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Consumer Insurance (Disclosure and Representations) Bill

Bill No 274 [HL] 2010/12

RESEARCH PAPER 12/06 20 January 2012

This Bill attempts to update, clarify and consolidate existing law and guidance about what insurance companies might reasonably expect their customers to tell them when they apply for insurance. The Bill is based on proposals from the Law Commission and the Scottish Law Commission and has support from the Financial Services Authority, the Financial Ombudsman and from the insurance industry.

Timothy Edmonds

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Research Paper 12/06

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Summary

Insurance business is a contract between insured and insurer. According to long established practice, insurance contracts are based on the principle of utmost good faith. Misrepresentations by one side or a failure to disclose relevant key information can lead to the other party being able to avoid liability.

A substantial element in the pricing of insurance is the degree of risk, or likelihood, of the insured event happening. Some elements of the risk are public knowledge, for example how likely it is that an area will flood, and the insurance company can make its own assessment of this. Other elements are known only to the insured, for example their health. The insurers try to discover these by asking questions in the proposal. Some questions – age, gender etc – are specific, however, insurers also rely on customers disclosing all relevant facts.

Since the overwhelming majority of people who take out insurance are neither underwriters or insurance lawyers their grasp of what information is relevant and what is not is less than perfect. This can lead to disputes if insurance companies refuse a claim on the grounds of non-disclosure.

Since the legal principle of utmost good faith was established in 1906, the practice of the industry, its regulators and those involved with dispute resolution has evolved. New rules and best practice guides have added further 'layers' of regulation and complexity to the original statute law. The Law Commission examined the workings of the non-disclosure rules and found them wanting as against modern business practice, standards and consumer expectations.

This Bill contains the recommendations of the Law Commission which simplify and codify the principles surrounding non- disclosure.

The Bill replaces the duty of the consumer to volunteer relevant material information to the company with a duty on them to take reasonable care not to make a misrepresentation during pre-contractual negotiations. If a consumer breaches this duty and this misrepresentation induces the insurer to enter the contract, the insurer will have a remedy. The nature of the insurer's remedy depends on the nature of the consumer's misrepresentation.

If a consumer makes a deliberate or reckless misrepresentation, the Bill permits the insurer to treat the contract as if it never existed and refuse all claims.

If, when answering questions posed by an insurer, a consumer answers carelessly, the Bill provides that the insurer may have a remedy according to whether it would have entered into the contract on different terms. If it would not have entered into the contract at all it may refuse all claims but it must return the premiums paid. If it would have entered into the contract on different terms, the contract may be taken to include those different terms. If the premium would have been higher this may have consequences for the amount of any claim. If the consumer acts with reasonable care, the insurer must pay the claim in full.

The Bill applies to the whole of the United Kingdom.

1 Introduction

Insurance is based on a contract between insured and insurer. The insurer weighs up the risks of the proposal and offers insurance at a price (premium). The level of risk affects the premium. Some elements of the risk are public knowledge, for example how likely it is that an area will flood, and the insurance company can make its own assessment of these factors. Other elements are known only to the insured. The insurers attempt to discover these by asking questions in the proposal. Some questions – age, gender etc – are specific, however, insurers can also ask that the customer discloses all facts that are 'material to the insurance decision'.

Up to this point in the application process the insured knows more than the insurer about the risks inherent in the contract. However, this asymmetry switches sides when the insured is asked to disclose all material facts. Relatively few people who take out insurance are insurance professionals; even fewer can predict with confidence exactly what one insurance company will deem material as compared to another. Many policyholders, for example, would not naturally think it material to tell their house insurer that a family member has returned to live with them after being released from prison. An even less obvious cause for disclosure is the reported case of a life policy claim for a woman, who died of leukaemia, which was refused by the company because her impaired hearing had not been disclosed.

Consumer groups, the industry, industry regulators and legal commentators all accept that reform is needed and have done so for some time. A Law Commission Report looked at the issue in the 1980s[1] and the then National Consumer Council argued for change in a campaign in 1997. Whilst the issues have not materially changed over time, the move from manually filled in forms to quick internet applications has, it is argued, made it more likely that consumers fail to disclose things which insurers can try to use to avoid liability. Written evidence from a group of consumer bodies to the Lords Special Bill Committee (see below) gave several examples of current insurance advertising where the emphasis is upon the speed within which insurance can be arranged. Whilst this aspect obviously has an appeal to consumers, one can see that if the insurers instead advertised 'the possibility of making important financial decisions that could, if done wrongly, lead to you (the consumer) being thousands of pounds out of pocket, in 30 seconds' then the attraction might be less.

This Bill has the aim of clarifying the procedures and responsibilities of both sides of the insurance contract. In written evidence to the Lords Special Bill Committee, the Financial Ombudsman summarised it thus:

> The Bill principally covers the issue of what a consumer should tell an insurer before taking out insurance. The current law requires a consumer to volunteer information about anything which a "prudent insurer" would consider relevant. However, as the Law Commissions have noted, most consumers are unaware of this requirement. As a result, generally accepted good practice within the industry now is that insurers ask consumers questions about the things that they want to know. The purpose of the Bill is therefore to codify this by replacing the duty to volunteer information with a duty on consumers to take reasonable care to answer insurer's questions fully and accurately, and to make a distinction between mistakes which are "reasonable", "careless" or "deliberate or reckless".[2]

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1 Law Commission, *Insurance Law , Non Disclosure & Breach of Warranty*, Cmnd 8064

2 Lords Special Bill Committee proceedings; memorandum from Financial Ombudsman Service

2 Insurance disclosure law

The Explanatory Notes to the Bill establish that there are multiple layers of law, regulation, commercial best practice and advice governing what firms and their customers should adhere to by way of reasonable commercial practice.

The Association of British Insurers (ABI), which broadly supports the Bill, illustrated the interaction of these 'layers' in its evidence to the Lords Special Public Bill Committee, the ABI wrote:

> Insurance industry practice has been developing over time, with a gradual shift of responsibility from the insured to the insurer. As mentioned in the Law Commissions' 2009 report, the insurance industry has long accepted that many of the rules set out in the Marine Insurance Act 1906 are outmoded and inappropriate for a modern consumer market. We accept that the operation of two regimes in parallel - one reflecting the strict letter of the law, the other good market practice - is incoherent and potentially confusing to the customer. Insurers want to be as clear as possible as to the information they require the customer to disclose.[3]

Similarly in his oral evidence to the same Committee, Law Commissioner David Hertzell quoted Lord Justice Lord Justice Rix, who, said in 2007,that:

> "in a country that prides itself on its adherence to the rule of law, the opening up of a gap between the law as applied in the courts and the self-regulation that applies as a matter of discretion to the relations between the insurance industry and its consumers might be said to be an unsatisfactory state of affairs".[4]

The next section of this Paper outlines in more detail the various approaches and 'layers' of rules and regulation.

Statute Law

At the top is statute law, then FSA Rules and then the principles adopted by those involved with dispute resolution, often devised in accordance with industry guidance. The Explanatory Notes set out this framework:

> 6. British insurance law developed during the 18th and 19th centuries, and was partly codified by the Marine Insurance Act 1906 ("the 1906 Act"). Although strictly the 1906 Act only applies to marine insurance, the courts have consistently held that it applies to all forms of insurance, including consumer insurance, on the grounds that it codifies the common law.
>
> 7. The 1906 Act requires that the insured person must disclose every matter that would be material to the insurer's decision to insure. Failure to do this permits the insurer to avoid the contract and refuse all claims under it, even where the insured person is not aware of what the insurer would consider material.
>
> 8. To ameliorate the effects of the existing statute law a series of guides and codes have been produced by regulators (the Financial Services Authority and the Financial Ombudsman Service have both produced guidance) and industry (the Association of British Insurers has produced a code of conduct). The 1906 Act specifies one set of

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3 HL Special Public Bill Committee; http://www.publications.parliament.uk/pa/ld201012/ldselect/ldspbc/219/21912.htm

4 HL SPB Committee 10 November 2011, http://www.publications.parliament.uk/pa/ld201012/ldselect/ldspbc/219/21913.htm

> rules, FSA Rules set out different standards and the FOS reaches decisions on a third and separate set of principles.[5]

The application of the wording in the *Marine Insurance Act* is critical to the issue affecting other (non-marine) insurance customers. Section 17 of the Act says:

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

Insurance law and practice has 'translated' the utmost good faith requirement into the business practice of 'full disclosure' without consistently setting out what this means in day to day practice and thereby having to rely on court cases, or decisions made by successive Ombudsmen, to determine it in individual cases.

Regulatory rules

The Financial Services Authority (FSA) is the regulator for general insurance. It has produced rules in its Handbook which are binding on authorised insurers. It states:

> A rejection of a *consumer policyholder's* claim is unreasonable, except where there is evidence of fraud, if it is for:
>
> (1) non-disclosure of a fact material to the risk which the *policyholder* could not reasonably be expected to have disclosed; or
>
> (2) non-negligent misrepresentation of a fact material to the risk; or
>
> (3) breach of warranty or condition unless the circumstances of the claim are connected to the breach and unless (for a *pure protection contract*):
>
> (a) under a 'life of another' contract, the warranty relates to a statement of fact concerning the life to be assured and, if the statement had been made by the life to be assured under an 'own life' contract, the *insurer* could have rejected the claim under this *rule*; or
>
> (b) the warranty is material to the risk and was drawn to the *customer's* attention before the conclusion of the contract.[6]

Jurisdictional practice

The body frequently called upon to judge whether a company or the customer are right in a case of non-disclosure is the Financial Ombudsman. It has produced the following principles which it follows in deciding cases brought before it:

> Taking account of the law and good industry practice, we approach non-disclosure/misrepresentation cases in three stages. We summarise these three stages below, before describing each one in a little more detail.
>
> When the customer sought insurance, did the insurer ask a clear question about the matter which is now under dispute?
>
> Did the answer to that clear question induce the insurer; that is, did it influence the insurer's decision to enter into the contract at all, or to do so under terms and conditions that it otherwise would not have accepted?

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5 Explanatory Notes Bill 274

6 FSA Handbook ICOBS 8.1.2

Only if the answers to both (1) and (2) are "yes", do we go on to consider whether the customer's misrepresentation was an honest mistake, a dishonest attempt to mislead or due to some degree of negligence.

1. clear questions

The insurer must first provide evidence that it asked the customer a clear question when the customer asked to take out or renew a policy. The insurer may ask questions via a traditional proposal form, which records the answers.

In many cases the transaction will have taken place over the telephone. If there is no evidence, such as a call recording and/or a copy of the statement of facts that the insurer has sent the customer, then we will have to decide what is likely to have happened. If the customer gives a credible account of events, we may find it more likely than the insurer's version.

A similar statement of fact would be required for internet sales; as would some evidence of the questions asked during the website process, as it existed at the time of the application.

In order for non-disclosure to occur, the insurer must show that it asked clear questions.

2. inducement

Legally, the insurer must establish that the non-disclosure or misrepresentation "induced"(or influenced) its decision to enter into the contract. This was established in Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd (Reported [1994] in Volume 3 of the Weekly Law Reports at page 677).

If the insurer cannot prove inducement then the policy will remain valid, even if the non-disclosure was deliberate. The burden of proving inducement will not be high in clear-cut cases. For example, if a customer fails to disclose that their house has serious cracks, we are likely to believe the insurer would not have offered them full buildings insurance.

However, it is rare for cases to be this clear-cut and we will usually require evidence that inducement took place. This may be in the form of a statement from the underwriters and/or a copy of the underwriting manual.

3. the customer's state of mind

Not all instances of non-disclosure or misrepresentation breach the duty of "utmost good faith". We have identified four types of non-disclosure (deliberate, reckless, innocent, and inadvertent) to help us decide whether, with regard to all the available evidence, the customer acted in breach.

It is possible to deliberately non-disclose without being fraudulent. While dishonesty is one of the essential criteria for fraud, there must also be deception, designed to obtain something to which you are not entitled. For example, a customer might deliberately withhold information they are embarrassed about. Although, in doing so, they are acting dishonestly and deliberately, they are not acting fraudulently because there is no deceitful intention to obtain an advantage.

Only where there is clear evidence of fraud should the insurer retain the premium. In all other cases of deliberate or reckless non-disclosure, the premium should be returned, not least so as to protect the insurer's position. Retaining the premium could be

interpreted as an intention to affirm the contract and/or waive the right to "avoid". Our experience is that most insurers return the premium in any event.

deliberate

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

reckless

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

innocent

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

inadvertent

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

Inadvertence occurs when the customer unintentionally misleads the insurer. This can occur just by failing to read and check the questions and answers thoroughly enough. When this happens there is no breach of the duty of utmost good faith.

For example, a policy application may contain a clear question about motoring convictions and penalty points. The customer discloses a careless-driving conviction but fails to disclose that they have three penalty points for speeding. In that situation, we might believe that the customer genuinely overlooked his conviction. The customer clearly did not intend to mislead the insurer because he disclosed the more serious offence; he simply failed to realise that penalty points were also part of the question. So the insurer should act as it would have done if it had been in possession of the full facts.

Where there has been inadvertent non-disclosure or misrepresentation, we expect insurers to rewrite the insurance. This should be done on the terms they would originally have offered if they had been aware of all the information. In some cases this may result in a proportionate payment; in others it may result in no payment at all. This is because the inadvertently-withheld information would, if disclosed, have led to the firm declining the application altogether.

Everything turns on the individual circumstances. Customers will find it more difficult to prove that they acted inadvertently if they answered several questions badly. To get

> one or two questions wrong may be regarded as inadvertent; to get several wrong starts to look like recklessness.[7]

The same publication from which this guidance is taken – *Ombudsman's News* – also has compilations of cases brought before it on the theme of non-disclosure. A selection of these can be found in the Appendix to this Paper.

7 Website of Financial Ombudsman, *Ombudsman's News*, May June 2005

Industry guidance

The ABI introduced industry guidance in 2008. It was drawn up in conjunction with the Financial Ombudsman Service and was specifically targeted at claims for critical illness and other health related protection policies. The guiding principles are shown in the table below

Category	Explanation	Outcome
Innocent	• The customer has acted honestly and reasonably in all of the circumstances, including the customer's individual circumstances but only where these were known to the insurer. • In the circumstances, a reasonable person would have considered that the information was not relevant to the insurer. • The non-disclosure would have resulted in a different underwriting outcome.	Pay the claim in full
Negligent	• Applies where the non-disclosure resulted from insufficient care – the failure to exercise reasonable care. This includes anything from an understandable oversight or an inadvertent mistake to serious negligence. • In the circumstances, a reasonable person would have known that the information given was incorrect and was relevant to the insurer. • The non-disclosure would have resulted in a different underwriting outcome.	Apply a proportionate remedy
Deliberate or without any care	• Only applies where the non-disclosure was deliberate or without any care. • In the circumstances, on the balance of probabilities, the customer knew, or must have known, that the information given was both incorrect and relevant to the insurer, or the customer acted without any care as to whether it was either correct or relevant to the insurer. • The non-disclosure would have resulted in a different underwriting outcome.	Avoid the policy (decline the claim and cancel the policy from inception)

According to an ABI press release issued in 2009:

> ABI guidance on insurance claims has helped halve long-term protection complaints to the Financial Ombudsman Service (FOS) since it was introduced in January 2008 according to new figures. The guidance was established to ensure that all ABI members were treating customers fairly in dealing with claims where they had made unintentional mistakes by failing to disclose medical and other information.
>
> New figures from the FOS show that since the guidance was introduced the number of referrals they have received for disputed protection claims of this nature have declined dramatically throughout the year. The first quarter of 2008 saw 85 cases referred to the FOS, compared to 40 cases in the last quarter of the year.
>
> As from today, the guidance has been formally upgraded to a Code of Conduct, in order to avoid any doubt that it was not mandatory for ABI members. The new code has also been extended to include group protection, extending the benefits to more customers. This sends a powerful signal that insurers put their customers' interests first.[8]

[8] ABI press release 19 January 2009

3 Law Commission Report

The Law Commission and Scottish Law Commission produced a joint Report in 2009 called *Consumer Insurance Law: Pre – Contract Disclosure and Misrepresentation*.[9] Extracts from the Summary version of the Report are shown below:

> 1.3 It is clearly important that insurers receive the information they need to assess risks. Most insurers, however, now accept that they should ask questions about the things they want to know. Our draft Bill replaces the duty to volunteer information with a duty on consumers to take reasonable care to answer the insurer's questions fully and accurately.
>
> 1.4 Where a consumer does make a mistake on an application form, the draft Bill distinguishes between mistakes which are "reasonable", "careless" or "deliberate or reckless":
>
> (1) For *reasonable* misrepresentations, the insurer must pay the claim.
>
> (2) For *careless* misrepresentations, the draft Bill provides a proportionate remedy, based on what the insurer would have done had it known the facts.
>
> (3) For *deliberate or reckless* misrepresentations, the insurer may refuse the claim.
>
> [...]
>
> The report identifies four problems with the 1906 Act, which the draft Bill is designed to address:
>
> (1) *The duty to disclose may operate as a trap for consumers*. Consumers are usually unaware that this duty exists or, even if they know that they should disclose facts, they may have no idea of what is relevant to the insurer.
>
> (2) *Policyholders may be denied claims when they have acted honestly and reasonably*. If the untrue statement is deemed to be one of fact rather than belief, it does not matter that the consumer tried his or her best to get it right.
>
> (3) *The remedy for misrepresentation and non-disclosure may be overly harsh*. The law entitles the insurer to "avoid" the policy. This means that the insurer may refuse all claims, even claims which the insurer would have paid had it been given full information. This is appropriate where consumers are deliberate or reckless, but not appropriate where they are merely careless.
>
> (4) *A statement on a proposal form can be converted into a warranty using obscure words that most policyholders do not understand*. If a prospective policyholder signs a statement on the proposal form stating that the answers form "the basis of the contract", this converts all the answers into warranties. If any statement is incorrect, the insurer may refuse all claims, even if the mistake is of no importance to it.
>
> [...]
>
> THE NEED FOR LEGISLATION
>
> 1.19 Each year, around three-quarters of households buy insurance. The question of what a consumer must tell an insurer before entering into the contract is one which

[9] LC 319; 15.12.2009

concerns all consumers who take out insurance and all the insurers who deal with them.

1.20 We estimate that each year the issue generates around a thousand complaints to the FOS, and an unknown number of disputes not taken to the FOS. These disputes often come at a particularly sensitive time. Many of the complainants in our surveys were seriously ill or recently bereaved. The disputes may also involve substantial claims: three out of the forty-seven recent cases we looked at involved more than £100,000.

1.21 The law in this area needs to be clear, straightforward and fair. The report identifies five problems with the current reliance on codes and guidance:

> (1) *Consumers are only able to obtain justice from the FOS, not from the courts*. Although the FOS decides cases according to what is fair and reasonable, it cannot help all those with disputes. Where the amount in dispute exceeds the FOS's compulsory jurisdiction limit of £100,000, the FOS can only recommend that the insurer pays the full amount: it cannot require it. The following case, taken from our survey, outlines the problems. In this case, if the insurer refused to pay the balance over £100,000, the insurer would be forced to go to court, where the 1906 Act would apply.
>
> (2) *The rules applying to non-disclosure and misrepresentation are unacceptably confusing*. Many of the "warnings" given by insurers on this subject are misleading rather than helpful. Claims handlers sometimes fail to understand what the FOS requires, leading to claims being rejected unfairly. Additionally, many consumers with rejected claims do not realise that they have a right to complain to the FOS. The resulting muddle leads to a loss of confidence in the insurance industry.
>
> (3) *Confusion over the law penalises some vulnerable groups*. We have been told that particular problems exist for older consumers, for those with criminal convictions and for those with multiple sclerosis.
>
> (4) *The present system imposes inappropriate roles on the FOS, the FSA and the courts*. The FOS is forced to act as a policy-maker rather than an adjudicator; the FSA is distracted from its key purpose; and the courts are systematically forced to reach unfair decisions.
>
> (5) *Increasingly, differences in law between the UK and its European partners need to be justified*. The law as set out in the Marine Insurance Act 1906 and the various layers of rules and guidance cannot be justified before an international audience.

[...]

1.24 The draft Bill abolishes the duty currently imposed on consumers to volunteer material facts. Instead, consumers are required to take reasonable care not to make a misrepresentation. This new duty is central to the draft Bill. It means that consumers must take reasonable care to answer insurers' questions fully and accurately. If consumers do volunteer information, they must take reasonable care to ensure that the information is not misleading.

1.25 Where an insurer has been induced by a misrepresentation to enter into an insurance contract, the insurer's remedy will depend on the consumer's state of mind:

> (1) Where a misrepresentation is *honest and reasonable*, the insurer must pay the claim. The applicant is expected to exercise the standard of care of a

> reasonable consumer, bearing in mind a range of factors, such as the type of policy and the clarity of the question. The test does not take into account the individual's own subjective circumstances (such as knowledge of English), unless these were, or ought to have been, known by the insurer.
>
> (2) Where a misrepresentation is *careless*, the insurer has a compensatory remedy. This is based on what the insurer would have done had the consumer taken care to answer the question accurately and completely. For example, if the insurer would have added an exclusion, the insurer need not pay claims which fall within the exclusion but must pay all other claims. If the insurer would have charged more, it must pay a proportion of the claim.
>
> (3) Where the misrepresentation is *deliberate or reckless*, the insurer may "avoid the policy". In other words, it may treat the policy as if it does not exist and decline all claims. The insurer would also be entitled to retain the premium, unless there was a good reason why the premium should be returned.

[...]

> 1.36 In addition, the draft Bill:
>
> (1) Abolishes "basis of the contract" clauses.
>
> (2) Makes special provisions for group schemes, where one party (typically an employer) arranges insurance to benefit members of the group (typically employees). The draft Bill brings the law into line with good practice by providing that where a group member makes a misrepresentation, it has consequences only for that individual, not for others within the group.
>
> (3) Deals with situations where one consumer takes out insurance on the life of another. If the person whose life is insured makes a careless or deliberate misrepresentation, the insurer has a remedy.
>
> (4) Prevents insurers from contracting out of the proposed scheme to the detriment of the consumer.[10]

4 The Bill

The Bill was introduced in the House of Lords on 16 May 2011. It had a short second reading committee[11] and a purely formal third reading.[12] It was the first Bill to go forward under the new Law Commission Bill procedures since they were made permanent in 2010.[13]

Law Commission Bills are committed to a Special Public Bill Committee. The Committee may call for oral and written evidence from witnesses.

Proceedings of the Committee can be traced from here.[14] One amendment was made to the Bill in Committee. It concerned the renewal of an insurance contract. Technically this is a

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10 The Law Commission and Scottish Law Commission Joint Report; *Consumer Insurance Law: Pre – Contract Disclosure and Misrepresentation, Summary*

11 HL Deb 13 June 2011 GC89-102

12 HL Deb 17 January 2012 c463

13 HL Deb 3 June 2011 GC99

14 HL Special Public Bill Committee http://www.publications.parliament.uk/pa/ld201012/ldselect/ldspbc/219/21902.htm

new contract, not an extension of an old one. The amendment clarified that questions asked at renewal "constitute the entire set of questions relevant to the new contract".[15]

The Bill before the Commons can be found here. The Bill extends to the whole of the United Kingdom.

The Explanatory Notes to the Bill can be found here.

A good description of the main points of the Bill can be had from evidence given to the Special Bill Committee by Law Commissioner David Hertzell. He said:

> I will run through the key features of the Bill so that we have them in mind. The key thing is that the Bill abolishes the consumer's duty to volunteer information. The Marine Insurance Act imposes a duty on the consumer to tell the insurer anything that could influence the judgment of the prudent insurer. If the consumer fails to disclose that information, the policy may be treated as void. That is being abolished by this Bill; instead, the consumer must take reasonable care to answer the insurer's questions fully and accurately. If the consumer chooses to volunteer information, they must take reasonable care to ensure that that information is not misleading. [...]
>
> It is already accepted good practice that insurers should ask questions about what they want to know. The ombudsman refuses to allow insurers to avoid consumer policies for non-disclosure where no questions have been asked. The Bill also sets out the insurer's remedies where they have been induced by misrepresentation to enter into an insurance contract, and the remedy will depend upon the consumer's state of mind. If the misrepresentation was honest and reasonable—the sort of representation that anyone could make in the circumstances—the insurer must pay that claim. As I said, though, there is an obligation on consumers to answer the questions that they are asked by insurers honestly and reasonably and to ensure that their replies are accurate and complete. [...]
>
> The consumer is expected to exercise the standard of care of a reasonable consumer, taking into account a range of factors—and I quoted a couple that are listed in the Bill, including the type of insurance policy and the clarity of the question that they were asked. If the misrepresentation was careless, the insurer will have a compensatory remedy based on what the insurer would have done had the consumer taken care to answer the question accurately. For example, if the insurer would have charged more, it will have to pay only a proportion of the claim. If the misrepresentation was deliberate or reckless, the insurer may treat the policy as if it never existed and may decline all claims. It would also be entitled to retain the premiums. It is fair to say that this approach is supported by the ombudsman. It is reflected in the 2009 ABI code on group life, critical illness and income protection, so it is familiar to the industry in a consumer context.
>
> We are abolishing the basis of the contract clauses in the Bill. Under current law, an insurer may add a declaration to a proposal form or policy in which they state that the consumer warrants the accuracy of all the answers that they give. That means that if some of that information is inaccurate, whether or not it was relevant to the claim or the loss, the insurer is discharged from all liability—even if the insurer was not induced to enter the contract by that statement. It is a very harsh remedy. It was recognised by the Statement of General Insurance Practice in 1986 that these clauses should be barred for consumers as they were not thought to treat consumers fairly.

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15 HL Special Public Bill Committee 10 November 2011 Lord Eatwell

> We also deal with group insurance. Typically, a group scheme is where an employer takes out insurance on behalf of the employees. The problem is that the employer is the contracting party and therefore, under the obligation to disclose information, but the information is in the knowledge of the individual employees who are protected by the policy. This is a very important sector to individuals—about 40 per cent of life cover comes through such group schemes—but the law is quite underdeveloped. We have tried to bring it into line with good practice so that, where a misrepresentation is made by a group member, the consequences of that fall on the group member in line with the Bill but do not affect the rest of the members. That is pretty well the approach applied by the industry now.
>
> We are trying to deal with the position of intermediaries. If there is an intermediary between the proposer and the insurer, it is not unusual for consumers sometimes to blame intermediaries for the failure to transmit information. The central question is who should bear the risk. Should the insurer pay the claim and then recover from the intermediary, or may the insurer refuse to pay the consumer's claim, leaving the consumer to proceed against the intermediary? It is a question of whose agent the intermediary was when they were acting, and we are trying to set out some guidance to establish that.
>
> This Bill is being prepared in the context of a significant part of the UK economy. Consumer insurance is worth about £40 billion a year to the economy. The FOS receives around 1,000 complaints a year about misrepresentation and non-disclosure, and around half of those complaints are upheld. In the overall context, that is an extremely good record, although, as Lord Sassoon has said, this uphold rate is lower than one might expect if the rules were clear. One would expect the insurers to know what the rules were and the uphold rate to be much higher. By "uphold rate" I mean the claims that are upheld in favour of the insurer. It is also worth bearing in mind that even though the overall number of such disputes going to the ombudsman is relatively small, it affects consumers at a time when they are particularly vulnerable and not in a position necessarily to take on a dispute about whether their claim should be paid.
>
> Looking forward, it is possible that insurance may play a greater role in providing welfare and security—for example, in the funding of long-term care—and it is difficult to see how the current hotchpotch of different rules and fairly antiquated legislation gives us a firm foundation to do that. We sought to codify the current best practice and put the rules into one place so that both parties know what their rights are.[16]

The Explanatory Notes state:

The Bill replaces the duty of the consumer to volunteer relevant material information to the company with a duty on them to take reasonable care not to make a misrepresentation during pre-contractual negotiations. If a consumer breaches this duty and this misrepresentation induces the insurer to enter the contract, the insurer will have a remedy. The nature of the insurer's remedy depends on the nature of the consumer's misrepresentation.

If a consumer makes a deliberate or reckless misrepresentation, the Bill permits the insurer to treat the contract as if it never existed and refuse all claims.

If, when answering questions posed by an insurer, a consumer answers carelessly, the Bill provides that the insurer may have a remedy according to whether it would have entered into the contract on different terms. If it would not have entered into the contract at all it may

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[16] HL Special Public Bill Committee, 11 October 201, http://www.publications.parliament.uk/pa/ld201012/ldselect/ldspbc/219/21903.htm

refuse all claims but it must return the premiums paid. If it would have entered into the contract on different terms, the contract may be taken to include those different terms. If the premium would have been higher this may have consequences for the amount of any claim. If the consumer acts with reasonable care, the insurer must pay the claim in full.

Appendix 1 – Non-disclosure insurance cases brought before the Financial Ombudsman

Cases taken from *Ombudsman's News* August 2005

life assurance – inadvertent non-disclosure

In December 2002 Mrs D applied to the firm for life assurance cover of £100,000 and for £35,000 critical illness cover. Two years later she was diagnosed with breast cancer. The firm refused to meet her claim. It said this was because she had not disclosed that for most of the early 1990s she had been suffering from, and received treatment for, back pain following childbirth. It considered the fact that she had not revealed this information to be reckless non-disclosure. Mrs D told the firm that she had not thought she needed to disclose this information. She had thought the question on the firm's application form referred only to illnesses that had resulted in her taking time off work during the previous five years. It was more than five years since she had suffered from the back pain and she had never needed to take time off work because of it.

In response, the firm pointed out that it had asked whether she had "***ever*** suffered" from "back or spinal trouble". Mrs D said she did not believe that back pain due to childbirth was "back or spinal trouble". Unable to reach agreement with the firm, Mrs D came to us.

complaint upheld
After studying the questions that the firm put to Mrs D when she applied for insurance, we noted that – in answer to most of the questions – Mrs D needed to give information only about any medical consultations that had occurred during the previous five years.

However, the firm's question about "back or spinal trouble" was not limited to that five-year period. We felt that the wording of this question was potentially misleading. We accepted that Mrs D had genuinely misunderstood the question and that any non-disclosure was inadvertent.
However, we thought that that a careful reading should have made it clear that the firm wanted to know about all back and spinal trouble, regardless of how it occurred or when she had sought treatment for it. We took the view that Mrs D had been slightly careless in completing the application.

Slightly careless or inadvertent non-disclosure entitles an insurer to rewrite the insurance policy. It should do this on the terms that it would have offered originally, if it had been fully aware of the applicant's medical history. In this case, the firm would have offered full cover except for back and spinal problems.

We required the firm to reinstate Mrs D's policy – adding the exclusion for back and spinal problems – and to deal with the claim on those terms. There was no connection between Mrs D's breast cancer and the exclusion clause so the firm had to meet her claim in full, together with interest.

motor insurance – deliberate non-disclosure

Mrs G took out motor insurance by telephone. In answer to one of the firm's questions she said that she was the owner and keeper of the car. Mrs G asked for her son, A, to be added to the policy as a named driver. The firm sent Mrs G details of all the information she had given and that it had relied on when deciding the terms of her insurance policy, asking her to let it know if anything was incorrect. Mrs G did not make any changes.

A few months later, after A was involved in a road traffic accident, the firm discovered that the car was registered in his name, not his mother's. The firm also found that the receipt for the car named A as the purchaser. When the firm declined to meet the claim, Mrs G insisted that she was indeed the real purchaser and owner of the car. She said that the registration documents had been issued in her son's name by mistake. The firm told her it would not have insured the car at all if it had known that A was the owner. Unable to reach an agreement, Mrs G came to us.

complaint rejected
In our view, the questions that the firm had asked Mrs G when she applied for insurance were clear and unlikely to be misunderstood. And the firm had specifically drawn Mrs G's attention to the importance of accurate information and records.

Her failure to reveal that the car was registered in A's name had induced the firm to offer insurance. As it would not have insured the vehicle if it had been aware of the true position, the firm was entitled to *avoid* the policy (treat it as though it had never existed). We rejected the complaint.

life and critical illness insurance – innocent non-disclosure

In January 2005, Mr E was diagnosed with lung cancer and put in a claim to the firm. Over six years earlier, in November 1998, he had taken out life and critical illness insurance cover worth £150,000. After carrying out enquiries, the firm found that in September 1997 Mr E's GP had recorded that Mr E was consuming approximately 80 units of alcohol a week (21 units is the recommended maximum weekly amount for men). In February 1998 Mr E's alcohol consumption was up to 84 units a week but by July of the next year it had gone down to a more moderate 40+ units a week.

The firm said this differed greatly from the declaration Mr E made when applying for insurance. He had said then that his average alcohol consumption was five units a day (35 per week). The firm told him that if it had been aware of his drinking habits, it would have increased his premium by 200-300%. It refused to pay the claim and it returned his premium, avoiding the policy from its start date.

Mr E was extremely angry with the firm's response. He said that when he applied for the insurance he had answered all the firm's questions accurately. He pointed out that he had, at that time, been the sole carer for his newly-born daughter and could not have handled his responsibilities if he had been drinking as heavily as before. The firm still maintained that he was likely to have been drinking more than he had claimed.

complaint upheld
When the complaint was referred to us we found no evidence concerning Mr E's drinking habits at the time he applied for the insurance. The amount he had said he was drinking (five units a day or 35 units a week) was close to the 40+ units a week that his GP had recorded eight months later. Mr E had given a plausible explanation for his answer and the firm had no justification for disregarding it. As there was no evidence of non-disclosure or misrepresentation, we required the firm to reinstate the policy and meet the claim. The firm agreed to pay the full sum of £150,000, plus interest.

household insurance – deliberate non-disclosure

Mr A applied for household insurance. After receiving his completed questionnaire, the firm agreed to put the policy into effect from 28 June 2002. They also sent him a statement of facts, setting out the information he had given. In response to a question asking whether he had any "non-motoring convictions" he had replied "none".

The following day, Mr A contacted the firm to say that his house had been burgled. However, the firm was unable to get any response when it tried to arrange for its investigator to visit him at home. It heard nothing more until January 2003, when it was informed that Mr A was in jail.

In the course of the firm's subsequent investigations, it discovered that – at the time Mr A took out his policy – he had a criminal record for possession of drugs and resisting arrest. After making the burglary claim, Mr A had again been found in possession of drugs and was fined for resisting arrest. Finally, three months after the burglary, he was remanded in custody on a murder charge.

The firm told Mr A that it would not have insured him if it had been aware of his criminal record. It said it would *avoid* his policy and refund the premium. Mr A complained to the firm, saying he had not been asked about his criminal record. When the firm rejected his complaint he came to us.

complaint rejected
Unfortunately the firm was unable to produce the questionnaire that Mr A had completed when he applied for the insurance. It had only kept a copy of the statement of facts. This established that the firm was likely to have asked Mr A whether he had any non-motoring convictions. Mr A admitted that he had kept a copy of the application form. However, he would not let us see it. We concluded that although the firm was remiss in not keeping all the original paperwork, it had still been entitled to decide that Mr A had not answered its questions accurately, and to *avoid* his policy for deliberate non-disclosure.

household insurance – deliberate non-disclosure

Mr M's home was broken into in October 2002. The burglars had kicked in a panel in his back door and stolen many of his possessions. After accepting his claim for the stolen contents, the firm arranged for one of its approved contractors to replace the back door, even though the council owned the property and was responsible for repairing the damage.

Early the following year, shortly before Mr M's policy was due to expire, the firm sent him a renewal questionnaire. This asked for details of his current security arrangements. Mr M completed the form, confirming that his external doors had *"a mortise deadlock and security bolts or a key-operated locking system"*.

The firm renewed the policy, but within a month Mr M's property was broken into a second time. Again, the thieves had kicked in the rear door panel. When the firm discovered that the back door did not, in fact, have security bolts or a key-operated locking system, it refused to meet Mr M's claim. After complaining unsuccessfully to the firm, Mr M came to us.

complaint upheld
We accepted Mr M's explanation that he had assumed the firm's contractors had installed a door that met the firm's own security requirements. It was *careless* of him not to have double-checked this. However, given that his other answers were accurate, we were satisfied that he had not deliberately or recklessly supplied an incorrect answer.

We also took two further factors into account. First, even if Mr M had realised that he needed to fit bolts, we did not believe they would have impeded the burglary. This was because the burglars had entered the house by kicking in the door panel. Second, even if Mr M had answered the question correctly, the firm would still have allowed him a reasonable period of time in which to change the locks. The burglary occurred within this timescale.

We upheld the claim. We did not think Mr M's failure to comply with the security condition was connected with the loss and we pointed out to the firm that it was good insurance practice to meet claims in such circumstances.

term life assurance and critical illness insurance – reckless non-disclosure

In December 2001, Mr and Mrs W applied for term life assurance and critical illness insurance. This included own occupation cover, which paid benefits if either of them was unable to continue with their own occupation because of permanent total disablement.

In response to the firm's questions they both stated that they were not *"currently receiving any medical treatment or attention or awaiting any medical or surgical consultation, test or investigation" and had "never had any medical or surgical treatment, including investigations, tests, scan or X-rays for any … mental or nervous illness (including depression) lasting for more than 3 months and/or requiring more than 10 consecutive days off work"*.

The firm accepted the application on the condition that, since signing the application, Mr and Mrs W had not *"suffered any illness or required any medical attention or changed occupation"*.

Two years later, Mrs W submitted a claim for rheumatoid arthritis but the firm refused to meet it. It said her medical records showed that she had been consulting a doctor for carpal tunnel syndrome and depression for about eight years before the date when she applied for the policy. She had not disclosed this. In addition, she had never disclosed that – after she had submitted her application but a few days before it was accepted – she had seen her doctor for pain and swelling in her ankle. And she had failed to tell the firm that, before she received the firm's offer of acceptance, she had changed her occupation.

The firm said that although it was entitled to treat the whole policy as void from the start, it would not do this. However, it would exclude claims for Mrs W's previous health problems and would no longer provide the *own occupation cover*. Unhappy with this, Mr and Mrs W referred the complaint to us.

complaint rejected

We did not consider there to be any basis for requiring the firm to pay the sum insured for Mrs W's rheumatoid arthritis. We accepted that there was no link between her carpal tunnel syndrome and depression and the onset of her rheumatoid arthritis. However, this did not change the fact that, in response to clear questions, she had failed to disclose information about her health. In our opinion it was fair and reasonable of the firm to offer to rewrite the policy on the terms it would have offered originally — if it had been given the correct information. Mr and Mrs W appeared to have given very little thought to the accuracy of their answers, and their non-disclosure appeared to be at least *reckless*, which would have entitled the firm to void the policy.

commercial insurance – non-disclosure

In January 2001, there was a serious fire at Mrs Y's shop, which was insured with the firm under a commercial policy. The fire brigade thought the fire might have been caused by an electrical fault.

The firm made an interim payment to Mrs Y of £10,000 and appointed loss adjusters. In the course of their investigations the loss adjusters discovered that Mrs Y's business owed its suppliers £70,000. Mrs Y had borrowed almost £100,000 from her bank over the previous two years and had made incorrect statements when applying for the bank loans. The loss

adjusters also discovered that, in her original insurance application, Mrs Y had failed to disclose that the ground floor of her shop unit was unoccupied and was not properly secured.

The firm told Mrs Y that it was treating her policy as void. This was because she had failed to disclose that the building was not secure and that her business was in difficulty, even though it had questioned her directly about these matters. The firm also believed that Mrs Y had committed a criminal offence in misrepresenting the purpose of the loans. Unhappy with the firm's actions, Mrs Y referred her complaint to us.

complaint dismissed

Mrs Y denied that her business was in difficulty. She said the money she had borrowed from the bank had originally been intended for home improvements, but she had later changed her mind. We noted that Mrs Y had run her business for several years and claimed to have run a previous business overseas. So the firm was entitled to treat her as a commercial customer and not a consumer. This meant that the firm was entitled to rely on the strict legal position. In the circumstances of this case and because of the fraud allegations, we concluded that the dispute was not suitable for our informal procedures and would better be dealt with in a court.