

New Chairperson for the ISO Commission

The ISO Commission has pleasure in announcing the appointment of Alison Timms as its new Chairperson. Alison has been appointed to replace Beverley Wakem CBE, who has been appointed a Parliamentary Ombudsman. Alison is based in Wellington and is well-known as a manager in the public sector at a senior level. Alison is currently Deputy Chair of the Radio NZ Board, a director of Wellington Waterfront Limited and a member of the NZ Parole Board. She has expressed her commitment to the role and joins the ISO Commission at a time when change is expected across the financial services market.

Fraud and *De Minimis*

Allegations of false statement and fraud are common in complaints made to the ISO Office.

Participants often argue that, because the insured made a misrepresentation in support of the claim, it follows that the claim is false or fraudulent. Irrespective of the misrepresentation's lack of significance to the claim, the insured's dishonesty in making the misrepresentation raises doubts about the validity of the entire claim.

Where a Participant alleges a claim is false or fraudulent, it must prove the insured's misrepresentation was more than trivial: it must prove the misrepresentation was material. As held by Harrison J in *Blanshard*¹, the misrepresentation's "*impact and falsity must have been of real significance when considering the causes, nature, extent or investigation of the loss*" (our emphasis).

If the insured's misrepresentation is not of "*real significance*", it can be considered a matter *de minimis*. This means the misrepresentation is so insignificant or immaterial that it is not legally relevant and, therefore, does not affect the validity of the insured's claim.

Accordingly, if the Participant cannot prove the insured's misrepresentation was of "*real significance*" or material, the misrepresentation is not legally relevant. In such circumstances (as the following casenote demonstrates), the ISO Office will suggest that the Participant reconsider its decision and pay the claim.

Casenote

Background

In September 2001, C arranged vehicle insurance with P. In November 2003, the vehicle was stolen and C made a claim to P. P appointed an investigator to make enquiries into the circumstances of the claim.

On 7 November 2003, the investigator asked C whether he had ever advertised the vehicle for sale, to which C answered "*no*". On 12 November 2003, the investigator discovered C had, in fact, advertised the vehicle for sale in the *Trade & Exchange* on 1 November 2003.

¹ *Blanshard v The National Mutual Life Association of Australasia Limited* (22 September 2003) unreported, High Court, Auckland Registry, CP265-SD01.

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

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On 14 November 2003, the investigator asked C about the advertisement. C explained that, when he sought to place the advertisement with the *Trade & Exchange* by email, his “*email wasn’t successful at the time ... so [he] wasn’t too sure whether [Trade & Exchange] received [his] email.*” C apologised to the investigator for providing him with incorrect information. Some hours later, at C’s request, the investigator re-interviewed C. C apologised again for providing incorrect information and stated he did not tell the investigator about advertising the vehicle for sale because he thought that, if he did, he “*wouldn’t have a good chance of getting case finished (sic).*”

On 24 November 2003, P advised C that, because he had made a false statement in support of the claim, P had declined the claim and cancelled all the policies C held with P. While C appreciated he made a false statement in support of the claim, he believed this remedy was too harsh and requested that P reconsider its decision.

Assessment

The policy stated that “[y]ou ... *must*: ... *not make a claim that is false or fraudulent in any way*”. Therefore, P had to prove the elements of a false/fraudulent claim to the civil standard (subject to the “clear and convincing” evidential requirement), as follows:

1. There must be a misrepresentation which would give a misleading impression to a reasonable reader/listener;
2. The misrepresentation must have been deliberately made by the insured, in the sense that he/she:
 - a) knew the misrepresentation was incorrect; or
 - b) was deliberately reckless as to the misrepresentation’s truth or falsity;
3. It must not be possible to dismiss the misrepresentation as a matter *de minimis* (of no legal significance); and
4. The insured must have intended the insurer to act on the misrepresentation.

• Misrepresentation/deliberately made

On the evidence, it was clear that C had deliberately made a misrepresentation about advertising the vehicle for sale.

• A matter de minimis?

P argued that C “*intentionally set out to mislead both the investigator and [P]*” and, therefore, because C was dishonest with respect to the advertisement, it followed he had made a false/fraudulent claim. P believed the impact and falsity of a misrepresentation will always be of “*real significance*”, because of the element of dishonesty involved.

In his paper, *Lies, Damned Lies and Insurance Claims: The Elements and Effect of Fraud*, 10 February 2000, Professor Malcolm Clarke discussed the English law relating to “[m]aterial [f]raud” and, on page 14, stated as follows:

“The law deals with non-material ‘fraud’, not by saying it is indeed fraud but lesser fraud which does not justify termination, but on the basis that, as it is not material, in law it is not fraud at all; that there is a difference between telling ‘fibs’ to avoid giving a wrong impression and telling lies to create a false impression. The law can be justified more easily perhaps on grounds of pragmatism rather than principle. As has been said in New Jersey, to hold less than material statements to be fraud of a kind that allows an insurer to end the cover ‘would encourage an insurer, after the loss, to continually attempt to question its insured in the hope of obtaining misstatements.’”

In *Action Scaffolding Ltd v AMP Fire & General Insurance Co (NZ) Ltd*², the insured was the owner of a vehicle, which was damaged in an accident. The driver of the vehicle had consumed alcohol prior to the accident; however, on the claim form, he untruthfully stated he had not.

² (1992) 7 ANZ Insurance Cases ¶61-114.

Casenote 1

C’s vehicle was insured with P. In April 2004, while C was driving the vehicle, it was involved in an accident. Because no other vehicle was involved, it was 11 p.m. and he was uninjured, C decided to notify the police about the accident the next morning. When C got home, he had “*a couple of beers ... because [he] was ... stressed*”, then went to bed. Approximately 2 hours later, the police entered C’s house and asked him to take a breathalyser test, which he passed.

C made a claim to P for the damage to the vehicle. One of the questions on the claim form asked C whether he had consumed “*alcohol and/or drugs ... in the 24 hours prior to the accident*”, to which C answered “*NO*”.

In May 2004, C forwarded the Traffic Crash Report (“the report”) to P. The report stated that C “[h]ad a couple of drinks at work.” P declined the claim and cancelled the policy, stating that C had made a false statement in support of the claim, regarding his consumption of alcohol prior to the accident.

C argued that, because the report wrongly stated he had been drinking prior to the accident, he had a valid claim.

Before P could decline the claim on the basis that it was “*false or fraudulent*”, it had to prove the elements of a false/fraudulent claim to the civil standard (subject to the “clear and convincing” evidential requirement), as follows:

1. There must be a misrepresentation which would give a misleading impression to a reasonable reader/listener;
2. The misrepresentation must have been deliberately made by the insured, in the sense that he/she:
 - a) knew the misrepresentation was incorrect; or
 - b) was deliberately reckless as to the misrepresentation’s truth or falsity;
3. It must not be possible to dismiss the misrepresentation as a matter *de minimis* (of no legal significance); and
4. The insured intended the insurer to act on the misrepresentation.

C consistently maintained the police officer misinterpreted information about him drinking after the accident, rather than before the accident.

The police officer remained adamant that C had informed him he had been drinking at his work before driving home.

Hardie Boys J (as he then was) delivered the judgment of the Court of Appeal and, at page 77,542 of the judgment, stated why the driver's statement was material:

"A statement is material if it would have influenced the judgment of a prudent insurer in determining whether to investigate the claim further, or whether to accept it without investigation or after such investigation as it has thought proper to undertake. The exclusion of liability for accidents caused by drivers affected by alcohol is a standard feature of motor vehicle policies. The importance of answers to questions as to the driver's alcohol consumption is self-evident."

Having regard to the specific circumstances in *Action Scaffolding*, the Case Manager believed the driver's statement was held to be material because it had a decisive, as opposed to marginal, effect on the insurer's readiness to pay the claim (due to the exclusion). Therefore, the truth of the driver's statement was directly relevant to the insurer's liability under the policy. In C's case, the misrepresentation was not directly relevant to P's liability under the policy.

C did not advertise the vehicle for a prolonged period of time, or on numerous occasions; rather, C advertised the vehicle for sale on one occasion; and, after making enquiries into C's financial situation, the investigator noted *"nothing of concern."* This was in contrast with the circumstances in *Engel v The South British Insurance Co. Ltd*³, where the insured's house was badly damaged by fire and, at claim, the insured falsely stated the property had been for sale for *"several months."* However, the property had been on the market for 4 years and the insured was encumbered with *"substantial debts"*. At page 77,948 of his judgment, Davison C.J. held the insured's false statement was *"relevant to the claim and was not a matter de minimis."*

On the evidence, the Case Manager did not believe P had demonstrated the impact and falsity of the statement was of *"real significance when considering the causes, nature, extent or investigation"* of the loss of the vehicle.

Accordingly, after careful consideration of the specific circumstances of the complaint, the Case Manager believed the statement could be dismissed as a matter *de minimis*.

Recommendation

P requested a Recommendation. In its submissions, P reaffirmed its belief that, *"[w]hen an insured is prepared to lie about a seemingly innocuous question as to whether the car has been for sale, it is a trigger point as to what else he would be prepared to lie about"*. P argued that, because of C's misrepresentation, it was deprived of further investigating the circumstances surrounding the advertisement.

The ISO acknowledged P's point that lying in response to a *"seemingly innocuous question"* will always raise a concern about the veracity of a claim. However, it was stressed that, while C deliberately made a misrepresentation, this did not amount to a false/fraudulent claim, unless the misrepresentation was of *"real significance"* or material. Otherwise the misrepresentation, albeit deliberate, was not legally relevant.

The ISO did not accept that, because of C's statement, P was deprived of further investigating the circumstances surrounding the advertisement. This was evidenced by the fact P did not stop *"pursuing any enquiry along those lines"* and, consequently, discovered the advertisement, 5 days after the first interview.

The ISO noted P's identification of 8 issues it would have *"investigated at least"*, if C had disclosed he had advertised the vehicle for sale. It was of interest that P received a report from the investigator on 20 November 2003, which contained specific information about: why C was selling the vehicle; where and how it had been listed for sale; the number of times the vehicle had been advertised for sale; the sale price; buyer interest; and details of the purchase price. In terms of these issues, the ISO did not know what further investigation P would have done, that it did not do.

However, there was no independent evidence to suggest that C had been drinking at his work.

The Case Manager believed it was important to note that C had no opportunity to check what the police officer wrote in the report. In addition to this, C's alleged *"admission"* to the police officer, as recorded in the report, was neither accepted nor signed by C as being true and correct.

The Case Manager believed the evidence in the report was undermined by section 10 of the report, where the police officer initially wrote the *"admission"* in direct speech and then crossed it out. Section 5 of the report, on which P primarily relied, was in reported speech and the only *"admission"* made by C was *"crashing into [the] fence."*

Accordingly, in the absence of more compelling evidence, the Case Manager did not believe P could, at law, rely on the report as evidence that C *"[h]ad a couple of drinks at work."*

Because the Case Manager did not believe P had shown C made a misrepresentation regarding his consumption of alcohol prior to the accident, it was unnecessary to consider the further elements of a false/fraudulent claim.

The Case Manager suggested that P pay the claim.

Complaint upheld

Casenote 2

C's house was insured with P. In June 2004, C's house was broken into and items, including a gold chain, were stolen. C made a claim to P for the loss.

After investigating, P declined the claim on the basis that C had breached a policy provision, which required all statements to be correct and that, *"if any claim ... [was] in any respect fraudulent"*, the claim could be declined and cover cancelled immediately. P also believed C had breached her duty of utmost good faith. This was because, on the schedule of loss, C had stated the value of the gold chain was \$200 and presented an invoice to confirm its value. However, P found C had written *"\$200"* on the invoice.

C initially denied having written on the invoice, but later said that, while she had written on the invoice, she had not *"attempt[ed] to change any [of the] figures"*.

³ (1983) 2 ANZ Insurance Cases ¶60-516.

The ISO questioned the investigator's training "to identify triggers to potential fraud", on the basis of an exchange between C and the investigator in the second interview, on 14 November 2003. The ISO believed it was of some concern that the investigator specifically told C "we don't even make a recommendation" and, indicated to C that, having "accepted" he had previously misled the investigator, it "reflect[ed] well on [him]self".

On the face of the report, its contents were not an accurate account of the investigator's statements to C. In these particular circumstances, the ISO believed this undermined P's position in respect of the *de minimis* aspect of C's misrepresentation.

The ISO did not believe P had provided any relevant, new evidence to change the conclusion reached by the Case Manager. The ISO supported the Case Manager's decision that C's false statement could be dismissed as a matter *de minimis* and, therefore, C was entitled to have his claim paid.

The ISO emphasised that this decision was based on the specific circumstances of the complaint.

Complaint upheld

A Reminder to Participants about "Deadlock"

When a consumer has exhausted a Participant's internal complaints process, the Participant is obliged to provide the consumer with a "deadlock" letter.

A "deadlock" letter confirms the consumer has exhausted the Participant's internal complaints process and "deadlock" has been reached, that a complaint can be referred to the ISO Office and, importantly, that the complaint must be referred to the ISO Office within 2 months of "deadlock" being declared (as set out in paragraph 3 of the ISO's Terms of Reference).

We frequently see letters purporting to be declarations of "deadlock", which are issued prior to the completion of the internal complaints process, or without any reference to the 2-month time limit. If a complaint is referred to the ISO Office outside the 2-month time limit and the "deadlock" letter does not refer to the 2-month time limit, we will accept the complaint for consideration. However, if the "deadlock" letter was issued in the appropriate form and at the appropriate time, we will ask the Participant whether it is prepared to waive the time limit.

Casebooks

The Casebooks for complaints investigated in 2000, 2001 and 2003 are now available for purchase at a reduced price, to clear. All future casenotes from 2003 onwards will be available on-line.

While the ISO Office strives for consistency in its decisions, it is important to recognise that individual casenotes do not set precedents. Each complaint 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.

On a Lighter Note ...

A lawyer and an engineer were fishing in the Hauraki Gulf. The lawyer said, "I'm here because everything I own was destroyed by fire. My insurer paid for everything". "That's a coincidence", said the engineer. "I'm here because everything I own was destroyed by a flood and my insurer paid for everything".

The mystified lawyer asked, "How do you start a flood?"

Before P could decline the claim on the basis that it was fraudulent, it had to prove the elements of a fraudulent claim to the civil standard (subject to the "clear and convincing" evidential requirement), as follows:

1. There must be a misrepresentation which would give a misleading impression to a reasonable reader/listener;
2. The misrepresentation must have been deliberately made by the insured, in the sense that he/she:
 - a) knew the misrepresentation was incorrect; or
 - b) was deliberately reckless as to the misrepresentation's truth or falsity;
3. It must not be possible to dismiss the misrepresentation as a matter *de minimis* (of no legal significance); and
4. The insured intended the insurer to act on the misrepresentation.

The Case Manager found that C had made a misrepresentation in the following respects: C had stated on the schedule the gold chain's value was \$200; C presented an invoice to confirm the gold chain's value; and C had stated she had not written on the invoice.

The Case Manager believed C had deliberately made the misrepresentation about the value of the gold chain, because C knew the \$200 figure was incorrect.

Although the misrepresentation of the gold chain's value was not a gross exaggeration, the Case Manager found that, after considering the specific circumstances of the complaint, the misrepresentation was of "real significance when considering the ... extent of the loss". Therefore, the Case Manager did not believe the misrepresentation could be dismissed as a matter *de minimis*.

The Case Manager believed C intended to induce P to pay the inflated value of the claim, because C submitted an altered invoice to support her assertion that the gold chain's value was \$200.

The Case Manager found that C's misrepresentation regarding the gold chain's value meant the claim was fraudulent. Accordingly, the Case Manager believed P was entitled to decline the claim on the basis that C had breached the policy's terms and conditions and her duty of utmost good faith.

Complaint not upheld