



CURRENT ISSUES IN INSURANCE LAW

MATERIAL NON-DISCLOSURE: PROPORTIONALITY, GOOD FAITH and REASONABLENESS

By Michael Kent QC



His practice is in professional negligence, building contracts, property disputes involving developers, product liability (contaminated blood products, the Camelford water pollution cases, CJD from human growth hormone) and other group litigation.

The General Principle

Pan Atlantic Insurance Co. Ltd v Pine Top Insurance Co. Ltd. [1995] 1 A.C. 501

1. Two limbs:
 - 1.1. That a material fact which had to be disclosed is one which would have had an effect upon the mind of a notionally prudent insurer in estimating the risk but the

House of Lords stopped short of requiring that it be something which would have had a decisive effect upon that prudent underwriter's acceptance of the risk or on the amount of premium demanded;

- 1.2. That before an underwriter could avoid a policy for non-disclosure of a material fact the underwriter had to show that he had actually been induced to enter into the policy on the terms which he did accept the risk.
2. Note: that many policies contain a clause whereby the insured warrants the accuracy of the contents of a proposal form. In such a case the insurer does not have to establish the second Pine Top limb – reliance and inducement. See: Unipac (Scotland) Ltd. v Aegon Insurance Company (UK) Ltd. [1999] 1 Lloyd's Rep. IR 502.
3. An insured's duty to disclose is likely to be affected by the terms of the proposal form so that the answers given in the proposal form may not be treated by the courts as unqualified assertions of truth. On the contrary they may be regarded merely as statements to the best of the knowledge and belief of the company secretary – see in this regard Economides v Commercial Assurance Co. Ltd. [1998] Q.B. 587.

Drake Insurance plc v Provident Insurance plc [2004] Q.B. 601

4. Propositions:
 - 4.1. It is for the insurer who wishes to avoid to show what would have happened if the truth had been told. (Rix L.J. at paragraph 64)
 - 4.2. It is the insurer who takes the risk that the true facts as of the time of contract do not support the right to avoid. Thus if the insured can show that although there was non-disclosure of some material facts if a full investigation of the facts as at the time of proposal would have resulted in the policy being written on the same terms the insurers will not be able to avoid even if the decision to avoid was made in good faith and was soundly based upon the information actually known to insurers at the time of making the decision to avoid. (Rix L.J. at paragraph 78). Note: Rix L.J. distinguished a case where the risk can be shown by later events not to be as great as the risk would have been assessed as being if

viewed in the light of the information available upon the basis of a full disclosure of all material facts at the time of underwriting the risk. See in this connection *Brotherton v Aseguradora Colseguros (No.3)* [2003] EWCA Civ. 705).

- 4.3. *“The existence of widespread insurance contracts of a consumer nature presents new problems. It may be necessary to give wider effect to the doctrine of good faith and recognise that its impact may demand that ultimately regard must be had to a concept of proportionality implicit in fair trading”.* (Rix L.J. at paragraph 89).
- 4.4. Pill L.J. held in effect that before avoiding the Provident should at least have told the insured what they had in mind and have given him an opportunity to update on the January 1994 accident. *“If more than lip service is to be paid to the principle that an insurer shall show the utmost good faith, the principle required that inquiry be made before the wholly one-sided remedy of avoidance was exercised”* (Pill L.J. at paragraph 177).
- 4.5. In any event Provident had waived any right to avoid by later accepting premiums and by issuing insurance documentation to Dr. Singh in respect of another car (paragraphs 94-104, 146, 183-184).

THE FINANCIAL SERVICES AUTHORITY HANDBOOK

Insurance Code of Business

5. Statutory background: Financial Services and Markets Act 2000 has been applied since 14th January 2005 so that certain activities relating to insurance contracts became regulated by the FSA for the first time.
6. For claims arising after 14th January 2005 the Insurance: Conduct of Business Sourcebook (“ICOB”) replaces the previous ABI General Statements of Insurance Practice. (The Statement of Long-Term Insurance Practice survives for the moment).
7. The ICOB distinguishes

7.1. between rules and guidance

and

7.2. between “Retail customers” and “customers”

and also

7.3. between “private persons” and “other persons”

8. Section 150 of 2000 Act gives a right to damages in certain cases – generally “Private persons” are given a right of action whenever a rule is broken and “any other person” is given a right of action if certain specified rules are broken.

9. Clause 7.3.6 of the ICOB provides

An insurer must not

(1) unreasonably reject a claim made by a customer;

(2) except where there is evidence of fraud, refuse to meet a claim made by a retail customer on the grounds:

(a) of non-disclosure of a fact material to the risk that the retail customer could not reasonably be expected to have disclosed;

(b) of misrepresentation of a fact material to the risk, unless the misrepresentation is negligent;

(c) in the case of a general insurance contract, of breach of warranty or condition, unless the circumstances of the claim are connected with the breach; or

(d) in the case of a non-investment insurance contract which is a pure protection contract, of breach of warranty, unless the circumstances of the claim are connected with the breach and unless:

(i) under a ‘life of another’ contract, the warranty relates to a statement of fact concerning the life to be assured and that statement would have constituted grounds for rejection of a claim by the insurer under ICOB 7.3.6R(2)(a) or (b) if it had been made by the life to be assured under an ‘own life’ contract; or

(ii) the warranty is material to the risk and was drawn to the attention of the retail customer before the conclusion of the contract..

10. Thus in relation to all customers a claim must not be rejected “unreasonably”.

11. So far as retail customers are concerned the right to avoid for “*innocent*” misrepresentation goes.

Financial Services Ombudsman

12. Statutory background. The Financial Ombudsman Service substantially replaces the previous voluntary Insurance Ombudsman Bureau. (The FOS was established pursuant to section 225(1) of the FSMA 2000).
13. The Ombudsman will not necessarily determine a claim by reference to express legal rights: s 228 (2) of FSMA 2000 requires complaints “*to be determined by what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case*”.
14. The rules, found in the “DISP” module of the FSA Handbook, confer on the ombudsman express power to require redress which goes beyond anything available at common law:
- 14.1. DISP 3.8.2 (2) (designated a “Rule” and thus binding): “*In considering what is fair and reasonable in all the circumstances of the case, the ombudsman will take into account the relevant law, regulations, regulator’s rules and guidance and standards, relevant codes of practice and, where appropriate, what he considers to have been good industry practice at the relevant time*”
- 14.2. DISP 3.9.2 (again a “Rule”) allows the ombudsman to award monetary compensation for financial loss, pain and suffering, damage to reputation and distress or inconvenience.
15. The service is available to: “*private individuals*”; businesses with a turnover of less than £1m; charities with a turnover of less than £1m; trustees of a trust with a net asset value of less than £1m (DISP 2.4.3 (1)).
16. Binding awards up to £100,000 may be made (binding on the insurer or intermediary but not on the insured). Thus the insured can take the award if he or she likes or sue in the courts if the award is regarded as unacceptable. The firm is not bound to pay the balance of awards over £100,000 (DISP 3.9.5).
17. The effect of all this can be seen in *The Queen on the Application of IFG Financial Services Ltd. V Financial Ombudsman Services Ltd.* [2005] EWHC 1153 (Admin) in which the FSO’s decision to award compensation for losses which could not have been foreseen was upheld. The IFA was

in breach of its duty in putting the customer's funds in a high risk rather than low risk investment and that was enough, in the ombudsman's view, to require compensation to be paid though there would otherwise be no legal liability. This subjective judgment is subject to control by the courts only if it can be shown to be perverse or for other well established grounds of judicial review.

18. The Ombudsman has issued guidance as to *"our approach"* when dealing with non-disclosure cases:

18.1. *"It is widely recognised that applying the strict legal position in non-disclosure cases can result in unduly harsh outcomes"*.

18.2. That it is no longer appropriate for insurers to have the right to avoid a policy in toto for every breach of duty by the assured

and

18.3. That a proportionate award to the assured may be a fairer result particularly when the assured has not been fraudulent and the loss was not causally connected with the information withheld or misstated.

19. It is clear that the Ombudsman's approach is merits based. He distinguishes between *"fraudulent or deliberate"*, *"innocent"*, *"inadvertent"* and *"clearly reckless"* cases of non-disclosure. The FSO is likely to take into account a wide variety of factors including

19.1. The wording of the proposal form and the extent to which the questions asked are clear and concise

19.2. The reasons for the non-disclosure or misrepresentation and the state of mind of the insured at the time, in particular whether the non-disclosure can properly be described as inadvertent

19.3. The circumstances in which the proposal form was completed, including the role of any adviser or intermediary

19.4. The effect which the non-disclosure has had upon the policy terms, in particular whether the true facts would have resulted in only a small increase in premiums

- 19.5. Whether the outcome is manifestly unfair, when compared with the non-disclosure of the insured.

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