

## Non-Disclosure

*Some observations from the Office of the Insurance & Savings Ombudsman (“the ISO”)*

It is a fundamental principle of insurance law that the parties to a contract of insurance act with the utmost good faith in their dealings with each other. For consumers, this imposes a “*duty of disclosure*” which means they must tell the insurer everything “*material*” to the insurance cover sought. The test of materiality is whether a fact or circumstance is one that would influence the judgement of a “*prudent insurer*” in determining whether to accept a risk and, if so, on what terms. Whether a particular fact is material depends upon the circumstances of the case and is a question of fact.

While this fundamental principle is well known in the insurance industry, many consumers have a limited knowledge of their duty of disclosure. The ISO often encounters complaints in which it is clear the consumer did not understand what non-disclosure was and how it had affected the subsequent claim. For example, consumers have difficulty understanding how the non-disclosure of speeding tickets can impact on a claim made as a result of a house burglary, or how the non-disclosure of asthma can impact on a claim for a critical illness benefit after the life insured has been diagnosed with a malignant tumour.

Against this framework and, based on the experience of the ISO Office, we would like to make some observations regarding non-disclosure.

### Problems and issues for consumers

Non-disclosure is often something consumers are unfamiliar with until they make a claim and the non-disclosure is discovered. A common reaction we encounter from consumers is that, had they known the extent of their duty of disclosure, they would have told the insurer. This lack of understanding and awareness extends to all aspects of a consumer’s duty of disclosure.

#### In this Issue

##### Non-Disclosure

- Problems and issues for consumers
- Problems and issues for insurers
- Steps insurers can take to assist consumers

*In this publication, the Insurance & Savings Ombudsman is referred to as the ISO. In the case studies, the letter “P” is used to denote Participant and “C” to denote Complainant.*

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- ***Extent of duty***

Most consumers find it difficult to understand the extent of their duty of disclosure. They fail to realise that it is their duty to disclose, rather an insurer's duty to ask for, information.

A good example of this is in applications for medical, income protection, critical illness or life insurance. In these situations, many consumers do not realise the extent of their duty of disclosure regarding their medical history. They do not realise what, or how much, information they need to disclose on the application.

While many of the questions are specific, others can be very broad and so are not completed fully by the consumer. One question which consumers often fail to complete fully is the usual "catch all" question regarding visits to the doctor, tests, medication etc. Often, after non-disclosure is discovered, a consumer feels that he/she should have been advised to supply his/her full medical history, rather than being asked for details which he/she may or may not remember.

Many consumers believe that, because they have given the insurer approval to access their medical records, the insurer will automatically obtain them and information omitted will be found. Consumers can be surprised and dismayed when they find this is not the case and, as a result of non-disclosure, the insurer subsequently avoids the policy. Unless consumers can remember their full medical history, they may need to obtain their medical records before completing an application.

For fire and general insurance a similar situation can arise, with criminal and/or traffic convictions, where consumers often fail to disclose all their convictions.

Insurers could do a lot more to assist consumers by ensuring they have an appropriate warning in the application, which is reinforced in the policy wording.

- ***Relevance and materiality of information***

Consumers are often not aware that, from a legal perspective, the decision about whether information is material is based on what a prudent underwriter considers material and not on what an ordinary person considers material. Although the duty is on consumers to disclose material information, as the more informed/powerful party, the insurer is in the best position to indicate the kind of information it requires or regards as material, through directions, questions and examples on the application and in the policy document.

Consumers are also often unaware of how important some information is to an underwriter and so do not disclose what they see as minor/irrelevant information. This is especially true where a combination of different, seemingly unimportant, medical consultations/tests/diagnoses can be material to an underwriter.



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A common misunderstanding for consumers relates to how the moral hazard they may present can be relevant to an insurer's decision about whether to accept the risk and, if so, on what terms. If consumers do not fully understand the concept of materiality, they will not appreciate the necessity of disclosing convictions (even those they might not believe to be relevant). If consumers have a better appreciation of why such information is relevant to an application for insurance, they may be more inclined to disclose the information.

- ***What is to be disclosed***

Consumers can be unaware of what they have to disclose, particularly when this involves questions using specific terms which have special meanings within the insurance industry. For example, consumers often do not understand that a “*modification*” to a vehicle is anything which alters the vehicle from the manufacturer's original specifications (for the particular make and model of the vehicle), as opposed to alterations they initiate and complete after purchase. Similarly, consumers often do not understand what is meant by terms such as “*mental or nervous disorders*”.

Insurers could consider the level of guidance provided, both on the application and in the policy.

- ***When material information needs to be disclosed***

The consumer has a duty to disclose all material information when completing the application for insurance. For fire and general insurances, the majority of which are annually renewable policies, this duty is also activated at renewal. Many consumers fail to disclose new or changed circumstances at renewal, because they forget, or say they were not aware they had to disclose the information (despite reminders on the renewal notices issued by insurers).

If fire and general insurers want people to disclose information at times other than at inception and renewal (e.g. an ongoing duty to disclose modifications), they should make this clear in their policies, as some have done. We believe insurers should indicate in the policy what should be disclosed and when, if they seek to rely on non-disclosure mid-term.

For policies providing health, income protection, critical illness and life insurance benefits, the duty of disclosure extends beyond the date on which the application is completed. Because there is often the need to obtain medical information, there can be delays before an insurer is on risk and the consumer has an ongoing duty of disclosure until the commencement of the policy. (Commencement of the policy usually requires the underwriting process to be completed, any special terms to be accepted by the insured/policy owner and payment of the first premium.)

Occasionally, after an application is completed and before the policy is issued, changes occur which would alter the terms on which cover is offered. These could



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include changes in matters such as the applicant's health, occupation or recreational activities. Many consumers are not aware of their obligation to advise insurers of new or changed circumstances which occur between completing the application and the policy commencing. Non-disclosure of this information will entitle the insurer to avoid the policy. This can often be the result of an innocent non-disclosure and may have serious repercussions for the consumer.

- ***Repercussions of failing to disclose material information***

Most consumers are unaware of the repercussions of not disclosing material information. The effect of avoidance is often harsh and difficult for a consumer to comprehend and, coupled with this, is the stigma attached to avoidance. This can result in the consumer being unable to obtain insurance in the future. If house insurance cannot be obtained, the consumer may be prevented from obtaining mortgage finance.

Discovery of non-disclosure entitles the insurer to avoid the whole policy, not specific benefits. For example, if a policy is issued for one person which provides life, critical illness and income protection insurance, but the non-disclosure would have been material to the original decision to accept the income protection cover, the insurer is entitled to avoid the entire policy. Similarly, if a policy is issued which provides separate cover for a husband and wife, discovery of material non-disclosure by either one of them entitles the insurer to avoid the entire policy.



We believe it is important that insurers consider the social impact which can arise from avoiding a contract and make sure that there are sound reasons for doing so, or that alternative solutions have been considered.

It is often difficult for an insurer to pursue other options to resolve the issue of non-disclosure, because the only remedy available at common law is avoidance. If an insurer would like to continue the policy with varied terms, or decline the claim and cancel the policy, it may not be able to do so, because there is no provision for alternative remedies in the policy. We believe it is important for insurers to consider including other remedies for non-disclosure in policy wordings, to provide alternative solutions to avoidance. However, where other remedies are included, it is of the utmost importance for insurers to use their contractual remedies and not try to resort to common law avoidance in certain cases.

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## Problems and issues for insurers

The ISO sometimes finds that insurers can have problems relying on non-disclosure as the basis for declining to consider a claim. This can be for a number of reasons.

- *Application Questions*

Occasionally, by asking for specific information, the questions an insurer asks in the application limit the duty of disclosure. Insurers often ask very specific questions relating to past medical conditions, tests, symptoms and the like, by providing definitive lists of required information. The ISO takes the same view as the courts that, in some instances, this can limit a consumer's duty of disclosure.

For example, if an insurer asks for details of criminal/traffic convictions or doctor's visits in the last 5 years, then any information beyond the 5 year period would not be considered material for the purposes of non-disclosure.

- *Application Answers*

Many insurance applications are now completed by telephone. A number of complaints received by the ISO have been about the information which the applicant allegedly failed to disclose in the telephone call. Often the insurer is unable to provide the ISO with an audio recording of the telephone call. This creates a problem for the ISO, because the audio recording is the only way of verifying what was said and whether the telephone operator correctly recorded the information provided or asked the applicant the right questions.

The Fair Insurance Code, which applies to fire and general insurers, requires insurers to provide the applicant with a copy of the application for insurance, if requested to do so. Very few insurers automatically provide copies of applications completed by telephone.

We believe that, if the conversation is recorded and/or the answers are provided to the consumer upon the completion of the application, insurers may find it easier to prove information, which they regard as material, was not provided when the application was completed.

- *Materiality*

Insurers often seek to rely on information which is not material when seeking to avoid a policy. An insurer must do more than prove it wanted to know about the information – it must show that the information was material.

The information itself must be material to the decision to offer insurance or the terms on which it is offered. This is quite different from the insurer wanting to know about the information, or saying it would have asked further questions if the information



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had been disclosed. Therefore, an insurer must, if necessary, make further enquiries to obtain answers to the questions it would have asked, to ascertain whether the information obtained was material.

- ***Advisers/agents***

Frequently, it is advisers who complete applications, in conjunction with consumers. This can cause problems when, in some circumstances, advisers appear to have failed to fully advise consumers about the duty of disclosure and the possible consequences of a breach of the duty.

The ISO has also encountered situations where, after a policy has been avoided for non-disclosure, a consumer says the adviser told him/her what to write on the application. In some cases, a consumer says he/she asked the adviser if particular information was relevant. When questioned, the adviser will usually deny the consumer's assertions, but has no evidence, such as file notes or letters, to confirm his/her position.

Advisers appear to be tentative about fully documenting all contact with consumers. This could, in part, be due to section 10 of the Insurance Law Reform Act 1977, under which, an adviser is deemed to be a representative of the insurer in certain circumstances and the insurer is deemed to have notice of information given to the adviser. However, full documentation is desirable and should assist advisers in the event of professional indemnity claims arising.



- ***Remedies***

Insurers often attempt to cancel a policy or decline a claim on the basis of non-disclosure. However, unless the policy entitles the insurer to do this, the only common law remedy available is avoidance of the policy and declining to consider the claim. There is a big difference between this and cancelling a policy and declining a claim.

Insurers often mistakenly believe they can retrospectively cancel policies. An insurer can only cancel a policy prospectively for non-disclosure, if the policy provides for this. It cannot cancel retrospectively.

Periodically life and disability insurers will endeavour to avoid the benefit to which the non-disclosure relates rather than the policy itself (e.g. a total disability benefit attached to a life policy). However, in the absence of a specific policy provision which permits them to do so, this option is not available.

Although it has not yet gained favour with fire and general insurers in New Zealand, there is a case, particularly where the non-disclosure is clearly unintentional, for insurers to deal with claims on a proportional basis. This would apply as an alternative to avoidance, in circumstances where the insurer would clearly have accepted the insurance, but for a different premium, if full disclosure had been made.

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The principle involved means that the insurer would meet the same proportion of the claim as the premium paid bears to the premium which should have been paid. This would need to be specified in the policy, or on the basis of a settlement agreement between the parties.

- ***Innocent vs. blameworthy***

The current law does not distinguish between innocent and blameworthy non-disclosure. (“Blameworthy non-disclosure” occurs where the consumer knew, or a reasonable person could have been expected to know, both the undisclosed fact and its disclosure would have affected the judgement of a prudent insurer in accepting the risk or the terms of such acceptance.) This means that even unintentional non-disclosure entitles an insurer to rely on its legal right to avoid the contract. When this is combined with consumers’ lack of understanding of the extent of their duty of disclosure and their difficulty with the materiality test, the insurer’s right to avoid the contract may be considered too harsh.



## **Steps insurers can take to assist consumers**

1. Insurers could do more to outline what information they require. As some already do, insurers could provide more explicit questions and examples which indicate what to disclose, or find other ways of showing the kind of information they need to know in order to offer the consumer insurance cover.
2. Insurers could do more to make it clear what information they require and when they require it to be disclosed. For example, more guidance could be provided for vehicle modifications by providing examples of the types of alterations to a vehicle’s original specification the insurer wants to know about. Also, if an insurer wants “immediate” or “as soon as possible” notification about modifications subsequent to commencement of the policy, its policy wording must reflect this requirement, otherwise the modifications only have to be disclosed at the next renewal of the policy.
3. Insurers could indicate more fully the kind of information they require or regard as material, through directions, questions and examples on the application and in the policy document.
4. Most direct contracts now appear to be arranged by telephone. Some insurers record the initial telephone conversation and/or provide the consumer with a copy of the questions and the answers provided, to enable the consumer to check the information captured.

It would be beneficial if, as some insurers do, all insurers provided applicants with copies of the application. If an applicant is given the opportunity to check to ensure the details are recorded correctly and, at a later date, the issue of non-

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disclosure arises, it will be much easier to address. This is especially significant when the application is completed by telephone.

However, it is essential that call centre staff are properly trained and fully understand the importance of the questions they are asking and the rationale for the questions. In this way they can better guide the consumer through the “disclosure” questions. Better communication and explanation at point of sale is the key.

5. For medical, income protection, critical illness or life insurance, insurers could make it clear they do not automatically obtain a copy of the applicant’s medical records and that, if the consumer is not confident they have remembered their full medical history, they may wish to refer to their medical records.
6. Insurers have to help consumers understand the reason/s why their claim is not being met. If a policy is being avoided for non-disclosure and, therefore, the claim is unable to be considered, it is important that this is clearly explained. We often find that, when writing to consumers after a claim is made, insurers have a loose approach to the terminology used. In particular, we often find loose use of the terms “cancellation”, “avoidance” and “declinature”. If a policy is avoided, it cannot be cancelled and the claim declined, because the policy is deemed to have never existed. On the other hand, if a policy is cancelled, it has to be cancelled in accordance with the terms of the policy. Clearly, a claim can be declined and the policy subsequently cancelled. However, if the policy is avoided, the claim cannot even be considered. Loose and incorrect use of such terminology can lead to confusion.
7. Insurers need to ensure they are entitled to take a proposed course of action. We have had examples of insurers attempting to cancel a policy or decline a claim on the basis of non-disclosure. However, unless the policy entitles the insurer to do this, the only remedy available is to avoid the policy and decline to consider the claim. There is a big difference. Insurers often mistakenly believe they can retrospectively cancel policies and ignore the requirements of the cancellation condition in the policy.

We have also had examples of insurers avoiding policies mid-term e.g. from when modifications were made to a vehicle after commencement of the policy and not disclosed. In these cases, the policies did not specifically provide for such action to be taken and avoidance could only apply from the subsequent renewal.

8. Insurers could consider payment on a proportional basis where the non-disclosure was clearly unintentional.

