Any current symptoms for which the applicant might seek medical attention.

## **Family history questions**

- 7.1 Applicants are often only asked questions about first degree relatives because there is less likelihood that they will have knowledge about remoter relatives, unless this has been specifically drawn to their attention because of a potentially inherited disease. Application forms should be clear about what is relevant information concerning the relationship of the relatives, the conditions themselves and the age of onset of the condition in the family member. Firms may wish to consider including a 'don't know' option in this section.

## **Additional information about disclosures**

- 8.1 Where a disclosure has been made, it is advisable that as much relevant information as possible is obtained. This may be achieved by asking the applicant to complete a further section within the proposal form, or by completing an appropriate questionnaire, or by requesting a GP Report (GPR) or a medical examination, or any combination of these. This helps to improve disclosure (and reduce contested claims) by enabling the collection of all relevant information before the contract is agreed. In some cases this may also have the advantage of underwriters being able to accept higher volumes of business from the proposal form and reducing the need to obtain unnecessary medical evidence.
- 8.2 When asking for additional information, it is important that further questions are carefully worded to request specific detail where the applicant is asked to elaborate on their disclosures and expected to know what type of information is required.
- 8.3 Additional questionnaires should repeat the warning about the consequences of non-disclosure.
- 8.4 Applicants should be advised to consult their doctor if they are not confident they will remember to disclose all health details that may be relevant.

## **Declarations and Warnings**

### **9.1 Prominent and easy to understand text**

Warnings should be shown prominently, for example in bold text, with greater emphasis over any other notes that might be included. Plain English should be used, avoiding jargon at all times.

### **9.2 Consistency of approach**

All warnings should be consistent across all new business related documentation, including proposal forms, acceptance letters, Key Features Documents and marketing literature.

### 9.3 **Completion of proposal forms**

Warnings should state that the applicant is advised to complete the proposal forms themselves. Where this is not possible, warnings should state that the applicant is advised not to sign the proposal form until they have read and agree that the answers given to the questions are accurate and complete. They should also be asked to state who completed the form

9.4 Firms may wish to consider providing customers with a copy of their completed and signed application form.

### 9.5 **Confirmation schedules**

Warnings should be repeated in confirmation schedules that applicants are sent before going on risk.

### 9.6 **Detailing the consequences of non-disclosure**

The consequences of failure to disclose material facts should be as explicit as possible. Companies are free to decide on wordings. A common example is:

**“FAILURE TO DISCLOSE RELEVANT INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM AND ALL COVER UNDER THE POLICY BEING CANCELLED”**

In addition, firms may wish to advise customers that they will not automatically write to their doctor and that it is the customer’s responsibility to complete their application form correctly. An example is:

**“PLEASE DO NOT ASSUME THAT WE WILL WRITE TO YOUR DOCTOR, IT REMAINS YOUR RESPONSIBILITY TO COMPLETE THE APPLICATION FORM PROPERLY”**

Alternatively, companies may wish to add an additional warning at the point when the applicant gives consent to approach their GP. An example is:

**“YOU CANNOT ASSUME THAT YOUR DOCTOR WILL PROVIDE THE INFORMATION WE NEED. IT REMAINS YOUR RESPONSIBILITY TO COMPLETE THE APPLICATION FORM PROPERLY”**

9.7 The first warning could be repeated, for example on the first page of the documentation and again at the top of each and every page where personal or medical questions are asked.

### 9.8 **Opportunity to disclose medical details to a Chief Medical Officer/Underwriter**

All applicants should be given the opportunity to provide answers to medical questions in private, directly to the insurer’s Chief Medical Officer. This should also be highlighted or in bold print. Individuals may also be given the option of returning such information to the Chief Underwriter. Confidentiality rules should be mentioned, particularly in the latter situation.



## **Continuing Duty to Disclose**

### **Application forms**

- 10.1 Insurers should tell applicants that they must advise the insurer, in writing, of any changes in their circumstances which happen before the policy commences (or beyond if appropriate e.g. if you change your occupation, move abroad) that now make any of the answers on the proposal form wrong or incomplete. Please advise of any changes to the following:
- Personal health;
  - Family history;
  - Occupation;
  - Travel or Residence;
  - Hazardous pastimes;
  - Alcohol consumption;
  - Smoking habit
  - Use of recreational drugs (e.g. cocaine, heroin)
- 10.2 Warnings under this section should be shown as a list (rather than free text) to add clarity, as well as including a statement that disclosures to any of the questions, medical or otherwise, are of equal importance.

### **Acceptance letters and policy documents confirming cover**

- 10.3 it is advisable that acceptance letters and policy documents, remind applicants of their continuing duty to disclose until the policy starts. Warnings about the consequences of non-disclosure and the continuing duty to disclose should be included and prominent.
- 10.4 Other ways of re-enforcing the continuing obligation to disclose include:
- a. repeating the list of changes that need to be reported as in 10.1
  - b. specifically asking about the key changes that the insurer is most interested in – for example any visits to a doctor
  - c. reminding applicants of what they disclosed on their application form
  - d. issuing a copy of the application form
  - e. issuing reminders at regular intervals

- 10.5 For joint life applications, the applicants should be made aware that the contract does not commence until both lives have been underwritten and accepted. As a result the continuing duty of disclosure continues until both applicants have been approved and the policy has reached commencement date.

### **Electronic and telephone applications**

- 11.1 Separate discussions have been held with the FOS on electronic and tele-underwriting processes and are outside the scope of this consultation.

### **Post issue verification**

- 12.1 When companies choose to obtain medical evidence shortly after completion to monitor accuracy and completeness of disclosure and/or to confirm smoker status they should consider including a statement within the documentation or the section headed 'Important Notes' which describes the practice to the applicant and details (again) the consequences of failure to disclose.
- 12.2 Insurer's should tell applicants when such a report is requested/required.
- 12.3 Post issue verification allows insurers to monitor the clarity of questions asked, non-disclosure, and prevent disputes at the point of claim.

## **ANNEX A**

**(Highlighted section moves to ICOB 7.3.6 from 2005 with some small amendments to the wording. The rest of the Statement remains ABI guidance)**

### **STATEMENT OF LONG-TERM INSURANCE PRACTICE**

The following Statement of normal insurance practice applies to policies of long-term insurance effected in the UK in a private capacity by individuals resident in the UK. Nothing in this statement should be interpreted as conflicting with or overriding the rules of LAUTRO in respect of long-term insurance policies which are treated as investments for the purposes of the Financial Services Act 1986.

#### **1. PROPOSAL FORMS**

- a. If the proposal form calls for the disclosure of material facts a statement should be included in the declaration, or prominently displayed elsewhere on the form or in the document of which it forms part:-
- i. drawing attention to the consequences of failure to disclose all material facts and explaining that these are facts that an insurer would regard as likely to influence the assessment and acceptance of a proposal;
  - ii. warning that if the signatory is in any doubt about whether certain facts are material, these facts should be disclosed.

- b. Neither the proposal nor the policy shall contain any provision converting the statements as to past or present fact in the proposal form into warranties except where the warranty relates to a statement of fact concerning the life to be assured under a life of another policy. Insurers, may, however, require specific warranties about matters which are material to the risk.
- c. Those matters which insurers have commonly found to be material should be the subject to clear questions in proposal forms.
- d. Insurers should avoid asking questions which would require knowledge beyond that which the signatory could reasonably be expected to possess.
- e. The proposal form or a supporting document should include a statement that a copy of the policy form or of the policy conditions is available on request.

## 2. POLICIES AND ACCOMPANYING DOCUMENTS

- a. Insurers will continue to develop clearer and more explicit proposal forms and policy documents whilst bearing in mind the legal nature of insurance contracts.
- b. Life assurance policies or accompanying documents should indicate:-
  - i. the circumstances in which interest would accrue after the assurance has matured;
  - and
  - ii. whether or not there are rights to surrender values in the contract and, if so, what those rights are.

(Note: The appropriate sales literature should endeavour to impress on proposers that a whole life or endowment assurance is intended to be a long-term contract and that surrender values, especially in the early years, are frequently less than the total premiums paid.)

## 3. CLAIMS

- a. **An insurer will not unreasonably reject a claim. In particular, an insurer will not reject a claim or invalidate a policy on grounds of non-disclosure or misrepresentation of a fact unless:**
  - i. **it is a material fact; and**
  - ii. **it is a fact within the knowledge of the proposer; and**
  - iii. **it is a fact which the proposer could reasonably be expected to disclose.**

(It should be noted that fraud or deception will, and reckless or negligent non-disclosure or misrepresentation of a material fact may, constitute grounds for rejection of a claim.)

- b. Except where fraud is involved, an insurer will not reject a claim or invalidate a policy on grounds of a breach of warranty unless the circumstances of the claim are connected with the breach and unless:**
  - i. the warranty relates to a statement of fact concerning the life to be assured under a life of another policy and that statement would have constituted grounds for rejection of a claim by the insurer under 3(a) above if it had been made by the life to be assured under an own life policy or**
  - ii. the warranty was created in relation to specific matters material to the risk and it was drawn to the proposer's attention at or before the making of the contract.**
- c. Under any conditions regarding a time limit for notification of a claim, the claimant will not be asked to do more than report a claim and subsequent developments as soon as reasonably possible.
- d. Payment of claims will be made without avoidable delay once the insured event has been proved and the entitlement of the claimant to receive payment has been established.
- e. When the payment of a claim is delayed more than two months, the insurer will pay interest on the cash sum due, or make an equivalent adjustment to the sum, unless the amount of such interest would be trivial. The two month period will run from the date of the happening of the insured event (ie death or maturity) or, in the case of a unit linked policy, from the date on which the unit linking ceased, if later. Interest will be calculated at a relevant market rate from the end of the two month period until the actual date of payment.

#### **4. DISPUTES**

The provisions of the Statement shall be taken into account in arbitration and any other referral procedures which may apply in the event of disputes between policyholders and insurers relating to matters dealt with in the Statement.

#### **5. COMMENCEMENT**

Any changes to insurance documents will be made as and when they need to be reprinted, but the Statement will apply in the meantime.

## Note Regarding Industrial Assurance Policyholders

Policies effected by industrial assurance policyholders are included amongst the policies to which the above Statement of Long-Term Insurance Practice applies. Those policyholders also enjoy the additional protection conferred upon them by the Industrial Assurance Acts 1923 to 1969 and Regulations issued thereunder. These Acts give the Industrial Assurance Commissioner wide powers to cover inter alia the following aspects:-

- a. Completion of proposal forms.
- b. Issue and maintenance of Premium Receipt Books.
- c. Notification in Premium Receipt Books of certain statutory rights of a policyholder including rights to:-
  - i. an arrears notice before forfeiture,
  - ii. free policies and surrender values for certain categories of policies,
  - iii. relief from forfeiture of benefit under a policy on health grounds unless the proposer has made an untrue statement of knowledge and belief as to the assured's health.
  - iv. reference to the Commissioner as arbitrator in disputes between the policyholder and the company or society.

The offices transacting industrial assurance business have further agreed that any premium (or deposit) paid on completion of the proposal form will be returned to the proposer if, on issue, the policy document is rejected by him or her.

## ***Annex B***

### ***Summary of Additional Law of Relevance to Application Forms***

#### **Data Protection Act 1998**

The Data Protection Act applies to forms that ask for any form of Personal Data if that data is held in an automated or relevant filing system. Personal data is data that relates to any living individual. All personal insurance applications are expected to fall within the scope of this Act as they ask for Personal Data and will be held in a filing system, which is accessible in a way that can identify data relating to the individual.

Forms and the way they are used must, therefore, comply with the Principles of the Act.

Also some personal data is further defined as Sensitive Personal Data and this has special requirements under the Act.

Sensitive Personal Data is defined as information about

1. The racial or ethnic origin of the data subject
2. Their political opinions
3. Their religious beliefs or other beliefs of a similar nature
4. Whether they are a member of a trade union
5. Their physical or mental health or condition
6. Their sexual life
7. The commission or alleged commission by them of any offence
8. Any proceedings for any offence committed or alleged to have been committed by them, the disposal of such proceedings or the sentence of any court in such proceedings.

Forms for insurance ask for such sensitive data to be disclosed and the specific requirements of the Act relating to Sensitive Data must be followed.

Personal data will be required for the performance of the insurance contract. This fulfils the requirement for lawful processing of data. In addition consent will be obtained in the form and as sensitive data is processed explicit consent is necessary. To demonstrate explicit consent a signed consent from the data subject should fulfil the requirement for processing such data.

The concept of fairness of collecting and processing of data is part of the scope of the Act. To ensure that a person is aware of why questions are asked on application forms details should be given about how the data will be used and any third parties that may also process personal data. The second principle refers to “specified” purposes.

The primary purpose of the data that will be collected should be specified in application forms. This will generally be to underwrite, set-up and administer an insurance contract.

If data may be given to third parties the possibility of this must be mentioned and an explanation given about how details of any third parties, who are given data, can be identified. Third parties will include:

- Reassurance companies
- Third party administrators who may be involved in any part of the set-up or administration.

Care is required with other third parties that may be involved (GPs) and data from application forms should not be given to them unless it is reasonable to presume they are already in possession of the data. The medical history of the subject is data that can be expected to be in their possession but not necessarily data on sexual health or family history.

Data collected must be relevant to the purpose for which it will be used. Forms should ask questions about matters which are relevant to the insurance risk but any data which is not relevant or not needed to administer the contract should not be asked for.

Other aspects of the Data Protection Act relevant to application forms are

- Retention policy for data. The DPA does not state how long companies need to hold records. This is determined by the FSA. An explanation on a company's data retention can be given in the application form
- Right to prevent processing for the purposes of marketing. The process for an opt-out from marketing material can be given.
- Right in respect of automated decision taking. There is a right to ensure that no decision that significantly affects the person is based only by automatic means
- The application of the Privacy and Electronic Communications Regulations

The Data Protection Act also brings an obligation to hold data securely. A reference to the Confidentiality Policy of the Company will demonstrate that there are appropriate measures for data security.

Collection of data in application forms that involve third parties may inadvertently cause breaches of security. Providing a means for relevant data to be forwarded securely to those who require access to such data will remove this potential difficulty.

Access to personal data is also allowed under the Data Protection Act by a subject access request. When access is required to data that includes medical data there is an exemption in respect of data that may be harmful to the individual or others.

### **Access to Medical Reports Act 1988**

A statement of the rights provided by this Act must be given to the applicant before a medical report can be obtained from the doctor.

This essential provision of this Act is to allow an individual to have access to any medical report about him or her that has been prepared by a doctor who has given the individual care. However the issue of concern to insurers is the effect of the Act on doctors' reports obtained by insurers to assess insurance applications.

Before a report can be requested by an insurer from a doctor the applicant must have consented to the report being obtained. The right to refuse to give consent is also provided by the Act, although this may result in an insurer refusing to process an application.

When consent is given the applicant should indicate whether or not he/she requires access to the report.

If access is required the applicant must be notified if a report is requested from the doctor. The doctor who has prepared the report will not release the report until the applicant has seen it or until 21 days have elapsed. If there is anything in the report with which the applicant disagrees he or she can ask to have the report amended or attach a statement of their own if the doctor refuses.

If access is not required, the applicant does not need to be informed if a report is requested.

The applicant also has the right to have access to this report for up to six months after it has been completed.

# APPENDIX E

## EXTRACTS FROM THE FSA HANDBOOK

### EXTRACTS FROM THE ICOB SOURCEBOOK

#### **4.3.1 Requirement for suitability**

- (1) An insurance intermediary must take reasonable steps to ensure that, if in the course of insurance mediation activities it makes any personal recommendation to a customer to buy or sell a non-investment insurance contract, the personal recommendation is suitable for the customer's demands and needs at the time the personal recommendation is made.
- (2) The personal recommendation in (1) must be based on the scope of the service disclosed in accordance with ICOB 4.2.8 R(6).
- (3) An insurance intermediary may make a personal recommendation of a non-investment insurance contract that does not meet all of the customer's demands and needs, provided that: there is no non-investment insurance contract within the insurance intermediary's scope, as determined by ICOB 4.2.8 R(6), that meets all of the customer's demands and needs; and the insurance intermediary identifies to the customer, at the point at which the personal recommendation is made, the demands and needs that are not met by the contract that it personally recommends.

#### **4.3.2 Information about the customer's demands and needs**

In assessing the customer's demands and needs, the insurance intermediary must:

- (1) seek such information about the customer's circumstances and objectives as might reasonably be expected to be relevant in enabling the insurance intermediary to identify the customer's requirements. This must include any facts that would affect the type of insurance recommended, such as any relevant existing insurance;
- (2) have regard to any relevant details about the customer that are readily available and accessible to the insurance intermediary, for example, in respect of other contracts of insurance on which the insurance intermediary has provided advice or information; and
- (3) explain to the customer his duty to disclose all circumstances material to the insurance and the consequences of any failure to make such a disclosure, both before the non-investment insurance contract commences and throughout the duration of the contract; and take account of the information that the customer discloses.

#### **7.31 Requirement to handle claims promptly and fairly**

An insurer must carry out claims handling promptly and fairly.

#### **7.3.5 Giving customers guidance on claiming**

When an insurer is informed that a customer wishes to claim under his policy it must give the customer reasonable guidance to help him make a claim under his policy.



### **7.3.6 Rejecting or refusing claims**

An insurer must not:

- (1) unreasonably reject a claim made by a customer;
- (2) except where there is evidence of fraud, refuse to meet a claim made by a retail customer on the grounds:
  - (a) of non-disclosure of a fact material to the risk that the retail customer who took out the policy could not reasonably be expected to have disclosed;
  - (b) of misrepresentation of a fact material to the risk, unless the misrepresentation is negligent;
  - (c) in the case of a general insurance contract, of breach of warranty or condition, unless the circumstances of the claim are connected with the breach; or
  - (d) in the case of a non-investment insurance contract which is a pure protection contract, of breach of warranty, unless the circumstances of the claim are connected with the breach and unless:
    - (i) under a life of another contract, the warranty relates to a statement of fact concerning the life to be assured and that statement would have constituted grounds for rejection of a claim by the insurer under ICOB 7.3.6 R(2)(a) or (b) if it had been made by the life to be assured under an own life contract; or
    - (ii) the warranty is material to the risk and was drawn to the attention of the retail customer who took out the policy<sup>1</sup> before the conclusion of the contract.

## **EXTRACTS FROM THE COB SOURCEBOOK**

### **8A.2 Claims handling: general**

#### **8A.2.1 Requirements to handle claims promptly and fairly**

An insurer must carry out claims handling promptly and fairly.

#### **8A.2.5 Giving policyholders guidance on claiming**

When an insurer is informed that a policyholder wishes to claim under his policy it must give the policyholder reasonable guidance to help him make a claim under his policy.

#### **8A.2.6 Rejecting or refusing claims**

An insurer must not:

- (1) unreasonably reject a claim made by a policyholder;
- (2) except where there is evidence of fraud, refuse to meet a claim made by a policyholder on the grounds:
  - (a) of non-disclosure of a fact material to the risk which the policyholder could not reasonably be expected to have disclosed;
  - (b) of misrepresentation of a fact material to the risk unless the misrepresentation is negligent; or

- (c) of breach of warranty, unless the circumstances of the claim are connected with the breach and unless:
  - (i) under a 'life of another' contract, the warranty relates to a statement of fact concerning the life to be assured and that statement would have constituted grounds for rejection of a claim by the insurer under COB 8A.2.6R (2)(a) or COB 8A.2.6R (2)(b) if it had been made by the life to be assured under an 'own life' contract; or
  - (ii) the warranty is material to the risk and was drawn to the attention of the policyholder before the conclusion of the contract.

# APPENDIX F

## THE FSA HANDBOOK, MISREPRESENTATION AND NON-DISCLOSURE

### OVERVIEW

- F.1 The FSA uses a different classification of insurance business from that used for the purposes of the ABI Statements. It distinguishes between pure protection insurance on the one hand, and investment insurance on the other. The FSA took responsibility for conduct of business regulation of the latter with effect from 1 December 2001 and the former with effect from 14 January 2005.
- F.2 This distinction is maintained in the Rules contained in the FSA Handbook. Pure protection insurance is dealt with under the Insurance Conduct of Business ("ICOB") sourcebook and investment insurance is dealt with under the Conduct of Business ("COB") sourcebook. The consequence is that all business once covered by SGIP will now be covered by ICOB, and most business covered by SLIP is also covered by COB. However, some business covered by SLIP - such as term life insurance - is now also covered by ICOB. And the FSA has decided that pension term life insurance, for example, will be covered by both ICOB and COB.
- F.3 Like the Statements, the FSA Rules do not seek to amend the test of materiality. The relevant Rules under ICOB and COB are broadly based on the provisions of SGIP. Consequently, the approach is to restrict the right to repudiate a claim. There is no mention of avoidance, although this is, of course, an essential precursor to repudiation. As with SGIP, the Rules fail to deal with those cases where misrepresentation and non-disclosure come to light when there has been no claim.
- F.4 The Rules also impose requirements on the content of proposal forms and renewal forms.

### Restrictions on the right to avoid

- F.5 Under the Rules, the right to avoid a policy depends on the state of mind of the applicant at the time of the misrepresentation or non-disclosure.

### Innocent misrepresentation or non-disclosure

- F.6 Under ICOB, a claim should not be rejected unless the material fact in question was one the *retail customer* could reasonably be expected to disclose. In this context *retail customer* is "an individual who is acting for purposes which are outside his trade, business or profession". COB provides that a claim should not be rejected for non-disclosure unless the material fact in question was one the *policyholder* could reasonably be expected to disclose. In this context *policyholder* is the legal holder of the policy. A claim may, of course, only be rejected if the policy is first avoided. These provisions are essentially aimed at barring avoidance where the applicant acted innocently.

### **Negligent misrepresentation or non-disclosure**

- F.7 Both ICOB and COB state that negligent misrepresentation will constitute grounds to repudiate a claim.

### **Fraudulent misrepresentation or non-disclosure**

- F.8 Both COB and ICOB state that any restrictions on refusing to meet a claim do not apply where there is evidence of fraud. As with SLIP it is not clear whether this relates to fraud and deception in the making of a claim generally, or specifically to pre-contractual misrepresentation and non-disclosure.

### **A requirement to ask questions**

- F.9 There are no provisions of COB which specifically require questions to be asked. It could be argued that the requirements of "know your customer" under COB 5.2 and "suitability" under COB 5.3 would require enquiries to be made, but even this would be of questionable assistance where:
- (1) the policy is not sold by the insurer, or
  - (2) the sale is execution-only (no advice is given).
- F.10 There may, however, be a penalty for not asking questions. As indicated above, under COB 8A.2.6 an insurer must not avoid a policy for non-disclosure of a fact which a policyholder could not reasonably be expected to have disclosed. If an insurer has not asked a question, what can a consumer reasonably be expected to disclose?
- F.11 For ICOB the position is broadly similar. There are no provisions of ICOB which specifically require questions, though there is a requirement of "suitability" under ICOB 4.3. In addition, a warning is required, as detailed below. There may, again, be a penalty for not asking questions. As indicated above, under ICOB 7.3.6 an insurer must not avoid a policy for non-disclosure of a fact which a policyholder could not reasonably be expected to have disclosed.

### **Consumers must be alerted to the duty of disclosure and the consequences of breach**

- F.12 There are no specific requirements under COB. In contrast, ICOB 4.3.2 requires an insurance intermediary to explain to the customer the duty:
- to disclose all circumstances material to the insurance and the consequences of any failure to make such a disclosure, both before the non-investment insurance contract commences and throughout the duration of the contract; and take account of the information that the customer discloses.

## **APPENDIX G**

### **COMPARATIVE LAW**

- G.1 This Appendix will look at how other legal systems deal with the issues raised by non-disclosure and misrepresentation in insurance contract law. Four systems will be considered, Australia, France, New York and Norway. Following a brief introduction to the governing provisions in each jurisdiction, this Appendix will take an issue at a time considering the various approaches.

#### **INTRODUCTIONS**

##### **Australia**

- G.2 Until 1984, Australian insurance law closely resembled its English counterpart. However, following the Australian Law Reform Commission's report in 1982,<sup>1</sup> the Insurance Contract Law Act 1984 (the "1984 Act") was enacted. This introduced a statutory basis for general insurance law. It must be noted that Marine insurance was excluded from the scope of the review and thus remained unchanged and in alignment with English marine insurance law. A review of marine insurance was conducted by the ALRC in 2004. The recommendations have not yet been implemented.
- G.3 The developments in Australia are of interest to this current review as their starting point was very similar to ours. Further, their system of law and the court system resembles ours and a comparison is therefore worthwhile. The relevant sections of the 1984 Act for this Appendix are contained in Division IV.

##### **France**

- G.4 Insurance law in France is governed by the Code des Assurances. It should be highlighted at this early stage that the basis of French contracts is very different from our own. Contracts in France are based on the concept of consent and further the principle of good faith is integral to contracts. Despite this, insurance contracts are afforded special treatment, for two reasons. First, insurance contracts are specifically of "bonne foi", placing a heavier burden of good faith on the parties. Secondly, the very nature of the risk involved is said to require stronger duties and harsher sanctions, as the insurer must rely heavily on the declarations and disclosures made by the insured when evaluating the risk and thus the contract. It should be noted that reinsurance contracts are expressly excluded from the remit of the Code des Assurances and further, although marine insurance is covered, it is subject to separate provisions.

<sup>1</sup> ALRC 20.

- G.5 The reason French insurance law could be of interest, is that if European harmonisation is a possibility it is important to highlight the differences between the major continental systems and our own. When considering the French approach, however, a word of caution is required. French contract law differs from our own in the way contracts are viewed and the way the French courts deal with disputes. France has a reputation for being very protectionist over consumers, an inclination reflected in the jurisprudence of the lower courts. Further, their system of separating questions of law, which are open to appeal by the Cour de Cassation, and questions of fact which are not, leaves the lower courts with much more freedom than their English counterparts.
- G.6 The relevant provisions in the Code des Assurances are Articles 113, 114 and 172.

### **New York**

- G.7 New York State has its own provisions of insurance law and the relevant sections for these purposes are sections 3104 and 3105. Following the *Wilburn Boat* case in 1955, it appears that marine insurance is subject to State laws, however, it must be noted that the courts have stated that different rules apply to marine insurance and indeed to reinsurance as in these cases “courts impose the doctrine of uberrimae fidei”.<sup>2</sup>
- G.8 New York law is considered here as the New York insurance market is perhaps a competitor to the London one and thus it is important to highlight the differences.

### **Norway**

- G.9 The provisions for Norwegian non-marine insurance law are set out in the Norwegian Insurance Law Act of 16<sup>th</sup> June 1989. This deals with both life and non-life policies. Marine insurance is dealt with in the Norwegian Marine Insurance Plan of 1996. Again the provisions for marine and non-marine are different. Norwegian insurance law is of interest as their insurance market is growing. The recent implementation of the Marine Insurance Plan is particularly noteworthy.
- G.10 Norway is also of interest as businesses are treated differently from consumers without the need for separate rules.

### **IS A DUTY OF DISCLOSURE NECESSARY?**

- G.11 Perhaps the most significant question in the review of English and Scottish insurance law is whether or not the duty to disclose should be retained. There are two questions which follow on from this. First, if the duty is retained, should insurers be required to give the policyholder warning of the duty? Secondly, if the duty is to be abolished, what, if any, further controls are required? From the countries considered, almost the full spectrum is covered.

<sup>2</sup> *Home Ins Co v Spectrum Information Technologies*, 930 F. Supp. 825 (E.D.N.Y. 1996).

- G.12 In Australia the duty of disclosure has been retained across the board, for consumers as well as businesses. The details of the duty are set out in section 21, and there is a duty on insurers to warn policyholders of the existence of this duty.<sup>3</sup> Although at first glance retaining this duty appears to be against the interests of the insured, it must be noted that the duty has been altered as a result of a change in the test of materiality (see below). The duty on the insurer to warn the policyholder is of paramount importance and a prescribed form of words is provided in the schedules to the Act. If an insurer fails to comply with this requirement, and the onus is on the insurer to prove such compliance, then it cannot rely on the non-disclosure by the insured, unless such non-disclosure is fraudulent.<sup>4</sup> "Fraud" has been defined in the same way as in England in a recent case on life insurance.<sup>5</sup>
- G.13 Despite the retention of the duty of disclosure in Australia, a subsequent amendment to the 1984 Act has eased the burden on insureds. Section 21A, introduced in 1998, requires insurers to ask insureds specific questions rather than open-ended ones.
- G.14 New York has retained the duty to disclose only for certain types of insurance – marine and reinsurance. As stated above, this is because the relationships in these cases are said to be relationships of "uberrimae fide". The duty has been defined as requiring the insured to disclose all known circumstances that materially affect the risk being insured. In addition to disclosure, New York has the concept of concealment. This equally only applies to certain types of insurance contract, namely fire and life cases. It is dealt with below (in state of mind).
- G.15 Norway has a more subtle approach to distinguishing when there is and is not a duty to disclose. It is mentioned for both marine and non-marine, but the emphasis differs. For the former, the duty is clearly of paramount importance, however, for non-marine it appears to be an exceptional duty with the general duty of the policyholder being the duty to not misrepresent. This more nuanced approach is characteristic of the Norwegian insurance provisions, which leaves a wide discretion to the adjudicators in such cases in terms of remedies, as will be seen below.

<sup>3</sup> Insurance Contract Law Act 1984, s 22(1).

<sup>4</sup> Above s 22(3).

<sup>5</sup> *Muggleston v National Mutual Life Association of Australia Ltd* (Supreme Court of New South Wales) (23 September 2004).

- G.16 France has retained the duty of disclosure for marine insurance, and there is no requirement specified in the Code des Assurances for the insurer to warn the policyholder of such a duty. For all other policyholders, however, the French abolished the so-called “spontaneous” duty to disclose in 1990. This step was taken in response to recommendations of the “Commission des clauses abusives” which criticised the existence of such a duty on insureds. The Commission’s position was based on the fact that insureds are not technical experts of insurance and thus cannot be expected to raise pertinent points. Further it was thought that insureds would not even imagine that such a duty existed at all beyond the requirement to answer any questions put to them. The abolition of the duty was seen to be in line with the French State’s concern to protect consumers, a concern not normally shared by the English courts.
- G.17 In addition to abolishing the duty to disclose, France has introduced a section in the Code des Assurances which discourages the use of general questions. Article 112-3 para 2, provides that if an insurer asks a question expressed “in general terms”, it cannot complain when it receives a vague response. Although this provision applies to all questions and the fact that it does not prohibit the use of general or catch-all questions, the purpose of it is to put the insurer on warning that it cannot claim for misrepresentation by the insured if it insists on asking vague and general questions.

#### **MATERIALITY**

- G.18 The test of materiality in current English law is concerned with what the “prudent insurer” would want to know. This is the test applied to both non-disclosure and misrepresentation. The argument against such a test is often cited as being that an ordinary insured is unlikely to know what the prudent insurer would class as being relevant to consideration of the risk.
- G.19 Where the duty of disclosure is operative it must first be asked whether or not the same test of materiality applies to both misrepresentation and disclosure. This appears to be the case in Australia where the tests laid out in section 21 and 26 respectively amount to the same thing.
- G.20 In Australia the test of materiality for the duty of disclosure is set out in section 21. It requires the insured to disclose matters which
- (1) it knows to be relevant to the decision of the insurer whether to accept the risk and, if so, on what terms, or
  - (2) a matter which a reasonable person in the circumstances could be expected to know to be a matter so relevant to the insurer.



This test was seen to be somewhat of a compromise, as the ALRC had recommended a more subjective test taking into account the characteristics of the insured in question. However, the test enacted referred simply to “the circumstances” rather than to “the circumstances of the insured” as had been recommended. The test nonetheless contained subjective and objective elements, in that so-called “extrinsic” factors, such as how the policy was purchased, can be considered. In 2004 a review was carried out by the Australian Treasury of certain insurance law provisions and it was proposed that the subjective/objective nature of the test required elucidation to provide courts with an indicative list of factors which can be considered.

- G.21 An insured in Australia need only disclose what they actually know. There is no reference to “constructive knowledge”.
- G.22 In Australia the same test is reproduced in section 26 in relation to misrepresentations. Thus in order for a misrepresentation to be actionable it must be material in the same sense as a non-disclosure.
- G.23 In France the duty in general insurance law to not misrepresent is limited to truthfully answering the questions asked on circumstances that enable the insurer to assess the risks that it covers. Although the French Code des Assurances does not itself stipulate any further rules in relation to misrepresentation, it is thought that rules which applied to the now abolished duty of disclosure still apply to the answers the insured must give to the insurer. The rules are twofold. First the insured must only disclose information known to it. If the insured is unaware of something which would have affected the insurer’s assessment of the risk, the insured is not at fault and thus cannot be penalised.
- G.24 Secondly, the facts which the insured must disclose in response to the questions posed include both subjective and objective facts. Subjective facts relate to what in English law is known as “moral hazard” being information about the insured himself, whereas objective facts concern the risk.
- G.25 The emphasis in the general insurance regime in France is clearly on the questions asked, the test of materiality appears somewhat secondary.
- G.26 French Marine Insurance law, however, has a different and more prominent test of materiality for the duty of disclosure. Article 172-19 sets out the test which requires the insured to truthfully declare all circumstances known to him which of their nature are liable to have an impact on the insurer’s assessment of the risk that it covers. There is no reference to the “prudent insurer”, what appears to matter in France is what is relevant to the particular insurer in question. Thus the insured is bound by the particular decisions and processes of the specific insurer, which in turn favours the niche insurer.
- G.27 However, again, the insured must only disclose information known to them, no question of constructive knowledge is raised. Thus, the insurer must prove that the fact it claims was undisclosed was known by the insured, which is a question of fact left to the courts to decide. This must all be considered against the background of insured-friendly courts and questions which cannot be appealed to the highest courts in France (the Cour de Cassation) as they are questions of fact.

- G.28 Norway too, in its non-marine regime, takes a subjective view for the test of materiality for the exceptional duty to disclose. It is concerned with what the particular policyholder realises will be of material significance to the insurers when they evaluate the risk. In terms of misrepresentation however there is no specific test of materiality. The insured must simply answer the questions posed completely and exhaustively. This test therefore goes further than the Australian test in favouring the insured. There is no resort to the “reasonable man”.
- G.29 In marine insurance however, Norwegian law turns away from what the insured realised to a test of materiality for the duty of disclosure which depends solely on what the insurer would find relevant. The person effecting the insurance must disclose all information which is material to the insurer when evaluating the risk. The commentary to the Marine Insurance Plan does mention that retrospective evidence from the insurer as to what it would have done cannot, in such circumstances be decisive. What will be considered is what the insurer usually does in such cases. Thus although the emphasis is still on the insurer, a wider view of their practices is taken into account than may first be thought.
- G.30 It is clear that Norwegian marine insurance law is concerned more with the insurer than the non-marine law which focuses on the insured.
- G.31 New York has a very definite test for materiality. Information shall only be “deemed material” if the knowledge by the insurer of the facts would have led to a refusal by the insurer to make “such contract”.<sup>6</sup> While at first sight this test may appear to favour the insured in that it seems much stricter than the more typical “influencing the mind of the insurer”,<sup>7</sup> it must be noted that there is no requirement that the information must have been material to a reasonable insurer. In New York for facts to be material they must be facts which, had the insurer known them, it would not have entered into the contract such as it did. The test is simply one of inducement. The section states in part (c) that evidence of the practice of the insurer may be used as evidence to prove the test. Thus, again, there is no reference to the “prudent insurer”, much like Norwegian and French marine insurance laws. It is the actual insurer in question whose practices matter. Thus again the balance tips in favour of the insurer as it is the individual insurer’s standards which matter.
- G.32 The justification for placing so much emphasis on the insurer’s judgment was perhaps that insurance was subject to significant variations at the time when this section was enacted (over sixty years ago). However, this justification is somewhat outdated as insurance, especially certain lines, have become rather standardised.
- G.33 Thus it is clear that the test of materiality across the various jurisdictions vary enormously. It appears that there are two separate divisions – whether the focus should be on the insured or the insurer and secondly, whether the test should be subjective or objective.

<sup>6</sup> s 3105.

<sup>7</sup> It thus resembles the “decisive influence test” that was rejected by the House of Lords in the *Pan Atlantic* case: see above, para 2.21.

## STATE OF MIND AND REMEDIES

- G.34 The state of mind of the insured at the time of the non-disclosure or misrepresentation determines the remedy. Thus how the state of mind of the insured is classified is of importance. The general trend appears to be to treat fraud at one end of the spectrum, with the harshest of remedies and innocence at the other. It is the middle grey area which causes difficulty and complexity, as has been encountered by the FOS.
- G.35 France, Australia and Norway afford fraud special treatment and then deal with everything else, albeit differently. As will be seen below, the regime in non-marine Norwegian insurance law allows for innocent behaviour. However, France and Australia dispense with the need to consider innocence as by definition if the insured did not know the information allegedly not disclose, there is no misrepresentation. Actual knowledge is required in both these regimes.
- G.36 New York, on the other hand pays little attention to the state of mind of the insured. Save for the concept of concealment, the state of mind of the insured is irrelevant. For concealment, available only in fire and life policies, fraudulent intent is central to the offence. However, for misrepresentation it matters not whether the insured is innocent or fraudulent.
- G.37 The main question when reviewing the remedies in English insurance law is whether the “all-or-nothing” approach should be maintained. New York has maintained this somewhat harsh approach, whereas the other countries considered here have less strict approaches where anything less than fraud is found.
- G.38 Thus it can first be stated that in the case of fraud the principal remedy for all jurisdictions considered here is avoidance or nullity. In France the premiums can be kept by the insurer in all cases, marine and non-marine, save for life insurance cases. Norway is silent on the issue of premiums and it is unclear whether the “termination” stated in the provisions is retrospective or merely prospective.
- G.39 New York, as stated above, makes the same remedy available notwithstanding the state of mind of the insured. Premiums are returned even in the case of fraud except under the provisions of concealment<sup>8</sup> and sections 3425 and 3426<sup>9</sup> where cancellation of the policy is available to the insurer.
- G.40 Australia, though providing avoidance as the principal remedy for fraudulent non-disclosure or misrepresentation, gives the court a residuary discretion under section 31. This discretion allows the court to disregard avoidance if to not do so would be harsh and unfair. When exercising this power the court should have regard to the surrounding circumstances and to the need to deter fraudulent behaviour.

<sup>8</sup> in cases of fire and life insurance.

<sup>9</sup> in cases of property/casualty and commercial lines.

- G.41 For anything less than fraud the Australian approach is to consider what the insurer would have done had it known the true facts. The result may be that a higher premium would have been charge, so that would be deducted from any payment due. If the insurer can show that their liability would have been nil, then they can avoid liability.
- G.42 In Norwegian non-marine insurance law, where fraud cannot be established, the courts have discretion to decide whether to hold the insurer liable for part of the loss claimed or not. The Act sets out the factors which the courts must consider and allows them to afford no remedy for the insurer where the misrepresentation was entirely innocent.
- G.43 Norwegian marine insurance law, however, takes a different approach as the uncertainty of the discretion available for non-marine insurance was thought inappropriate for marine insurance. Fraudulent behaviour leads to termination and innocence leads to no sanction other than the chance for the insurer to cancel the policy with 14 days' notice. For any other type of non-disclosure – i.e. negligent or reckless – the sanction depends on what the insurer would have done. If the insurer would not have accepted the risk, then the insurer is free from liability and the contract is “not binding”. The burden of proving that the risk would not have been covered lies on the insurer.
- G.44 If the risk would have been covered but on different terms, then the insurer can escape liability unless the insured proves that the information not disclosed was not linked in anyway to the loss suffered. Thus the concept of a causal link of sorts is introduced.
- G.45 The remedies in France for non-marine insurance are two-fold. For anything less than fraud, proportionality is considered. Before considering proportionality the differences between the marine and non-marine schemes will be highlighted. First, in marine insurance the insured must prove its good faith in order to prevent avoidance of the contract. This alters the usual burden of proof. Secondly, Article L172-2 allows for nullity of a marine insurance contract where the insurer can show it would not have taken on the risk had it known the facts. This is not the case in general insurance, where there must be a formal exclusion clause for the insurer to be able to avoid the contract in cases other than fraud.
- G.46 In all other cases proportionality applies where any payment is reduced in proportion to the extra premium due, had the full facts been known. There is no need for there to be a link between the information withheld and any loss suffered.