

The 2002 Casebook

The casebook for complaints investigated between 1 January 2002 and 31 December 2002 is now available.

While the ISO strives for consistency in decisions issued by this Office, it is important to recognise that individual case summaries do not set precedents. Each case is considered on its facts in accordance with the law, any applicable Code and good insurance practice.

We have included an order form in this *Assessment*, which can be posted or faxed back to us. (Please note that each Participant and nominated consumer groups will receive 1 copy free of charge).

Useful Consumer Information

A Guide to Insuring Jewellery

Items of jewellery are normally covered by contents insurance policies. These policies insure the contents of your house against a wide range of misfortunes.

This guide has been produced to help you make sure your contents policy adequately covers your items of jewellery and tells you how to make a claim should you need to. It has been prepared by the Insurance Council in conjunction with the Jewellers and Watchmakers of New Zealand Inc and the Jewellery Appraisers Association of New Zealand.

There is a range of insurance policies available – from the basic and inexpensive through to policies that offer generous cover against nearly every type of loss. You should discuss the best option for your circumstances and any specific questions about jewellery insurance with your insurance company or broker.

Value of Cover

With most insurance policies, items of jewellery worth more than \$1,000 must be specified (listed and described on your policy document) and supported by a valuation. If the item is lost or stolen, the settlement (the payment from the insurance company) will be based on either the indemnity or replacement value of the item, depending on the policy.

If you request a cash settlement rather than electing to replace the items, you may receive a percentage of the replacement value. Check your policy for details or ask your insurer.

The indemnity value is the value of the piece of jewellery minus its depreciation from age and day-to-day wear and tear. In other words, the settlement you receive will be based on how much you would expect to pay to buy the item second-hand.

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The 2002 Casebook

Useful Consumer Information –

A Guide to Insuring Jewellery

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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.

Assessment mailing list

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Replacement value is the cost of replacing the jewellery with a new item of comparable quality and specification.

Many people are unaware that most jewellery depreciates over time and usually this is the basis on which the claims are settled. This means that settlement will reflect the second-hand retail value of the lost item, which takes into account age, wear and tear, and fashion appeal.

Know the value of your jewellery by having it valued by a jeweller. Have your valuation updated at regular intervals, say every two years. The cost of valuation will depend on the item. Items of jewellery valued at \$1,000 or less don't usually have to be specified on your policy. However always ensure that you include the value of your jewellery when determining your total contents sum insured. Check your policy to see what you're insured for.

How can you help reduce the chances of having to make a claim?

- When not wearing your jewellery keep items in a locked container and in a secure, but not obvious, place. Perhaps in a room other than the bedroom or the bathroom – but not somewhere so unusual that you'll have trouble remembering where it is!
- Replace worn clasps or chains so your jewellery doesn't fall off. Some policies require that you have your jewellery examined for wear and tear regularly. Check your policy.

How you can help if your jewellery is lost or stolen:

- Make every effort to find it.
- Notify the police immediately and get written confirmation that you have notified them.
- Report the loss to your insurance company as soon as possible. Take with you any documents you have for the items such as receipts, valuations, guarantee and warranty certificates.

How you can help speed up the processing of your claim:

- Have proof of ownership. One of the major causes of delay in settlement is proving ownership. To avoid this, keep all receipts and other documentation relating to the items. Photos of the jewellery being worn are very helpful in proving ownership.

There are a number of companies that specialise in photographing jewellery and other personal valuables for the purpose of both proving ownership and value. See your insurance company for a recommendation.

Check List:

- Make sure items worth more than \$1,000 are specified on your policy, as required.
- Have accurate and up-to-date valuations of your jewellery, both indemnity and replacement sums.
- Keep documents proving ownership in a safe but separate place from your jewellery.

Case Study 1

C and her partner arranged contents insurance with P. On the proposal C specified 4 items of jewellery which were in excess of the unspecified policy limit of \$3,000, including a watch which was listed as \$7,000. C put the watch in her bag to take to the valuers the next day. The bag was put in C's vehicle which was subsequently broken into and C's bag and a briefcase were stolen.

C made a claim for the stolen items, which was accepted by P. P's loss adjuster advised C that the claim for the watch was limited to \$3,000. C argued that the item had been noted on the proposal as being worth \$7,000 and that amount should be paid accordingly. P offered to pay \$4,480 on the basis of a 1995 valuation, but C wanted P to pay the post-loss valuation of \$8,685.

The Case Manager initially thought P's offer to settle at \$4,480 was very reasonable. However, following further consideration of the matter and, having discussed the claim with C, the Case Manager believed there was a valid case for asking P to increase its settlement offer to \$7,000. While the proposal referred to the need to provide proof of value for items of jewellery, it did not indicate that cover on specified items was restricted to \$3000 for each item, until such time as a recent valuation was provided. However, the wording on the policy schedule made this intention quite clear. The policy and its schedule were not issued until after the loss occurred. Therefore, because C had not seen the policy schedule, she believed she was being covered for \$7,000 in respect of the watch, pending an updated valuation.

The Case Manager believed that, if C had obtained a valuation earlier, P would have backdated cover on the watch to the inception date on the proposal to reflect its current value. The Case Manager found that the value of the watch specified by C on the proposal was fairly accurate, as evidenced by the post-loss valuation. There was nothing to suggest that, until C received the policy schedule, C was advised that cover on the watch was restricted to \$3,000 until a valuation was obtained. If C had been so advised, the Case Manager believed she would have obtained a valuation much sooner and P would have been required to pay \$8,685. Having regard to all the circumstances, the Case Manager believed settlement for the watch should be based on the initial value of \$7,000 indicated on the proposal.

What You Need to Know About Insurance Law and How it Applies to Your Policy

1. When you take out a policy

• Duty of Disclosure

The avoidance of policies for non-disclosure is the most common complaint made to the ISO.

At law, the insurer is entitled to rely on its legal rights and, unfortunately, the ISO cannot make a decision which ignores those legal rights, even if it does not seem fair, or has harsh results, in all of the circumstances.

The information provided when a proposal/application for insurance is completed, becomes the basis of the contract of insurance. The insurer relies on the information provided by you, or on your behalf, in making its decision whether to accept the risk.

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. This means that you and the insurer are obliged to clearly and accurately inform each other about all of the important information relating to the proposed insurance.

In the case of a consumer, the principle of utmost good faith means that you must tell the insurer about any facts, which may be material to the insurance cover sought, such as criminal or traffic convictions, previous claims history, or bankruptcy in the case of fire and general insurance; and medical advice, treatment, medication and any pre-existing health conditions in the case of life and disability insurance. This is referred to as the “*duty of disclosure*”. Information is “*material*” and must be disclosed, if it would influence the mind of a prudent insurer in deciding whether or not to accept a proposal/application for insurance and, if so, on what terms.

Most insurers ask a range of questions in a proposal/application, in order to obtain sufficient information from you. However, you cannot rely on the questions asked to provide limits on the information required by the insurer. The law says that any information which may be material to a prudent insurer must be disclosed.

A fact is material if it would influence the mind of a prudent insurer in deciding whether or not to accept a proposal/application for insurance 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. The ISO may obtain prudent insurer opinions from a number of insurers, in order to make an informed assessment about materiality in a complaint.

The courts have said that it is up to the judge to determine what is material. The insurer must show the judge the information is material, but the opinion of the particular insurer or the opinion of another underwriter is not absolute. The courts have said it is up to the judge to make his/her own appraisal of materiality on the facts of the case. The judge must decide if the information would have affected the ultimate decision of an insurer in terms of acceptance or rejection of insurance, the setting of premiums and the attachment of conditions.

While the ISO can consider and weigh the evidence provided by prudent insurers, ultimately whether a given fact is material depends upon the ISO’s own appraisal of the relevance of the disputed fact to the subject matter of the insurance.

While the duty of disclosure exists when the proposal/application is completed, the duty also applies in fire and general cases on renewal of the contract, which is usually on an annual basis. This means you must disclose any material information, which has not been previously disclosed, about anything which has occurred since the last renewal date.

Case Study 2

C made a claim to P for depression. P advised C it was avoiding the policy from renewal, because she had not disclosed 4 consultations with a counsellor/psychotherapist one year earlier. She had not been diagnosed with depression at that stage, nor referred for further treatment by the counsellor.

Underwriters of health and disability policies generally view symptoms of stress and depression cautiously. Any reference to these symptoms in an insured’s medical history is material to the underwriting of a policy. The Case Manager believed that the consultations would have been material to P’s consideration of which terms and conditions of the policy it would have offered at renewal.

However, *Hardie Boys J* (as he then was) held in the case of *State Insurance General Manager v McHale* [1992] 2 NZLR 399 (at page 409), that the duty of disclosure is not absolute; “*the insurer can expect disclosure only of facts that are within the knowledge of the insured*”.

The renewal form asked C to disclose “*ANY CHANGES IN HEALTH*”. C had to have had knowledge that she had experienced changes in her health, in order for the duty of disclosure to apply. The Case Manager considered *Royal & Sun Alliance Life and Disability (New Zealand) Limited v Laurence* (1990) ANZ Insurance Cases ¶61-434, which held that the level of stress an insured is required to disclose is that which he/she knew or ought to have known was beyond the level “*which is usually experienced day to day*” (page 74,936-79,937). On appeal, the judge agreed with the trial judge’s findings that symptoms of stress only needed to be disclosed if the insured had knowledge of:

“...a medically diagnosed stress condition – a conclusion which would have been unavoidable if he had been placed on medication for stress or referred to a psychologist or psychiatrist.”

C’s doctor did not believe that C was significantly depressed, or needed treatment, at the time of the consultations. The counsellor stated that she had not believed it necessary to refer C for medical treatment or intervention at the time of the consultations. There did not appear to have been any advice given to C that she was suffering from any stress or depression beyond a usual level.

In life and disability cases, where contracts are not renewed annually, the duty continues from when the proposal/application is completed until the time the contract is established. This means you must disclose any material information which has not previously been disclosed and which comes to your notice after the proposal/application is completed, but before the contract is established. It applies equally to material information which should have been disclosed in the original proposal/application.

If you do not disclose material information, you have breached your obligation under the contract, whether the non-disclosure was intentional or not. The current law does not distinguish between innocent and blameworthy non-disclosure. Any non-disclosure of material information gives the insurer the right to avoid the contract “*ab initio*,” from the date of its commencement. The reasoning is that the contract was not properly made and, therefore, never existed. The ISO supports the Law Commission’s recommendations that a remedy for non-disclosure should be included in a new section in the Insurance Law Reform Act and should distinguish between innocent and blameworthy non-disclosure.

There are an increasing number of complaints made to the ISO about claims declined on the basis of untrue/false statements or a breach of the duty of utmost good faith at claim time.

2. *When you make a claim*

• **Untrue/False Statements**

It is established law that an insurer is entitled to decline a claim in support of which a false statement has been made, if the policy contains an exclusion or condition to that effect. The falsity of the statement must be wilful, in that you or the person making the statement knows it is false. The term the courts have used in relation to this is “*moral obliquity*” (see *F.A.M.E. Insurance Co. Ltd. v McFadyen* [1961] NZLR 1070), in which the court held that proof of inaccuracy or incorrectness of a statement is not enough to decline the claim. The insurer must show that the statement was deliberately incorrect (see *Vermeulen v S.I.M.U. Mutual Insurance Association* (1987) 4 ANZ Insurance Cases ¶60-812).

• **Incorrect Statements**

In accordance with *Vermeulen v S.I.M.U. Mutual Insurance Association* (1987) 4 ANZ Insurance Cases ¶60-812, an insurer is entitled to decline a claim in support of which an incorrect statement has been made, if the policy contains an exclusion or condition to that effect. The statement must be substantially incorrect and material, which is the same for a mis-statement on a proposal, as set out in sections 4 to 6 of the Insurance Law Reform Act 1977. The courts have made a clear distinction between incorrect and false statements. A statement can be incorrect without the moral element required to be a false or untruthful statement.

• **Duty of Good Faith**

The duty of utmost good faith is a common law duty and exists independently of the policy. Following the House of Lords’ decision in the *Manifest Shipping Co v Uni-Polaris Shipping Co* [2001] UKHL/1, [2001] 2 WLR 170, the duty of good faith at claim time is only the duty of honesty and not the wider duty imposed pre-formation of the contract. There will only be a breach of the duty of good faith where you withhold information you know the insurer would regard as material. In *Vermeulen v S.I.M.U. Mutual Insurance Association* (1987) 4 ANZ Insurance Cases ¶60-812, Hardie Boys J stated that non-disclosure or error does not constitute a breach of the duty, unless there is also dishonesty. The ISO believes the remedy for a breach of the duty at claim time is to decline the claim and cancel the policy in accordance with its terms, rather than avoidance.

Accordingly, the Case Manager believed that C did not know, nor could reasonably have been expected to know, that she was suffering from symptoms of depression at the time of the consultations. Therefore, C had not breached the duty of disclosure, because she could only disclose information of which she had knowledge. The complaint was upheld.

Case Study 3

C’s vehicle was stolen, containing a number of personal effects for which C made a claim to P. P declined the claim, on the basis that C had made untrue statements about the purchase of a laptop and digital camera, which he claimed had been stolen.

C advised the assessor that the laptop had been purchased through the “*Trade & Exchange*” publication for cash. Subsequently, C stated that he purchased the laptop second-hand from a person whose name he had been given by a colleague. C advised he was unable to locate the seller to obtain proof of purchase. C then said he had a receipt for the purchase of the laptop, but the receipt was in a shoebox of documentation, which was in the vehicle when it was stolen. C also advised he purchased a digital camera from the “*Trade & Exchange*” publication. However, later he advised he bought it, through word of mouth, from another colleague. The colleague confirmed the purchase, which was considered sufficient for the purposes of the claim. It was also noted by P that, when C initially notified the police of the theft by telephone, he advised that he could not remember what was in the boot of the vehicle, but noted there were approximately 20 CDs in the vehicle, and did not mention the laptop or the digital camera. Later, when C provided the police with an inventory of what was in the vehicle, it was an extensive list of over 20 separate items, including the laptop, the digital camera and the shoebox of receipts.

There were a number of inconsistencies in the statements made by C to the claims assessor and the police. The Case Manager believed, when the inconsistencies were considered together, it was more likely than not, that C had provided deliberately incorrect information, which was in breach of a specific policy condition requiring all statements made in relation to the claim to be “*true in all respects*”. Furthermore, P noted that, if it had not declined the claim on the above basis, it believed it could avoid the policy for C’s non-disclosure of a previous bankruptcy. The complaint was not upheld.
