Law Commission
Reforming the law

Scottish Law Commission
promoting law reform

Reforming Insurance Contract Law

SUMMARY OF RESPONSES TO SECOND CONSULTATION PAPER Post Contract Duties and other Issues

Chapter 2: Insurers' Remedies for Fraudulent Claims

This document summarises the responses to chapter 2 of the Law Commissions' second consultation paper in the joint insurance law project

December 2012

THE LAW COMMISSION
THE SCOTTISH LAW COMMISSION

Joint Review of Insurance Contract Law

SUMMARY OF RESPONSES TO SECOND CONSULTATION PAPER: POST CONTRACT DUTIES AND OTHER ISSUES

Chapter 2: Insurers' Remedies for Fraudulent Claims

Contents

Approach taken in this paper

Describing responses

This paper describes the responses we have received to the proposals on insurers' remedies for fraud set out in our joint Consultation Paper: Post Contract Duties and other Issues. This document aims to report the arguments raised by the consultees. It does not give the views of the Law Commission or the Scottish Law Commission.

Comments and Freedom of Information

We are not inviting comments. However, if having read the paper you do wish to put additional points to the Commissions, we would be pleased to receive them.

Please contact us:

By email at commercialandcommon@lawcommission.gsi.gov.uk

By post, addressed to Laura Burgoyne, Law Commission, Steel House, 11 Tothill Street, London SW1H 9LJ

We will treat all responses as public documents. We may attribute comments and publish a list of respondents' names.

Information provided, including personal information, may be subject to publication or disclosure in accordance with the access to information regimes (such as the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002 and the Data Protection Act 1998). If you wish your information to be confidential please explain to us why and whilst we will take a full account of your explanation, we cannot give assurance that your confidentiality will be maintained in all circumstances.

PART 1
INTRODUCTION

1.1 The Law Commission and Scottish Law Commission are carrying out a major review of insurance contract law. As part of that review, in December 2011 we published a joint Consultation Paper on "Post Contract Duties and other Issues".[1]

1.2 The second chapter considered the remedies available to an insurer when an insured had committed an act of fraud. The law in this area is convoluted and confused. There is a tension between the common law rule that a fraudster forfeits the claim, and the statutory rule in section 17 of the Marine Insurance Act 1906 that the policy is avoided. It is not clear whether following a fraud the insurer must pay a subsequent non-fraudulent claim; can recover previously paid valid claims; or whether the insurer can claim damages for the costs of investigating a fraud.

1.3 It is important that the law sets out clear sanctions to deter policyholders from acting fraudulently, and provides the insurer with remedies which are principled and proportionate. We proposed that fraud should invalidate the contract from the date of the fraudulent act. Thus, earlier claims would remain valid, but the insurer would not have to pay out any later claims (including the claim which was fraudulently submitted or exaggerated). We also proposed that the parties to a business insurance contract should be able to modify the remedies available for fraud by the use of express contractual terms.

[1] Insurance Contract Law: Post Contract Duties and other Issues, the Law Commission and the Scottish Law Commission, LCCP 201 / SLCDP 152 (December 2011) (hereinafter referred to as the "Consultation Paper").

1.4 Finally we sought the opinions of consultees on the effect of fraud on group and co-insurance policies. The strict legal position in relation to joint insurance policies is that the fraud of one party taints the whole contract, and all claims are forfeit. By contrast, in group insurance policies, it is often the case that the people who receive the benefit under the insurance contract are not parties to the contract, leaving insurers with very limited remedies where the person entitled to benefit acts fraudulently when making a claim.[2]

RESPONSES

1.5 We received 40 responses to our proposals on insurers' remedies for fraud, as shown in the table below:

Type of respondent	**Number**
Insurers and insurance trade associations	13
Lawyers, legal associations and the judiciary	14
Brokers and brokers' associations	3
Academics	2
Policyholders and policyholder/consumer groups	1
Other	7
Total	**40**

THANKS

1.6 We would like to thank all the consultees who responded to the Consultation Paper, or who met with us or contacted us to express their views. Whilst we are unable to directly quote all consultees' submissions in this brief summary, those views are important to us as we put together our recommendations for the final report. A list of all the consultees is contained in the Appendix.

[2] Consultation Paper, paras 9.1-9.9.

PART 2
FORFEITURE

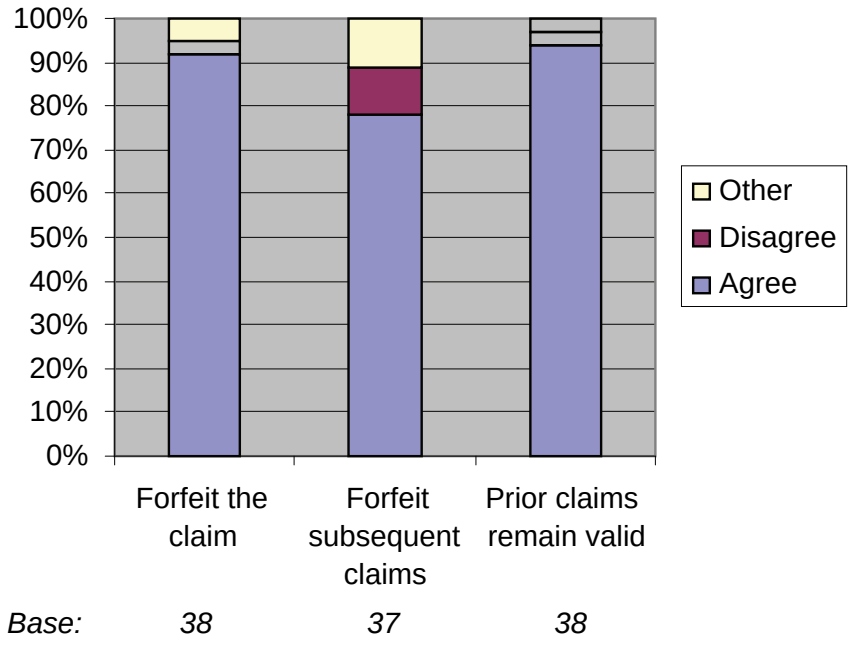
2.1 We proposed that a policyholder who commits a fraud should:

(1) forfeit the whole claim to which the fraud relates;

(2) forfeit any claim where the loss arises after the date of the fraud; and

(3) be entitled to be paid for any previous valid claim which arose before the fraud took place.[3]

2.2 The graph below shows the proportion of consultees who agreed and disagreed with each of these proposals:[4]



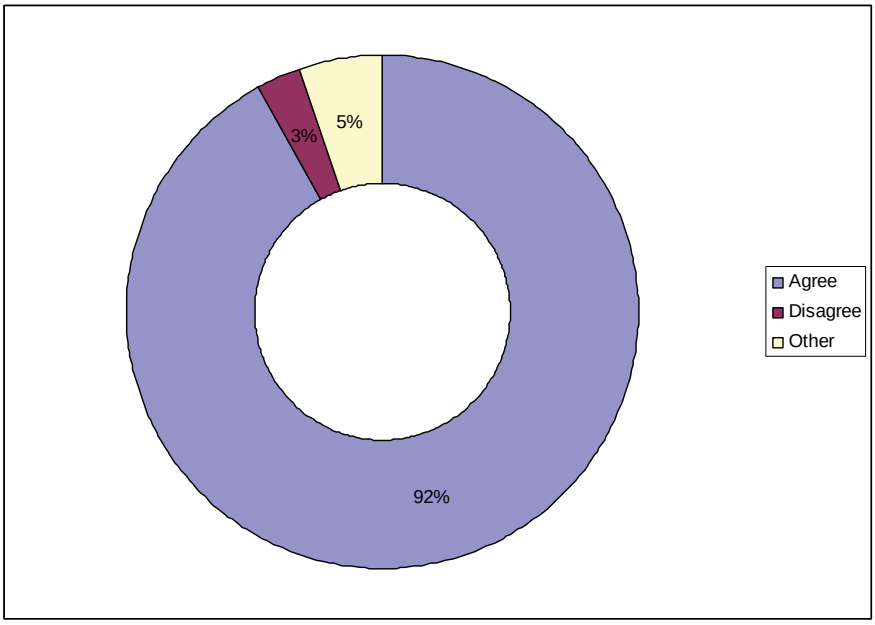
[3] The response form provided tick boxes, namely "agree", "disagree" and "other".

[4] These results are discussed in more detail below.

FORFEITURE OF THE CLAIM AS A GENERAL RULE

Agreement

2.3 The vast majority of consultees (35 of the 38 who responded to this question, or 92%) agreed that a policyholder should forfeit a claim in relation to which he has committed fraud. Only one consultee disagreed and two marked "other".



Do consultees agree that a policyholder who commits fraud should forfeit the whole claim to which the fraud relates?

2.4 Norton Rose LLP thought that our proposal would "provide greater clarity and certainty in relation to remedies against fraud". RSA welcomed "statutory confirmation" of the remedy and K&L Gates LLP agreed that "this is the current legal position and is a necessary deterrent". A number of consultees noted this "deterrent" effect of forfeiture. Without forfeiture of a fraudulently inflated claim, Zurich thought "the temptation to inflate or fabricate claims for financial gain would increase significantly". David Turner QC noted that without forfeiture, "the policyholder has no disincentive to attempting to commit fraud".

2.5 The Law Reform Committee of the Bar Council of England and Wales (the Bar Council) argued that the traditional rationale for forfeiture was not as strong as it once was, since "it is not realistic to say that the fraudulent insured will 'lose nothing' if his fraud is unsuccessful". Criminal sanctions, costs liabilities and difficulty in obtaining insurance in the future were all detriments which an insured would suffer if caught acting fraudulently. Nevertheless, they thought there remained "strong grounds for a general rule depriving the insured of the whole claim where an element of that claim is fraudulent".

2.6 The Financial Services Consumer Panel noted that:

> Insurance fraud is not a victimless crime, with industry estimates suggesting this adds £50 to the cost of a personal lines general insurance policy. We therefore endorse the current position whereby any policyholder that commits fraud should forfeit the whole claim to which the fraud relates. We consider this an appropriate deterrent to discourage people from committing fraud and, where fraud is committed, a fair sanction.

Proportionality / minor exaggerations

2.7 The City of London Law Society Insurance Law Committee agreed that forfeiture was appropriate and recognised deterrence as the "paramount objective". A minority of their members were concerned that it might be too draconian an approach in response to certain conduct, such as "writing a false receipt for an item [the insured] has genuinely lost." They would "draw a distinction between this type of conduct and cases where the claimant never had a genuine claim or has made a materially exaggerated claim" and would:

> … favour giving the courts some discretion to award [the insured] an appropriate amount of his claim but to penalise him (eg in costs) in recognition that such conduct was reprehensible.

2.8 The majority of their members however thought that there was no need for an exception to the general rule of forfeiture.

2.9 The Bar Council thought that a discretion would have practical benefits for insurers as well as insureds, in that a discretion gave insureds an incentive to abandon fraudulent elements of a claim at an early stage.

2.10 RSA on the other hand was sure that there was no place for any "de minimis" exception to this rule. They thought that such a principle "encourages customers to inflate claims to cover the excess with impunity".

Other concerns

2.11 RSA found it "disappointing that the Law Commission has decided that a fraud definition is 'out of scope'", thinking that there were several areas in which statutory clarification could be useful.

2.12 CIFAS warned that "due care and attention must be made to ensure that what could be described as a mistake is not automatically classified as a fraud."

Disagreement

2.13 Mrs Justice Gloster DBE and other judges of the commercial court[5] gave the only substantial arguments against forfeiture as an appropriate remedy. They said:

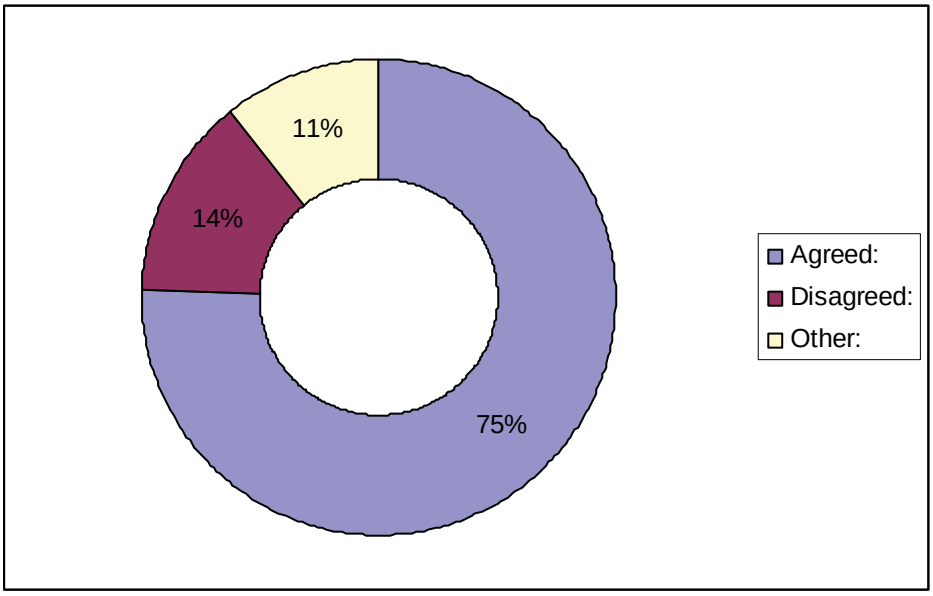
> It is difficult to bring to mind any other area of the law in which we have a policy of penal non-damages, ie depriving a party of the damages to which they are legally entitled as a result of some deliberately false aspect of the claim or evidence advanced to support it. Yet insurers are not unique in facing exaggerated claims. Exaggerated claims are commonplace in many types of civil claim, as are fraudulent devices to support valid claims. For example personal injury claimants regularly exaggerate their injuries. One wonders why an assured whose house burns down loses his buildings and contents entitlement to hundreds of thousands of pounds because he falsely claims for extra laptops, when a personal injury claimant whose dishonesty about his injuries may be grosser and more reprehensible still gets his true entitlement.

[5] Specifically Mr Justice Burton, Mr Justice Beatson, Mr Justice Christopher Clarke, Mr Justice Flaux and Mr Justice Popplewell.

TIMING OF TERMINATION OF THE CONTRACT: PRIOR AND SUBSEQUENT CLAIMS

Claims arising after the date of the fraud

2.14 We proposed that as well as forfeiting the claim to which the fraud related, an insured who had committed a fraudulent act should lose his entitlement to any claims relating to losses arising after the date of the fraud. Effectively the contract would be taken to terminate at the date of fraud, regardless of when the fraud was uncovered or when the insurer actually gave notice of termination. In the Consultation Paper, we acknowledged that this was in line with current market practice. A large majority of consultees agreed with this proposal (27 out of 36, or 75% of those who responded on this point). Five (14%) disagreed and four (11%) marked "other".



Do consultees agree that where a policyholder commits fraud they should also forfeit any claim where the loss arises after the date of fraud?

Agreement

2.15 RSA agreed "that s17 of the Marine Insurance Act, resulting in voidance from inception, should not apply to insurance claim fraud. Forfeiture of the tainted claim is the remedy, and forfeiture of any separate post fraud claims." They were satisfied that "any legitimate claim prior to the fraud should be accepted and dealt with."

2.16 Keoghs LLP agreed that the forfeiture of claims after the date of fraud "would be entirely fair and just" and would "act as a deterrent to fraudsters".

2.17 QBE agreed with our proposal and commented on the trigger factor for forfeiture of post-fraud claims. They said that "identifying a date of fraud may be difficult", and suggested that the "date of claim submission presents more certainty", proposing that insureds should lose their entitlement to claims from that date.

Automatic termination vs right to terminate

2.18 While a majority of consultees agreed with our proposal, some commented on how termination should be effected. The Consultation Paper envisaged that on discovery of the fraud the insurer would be entitled to terminate the contract with retrospective effect, unless it waived that right or was deemed to have waived it having failed to take action after discovering a fraud.

2.19 The Judges of the Court of Session agreed that forfeiture should happen from the date of fraud rather than from the date of rescission by the insurer. They thought though that it:

> … should be made clear in any legislation whether this forfeiture is to happen automatically, as a matter of law, or whether it will happen only if the insurer elects to terminate or rescind the insurance cover on discovery of the fraud. The latter … is, we suggest, consistent with the need for both parties to the contract to know where they stand.

2.20 The City of London Law Society stressed that insurers should be able to waive termination, or continue the policy. Again, this suggests that the insurer should have the right to terminate the contract on discovery of the fraud with retrospective effect, rather than that the fraud should result in automatic termination.

Other concerns

2.21 The existing law treats each renewal of an insurance contract as a separate contract so that a fraud in one contract year would not invalidate any subsequent contract. We did not propose any change to this position. The Association of British Insurers (ABI) was concerned about this issue:

> If a policyholder makes a fraudulent claim in month 1 and a valid claim in month 12, their insurer would be entitled to repudiate the policy in month 1 and thereby avoid paying the month 12 claim. However if the second claim was made in month 13, it is not clear whether the insurer could repudiate the year 2 policy as well as the year 1 policy and avoid paying the claim in month 13.

2.22 The ABI raised the prospect of similar issues in relation to multiple policies covering the same event: could insurer B avoid claims after a fraudulent claim had been made on insurer A?

Disagreement

2.23 The Bar Council thought “it would be unfair automatically to deprive the insured of a genuine claim which arises after the fraud”. They suggested that the loss of trust between insurer and insured “would not affect the actual merits of the subsequent genuine claim”. Giving the insurer a right of termination “would also be consistent with the common law which treats a contract as alive until terminated”. They therefore thought that the court should have “a discretion to disallow a valid claim which arises between fraud and termination where it is very closely linked with the fraudulent claim”. They did though think that express clauses specifying automatic termination from the date of fraud should be valid and enforceable.

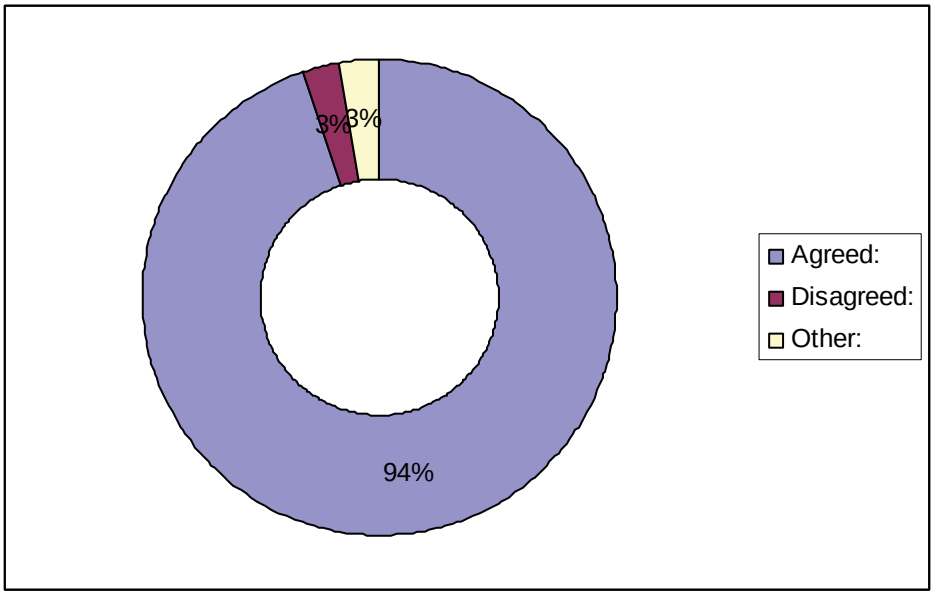
2.24 K&L Gates LLP disagreed. They thought that automatic termination:

> … could have dramatic consequences in the commercial context where the ongoing validity of insurance cover may be important for the purpose of fulfilling ongoing contractual and/or regulatory requirements … If there were to be a dispute as between insurer and insured as to whether the claim was fraudulent, the insured would be in the untenable position of potentially having to purchase substitute insurance (if available in the market) while fighting with the original insurer as to whether or not the claim was indeed fraudulent.

2.25 The risk managers' association Airmic also disagreed, thinking that forfeiture of future claims "is equivalent to avoidance of the policy and will be a harsh remedy in certain circumstances". Marsh marked "other", concerned that the remedy "should not be disproportionate, particularly for consumers" and gave the example of "a householder exaggerating a small claim, by, say, £100 and then being denied cover for his house burning down while the first claim was being investigated".

Claims preceding the fraud

2.26 We proposed that any valid claim which arose before the insured committed an act of fraud should be unaffected by that fraud. Thirty six of 38 (94%) consultees who responded to this proposal agreed with us. Only one disagreed and one marked "other".



Do consultees agree that a policyholder who commits a fraud should be entitled to be paid for any previous valid claim which arose before the fraud took place?

2.27 The City of London Law Society said "it is difficult to see why the insured should be denied indemnification retrospectively because of subsequent events". The Bar Council thought it "disproportionate and harsh" to allow insurers to recover previously paid benefits. Norton Rose LLP agreed that "claims made before the fraud should be paid, provided these were made in good faith", and K&L Gates LLP said that "prior claims which have been validly and honestly made" should not be affected.

2.28 Many consultees, particularly from within the insurance industry, agreed with us that insurers should be entitled to investigate previous claims in the light of later fraud. For example, the ABI said "it is however justifiable and in the interests of public policy that an insurer be permitted to investigate claims that have previously been made by a proven fraudster". Geoffrey Lloyd agreed with the proposal, but "subject to the insurer being satisfied after re-examination of earlier claims that there were no factors to cause the insurers to reconsider".

DEFINITION OF "WHOLE CLAIM"

2.29 Our proposals were that an insured should forfeit the "whole claim" to which an act of fraud related. We noted in the Consultation Paper that there is in some cases a possible opportunity to split a claim between fraudulent and non-fraudulent elements, such that only the fraudulent aspect is forfeited. For example, an insured covered by buildings and contents insurance whose house burned down might exaggerate the value of their possessions when making their contents claim but claim accurately under their buildings cover. We noted that in such situations the claim would be regarded as a single claim and forfeit in its entirety. We did not propose changing the law in that regard but asked consultees whether they thought the definition of a "whole claim" for forfeiture purposes should be left to the courts, or whether legislation should give a definition.

2.30 Thirty four consultees answered this question, of whom 30 (88%) agreed that the definition should be left to the courts. Four (12%) disagreed.

Agreement

2.31 RSA was "unaware of any difficulties with this in the past", content with the common law position that claims arising from the same event are regarded as the same claim. They were reluctant to do anything that might encourage the courts to divide a claim to the advantage of fraudsters. Browne Jacobson LLP said that "in most cases the proper interpretation will be straightforward".

2.32 Others agreed that, because of the fact-sensitive nature of the definition, the courts are best placed to decide on the facts of the case whether an insured has made a single claim or more than one separate claim. QBE said this will "depend upon all the circumstances", and Zurich said "the court will hear all the evidence and be best placed to make that judgement". The ABI supported the "wide meaning" that courts have given to "whole claim".

2.33 The City of London Law Society agreed, stating "attempts to define it may generate more problems than solutions". David Turner QC saw "no need for legislative interference".

2.34 Lloyd's Market Association (LMA) agreed, but thought that a satisfactory statutory definition "may result in lower claims handling costs than if it was left to the courts".

Disagreement

2.35 ACE disagreed, stating "to minimise costs of handling fraud, this should be defined as fully as possible in the statute. The statute can then be subject to interpretation by the courts in the usual way".

2.36 Direct Line Group advocated a statutory definition on the basis that this was not a contentious area, and a statutory definition "should be written in plain English and be sufficiently clear to support such a definition".

2.37 Our "whole claim" proposal has also been the subject of academic debate, including some suggestion that its effect is too harsh on policyholders. Aysegul Bugra and Rob Merkin have argued that:

> …it is not obvious why the all or nothing approach should extend beyond the precise fraudulent claims and to other claims which arise from the same event but falling under different policy sections. Can it be said that that principle gives a proportional remedy, particularly where … the innocent element dwarfs the fraudulent element?[6]

[6] Aysegul Bugra and Rob Merkin, "'Fraud' and fraudulent claims", *Journal of the British Insurance Law Association* (No 125, October 2012) p3, at p14. See also Gerald Swaby, "The Price of a Lie: discretionary flexibility in insurance fraud", *Journal of Business Law* 2013, Issue 1, p77-102.

PART 3
RECOVERY OF COSTS OF INVESTIGATION

3.1 We asked whether insurers should be able to recover the costs of investigating fraud (where fraud is found to have occurred) where those costs are:

(1) actually incurred,

(2) reasonable and proportionate in the circumstances, and

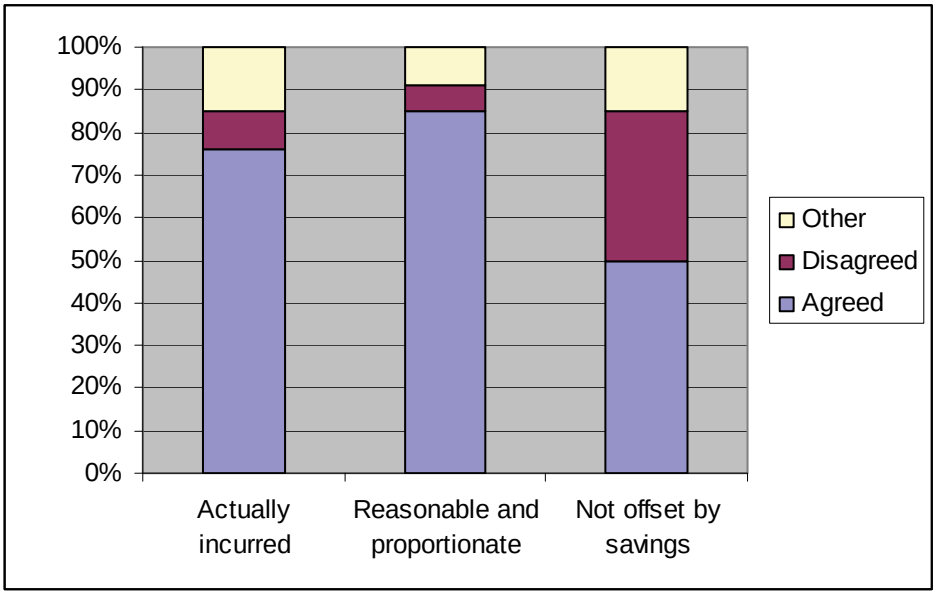
(3) not offset by any saving from legitimate, forfeited claims.

RECOVERY OF REASONABLE AND PROPORTIONATE COSTS ACTUALLY INCURRED

3.2 We proposed that an insurer should be able to recover from the insured all costs actually incurred in investigating a fraudulent claim. We noted that it was already technically possible for an insurer to do so through the tort of deceit, but suggested giving insurers a statutory remedy.

3.3 There was support in principle for recovery of costs but respondents expressed significant concern about how our proposals would work in practice. This was demonstrated in the figures. While 27 of the 35 (77%) consultees who responded to this question agreed with our basic proposal, only half agreed with the detail of our proposal – namely set off (further discussed below). Equally, many who agreed in principle expressed serious doubts over how practical our recommendations were, and there was a range of opinions as to how the problems could be resolved. Others who agreed with the principle of recovery of investigation costs were content that the existing common law remedies were sufficient.

3.4 This graph shows the proportion of consultees who agreed with each suggestion:



(Base 35)

3.5 The Financial Ombudsman Service (FOS) disagreed with the proposal:

> It seems to us that the investigation of claims is an integral part of an insurer's business. In law, consumers are not compensated if a legitimate claim is declined in bad faith, so it strikes us as unfair and unbalanced for insurers to be entitled to such damages where consumers are not.

3.6 Both the British Insurance Law Association (BILA) and the City of London Law Society suggested that legislation was not required because "the common law already provides insurers with the remedy of damages for the tort of deceit". Norton Rose LLP made a similar point.

Concerns

3.7 A range of concerns were expressed about the proposal. It was suggested that it would have little practical effect; that the costs would be difficult to assess (especially when the investigations were undertaken in-house); and there was debate about whether costs should be proportionate to the value of the claim. Finally, there was disagreement about how any forfeited valid claim should be treated.

Difficult to enforce in practice

3.8 The Bar Council suggested that existing common law remedies were sufficient, and a statutory remedy would not help insurers to recover their costs:

> The nub of the difficulty in bringing a claim for deceit/fraudulent misrepresentation against an allegedly fraudulent insured is (a) obtaining evidence to the requisite standard to convince a court and (b) the likelihood that an insured may not be able to meet the claim, even if successful. But both those difficulties would exist even if there were a right to recover such costs enshrined in statute.

Assessing the amount of recoverable costs

3.9 Browne Jacobson LLP highlighted "that assessment of costs may prove problematic", particularly where in-house employees conducted the investigation. They proposed, as a solution, "a tariff of fixed costs which can be recovered by insurers in these circumstances".

3.10 Direct Line Group said that insurers might find it difficult to show incurred costs. They were concerned that recovery only of special costs would be too limited:

> We also believe that only being able to claim invoice-type costs would defeat the purpose of having in house fraud investigation teams (and thereby achieving economies of scale) in that insurers would outsource fraud investigation to establish the actual cost incurred. This could make the cost of investigating fraud increasingly expensive and go against Government pressure to do more to combat fraud and the rising cost of premiums.

3.11 The ABI also thought that recoverable costs "should include provision for costs incurred internally as well as externally".

3.12 K&L Gates LLP thought that there might be difficulties in identifying the costs attributable to the investigation of the fraudulent element of the claim, as opposed to the legitimate part. They did not:

> … see any justification for insurers being able to recover the costs of investigating the honest element … these are presumably costs which are taken into account at the time of setting the insurance premium.

Should costs be proportionate to the value of the claim?

3.13 We had proposed that costs should be reasonable and proportionate. Zurich did not wish proportionality to dominate and unduly limit the recoverability of costs:

> A low value fraudulent claim will still draw resource and time to detect. Detection methods may be applied to a series of small claims from the same source for very valid reasons. Fraudulent claims are not restricted to sophisticated, complex high value criminal situations, much of what is detected is low value opportunist fraud and the cost of protection and detection in this category must be recoverable as a matter of principle and as a deterrent.

3.14 ACE also noted that the costs of investigation can "often far outweigh the value of the claim". They thought that "investigation and handling cost should be recoverable, and the fact that it often outweighs the value of the claim should act as a deterrent."

Set off of forfeited claims against insurer's costs

3.15 We asked whether the insured should be entitled to set off any "savings" the insurer had made by not paying out legitimate but forfeited claims (or parts of claims) where the insurer sought to recover costs of investigation. For example, if an insured exaggerated their contents claim following a house fire, they would forfeit their entire claim (for buildings and contents). If the "legitimate" portion of the claim were £100,000, the insurer would have effectively saved that money as a result of the forfeit. We suggested that the insured should be able to set off the value of any forfeited legitimate claims against the investigation costs of the insurer.

3.16 Only 51% of consultees (18 of the 35 who responded to this question) agreed with this proposal. Twelve consultees (34%) disagreed and five (15%) marked "other".

3.17 K&L Gates LLP agreed with the proposal, and said:

> Insurers cannot claim to have suffered any real loss if the quantum of the legitimate element outweighs the costs of investigation which, in the commercial context, is quite likely to be the case.

3.18 Airmic thought that an insurer should only be able to recover investigation costs where it could demonstrate "that the costs were actually incurred, reasonable and proportionate in the circumstances and were not offset by any savings".

3.19 Zurich said that they "would prefer that there is no offset and that the:

> … “legitimate claim” is not described as representing a saving. It is part of an attempted fraud … Implicit in this model is a tacit admission that an exaggerated claim is more acceptable than a made up claim.

3.20 The Investment and Life Assurance Group (ILAG) also raised issues with describing a “legitimated, forfeited claim” as a “saving”. The City of London Law Society made the same point and said that “the ‘benefit’ to the insurer of such forfeiture would be an established right”.

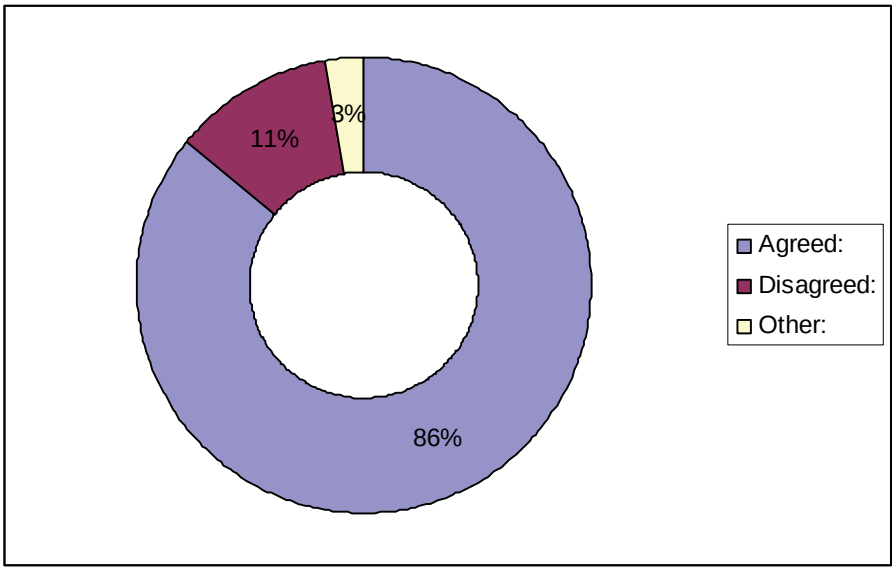
3.21 DAC Beachcroft LLP noted a practical problem:

> The illustrations in the paper assume that the genuine and fraudulent losses can be readily established. The practicality is that an allowance only for net losses will require insurers to run the whole claim and incur all the adjustment costs in order to calculate both the genuine and fraudulent elements of the loss.

PART 4
EXPRESS TERMS

VALIDITY OF EXPRESS TERMS IN BUSINESS INSURANCE

4.1 We proposed that insurers should be able to add to the statutory remedies for fraudulent claims through express contractual terms. There was strong support for this proposal, with 86% of consultees (30 of the 35 who responded to this question) agreeing, 11% (three consultees) disagreeing and 3% (one consultee) marking "other".



Do consultees agree that in business insurance the remedies for fraud should be subject to an express term of the contract?

Agreement

4.2 The vast majority of respondents agreed that commercial parties should be free to vary remedies for fraud by express contractual terms. Several noted that courts currently uphold such express clauses and this should be continued. The ABI argued that:

> … the current law on remedies following fraudulent activity should be maintained. That is to say, a contractual extension to available remedies may be included in a policy of insurance … provided that the clause is clear and unambiguous.

4.3 A few consultees, including ACE, emphasised that while contract may be used to vary the statutory position, "the parties should not have to insert a specific clause in order for the insurer to have a remedy". A small number of consultees, while agreeing with the proposal, expressed concern for small businesses. For example, BILA thought that:

> … freedom of contract should govern, although we are conscious that the proposed dividing line between consumer and business insurance takes no account of small businesses which are not realistically able to protect their interests any more effectively than consumers.

Disagreement

4.4 A small number of respondents disagreed, with one arguing that greater clarity would be achieved by relying on statute and another feeling that such a right would not be necessary. The Faculty of Advocates queried whether avoidance should be permitted by a contractual provision when that remedy has been deemed "unwarranted in principle".

4.5 K&L Gates LLP said:

> If the proposal is for the remedies available in the event of fraud to be set out in statute then there should be no need for an express contractual provision save to the extent that the parties are permitted to alter the statutory remedies. We have real concerns that, if insurers are permitted to extend the remedies available in the event of fraud, for example to allow for the avoidance of the contract, insurers will simply adopt this as a standard term. If the insured in question does not have sufficient negotiating power to get this amended (which is often the case for SMEs) then this is likely to result in the preservation of the right of avoidance, despite the Law Commissions' overall assessment that avoidance of past claims which were honestly made is unprincipled, impracticable and unnecessarily harsh.

4.6 The Law Society of Scotland, marking "other", queried whether:

> … for Scots law, the proposed rule may fall foul of the common law rule that it is not possible to contract out of fraud and, as a consequence, it may not be possible by contract to regulate the remedies that either party has for fraud.

PRESENTATION OF EXPRESS CONTRACTUAL TERMS

4.7 We asked consultees whether any clause which changes the statutory remedies ought to be written in clear, unambiguous terms and specifically brought to the attention of the other party. 34 consultees answered this question, of whom 24 (70%) agreed with our proposal. Five (15%) consultees disagreed and five (15%) marked "other".

Agreement

4.8 Most consultees who agreed with our proposals did so without further comment. Airmic was:

> … strongly of the opinion that remedies for fraud should be subject to an express term in the contract and this can be negotiated separately as an opt-out from the suggested provisions of any revision to the law. Clearly, such a clause that amends statutory remedies should be written in clear and unambiguous terms and such a clause must be brought explicitly to the attention of the insured.

4.9 The Bar Council said that such requirements should be "a minimum":

> Given the potentially draconian nature of the insurer's right to avoid, such a clause ought to be subject to those conditions. It should also be the case that the insured could rely upon any existing other statute or common law rights which might impact upon the rights of the insurer to avoid (eg UCTA 1977).

Disagreement

4.10 Those respondents who disagreed with our proposal or who marked "other" generally agreed that, like all contractual terms, a provision altering the statutory remedies for fraud should be drafted clearly and unambiguously. However, many felt that there was no basis for bringing this clause, over other key clauses of an insurance contract, to the particular attention of the insured. The LMA pointed out that "there are many important clauses in an insurance contract and this clause should be drafted clearly like any other."

4.11 RSA said:

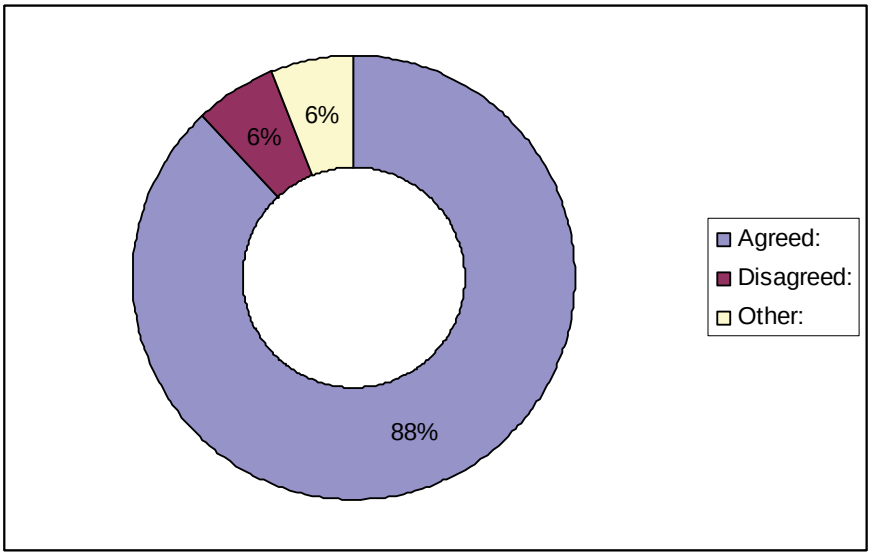
> Any fraud clause that alters the statutory position should be clear and unambiguous. We are, however, not persuaded that the clause must be brought to the attention of the other party at inception. The relevance of such a clause at inception is dependent upon fraud being contemplated by the applicant. Otherwise there can be no inducement. Where fraud is contemplated at inception, the party should have no remedy to defeat an express fraud term, as this would seem unjust. Those taking out insurance to perpetrate a fraud must suffer the full consequences of this decision.

4.12 QBE did not:

> … consider it necessary to legislate on the presentation and enforceability of contract terms which vary the statutory remedy for fraud. FSA Regulations provide supervision over the presentation of clauses and remedies can be found in general law. An ambiguous clause drafted by an insurer would be interpreted against an insurer. In addition, in relation to business insurance contracts, the insurer rarely has a direct relationship with the policyholder as the contract is intermediated by a broker. Where the broker is appointed, the broker is subject to fiduciary obligations to draw conditions of the contract to its client's attention. This proposal shifts the burden of responsibility from the broker to the insurer in circumstances where the insurer may not be in a position to comply.

VALIDITY OF EXPRESS TERMS IN CONSUMER INSURANCE

4.13 In consumer insurance, we proposed that any term which purported to give the insurer greater rights in relation to fraudulent claims should be of no effect. 28 of 32 consultees (88%) who responded to this proposal agreed. Only two (6%) consultees disagreed and two (6%) marked "other".



Do consultees agree that in consumer insurance, any term which purports to give the insurer greater rights in relation to fraudulent claims than those set out in statute would be of no effect?

Agreement

4.14 Most consultees agreed with our proposal on the basis that, as the ABI said, "the consumer is unlikely to understand the full consequences of a clause which permits avoidance and would not be able to exercise any bargaining power."

4.15 RSA said:

> We agree that any express term that allows for s17 type avoidance should have no effect. However, in the absence of any legislation on important aspects such as the use of fraudulent means or devices, the de-minimus principle, and the loophole of 'compromise', we consider that insurers should be allowed to introduce express provisions to deal with such matters.

4.16 City of London Law Society agreed and further suggested that:

> Consideration should be given to the question whether small businesses should be treated in the same way as consumers, although we are conscious of the difficulties inherent in deciding where the dividing line between consumers and small businesses should be drawn.

Disagreement

4.17 ACE disagreed with our proposal and argued that:

> … a term giving the insurer greater rights should be enforceable provided it satisfies the tests of reasonableness for consumer contract terms, and has been brought to the insured's attention as appropriate e.g. in the Key Facts Document.

4.18 Marking "other", two law firms made similar points. BTO Solicitors said:

> We don't think it is that difficult to frame a clause in clear and unambiguous terms which a consumer could understand. The issue is really how tough are we as a nation prepared to be in relation to fraud committed by individuals. If you go down a similar route to that being proposed for businesses one is likely to end up having to introduce some form of "fairness" test for consumers but we wouldn't have a problem with that.

4.19 Browne Jacobson LLP suggested that:

> This is a matter of general contract law, the Unfair Contract Terms Act and the Unfair Terms in Consumer Contracts Regulations. In many types of insurance, these may well render such terms ineffective, but this would be a matter for the Courts to consider. As we have set out above, insurance is available to cover an extremely wide variety of circumstances from the very serious to the rather trivial. A 'one size fits all' approach cannot be assumed and in any event is not desirable.

PART 5
CO-INSURANCE AND GROUP INSURANCE

CO-INSURANCE: EVIDENCE OF PROBLEMS CAUSED BY FRAUD BY JOINT INSURED

5.1 In the Consultation Paper we noted that difficulties can arise where two or more policyholders are insured under the same policy, and one policyholder commits fraud or a deliberate destructive act. An example would be where one spouse sets fire to the matrimonial home after a relationship breakdown. Where two or more people take out insurance jointly to protect their property, the law usually treats them as acting together. This means that fraud by one party will result in forfeiture of the entire claim, with the innocent party recovering nothing. This appears unfair where one party is genuinely innocent of the fraud and unaware of the other's intentions. We asked consultees to provide us with evidence that the law of fraudulent claims by joint insureds causes problems in practice. We also asked how these issues were dealt with (either by the firm concerned or by any other body). 23 consultees responded to this request, which looked for qualitative responses rather than yes or no answers.

5.2 No-one provided evidence of a practical problem. Several respondents, including insurance companies and professional bodies such as the ABI and LMA said they did not have specific evidence or examples of problems arising from fraud in joint insurance.

5.3 The City of London Law Society and BILA thought that the current law was clear and "although in theory it could operate harshly on innocent joint insureds, in practice we are unaware that it causes many problems". Other respondents, including Hannover Life Re and ILAG said that, even though they did not have specific knowledge of problems arising, the issue would benefit from clarification.

5.4 The Financial Ombudsman Service also said it was "not an issue [they] encounter very much of in practice", but could not "safely say that it is not a widespread problem". They advised:

> The approach we take to such an issue is that, if a joint policyholder provides evidence that the fraud was not carried out on their behalf or with their knowledge, we consider that the innocent policyholder's share of the claim should be paid whilst the share of the fraudulent party should not.

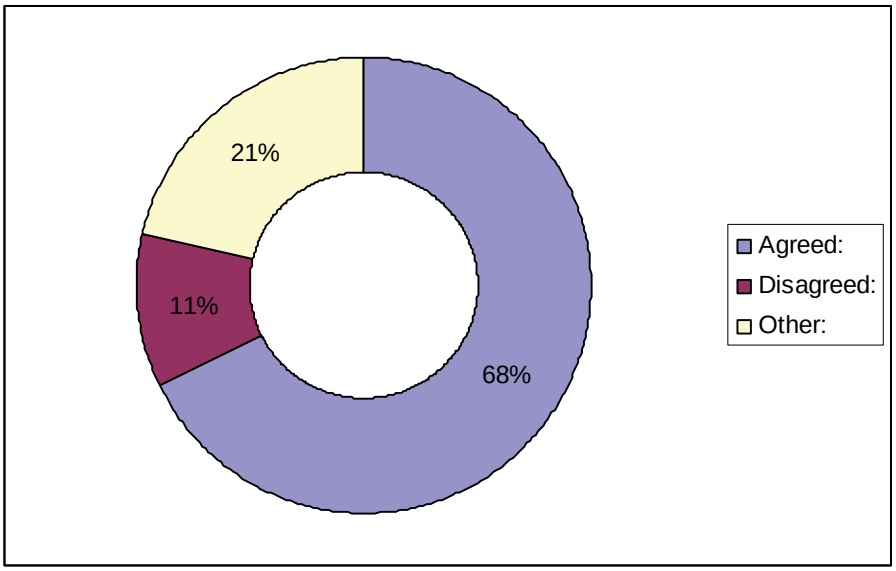
5.5 The International Underwriting Association (IUA) advised that, in a business context:

> … the parties have largely moved to develop policy clauses to negate potential problems in this area. For example there are a number of agreements in the professional indemnity insurance market relating to minimum (and compulsory) insurance term requirements (e.g. solicitors and accountants) that address fraudulent activity by partners. Further, in such professional relationships, contracts of insurance will usually contain a 'separation of insureds' or 'anti-avoidance' clause. The former has the practical effect of creating separated indemnities with regard to fraud by a single partner and subsequent recovery by innocent parties.

CO-INSURANCE: NEED TO LEGISLATE ON THE EFFECT OF FRAUD BY A JOINT INSURED

5.6 In the Consultation Paper, we tentatively concluded that there was no need to legislate on the effect of fraud by one joint insured on the other joint insured's claim, and asked whether consultees agreed.

5.7 Twenty eight consultees answered this question. Nineteen (68%) consultees agreed that there is no need to legislate on the effect of fraud by one joint insured on the other joint insured's claim. Three (11%) consultees disagreed and six (21%) marked "other".



Do consultees agree that there is no need to legislate on the effect of fraud by one joint insured on the other joint insured's claim?

Agreement

5.8 Some respondents, including ACE, felt that "as this would depend on the specific circumstances, which can often be complex, it would be difficult to legislate appropriately and should therefore be left to the courts."

5.9 RSA also felt that such cases must be dealt with on a case by case basis and that legislation would not be appropriate, saying:

> There will always be difficulties where one party to insurance does something to negate a benefit otherwise owed to another joint insured. Insurers normally consider such cases on their merits, and may, where possible, act to protect the interests of the innocent. There can be no formula, and we agree that this should not be addressed in the proposed legislation. The legal position as it presently stands should remain intact.

5.10 Airmic suggested that "the effect of fraud by one joint insured on the other joint insured's claim should be the subject of a clause in the contract and not a matter for legislation."

5.11 The ABI also suggested that this could be dealt with at a practical level:

> The current law is sufficient, as in practice insurers sometimes pay out to the innocent party without prescribed legislation. To have prescribed legislation in this area would prove incredibly difficult and put unnecessary and unfair burdens and costs on the insurer. They would have difficulties both in investigating the claim and in proving the innocent parties' innocence to the court or FOS. The burden of ensuring that the fraudulent party was not in any way being compensated would also create problems for the insurer and may even encourage fraudulent acts if there was a general rule that part of it may be paid out.

5.12 Zurich said that "the courts would be capable of hearing the evidence and forming a view as to eligibility of policy benefits" without statutory remedies.

5.13 The Bar Council and the Judges of the Court of Session felt legislation was not required in the absence of any evidence to suggest that this is a problem in practice. Geoffrey Lloyd supported "the idea that as this is not an area for controversy there is no pressing need to intervene now."

Disagreement

5.14 Of those respondents who disagreed or marked "other", several felt that clarification in statute would be beneficial in order to protect the position of an innocent co-insured. For example, K&L Gates said:

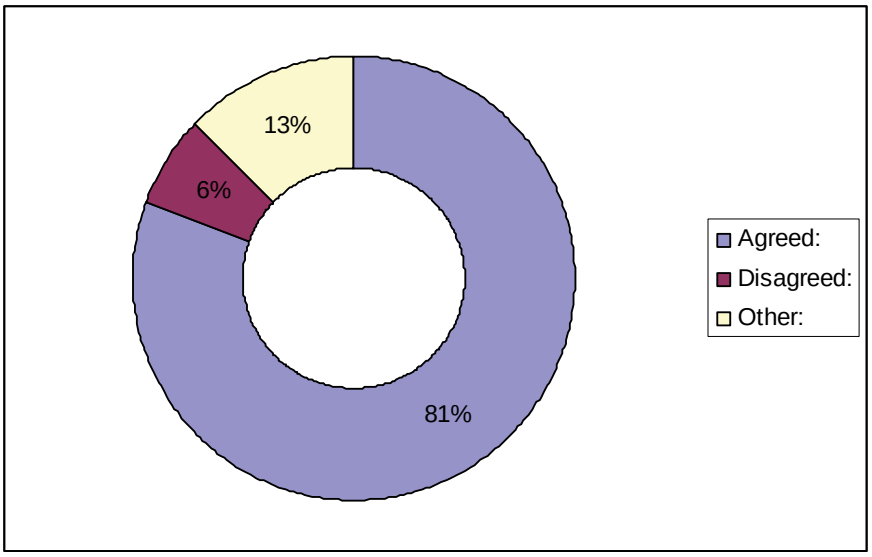
> We agree with the Law Commission that the position of joint insureds is a difficult area and one that is difficult to address in legislation. However, as mentioned above, we consider that the position of co-insureds under a composite policy does need to be protected and, where it is clear that insureds have different interests or rights in property, it should be clear from the legislation that the fraud of one shall not result in the forfeiture of valid claims honestly made by another insured.

5.15 BILA said they would:

> … favour some modification to the current rule that in cases where there is a true joint interest in the subject matter insured, the fraudulent conduct of one insured must result in forfeiture of the whole claim, even if the other joint insured(s) is/are entirely innocent: the fact that at present the evidence does not reveal a significant practical problem in England or Scotland does not mean that the law should not attempt to deal with a potential source of injustice when an opportunity to do so is presented.

FRAUDULENT ACT BY MEMBER OF A GROUP

5.16 We asked consultees whether they agreed that a fraudulent act by one or more group members should be treated as if the group member concerned was a party to the contract. Thirty one consultees answered this question. There was strong support for our proposal, with 25 of the 31 (81%) consultees who responded agreeing. Only two (6%) consultees disagreed and four (13%) marked "other".



Do consultees agree that a fraudulent act by one or more group members should be treated as if the group member concerned were a party to the contract?

Agreement

5.17 Many respondents agreed with this proposal without further comment. The British Vehicle Rental and Leasing Association agreed on the basis that:

> this would align the law for group insurance policies and individuals. This would make group members responsible for their fraudulent actions and allow insurers to take action and recoup monies.

5.18 The ABI agreed and said:

> If the fraud is by a group member, only that claim should be affected. The insurer would therefore be entitled to the prescribed remedies following misrepresentation or fraud by a group member, as if the group member were an individual policyholder, although contractually it is the policyholder that makes a claim and not the member.

5.19 Several other respondents including Zurich, ACE and the Financial Services Consumer Panel also agreed on the understanding that innocent group members should not be prejudiced. The Financial Ombudsman Service noted that:

> The current law provides no remedy for the insurer in such circumstances and we would welcome the proposal provided that it does not prejudice innocent group members.

5.20 IUA anticipated the following issues as requiring further consideration or clarification:

> (i) In line with not penalising innocent group members, we presume that any introduced option of forfeiture would only apply to the individual member and not for the group policy as a whole. This needs to be clarified.
>
> (ii) Is it proposed that the insurer be able to recover claims investigation costs from the individual group member or from the group member insured, ie the employer?
>
> (iii) Giving the third party claimant first party insured status has other potentially important implications. Insurers would be required to deal with insureds of whom they had limited knowledge at inception of the contract. The first party insured status would also allow for access to other recourses such as the Ombudsman.

Disagreement

5.21 Those respondents who disagreed felt that legislation was not necessary or appropriate and that the issue should be dealt with in contractual provisions.

5.22 The City of London Law Society, marking “other”, noted that:

> the concept of repudiatory breach of contract will need some modification to deal with a fraud by an individual who is not the contracting party. We question, in any event, whether this issue needs to be addressed by legislation, or whether (on the assumption that group policies will be treated as falling into the “business” rather than “consumer” category) the remedy is for insurers to provide in their contracts.

5.23 GRiD, an association for the group risk industry, also ticking “other”, said:

> We agree that if the fraud is by a group member, then only that claim should be affected, but the member should not be treated as being a party to the contract as in many cases 3rd Party rights are excluded. It should be noted that contractually it is the policyholder that makes a claim and not the member.

APPENDIX
LIST OF CONSULTEES

Association of British Insurers (ABI)
ACE
Airmic
British Insurance Brokers' Association (BIBA)
British Insurance Law Association (BILA)
British Vehicle Rental & Leasing Association
Browne Jacobson LLP
BTO Solicitors
Richard Buttle
CIFAS
City of London Law Society Insurance Law Committee
Professor Malcolm Clarke
DAC Beachcroft LLP
Direct Line Group (formerly RBS)
Faculty of Advocates
Financial Ombudsman Service (FOS)
Financial Services Consumer Panel
Mrs Justice Gloster DBE, Mr Justice Burton, Mr Justice Beatson, Mr Justice Christopher Clarke, Mr Justice Flaux and Mr Justice Popplewell
GRiD
Hannover Life Reassurance (UK) Limited (Hannover Life Re)
Investment and Life Assurance Group (ILAG)
International Underwriting Association (IUA)
Judges of the Court of Session
Keoghs LLP
K&L Gates LLP
The Law Reform Committee of the Bar Council of England and Wales (the Bar Council)
The Law Society of Scotland
Dr Kate Lewins
Geoffrey Lloyd
Lloyd's Market Association (LMA)
Marsh Ltd
Norton Rose LLP
QBE European Operations (QBE)
RGA UK
RSA
Dr Caroline Sijbrandij
David Turner QC
Mark Wibberley
Zurich Financial Services (Zurich)
One confidential response

We are also very grateful for the helpful articles submitted by Gerald Swaby.