Law Commission
Reforming the law

Scottish Law Commission
promoting law reform

Reforming Insurance Contract Law

A Summary of Responses to Consultation

This document summarises the responses on consumer issues to the Law Commissions' Consultation Paper
Insurance Contract Law: misrepresentation, non-disclosure and breach of warranty by the insured.

May 2008

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PART 1
INTRODUCTION

AIM OF THIS PAPER

1.1 In July 2007, the Law Commission and the Scottish Law Commission published a joint Consultation Paper on misrepresentation, non-disclosure and breach of warranty by the insured.[1] It made provisional proposals and asked questions in relation to both business and consumer insurance.

1.2 This document summarises the responses we received to that paper in relation to consumers. It does not give the views of either Law Commission. Instead, it is issued with the purpose of reporting the arguments raised. It is, for the most part, a factual summary of the views put to us. **The Law Commissions have not yet formulated their final recommendations on this subject**.

OVERVIEW

1.3 There is a wide consensus that consumer insurance law is in urgent need of reform. Support for reform was shown not only by consumer groups, brokers and lawyers, but also by insurers themselves. Of the 39 insurers and insurance organisations responding to our paper, only four argued against reform. Many actively welcomed reform to make the law simpler and clearer. We were also told that reform would improve confidence in the industry.

1.4 In general, our provisional proposals followed the approach already taken by the Financial Ombudsman Service (FOS). Most insurers supported enshrining the FOS approach into law by, for example, abolishing consumers' legal duty to volunteer information, protecting those who act honestly and reasonably, and providing insurers with proportionate remedies for negligent misrepresentations. We therefore intend to draft new legislation to deal with consumers' obligations to give pre-contractual information to insurers, and insurers' remedies where they fail to do so.

1.5 Given the support expressed for this reform, we are treating draft legislation to deal with pre-contract information from consumers as a priority. Therefore, we are publishing this summary of responses on consumer issues first. A further paper will summarise the responses received to the business insurance proposals.

[1] Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134.

1.6 Our first Bill will be confined to the law on consumer pre-contract information. In Part 4, we explain why we intend to postpone reform of consumer future warranties and deal with them alongside the business reforms. The main reason is that the need for reform is less pressing. Warranties in the strict legal sense are used only rarely in consumer insurance. And if they are used unfairly, consumers have remedies not only under the Financial Services Authority rules but also under the Unfair Terms in Consumer Contracts Regulations 1999. Furthermore, we think that the law on consumer future warranties should be consistent with the law on business warranties.

1.7 Our provisional proposals on insurance intermediaries proved to be much more controversial than other aspects of the Consultation Paper. In Part 5, we report the criticisms made of our proposals on intermediaries and suggest possible alternative approaches.

CONSULTEES' RESPONSES

1.8 Since the Consultation Paper was published we have received 105 written responses from consultees and attended over 50 meetings with buyers, insurers, brokers, lawyers and representative groups.

1.9 The table below shows the identities of those who submitted the 105 responses we received.

Table 1: Respondents to the Consultation Paper, by category

Type of respondent	*Number*
Insurers and insurance associations	39
Lawyers, legal associations and the judiciary	25
Brokers and brokers' associations	13
Consumer insureds and consumer groups	7
Business insureds and trade associations	8
Academics	5
Other	8
Total	105

1.10 Several of those 105 consultees do not work in the consumer market and therefore made comments only in relation to our proposals for business insurance. Between 60 and 70 respondents made comments on a substantial number of consumer proposals. We identified 63 respondents who addressed four out of the first eight consumer questions in the paper – and we categorise them in Table 2.

Table 2: Respondents commenting on a substantial number of consumer proposals, by category

Type of respondent	*Number*	*%*
Insurers and insurance associations	28	44%
Lawyers, legal associations and the judiciary	17	27%
Brokers and brokers' associations	7	11%
Consumer insureds and consumer groups	4	6%
Business insureds and trade associations	1	2%
Academics	2	3%
Other	4	6%
All	**63**	**100%**

CONTENTS OF THIS PAPER

1.11 This paper is divided into a further five parts. They follow the order set out in the Consultation Paper.

(1) Part 2 looks at the overall scheme we are proposing for pre-contract information from consumers. It follows the questions discussed in Part 4 of the Consultation Paper, and listed in paragraphs 12.1 to 12.25.

(2) Part 3 considers issues relating to pre-contract information in group insurance, co-insurance and insurance on the life of another. It follows the questions discussed in Part 6 of the Consultation Paper, and listed in paragraphs 12.44 to 12.51.[2]

(3) Part 4 gives a brief indication of our approach to future warranties in relation to consumers. Most of the proposals discussed in Parts 7 and 8 of the Consultation Paper (and listed in paragraphs 12.53 to 12.69) relate primarily to business insurance. We will therefore report on responses to them in our second paper on business insurance to be published in Summer 2008.

(4) Part 5 deals with the role of intermediaries in communicating pre-contract information from consumers to insurers. These issues were discussed in Parts 9 and 10 of the Consultation Paper, and listed in paragraphs 12.70 to 12.77.

[2] Question 12.52 relates only to business insurance, and will be considered in the next paper.

(5) Finally, Part 6 considers the costs and benefits of reform. These were discussed in Part 11 of the Consultation Paper. We asked five questions, listed in paragraphs 12.84 to 12.88.

APPROACH

1.12 For each proposal or question, we give a limited amount of context and background information about the reasons why the Law Commissions made the proposal or asked the question. For a full explanation of our proposals, readers are referred back to the Consultation Paper.

1.13 We then attempt to summarise the written responses we received, indicating the spread of opinion on a particular point. We outline the arguments raised both for and against our proposals. We have provided a few quotations from those responses that were not sent on a confidential basis. We hope these will give a flavour of the arguments raised. However, in a paper of this length, we have needed to be selective. Many other points were made that we have not quoted in the paper, but which will be taken into account in formulating our views.

1.14 Finally, we attempt to give an overview of responses, highlighting any emerging consensus over the way forward. However, there is not always a consensus. The proposals on intermediaries remain controversial, with strong arguments on both sides.

FUTURE WORK

1.15 This paper will be followed by a similar summary of responses to our proposals for business insurance.

1.16 In the area of pre-contractual information for consumer insurance, we are working towards publishing a report and draft bill in Summer 2009. As will be seen from this paper, there are still issues that we will need to explore in greater depth. We intend to consult on these informally as the need arises.

1.17 In relation to the topics to be covered in our second joint consultation paper, we published an Issues Paper on Insurable Interest in January 2008. In Autumn 2008, we plan to publish further Issues Papers on post-contractual good faith and on whether insurers should be liable in damages for the late payment of claims.

THANKS

1.18 Consultees have produced detailed and well-argued documents that set out arguments both for and against our proposals. Many people have clearly devoted considerable time and resources to this project. We would like to thank all those who have sent written responses to our Consultation Paper and met us to discuss their views.

1.19 We are not inviting comments at this stage. However if, having read this paper, anyone does wish to put additional points to the Commissions, we would be pleased to receive them.

1.20 Please contact us at commercialandcommon@lawcommission.gsi.gov.uk or by post to Elizabeth Waller, Law Commission, Conquest House, 37-38 John Street, Theobalds Road, London WC1N 2BQ. Tel: 020 7453 1231, Fax: 020 7453 1297.

PART 2
PRE-CONTRACT INFORMATION FROM CONSUMERS

IS THERE A NEED FOR REFORM?

2.1 In the Consultation Paper, the Law Commissions argued that the law on pre-contract information in consumer insurance is in need of reform. The current position has overlapping layers of law, regulation and ombudsman discretion, which we described as needlessly complex, confusing and inaccessible. Although the Financial Ombudsman Service (FOS) provides effective remedies for the cases that come before it, there are serious gaps in the cases the FOS can handle. We provisionally concluded that there should be a clear statutory statement of the obligations on consumers to give pre-contract information and the remedies available to insurers if consumers fail to do so (CP para 12.1).

Support for reform

2.2 The great majority of consultees agreed. This was true not only of consumer organisations, brokers and lawyers, but also of insurers. Of the 39 insurers and insurer representatives who responded, only four argued against statutory reform affecting consumers. Many actively supported reform:

> We support the view that the current regime applicable to consumer insureds would benefit from a clear statutory statement of obligations… and we support an update to the current law to align with best practice. [Royal & SunAlliance Insurance]

> The law should be reformed where it currently bears little or no resemblance to market practice. [Zurich Financial Services]

2.3 Insurers argued that a new statute would make the law simpler and clearer for both policyholders and insurers:

> Aviva believes that to codify current best practice would simplify the position and ensure that it was adopted by all. [Aviva]

> We would welcome [reform] so that both the insured and the insurer have a clear understanding of the position. [Aegon UK]

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

2.4 The British Insurance Law Association (BILA) agreed, commenting that "a clear statement would help consumers know their obligations and the consequences of breach and would be a welcome improvement on the current patchwork of voluntary statements, regulation and FOS practice".

2.5 The Chartered Insurance Institute thought that the current lack of legal clarity had a direct impact on the industry's reputation. They quoted the *Financial Mail on Sunday* which described the practice of trawling back through claimants' medical records as "the unacceptable side of the insurance industry". Reform would give improved peace of mind that claims would be paid, and provide greater clarity to insurers' claims handling, thereby resulting in improved consumer confidence.

The FOS view

2.6 The FOS argued strongly in favour of statutory reform, and against the view that ombudsman discretion was adequate to ameliorate the harshness of the law.

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

2.7 The FOS also pointed out that although it could provide a fair solution to the cases that came before it, not all disputes were within its remit. For example, where disputes exceeded £100,000 it could only make a recommendation. Furthermore, some sectors of the industry continued to follow the law as opposed to the ombudsman approach:

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

2.8 Some insurers argued that once the law had been changed, the FOS should be required to make decisions that were in line with the law rather than by reference to a wider concept of what is fair and reasonable. The FOS responded by stating that the industry had no reason to fear that it would use law reform as a stepping stone to make further changes in favour of consumers. The reforms by and large reflected its current approach and it had no reason to change this. In handling consumer credit, pensions and investment the FOS strove to follow the law and regulations. If the law were updated, it would be able to follow the same approach in insurance. One advantage of law reform would be that it would be much easier to identify where the FOS had departed from what Parliament regarded as "fair", and to hold the FOS to account, through judicial review if necessary.

Arguments against reform

2.9 The case against reform was put by the Association of British Insurers (ABI), arguing that the current system provided flexibility:

> The Law Commission should recognise the importance of the protection currently provided and the value of flexibility in the different approaches. A sophisticated system of regulation exists via the FSA and any reform that might take place should not impinge on this system thereby creating duplication and uncertainty. There is no widespread evidence of consumer detriment in relation to the current legal position on non-disclosure and misrepresentation, and the need for reform is therefore not evident. [ABI]

2.10 Fortis Insurance Ltd and ACE European Group supported the ABI's arguments.

Consumer detriment

2.11 Contrary to the views of the ABI, consumer groups argued that the current legal position caused consumer detriment. Age Concern cited research they had conducted with older people about their experience of motor and travel insurance. It found that many older consumers "were confused about what they need to tell their insurer, particularly in relation to health problems".

> The effects can be severe for the individual and also weaken trust in the insurance industry. [Age Concern][3]

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

2.13 The National Consumer Council (NCC) argued that it was unacceptable that consumers should have to rely on forbearance by insurers, the rules of the Financial Services Authority (FSA) or the practices of the FOS:

> The law is out of line with good practice and reformed law that encapsulates good practice should be accessible to consumers. [NCC]

2.14 The Financial Services Consumer Panel described reform as "long overdue".

Overview of responses

2.15 We are encouraged by the widespread support for reform, particularly from the insurance industry. The great majority of consultees agreed that there is an urgent need for clear, accessible legislation on consumers' duties to provide pre-contract information and insurers' remedies where information is not provided.

[3] Age Concern cited several cases reported in their groups where claims had been refused for non-disclosure, even though the consumer had not realised the need to disclose.

DEFINING CONSUMERS

2.16 If there is to be new legislation affecting consumers, the first question is how consumers should be defined. In the Consultation Paper we provisionally proposed that the consumer regime should apply to all individuals who entered into a contract of insurance wholly or mainly for purposes unrelated to their business (CP para 12.2).

2.17 Of the 65 respondents who addressed this issue, two fifths simply agreed without comment. However, among those who gave a reasoned response, views were divided. Three respondents argued that the consumer regime should apply to all policyholders, including businesses. Some argued that small businesses in particular needed more protection, and should be included within the consumer regime if they bought off the shelf products. Others, however, suggested that the definition was too wide. Instead they wanted us to follow the narrower approach adopted by the FSA, which is discussed below.

Mixed use policies

2.18 The main issue revolves around mixed use policies. For example, a self-employed contractor may use a car partly for business and partly for leisure, or household contents insurance may include the contents of a home office. In these circumstances, we suggested that the court should look at the main purpose of the contract. For example, insurance on a car used mainly as a taxi with only the occasional private trip would be considered commercial insurance. However, an individual who insured their home contents for £30,000 including £3,000 of business equipment would be considered a consumer.

2.19 However, the FSA takes a different approach to mixed use policies. The new ICOBS rules introduced in January 2008 define a consumer as a natural person who is acting for purposes that are "outside his trade or profession".[4] The FSA clarifies these words by saying:

> If a customer is acting in the capacity of both a consumer and a commercial customer in relation to a particular contract of insurance, the customer is a commercial customer.[5]

This would suggest that an individual insuring a home that includes a home office would be classified as a commercial customer. Many insurers urged us to follow the FSA approach.

2.20 However, a few people argued that the FSA definition was too narrow, and gave insufficient protection to the self-employed. For example, the Financial Services Consumer Panel said they fully supported the inclusion of "or mainly" in the definition of consumer insurance:

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

[5] ICOBS Guidance 2.1.3.

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

2.21 We are keen to eliminate unnecessary differences between our definitions and those used by the FSA. We therefore held discussions with the FSA to explore this issue further. The FSA told us that the new ICOBS rules do not draw sharp distinctions between types of insured. The principles and high-level standards set out apply to all customers. It appears that their definition is not intended to draw a sharp or legalistic distinction between people who do (or do not) insure a home office, for example. The problem is that our own legislation will give consumers considerably more protection than business customers, and the definition will be more significant. Therefore, it may well be necessary to take a different approach from that of the FSA.

High value goods

2.22 We asked whether there was a need to exempt insurance on specific high value items (such as jets and yachts) from the consumer regime (CP para 12.3). A majority of those who addressed the issue thought that, on balance, there was no need for special exemptions. It would add complexity and cause definitional problems. It was also pointed out that a house is often worth more than a yacht: the purpose for which an item is used is more important than its value.

2.23 Only two respondents put forward a reasoned case for an exemption, on the grounds that those owning high value items often received specialist advice. The Liverpool Underwriters and Marine Association, for example, argued that the consumer regime should not apply to items such as valuable art, jewellery or antique collections.

Overview of responses

2.24 The arguments put to us highlighted the difficulties of classifying mixed use policies. It is increasingly common for people to mix home and work by, for example, setting up businesses from home. It is important to protect people who are insuring cars and homes mainly in a private capacity, but who make occasional use of these items for business. These people may be unsophisticated buyers, who would not usually be regarded as commercial customers.

2.25 Most respondents thought that exemptions for high value goods would be an unnecessary complication.

ABOLISHING CONSUMERS' DUTY TO VOLUNTEER INFORMATION

2.26 In the Consultation Paper we pointed out that it is now generally accepted good practice that insurers should ask consumers questions about any material facts they wish to know. The FOS recognises this, and will refuse to allow an insurer to avoid a policy for non-disclosure where no question is asked. We thought that this should be codified in law. We provisionally proposed that there should be no duty on a consumer proposer to disclose matters about which no questions were asked (CP para 12.4).

2.27 Most respondents, including most insurers, agreed on the grounds that this reflects the FOS's existing approach and long established good practice. As Aegon UK put it:

> In reality we come across very few situations where the residual duty of disclosure kicks in. There is, we believe, some confusion in the industry as to the difference between the residual duty of non-disclosure and misrepresentation. The term "non-disclosure" is routinely used when referring to something that amounts to a misrepresentation. [Aegon UK]

2.28 The argument made against abolishing the duty was that it would lead to long and complex application forms. The Institute of Insurance Brokers said:

> We do not believe that it is practically possible for an insurer to ask every possible material question relating to a risk at the time of proposal. An attempt to do so would create proposal forms of enormous size and complexity – which would add substantial costs to the business process. [IIB]

2.29 They thought that private policyholders should be under a duty to disclose anything that a right-minded lay person would consider material, whether specifically asked for or not. Hill Dickinson LLP gave an example where keys had been taken in a previous break-in and the locks had not been changed.

2.30 That said, most insurers accepted the FOS approach. In practice, they already operate on the principle that policyholders are only required to answer the questions asked – and they still respond to market pressures to keep forms short. Lloyd's said that whilst they would prefer in principle to retain a duty of disclosure, they recognised that "the practice of the FOS may have taken expectations past the point of no return".

2.31 A few respondents asked how abolishing the duty to disclose would operate in specific fact circumstances, such as renewals and cases of commission fraud. Our proposals meant that, for renewals, insurers would at least have to ask a general question about whether anything had changed. The effect of such a question is explored below.

The effect of general questions

2.32 In the Consultation Paper we proposed that insurers should be allowed to ask general questions, but should take the risk they may receive vague answers. For example, if a proposal form asked about "any ailment or disease from which you suffer or have suffered", a reasonable policyholder would understand that they should mention the recent diagnosis of cancer. However, they may not realise that they should mention an operation for an ingrowing toe-nail five years ago. We thought that insurers should be entitled to a remedy for the first omission, but not for the second. We provisionally proposed that the insurer should have no remedy in respect of an incomplete answer unless a reasonable consumer would understand that the question was asking about the particular information in issue (CP para 12.5).

2.33 Most respondents agreed with us. The FOS commented that "this reflects our existing approach, which itself reflects long-established good industry practice".

2.34 Fifteen respondents disagreed with the proposal. Several industry representatives were concerned that the test was uncertain, and that judges may disagree about what was reasonable for a consumer to do. The Investment & Life Assurance Group (ILAG) asked for more clarity about what constitutes a reasonable consumer.

> Any assessment is bound to involve a degree of subjectivity and it would be useful for the industry to work to commonly recognised benchmarks based on the normal characteristics of consumers. [ILAG]

2.35 The ABI suggested that the statute should be less specific. Instead they argued that the matter should be left "to the FSA Conduct of Business Rules and application of the Treating Customers Fairly (TCF) principle".

2.36 By contrast, some academics and consumer groups thought that general questions could operate as a trap and should not be allowed at all. Age Concern commented that for some consumers, "answering a general question may involve quite a lot of worry and inconvenience" while others are "less careful". They asked for more exploration of alternative approaches.

2.37 In some cases, respondents were unclear about the test we were proposing. TH March & Co, the brokers, gave an example: if a question in a buildings policy proposal asked "are there any other hazards we should know about?" would a reasonable consumer mention that they manufactured fireworks at home? We think the answer would be: "yes". Although the question was general, this particular hazard was so obvious and extreme that it is the sort of thing that ought to be mentioned by a reasonable consumer. However, it may not be reasonable to expect the consumer to mention that they are near a river in response to such a question: if insurers want information to assess flood risk, they should ask for it.

Overview of responses

2.38 Most insurers agree that consumers should not be expected to volunteer information for which they have not been asked, and that this represents accepted practice. Furthermore, most respondents agreed with our proposals on general questions, which represent the current FOS approach.

THE BASIC REQUIREMENTS: MISREPRESENTATION AND INDUCEMENT

2.39 Under current law, to establish liability for misrepresentation, the insurer must show that the consumer has made a misrepresentation that induced the insurer to enter the contract. We provisionally proposed to retain these elements of the current law (CP para 12.6). We also asked whether we should define what constitutes a misrepresentation and inducement in the new Act (CP para 12.7).

2.40 Given that this question merely replicates the current law, we did not expect the issue to be controversial. This proved to be the case. Respondents mostly agreed that we should retain the current law. The majority thought that we should define misrepresentation and inducement, especially if we could do so in a way that was "clear, unambiguous and free from jargon". However, a substantial minority thought that the matter could be left to the common law. Lord Justice Rix suggested that the rules should be stated only "in barest outline". We should "beware instant ossification".

2.41 The only issue to generate debate was on how far it may be possible to make a misrepresentation by omission – that is, by failing to answer a question fully. In the Consultation Paper, we explained that an answer may be literally accurate but may still amount to a misrepresentation because it is incomplete. We gave an example where the proposer was asked whether they had ever suffered from a list of illnesses, and mentioned some illnesses but not others. We explained that this may well amount to a misrepresentation.

2.42 Several respondents referred us to the case of *Winter v Irish Life Assurance plc*,[6] which illustrates this principle. The applicant filled in a form. Question 2 asked "are you at present suffering from any physical defect or illness?", the answer to which was left blank. Question 3 asked "have you had any medical or surgical attention? If yes please give full details. The applicant answered "yes" and wrote "MECONIUM ILEUS (3 days old)". She did not mention that she had cystic fibrosis or that she had undergone a liver biopsy. The judge found that the two answers taken together could fairly be taken to mean that she was misrepresenting the facts by claiming that she was suffering from no physical defect or illness, and had had no significant medical attention since she was three days old.

2.43 Our intention was to preserve the approach taken in *Winter*: it would remain possible to mislead by failing to add information to the form. However, if the applicant clearly fails to answer questions, in a way that is not misleading, then the onus would be on the insurer to follow up the issue.

Overview of responses

2.44 The requirements for misrepresentation and inducement are already part of the law, and there was general support for preserving them.

DELIBERATE OR RECKLESS MISREPRESENTATIONS

2.45 In the Consultation Paper, we proposed that where a consumer has made a deliberate or reckless misrepresentation, the insurer should be entitled to avoid the contract and refuse all claims that arise under it. We thought this was appropriate even if the effect of avoiding the policy over-compensates insurers for the loss they have suffered – where, for example, the insurer would still have accepted the risk for only a slight increase in premium had it known the truth. The reason was that where the policyholder is morally blameworthy, it is right to show society's disapproval of the behaviour and discourage wrongdoing. Almost all respondents agreed with us.

[6] [1995] 2 Lloyd's Rep 274.

The definition of "deliberate or reckless" misrepresentations

2.46 The difficult issue is how "deliberate or reckless" should be defined. In the Consultation Paper we proposed that the insurer would need to show, on the balance of probability, that the proposer made the representation:

(1) knowing it to be untrue, or reckless as to whether or not it was true; and

(2) knowing it to be relevant to the insurer, or being reckless as to whether or not it was relevant (CP para 12.8).

2.47 The FOS commented that "this reflects our existing approach". However, some insurers thought that it went further than the current position, and would be too difficult to meet:

> We question whether insurers will be able to take advantage of the concept because of the evidential burden. [Brit Insurance]

2.48 Around 10 insurers expressed concerns about the second limb of the test. As the British Insurance Law Association (BILA) put it:

> We have some concern that this two-part test would effectively allow the insured to provide information it knows is false… provided it did not think it was relevant to the insurer. [BILA]

2.49 The ABI thought that "it would be impossible to prove or disprove" what a proposer thought was relevant. The Lloyd's Market Association felt that this paved the way for dishonest behaviour.

2.50 On the other hand, the MS Society thought that more ought to be done to protect those who omitted medical details that they thought were trivial at the time, only to find in retrospect that the insurer regarded them as relevant early symptoms of multiple sclerosis. They gave examples of members being refused payouts on the basis of undeclared pins and needles or very brief episodes of numbness that seemed irrelevant at the time. The MS Society was concerned about any definition based on "recklessness": they thought that avoidance was only appropriate where information was "knowingly withheld".

2.51 We were interested to note that this issue was recently considered by the Privy Council in *Zeller v British Caymanian Insurance Co Ltd*.[7] Lord Bingham of Cornhill, giving the opinion of the court, commented that where an applicant is asked whether he had recently consulted a doctor

> he is expected to exercise his judgment on what appears to him to be worth disclosing. He does not lose his cover if he fails to disclose a complaint which he thought to be trivial but which turns out later to be a symptom of some much more serious underlying condition.[8]

[7] [2008] UKPC 4. The case is decided under Cayman Law, which follows the common law approach.

[8] [2008] UKPC 4, para 20.

It would therefore appear that knowledge of relevance is already a factor the courts take into account in assessing the answers consumers give to questions.

Presumptions of knowledge

2.52 There is clearly a difficult balance here. On the one hand, it should not be made overly difficult for insurers to prove that a proposer acted deliberately or recklessly when they must have known that they were not giving the correct information. On the other hand, many questions are extremely general. Where a form asks people if they have visited a doctor in the last five years, they routinely interpret the question to refer only to relevant issues. Consumers may omit a visit about a viral infection without having any notion that they are acting dishonestly, or that it may turn out to be a relevant early symptom.

2.53 In order to achieve this balance, we asked whether the statute should expressly state that:

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

(2) if the insurer asked a clear question about an issue, the proposer would be presumed to know that the issue is relevant to the insurer. (CP para 12.11)

2.54 We explained that this would not help insurers if they asked vague, general or ambiguous questions. But where a question was clear, the onus would be on the policyholder to show why they did not think the issue was relevant.

2.55 Most respondents welcomed these presumptions. The ABI described them as "vital presumptions needed to assist insurers". However, they thought that where a question was specific, there was no need to consider whether the consumer knew its relevance: the fact that the insurer had asked the question demonstrated its relevance.

2.56 A few respondents commented on the wording of these presumptions, taken together with the primary test. For example, it was suggested that presumption (2) should only apply to questions that were clear and *specific*. As the Financial Services Consumer Panel put it, "a clear question can still be a general question". Lloyds thought that insurers should not have to show that the consumer knew or was reckless as to whether a matter was relevant. Instead it would be enough if they knew (or were reckless) as to whether it *might* be relevant.

"Recklessness"

2.57 Recklessness is a difficult concept to pin down. In the case law it is described as making a statement without caring whether it is true or false.[9] It is said to require a lack of interest in whether a statement is true – not just a lack of reasonable grounds for believing it is true (which is merely negligent). In the Consultation Paper we explored ways in which we could explain the concept more precisely, but concluded that the issue was best left to the common law (CP para 12.9).

2.58 Of the 60 consultees who addressed this issue, four fifths agreed with us. The ABI thought that the common law definition should be retained, but suggested that further guidance could be given by regulatory bodies or the ABI. Munich Re UK Life Branch suggested that the Law Commissions might engage with the ABI and the FOS over such guidance.

2.59 Those who argued for a definition thought that there was a need to clarify the concept for policyholders and/or insurers. The FOS commented that:

> Our workload suggests that there is a very poor understanding of the definition of "reckless" in law amongst insurance practitioners. It would be worthwhile attempting a statutory definition to put the matter beyond doubt and to introduce some consistency amongst those seeking to respond to any new legislation. [FOS]

Overview of responses

2.60 There seems to be general agreement about the concept of "deliberate or reckless misrepresentation", but some continuing concern over the details of the definition. Respondents generally agreed with the *Derry v Peek* approach to recklessness (which distinguishes between "not caring" whether a statement is true and acting "carelessly"). They also supported enshrining the presumptions in legislation. The most controversial issue is whether someone is dishonest if they do not mention something because they do not think it is relevant, though a recent Privy Council case suggests that the courts already take into account the consumer's knowledge of relevance in assessing misrepresentations.

Retaining premiums

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

2.62 In the Consultation Paper we argued that where a consumer had acted deliberately or recklessly, it was important to send a strong social message that such behaviour was unacceptable. We therefore asked whether in cases of deliberate or reckless misrepresentation, the insurer should be entitled to retain the premium (CP para 12.10).

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

2.63 Out of 64 consultees who responded to this question, the vast majority (85%) agreed. It was felt to be appropriate to show society's disapproval, to deter wrongdoing and to compensate the insurer for the administrative costs they had incurred.

2.64 The minority who argued against this proposal thought that it would be overly harsh on the policyholder and would give the insurer an unjustified windfall. The FOS commented that the remedy of avoidance was harsh enough. They were concerned that "insurers might wrongfully retain premiums without being able to adequately prove that the insured acted dishonestly or fraudulently". Jonathan Hirst QC and the Financial Services Consumer Panel argued that there should be discretion for the courts or the FOS to order repayment in appropriate circumstances.

2.65 Two brokers suggested the money might instead be paid to a central fund:

> [Retaining the premium] would constitute a windfall for the insurer… If the insurer is able to avoid the policy and it is deemed necessary for a sanction to be applied to the insured, the premium could be forfeited to a central fund. [Marsh and Guy Carpenter Ltd]

It was suggested that the fund might be used, for example, to offset the running of the FOS or to support insureds affected by failure of an insurer.

2.66 It was also pointed out that we failed to explain how the principle would apply to investment policies:

> The premium for a With Profits endowment policy has an element of life cover, it also has an element of the investment. Is it equitable that the insurer will profit by the retention of any investment gain? [Mr Mark Wibberley, Broker]

2.67 Thus there was general support for retaining premiums, but some notes of caution that it should not operate unduly harshly, by (for example) depriving a deceased's estate of the investment element of a life policy.

The ABI Guidance on long-term protection policies

2.68 Since we published our Consultation Paper, the ABI has provided further guidance about how the long-term protection industry should handle claims. This sets out circumstances in which the life and critical illness insurer should not avoid the policy, even though the applicant has acted deliberately or without any care in giving incorrect information. In particular, the Guidance states that the insurer should not avoid where:

(1) the degree of materiality associated with the non-disclosure is relatively low (for example where it would have increased some part of the premium by no more than +50%);[10]

[10] Para 8.3.2.

(2) the information relates only to a "severable benefit" such as a Total Permanent Disability benefit, where the claim is for a critical illness;[11]

(3) the insurer only knows about the incorrect statement because it has conducted an unjustified trawl through medical information.[12]

2.69 In the Consultation Paper we said it was important to give a clear and unambiguous message that this behaviour is wrong, even if the insurer would have accepted the risk for only a slight increase in premium. Otherwise the law risked giving policyholders the impression that they could get away with lying.

2.70 However, the industry has agreed to a softer approach. This raises questions about what status such Guidance might have under a new statutory regime, where insurers voluntarily agree to treat dishonest consumers more leniently than the law requires.

2.71 Professor Robert Merkin of Southampton University drew attention to the Australian legislaton. This gives the courts a discretion to prevent avoidance in the case of fraud where it would be harsh and unfair and a lesser remedy of damages would be just and equitable.[13] He thought this worked well and the same discretion should be available in the UK.[14]

"INNOCENT" MISREPRESENTATIONS

Protecting consumers who acted honestly and reasonably

2.72 In the Consultation Paper we argued that a consumer's duty is to be honest and careful in answering the insurer's questions. We provisionally proposed that an insurer should not be able to rely on a misrepresentation if the insured was acting honestly and reasonably in the circumstances when they made the misrepresentation (CP para 12.12(1)).

2.73 The responses suggested that this is already a well-established principle within current insurance practice. Out of the 62 consultees who addressed this issue, 82% agreed with our proposal, usually without comment. The ABI said:

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

[11] Para 6.2.

[12] Para 3.7 states that insurers should not ask for information beyond that needed to assess the claim or to manage a disability claim, unless they have reasonable grounds for thinking there may be a non-disclosure. It does not say what should happen if the insurer obtains information improperly and then discovers a deliberate misrepresentation. However, we have been told that the Guidance implies that insurers will not use the information against the policyholder.

[13] Insurance Contracts Act 1984, s 31.

[14] He argued that a discretion would be particularly important if the agent's intention were to be imputed to the policyholder, so that the insured would be denied all claims because their intermediary had been fraudulent. He did not think that the policyholder's right to sue the broker would be adequate in such circumstances.

However, the ABI thought that legislation was not required.

2.74 The Lloyd's Market Association was the only respondent to argue strongly that insurers should retain the right to avoid policies for innocent mistakes. Lloyd's themselves thought that avoidance was right in principle, but could see reasons to bring the law into line with current market practice:

> Our preference would have been to retain the right of avoidance because we do not think that there is a sufficient case for the risk transfer of the facts not being as stated or perceived where the insurer would have regarded them as material. However, we recognise the undesirability of the substantive law being out of kilter with ICOBS 8.1.2 and FOS practice on this point. A proportionate remedy, such as that proposed in cases of negligent misrepresentation might have been more appropriate. Ultimately the additional risk transfer may be reflected in the pricing. [Lloyd's]

2.75 A few respondents pointed out that the proposed approach differed from the remedy available for an innocent misrepresentation in general contract law. In England and Wales, the court has a discretion under the Misrepresentation Act 1967 to award damages in lieu of rescission.[15] The appropriate measure of damages is uncertain: we did not find any cases in which the section had been raised in a consumer insurance case, or indeed where a consumer had been ordered to pay damages to any non-insurance business for an innocent misrepresentation. It is likely however that the measure of damages would be low,[16] probably no more than the difference between the premium paid and the premium that should have been paid. There was little enthusiasm for a damages remedy of this type.

The "reasonableness" test

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

2.77 We provisionally proposed that the basic test should be objective, looking only at those issues that apply to normal consumers in the market, including the type of policy and the way the policy was advertised and sold. It would only take account of issues such as the consumer's age or knowledge of English in so far as these were known to the insurer (CP para 12.12 (2) & (3)).

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

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

2.78 The FOS pointed out that this was a harsher test than the one they currently employ. They feared that our proposals did not provide sufficient protection for those without financial capability (described as "honest but dim"). At present, the FOS will often apply a subjective standard, and take into account consumers' lack of capability.

2.79 Age Concern strongly supported the proposal that insurers should not be able to avoid for innocent misrepresentations. However, they thought that the proposed test was too harsh:

> This definition will greatly prejudice vulnerable consumers, such as the example cited in the paper of a widow who has never had to deal with home maintenance and who is unaware that the cracks are a symptom of subsidence. [Age Concern].

2.80 Perhaps unsurprisingly, most industry representatives supported our proposal for a more restricted test of reasonableness, usually without discussion. However, many respondents were uncertain about how our test differed from current practice. One insurer sensed that our intention was "to reduce the standards that apply to insureds". In fact, our intention had been the opposite: to tighten the current subjective test in favour of insurers. However, this was not always understood.

2.81 Many industry respondents opposed the idea that the test should take into account consumers' subjective circumstances where these were known to the insurer. The ABI viewed the proposal as placing an obligation on sales staff to assess whether or not the proposer fully understands the nature of the contract. They thought that insurers may refuse to deal with some applicants for fear that they may later argue that they were not in a position to contract. Scottish Widows and Scottish Re also thought that the proposal may lead to social exclusion, as insurers would become more wary of dealing with some classes of consumers:

> This proposal places an obligation on sales advisers to assess whether or not the applicant fully understands the nature of the contract. A line is then expected to be drawn between advisers acknowledging a genuine application for insurance from someone recently bereaved or who is not fluent in English and refusing to deal with the applicant for fear that the applicant may later argue that they were not in a position to contract. This line may be difficult to draw. In the event of a recently bereaved applicant, being refused to be dealt with is likely to exacerbate an already difficult time leading to complaints against the adviser. [Scottish Widows]

2.82 It was also suggested that consumers might use their poor knowledge of English as an excuse:

> If somebody genuinely does not have a sufficient knowledge and understanding of English they should utilise the services of a friend, family member or broker to help them arrange an insurance contract. Aviva has seen a few cases in the past where the client suggests that they do not "understand" at the time of the claim. The inception call does not however support that statement. [Aviva]

2.83 The insurers who made these comments did not appear to appreciate that the FOS will already take subjective factors into account, and may (for example) require less understanding from someone with limited literacy than they would from a graduate. The proposal would protect insurers where they are unaware of subjective factors, and keep it much as it is where insurers are aware of the problem.

2.84 A few respondents made more specific comments on the test. Friends Provident, for example, commented that when looking at the way the insurance was sold, it was important to distinguish the actions of the insurer from those of the intermediary. They therefore suggested that, instead of looking "at the way the policy was advertised and sold" the test should look at "any policy literature and other advertisements issued by the provider".

The issue of relevance

2.85 In the Consultation Paper we commented that a consumer may make an honest and reasonable misstatement for several reasons. They may, for example, have an honest and reasonable belief that what they said was true. Alternatively, they may genuinely and reasonably have thought that any inaccuracy or omission was not relevant to the insurer, often because a question was worded in a confusing, general or ambiguous way. Our survey of ombudsman cases suggested that many cases turned on what a reasonable person would understand by the question. For example, what would a reasonable person think an insurer wanted to know about when it asked for a list of "uninsured losses" in the context of a household contents policy?

2.86 We asked if the legislation should specify that the insurer is entitled to a remedy for a misrepresentation only if:

(1) a reasonable insured in the circumstances would have appreciated that the fact would be one that the insurer wanted to know about; or

(2) the proposer actually knew that the fact was one that the insurer would want to know about (CP para 12.13).

2.87 Most respondents who addressed this question agreed with our proposal, often without comment. However, a minority argued that the test was unnecessary and potentially confusing. The ABI, for example, was unclear what further assistance the test provided.

2.88 It is true that this proposal does not add anything of substance to the general test of reasonableness (in CP para 12.12) or to the general test of honesty (in CP para 12.8). The proposal is only intended to make explicit a point that is already implicit in those tests. If respondents do not find it a helpful clarification, the provision could be omitted from legislation.

The burden of proof

2.89 In the Consultation Paper we proposed that the burden of showing that a consumer proposer who made a misrepresentation did so unreasonably should be on the insurer (CP para 12.14).

2.90 This drew a mixed response. Over half of the sixty respondents who answered this question agreed with us. BILA, for example, gave their qualified approval, stating:

> Provided… that the standard of reasonableness is always that of the reasonable insured in the circumstances, the presumptions as to the insured's knowledge are as in Q12.11 and the standard of proof is the balance of probabilities, we consider the test sufficiently objective for insurers to take on this burden. [BILA]

2.91 However, many insurers disagreed. They argued that it would be extremely onerous for the insurer, as the consumer knows more about the circumstances than the insurer. As the ABI put it, "the consumer is in a far better position to provide evidence about what they did or did not know".

2.92 The provisional proposal was based on the assumption that, in most cases, very little evidence would be needed. The insurer would prove that the applicant had made a misrepresentation, providing a copy of the form. It will usually be sufficient for judges or ombudsmen to put themselves in the position of a reasonable consumer and ask what they would have done in the circumstances, bearing in mind the questions asked.

Materiality: an end to the test based on a hypothetical "prudent insurer"?

2.93 Under our provisional proposals, insurers would need to show that the misrepresentation induced them to enter into a contract, and that a reasonable insured would realise that the issue was relevant to them. We proposed that, once an insurer had done this, it should not also have to show that the issue would be relevant to a hypothetical prudent insurer, as is currently required under section 20 of the Marine Insurance Act 1906. We thought that an additional "prudent insurer" test might place a burden on niche insurers, whose underwriting criteria differed from others in the market.

2.94 We therefore proposed that insurers should not be required to prove that a misrepresentation is "material", in the sense that it would be relevant to a "prudent insurer" (CP para 12.15).

2.95 This was supported by the great majority of those responding. As Aegon UK put it:

> We agree with this as it is open to insurers to insure on whatever basis they decide and what is material to one insurer may not be material to another. Whether or not that is prudent in the eyes of another insurer is of no relevance to the risk that the insurer in question wishes to take on. [Aegon UK]

2.96 No-one wanted to see a "prudent insurer" test of materiality operate in addition to a reasonable insured test. The only objections to this proposal came from those who opposed a reasonable insured test. The Lloyd's Market Association wished to preserve a test of materiality based on a reasonable insurer rather than a reasonable insured.

Where the policyholder thinks the insurer will obtain the information

2.97 A common reason why consumers do not fill in forms completely is because they think the insurer already has access to the information and will check the information for itself. In one survey, the main reason consumers gave for failing to provide all the relevant information on their medical history was that they assumed the insurer would ask their doctor.[17] Similar problems may occur where the insured knows that the insurer holds detailed information about previous claims or is in a much better position to check the area's flood history.

2.98 In our first issues paper, we considered whether there should be specific obligations on insurers to check their own records, or to obtain medical reports where they have gained consent for them. However, in the Consultation Paper we argued that this was too prescriptive, and may cause practical difficulties. Instead, we thought that the issue was best addressed as part of the reasonableness test.

2.99 We provisionally proposed that in considering whether an insured acted with insufficient care in failing to give information, the judge or ombudsman should consider how far it was reasonable for the insured to assume that the insurer would obtain that information for itself (CP para 12.16).

2.100 In particular, we were concerned about cases where the insurer suggested that it would obtain information from a third party (by for example asking the insured for consent to obtain a medical report). We thought that an insurer should not be allowed to rely on an honest misrepresentation if the insured reasonably thought that the insurer would obtain the relevant information from the third party (CP para 12.17).

2.101 Over half of the respondents agreed with us. In the Consultation Paper we suggested that, in practice, many of the problems could be solved by including clear warnings on forms (such as those recommended by the ABI). This, in particular, drew support. For example, RGA Reinsurance UK Ltd (RGA) endorsed the ABI guidelines on this issue. They thought that insurers:

> should warn proposers that they may not necessarily obtain a doctor's report and that providing an accurate disclosure remains their responsibility. [RGA]

2.102 The National Consumer Council disagreed with our proposals, arguing that insurers should be under an obligation to check information:

[17] Swiss Re Life and Health, *The Insurance Report* (2005) p 28.

> As the Consultation Paper acknowledges, the NCC made the point about insurers' access to databases etc in its 1997 Report. We remain of the view that in this technological age, insurers ought to be able easily to check a proposal form against information to which they have access, including in their own files and on Claims and Underwriting Exchange and publicly available information relating to flood risks. We firmly believe that they should be deemed to have this knowledge, notwithstanding alleged difficulties regarding incompatible systems etc. We are also very strongly of the view that they should be deemed to know what is in their own paper-based files. [NCC]

2.103 However, many insurers expressed considerable concern about any idea that insurers should be required to check files. It was thought to encourage dishonesty. The Investment & Life Assurance Group (ILAG) said it might create "an unfortunate loophole for the proposer to exploit". Some insurers suggested that although we were not proceeding with the idea that insurers should be deemed to know information on their files, our proposals would still allow consumers to raise this as an argument. As NFU Mutual put it:

> It will allow insureds to manipulate the system. For example, an insured might disclose a speeding conviction in the course of buying his house insurance but conceal the same conviction when purchasing motor insurance from the same insurer. On the current proposal, the insured would be able to raise a defence that the insurer ought to have checked its own records to discover the speeding conviction itself. Whilst insurers would probably still prevail in these circumstances…, the existence of a potential defence seems incongruous and unnecessary. [NFU Mutual]

2.104 The ABI commented that if insurers are to rely on questions they ask, they must be able to expect full and complete answers.

> There should be no scope for an insured to presume that an insurer already has information that they are specifically asking about in a proposal form. [ABI]

2.105 We agree that insurers are entitled to expect consumers to answer questions honestly and fully to the best of their knowledge and belief. Our proposals did not cover the situation where a consumer has deliberately or recklessly failed to give information. They deal with the more difficult issue of what standard of "reasonable care" a consumer must meet in obtaining and checking information. The proposals are designed to impose an objective test. The consumer must act reasonably in answering the question, but is not expected to go to "unreasonable" lengths in checking their own records, contacting their doctor, or searching external databases.

2.106 As we said in the Consultation Paper, it seems harsh to reject a claim because a consumer has not taken the trouble to find out the true facts, when the same can equally be said of the insurer. If the insurer expects a consumer to check papers relating to their claims or medical records in circumstances when the insurer is not prepared to carry out the checks itself, we thought that it must draw this obligation to the consumer's attention very clearly. Lloyd's suggested that this was particularly important on renewal when it came to giving information about previous claims with that insurer.

> In most cases the renewing insured will assume that his claims record is accessible to the insurer from the insurer's own records, and will be automatically available to the insurer in considering the renewal/premium etc. If this is not a valid assumption the insurer should be required to say so expressly. [Lloyd's]

Overview of responses

2.107 There is widespread support for the view that applicants who act honestly and reasonably should be protected. As the ABI point out, this is already in line with industry practice.

2.108 The challenge is to draft a test for what amounts to a "reasonable misrepresentation" that is at the right level of principle. The Act needs to give sufficient guidance about how the test applies, without being overly prescriptive in a changing market.

A CONTINUING DUTY OF DISCLOSURE?

2.109 In the Consultation Paper, we considered what should happen where a consumer made an innocent mistake on an application form and then discovered it was wrong. Should they have a duty to inform the insurer?

2.110 Under current law, if a party has stated a material fact that was true at the time, but ceases to be true before the contract has been made, they must correct the statement. A similar principle would apply if someone says something in good faith, and then discovers they are wrong.

2.111 However, once the contract has been made, the duty to disclose ends. There is no general or statutory obligation on the policyholder to inform the insurer of a change of circumstances. If an insurer wants to be notified about changing circumstances, they must add an express term to the policy. Such a term would be subject to review under the Unfair Terms in Consumer Contracts Regulations 1999.

2.112 It is common for critical illness cover to start several months after the policy has been agreed. Where this happens, insurers often include express terms requiring consumers to notify the insurer of any changes in their health between completing the application and the date that cover starts. These terms generate some dispute.[18] Where an insurer rejects a claim on the basis of a failure to notify after the contract has been formed but before cover starts, the FOS will look at the decision critically. Ombudsmen are prepared to overturn a decision if the applicant had not been given a clear warning.

2.113 Essentially we proposed to retain the current law. We provisionally proposed that:

(1) Where, before a proposal is accepted, a consumer proposer becomes aware that a statement they have made has become incorrect, they should continue to have a duty to inform the insurer. If they failed to do so unreasonably or dishonestly, the insurer should have a remedy. The insurer would not need to include an express term to this effect.

(2) There should be no general obligation to inform the insurer of the changes that became known to the insured only after the policy has been agreed. If insurers wished to receive such information, they would need to add an express term to that effect to the policy (CP para 12.18).

Before acceptance

2.114 The great majority of respondents agreed that consumers should have a duty to correct mistakes up until acceptance. A few respondents commented, however, that the insurer must bring this duty to the consumer's attention:

> We agree but only if the insurer brings the continuing duty of disclosure to the attention of the proposer and provides a list of the proposer's statements in order for the proposer to know whether any statements have changed. [FOS]

> We are strongly of the view that the duty should only apply if there was a clear warning about it given to the proposer. [NCC]

2.115 Under our proposal, the insurer would only have a remedy insofar as the failure was dishonest or unreasonable. The issue of warnings would be an important factor in assessing reasonableness.

After acceptance

2.116 The issue of a continuing duty to inform after acceptance drew more comments. Many lawyers and insurers asked whether they would continue to be entitled to add express terms to notify within their contract. We were asked to explain when such terms would be permitted and what their status would be. As the ABI put it:

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

> In the case of annual travel insurance, a policyholder is often required to disclose new illnesses/conditions before taking a trip but after the policy has been issued. It is not clear how such an instance would be dealt with under these proposals. [ABI]

2.117 Many life and protection insurers stressed the need for disclosure after agreement but before inception of the policy. As Scor Global Life put it:

> In the absence of such a disclosure regime, life insurers are exposed to a risk of anti-selection, particularly when there is a significant time lag between acceptance of the risk and the date the policy actually goes on risk – such delays typically occur when policyholders apply for cover in connection with a mortgage. Life insurers will typically ask the customer to sign a further Declaration of Health after three to six months in these cases. [Scor Global Life]

2.118 We think these comments are based on a misunderstanding. Under the current law, insurers may include an express term in the contract requiring such disclosure. This would continue. Our proposals do not involve changing the law in this regard.

NEGLIGENT MISREPRESENTATIONS: A COMPENSATORY REMEDY

2.119 Many misrepresentations are made honestly but negligently. This covers a broad swathe of conduct, where the policyholder failed to take sufficient care to understand what the insurer wanted to know or to check their facts. In the Consultation Paper, we said that we did not need a separate definition of negligence. A misrepresentation is negligent if it is not deliberate or reckless (as discussed above), but was not made with reasonable care.

2.120 For negligent misrepresentations, we thought that the insurer should have a remedy - but the right to avoid the whole policy went further than was necessary to protect the insurer. Avoidance, for example, allows an insurer to refuse a claim for cancer because they were not told about hearing loss - even if, had they known about the hearing loss, they would only have excluded hearing claims from the policy.

2.121 We said that the law should aim to place the insurer in the same position as it would have been in had it known the true facts. This would involve looking at what this particular insurer would have done. For example:

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

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

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

(4) Where an insurer would have charged more, the claim should be reduced proportionately to the under-payment of premium. For example, if an insurer would have charged £2,000, but only charged £1,000, the consumer would receive half their claim (CP para 12.19).

Arguments in favour

2.122 Around three-quarters (74%) of those who addressed this issue agreed. The FOS, for example, thought it was a fair and workable solution:

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

2.123 The Chartered Insurance Institute agreed and welcomed the change in principle:

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

2.124 Lloyd's reluctantly accepted it as current FOS practice:

> We agree, not in principle, but rather on the basis that this proposal will bring the substantive law as regards consumers into line with established FOS practice and it is undesirable to have concurrent conflicting systems. [Lloyd's]

Possible problems

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

2.126 The first difficulty raised was proving what an insurer would have done had it known the information. The ABI commented that there were many ways in which an insurer might have reacted, and the test could not deal with every possible eventuality. Insurers would be left re-rating the claim with hindsight, after the loss had occurred. The Liverpool Underwriters and Maritime Association agreed that the proposal would "increase post loss underwriting". It would also "require voluminous disclosure to be given, contrary to the CPR [Civil Procedure Rules]". Lloyds pointed out that this would be a particular problem where the court rejects an insurer's argument that it would have declined the policy. The court will then be left with no evidence about what an appropriate premium may have been.

2.127 Several life and protection insurers asked what would happen if the insurer would have postponed a decision pending further tests. In these circumstances, the court or ombudsman would need to go on to ask what the result of the test would be likely to be. The ABI pointed out that it is not always possible to answer this question with precision. For example, if a customer had a history of sexually transmitted infections the insurer may have asked for an HIV test. It may not be possible to know what the result would have been: "having a positive HIV test at the point of claim is not proof that the customer was positive at the point of proposal". Our view was that there would be some uncertainties of this sort, but that the problem would not be overwhelming.

2.128 Friends Provident pointed out that proportionate remedies may lead to arbitrary results, when seen from a consumer's point of view. For example, insurers often make premium additions for mild cases and exclusions for more serious problems. This means that if two people make identical misrepresentations, the person with the mild case may receive only a proportionate settlement, while the person with the more serious case may have an unrelated problem and be paid in full. We would reply, however, that results of this type occur whenever the law compensates the victims of negligence. The amount is based on the victim's loss, and may have little to do with the extent of the perpetrator's fault.

2.129 K&L Gates, a solicitors' firm who only represent policyholders, were concerned about limb 3. This allows insurers to avoid when they can show they would not have accepted the risk at all. They thought that insurers should always produce supporting evidence for such a claim.

2.130 Several insurers thought that proportionate payments under limb 4 were suitable for minor increases in premium, but would give insurers inadequate compensation where the premium would have been increased substantially.

> Aviva believes these proposals present a reasonable approach where there is an honest but negligent misrepresentation, which results in a small additional premium. However, Aviva is slightly concerned about "fronting" cases where the premium could be 2 or 3 times what the client originally paid. [Aviva]

> There should be consideration of a threshold above which the claim should be denied. It is not fair to charge honest applicants rated terms and allow others to be no worse off in all the circumstances even if there is a negligent misrepresentation. For example, life insurers should not be expected to treat someone whose premium should be rated at up to +50% extra mortality the same as someone whose premium would be rated at +400% extra mortality. [ABI]

2.131 The advantage of proportionate payments is that the effect of the misrepresentation on the insurer is directly related to the size of the payment. Take a case where a consumer insured their life for £100,000 and paid a premium of £500. If the premium ought to have been 50% higher (that is, £750), the consumer has paid only two-thirds of the correct premium and hence will be entitled to only two-thirds of the sum assured (£66,667). If, however, the premium should have been 400% higher (that is, £2,500), then the consumer has paid only one-fifth of the correct premium and accordingly will be entitled to only one-fifth of the sum assured (£20,000). This means that those who make more significant misrepresentations will receive substantially less in payment, without the need for an arbitrary threshold.

Overview of responses

2.132 Proportionate remedies are now an accepted part of FOS decisions, and are widely regarded as workable and just. In some cases it will not be possible to say what the insurer would have done with scientific precision and the court or ombudsman will need to make their best estimate. However, courts and ombudsmen are used to this. It occurs wherever the law attempts to put people in the position they would have been in had an event not taken place. It may be better to aim imprecisely at the right target than to aim precisely at the wrong one, as avoidance does.

CLAIMS THAT ARE UNRELATED TO THE MISREPRESENTATION

2.133 The compensatory approach considers what the insurer would have done had it known the information at the time of underwriting. It does not look at whether there is any causal link between the misrepresentation and the claim. For example, if an insurer would have charged three times more for a buildings insurance premium had it known of a flood risk, it will only have to pay a third of a burglary claim. It is irrelevant that the burglary was completely unconnected to the risk of flooding.

2.134 In the Consultation Paper we considered – and rejected – an alternative approach, which would have looked at whether there was a causal connection between the misrepresented information and the claim (CP para 12.22). This is the approach in some other European systems. The Restatement of European Insurance Contract Law, for example, gives the insurer a remedy only "if an insured event is caused by an element of the risk that is the subject of negligent non-disclosure or misrepresentation by the policyholder".[19]

[19] Draft 17 December 2007, art 2:102(5).

2.135 We acknowledged that denying claims for unrelated issues may sometimes seem unfair. For example, if a policyholder dies in a rail crash, it can appear distasteful for the insurer to trawl through medical notes looking for a careless omission about anti-depressants. However, we did not think that requiring a causal connection was practical. Many questions are about criminal records or previous claims. Although the fact that someone was involved in a motor accident last year does not cause an accident next year, it is still highly relevant to the risk. Similarly, an insurer may find information about previous depression relevant to the risk of serious illness without being able to prove a causal link between depression and cancer.

2.136 Almost everyone who addressed the causal connection point agreed with us that a causal connection should not be required between the misrepresented information and the claim.[20] The exception was Ray Hodgin of the University of Birmingham, who argued that the negligence could be minor and the unconnected claim may be major: "it seems unfair that the insurer should be able to escape all payments".

2.137 The National Consumer Council also thought that allowing insurers to avoid for unconnected reasons could lead to some harsh decisions. They agreed with us only on condition that there was a discretion to prevent clear injustice: otherwise it may be necessary to reconsider imposing a causal connection requirement.

IS THERE A NEED FOR A JUDICIAL DISCRETION?

2.138 In the Consultation Paper, we argued that in general a compensatory approach would be fair between the parties. However, we pointed out that it may operate harshly in some cases.

2.139 One problem is that where an insurer would have declined the risk, the policy is avoided. However, another insurer may have accepted the risk for only a small increase in premium. Similarly, the misrepresentation may have nothing at all to do with the claim. We thought this problem would be compounded where the mistake was negligent but the consumer would be regarded as acting excusably in their particular circumstances.

2.140 We gave the example of a recently bereaved widow who failed to notice signs of subsidence. This may have been negligent but totally understandable in the circumstances of her individual case. We commented that it would be reasonable for an insurer to refuse to pay a subsidence claim that it would never have taken on had it known. However, our proposals mean that if the insurer shows that had it known about the subsidence it would not have written the policy at all, it may refuse to pay her burglary claim. This might be thought by some to be overly harsh.

[20] However, several respondents said they did not understand the question. A few misread it: they thought we had proposed a causal connection test, rather than rejecting one, and they argued against such a test.

2.141 We therefore asked whether there was 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 was minor, and any prejudice the insurer suffered could be adequately compensated by a reduction in the claim (CP para 12.20).

Responses

2.142 Out of 64 responses to this question, around 40% answered that a discretion was necessary. Some consumer organisations thought that it was needed to off-set potential injustices in our proposals. Age Concern thought that "the discretion would go some way towards balancing any unfairness that might arise from a definition of 'unreasonableness' that ignored personal circumstances". Similarly, the National Consumer Council thought that it was important where the insurer refused a claim for unconnected reasons.

2.143 Some people thought that a new statutory discretion was unnecessary. The FOS pointed out that it already had "an overriding obligation to reach a decision that is fair and reasonable". Effectively, therefore, it could operate such a discretion even if it was not specifically included in legislation. Professor John Lowry thought that the courts could come to a similar result by finding that "good faith applies to the exercise of this remedy".

2.144 However, the majority of respondents opposed the discretion in principle. Most insurers and insurance organisations thought that it would introduce uncertainty and lead to unacceptable interference with insurers' freedom to write business. For example, BILA described our proposal as an "uncertain test, which will lead to fewer cases settling". The ABI said it would "effectively allow interference with insurers underwriting practices". Zurich Financial Services said that it was not clear what effect this would have on reinsurance.

2.145 Many respondents found it difficult to understand how it might operate. For example, Lord Justice Rix thought that there might be a case for some discretion, but it "should be narrowly confined, e.g. where the loss is unrelated to the fault and the fault does not extend to fraud or recklessness". However, he criticised the formulation set out in the Consultation Paper:

> It is not clear how, on the hypothesis that the insurer would have declined the proposal, the insurer "could be adequately compensated by a reduction in the claim". I agree that the case where the insurer in particular would have declined the claim, but his competitor would not (but would have raised the premium, etc) may need some special rule, at any rate in cases of hardship. [Lord Justice Rix]

Overview of responses

2.146 Consumer groups generally welcomed the proposed discretion, while most insurers opposed it. The FOS saw it as unnecessary, as the FOS already has a discretion to reach decisions that are fair and reasonable.

The ABI Guidance

2.147 The ABI Guidance on Non-Disclosure and Treating Customers Fairly issued in January 2008 raises several cases where the industry thinks it would be unfair to reject claims, even if this would be the result of applying a compensatory remedy. The most obvious case is where an insurer goes on a "fishing expedition" for misrepresentations that are unconnected with the claim. The example given in the Guidance is Case 2, where a man takes out life insurance and is then killed in a traffic collision. The Guidance spells out that where there is no evidence to suggest that the customer had a contributory medical condition, the insurer should pay the claim. It should not look through medical records to see whether the insured had failed to disclose some unconnected medical condition.

2.148 We can see that fishing expeditions of this sort cause public disquiet. It seems wrong that insurers should "underwrite at claims stage" by trawling through unconnected issues. However, under the strict regime we have set out above, the insurer would be entitled to point to an unconnected careless error. If, for example, the insurer can show that if questions about family history or weight were answered incorrectly, it can adduce evidence of what the insurer would have done had it known the correct information. If the insurer would have increased the premium, it may pay only a proportion of the claim. If it would have declined cover, it may refuse the whole claim.

2.149 The ABI Guidance deals with this issue as a matter of evidence: the insurer may not rely on medical information that has been wrongly obtained. However, we think it will be difficult to set hard rules about what evidence may be used, especially where a doctor has sent more information than was asked for. If the industry thinks that it would be wrong to deny a claim for a death in a traffic collision for unconnected misrepresentations (despite the fact that it tells us that a causal connection test is the wrong one), then we ask whether it would be better to provide a discretion to address this issue.

2.150 Similarly, the ABI acknowledges that it seems unfair to reduce claims as a result of questions that address different risks. Case 11 gives an example where a woman takes out critical illness insurance with total permanent disability benefit (TPD). She fails to mention a history of back problems, which was relevant only to the TPD, and then submits a valid claim for breast cancer. The Guidance suggests that the TPD should be treated as severable, so that a misrepresentation in connection with the TPD should not affect the cancer claim. However, as a matter of strict law the TPD element may not necessarily be severable in this way. It would depend on the construction of the particular policy.

2.151 Surprisingly, the ABI suggests that the claims should be paid even where the misrepresentation is dishonest. As already discussed, the Consultation Paper argued against a lenient approach to those who act dishonestly. However, we thought that there is a case for leniency for excusable errors. The ABI Guidance is clearly attempting to find ways to mitigate harsh results when claims would be denied or substantially reduced for reasons unconnected with the claim. Further thought needs to be given to whether these initiatives should be built into our proposed scheme, and if so, how this might best be done.

CANCELLING FOR THE FUTURE

2.152 In the Consultation Paper we briefly considered the effect of a misrepresentation on future cover.

2.153 We thought that where an insurer would have declined cover, the policy should be avoided, and the premium returned (as happens at present). However, where the insurer would have offered the policy on different terms, we preferred the current FOS practice to the strict letter of the law. The FOS generally allows the consumer a choice. For an inadvertent misrepresentation, the policy may be avoided and the premium returned. Alternatively, the cover may continue on amended terms. For example, the consumer may pay an additional premium. Alternatively, the cover may continue for the same premium, but subject to an exclusion. We pointed out, however, that this would not prevent the insurer from relying on a more general contractual right to cancel on notice (CP para 12.21).

2.154 This proposal drew relatively little comment. Most issues of misrepresentation arise in the context of claims, and disputes about future cover are relatively rare. Only 51 consultees addressed the issue, and of those who did, two thirds (67%) simply agreed without comment.

2.155 A minority of insurers opposed the proposal, on the grounds that insurers should not be forced to contract with those who have behaved negligently.

NEGLIGENT MISREPRESENTATIONS IN LIFE POLICIES: SHOULD THE LAW IMPOSE A CUT-OFF PERIOD?

2.156 Particular problems may arise in long-term business where many years may elapse between filling in the proposal form and making the claim. In the Consultation Paper, we noted that many jurisdictions dealt with this issue by imposing cut-off periods. This means that the insurer is prevented from relying on a non-fraudulent misrepresentation at the applications stage once the policy has been in force for a set period – usually between two and five years.

2.157 In our first issues paper, we asked whether insurers should be prevented from relying on non-fraudulent misrepresentations after the policy has been in force for three years. This drew strong reactions, both for and against. Some argued that it would increase consumer confidence. Others thought it would encourage fraud, increase costs and lead to inconsistent treatment between consumers.

2.158 We were told that at present most life insurers do not investigate non-disclosures made more than five years previously in the absence of evidence of fraud. It was suggested that it would increase consumer confidence to have this good industry practice built into law, without adding substantially to costs. On this basis we asked whether in consumer life insurance, insurers should be prevented from relying on a negligent misrepresentation after the policy has been in force for five years (CP para 12.23).

Responses

2.159 Respondents were again split on this issue. Of the 61 consultees who addressed this issue, 34 were in favour; 24 thought that there should not be a cut-off period; while three would have preferred the shorter period of three years.

2.160 The FOS commented that they did not think this proposal would have a significant effect if the other proposals were enacted. However, they did see some benefit:

> It would serve as an additional safeguard for consumers, knowing that their cover would enjoy extra certainty after five years. It would also serve as a practical safeguard against insurers wrongly disputing claims after five years and relying on consumers and their executors or relatives having the capability and fortitude to challenge them. [FOS]

2.161 Some insurers gave tentative agreement, on the basis that the proposal did not extend to fraud, only applied to life cover, and was five years (rather than the original three). Aegon UK, for example said there would have to be a very clear definition of consumer life insurance, especially in umbrella policies. Scottish Re said they would agree with this proposal provided that it was made absolutely clear that deliberate or reckless misrepresentations remained actionable after five years, and that where the insurer asked a clear question the proposer should be taken to know the fact was relevant. In these circumstances, they did not think the proposal would lead to consumers taking calculated risks in not disclosing illnesses.

2.162 However, a majority of insurers (including most life insurers) opposed the proposal, on the grounds that it would lead to more misrepresentations in life policies and increase costs.

2.163 Insurers feared the effect of such a rule on consumer behaviour. For example Scor Global Life accepted that it was already standard practice in the life industry to disregard minor matters if the policy has been in force for five years or longer. However, it was hard to predict how consumers would react if this was known to be a hard and fast rule. Given the difficulties of costing the effect, it was better not to take the risk. Similarly Friends Provident said that the FOS had sometimes applied a five-year cut off. However, it was very different for the FOS to do this because it was fair and reasonable in the individual case and for the courts to do it as a matter of law.

2.164 Some argued that there was no logic to apply more restrictive tests to life insurance than to other long term insurance, including critical illness and income protection. Others, however, suggested that fraud was more of a problem in relation to critical illness and income protection insurance because the insured was alive to enjoy the benefits of it. Insurers therefore needed greater protection in relation to these policies.

NO CONTRACTING OUT

Mandatory rules for consumer insurance

2.165 In the Consultation Paper we argued that insurers should not be entitled to give themselves greater rights to reject claims for non-disclosure and misrepresentation by adding terms to their contract to this effect. We provisionally proposed that it should not be possible to contract out of the consumer rules governing misrepresentation and non-disclosure in consumer insurance except in favour of the consumer (CP para 12.24).

2.166 Almost everyone who responded to this question agreed. The FOS described it as "an essential element of the reform".

Statements of past and present fact

2.167 The strict letter of insurance contract law allows insurers to increase their legal rights for misrepresentation by using warranties of existing and past fact. If a policyholder agrees to a contractual term that warrants that a fact is true, the Marine Insurance Act 1906 provides that the insurer is automatically discharged from liability under the policy if the fact is untrue.[21] This may occur even if the warranty is immaterial and given in good faith.

2.168 Historically, insurers used these terms to increase their rights. In particular, the law allowed insurers to turn all the facts given on an application form into warranties by stating that these form "the basis of the contract". In law, the effect of a "basis of the contract" clause was that any mistake on the form, however innocent and however immaterial, would entitle the insurer to refuse all claims.[22]

2.169 It is now generally accepted that in the consumer market insurers should not rely on basis of the contract clauses. In 1986 the ABI Statement of General Insurance Practice barred their use, and the FOS would reject any defence based on them. Although the FSA rules do not specifically mention basis of the contract clauses, the ABI has confirmed to us that it would consider the use of such clauses to contravene insurers' duty to treat customers fairly.

2.170 We thought that the law should be reformed to prevent insurers from using warranties of past or present fact or basis of the contract clauses to add to their rights for misrepresentation. We provisionally proposed to follow the Australian approach, which provides that a statement by the insured about past or present fact takes effect as a representation rather than as a warranty (CP para 12.25).

Responses

2.171 The great majority of respondents agreed with us. Out of 57 responses, 53 simply agreed without comment.

The ABI, Fortis Insurance Ltd and ACE European Group disagreed. They thought that insurers may want to include warranties for past or existing facts for good reason, though they did not give any illustrations. We find it difficult to think of examples where characterising a statement of past fact as a warranty would be both helpful to the insurer and fair to the policyholder.

Overview of responses

2.172 There is a widespread consensus in favour of making the consumer regime mandatory, in the sense that insurers will not be entitled to contract out of it except in favour of the consumer.

[21] Marine Insurance Act 1906, s 33.

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

PART 3
GROUP INSURANCE, CO-INSURANCE AND INSURANCE ON THE LIFE OF ANOTHER

GROUP INSURANCE

3.1 In the Consultation Paper, the Law Commissions discussed how issues of non-disclosure should be treated in relation to group schemes. We focused on group insurance provided by employers for their employees. This is an important form of protection insurance: nearly 40% of life cover, for example, is provided through such schemes. Yet the legal principles that apply to such schemes are uncertain and under-developed. Our objective was to bring the law into line with the FOS approach and accepted practice in the market.

3.2 Our proposals made a sharp distinction between representations made by the policyholder (usually the employer) and those made by individual group members (as where an employee fills in a health declaration form). We thought that where the employer failed to provide correct information, it should be treated under the business scheme.

3.3 However, we proposed that where a misrepresentation was made by a group member (such as an employee):

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

(2) Any dispute should be determined in accordance with our proposals for consumer insurance. Thus if a group member had misrepresented their health on a declaration form, the court or ombudsman should ask whether the misrepresentation was innocent, negligent or deliberate/reckless (CP para 12.44).

Misrepresentations by individual group members

Applying consumer-type remedies

3.4 Most respondents agreed with our proposals. Out of 46 respondents, over half (54%) agreed without comment. The FOS said that the proposal reflected current market practice, which it has adopted.

3.5 By contrast, the ABI thought there was no need for reform, as the current legal situation was satisfactory. They said:

> On the basis that the proposals are already market practice, we are unconvinced that the case has been made for any reform or intervention by the Law Commission. Further, we are keen to protect insurers' freedom of contract in negotiating more tailored remedies. [ABI]

They were supported in this by three other insurers.

3.6 No one argued that a misrepresentation by an individual member should affect others within the group. However, a handful of insurers expressed unease about treating misrepresentations by group members under the consumer regime. For example, the Investment and Life Assurance Group (ILAG) commented that "the dispute should not be dealt with under consumer insurance rules as the employer – not the employee – is the policyholder". Scottish Widows thought that treating group members as consumers would create practical difficulties:

> This scenario expects a life office to be able to readily switch between insurance regimes. In practice, this will only create unnecessary administrative confusion with resultant delay or complaint over the handling of a claim. [Scottish Widows]

3.7 The Group Risk Development Group (GriD) also thought that it would create confusion and administrative delays, as the policy itself is business insurance.

Free cover

3.8 In the Consultation Paper we asked what should happen where a group member made a deliberate or reckless misrepresentation, but the insurer would have given a certain level of "free cover" without that information. Should the insurer be entitled to refuse all benefits in respect of that member? Alternatively, should the law support current practice? This provides the member with the so called "free cover" that would have been provided in any event, provided the basic eligibility criteria for the scheme are met (CP para 12.45(1)).

3.9 Only a few respondents addressed the issue, and among those who did, views were fairly evenly divided. Nine respondents argued that where the member has made a deliberate or reckless misrepresentation, the insurer should be entitled to refuse all benefits in respect of that member. Eight respondents agreed with the alternative option of providing the free cover subject to satisfying the eligibility criteria for the scheme.

3.10 The FOS thought that free cover should be given:

> If the insurer would have provided a certain level of free cover in any event in respect of that member without underwriting, then arguably, there is no "inducement" in respect of that free cover, and the insurer should not be able to rely on non-disclosure to avoid that element of cover. [FOS][23]

3.11 However, the Faculty of Advocates believed that insurers should not be compelled to make provision for the minimum free cover, even though it is done in practice:

[23] This would be true only if the free cover and extended cover were in separate or severable policies. If the policy were treated as a whole, then there would be inducement if the insurer had offered different terms, such as a greater level of cover.

> The insurer should not be compelled to make such provision. "Free cover" is only "free" in one sense. In another sense, it costs the insurer. In our view, the insurer should continue to have discretion in dealing with such circumstances, and should continue to be entitled to refuse all benefits in respect of that member. This promotes consistency of treatment in relation to deliberate or reckless misrepresentations made by any proposer. We would not expect the [current] accepted practice necessarily to change. [Faculty of Advocates]

3.12 Friends Provident also said that they do not want a law requiring free cover to be given. They would still honour claims for free cover in such circumstances.

> However, to make a law requiring this to be done would set a precedent which is inconsistent from the general message of this new legislation. [Friends Provident]

3.13 The Liverpool Underwriters and Marine Association believe that this proposal offends Lord Hobhouse's comments made in the case of *The Star Sea*: "the fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing".[24]

Overview of responses

3.14 Most people agree that if a policyholder has made a misrepresentation to a group insurer, the ombudsman should apply normal consumer-type remedies. This would involve, for example, providing proportionate remedies for negligent misrepresentations and avoiding the policy for deliberate/reckless ones.

3.15 Some insurers expressed concern that group insurance should not be treated under the consumer regime. However, they did not appear to be suggesting that a group member should, for example, be required to volunteer information in the same way as a business policyholder. Rather insurers seemed to be expressing a more general concern that if group members were treated as consumers for this purpose, then other elements of consumer regulation would be imposed upon them. This was not our intention. We were not saying that group insurance is consumer insurance – simply that the insurer's remedies against a group member for a misrepresentation should be similar to the one we have proposed for consumers. Most people thought that the FOS practice of treating group members in this way works well, and should be supported by statute.

3.16 The arguments over "free cover" are finely balanced, and there was no clear consensus on this issue.

[24] *Manifest Shipping Ltd v Uni-Polaris Insurance Ltd – the 'Star Sea'* [2001] 1 Lloyd's Rep 389 at 403.

Misrepresentations by the policyholder (employer)

3.17 Under our reforms, if the policyholder makes a misrepresentation or non-disclosure, it would be regarded as a commercial matter and dealt with under the business regime. In our Consultation Paper we asked if consultees agree that a non-disclosure or misrepresentation by the policyholder should provide the insurer with the same rights to avoid a policy as would apply to other business insurance (CP para 12.45(2)).

Arguments in favour of applying a business regime

3.18 The majority of the respondents agreed that the insurer should still have the right to avoid. Aegon UK argued that this is a vital remedy as

> a non-disclosure/misrepresentation by the policyholder could have a fundamental impact on an insurer in financial terms. [Aegon UK]

3.19 ILAG believed that businesses should be held to a higher standard than members under a group scheme, on the basis that:

> the employer should be expected to have greater knowledge than the group member does. [ILAG]

3.20 GRiD also agreed, but pointed out that it "could leave all employees under the policy without cover, which could have other far-reaching implications".

Arguments against applying the business regime

3.21 Eleven respondents disagreed with this proposal, on the grounds that it would have an unduly harsh impact on employees. They feared that employees would be deprived of cover by mistakes that are not their own. As K&L Gates put it:

> It would seem excessively harsh on the employees for them to lose any potential benefits under the policy as a result of a misrepresentation or non-disclosure of which they were unaware and over which they had no control. [K&L Gates]

3.22 The FOS believed that all employee benefits under a group scheme should be protected where an employer has made a misrepresentation or a non-disclosure:

> Where the insurer has with the knowledge of the employer held the insurance out to the employees, as being for their direct benefit then the employee's right to claim under the policy should not be affected by the employer's misrepresentation or non-disclosure. The insurer would no doubt seek to recover its liability to employees in these circumstances from the employer under the terms of the policy between them. [FOS]

Overview of responses

3.23 Some group schemes cover thousands of employees. If an insurer were to avoid such policies the results could be serious, as many employees would find themselves without cover through no fault of their own. They may well have a claim against their employer, but this will not help them if the employer becomes insolvent.

3.24 However, the same problems arise for third party claimants in many situations. Most respondents did not think this was a problem that could be solved by contract law. Insurers were concerned about any suggestion that they might lose the right to avoid a policy against an employer who breached their duty of disclosure.

Other types of group insurance

3.25 In the Consultation Paper, we asked consultees if they were aware of problems in other types of group insurance, which were not linked to the employer/employee relationship. We asked whether similar rules should also apply to those types of group scheme (CP para 12.46).

3.26 Several respondents mentioned group schemes that only apply in the business context (such as construction policies, P&I policies and parent and subsidiary policies).

3.27 The only types of policy mentioned that are relevant in the consumer field were block building policies. The FOS said that they occasionally consider complaints from tenants who benefit from block building policies, where the tenant's interest is noted on the policy. In those circumstances they treat the tenant as though they had arranged the insurance directly with the insurer (that is as a consumer) even though the actual policyholder tends to be a limited company. Friends Provident also mentioned these types of policy.

CO-INSURANCE

3.28 In the Consultation Paper we explained that the current law draws a distinction between "joint" policies and "composite" policies. Co-insureds under a joint policy stand or fall together. However, where a policy is composite, an innocent co-insured is unaffected by their co-insured's misrepresentation.

3.29 We said that we would return to this distinction when we looked at fraudulent claims. However, in the context of pre-contractual information we did not propose any changes. We asked consultees if they were aware of any problems concerning the law of co-insurance in relation to issues of non-disclosure and misrepresentation (CP para 12.47).

Agreement

3.30 Out of the 35 respondents who gave their views on this question, most said that there are no problems with this area of law. Scottish Widows and Allianz said they did not want to see any changes being made. The National Consumer Council also said that the current law is satisfactory:

> The law in this area is probably satisfactory and those consumer co-insureds will be protected sufficiently by the proposed reforms for consumer insurance generally. [NCC]

Problems with the current law

3.31 Several people raised difficulties with the joint/composite distinction. Professor Robert Merkin argued that there are "massive problems". He raised doubts about whether the co-insurance rule applies to warranties, and thought that *Arab Bank v Zurich Insurance Co*[25] did not resolve the issue. There were regular difficulties in the professional indemnity market:

> It is necessary to decide who knew what, whether that person's knowledge is imputed to other co-assureds and whether the position is different where the person who signs the proposal form is himself in possession of material facts. [Professor Merkin]

3.32 Several other respondents, including the Bar Council's Law Reform Committee also highlighted the problems that can arise in professional indemnity and directors' and officers' liability policies. As far as consumers were concerned, Age Concern raised possible problems with travel insurance.

3.33 The ABI thought that the law was satisfactory, but said the issue was of growing importance where unrelated individuals bought homes together. One respondent said that it was unclear whether such a policy would be joint (as joint or co-owners of the property) or composite (having separate possession).

Overview of responses

3.34 The distinction between joint and composite insurance is a difficult one. However, most of the problems arise in business insurance, particularly in professional indemnity and directors' and officers' liability policies. We shall be returning to the issue in the context of fraudulent claims and business insurance. Most people did not think that there was an urgent need for reform in the context of consumer misrepresentations.

INSURANCE ON THE LIFE OF ANOTHER

Consumer life-of-another policies: misrepresentations by the life insured

3.35 This issue arises where the consumer policyholder takes out insurance on another person's life. The person whose life is being insured is asked questions about their age and state of health and the insurer relies on that information when writing the risk. However, the life insured is not a party to the contract. This means that if the life insured makes a misrepresentation the insurer would not normally be entitled to a remedy unless the policyholder knows of it.

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

[25] [1999] 1 Lloyd's Rep 262.

3.37 In the Consultation Paper, we said that in the absence of an agreement to the contrary, the policyholder should bear the risk that the person whose life is insured has acted negligently or dishonestly. Therefore, we provisionally proposed that in consumer life-of-another policies, representations by the life to be insured should be treated as if they were representations by the policyholder. If the insurer can show that either the life insured or the policyholder (or both) behaved deliberately, recklessly or negligently, it will have the remedy that is appropriate for that kind of conduct (CP para 12.48).

3.38 All of the 35 replies we received agreed with the proposal.

Parallel issues in other consumer contexts

3.39 In the Consultation Paper, we asked consultees whether parallel issues arise in other consumer contexts and, if so, whether the same solution is appropriate (CP para 12.49).

3.40 The ABI pointed out that problems might arise where there are additional drivers on motor policies and the driving history of those drivers has to be obtained and provided by the policyholder. The extent of the policyholder's knowledge of the driver's true history will vary from case to case.

> It may be useful to clarify the position of persons who are not the contracting party but who may be entitled to an indemnity and in respect of whom information is provided to the policyholder. [ABI]

3.41 Munich Re UK Life Branch said problems can arise with policies written under trust. In those circumstances they suggest that the same solution should also apply.

Overview of responses

3.42 Everyone agreed that representations by the life to be insured should be treated as if they were representations by the policyholder. It was suggested that similar problems might arise in other areas, such as motor insurance which covers named drivers who are not parties to the contract.

CONSUMER INSURANCE: "JOINT LIVES, FIRST DEATH" POLICIES

3.43 An example of a "joint lives, first death" policy is where spouses take out a joint policy on each other's lives to be paid out on the first person's death. Problems arise when one spouse makes a deliberate misrepresentation without the other party's knowledge. Under current law and ombudsman practice, the insurer may refuse the claim irrespective of which party survives and makes the claim. In our Consultation Paper we asked whether consultees agreed that in a "joint life, first death" policy, the insurer should be entitled to refuse claims where either the deceased or the beneficiary has made a deliberate or reckless misrepresentation (CP para 12.50).

3.44 Thirty-three respondents gave their views on this question and almost all of them agreed with this proposal. Aegon UK said that it should make no difference as to who made the misrepresentation:

> One policyholder should be tainted by the actions of the other (whether or not the insurer may decide to pay a claim where it was the beneficiary that made the misrepresentation should be left to the discretion of the insurer). [Aegon UK]

Continuing the policy for the innocent party

3.45 At present, when the guilty party dies and the claim is rejected, the FOS may use its discretion to order the insurer to continue the policy on the life of the innocent party. We asked whether this should continue within a statutory scheme. Should the court or ombudsman have discretion to order the insurer to continue the policy as a single life policy, payable on the death of the innocent party (CP para 12.51)?

3.46 Of the 35 respondents answering this question, two-thirds agreed that the court or the FOS should be given discretion to adjust joint life policies in this way.

3.47 Scor Global Life agreed with this proposal in principle, but pointed out that various practical issues may arise. They believe the court and the FOS would need to consider factors such as premium rates and terms of cover before making such an order, bearing in mind that the rates and terms of the original policy may not be appropriate.

3.48 One broker believed that consideration should be given to a refund of the premiums relating to the party whose life insurers have declined to pay to the party who was expecting to receive the benefit of the policy. The City of London Law Society made the same point:

> The court or ombudsman should have the alternative of ordering a return of the premium or the policy value to the survivor, subject to any tax implications. [City of London Law Society]

Overview of responses

3.49 There was general support for the view that in a "joint life, first death" policy, the insurer should be entitled to refuse claims where either the deceased or the beneficiary has made a deliberate or reckless misrepresentation.

3.50 There was less agreement about what should happen following the guilty party's death. Some thought that the policy should be extended on the innocent party's own life, while others thought that the premiums should be returned to the survivor.

PART 4
WARRANTIES AS TO THE FUTURE

INTRODUCTION

4.1 In our Consultation Paper, we divided our discussion of warranties into two parts. We considered warranties of past or present fact alongside other forms of pre-contract information. We have already summarised the responses we received on this issue.

4.2 Warranties about future conduct were discussed in Part 7 of the Consultation Paper and our detailed provisional proposals were set out in Part 8. By and large, we proposed dealing with future warranties in the same way in both business and consumer policies, and our provisional proposals often did not distinguish between the two.

4.3 Future warranties are much more important in commercial policies than in consumer policies, and most people who considered our reforms on future warranties addressed them from a business point of view. We will therefore publish a more detailed account of responses on our future warranty proposals in our next Summary Paper, which will deal with our business proposals.

4.4 The current team view is that we should not reform the law of warranties separately for consumer insurance. Instead, the issue should be addressed for both consumers and businesses together. Below we provide a brief description of our proposals on this issue, and our reasons for looking at warranties on a combined basis across both consumer and business insurance.

WHAT IS A WARRANTY? A WIDE OR NARROW DEFINITION

4.5 As we explained in our Consultation Paper, the same obligation can be phrased in different ways. A consumer may "warrant" to fit (and use) a mortice deadlock: alternatively, the policy may exclude burglary claims unless a mortice deadlock was fitted (and in use) at the time of the loss. Under strict law these two provisions have different consequences.

(1) The first may be considered a warranty. If so, section 33 of the Marine Insurance Act 1906 provides that if the policyholder commits a minor breach (by for example fitting the lock a week after the promised date) the insurer is discharged from all future liability under the policy. The insurer would not be liable for a subsequent burglary, even if the mortice lock had been fitted by the time the burglary took place.

(2) The second approach would be a "temporal condition". The insurer could only refuse to pay a claim if it could show that the lock was not in use at the time of the burglary. However, it would not have to show that the lack of a lock made any difference. It could refuse a claim even if the burglars had climbed in through a smashed window.

4.6 It has long been accepted that the strict legal consequences of a breach of warranty would be overly harsh if applied to consumers. In 1986, the ABI Statement of Practice provided that insurers would not reject a claim unless the circumstances of the claim were connected to the breach. This now forms part of the FSA rules.[26]

4.7 Technically, the FSA requirement for a causal connection between the breach and the loss only applies to warranties in the strict sense. However, the FOS has interpreted its spirit more widely, to apply to temporal exclusions as well. In the Consultation Paper we quoted a case where the complainant claimed for a stolen bicycle that had not been locked at the time. Although the requirement for a lock had been phrased as a temporal exclusion rather than a warranty, the ombudsman allowed the claim on the grounds that the lock would not have made a difference. The circumstances of this particular claim were not causally related to the breach.

4.8 We thought that insurers should only be entitled to refuse claims for breach of warranty if there was some causal connection between the breach and the loss. The more difficult decision, however, was whether this reform should only apply to warranties in the strict sense, or whether it should also apply to terms that had the same effect.

The Issues Paper approach: a wide definition

4.9 In Issues Paper 2, published in November 2006, we thought that a causal connection should be required not only for warranties but also for terms that had the same effect. We suggested following the Australian model. This applies a requirement for a causal connection to all exclusions based on acts or omissions by the insured that "could reasonably be regarded as capable of causing or contributing to a loss".[27]

4.10 However, we accepted that some provisions were so important that the policyholder should not be able to claim even if the loss were not connected with the breach. These might include, for example, provisions about whether a car was used for private or business purposes; about the age or identity of a driver; or the geographic area in which the loss took place. We tentatively proposed that these terms should be specifically excluded from the requirement for a causal connection. Many of those responding to the Issues Paper thought these proposals were unduly complex and arbitrary.

The Consultation Paper: a narrow definition, coupled with a "reasonable expectations" approach

4.11 In the Consultation Paper we proposed a different approach. We said that the causal connection test should be confined to warranties in the strict sense.

[26] ICOB Rule 7.3.6, now replaced by ICOBS 8.1.2(3).

[27] Insurance Contracts Act 1984, s 54.

4.12 Other terms have the potential to be similarly unfair. However, for consumer policies we thought such problems could be dealt with by the Unfair Terms in Consumer Contracts Regulations 1999. These already provide the courts and the FOS with extensive powers to review the fairness of exclusions. We thought that the main problem was for small and medium businesses that contracted on the insurer's standard terms. We therefore proposed that the court should review standard terms in business contracts if they would undermine the policyholder's reasonable expectations.

4.13 Several of those responding to the Consultation Paper felt that this was the wrong decision. They disagreed with all our proposals on warranties because they believe that terms that have the same effect should be treated in the same way. This point was strongly put forward by academics. Professor Robert Merkin and Professor John Lowry wrote:

> In our view it makes sense for clauses with the same objective to be regulated in the same way, and indeed any attempt to ban a particular form of clause may well lead to insurers adopting another form of clause to the same effect. It makes particular sense for insurers not to use clauses which have consequences far beyond their purpose, a warranty being the obvious example of that possibility. Our starting points are, therefore, that: clauses with the same object and effect should be treated in the same way; and warranties should be removed from English jurisprudence.

4.14 They described our proposals on warranties as "disappointing" and thought they did not go far enough. Jardine Lloyd Thompson also agreed that terms that have a similar effect, such as conditions precedent, should be regulated in the same way. Other respondents, however, did not specifically address the issue.

THE LIMITED EFFECT OF OUR PROPOSALS ON CONSUMER POLICIES

4.15 It is worth pointing out that for consumers our proposals would only apply where an insurer used a warranty in the strict sense. Their main effect would be to prevent insurers from using such a term to reject a claim that was not causally connected to the breach.

4.16 However, the use of strict warranties in consumer contracts is rare. In our survey of 50 FOS cases concerned with policy terms, we did not find any consumer policies that used strict warranties in this way. Many insurers confirmed this position in their responses. Furthermore, in almost all cases in which an insurer wished to use a warranty, it would be easy enough for the insurer to re-write the term as a temporal exclusion or definition of the risk.

4.17 Effectively, our proposals were a tidying up exercise, in which the more extreme provisions of the Marine Insurance Act 1906 would be repealed. The purpose of our reform was to resolve inconsistencies in the law rather than to address a substantive injustice. In the absence of a widespread or a specific consumer problem, our current view is that this would be done more effectively alongside the business provisions.

THE IMPORTANCE OF THE UTCCR

4.18 We thought that the Unfair Terms in Consumer Contracts Regulations 1999 (UTCCR) should remain consumers' main substantive protection against unfair terms. Professors Rob Merkin and John Lowry criticised this on the grounds that the Regulations "do not apply to terms which define the main subject matter of the contract, so risk definition is unaffected".

4.19 In the Consultation Paper we said that the UTCCR had surprisingly little impact on the insurance industry. This was partly because the Regulations are not well understood. In particular, there were misunderstandings about which terms are exempt from review because they are "core terms", that is they define the main subject matter of the contract or the price.

4.20 In 2005 the two Law Commissions published a joint report and draft Bill on Unfair Contract Terms.[28] The Bill includes three separate regimes: for consumers, for small businesses and for all businesses. The small and general business sections do not apply to insurance. However, the consumer section does. It is not intended to make substantive changes, but rewrites the effect of the UTCCR in clearer and more accessible terms.

4.21 In particular, the draft Bill gives a clearer definition of which core terms are exempt from review. It states explicitly that in order for a term to be exempt from review it must be "transparent", that is expressed in reasonably plain language, legible, presented clearly, and readily available. A term that defines the main subject matter of the contract must also be substantially the same as the consumer reasonably expected.[29] The report has been accepted in principle and is awaiting Parliamentary time.

4.22 If Parliament considers a Consumer Insurance Bill before the Bill on Unfair Contract Terms, it would be possible to copy across the provisions in our Unfair Terms Bill that apply to insurance.

4.23 We do not think that this would involve a substantive change. The FOS regularly reviews consumer policy terms for fairness, as did its predecessor, the Insurance Ombudsman Bureau (IOB). In 1990, the IOB said it would apply the spirit of the Unfair Contract Terms Act 1977. The FOS continues this tradition, applying both the spirit of the 1977 Act, the UTCCR and the FSA rules requiring significant or unusual terms to be brought to the consumer's attention. In the rare cases in which consumers choose to go to court, the courts may also review terms for fairness under the UTCCR.

4.24 However, the law in this area is not always well understood. We will give further consideration to whether implementing the relevant consumer sections of our draft Bill on Unfair Contract Terms in an insurance context would be helpful by making the law clearer and more explicit, or whether the current provisions are sufficient.

[28] Unfair Terms in Contracts (2005), Law Com No 292; Scot Law Com No 199.

[29] Draft Bill, clauses 4(2) and 14(3).

PART 5
PRE-CONTRACT INFORMATION AND INTERMEDIARIES

THE PROBLEM

5.1 Where insurance is arranged through an intermediary, the intermediary may introduce inaccuracies into the pre-contract information the consumer is required to provide to the insurer. An agent may, for example, act fraudulently to obtain a commission by deliberately altering the information the consumer has provided. Or the agent may give wrong advice about what the insurer wants to know, either deliberately or negligently. For example, in our study of FOS cases, a consumer who applied for critical illness insurance was required to complete a proposal form asking whether she suffered from asthma. The agent wrongly told the consumer that she did not need to mention mild asthma because the insurer only wanted to know about serious asthma.

5.2 Under current law, the crucial issue is whether the intermediary is considered to act for the insurer or for the consumer.

(1) If the intermediary acts for the consumer, the intermediary's actions and state of mind are imputed to the consumer. This means that where an agent has deliberately falsified information, the insurer is entitled to treat the consumer as if they had made a deliberate misrepresentation. The insurer may avoid the policy and deny all claims (even where the consumer is innocent of all wrongdoing). Similarly, if the intermediary has given negligent advice, the consumer would be treated as if they had made a negligent misrepresentation (even if the consumer acted reasonably in relying on the advice). In both circumstances the consumer may bring a separate action against the intermediary for compensation.

(2) If the intermediary is taken to act for the insurer, the intermediary's actions are imputed to the insurer. Where a consumer has acted honestly and reasonably, the insurer would be required to pay the claim, and bring its own action against the intermediary.

5.3 It is therefore important to establish whether an intermediary who conveys information to an insurer is acting for the consumer or for the insurer. We concluded that the law governing these arrangements was complex, confusing and uncertain. It is difficult to apply cases dating from the early twentieth century[30] to a modern, dynamic market place (with, for example, increasing use of multi-ties, panels and "white labelling", where insurance is branded with the distributor's name). We thought there was a need to clarify the law in this area.

[30] See, for example, *Biggar v Rock Life Assurance Co* [1902] 1 KB 516 and *Newsholme Brothers v Road Transport* [1929] 2 KB 356.

5.4 As a general principle, we thought that an intermediary should be regarded as acting for an insurer for the purpose of obtaining pre-contract information, unless it is clearly an independent intermediary acting on the insured's behalf. We then went on to discuss how an "independent intermediary" should be defined. We suggested adopting the same approach as the Insurance Mediation Directive, which uses the concept of a "fair analysis" of the market.

5.5 These proposals proved to be controversial in three areas:

(1) Some respondents disagreed that the law was uncertain, and saw no need for reform.

(2) Some queried the principle that intermediaries should be considered to act for insurers unless they were clearly independent.

(3) Many expressed concern over our definition of "independence".

Below we consider each element in turn.

IS THERE A NEED FOR REFORM?

"The law is sufficiently clear"

5.6 Just over a quarter of respondents (including 13 insurers) considered that the law was sufficiently clear, or did not cause enough problems to justify reform. Most of those who described the law as clear thought that it was generally accepted that intermediaries act for consumers in providing information. As Friends Provident put it:

> There is no uncertainty in the current law that where the intermediary completes this process [collating information on a proposal] he is acting for the customer. To suggest otherwise makes the intermediary and the provider essentially the same person, which defeats the whole point of the process. Furthermore it is invariably the practice of most Insurers to make abundantly clear both the need for accurate disclosure and the fact that agents act for the customer and not the Provider for this purpose. [Friends Provident]

5.7 The ABI said:

> The law is very clear in this area and if properly applied, should not cause the confusion feared by the Law Commission. In any event, the perceived problems identified can be dealt with through the existing regulatory framework provided by the FSA and the FOS. [ABI]

5.8 The ABI argued that the relationship depended on the Terms of Business Agreements ("TOBAs") between insurer and intermediary. It was "common for such agreements to state categorically that the intermediary acts on behalf of the insured on all matters except in relation to the collection of premiums where they act on behalf of the insurer". The ABI appeared to suggest that the courts would consider such a statement to be definitive. Where it existed, the insurer would automatically be considered to be the consumer's agent. Several insurers agreed with the ABI on this point.

5.9 Aviva said that the distinction should depend on how the intermediary is authorised: "all directly authorised intermediaries should be the agent of the consumer, and all appointed representatives should be agent of the insurer". Aviva also said that the law should remain as it is, indicating that Aviva considers this to be the current law.

Why we thought the law was unclear

5.10 Given the views expressed it may be helpful to explain why we argued that the law in this area was unclear. Our conclusions are set out in Part 9 of the Consultation Paper and may be summarised as follows:

(1) In receiving pre-contract information, intermediaries will generally be considered to act for the insurer if they are:

(a) the insurer's employee;

(b) the insurer's appointed representative;[31]

(c) given binding authority to issue cover;[32] or

(d) sent by the insurer to solicit business.[33]

(2) Intermediaries will generally be considered to act for the policyholder if they:

(a) are not paid a commission by the insurer;

(b) are Lloyd's brokers;[34] or

(c) undertake to give the consumer independent advice (even if the insurer does pay them a commission).[35]

(3) If an independently authorised intermediary sells the product of only one insurer, without the authority to bind cover, the legal position is less clear. The FOS told us that ombudsmen often consider such agents to be acting for the insurer. This was borne out in our survey of cases, in which we noted that insurers usually accepted the FOS approach. Under current law, we think that insurers may struggle to argue before the courts that such an agent does not act for them.

[31] The Financial Services and Markets Act 2000, s 39(3) states that the principal is responsible for the intermediary's acts or omissions. Although technically this section only applies to regulatory issues, we think that industry practice suggests that insurers give implied authority to their appointed representatives to receive pre-contract information.

[32] See *Stockton v Mason* [1978] 2 Lloyd's Rep 430 and *Woolcott v Excess Insurance Co Ltd* [1979] 1 Lloyd's Rep 231.

[33] See *MacGillivray* at para 18-6. This received judicial support in *Winter v Irish Life Assurance* [1995] 2 Lloyd's Rep 274 and *Arif v Excess Insurance Group* 1986 SC 317.

[34] *Roberts v Plaisted* [1989] 2 Lloyd's Rep 341.

[35] See *Winter v Irish Life Assurance* [1995] 2 Lloyd's Rep 274 and *Arif v Excess Insurance Group* 1986 SC 317.

(4) The most controversial area is where the intermediary sells the products of a limited number of insurers (and is paid a commission to do so) without giving the consumer independent advice. This is a fairly common situation, and we do not know what a court would decide. Under basic principles of agency law, the issue would depend on whether the insurer acted in such a way as to give the agent "ostensible authority" to collect pre-contract information from the consumer. This in turn would be influenced by what a consumer would reasonably understand from any written material the insurer allowed the intermediary to give to the consumer.

5.11 We think insurers would be poorly advised to rely exclusively on a statement within their TOBAs that the intermediary acts for the consumer. Even when looking at the issue of express authority, the court would need to construe the agreement as a whole, not simply rely on one statement. And in the absence of express authority, an intermediary may still be held to be the insurer's agent if it has implied or ostensible authority from the insurer.

5.12 In practice, we were not able to find a single court or FOS decision in which the insurer had relied on their TOBA, or indeed revealed the TOBA to the court or ombudsman. This makes it difficult to be certain how much emphasis a court would be prepared to place on it.

Do consumers understand the legal position?

5.13 Some insurers said consumers generally understood the legal position:

> We therefore dispute that there is any misunderstanding in the mind of the customer about the role the intermediary plays in collecting this information. [Friends Provident]

5.14 However, consumer groups disagreed. The Multiple Sclerosis Society thought that intermediaries need to make their status clear to the assured. The National Consumer Council (NCC) wrote:

> We suspect that many consumers do not always realise that they are dealing with someone who is an intermediary rather than an insurer. [NCC]

5.15 The Financial Services Consumer Panel stated that:

> Many insureds simply see the intermediary "as part of the industry". They do not understand that the intermediary acts for them and not for the insurer. [Financial Services Consumer Panel]

5.16 In responding to our Issues Paper, the FOS said:

> The applicant for insurance is frequently unaware that the insurance intermediary is acting as their agent in this part of the overall process of applying for and receiving insurance cover. Indeed, it appears from the experience of the Financial Ombudsman Service that most consumers applying for insurance cover believe that the intermediary is acting as the seller of the insurance policy (and they do not consider whether they act on behalf of the insurance company or on their own account). The exception is where the intermediary is expressly offering a service that reviews insurers and offers the cheapest or most suitable policy.[36] [FOS]

5.17 We note that the FSA has drawn attention to the problems facing commercial customers in this area, stating that "a key concern is the lack of clarity about whether the intermediary is acting for the customer, for the insurer or, in some cases, both".[37] It is likely that consumers are similarly unclear about the status of the intermediary they are using.

The ABI Guidance on long-term protection policies

5.18 As previously discussed, in January 2008 the ABI issued guidance to the protection industry about how to deal with issues of non-disclosure. This states:

> Whether an intermediary was acting as an insurer's agent in a transaction will depend on the facts and circumstances of each case.[38]

5.19 This highlights (correctly, in our view) that there is currently no single test to determine who an insurer is acting for. It is not enough, for example, just to look at whether the intermediary is independently authorised or whether it is deemed to be the consumer's agent in the insurer's TOBA. However, the statement is of limited practical value. It would be helpful to know what facts and circumstances are relevant.

[36] Response by Peter Hinchliffe sent on 22 January 2007, and quoted in the Consultation Paper at p 252.

[37] FSA, *Transparency, Disclosure and Conflicts of Interest in the Commercial Insurance Market*, DP 08/2, March 2008. See also the research by CRA International, *Commercial Insurance Commission disclosure: Market Failure Analysis and High Level Cost Benefit Analysis*, December 2007, which showed confusion among commercial customers over whether their intermediaries provided a fair analysis of the market.

[38] Para 3.4.2. The ABI Guidance is discussed in this paper at paras 2.68 to 2.71 and paras 2.147 to 2.151.

Is there a need to clarify the law? Overview

5.20 Whilst the law may be clear at either extreme (such as authorised representatives or fully independent advisors) there are a wide range of relationships where the legal position is difficult to ascertain. Insurers appear to over-estimate the extent to which intermediaries would be taken to act for the consumer in providing pre-contract information. This is true especially when intermediaries are independently authorised but sell a limited range of products on a non-advised basis. Similarly, consumers may under-estimate the extent to which they are responsible for the actions of an intermediary. Many would be surprised to discover that an insurer is entitled to treat an honest consumer in the same way as a dishonest consumer because the intermediary has altered information without their knowledge.

5.21 Our aim is to provide clear, accessible law on consumers' duties to provide pre-contract information and insurers' remedies when they do not. Rules need to be sufficiently flexible to meet developing business practices. However, the responses suggest that it would be helpful if the law provided more guidance than that currently derived from the cases, several of which were decided early last century.

SHOULD INTERMEDIARIES BE TAKEN TO ACT FOR INSURERS UNLESS THEY ARE CLEARLY INDEPENDENT?

5.22 As a basic principle, we thought that responsibility for misconduct by intermediaries should be placed on the party best able to prevent that misconduct.

5.23 We noted that most consumers dealt with intermediaries only rarely, and were in a poor position to influence the intermediary's business practice. This was particularly true in the protection market. Consumers would only know that a misrepresentation had been made when they came to make a claim, which may be many years later (and often after the fraudulent agent had left the firm). Recently bereaved or seriously ill consumers were rarely in a strong position to bring an action against the intermediary, and may decide not to litigate when the circumstances merited it.

5.24 We thought that insurers were better able to monitor and discipline the intermediaries they sold through. We were particularly concerned about the rule allowing insurers to avoid policies whenever the intermediary has falsified information. As noted in Part 2, avoidance is a penal remedy that over-compensates insurers for the loss they have suffered. It sets up a perverse incentive, whereby the insurer may make a greater profit from a fraudulent intermediary than from an honest one.[39] Although we did not think that an insurer would ever encourage such behaviour, we thought that the current law may not do enough to encourage insurers to take swift and firm action against dishonest intermediaries.

[39] See the example in the Consultation Paper p 254.

5.25 We noted that in 1957 the Law Reform Committee recommended that intermediaries should always be regarded as the insurer's agent in receiving pre-contract information. However, we did not go this far. We thought that an absolute rule of this kind would have a deleterious effect on small independent brokers. Insurers would find it hard to police a large number of small independent firms and may refuse to deal with such firms.

5.26 We therefore provisionally proposed a compromise: an intermediary should be regarded as acting for an insurer for the purposes of obtaining pre-contract information, unless it is clearly an independent intermediary acting on the insured's behalf (CP para 12.70).

5.27 This was controversial. Of the 67 consultees addressing this question, just over half (36) disagreed with our proposal.

Arguments that our proposal was too timid

5.28 Three consultees thought we were wrong to reject the straightforward solution put forward by the Law Reform Committee in 1957. They argued that intermediaries should always be considered as the insurer's agent for disclosure purposes.

5.29 Professors Robert Merkin and John Lowry addressed this issue at length:

> If the brokers have asked the right questions, including a sweeping question, the assured will either tell the truth or make false statements. Given that the information-gathering exercise has to take place as between the assured and the broker, it is not immediately apparent why the assured should bear the risk of that process being improperly replicated as between broker and insurers. [Professors Merkin and Lowry]

5.30 It was argued that the intermediary's role changes from function to function. Intermediaries may give the consumer independent advice, but their role changes when it comes to completing the form and concluding the contract. Insurers provide the forms and pay intermediaries for this work, so should be considered to act for the insurer while they do so. Lord Justice Rix wrote:

> Typically the broker will search the market on price; but what does that tell you about his role for the purposes of pre-contract information? Particularly in the field of consumer insurance, I suspect that when once the broker finds a price acceptable to the insured (based on standard information from the assured), the hard work of the proposal form begins from there, with only one insurer in mind at that stage. Moreover, everything the broker does is done behind the scenes, so far as the assured is concerned. In these circumstances, I would prefer a functional rule, which reflects that brokers and insurers are part of the same industry to which the assured is not party. [Lord Justice Rix]

5.31 Age Concern thought that intermediaries who are paid commission by the insurer should always be deemed to be the insurer's agent. Only those who are paid directly and solely by the consumer should be their agent.

Arguments that our proposal was too radical

5.32 Most insurers, however, thought that our proposal went too far in making insurers responsible for intermediaries. The main argument was that this would be costly and disruptive to the market. The Chartered Insurance Institute, for example, argued that a change in agency law "would come with huge implications on underwriting and broking practices, as well as insurer internal systems and controls". Aegon UK commented that

> Were this proposal to come into force there would need to be wholesale changes to the compliance regime and intermediaries would be potentially left with the unsatisfactory situation of having several insurers requiring to have control over their compliance/training etc. [Aegon UK]

5.33 The ABI thought that it would add to costs:

> Should the Law Commission's proposals be adopted, revisions of Terms of Business Agreements may be necessary at great expense to the industry. Further, there may well be the need for a complete overhaul of insurers' intermediary application/assessment processes, again at substantial cost. [ABI]

The ABI thought that it would lead insurers to restrict those firms with whom they traded, making it harder for new firms to enter the market.

5.34 Respondents suggested that in practice insurers were often not able to monitor or control their agents, especially large composites who have thousands of agreements in place. The Lloyd's Market Association commented that our proposal would render the insurer liable for the acts of intermediaries, even where that intermediary has not entered into a TOBA with the insurer. Without such an agreement, the insurer would have no contractual basis for suing the intermediary to recover the cost of the paid claim.

5.35 The Institute of Insurance Brokers feared that insurers would seek an indemnity from the broker for instances where the broker was deemed to be acting for them and threaten to terminate the agency agreement if the intermediary did not provide the indemnity.

DEFINING "INDEPENDENCE": THE "FAIR ANALYSIS" TEST

5.36 In the Consultation Paper we noted that under the Insurance Mediation Directive, intermediaries must tell their customers whether their advice is based on "a fair analysis" of the market. We saw advantages in using the same test to define whether an intermediary is giving the policyholder independent advice. The distinction already exists; and consumers must already be given this information. We thought it would be confusing for consumers to receive two separate statements, one about a fair analysis and one about whether the intermediary is acting for them. We therefore asked whether the test to determine whether an intermediary is independent should depend on whether the intermediary conducts "a fair analysis" as defined by the Insurance Mediation Directive (CP para 12.71).

5.37 Most people thought it should not. Of the 64 consultees who gave their views, almost two thirds said no.

Uncertainty over "fair analysis"

5.38 The main argument against using a fair analysis test was that it would be unpredictable. Despite the fact that intermediaries are compelled to tell potential policyholders whether they offer a fair market analysis, many of those working in the market appear to be genuinely uncertain about what it means. They are therefore reluctant to extend its influence further.

5.39 The Directive defines a fair analysis in the following terms:

> When the insurance intermediary informs the customer that he gives his advice on the basis of a fair analysis, he is obliged to give that advice on the basis of an analysis of a sufficiently large number of insurance contracts available on the market, to enable him to make a recommendation, in accordance with professional criteria, regarding which insurance contract would be adequate to meet the customer's needs. [40]

5.40 The test is therefore framed in terms of high-level principle. At first sight, it does not appear to be unduly onerous. It does not require an intermediary to recommend the best policy, merely one that is "adequate". It is intended that the details would be provided by professional bodies setting out professional criteria.

5.41 However, it is clear that the test has no generally agreed meaning. Most respondents thought that offering the products of only one insurer would not be a fair analysis, and searching the whole market would be a fair analysis. But there was concern over where the dividing line should be drawn, particularly where intermediaries arranged policies from a limited panel of insurers.

5.42 The solicitors Hill Dickinson pointed out that what would be reasonable for one geographical area or specialist market might be completely inadequate in another. Consultees felt that the test would not reflect the complexity of the different products and business arrangements. Further questions were also asked. How often does the intermediary have to review the list of insurers that it recommends? What about renewals where there is a fair analysis on first placement but no analysis when the policy is renewed? Even intermediaries themselves did not have clear answers to these questions.

5.43 The Institute of Insurance Brokers said "few brokers use the whole market because they cannot enter into TOBAs with every provider or do not want to recommend insurers with low solvency ratings or restrictive policy wordings or poor service standards". It would, however, not be clear from the test proposed how many providers they would need to have TOBAs with in order to be deemed to be making a "fair market analysis".

5.44 The fair analysis test has implications far beyond issues of pre-contract information. Yet there appears to be general confusion about the standard of advice the test requires.

[40] Directive 2002/92/EC, Art 12.2.

Undertake to conduct a fair analysis, or *actually* conduct a fair analysis?

5.45 The way the Consultation Paper question was phrased suggested that the test should depend on whether the intermediary *conducts* a fair analysis. We did not say it would depend on whether the intermediary *undertakes* to provide a fair analysis. It was pointed out that an insurer could find itself responsible for an intermediary's actions where the intermediary informed the consumer that it will offer advice on the basis of a fair analysis of the market, but then failed to live up to its promise.

5.46 This raised criticism, especially from insurers, that they will "unwittingly become responsible for intermediaries that fail to search a sufficiently large number of insurers through negligence or laziness" (Keoghs). The British Insurance Law Association, Aegon UK, the Group Risk Development Goup, Swiss Re and Royal & SunAlliance all questioned how assureds seeking to make a claim or insurers seeking to defend one would know whether the intermediary actually did carry out a fair analysis. BILA pointed out that neither party could prove a case without the co-operation of the intermediary. The Law Reform Committee of the Bar Council echoed the comments. They pointed out that the facts are almost exclusively in the possession of the intermediary.

5.47 On reflection, we accept this was an error. If we were to use this test it would have to depend on what the intermediary informed the consumer it would do, as required under FSA rules. If an intermediary undertook to provide independent advice but then failed to do so, it would still be the consumer's agent - albeit one that was in breach of its duty to the consumer.

5.48 However, some insurers also pointed out problems with the "undertake to conduct a fair analysis" test. The result, they argued, was that if an intermediary fails (whether deliberately or not) to tell a consumer that it has carried out a fair market analysis, that intermediary will be deemed to be the agent of the insurer for the purposes of passing on pre-contractual information. The Lloyd's Market Association thought that this would render the insurer liable for the acts of intermediaries, even where that intermediary has not entered into a TOBA with the insurer.

The independent agent given specific instructions

5.49 It was pointed out that a policyholder may approach an independent intermediary with specific instructions, and without requesting a recommendation. Arthur J Gallagher raised this point saying that "if an assured instructs a broker to seek the terms of one insurer that does not make the broker an agent of that insurer".

5.50 This may happen, especially with renewals. A consumer may initially approach an independent intermediary for advice, but then decide to stay with the original insurer (perhaps because a claim is in hand). The consumer may tell the intermediary to renew the policy without the intermediary having provided further advice. This would not necessarily make the intermediary the insurer's agent.

The consumer view

5.51 Several consumer organisations criticised our approach on the basis that it will not necessarily alert policyholders to the fact that the intermediary is working for them and not for the insurer.

5.52 The Financial Services Consumer Panel put it as follows:

> The Panel is ... concerned that the mere requirement in the FSA Rules that a proposer be informed that the intermediary conducts a 'fair analysis' is insufficient, without more, to make the proposer aware that the intermediary is in fact acting for the proposer for the purposes of obtaining pre-contractual information. [Financial Services Consumer Panel]

Alternative proposals

5.53 Several consultees put forward alternative ways of solving the problem of working out who an intermediary is acting for when passing pre-contractual information to insurers:

(1) About a fifth of consultees felt that the issue would be more suitable for regulation than for legislation. The point was strongly made by the ABI. Insurers and brokers were concerned that legislation would prevent new methods of selling being developed.

(2) Several consultees (including brokers, lawyers and insurers) suggested that intermediaries should at the outset make a declaration to the consumer stating for whom they are acting. These consultees felt that our arguments about the effectiveness of warning notices and the risks of damaging brokers' reputations (CP para 10.19) were not persuasive.

(3) Geoffrey Lloyd and Derrick Cole thought that where there is a single tie, the intermediary should be deemed to act for that insurer. In all other instances the intermediary should be deemed to act for the consumer.

THE WAY FORWARD: OVERVIEW

5.54 It is important to stress that this discussion is not concerned with the status of insurance intermediaries generally. It addresses very specific issues: what happens when a consumer has behaved honestly and reasonably in answering an insurer's questions, but the insurer has nevertheless been misled by the intermediary's dishonesty or negligence? Should the insurer pay the claim, and pursue a remedy against the intermediary? Or should the insurer be entitled to avoid the policy, or pay only a proportionate settlement, and leave the consumer to pursue the intermediary?

5.55 The issue also arises where the intermediary has been dishonest in falsifying information, and the consumer has been negligent in failing to notice (for example, in not reading the form sufficiently carefully before signing it). In these circumstances, should the insurer be entitled to avoid the claim (on the grounds that the consumer is imputed with the intermediary's dishonesty) or should the insurer pay a proportionate settlement?

The practical effect

5.56 Some respondents thought that our proposals were more far-reaching than this, and would have changed the agency status of intermediaries for other purposes. It was thought to be "the thin end of the wedge", leading to other changes in regulatory status. This was not our intention. We do not think that change in this particular area would lead to the widespread changes in internal systems and controls that some suggested.

5.57 The issue of intermediary misrepresentation does arise in practice, but should not be exaggerated. In our survey of FOS cases on non-disclosure, 13% of cases raised allegations that the fault lay with the intermediary, but not all these allegations would be proved. We can understand the fear that change may increase costs. However, the industry also needs to be aware of the cost to its reputation caused by the current situation. It is important that the rules are fair and seen to be fair, and do enough to encourage good practice.

5.58 If the industry is concerned about agent misrepresentation, there are targeted solutions, which do not involve the insurer becoming intimately involved in the intermediary's compliance processes. The most obvious is "tele-underwriting". Here intermediaries do not take consumers through the proposal forms. Instead, consumers phone a call centre, in which the staff who ask the questions are not paid commission based on the number of people who complete the process.

5.59 The Pricewaterhouse Cooper research submitted by the ABI noted an interesting study on this issue.[41] It took a sample of cases in which consumers had been guided though a form by a commission-based intermediary, and had raised no health problems. The consumers were then contacted by telephone by staff not paid on a commission basis. In 75% of cases, the consumers mentioned something not raised on the form and in 25% of cases the issue was significant. The consumers had not changed: if they were lying they would have lied to the telephone staff as well. The only difference was in the way the questions were put. If this study is of general application, it raises serious concerns about the way that that the industry gathers information from consumers. It would suggest that the current legal rules do not do enough to incentivise insurers or intermediaries to ask questions in a way designed to get the right information.

5.60 Clearly, the problem is difficult. As many respondents pointed out, there are no easy solutions. However, if the rules are clarified to give the right incentives and prevent cases of apparent injustice, the industry as a whole will benefit.

No bright line test

5.61 In an ideal world, the issue of whom an intermediary is acting for would have a simple straightforward answer. The many detailed arguments we received suggest that we do not live in such an ideal world. The only simple solution would be to adopt the 1957 test, and state that intermediaries always acted for the insurer in receiving pre-contract information. However, we thought this would damage small, independent intermediaries.

[41] "Clean" applications? How clean?, MorganAsh, cited by PricewaterhouseCooper, *The Financial Impact of the Law Commission's Review of Insurance Contract Law*, ABI Research Paper 5, at p 49.

5.62 Without such a radical change to the law, the issue will remain complex. It would not be possible to say that any given intermediary always acts for one side or the other in receiving pre-contract information. Intermediaries stand between insurers and consumers and often change hats during the process. Take the case of an independent intermediary with authority to bind the insurer to temporary cover but not the main cover. Under current law, the intermediary acts for the insurer in receiving information in respect of the temporary cover but not in respect of the main cover.

5.63 Another example would be where an independent intermediary completes a paper proposal form in face to face discussion with the consumer and is then paid by the insurer to transcribe the results onto the insurer's system. Even if the intermediary acts for the consumer in the face to face discussion, we think they act for the insurer while transcribing. The insurer would not be able to refuse a claim because errors occurred in the transcription process.

5.64 The responses we have received suggest that it is not possible to impose a single test to decide whether an intermediary is independent. Technology is changing the way that insurance is distributed and sold. Although there is a need for greater clarity, we do not wish to restrict product development or place regulatory obligations on parties who are not in a position to enforce them.

Is it possible to produce statutory or non-statutory guidance?

5.65 We have considered whether it is possible to set out the current law with greater precision.

5.66 In law some factors are decisive. For example, an intermediary with authority to bind to cover will always be taken to act for the insurer. Although the point is not beyond all argument, we also think there is general agreement that an insurer's appointed representative will also be regarded as the insurer's agent. By contrast, if an intermediary is only paid by the consumer, and does not receive a fee or commission from the insurer, it will be taken to act for the consumer.

5.67 Other factors are persuasive. They need to be taken into account, though will not necessarily determine the issue if other factors point in the opposite direction. Persuasive factors that may indicate that an intermediary acts for the consumer are that:

(1) The consumer pays the intermediary a fee, even if the insurer pays a fee as well. The greater the amount of the intermediary's remuneration that comes from the consumer, and the more open and transparent the commission arrangements, the greater the likelihood that the intermediary acts for the consumer;

(2) The intermediary undertakes to carry out a fair market analysis;

(3) The intermediary would normally undertake to carry out a fair market analysis but is instructed by the consumer to contract with a particular insurer.

(4) The intermediary makes a declaration stating that it does not act for the insurer.

5.68 Persuasive factors that indicate that an intermediary acts for the insurer are that:

(1) The intermediary has a 'terms of business agreement' with the insurer. This would not be sufficient on its own to establish that the intermediary acts for the insurer but would indicate that there is a connection;

(2) The intermediary only ever contracts with one insurer or a limited number of insurers. What constitutes a 'limited number' will depend on the product and the market;

(3) The consumer is given the impression that the intermediary and the insurer are part of the same brand, for example, if the intermediary uses stationery or a website that is branded by the insurer, or vice versa.

5.69 We will give further thought to whether guidance along these lines would be a helpful clarification of the current law, particularly for insurers, the FOS and the courts. We will also consider whether guidance of this sort should take statutory or some other form and we shall be seeking views on this from interested parties.

5.70 We accept that such guidance would be fluid and would not always give an easy answer in each case. This is the inevitable consequence if we reject a bright line test in favour of a more nuanced and flexible approach, which takes into account all the circumstances of the relationships between intermediary, insurer and consumer.

Joint complaints

5.71 A major problem with the current position is that consumers must make two separate complaints to the FOS, one against the insurer and one against the intermediary. This is time consuming and difficult, and often occurs when consumers are particularly vulnerable, because, for example, they are critically ill or recently bereaved. We noted cases in which consumers had pursued complaints to a final ombudsman decision over the course of months or years, to be told that they must start again at the beginning against a financial adviser.

5.72 In the Consultation Paper we expressed the hope that "more could be done to assist consumers to bring complaints against the correct organisation, if necessary considering complaints in tandem where the status of the agent is disputed".[42]

5.73 Where a complaint or case involves both intermediary and insurer together, the issue of who the intermediary is acting for becomes much less important. In any event the intermediary pays to the full extent of the claim.

[42] Para 9.124.

INTERMEDIARIES NOT REGULATED BY THE FSA

5.74 In the Consultation Paper, we noted that some intermediaries were not regulated by the FSA. An example is where a consumer buys a car using a finance agreement and the car retailer sells the consumer insurance to cover the future payments under the finance agreement. We asked whether any additional protection was necessary for the consumer buying from these intermediaries (CP para 12.72).

5.75 Of the 45 consultees who gave their views on this question, the majority (71%) said that no additional protection was needed. Most thought the issue should be left to the FSA to monitor. The fact that the FSA announced in June 2007 that it would regulate travel agents selling travel insurance was quoted as evidence that the FSA will extend its jurisdiction when it feels that there is a problem. The National Consumer Council agreed that the FSA should continue to monitor the market.

5.76 There appears to be general agreement that this issue does not need to be considered in the course of our review of insurance contract law.

THE NEWSHOLME CASE

5.77 In the Consultation Paper, we drew attention to the case of *Newsholme Brothers v Road Transport and General Insurance Co Ltd.*[43] This dates from 1929, and suggests that even if an intermediary is an agent of the insurer, it should be considered to be an agent of the insured for the purposes of completing a proposal form. We said that there was uncertainty over whether the case remained good law.

Transferred agency

5.78 Insurers' employees and authorised representatives often give consumers advice about completing proposal forms in the course of their duties. We thought that the suggestion in *Newsholme* that when they do so they become the consumer's agent made little sense in a contemporary environment. We provisionally proposed that the rule in *Newsholme* should be overturned, so that an intermediary who would normally be regarded as acting for the insurer in obtaining pre-contract information should remain the insurer's agent while completing a proposal form (CP para 12.73).

5.79 Most people agreed with us, though some insurers thought the law should be left as it is. The ABI said that the law in this area was clear and should not be subject to change.

[43] [1929] 2 KB 356.

Signature

5.80 In *Newsholme* the policyholder had signed a basis of the contract clause. The decision could be interpreted as saying that a policyholder is bound by their signature on the proposal form, no matter what the circumstances. A problem might arise when a consumer has signed a form without being aware that an intermediary has made a particular statement on it. If the consumer would have known that the statement was untrue had they known that it was there, there is an argument that they could be deemed to have made a deliberate misrepresentation, even though they were guilty of nothing more than carelessness.

5.81 We provisionally proposed that a consumer insured's signature on a proposal form that has been completed incorrectly by a third person should not be regarded as conclusive evidence that the insured knew of or adopted what was written on the form (CP para 12.74).

5.82 Although most people agreed, many thought that a provision of this sort would send the wrong message to consumers. Of the 61 consultees providing views, just over a quarter thought that the proposal would encourage reckless behaviour. They wanted a clearer signal to be sent to consumers that they must take responsibility for their actions. Some thought that the proposal would mean that they would no longer be able to rely on anything that the consumer wrote in the form as being accurate.

Is *Newsholme* good law?

5.83 There is a strong argument that *Newsholme* is no longer good law.[44] If the "transferred agency" rule were to be applied, it would mean that if a member of an insurer's call centre staff made a mistake, the consumer would be held responsible for it. We have not found a FOS case or contemporary court case in which an insurer attempted to run such an argument, and we think that the courts would give it short shrift if it did. Furthermore the argument that a policyholder is bound by their signature on a proposal form, no matter what the circumstances, is addressed by our proposals on basis of the contract clauses.

5.84 If the courts would no longer attempt to apply the *Newsholme* rule, then there may be no need for specific legislative provisions to remove it.

MARINE INSURANCE ACT 1906, SECTION 19

5.85 Section 19 of the Marine Insurance Act 1906 states that:

> Subject to the provisions of the preceding section as to circumstances which need not be disclosed, where an insurance is effected for the assured by an agent, the agent must disclose to the insurer –

[44] See for example "Reform of Insurance Law: Intermediaries" (May 2007) 19 *Insurance Law Monthly* 1.

(a) Every material circumstance which is known to himself, and an agent to insure is deemed to know every circumstance which in the ordinary course of business ought to be known by, or to have been communicated to, him; and

(b) Every material circumstance which the assured is bound to disclose, unless it comes to his knowledge too late to communicate it to the agent.

5.86 Where the section is breached, the insurer has a right to avoid the policy against the policyholder.

5.87 Although in theory the section applies to consumer insurance, we have not found any case in which the section has been applied in a consumer context. We asked whether there was any reason to retain the two sub-sections for consumer insurance (paras 12.75 and 12.76).

Respondent views

5.88 Most respondents confirmed that the section had never been used, and that the issue was "largely academic".

5.89 The ABI agreed that section 19(b) added little to an insurer's existing remedies and was at odds with the FOS position. They also thought that if any insurer attempted to rely on section 19(a), the FOS would uphold the consumer's claim and find that the insurer's decision was unfair. It would also be contrary to the FSA's initiative to Treat Customers Fairly. However, the ABI doubted that on its own the issue was of sufficient practical importance to justify a change in the law.

Overview of responses

5.90 There is general agreement that section 19 has no practical effect, and any insurer who attempted to rely on it against a consumer would not succeed. The ABI thought that the existence of this section would not justify reform on its own. However, if there is to be legislation, there appears to be general agreement that section 19 should be disapplied in a consumer context.

PART 6
ASSESSING THE COSTS AND BENEFITS OF REFORM

LONDON ECONOMICS REPORT

6.1 Our Consultation Paper included a preliminary investigation by London Economics into the economic impact of our proposals relating to non-disclosure and misrepresentation in the consumer market for critical illness insurance. We chose to examine this limited area of reform to consult on the methodology used to assess the impact, rather than to consult on the impact itself. Nevertheless, we asked London Economics to produce as accurate results as were possible.

6.2 In assessing the costs and benefits of reform, London Economics divided insurers into Type 1 and Type 2 firms. Type 1 firms followed guidance from the Financial Ombudsman Service (FOS) and the FSA regulations and had institutionalised the Treating Customers Fairly initiative. On the other hand, Type 2 firms had not done either of these things and would be forced to make wholesale changes to their underwriting practices. The model assumes that 93% of firms are Type 1.

6.3 London Economics concluded that the impact on those firms who already follow FOS guidance (Type 1) would be minimal. Their estimate was that the costs of law reform for these firms would translate into no more than a 1 to 1.5% increase in premiums.[45] This included extra administration costs. The costs of claims would be relatively unaffected as firms continued to follow the good practice expected by the FOS and codified in our proposals. For firms that did not follow the FOS approach (Type 2), London Economics concluded that the impact would be more dramatic. These firms would need to increase their premiums by 85% to 95%. As it is unlikely that any consumer would pay such an increase, such firms would either go out of business or would have to rewrite their business model to comply with current FOS practice.

CONSULTEES' RESPONSES

6.4 Relatively few consultees responded to the questions we posed about the London Economics report methodology. Around 20 responded to each question. Many felt that the distinction between Type 1 and Type 2 firms was artificial. The ABI and Zurich Financial Services advised us that the vast majority of firms were Type 1 and that any analysis should concentrate only on them. Many consultees, however, referred us to the work that had been carried out by PricewaterhouseCoopers (PWC).

6.5 The ABI commissioned PWC to write a report on the financial impact of our review of insurance contract law. Their report covered all of our reforms, for a sample of both commercial and personal lines. The report is detailed and a wide range of insurers have contributed to it.

[45] Appendix B to Consultation Paper, table 17.

6.6 PWC's work on our consumer proposals shows that for consumer insurance the Law Commissions' proposals will have either no net financial impact on insurers or only a minimal impact.

6.7 We should, however, mention that PWC have assessed the costs and benefits of some reforms that were described in our issues papers but that, after consideration by the Law Commissions, were not proposed in the formal consultation paper. For example, PWC's data showed that insurers would suffer a "high negative impact" if insurers were deemed to know details of previous applications or claims by consumers within their firm and others within their group. Likewise a presumption that insurers would seek information from third parties, such as doctors, was also assessed and felt to have a "high negative impact". Neither of these proposals was in our Consultation Paper.

6.8 Despite this, PWC concluded that costs for general insurance personal lines would be small.

> The overall impact on general insurance personal lines is estimated to be negative and of the order of £20 million to £80 million per annum for ongoing costs and negligible for one-off costs. This indicates that the costs of these implementations are likely to be small.

One-off costs for these lines were estimated to be zero and on-going costs were small, estimated at 0.1% to 0.3% of premiums.

6.9 For life and protection lines PWC also estimated that one-off costs would be zero and gave a range of on-going costs between zero and 4.3% depending on the approach taken by insurers. Much of the estimated costs related to the suggestion in Issues Paper 1 that there might be a three year non-contestibility period for life and critical illness policies.

6.10 It is likely, therefore, that if our proposals as set out in our Consultation Paper had been assessed the costs for consumer reform would have been assessed by PWC as lower still.

FUTURE WORK

6.11 We will be publishing an impact assessment with our final report and draft bill on consumer insurance.

6.12 Collecting accurate data will be difficult. As PWC found, insurers do not currently store data on whether they have turned down a claim for negligent or innocent misrepresentation. We would, however, be grateful for any extra help that insurers can give us in this regard.