# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Background and proposals of the Law Commission review</td>
<td>6</td>
</tr>
<tr>
<td>Issues Paper on Misrepresentation and Non-disclosure</td>
<td>6</td>
</tr>
<tr>
<td>Issues Papers on Warranties and Intermediaries</td>
<td>8</td>
</tr>
<tr>
<td>Joint Consultation Paper on Misrepresentation, Non-disclosure and</td>
<td>8</td>
</tr>
<tr>
<td>Breach of Warranty by the Insured</td>
<td>9</td>
</tr>
<tr>
<td>Issue Paper on Insurable Interest</td>
<td>9</td>
</tr>
<tr>
<td>Discussion of the key issues arising from the draft Bill</td>
<td>9</td>
</tr>
<tr>
<td>Scope</td>
<td>9</td>
</tr>
<tr>
<td>The replacement of the duty of the consumer or proposer</td>
<td>10</td>
</tr>
<tr>
<td>to volunteer relevant information</td>
<td></td>
</tr>
<tr>
<td>Distinguishing between mistakes that are 'careless' or 'deliberate or</td>
<td>11</td>
</tr>
<tr>
<td>reckless'</td>
<td></td>
</tr>
<tr>
<td>Group schemes</td>
<td>13</td>
</tr>
<tr>
<td>Life of another</td>
<td>13</td>
</tr>
<tr>
<td>Insurers are prevented from contracting out of the proposed scheme</td>
<td>13</td>
</tr>
<tr>
<td>to the detriment of the consumer</td>
<td></td>
</tr>
<tr>
<td>Featured issue – Does the Intermediary act for the Insurer or the</td>
<td>13</td>
</tr>
<tr>
<td>Consumer?</td>
<td></td>
</tr>
<tr>
<td>Featured issue – Using tele-interviewing to gather pre-contract</td>
<td>16</td>
</tr>
<tr>
<td>information</td>
<td></td>
</tr>
<tr>
<td>Practical issues</td>
<td>18</td>
</tr>
<tr>
<td>Interaction with the Ombudsman</td>
<td>21</td>
</tr>
<tr>
<td>Financial impact of the draft Bill</td>
<td>21</td>
</tr>
<tr>
<td>What for the future – will this draft Bill ever become Law?</td>
<td>21</td>
</tr>
<tr>
<td>Political commentary</td>
<td>21</td>
</tr>
<tr>
<td>What would SCOR Global Life like to happen?</td>
<td>22</td>
</tr>
<tr>
<td>Conclusion</td>
<td>22</td>
</tr>
<tr>
<td>Appendix – Insurable Interest</td>
<td>23</td>
</tr>
</tbody>
</table>
Executive Summary

After years of discussion, consultation, Issues Papers and full engagement with insurers, consumer groups and other interested parties, a new Insurance draft Bill was published on 15 December 2009 jointly by the Law Commission and the Scottish Law Commission. It is intended that this will wend its way through the political process to hopefully be enacted over the next 12 to 18 months. It has been a very interesting process and some of the proposals were highly innovative.

As is often the case, the end result is not as far reaching as first suggested. Although various issues relating to insurance were discussed, the draft Bill only covers the area where there has been most demand for change; pre-contract disclosure and misrepresentation in consumer insurance. Nonetheless this will serve the industry and consumer groups well and lay some foundations for the possibility of further change in the years to come. It took most of what was good from the current Association of British Insurers’ (ABI) guidance and Financial Ombudsman Service (FOS) practice, simplified the process, highlighted the remedies and duties of all parties and should permit insurers to gain some much needed positive reputational value.

The key issues in the draft Bill are as follows:

- The replacement of the duty of the consumer or proposer to volunteer relevant information i.e. ‘the duty of disclosure’ of the consumer that the insurer currently relies on to assess the risk, is replaced with a duty for consumers to take reasonable care to answer the insurer’s questions fully and accurately.
- If the consumer does make a mistake on the application form, the draft Bill distinguishes between mistakes that are ‘honest and reasonable’, ‘careless’ or ‘deliberate or reckless’ and details the remedies available or not as the case may be for each such instance.
- Clarification of for whom an intermediary is acting when transmitting pre-contract information from the consumer to the insurer. An intermediary is acting for the insurer if:
  - He/she is the appointed representative of the insurer
  - The insurer has given the intermediary express authority to collect the information as its agent, or
  - The insurer has given the intermediary express authority to enter into the contract on the insurer’s behalf.
In all other cases the intermediary is presumed to be acting for the consumer unless it appears it acts for the insurer as determined by examining all the circumstances. The draft Bill sets out a list of factors that may be relevant, but the courts and the FOS would be able to consider new factors as the market changes.

- It abolishes ‘basis of the contract’ clauses.
- It makes special provisions for group schemes where one party (typically the employer) arranges insurance to benefit members (typically the employees).
- It deals with situations where one consumer takes out insurance on the life of the other.
- It prevents insurers from contracting out of the proposed scheme to the detriment of the consumer.

These issues are discussed further in sections 3, 4 and 5.

Some proposals made in the Consultation Paper and various Issues Papers are not included in the draft Bill, namely the following:

- Warranties – no reform is proposed currently except to abolish ‘basis of the contract’ clauses. It is intended to deal with these when the Law Commission gets the opportunity to deal with their proposals for business insurance reforms.
- A five-year non-contestability period for life policies – a proposal was put forward in the Consultation Paper to prevent insurers from relying on negligent misrepresentations after a life assurance policy had been in force for five years.
- Insurable interest – the rather interesting and innovative issues on the definition of insurable interest have not been included in the current proposals. This is discussed further in the Appendix.
- Business insurance – this may be reviewed at some point in the future.

This draft Bill is very unlikely to be passed before the next election, but does this mean that we should ignore what it says? In our view the proposed changes to the law cement many aspects of good practice and they were welcomed by most of the insurance industry when first mooted. Eventually, the current grossly outdated legislation will be brought into line with good operating practice and this will surely be to the benefit of insurance practitioners and consumers alike.
Introduction

Over the past few months, SCOR Global Life has monitored closely the production of the draft Bill on Pre-Contract Disclosure and Misrepresentation in Consumer Insurance Law. It has always been accepted that although the changes would be mostly in line with the practices that are currently adopted within the protection industry, the actual changes to the current Law would be quite robust.

We have worked with two of the industry’s respected consultants: Rona Doyle from Rona Doyle & Co Solicitors, and Karin Lloyd, a claims and underwriting specialist, to review the process from the initial consultation papers in 2006 to the issuing of the draft Bill and to produce this report, which helps identify the key issues from this complex and lengthy process.

This report is intended to provide an easy reference of the key issues. The Law Commission has issued a Final Report that contains the draft Bill as an appendix. We have included page references where appropriate so further information can be obtained from the relevant section of the Law Commission’s reports. LCR refers to the Law Commission’s Final Report and LCS refers to their Summary Report. Both of these are available for full review at http://www.lawcom.gov.uk.

For the purpose of this report, unless specified individually, the terms non-disclosure and misrepresentations are interchangeable.

2. Background and proposals of the Law Commission review

Insurance law was last considered by the Law Commission in 1980 where it concluded at that time that the law was undoubtedly in need of reform. Reform was also urged in the report of the National Consumer Council in 1997. The British Insurance Law Association published a report in 2002 again recommending review.

As a consequence, a Scoping Paper was issued by the Law Commission on 18 January 2006 in which they stated that misrepresentation, non-disclosure and breach of warranty would be included in the review of insurance contract law. It invited views on other topics that might be included.

The Responses to this Scoping Paper were published in August 2006 and its conclusions were rather wide ranging. Insurable interest, issues of agency, post-contractual good faith, issues of fraud and the remedies available to consumers and insurers were amongst the long list of areas to be considered.

The Law Commission then published several Issue Papers to consult and discuss some of the major issues more fully. The largest and most far reaching was the Issue Paper on Misrepresentation and Non-disclosure published in September 2006. The Law Commission was keen to state clearly what rights and obligations an insured consumer should have with the aim of being fair and meeting the reasonable expectations of both consumers and insurers.

A Joint Consultation Paper on Misrepresentation, Non-disclosure and Breach of Warranty by the insured was published in July 2007, for full consultation within the industry and various stakeholders.

2.1 Issues Paper on Misrepresentation and Non-disclosure

2.11 Ways in which the Law Commission felt the present law was unsatisfactory

- It fails to prevent insurers avoiding policies for any non-disclosure regardless of the circumstances or whether relevant questions were asked.
- It is inaccessible and obscure.
- Consumers are deprived of a genuine choice between the FOS and the courts.
- It requires the FOS to exercise undue discretion instead of using its discretion to supplement the law. The FOS has been required to develop its approach almost from first principles.

2.12 New statute inclusions as suggested by the Law Commission

- Abolish the requirement that consumers should volunteer information.
Redefine what is and what is not a material fact in terms of what the reasonable consumer will think is material.

Provide that avoidance is appropriate only to fraud, and clarify what amounts to fraud for these purposes.

Clarify the remedies that should be applied in cases of negligent misrepresentation.

‘Basis of contract’ clauses should be rendered ineffective.

The new law should be mandatory and the parties should not be able to contract out of it to the detriment of the consumer and they suggest that contracting out can only be done if it is in favour of the consumer.

Emphasis was geared towards a new test of materiality as the Law Commission felt it needed reform from the point of view of the reasonable consumer. The suggestion was that insurers should only be entitled to a remedy for an insured’s non-disclosure or misrepresentation in so far as it is material and that the same test should apply to both misrepresentation and non-disclosure. The Law Commission proposed the test for materiality as follows:

1. The insurer must show inducement, in that had it known the true facts it would not have entered into the same contract on the same terms or at all.
2. Additionally, the insurer must show either:
   • that the proposer appreciated that the fact in question would have that significance, or, if not
   • that a reasonable insured in the circumstances would have appreciated its significance.

The courts should take into account the type of policy, the way the policy was advertised and sold and the normal characteristics of the consumers in the market.

The remedy available should differ according to the state of mind or conduct of the insured, which will raise problems of proof by the insurer as how will they be able to prove ‘the state of mind of the insured’.

For fraudulent conduct – the remedy is avoidance

The insured must know both that the information they give is inaccurate (or realise that it may be inaccurate and not care) and that the issue is material (or realise that it may be material and not care) For innocent conduct – there is no remedy available to the insurer

A claim should not be rejected because of an inaccurate answer or a failure to disclose information where the consumer acted honestly and reasonably and thought the information provided so inaccurately or not disclosed was not material.

For negligent conduct – the remedy is proportionate

Where the insured failed to take sufficient care to understand what the insurer wanted to know or to check their facts. Here they thought the law should provide a proportionate remedy, which as far as possible aims to compensate the insurer for the loss it has suffered. They did not see the need to define negligent conduct. So where a non-disclosure or misrepresentation has been negligent the law should aim to place the insurer in the position it would have been in had they known the true facts, but no better.

• If the insurer would have excluded a particular type of claim, the insurer should not be obliged to pay claims that would have been so excluded.
• If the insurer would have declined the risk altogether, the claim may be refused.
• Where the insurer would have charged a higher premium, the claim should be reduced proportionally to the under-payment of premium.

However insurers must:

• Ask clear questions about any matter that is material to them and if they do not ask questions on a particular point, the insurer should be regarded as having waived its right to such information
• As regards general questions, ask whether a reasonable consumer would understand that the question was asking about particular information, i.e. would a reasonable consumer understand the information that was required under this question?

2.13 Further points raised in the Issue Paper on Misrepresentation and Non-Disclosure

This Issue Paper raised further points that were of particular interest. These have been covered within the draft Bill, however some more explicitly than others.
An insurer should have no right to rely on non-fraudulent misrepresentations made at renewal unless the consumer was supplied with copies of the information he previously supplied to the insurer. As we discuss in section 3.1, the draft Bill refers to a renewal as a new contract and therefore the same rules apply as if the contract was being entered into for the first time.

Insurers should be precluded from relying on a non-disclosure or misrepresentation when a question on a proposal form that required an answer has not been answered or has an obviously incomplete answer. The draft Bill takes a wide and flexible approach as to what amounts to a misrepresentation and refers to an ‘obviously incomplete answer’ as being a misrepresentation. However, if a question has not been answered and the insurer accepts the application, this would not amount to a misrepresentation.

If the insurer has information in its own files, the insurer should be treated as knowing that information, if it was reasonably identifiable. This is discussed further in section 3.2.

Although the following points were discussed in the Issue Paper, they have not been covered in the draft Bill specifically as it was felt unnecessary to specify the ways in which a consumer may take reasonable care but still make a statement that is inaccurate or misleading. Instead, the draft Bill has just set out a general test of reasonable care. This is discussed further in section 3.2.

- An insurer should not be able to rely on a failure to disclose or a misrepresentation because of an incomplete answer if the insured reasonably thought that the insurer would investigate and verify the matter.
- If the insurer has indicated that it may obtain information it should not be allowed to rely on non-fraudulent misrepresentation or failure to disclose if the insured reasonably thought the insurer would obtain such information.

2.2 Issues Papers on Warranties and Intermediaries

Further Issue Papers were published subsequently, namely Issue Paper 2 on Warranties in November 2006, and Issue Paper 3 on Intermediaries and Pre-Contract Information in March 2007.

Issue Paper 3 is discussed in more depth in our Featured Issue on Intermediaries in section 4, along with the Policy Statement on Intermediaries, but note should be taken of the following proposals:

- The main question is for whom does the intermediary act in all the various situations?
- Is it agreed the intermediary acts for the insurer in gathering pre-contractual information unless it genuinely searches the market on the insured’s behalf?
- Does the intermediary then remain acting on behalf of the insurer in completing the proposal form?
- Is it agreed an insured’s signature on an erroneous proposal form should not be regarded as conclusive evidence of an insured’s dishonesty or lack of care?

2.3 Joint Consultation Paper on Misrepresentation, Non-disclosure and Breach of Warranty by the Insured

Following responses to the previous issues papers, a joint Consultation Paper was published in July 2007, which dealt with the three Issue Papers above in some depth and also dealt with consumers and businesses separately. For consumers they proposed a mandatory regime based largely on the current FOS practice.

The Responses for Consumers paper was published in May 2008 with a wide consensus that consumer insurance law was in urgent need of reform and some major innovations were proposed. The most important of these was the replacement of the duty of the consumer to volunteer information with a requirement instead for the consumer to answer all questions carefully and honestly. This means that a consumer who answers questions (or gives other information) honestly and takes reasonable care should be protected.

Where this conduct has not been adopted, the Law Commission proposed:

- Where a consumer deliberately or recklessly gives an incorrect answer the insurer will be entitled to avoid the policy and refuse all claims under it and potentially retain the premium.
Where a consumer has been negligent the law should aim to put the insurer in the position in which it would have been had it been aware of the full facts.

So if an insurer would have charged more, the claim should be reduced proportionately to the underpayment of the premium.

If the insurer would have excluded a particular type of claim, it should not be obliged to pay claims within that exclusion.

If the insurer would have declined the risk altogether, the policy may be avoided, the claims refused and the premiums returned.

These proposals were generally supported by protection insurers, but the following were areas of continuing discussion within the industry:

A need for Judicial Discretion to prevent avoidance where the insurer would have declined the risk but the consumer’s fault was minor. This was welcomed by consumers groups but most insurers were opposed to it and in fact this did not go ahead.

The ABI Code of practice: Non-Disclosure and Treating Customers Fairly (ABI Code of Practice) does suggest that certain claims should be paid even where the misrepresentation is dishonest and the Law Commission felt the ABI were trying to find ways to mitigate harsh results when a claim would be denied. The Law Commission felt that further thought needs to be given to whether these initiatives should be built into the law or indeed how it should be done. As discussed in section 3.11, the Law Commission has not made any associated recommendations in the draft Bill and therefore there is the potential of the law and the ABI Code of Practice providing different remedies for some dishonest misrepresentations.

Issue Paper on Insurable Interest

Issue Paper 4 on Insurable Interest was published January 2009. This was quite exciting for the Life and Disability Insurance industry as the Law Commission proposed innovative changes to the law on Insurable Interest. These have not been carried through but may be re-introduced at some point in the future and this area is looked at in more detail later in the Appendix.

Discussion of the key issues arising from the draft Bill

Scope

The Consumer Insurance (Disclosure and Representations) draft Bill was finally published in December 2009 following discussions with the ABI and other interested groups.

The draft Bill covers not only initial representations prior to a contract going into force but also variance of a contract. This was intended to give weight to the ‘statement of fact’ that is provided to consumers to give them an opportunity to check what was asked and what answers they have given and to change any errors or omissions. A reinstatement or renewal of an existing contract would be treated as if it was being entered into for the first time and the same rules apply.

The draft Bill does not define a misrepresentation and has left this as per existing law and precedents, e.g. omissions, errors of fact discovered on comparison with reliable evidence, etc. It does add to existing law in that a misrepresentation may take the form of ‘failure to comply with the insurer’s request to confirm or amend particulars previously given’. In their Final Report, the Law Commission states: ‘This would apply where an insurer writes to a consumer on renewal with a statement of the information it holds about the consumer, asking if anything has changed. It would also apply where the insurer takes information from the consumer over the phone, and then sends the consumer a statement of fact, asking the consumer to contact them if the statement is incorrect.’

We think this could be particularly relevant to tele-interviewing scripts that are sent to the client for verification, this is further discussed in section 5.

It is not proposed to change the existing law surrounding the duty to disclose a change in circumstances between the time that the contract was formed and the actual policy commencement i.e. for protection insurers this covers the underwriting period. Insurers are at liberty to include specific contract terms and warnings to the effect that any change must be disclosed but these will be considered under Unfair Contract Terms
legislation and the clarity of any clauses will be looked at critically in any dispute that arises. Source: LCR 5.61 – 5.66.

3.11 Difference with current practices

The protection industry have felt uncomfortable for some time with the rationale of cancelling a policy from inception where, although the non-disclosure was deemed to be deliberate, it would only have resulted in a minor amendment to the terms of the policy had a full disclosure been made. This notion was cemented in the ABI Code of Practice, where a proxy for the seriousness of non-disclosure of +50% (or £1 per mille) was imposed. This meant that any non-disclosure that did not alter the original underwriting terms by more than this amount, could not result in a policy being cancelled; a proportionate payment was to be made. However, as mentioned in 2.3, the Law Commission does not share this view as it felt that any dishonest behaviour should not be accepted. Therefore, the proposed remedies are purely based on the assessment of the behavioural conduct of the consumer.

ABI have supported the proposals in the draft Bill, but it remains to be seen if the Code of Practice will be amended. This is discussed further in section 8.

3.2 The replacement of the duty of the consumer or proposer to volunteer relevant information

The draft Bill sets out consumer duties more clearly than any previous legislation and makes it explicit that the existing idea of an insurance contract being one of utmost good faith is modified by its provisions. Specifically, it removes the duty of consumers to volunteer information for which they have not been asked but makes it clear that they must answer honestly and completely any questions that are asked.

The consultation paper discussed various ways in which a misrepresentation could be ‘reasonable’. One idea of particular concern to the protection industry was: ‘if the insurer indicated that it may obtain information from a third party, the consumer may reasonably think the insurer would obtain the information directly from the third party’. Source: LCR 3.71.

However the Law Commission does not now think it is necessary to specify ways in which a consumer may take reasonable care but still make a misrepresentation. Instead the draft Bill sets a general test of reasonable care.

The consumer has a duty to take reasonable care not to make a misrepresentation. ‘Reasonable care’ is defined as a matter for individual consideration in the light of all relevant circumstances. Some examples of factors to be taken into account are quoted, namely:

- Type of contract in question and its target market, for example an over 50’s plan which is described ‘quick to complete/minimum fuss’.
- Sales and supporting materials i.e. are they misleading, and/or do they match actual policy provisions? For example, does a Critical Illness brochure make it clear which conditions are covered and therefore what medical information might be relevant?
- How clear and specific proposal questions were. A great deal of work has already been done to improve proposal forms and tele-interviewing scripts but there is arguably a case for more consumer testing to cement this work. In a later part of the draft Bill, it sets out the presumptions about consumers and this includes: ‘but it is to be presumed, unless the contrary is shown… that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer’. Source: LCR App A Draft Bill 5 (5)

This places extra importance on the need for proposal forms to have clear and specific questions and begs the question how could the contrary be shown? One possibility is that the inclusion of a lot of irrelevant questions in amongst the relevant ones would dilute the consumer’s knowledge about what was and was not relevant. This could happen if, for example, a generic form is used for a variety of different product lines or if an insurer was looking to gather information from one sale to pre-qualify applicants for future products, so care must be taken.

- Whether an agent is acting for the consumer – this area is discussed fully as a featured issue in section 4.

All of this has to be looked at in the light of what ‘a reasonable consumer’ would have understood, which is again open to interpretation. The Final Report states that the test of a reasonable consumer does not take into account the individual’s own subjective circumstances (such as know-
ledge of English), unless these were, or ought to have been, known by the insurer. Source: LCR 5.74

The draft Bill states ‘if an insurer was, or ought to have been, aware of any particular characteristics or circumstances of the actual consumer’, this raises the question as to what extent insurers must trawl their own records before accepting a proposal. This has been clarified in the Final Report which states:

‘we intend it to focus in a practical way on the understanding of the relevant staff at the time the reply is received. We do not intend that the insurer should be deemed to know information held by other departments, which is not available to the staff at the time. For example, the ABI asked about a situation where a customer applies for house insurance with a poor knowledge of English and is helped through the process, and then later applies for car insurance with the same insurer over the internet. We accept that internet sales are an automatic process. We do not think that there should be any obligation on an insurer to check previous records in these circumstances.’ Source: LCR 5.80

### 3.32 Classifications of misrepresentation

In looking at the classification of a misrepresentation, the most obvious difference from current practice is the names of the three categories:

a) honest and reasonable  
b) careless, or  
c) deliberate or reckless

The current ABI categories of ‘innocent’, ‘negligent’ and ‘deliberate or without any care’ roughly equate to the new category names and provide similar remedies.

### 3.33 Dishonest conduct

Use of the word dishonest in only one place in the draft Bill was a deliberate attempt by the Law Commission to remind consumers that they have obligations too; the report leaves consumers in no doubt that dishonest misrepresentations are unacceptable and the industry should welcome this.

The Final Report is very clear in stating: ‘The draft Bill should specify that a dishonest misrepresentation is always to be taken as showing a lack of reasonable care’. This means that someone who has a greater level of knowledge should not be judged against the standards of an average consumer. For example, a misrepresentation that could be deemed to be reasonable if made by a carpet fitter who might not understand medical terminology, could be deemed to be dishonest if made by a general practitioner or nurse. Source: LCR 5.88

### 3.34 The test for Deliberate or Reckless conduct

The law introduces two presumptions about consumers in determining whether they have acted deliberately or recklessly:

‘The insurer should have to show on the balance of probabilities that the consumer acted deliberately or recklessly. However, the task should be made easier by two presumptions. These are that the consumer:
1. Had the knowledge of a reasonable consumer; and
2. Knew that the matter was relevant, if the insurer asked a clear and specific question.’

However it goes on to say:

‘Note that it is always open to the consumer to rebut these presumptions by providing evidence about his or her state of

---

3.31 Inducement and materiality

A qualifying misrepresentation i.e. one for which there is a remedy, includes the phrase ‘insurer shows that without the misrepresentation…’, which places importance on the ability of the insurer to demonstrate what it would have done had it known the information that was the subject of the misrepresentation. Although it is not explicitly stated, the implication is that this must be according to the practice and philosophy at the time of the original application so an archive of underwriting philosophy and practice will be required to allow the insurer to make such a demonstration. It is also made clear that rather than ‘a prudent underwriter’, the draft Bill now refers to what the actual insurer would have done, so whether this is at variance with what other insurers would have done is irrelevant. Source: LCR 9.13 & App A Draft Bill 4 (1) (b)
mind.’ Source: LCR 6.37 ‘However, if a reasonable person would have known that the statement was untrue, the burden of proof would be on the consumer to show that he or she had less than normal knowledge. Similarly, if the question was clear, it would be up to the consumer to show why he or she did not think the matter was relevant.’ Source: LCS 1.27

If the consumer is able to show this lack of understanding, it would mean that the insurer would be given a compensatory remedy. The impact of this is that the insurer would only be able to avoid the policy if it would have declined the risk; it could not avoid the policy if it would have charged a higher premium or imposed different terms.

The draft Bill makes no special mention of areas of misrepresentation that have proved contentious for the industry, such as smoking history, so these should be treated in the same way as any other misrepresentation. However, smoking is mentioned in the Final Report in relation to the burden of proof as follows:

‘Thus once the insurer has shown (for example) that a smoker would normally be expected to know that they smoked, and that the question on the subject was clear, the onus of proof would shift to the consumer. The consumer would need to show why they had not acted deliberately or recklessly in making the representation.’

Source: LCR 6.35

Therefore, in summary, the burden of proof for the insurer is to show that the conduct of the consumer was deliberate or reckless when compared with a reasonable consumer; whereas it is for the consumer to show their specific lack of knowledge or understanding.

3.35 The test for Careless conduct

The Law Commission has not included a test for ‘careless’ conduct; it is simply defined as not ‘honest and reasonable’ or ‘deliberate or reckless’.

3.36 Remedies available to the insurer

For honest and reasonable misrepresentations, the insurer has no remedy and a valid claim would be payable in full.

For deliberate or reckless misrepresentations, the insurer is entitled to avoid the policy from outset.

For careless misrepresentations, the draft Bill enshrines the principle of proportionate settlements that would have resulted in a change of terms and is consistent with current practice. Proportionate settlements may also be appropriate for ‘deliberate or reckless’ non-disclosure where the consumer is able to show that the two presumptions about consumers (i.e. that they (1) had the knowledge of a reasonable consumer; and (2) knew that the matter was relevant, if the insurer asked a clear and specific question) do not apply in their case. When compared with current industry practice, although the remedy would be the same in this instance, the conduct would normally be reduced to the current classification of negligent.

Insurers must consider what to do with policies where there has been careless misrepresentation, however a claim has not yet been made. The Final Report states that life insurance is to be treated differently from other contracts in that existing life insurance must be maintained with amended terms based on the proportionate remedy. So for example, where a critical illness claim is paid proportionately due to careless non-disclosure, accompanying life cover cannot be cancelled but the same proportionate remedy can be applied at the time of the life claim, which may be many years later. It would be prudent for insurers to ensure that they fully inform policyholders of this as well as communicating the remedy for the claim that they are currently dealing with and, if not already included, this should be built into standard procedures. Failure to address future cover in this way will result in the insurer being deemed to have waived its rights to act in future claims.

Source: LCR App A Draft Bill A.78

3.37 Treatment for exclusions and postponements

Exclusions will effectively be treated in the same way as the current ABI practice although the wording does not specifically mention exclusions. Instead it refers to ‘...different terms (excluding those related to the premium)’ and provides that the contract is to be treated as if those different terms applied i.e. if a back exclusion was applied and the claim was for back pain, the claim can be declined, whereas if the claim was for a heart attack, the exclusion would not be invoked.

Non-disclosure of information that would have led to a postponement is more complex in that the insurer will need to make a judgement about what the likely underwriting decision would have been following the postponement period. For example, if the decision would have been to postpone for pending medical tests, but the tests were never conducted, the
The underwriter will need to decide what the likely outcome of the tests would have been given what is known about the cause of claim. If the test results are available, this is obviously much easier to judge. The available remedy will be based on what the underwriting decision would have been given the actual or estimated test results.

3.38 Return of premiums

The draft Bill now clearly states that premiums do not need to be returned in the event of ‘deliberate or reckless’ non-disclosure or misrepresentation and this represents a major change from current law. However, where retention of the premium would be unfair to the consumer, such as where there is an investment element to the policy, the policyholder should not be disadvantaged for that portion of the fund. This may also apply where a joint life with an interest in the policy has acted honestly and reasonably. The Ombudsman and Court will have discretionary power to order a refund of all or some premiums if retaining them would be unfair. Source: LCR 6.44.

3.4 Group schemes

In a group scheme, the group member will have the same rights and obligations under the draft Bill as if they were entering a consumer contract directly with the insurer. There is nothing in the new law which affects the remedies available should the person or entity affecting the contract non-disclose information relevant to the risk pertaining to the person insured. However, the draft Bill provides that where a group member makes a misrepresentation, it has consequences only for that individual, not for others within the group. Source: LCR 7.27

3.5 Life of another

The Law Commission states that representations by the life assured should be treated as if they were misrepresentations by the policyholder. So for example, if a policy is taken out by a wife (the policyholder) on the life of her husband (the life assured) and the insurer relies on information from the husband in order to take on the risk, any misrepresentation should be treated as if it was also made by the wife regardless of whether the wife had any knowledge of her husband’s health risks.

If the insurer can show that either the policyholder or the life assured, or both, behaved deliberately, recklessly or carelessly, it should have the appropriate remedy as per every other policy. An example is quoted:

‘For example, if L (the life assured) deliberately failed to mention a cancer diagnosis, the insurer is entitled to avoid the policy, even if the policyholder was unaware of the cancer. If L acted carelessly in failing to mention a mole, the court would apply a compensatory remedy.’ Source: LCR 7.28

Needless to say this makes it imperative that as with all policies, when writing life of another policies, appropriate warnings are provided and the consequences of failure to provide accurate information are stressed to all of those involved.

From a claims perspective this may appear unfair to a policyholder who has done nothing wrong and the situation will need to be managed sensitively. The same rules apply for the return of premiums as for misrepresentations on any other policy but companies may choose to look more leniently at return of premiums where it is clear that the policyholder is entirely innocent and has suffered the double blow of losing a loved one through health issues they knew nothing about and having the insurance claim denied.

3.6 Insurers are prevented from contracting out of the proposed scheme to the detriment of the consumer

Companies may be tempted to look at adding new contract terms to add clarity to some of the areas discussed. In doing so, they should bear in mind that the draft Bill states that there can be no contract clauses that put the consumer in a worse position than they would be in under the terms of this draft Bill.

4. Featured issue – Does the Intermediary act for the Insurer or the Consumer?

The current position in agency law is that the intermediary is deemed to be acting for the consumer unless there are clear
indications otherwise, although in practice, many factors are taken into account in settling disputes. If the intermediary is acting for the consumer, any actions taken by the intermediary are the responsibility of the consumer. Therefore, if an intermediary is careless in answering application questions on a consumer’s behalf, the insurer would still be able to apply the appropriate remedy, even if the consumer has acted honestly.

The current ABI Code of Practice reflects this law and states in para. 3.4.4 that ‘if the intermediary was clearly acting on behalf of the customer, for example, an independent financial adviser, the intermediary (as opposed to the insurer) should be accountable for any non-disclosure resulting directly from the intermediary’s action or omission’.

Although the law surrounding agency will not change, the Law Commission wished to address the issue of what should happen if the intermediary acts ‘carelessly’ or ‘deliberately or recklessly’ when transmitting pre-contract information from the consumer to the insurer. The draft Bill sets out a list of factors that will determine whether the intermediary is deemed to be acting for the insurer or the consumer at this time.

The Final Report states that; ‘The starting point under the draft Bill, as under current law, is that the agent acts for the consumer, unless there are circumstances which show that the intermediary acts for the insurer. Source: LCR 8.47’

Unfortunately the guidelines surrounding these tests are not as clear as they could be and we may well have to see how this pans out.

The draft Bill states that:

An intermediary will always be deemed to be acting for an insurer if the following applies:

- The intermediary was the appointed representative of the insurer.
- The intermediary had express authority from the insurer to collect pre-contract information as its agent. The insurer would have specifically told the intermediary to collect information as the insurer’s agent and this is likely to be stated in the terms of business agreement between the insurer and the intermediary. Source LCR 8.38. In our view, this will typically be a more specific arrangement than the standard agreement between the parties to conduct business. But this view may well be tested in the courts.

- The intermediary had authority to enter into the insurance contract on behalf of the insurer. If the intermediary has been granted this authority and they make the decision to enter into the contract for the insurer, then they are acting for the insurer at this time. Source LCR 8.40

‘In other cases, the intermediary acts for the consumer, unless it appears that the intermediary acts for the insurer. This would need to be determined in the light of all the circumstances, weighing the factors in each case’. Source: LCR 8.25

The list of factors tending to show the intermediary acts for the insurer are:

a) The agent places insurance with only a small proportion of the insurers who provide insurance of the type in question.
b) The insurer provides the relevant insurance through only a limited number of agents.
c) The insurer permits the agent to use the insurer’s name in providing the agent’s services.
d) The insurance in question is marketed under the name of the agent.
e) The insurer asks the agent to solicit the consumer’s custom. Source: LCR 8.35

Factor a) will need to take into account what is considered insurance of the same type in the eyes of the law; for example, would all forms of income protection in both the long and short term markets be considered to be the same type of insurance? If so, the very nature of the Life & Health insurance market means that intermediaries will quickly come to a very small pool of providers within that larger pool that have cover suitable for their clients’ specific circumstances and could be deemed to be placing insurance with a small proportion of the market.

Intermediaries will also be provided with branded sales materials and leads generated through insurer advertising campaigns or through their internet presence, so the lines between intermediary and insurer are heavily blurred in relation to factor c).

Both these examples highlight the difficulties with applying these tests.
The list of factors tending to show the intermediary acts for the consumer are:

a) The agent undertakes to give impartial advice to the consumer.
b) The agent undertakes to conduct a fair analysis of the market.
c) The consumer pays the agent a fee.

Source: LCR 8.48

Some of the factors quoted as indicating that an intermediary acts for the consumer are contradictory to the ‘insurer’ list of factors:

- If an intermediary conducts a fair analysis of the market and concludes that a particular product is the best option for his/her usual client base in any given time period, will he/she be deemed to have been acting for that insurer on the grounds that most of the actual business is placed with one company, i.e. a small proportion of the providers for a type of contract?

Under current guidance and FOS rules, the answer is yes. Note that this will be outside of the insurer’s knowledge and control in most cases - although the insurer will know how much business it has received from an intermediary, it might not know what percentage of the intermediary’s business that represents.

- Accepting a fee from a client does not preclude accepting additional fees from an insurer or incentives to favour particular products, therefore on its own, cannot be deemed to confirm that the intermediary is acting for the consumer. The Law Commission itself identified part of the problem as: ‘…for example, the agent deliberately excludes information relating to the insured’s ill health in order to ensure that the proposal is accepted and commission is earned.’ Anyone with knowledge of the underwriting process would be aware that the same behaviour could apply equally to earning a fee as to commission.

The Law Commission wants this to be a free-standing code within the draft Bill and intend it to be used as a framework of principles for the courts and FOS to apply to individual cases.

A key overarching principle not explicitly stated but repeated consistently in discussion documents is what the insured thought was the case at the point of sale – did the insured assume the intermediary was acting as an agent for a particular provider or as an independent advocate for his/her own best interests? In the Policy Statement, FOS are reported as stating that in the majority of disputes they see, the insured assumed that the intermediary was acting for the insurer in collecting pre-contract information.

To quantify the potential number of cases that could be affected by this change, the Law Commission conducted a survey of FOS decisions:

In our survey of 190 ombudsman decisions involving disputes about pre-contract information, 25 (13%) involved allegations about what an intermediary did or said during the placing of insurance.

Source: Policy statement – the status of intermediaries March 2009

It is not clear the extent to which this percentage of cases would be resolved differently under the new proposals and they do leave considerable margin for interpretation. From a claims perspective, how practical will it be for claims staff to unravel all of the factors to determine whether an intermediary was acting for the insured or the insurer in a case of non-disclosure?

If it is decided that the intermediary was acting for the insurer in transmitting pre-contract information, any potential remedy against the intermediary by the insurer will need to be considered; although in practice, it is unlikely that insurers will wish to antagonise the major distributors of their products.

Does this mean that insurers will be left with no remedy at all if an intermediary is proven to be involved in the non-disclosure or misrepresentation? It may be that this risk can be negated for insurers regardless of all the factors that make an intermediary’s actions effectively the responsibility of the insurer.

There are two potential ways for insurers to tackle this issue – one is to take steps to ensure that consumers have been directly made aware of what is relevant regardless of what they may have been told by an intermediary, and the other is to ensure that all intermediaries who may sell their products have been properly trained to gather information on their behalf.

The quality of questioning and warnings on application forms and subsequent correspondence may take on even greater
importance and there may be a role for the industry as a whole to improve consumer education about their rights and obligations.

Insurers will have to take perhaps greater responsibility than some already do for ensuring that robust procedures for collecting risk information are in place, with a full audit trail and education for anyone collecting information on their behalf. We will discuss the implications for gathering pre-contract information in our next featured issue.

Some companies already involve Underwriting and Claims staff in sales training but opportunities for ‘independent’ intermediaries to learn about Underwriting and Claims practices are limited and it may be in the interests of the industry as a whole to invest more in this.

Once non-disclosure has come to light at claims stage and it is clear that an intermediary is implicated, there may be a greater obligation on claims teams to monitor and report such issues. If an insurer becomes aware of a particular poor sales practice and does nothing to prevent it in the future, it is likely to weaken the insurer’s right to rely on the intermediary’s error or omission to avoid the claim although this is not explicit in the draft Bill.

The Policy Statement on Intermediaries states the following:

In practice, there are several ways in which an insurer could monitor and control fraud by the intermediaries who place insurance with it. For example, where the intermediary places a large volume of business, the insurers could monitor applications as they come through to check whether the forms provided by a particular intermediary reveal much lower rates of standard illnesses than one might expect from comparisons with the general population. For example, a particularly low level of reported asthma might indicate that an intermediary was discouraging clients from mentioning asthma on application forms.

Secondly, both as a matter of existing law and under our reformed scheme, an insurer who becomes aware of a particular practice and does nothing to prevent it in the future, is likely to weaken the insurer’s right to rely on the intermediary’s error or omission to avoid the claim although this is not explicit in the draft Bill.

The implications of this will vary between insurers as there is considerable variation in the extent to which insurers currently monitor the sources of their sales.

One further point to consider is the impact of the Retail Distribution Review (RDR) on how an intermediary will be viewed and the new responsibilities that will be enshrined as a result. The current RDR proposals to replace commission-based sales with fees will not be read across to the protection market. The proposals will increase professional standards for intermediaries in all markets, and this may help to avoid some of the problems that have arisen in the past. These new standards will be put in place in 2012 although many firms are taking steps to comply much earlier.

5. Featured issue – Using tele-interviewing to gather pre-contract information

In their Summary of Responses papers, the Law Commission raised ‘serious concerns about the way the industry gathers information from consumers’ and noted 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.’ These comments arose in response to a PricewaterhouseCoopers/ABI study that revealed the massive discrepancy in disclosures obtained using traditional methods and subsequently through tele-interviewing.

The draft Bill contains no reference to tele-interviewing as a requirement; only that questions should be clear and specific. However, the draft Bill does include an additional provision that if a consumer fails to comply with an insurer’s request to confirm or amend particulars previously given, this is capable of being a misrepresentation. An example is where information is obtained from the consumer by telephone and the insurer sends a copy of the statements made and requests that the consumer contacts them if any of the details are incorrect. This would therefore apply to the tele-interviewing process where a copy of the script is sent to the consumer for amendment if necessary.

Tele-interviewing does have some advantages over paper forms in ensuring that consumers fully understand what they
are being asked and why it is relevant, so this may eventually be reflected in pricing differentials.

In the Policy Statement on the status of Intermediaries, the Law Commission makes the following comment:

Another possible solution to the problem of intermediary fraud is “tele-underwriting”. This removes the incentive for fraud, by ensuring that the people who ask the questions are not paid commission for sending through “clean” forms (that is without answers that might lead to the application being rejected). Under “tele-underwriting” schemes, intermediaries provide advice on policies and help the consumer to reach a decision about the right insurance for them but do not take consumers through the proposal form. Instead, consumers telephone a call centre, in which the staff who ask the questions are not paid on a commission basis.

The discussion around the role of intermediaries may provide an incentive for more insurers to go down the Big T tele-interviewing route in which the gathering of pre-contract underwriting information is separated from the sale.

Tele-interviewing is also widely seen to be very effective at reducing rates of non-disclosure from consumers so that insurers can provide a greater degree of certainty about receiving their claim payment.

It may address some of the issues raised by the idea that the law will consider what a reasonable insured would have understood to be relevant to disclose. Crucially, any explanations given about the relevance of a question and the level of detail required are recorded so there is always an audit trail.

If we look at the risks in more detail:

- **Intermediary commits fraud by failing to state information given by insured** – as above, the Law Commission has already cited tele-interviewing as a possible solution to this although there is nothing explicit in the draft Bill itself.

- **Intermediary does not present the questions accurately so the consumer’s answers are distorted** – again, this risk would be removed if tele-interviewing were used, although it should be noted that a poor tele-interviewer could reinstate the risk. However, the insurer has much more control over the people it uses to conduct tele-interviews than it does over independent distributors and can find ways to mitigate the effects of poor tele-interviewing through terms of business and oversight in ways that it cannot do with independent intermediaries.

- **Intermediary misunderstands and misreports answer given** – as above, tele-interviewing addresses this risk.

- **Intermediary simply fails to collect key information** – as above.

- **Insured genuinely forgets information** – anecdotally, tele-interviewing has been found to be particularly effective at jogging the memory through skilled interviewing techniques, although this remains a risk under any method.

- **Insured deliberately fails to mention information** – tele-interviewing is key here and the fact that the applicant knows the interview will be recorded acts as a deterrent. However, there is no reason in theory why intermediaries could not create their own audit trail by recording their interviews. It may be that they have not gone to this expense traditionally because they have not felt sufficiently vulnerable - the new law does not change this but perhaps there will be more pressure from insurers for intermediaries to keep a robust audit trail.

- **Insured misunderstands the question** – any method in which a conversation takes place, whether it is with an intermediary or a tele-interviewer, allows the applicant to clarify the meaning and intention of questions. The recent trend towards direct sales does not always allow this opportunity and this places enormous importance on the clarity of written materials that accompany the sale. This can no longer be left to chance and treated reactively as problems arise. Formal testing of written materials prior to a product launch is likely to become more common if companies wish to avoid damaging their brand.

The Law Commission specifically cite the results of research into tele-interviewing and draw the conclusion that commission is the main factor driving lack of disclosures in intermediary-based sales:

The PricewaterhouseCoopers (PwC) research submitted to us by the ABI noted an interesting study on this issue. The study took a sample of “clean” cases in which consumers had been guided through a proposal 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 which had not been included in 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 main difference was in the way the person asking the question was remunerated.

It is not clear why they have drawn such a strong conclusion and as mentioned earlier, if an intermediary was receiving a fee instead of commission that was contingent on a policy sale, there would be the same incentive to push cases through the underwriting process. They also assert that if people were lying they would have equally lied to a nurse.

Tele-interviewing may become more important for new lines of insurance targeted at the over 50’s market where written forms will be less reliable due to the nature of the customers! In this case, the Court will take into account the applicant’s age in deciding what was reasonable to remember and understand in relation to the questions asked.

For tele-claims, some of the same risks apply and this is particularly relevant for living benefits and regular payment products such as Income Protection (IP) where the claimant’s own answers are key to driving the future handling and payment of the claim.

The draft Bill covers pre-contract information only and although it does not have any effect beyond this time, it is possible that they would be used as a guide in any such disputes.

Although there are not usually any issues with intermediaries in claims information-gathering, the question of what a reasonable insured understands to be relevant to the insurer does come up in this context. For complex benefits such as IP, this could be a driver towards greater use of telephone discussion at claims stage. SCOR Global Life strongly supports the use of a tele-claims service to enable a full in-depth discussion of the pertinent points of the claim and also to discuss any disclosure issues that may arise.

6. Practical issues

How will all this affect internal procedures for dealing with claim declinatures? Where they are not already as per the standard practice following the introduction of the ABI/TCF guidance, we would expect to see best practice features being maintained or introduced, to include but not limited to the following:

- Separate review and categorisation of each of the required elements involved in reaching the final decision – level of intent/honesty (including the reasonable insured and relevance tests), impact, retrospective underwriting decision, etc.
- Formalisation of the involvement of appropriate resources in the claims assessment process e.g. a declinature involving medical features should not be made without referral to CMO or other appropriately qualified medical resources to review the medical evidence (although the final decision should remain the preserve of claims resources with sufficient seniority).
- Ensuring that the consumer has the opportunity to explain any misrepresentation and state any mitigating circumstances and that the insurer has the ability to record the conversation.
- Investigation of the circumstances of the sale and what was said – where an audit trail is available from the intermediary, this should be viewed and indeed such audit trails should be encouraged.
- Consideration of reputational risk.
- Monitoring of key factors involved in the misrepresentation to learn lessons for future prevention. This can range from comments by consumers that they did not understand a particular question wording through to monitoring of cases attributable to particular sales sources and their outcomes.

So whilst much is familiar in many respects given that the Law Commission has adhered quite closely where possible to current practice as presently enshrined by the ABI and FOS, insurers need to be careful to ensure they are not too complacent about the changes, or indeed the perceived lack of them. The proposed changes do affect processes and the rationale behind those processes and every insurer will be better placed if they apply a rigorous analysis to their methods to ensure they now adhere to the proposed new ethos.

An outline of the thought processes that will be needed by a claims assessor once a misrepresentation has been identified are summarised as:
Is it a qualifying misrepresentation? i.e. one for which the insurer has a remedy:

- The consumer did not take reasonable care AND
- the insurer shows that without the misrepresentation, that insurer would not have entered into the contract (or agreed to the variation) at all or would have done so only on different terms.

Did the consumer take reasonable care? Judgement required but examples of factors to be taken into account:

- Type of contract in question and it’s target market e.g. older applicants, people who don’t have English as a first language, etc.
- Sales and supporting materials - are they misleading, do they match actual policy provisions?
- How clear and specific the application questions were. It is presumed, unless the contrary is shown, that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer.
- Whether an agent is acting for the consumer.

Is the consumer a reasonable consumer?

- Judgement taking into account:
  - Was the insurer aware, or ought to have been aware of any particular characteristics or circumstances of the actual consumer e.g. first language not English, previous records held for other contracts, etc
  - Was the misrepresentation dishonest?

If a reasonable consumer has made a qualifying misrepresentation, how should this be classified?

- Deliberate or reckless i.e. knew that it was untrue or misleading or did not care… AND knew that the matter to which the misrepresentation related was relevant to the insurer or did not care…
- Careless i.e. not deliberate or reckless.
- Honest and reasonable.

If a qualifying misrepresentation is classified as deliberate or reckless, what are the remedies?

- Avoid contract and refuse all claims AND
- Need not return any of the premiums paid, except to the extent (if any) that it would be unfair to the consumer to retain them.

If a qualifying misrepresentation is classified as careless, what are the remedies for a claim?

- Remedy based on what insurer would have done if the consumer had complied with the duty set out…
  - If the insurer would not have entered into the contract on any terms, it may avoid the contract and refuse all claims, but must return the premiums paid.
  - If the insurer would have entered into the contract but on different terms (excluding terms relating to the premium), the contract is to be treated as if it had been entered into on those different terms if the insurer so requires (e.g. if the insurer would have imposed an exclusion, it can invoke the exclusion OR if it would have restricted the term, it can apply the reduced term).
  - If the insurer would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim.
- But what happens if there is no outstanding claim to meet?
  - The insurer may give notice to the consumer to allow or invite the consumer to terminate the contract.
  - The insurer may terminate the contract by giving reasonable notice to the consumer except THE INSURER CANNOT TERMINATE THE CONTRACT IF IT IS WHOLLY OR MAINLY ONE OF LIFE INSURANCE.
  - The balance of premiums for the remainder of the contract period for any terminated cover must be returned.
The following diagram, as published by the Law Commission in its Summary, is helpful when assessing the impact of non-disclosure or misrepresentation and refers to the relevant section of the Law Commission Report:

Is the contract a consumer insurance contract? (clause 1)

Yes - the draft Bill applies to the insurance policy

No - the draft Bill does not apply to the insurance policy

Did the consumer make a misrepresentation before the contract was entered into or varied? (clause 2)

Yes

Did the consumer take reasonable care not to make the misrepresentation? (clause 2(2) and 3)

Yes - the misrepresentation was reasonable and the insurer has no remedy under the draft Bill

No - the insurer has no remedy under the draft Bill

No

Did the misrepresentation induce the insurer to enter into the insurance contract? (clause 4(1)(b))

Yes - the misrepresentation is a “qualifying misrepresentation” (clause 4(2))

Was the misrepresentation “deliberate or reckless”? (clause 5(2))

Yes - the insurer may avoid the insurance policy (Schedule 1, paragraph 2)

The insurer has a compensatory remedy (Schedule 1, paragraphs 3 to 9)

No - then it is a “careless” misrepresentation (clause 5(3))

No - the insurer has no remedy under the draft Bill
Interaction with the Ombudsman

The new law could operate differently from current FOS philosophy, so what impact will it have on FOS decisions in the future?

Under the Financial Services and Marketing Act 2000, FOS may depart from current law where they consider this to be unjust – will they depart from the new Law if it comes into force?

During the consultation process 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.’ They commented:

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. Source: Para 2.6, Summary of responses.

A fear was expressed within the industry that FOS would use the new law as a stepping stone to make further changes in favour of consumers. FOS responded by saying that it already had a track record of following the law and regulations in other areas such as consumer credit and pensions and that:

‘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’. Source: Para 2.8, Summary of responses.

It could be argued that the updating of the law will give insurers a much clearer stance from which to argue their position than the current situation as many areas that are subject to interpretation will have been clarified. Any discrepancy between FOS decisions and the law will be apparent. An industry-wide initiative to monitor such decisions would be helpful in understanding if there is an issue that needs to be addressed in the early stages of the operation of the law.

Financial impact of the draft Bill

We do not expect a significant change in the percentage of claims paid and in fact, the Law Commission’s own updated assessment (as per their Impact report) estimates the cost to the industry as £4.4m over 1 year as a result of a transition for some insurers who currently breach the ABI Code of Practice and who will pay more proportionate settlements. This was calculated based on past PWC research that estimated increased claims payments of £22m a year, but as that research was conducted before the introduction of the ABI Code of Practice, it is felt that at least 80% of those costs have now been absorbed. At that time, the increase in premium needed to pay for a rise in claim costs was estimated as 0.4% but this will now be even more negligible.

The actual claims statistics will require careful monitoring with a particular focus on whether the industry is acting consistently in its treatment of customers.

What for the future – will this draft Bill ever become Law?

One of the biggest questions about this draft Bill remains whether it will be passed at all, at least before the next general election in the first half of 2010.

In discussions with the ABI on 03/11/09, the Law Commission made the following statement:

‘The Bill will not be presented in the Queen’s speech but will be published and put before parliament in December 2009. The Law Commissions do not have the power to place a Bill onto the fast track scheme; this will be done by parliament if both the government and the opposition agree. Therefore this Bill may not be fast tracked.’

A list of current pending legislation is available at:
http://services.parliament.uk/bills/
A cursory glance at this list reveals a stack of legislation that is already further down the track than this draft Bill. Whilst the Installation of Letter Box Guards (Protection from Dogs) Bill might not be at the top of the list, considerable time will be taken up with emotive and topical issues such as the Child Poverty Bill and, no doubt, the Banker’s Pensions (Limits) Bill.

7.2 What would SCOR Global Life like to happen?

This draft Bill is very unlikely to be passed before the next election but does this mean that we should ignore what it says? In our view the law cements many aspects of good practice and it was welcomed by most of the insurance industry when it was first mooted. We feel that eventually, the current grossly outdated legislation will be brought into line with operating practice and the transition will be much easier if the industry is already united in operating to updated standards.

8. Conclusion

If the draft Bill is passed, it will come into effect 1 year later, although this is the subject of ongoing representations by the ABI to allow an extended period for transition. The earliest that this Act could come into force is likely to be 2011. The other point to note is that the Act will not apply in Northern Ireland.

The ABI initially expressed concerns over the need to reform the law; they felt their Code of Practice had been successfully adopted within the industry and provided a fair outcome for all stakeholders. However, as the process has evolved, they have withdrawn their opposition as they are now content that the draft Bill codifies existing practices, and does not place additional burdens on insurers.

However, it is not clear what status the current Code of Practice will hold if this draft Bill becomes Law. Whilst there was a need for a Code of Practice when the current insurance law did not allow the industry to treat its customers fairly, the draft Bill has been fully consulted upon and has the wide support of all stakeholders, therefore there seems little need to enforce a separate code. Of course, any insurer is entitled to choose to be more generous than the law if they so wish.

Finally, if anyone was in any doubt about whether the Bill should be welcomed, and given every support to proceed as quickly as possible, let’s refer to a statement made in the Law Commission’s Impact report issued alongside the Bill:

‘The intended effect is to increase consumers’ trust and confidence in the insurance industry, leading to increased sales’.
Appendix – Insurable Interest

An area of the original proposals that has not been included in this phase was an updating of the rules surrounding insurable interest and it is worth taking a look at this area in more detail.

What is Insurable Interest? For an insurance policy to be valid the law states that the policyholder must have sufficient interest in the subject matter of the policy. So the policyholder must gain a benefit from the preservation of the subject matter of the insurance or suffer a disadvantage should it be lost.

The rules on insurable interest for life insurance and other non-indemnity insurance are much stricter than for indemnity insurance. Policyholders may take out unlimited insurance on their own lives or the lives of a spouse or civil partner. However, parents have no insurable interest in the lives of their children and in England, children have no insurable interest in their parents nor can cohabitees insure each other’s lives except where there is a pecuniary interest. To insure the life of someone who is not the policyholder one must show ‘a pecuniary interest’ and the amount of the insurance must not exceed the value of that interest.

Do we need a doctrine of insurable interest at all? It does serve two purposes – to define insurance and prevent undesirable social effects.

Proposals for amending the rules surrounding insurable interest

- **Life Insurance**
  - Category of insurable interest based on natural affection should be increased so co-habitees can insure one another independent of any joint loan arrangements, and also dependent children and parents. What about other relationships e.g. fiancé(e)s, siblings, grandparents or grandchildren?
  - Amend the category of pecuniary loss to permit insurance to be more readily available, so base it on ‘a reasonable’ expectation of pecuniary or economic loss on the death of the life assured.
  - The consent of the life insured both to be so insured and to the amount of the insurance should provide an alternative ground for establishing insurable interest so as to give the system some flexibility and to also safeguard against the creation of a moral hazard.

- **Group Insurance**
  - It is currently unclear how insurable interest is to be found in group life or critical illness insurance schemes as a significant amount of life insurance and critical illness is written through employer sponsored group schemes. Therefore should not the law assist such an important part of the protection market?
  - The Law Commission propose that Group Life Schemes should be treated as being insurance on lives rather than insurance of a 3rd party liability, as in through the contract of employment.

- **Section 2 of the Life Assurance Act 1774**
  - This requires the names of all interested parties to be listed in the life policy, which can serve as an unnecessary technicality – should it be repealed as the Law Commission propose?

- **Remedies for life Insurance without sufficient insurable interest**
  - They should be void rather than illegal. In the absence of fraud the insured should have their premiums returned.

These proposals are potentially exciting for the industry, opening up new business opportunities, and we would hope that they will be revisited in the future.