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OMBUDSMAN

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Submission on Issues Paper: Review of Insurance Contract Law {Review)

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Thank you for the opportunity to comment on the issues paper dated May 2018. We are delighted that Minister Faafoi has instigated the Review, and support his aim to introduce new insurance contract legislation by the end of this parliamentary term.

Since 1995, the Insurance & Financial Services Ombudsman (IFSO) Scheme has provided an independent dispute resolution service for thousands of customers of its participating financial service providers (FSPs). Each year the IFSO Scheme responds to over 3,000 complaint enquiries and resolves about 300 formal complaints. This year, ending 31 June 2018, of the 3,357 complaint enquiries, 2,877 were related to insurance. Of the 320 complaints, 304 were related to insurance. In the financial advice sector, 108 complaint enquiries related to financial advice, with 7 complaints considered. Therefore, the majority of our work is disputes resolution in the insurance sector, and has been for over 23 years, which gives us a unique perspective on the issues raised in the Review.

We have made a number of submissions on insurance generally. In particular, I refer to our previous submissions to the Law Commission in November 2006, which I attach for your reference.

Where possible, we have made reference to cases considered by the IFSO Scheme. Generally, these are included as case studies, although sometimes we have only included the case number for brevity. Every case the IFSO Scheme considers has an anonymised case study available at www.ifso.nz/case-studies.

IFSO Scheme's Responses to Questions

Regarding the objectives of the review

1. Are these the right objectives to have in mind?

Yes.

2. Do you have alternative or additional suggestions?

No.

Regarding disclosure obligations and remedies for non-disclosure

3. Are consumers aware of their duty of disclosure?

No. Non-disclosure means nothing to a consumer until he/she makes an insurance claim, only to find the insurer will not pay it. Strictly speaking, the law does not provide any remedy for a consumer who has failed to disclose (either intentionally or not), material information - materiality being determined on the basis of what would be material to a prudent underwriter in assessing the risk. The trouble with using the prudent underwriter test is that most consumers do not know what a prudent underwriter is and neither do they understand how risk is assessed, until it is too late.

Most non-disclosure occurs when an application for insurance is completed, before the risk is accepted and the policy issued. Insurers ask specific and, sometimes, more general questions which consumers must answer. The common law takes this a step further and requires consumers to provide fill material information, even if no questions have been asked which would alert them to the fact the information is required. Not only is the common law duty of disclosure strict, but the remedies available to insurers, where there is a breach of the duty, are draconian. The common law allows an insurer to avoid a policy retrospectively from commencement *(ab initio),* or renewal, treating it as if it never existed. In these circumstances, an insurer should refund the premiums paid, unless they have a contractual provision to the contrary. The remedy is equally available in cases where there has been either an innocent or deliberate breach of the duty of disclosure.

Avoiding the policy can have extremely harsh consequences for a consumer, who will be left with no policy of insurance, no realistic prospect of obtaining replacement insurance and a very real possibility of having any other policies, held with the same insurer, cancelled on notice.

Complaint 00207120

Consumers often assume information will be obtained by the insurer e.g. medical notes.

Sally[1] made a claim for income cover, because she was unable to work due to being diagnosed with Crohn's disease. Her insurer avoided the policy and declined to consider the claim, on the basis that when completing the policy application, she failed to disclose that she had asked her doctor for a specialist referral for ongoing bowel issues. Sally initiated the referral, but did not follow through.

Sally said her adviser only asked if she was currently unwell, and that she believed the insurer should have obtained her medical records prior to the start of the policy. The case manager obtained opinions from senior underwriters that indicated the failure to disclose was material and, as a result, Sally's request for specialist referral should have been disclosed. This resulted in substantial hardship to Sally.

[1] Note: names used in examples are not the real names of Complainants.

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From 2000 - 2018, we received about 750 non-disclosure complaints out of a total of about 4,500 complaints investigated. This year we have received 56 complaint enquiries related to non-disclosure with 21 complaints considered. In some cases, the policy will allow an insurer to keep the premiums the insured has paid which means a consumer pays for a policy which would never provide cover.

4. Do consumers understand that their duty of disclosure goes beyond the questions that an insurer may ask?

No. For a number of years, the IFSO Scheme has taken the same approach taken by similar financial Ombudsman organisations in the UK and Australia, based on the principle of waiver - the insurer must ask specific questions on an application for insurance and, if it has not done so, has waived the right to avoid a policy, on the basis the information not disclosed was material.

Therefore, where an insurer does not ask a relevant question of an insured, unless there are exceptional circumstances, the IFSO Scheme will largely find that an insured did not have a wider obligation to disclose information, particularly in response to a broadly worded "catch-all" question.

We also note that consumers do not understand that, for fire and general insurance, they have an obligation of disclosure at every annual renewal, despite the fact that no questions may be asked and the previously recorded answers are in the middle of lengthy renewal documentation.

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Complaint 131308

Failure to disclose material information at renewal.

Anthony held rental property insurance. In 2010, with his consent, the tenants made structural changes to the property that made it into two separate units, without obtaining resource or building consents. The policy automatically renewed in May 2011, and Anthony did not contact the insurer to advise it of the structural changes. In 2013, the house suffered fire damage and Anthony made a claim.

In March 2014, the insurer informed Anthony that not informing it of the structural change was a material non-disclosure, and that it was avoiding his policy to the renewal period. Therefore, he held no insurance at the time of the fire and his claim was declined. The case manager did not uphold Anthony's complaint, because the evidence indicated that Anthony knew about the structural changes, they were of real significance to the risk and they should have been disclosed.

Complaint 00204503

Failure to understand the extent of disclosure obligations.

Truckers Limited held vehicle insurance on its trucks. Truckers made a verbal agreement with Heroes Limited, that Heroes drivers could use its trucks. A staff member of Heroes crashed the truck, and Truckers made a claim to its insurer.

The insurer declined the claim, on the basis that Truckers had breached its disclosure obligation by failing to disclose that it had not obtained an appropriate statutory transport services licence. Truckers stated it was not aware of all statutory requirements and the insurer had not asked about such a licence. The complaint was eventually settled.

5. Can consumers accurately assess what a prudent underwriter considers to be a material risk?

The "prudent underwriter test" is based on materiality of information to an underwriter and is not understood by consumers. Most consumers do not know what a "prudent underwriter" is and, therefore, have little or no understanding of how underwriters assess risk. Underwriting is an expert field requiring years of experience; from even a basic common sense perspective, consumers cannot be expected to understand how to assess a material risk.

Notably, when obtaining "prudent underwriter" opinions, the IFSO Scheme will contact two or more senior underwriters to take into account the fact that underwriters' assessments of risk will differ and will sometimes depend on the reinsurer's approach.

Complaint 00204671
Different underwriters may have different views of the risk presented.

Fenyi held life and critical illness cover. In 2016, she made a claim for a critical illness benefit following a cardiac arrest. The insurer initially declined the claim on the basis that the cardiac arrest was not a "serious heart attack" and, on reviewing the claim, determined that Fenyi had failed to fully disclose her medical history when arranging the insurance. Therefore, it avoided the policy and declined to consider the claim.

The case manager consulted three senior independent underwriters and asked how Fenyi's medical information would affect their decisions to insure her. Two said they would have offered cover on standard terms, and one advised he would have deferred cover until further questions were answered. The complaint was later settled.

Based on the principle of proportionality, the IFSO Scheme considers what the prudent underwriter would have done if it had been on notice of the material information.

Complaint 136461
Using anonymised information with other senior underwriters, the IFSO Scheme will benchmark the insurer's approach.

Terence, made a claim for trauma and income protection. On reviewing Terence's medical notes, the insurer declined the claim and added a 300% loading to his life cover. It believed Terence had failed to disclose recent treatment for shortness of breath when arranging the policy. Terence complained to the IFSO Scheme on the basis that a doctor had confirmed he was not aware he had any condition when he completed the policy application.

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The case manager believed Terence should have disclosed the shortness of breath, because the policy questionnaire asked whether he had *"ever... had symptoms of or had treatment for...* [a] *respiratory or breathing disorder".* The case manager then had to consider whether the non-disclosure was material. Two underwriters confirmed they would have deferred cover until the consumer underwent further medical tests.

Complaint 00205340

Innocent non-disclosure leads to avoidance of the policy and has harsh results for a consumer who does not understand the "prudent underwriter" test.

Felita claimed under a mortgage protection policy, because she was diagnosed with bowel cancer. The insurer declined her claim, after adding a retrospective exclusion for gastrointestinal issues, on the basis that Felita had previously had gastrointestinal type symptoms. Felita stated her doctor had advised that these were related to her contraception, and so she had answered the disclosure questions correctly.

The case manager believed that the symptoms should have been disclosed in answer to a disclosure question concerning general health issues. The case manager contacted two senior underwriters, who said they would have deferred cover until Felita underwent further medical examination. Even though the non-disclosure was innocent, it was still material and the retroactive exclusion was appropriate to the risk.

6. Do consumers understand the potential consequences of breaching their duty of disclosure?

In our experience, consumers do not understand the consequences of breach, either at application or at claim time.

Complaint 135835

Consumers will often provide information to insurers that they believe, on a subjective basis, is relevant; information that is material can be omitted as not being perceived by the consumer to be relevant.

In May 2013, Riley arranged life, trauma and temporary total disability (TTD) insurance. She made a claim in 2015 following a car accident. The insurer requested her medical information, learned she had attended counselling and been prescribed anti-depressant medication in 2010, and avoided the policy in its entirety. The insurer later offered to reinstate the policy with a mental health exclusion. Riley declined, because her counselling was taken for *"social reasons"* - she did not believe it was fair for the insurer to expect disclosure of counselling for reasons other than a mental health concern, and had never taken the antidepressants prescribed to her.

The case manager believed that Riley was not obliged to disclose the counselling, but that her prescription of antidepressants - even having never taken them - was material. In this case, although the claim was not upheld, the insurer and Riley eventually agreed to reinstate the policy with a mental health exclusion.

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7. Does the consumer always know more about their own risks than the insurer? In what circumstances might they not? How might advances in technology affect this?

While a consumer might understand their own circumstances better than anyone else, this is not the same as having a better appreciation of the risk they present to an insurer. Most consumers, even with advances in technology, are simply not equipped to conduct the same types of risk analysis that an insurer or an underwriter can e.g.in health, life and travel insurance, questions often have no temporal limitation and it is consumers are expected to remember their whole medical history.

8. Are there examples where breach of the duty of disclosure has led to disproportionate consequences for the consumer? Please give specific examples if you are aware of them.

Yes. The common law allows an insurer to avoid a policy retrospectively from commencement *(ab initio),* or renewal, treating it as if it never existed. In these circumstances, an insurer should refund the premiums paid, but sometimes will retain them if a contractual provision allows them, to do so. The remedy is equally available in cases where there has been either an innocent or deliberate breach of the duty of disclosure. While most of the cases of non-disclosure seen by the IFSO Scheme are innocent, and we believe that avoidance is not the appropriate remedy, it is acknowledged that some non-disclosure is deliberate and avoidance should be available to the insurer in those cases.

Avoiding the policy can have extremely harsh consequences for a consumer, who will be left with no policy of insurance, no realistic prospect of obtaining replacement insurance and a very real possibility of having any other policies, held with the same insurer, cancelled on notice.

Complaint 00205604

Avoidance can have extremely harsh results for a consumer who fails to disclose material information.

Connor failed to disclose counselling and self-harm as a teenager when applying for life insurance. Four years later, Connor, the sole income earner for the family, died suddenly and his estate made a life insurance claim on behalf of his wife and young children. On obtaining his medical notes, the insurer avoided the policy and declined to consider the life insurance claim.

9. Should unintentional non-disclosure (i.e. a mistake or ignorance) be treated differently from intentional non-disclosure (i.e. fraud)? If so, how could this practically be done?

The IFSO Scheme believes that a reasonable person test should be applied, similar to the approach taken in Australia, where s 21(1) of the Insurance Contracts Act 1984 establishes a reasonableness standard. A consideration of what a reasonable person

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would have known to disclose in the circumstances would be a much fairer test and one that consumers could understand.

10. Should the remedy available to the insurer be more proportionate to the harm suffered by the insurer?

Yes. Based on the proportionality principle, as used in similar financial Ombudsman schemes in the UK and Australia, the remedy reflects what the prudent underwriter would have done if it had been on notice of the material information.

We note that the Fair Insurance Code (Code) came into force on 1 January 2016, setting out minimum standards for fire and general insurers. The Code included a number of provisions on the insurer's obligation in relation to non-disclosure. However, it is hard to judge the effectiveness of the provisions, because there are far fewer complaints made to the IFSO Scheme in the fire and general sector which relate to non-disclosure.

11. Should non-disclosure be treated differently from misrepresentation?

In the UK, where a misrepresentation is deliberate or reckless (at paragraph 44 on page 19 of the Review), an insurer can avoid the policy. If non-disclosure is deliberate, the same remedy should apply, because it is deliberate misrepresentation by omission.

Under ss 4 and 5 of the ILRA 1977, a misstatement (being a positive statement) must be both material and substantially incorrect, but not necessarily deliberate or dishonest. Our experience indicates that a number of insurers in the life, health and disability sector do not understand there is a distinction between misstatement under the ILRA and non-disclosure, particularly because the same remedy of avoidance applies to both, and this anomaly should be addressed in the Review.

12. Should different classes of insureds (e.g. businesses, consumers, local government etc.) be treated differently? Why or why not?

In accordance with the Financial Service Providers (Registration and Dispute Resolution) Act 2008, the IFSO Scheme has jurisdiction to accept complaints from consumers, including small businesses of up to 19 FTEs, but under its Terms of Reference has no jurisdiction to consider commercial complaints.

We note that, should the reasonable person test be applied, as suggested, the distinction between classes of insureds might be unnecessary, as it could be included within the reasonable person assessment. However, a consideration of the UK's experience might be useful in this regard.

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13. In your experience, do insurers typically choose to avoid claims when they discover that an insured has not disclosed something? Does this process vary to that taken in response to instances where the insurer discovers the insured has misrepresented information?

In our experience, insurers tend to avoid policies and decline to consider claims. Of the 21 non-disclosure complaints we considered this year, only 4 did not result in avoidance. The remaining 81% of complaints resulted in either the entire policy being avoided, or some of the benefits being removed (e.g. income protection). However, this largely depends on the insurer, policy wording, claim type, product and sector. We note that a decision to retain or refund premiums may also be based on the insurer's perception of whether the non-disclosure was deliberate.

14. What factors does an insurer take into account when responding to instances of non-disclosure? Does this process vary to that taken in response to instances where the insurer discovers the insured has misrepresented information?

In regard to the first half of the question, factors taken into account include the degree of non-disclosure, the extent of any actual or perceived ongoing risk, and any moral hazard or issue of trust associated with the non-disclosure. Other questions include whether the non-disclosure is actually connected to the particular claim, and additionally, whether it appears likely to link to any future claim. Pressure from reinsurers also influences the decision making of insurers.

Where an insured has misrepresented information, our experience is that it will depend on whether the misrepresentation is deliberate or reckless, and made with the intention of deriving a benefit to which the insured would otherwise not be entitled.

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Regarding conduct and supervision

15. What do you think fair treatment looks like from both an insurer's and consumer's perspective? What behaviours and obligations should each party have during the lifecycle of an insurance contract that would constitute fair treatment?

Insurers and consumers often have different perceptions of fairness. These divergent approaches are backed up by international research.[2] Predominantly, insurers use a concept of procedural fairness, asking how the decision was made and, in particular, by reference to the policy wording or law. However, most consumers use a concept of substantive or relational fairness, focusing on the outcome or how they were treated, without necessarily taking into account their or the insurer's legal obligations.

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[2] DEPARTMENT FOR BUSINESS, ENERGY AND INDUSTRIAL STRATEGY. 2018 Resolving consumer disputes: Alternative dispute resolution and the court system. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698442/Final_report_-_Resolving_consumer_disputes.pdf and CHALMERS 2016. Ethical fairness in financial services complaint handling. *International Journal of Bank Marketing,* Vol. 34 Issue: 4, pp.570-586, https://doi.org/10.1108/IJBM-09-2014-0124.

This was best described by Lord Nicholls of Birkenhead in *White* in his comment "... *fairness, like beauty, lies in the eye of the beholder".*[3]

It is our experience that procedural and substantive or relational fairness are often difficult to reconcile. Procedural fairness most easily lends itself to prescribed behaviours or obligations. Because consumers typically approach their view about fairness from a substantive perspective, the outcome of the decision can have a significant impact on whether the consumer sees the outcome as fair. However, from a relational perspective, the view of fairness is coloured by how the insurer treated the consumer. The transactional and subjective nature of this may make it difficult to prescribe obligations or behaviours in a way that can be meaningfully measured.

16. To what extent is the gap between ICP 19 and the status quo in New Zealand (as identified by the IMF} a concern?

ICP 19 encourages a stronger regulation of the conduct of business at all points, particularly in relation to the aspect of fairness. The IFSO Scheme sees the gap between the conduct set out in ICP 19 and the lack of codification and regulatory oversight in New Zealand as significant concerns.

While the Code incorporates some aspects and aims of ICP 19, it is more limited and it does not bind all insurers. The Code's aim is to act as a minimum standard for fire and general insurers. However, in our experience, technical breaches occur reasonably frequently e.g. the five-day response period (Code, point 28}.

Utmost good faith is poorly defined in the status quo and, although not stipulated in ICP 19, a similar concept of fair treatment is the paramount concern in all dealings between insurers, intermediaries and consumers. The lack of a clear and codified definition of utmost good faith, combined with conflicting judicial statements, have created a situation where the duty is not balanced; it is more onerous on consumers than on insurers e.g. insurers only have to provide policy wording to the insured.

17. Does the lack of oversight over the full insurance policy 'lifecycle' pose a significant risk to purchasers of insurance?

Yes. The current system contains a number of agencies that exercise some form of regulatory function at some point in the process, including the FMA, Reserve Bank and Commerce Commission. At claim time and when managing disputes, the regulatory oversight ceases and is replaced by the approved dispute resolution bodies which are redress based only, and have no disciplinary or prosecutorial function. Taken as a whole, this fragmented approach to regulation and oversight, with regulatory gaps and differences in targets and drivers, does not create an environment conducive to consumer protection. We hope that this Review and resulting legislation will go a long way to improving the current framework.

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[3] *White and White* [2000] UKHL 54 at 54.

18. What has your experience been of the claims handling process? Please comment particularly on:
   - timeliness the information from the claims handler about:
     - o timeframes and updates on timeframes
     - o reasons for declining the claim (if relevant) o how you can complain if declined
   - The handling of complaints (if relevant)

Currently, there is no statutory requirement for an insurer to respond to a complaint within a specified period of time. Fire and general insurers who are members of ICNZ, undertake to adhere to the following process set out in the Code:

> 43. If you make a complaint to us. we ,Vill:
>
> » Acknov,ledge receipt within 5 business days of receiving your complaint.
>
> " Give you the name and contlct details of the person handling your complaint.
>
> » Ens,.ire that someone experienced who has not been handling)'OUr case fully investigates your complaint.
>
> » Respond to 1-our complaint within IO business days of the date we have all the information we need to detem1ine your complaint 1/v'here further information, assessment or investigation is required, ,ve v..il! agree reasonable timeframes with you. If we cannot agree on reasonable timeframes, you can contact our independent external dispute resolution scheme about those timeframes.
>
> » Update you at least once every 20 business days, or another such interval as we may agree with)'Cl:!, until 1-our complaint is resolved.
>
> 44. If we cannot resol.e your complaint to your satisfaction through our internal dispute resolution process within 2 months, we ,viii explain our reasons to 1-ou in writing and provide you with a 'deadlock' letter so you can take your complaint to our independent. external dispute resolution s.dieme.

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Paragraph 8.2 of the IFSO Scheme's Terms of Reference provides a discretion to consider that *"deadlock"* has been reached, if *"the Complainant has made a written Complaint to the Participant and at least 2 months have elapsed since the date of that Complaint"*.[4]

The IFSO Scheme reviews a broad range of complaints. We have noticed that in practice, internal dispute resolution (IDR) processes and timeliness can vary between insurers.

- <u>Timeliness</u>

When the IFSO Scheme first receives contact from a consumer, often they have entered into the insurer's complaint process. We make a record in our case management system of the date we advise a consumer to make a complaint to the insurer, for tracking purposes. We note that this date may not be the exact date a consumer makes a complaint to an insurer.

[4] https://www.ifso.nz/assets/TOR-1-July-2015.pdf

For those complaints that are escalated and are investigated by the IFSO Scheme, we also record the date that *"deadlock"* was issued by the insurer.

Of the 320 complaints accepted for investigation by the IFSO Scheme in 2018, about 60% of consumers contacted us after *"deadlock"* had been reached. For those who contacted us prior to *"deadlock"*, the timescales from contacting the IFSO Scheme to *"deadlock"* being reached were, as follows:

Fire and General Insurance (total 205)
Average time: 89 days
Median time: 40 days
Shortest time: 1 day
Longest time: 1,246 days
Number of complaints which took over 60 days: 22 (out of 75)

Health, Life & Disability Insurance (total 98)
Average time: 69 days
Median time: 27 days
Shortest time: 1 day
Longest time: 953 days
Number of complaints which took over 60 days: 12 (out of 38)

We note that the Code requires the fire and general insurers to declare *"deadlock"* within 2 months of the complaint. While the IFSO Scheme's figures demonstrate that this usually happens, these times run from when we refer the Complainant back to the insurer. Many of the complaints we see show that the Complainant had previously made what the IFSO Scheme considers to be a complaint, but which might not have been recognised as such by the insurer.

There are some instances where it can legitimately take an insurer some time to be able to consider a claim. For example, in income or TPD cover claims, an insurer may need specialist medical reports to confirm whether or not the claim requirements are met or not. We see many instances where there is a long wait for an appointment with the specialist and then for the report to be provided.

- <u>Process</u>

Each insurer has its own IDR process. Generally, the complaints processes are multi-level, escalating from: raising the matter directly with the relevant contact person / team leader 7 formal IDR process 7 complaint made to the IFSO Scheme.

Some IDR processes have additional steps within the overall complaints structure. For example, an insurer may have more than one escalation point within the IDR process, meaning an insured receives three types of correspondence from the insurer (the initial decline, stage one decline and letter of *"deadlock")*. Another IDR process may require an insured to write a formal complaint to senior management, after they have already raised the complaint to a claims staff member. Many of the insurers advertise their IDR process on their websites.

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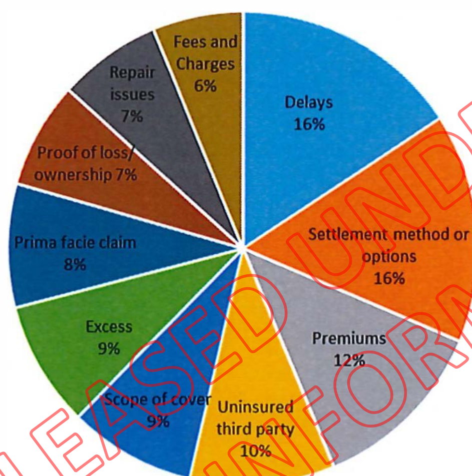
Anecdotally, our case managers encounter Complainants who have *"complaint fatigue"* -they feel that the complaint has been going on for too long and have minimal energy left to continue pursuing their complaint. An IDR process across the insurance industry that has minimal steps for an insured to make and escalate a complaint, could assist in minimising *"complaintfatigue"*.

- Claims generally

Between 1 July 2017 and 31 January 2018, the top 10 fire and general insurance issues received as complaint enquiries, were as follows:

Top 10 Complaint Enquiry issues

(1 July 2017 - 31 January 2018)



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As fire and general insurance made up the majority of the complaints and complaints enquiries we received, this demonstrates that delays are a significant issue for consumers.

Complaint 206890

Delays in the claims process can cause significant issues for consumers.

Yasmin's home was damaged following heavy rain. She contacted the insurer in March 2017 to make a claim. In August 2017, the insurer stated that the policy excluded damage due to earth movement, except under the EQC top up provision for natural disasters. The insurer then told Yasmin she could file a landslip claim with the EQC.

It was nearly five months between Yasmin filing the claim, and Yasmin's insurer formally suggesting she make a claim to EQC; however, EQC has a 3-month statutory deadline for making a claim. The case manager noted this had the potential to create significant issues for Yasmin. Although Yasmin's claim was accepted by the EQC, this case illustrates a situation where an insurer's delay presented a serious risk that a consumer would not have insurance cover.

Complaint 00205748

The length of time an insurer's process has taken can lead to a complaint.

Max had vehicle cover, and was involved in an accident in April 2017. He made a claim, which the insurer accepted, and the insurer authorised repairs which began in May. In June, the insurer obtained a revised repair estimate for more extensive damage and authorised the repairs. At the end of July 2017, Max complained about the time taken for the repairs. The repairs were completed in mid-September 2017, but the vehicle continued to have issues, and the insurer decided to resolve this by paying Max the sum insured of the vehicle, following a complaint about the timeliness and quality of repairs.

The case manager reviewed the timeline of events that occurred in relation to the claim, together with the relevant assessments about the quality of the repairs. The case manager determined a reasonable timeframe to repair the vehicle would have been about 11½ weeks. The actual repair of the vehicle exceeded the reasonable repair period by about 9 weeks. In this context, the IFSO Scheme believed it was appropriate for the insurer to pay interest to Max.

In our experience, complaints about an insurer's decision often relate to poor communication of the reasoning behind the decision. It is not always clear to a consumer exactly why their claim has been declined. There have been occasions where the core issue of a complaint turns out to be a miscommunication between parties.

Complaint 00206130

Poor communication leads to complaints.

An insurer had accepted a liability claim, but believed that the quantum of the claim was below the policy excess of $5,000. However, the insured had understood that the insurer had declined the claim in its entirety. During the course of the complaint with the IFSO Scheme, it became apparent that the excess applied was probably incorrect and, also, the claim was in excess of $11,000. Both the insurer and the insured had misunderstood the nature of the information being provided by the other party.

We also see differences in how established entities and newer entities handle the claims process and, for that reason, offer ongoing training to our members in best practice.

There is a key difference between institutional and individual complaints, especially in regard to advisers. This is because an individual adviser often has a closer, more personal relationship with a Complainant, which effects the likelihood of a complaint both being made and being appropriately dealt with. We have also identified that, for consumers, timing can be an issue, particularly with long-running situations like a TPD claim.

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19. Have you ever felt pressured to accept an offer of settlement from an insurance company? If so, please provide specific examples.

Not applicable.

20. When purchasing (or considering the purchase of) insurance, have you been subject to 'pressure sales' tactics?

Not applicable. (However, in our experience sometimes pressure is applied in the selling process, including in churn situations.)

21. What evidence is there of insurers or insurance intermediaries mis-selling unsuitable insurance products in New Zealand?

Complaint 00204491

Need for a policy to suit the needs of the consumer.

Roma held house insurance. She notified the insurer by phone she was moving to a rural area, and the insurer updated the policy and sent notification of change to Roma. The next year a third party ran into a fence on the perimeter of Roma's property, and Roma made a claim. The insurer declined the claim on the basis that the fence was a roadside fence and that the damage occurred outside the residential boundary of the house, which was the policy's geographic limitation.

Roma made a complaint on the basis that, because the insurer knew she was moving to a rural area, she believed the insurer should have offered her a lifestyle or farm policy.

In this case, the IFSO Scheme was unable to obtain recordings of any conversations between the parties and notes were minimal. On the basis of general insurance principles, the IFSO case manager believed that Roma had an obligation to ensure she understood and could confirm the accuracy of the policy wording she had received. Since Roma had been provided a copy of it, the insurer was entitled to rely on the policy wording.

Complaint 00204612

Sales of unsuitable products can occur because consumers often lack understanding about financial products generally.

Deepa held house and contents insurance. After her house was contaminated with lead, she made two claims. The insurer declined the claims based on a lack of a defined peril in the policy, and an exclusion for poor workmanship. Deepa made a complaint on the basis she believed that she had equivalent cover under the new policy to her original policy with another insurer. Following a conciliation conference, it was established that Deepa was not clearly advised of the type of policy she was purchasing, and had requested a policy equivalent to her previous one. The insurer settled the claim.

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22. Are sales incentives causing poor outcomes for purchasers of insurance? Please provide examples if possible.

Yes. We believe that consumers do not necessarily turn their minds to the role or motivation of their financial adviser, or even seem to understand that different financial advisers might operate differently. We believe that they often assume financial advisers are sufficiently expert to be able to advise them about all products. This could include those products the consumer already has in place, but that the financial adviser does not sell, and with which the financial adviser might be unfamiliar.

We see cases where consumers have replaced insurance policies, such as income protection or health policies, and then find they have no cover, because they had pre-existing conditions or failed to disclose material information. Often the consumer's stated reason for replacing the cover is to reduce the cost, which may be achieved with the replacement. However, they did not understand the risks in replacing policies or that, for a relatively small price reduction, they could have considerably reduced cover, or exclusions imposed that were not on the original policy. Some financial advisers do not make consumers aware of this risk, or that there may be ways of restructuring the existing policy to achieve a similar price reduction.

Consumers appear to be generally unaware that a financial adviser will usually receive a financial benefit for the replacement of a policy.

23. Does the insurance industry appropriately manage the conflicts of interest and possible flow on consequences that can be associated with sales incentives?

No. Our experience is that the insurance industry does not recognise conflicts of interest particularly well.

Complaint 125159

Adviser's Jack of awareness of conflict of interest.

Roger had asked a financial adviser to send a cancellation notice on his behalf. Although the adviser sent the notice, the insurer did not receive it, and the adviser did not follow up. This meant Roger continued paying premiums for six months. The adviser then made a complaint on behalf of Roger. As the adviser had the responsibility to Roger of cancelling the policy, he had the onus of proving it was "made known" to the insurer. Because he had failed to do so, the case manager believed Roger could equally pursue a complaint against the adviser.

Complaint 00206426

Adviser's Jack of awareness of conflict of interest.

Carol made a complaint that her financial adviser did not act in her best interests where the financial adviser continued to act as a financial adviser for both her and her estranged partner after they separated.

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In the circumstances, it was arguable the financial adviser could not provide proper advice to both Carol and her partner as their interests had ceased to be the same.

In addition, it is reasonably common for financial advisers to act as representatives of Complainants in complaints made to the IFSO Scheme. The complaints are often made about insurers and relate to decisions to replace insurance policies, where the financial adviser provided the advice to the consumer to replace the policy.

Regarding exceptions from the Fair Trading Act's unfair contract terms provisions

24. Are you aware of instances where the current exceptions for insurance contracts from the unfair contract terms provisions under the Fair Trading Act are causing problems for consumers? If so, please give examples.

Under the FTA, unfair contractual terms are limited in their application to insurance contracts. However, given the intention of this Review is to consolidate and improve insurance legislation, any inclusion of a provision on unfair contractual terms should be in the new statute, rather than the FTA. While we understand that insurers have a legitimate interest in having some exceptions, the Review is timely to consider whether the exceptions are still appropriate.

25. More generally, are there terms in insurance contracts that you consider to be unfair? If so, why do you consider them to be unfair?

Yes. There are terms which are unfair and while common law requires unusual or onerous terms to be brought to an insured's attention, if the term is commonly used in the industry, an insurer does not need to inform customers e.g. a provision allowing an insurer to decline a claim on the basis of an incorrect or incomplete statement, which does not require dishonesty; and broadly worded pre-existing condition (PEC} exclusions, which are not time limited, are often found in travel policies and allow an insurer to decline a claim for "any symptom or circumstance" an insured has ever had. It does not require the insured to know that what they had was a symptom of medical condition.

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Complaint 136228
Reliance on a PEC to decline a travel claim.

Mr and Ms Lowe sought medical advice for the lump on their daughter's head, prior to the start of the policy. The doctor and radiologist believed the lump might be a haematoma, so Mr and Ms Lowe went on their overseas family holiday. However, while overseas, the daughter was diagnosed with leukaemia and required treatment. This meant the family had to stay overseas for an extended period of time, at great expense. The doctors in that case linked the lump to the leukemia. Although Mr and Ms Lowe did not know their daughter had leukemia, they did know that she had a lump. Therefore, the insurer declined the claim.

In addition, the claim does not need to be directly related to the PEC, but instead, only indirectly related to it. In other words, if the PEC relates to the claim in any way, such

as increasing the risk or as a contributing factor, the insurer is entitled to decline the claim.

Complaint 137116
Reliance on a PEC to decline a travel claim.

While Awhina was travelling overseas in August 2016, she was diagnosed with kidney stones. Awhina returned to New Zealand earlier than planned, to undertake kidney stone treatment. The insurer declined the claim on the basis that Awhina was diagnosed with kidney stones prior to the start date of the policy, in 2009. The insurer stated that, as kidney stones could be recurrent, the claim arose from a PEC and was excluded. The kidney stone was a PEC, because it occurred in 2009, many years prior to the start of the policy. The insurer had medical evidence indicating that when an individual had one kidney stone, they were at a higher risk of getting another one. Therefore, there was at least an indirect link between Awhina's kidney stone in 2009, and the kidney stone in 2016. Consequently, the insurer could decline the claim.

Complaint 119461
Provisions limiting cover for cash and passport to only being covered while "on your person" i.e. no cover when showering, sleeping or swimming.

Complaint 00207460
Strict requirement on the age of a receipt or yearly valuation on contents i.e. no cover if a receipt or valuation is over 12 months old.

Complaint 00205565
Requirement to notify an insurer of hospitalisation within a specific timeframe.

Section 9 of the ILRA 1977 prevents an insurer declining a claim for delay in notification, unless an insurer can show prejudice. In travel cases it is relatively easy to show prejudice, given the costs of hospitalisation when compared to the cost to fly an insured back to New Zealand.

In the health sector, some health policies allow an insurer to make unilateral changes to health policies and an insured can lose cover that they previously had. The only requirement in such cases, is that the insurer notify the insured of the changes.

Complaint 00206884
Change in terms of health policy.

An insured had no cover for treatment and was unable to move to another insurer, due to the condition being a pre-existing condition.

26. Why are each of the specific exceptions outlined in the Fair Trading Act needed in order to protect the "legitimate interests of the insurer"?

Where terms directly affect the insurer's pricing and evaluation of the risk, exceptions are not unreasonable, but should be limited.

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27. What would the effect be if there were no exceptions? Please support your answer with evidence.

We note the courts can weigh the "legitimate interests of the insurer" in determining whether a contract term is unfair. The Review may take the opportunity to consider whether there should be "no exceptions" in future legislation.

Regarding difficulties comparing and changing providers and policies

28. Is it difficult for consumers to find, understand and compare information about insurance policies and premiums? If so, why?

Although comparison tools exist, these provide a relatively high-level overview of insurance policies and still ultimately require consumers to be able to read and interpret lengthy policy documents. Comparison tools rarely compare the details of exclusions or specifics of the scope of cover. They are also unable to compare all policy offerings, typically focusing on between six and seven different policies, and do not always include a policy wording. As a result, even where a consumer is able to compare policies, they are not able to evaluate the full scope of options available e.g. travel policies contain many exclusions, which are not comparable in meaning or effect, and require both close reading and background knowledge to understand.

Complaint 135580
Exclusion of liability.

An exclusion applied to loss or damage *"arising from... any process of cleaning, repairing or restoring"*. While a number of policies on the market have restoration or cleaning exclusions, these contain a saving provision, which means that the exclusion only applied to the item actually being cleaned or restored. The exclusion in this complaint had no such saving provision. In fact, the ICNZ had a frequently asked question directly on point, which indicated that consequential damage, such as in this case, would be covered.

This ability to compare policies requires technological literacy. Generally speaking, older consumers, and those without the ability to access a computer or the internet, are less likely to be able to enjoy the benefits of comparing different policies. Moreover, most health and life insurance wordings are not available online.

In-person comparisons are also compromised if a consumer cannot easily obtain information about the range of financial products on which the financial adviser is able to give advice. This is potentially more problematic when a policy is being replaced, because the adviser might have no knowledge of the terms of the original policy.

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29. Does the level of information about insurance policies and premiums that consumers are able to access and assess differ depending on the type of insurance? E.g. life, health, house and contents, car insurance etc.

Yes. As noted, not all policy wordings are easily available online, which results in different levels of information available. On one end of the spectrum, travel insurance policy wordings and costs are typically available online. On the other, life insurance policy wordings are significantly more difficult to find, and online quote generators can only account for a limited number of the factors which influence premiums. A lot of advice is given on policies that are no longer being sold and they are almost impossible to find on line, and the consumer might not still have a copy of the original policy. Fire and general policy wordings available on line are easier to compare, given the limited number of insurers.

30. What barriers exist that make it difficult for consumers to switch between providers?

In life, health and disability insurance, the primary barrier is the development over time of health issues that means a consumer becomes uninsurable, too costly to insure, or subject to exclusions on cover if they want to replace an existing policy. Over time, for this reason, a consumer cannot change their existing policy and take advantage of any of the newer, better products available on the market.

In fire and general insurance, the ICNZ Insurance Claims register {ICR) can cause problems for a consumer. Every major fire and general insurer is a member of ICNZ, and they share information on claims. However, the only obligation on the insurer is under the Privacy Act, to allow consumers to correct their information - not to ensure full disclosure of information, such as the final outcome of an investigation. This means a general flag of "refer to investigations" is often taken as implying fraud and, therefore, a reason to refuse cover, should a consumer wish to switch between providers. There is no oversight over the ICR.

Exclusion zones and embargoes can limit consumer options. For example, people living in a TC3 zone in Christchurch find it significantly harder to get insurance; new customers are unlikely to get cover at all, and those who have suffered previous structural, liquefaction or land damage are unlikely to receive home insurance.

Complaint 00204678

Dishonesty recorded on /CR.

Mr and Mrs Zhou held home and contents insurance. Mr Zhou made a claim for damage to a smartphone, which he said belonged to Mrs Zhou. Mr Zhou said their Au Pair, Mary, had taken it to a repairer. When the insurer first asked where and how the phone was purchased, Mr Zhou stated they purchased it second hand in New Zealand. Mr and Mrs Zhou later admitted that Mary had actually brought it to New Zealand, from overseas. However, Mrs Zhou had given Mary money towards the phone. The insurer declined the claim and voided the policy based on dishonesty and breach of the policy conditions. This information was entered on the ICR. By the time the IFSO

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Scheme reviewed the complaint, Mr and Mrs Zhou had been unable to obtain any insurance on their house, contents or vehicle, because of the ICR record and the fact that their house was in a TC3 zone. Mr and Mrs Zhou considered this a wholly disproportionate outcome, for what they believed a small misunderstanding. However, the case manager considered that Mr Zhou made a dishonest statement, and that the insurer was entitled by the policy wording to enter the claim details on the ICR.

31. Do these barriers to switching differ depending on the type of insurance? E.g. life, health, house and contents, car insurance etc.

Yes; refer to Q30.

32. What, if anything, should the government do to make it easier for consumers to access information on insurance policies, compare policies, make informed decisions and switch between providers?

To help consumers make more informed decisions when they need to, financial literacy needs to be taught in schools (we understand that there are some moves to have a "Leaver's Toolkit" introduced). In the majority of complaints dealt with by the IFSO Scheme, consumers have little or no understanding about financial products, insurance policies, and their obligations.

We also note that overseas jurisdictions have a one page summary of cover in insurance policy documents, and such a requirement would go some way to allowing better comparisons.

Regarding third party access to liability insurance monies

33. Do you agree that the operation of section 9 of the Law Reform Act 1936 (LRA) has caused problems in New Zealand?

Not applicable.

34. What are the most significant problems with the operation of section 9 of the LRA that any reform should address?

Not applicable.

35. What has been the consequence of the problems with section 9 ofthe LRA?

Not applicable.

36. If you agree that there are problems with section 9 of the LRA, what options should be considered to address them?

Not applicable.

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Regarding failure to notify claims within time limits

37. Do you agree that the operation of section 9 of the Insurance Law Reform Act 1977 (ILRA) has caused problems for "claims made" policies in New Zealand?

Not applicable.

38. What has been the consequence of the problems with section 9 of the ILRA?

Not applicable.

39. If you agree that there are problems with section 9 of the ILRA, what options should be considered to address them?

Not applicable.

Regarding exclusions that have no causal link to loss

40. Do you consider the operation of section 11 of the Insurance Law Reform Act 1977 (ILRA} to be problematic? If so, why and what has been the consequence of this?

In New Zealand, the onus solely rests with the insured to establish the loss *"was not caused or contributed to by the happening of such events or the existence of such circumstances".* This can prove problematic in complaints from time to time.

Complaint 118023
Section 11 does not apply to losses not covered by a policy.

Steve held insurance cover on a barn with a fit-out. A fire destroyed the barn and Steve made a claim to his insurer. Although the insurer accepted the cost of the barn, it declined to pay for the fit-out, because the appropriate consents had not been obtained for its construction. The insurer argued this meant it fell outside the scope of cover of the policy. The case manager referred to *Barnaby v South British Insurance Limited* (1980) 1 ANZ insurance cases 60-401. In that case, the court said thats 11 of the ILRA was intended to deal with exclusions which provide for circumstances likely to increase the risk of a loss which the policy actually covers, not for losses that the policy does not cover. This case fell into the second category and so the complaint was not upheld.

41. The Law Commission proposed reform in relation to exclusions relating to the characteristics of the operator of a vehicle, aircraft or chattel; the geographic area in which the loss must occur; and whether a vehicle, aircraft or chattel was used for a commercial purpose. Do you agree that these are the areas where the operation of section 11 of the ILRA is problematic? Do you consider it to be problematic in any other areas?

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The IFSO Scheme does not have a strong view about the comments made by the Law Commission on this point. We support a balance being struck between the ability of underwriters to accurately risk and consumers receiving fair treatment when a claim is assessed. We discuss these issues in our 2006 submissions, a copy of which is attached.

42. If you agree that there are problems with section 11 of the ILRA, what options should be considered to address them?

We believe thats 11 could be made clearer and more concise.

Regarding registration of assignments of life insurance policies

43. Do you agree that the registration system for assignment of life insurance policies still requires reform?

Not applicable.

44. If you agree that there are problems with the registration system for assignment of life insurance policies, what options should be considered to address them? Do you consider there to be problems with the current position in relation to whether an insurer or consumer bears the responsibility for an intermediary's failures? If possible, please give examples of situations where this has caused problems.

Not applicable.

Regarding responsibility for intermediaries' actions

45. Do you consider there to be problems with the current position in relation to whether an insurer or consumer bears the responsibility for an intermediary's failures? If possible, please give examples of situations where this has caused problems.

We note that the majority of the issues we see related to intermediaries are in the life, health and disability sector, rather than in fire and general insurance.

Although the adviser represents the consumer, we sometimes see a failure to put consumers' interests first in respect of, as an example, replacement insurance policies. Consumers also appear to be unaware a financial adviser will usually receive a financial benefit for the replacement of an existing policy.

There is no clarity over who takes responsibility for ensuring that a financial adviser is sufficiently familiar with the products they are selling.

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We see that consumers often believe the intermediary represents the insurer, rather than acting as the consumer's agent, leading to confusion over who is responsible for failures.

In our experience, the nature of a consumer's more personal relationship with their adviser affects how they allocate responsibility and whether and against whom they will make a complaint.

46. If you consider there to be problems, are they related to who the intermediary is deemed to be an agent of? Or the lack of a requirement for the intermediary to disclose their agency status to the consumer? Or both?

The role of an intermediary is generally poorly understood by consumers. In the context of life, health and disability insurance, one particular factor causing confusion is that when contacted directly, insurers will often refer consumers to an intermediary to go through the sales process or for any follow-up. This creates confusion from a consumer perspective about who the intermediary actually represents.

47. If you consider there to be problems, what options should be considered to address them?

The IFSO Scheme has previously suggested that there be a basic entry requirement for financial advisers.

In our experience written disclosure by intermediaries is the most effective, because it means consumers have a record they can refer to when required. However, one-off written disclosure requires consumers to keep all documentation and to remember to refer to it. For that reason, we believe there should be multiple points where key information is disclosed.

Most consumers now expect to be able to access information online and we believe that financial advisers' websites should be required to include specified key information, including what to do if their clients have a complaint.

We would also like to see a specific requirement that financial advisers and FSPs must provide consumers with information about their complaints handling processes when a consumer makes a complaint, regardless of whether that information has previously been provided.

Regarding insurance intermediaries - Deferral of payments / investment of money

48. Do you agree that the current position in relation to the deferral of payments of premiums by intermediaries has caused problems?

Not applicable.

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49. If you agree that there are problems, what options should be considered to address them?

Not applicable.

Other miscellaneous questions

50. Are there any provisions in the six Acts under consideration that are redundant and should be repealed outright? If so, please explain why.

No.

51. Are there elements of the common law that would be useful to codify? If so, what are these and what are the pros and cons of codifying them?

We believe the following common law tests should be codified for certainty and accessibility:

- **Duty of disclosure** covering the reasonable person test and the remedies for innocent and deliberate non-disclosure.
- **Fraud, false statement and dishonesty,** covering the UK approach to determining each, particularly with regard to the decision in *Versloot Dredging.*[5]
- **Utmost good faith** with particular reference to the insurer's obligations.
- **The test in *Percy,*** [6] which sets out a multi-step test for determining if an insurer's opinion has been validly formed.
- ***The test in Cook,*** [7] which outlines that a "condition" for a pre-existing condition exclusion means a condition actually recognised by doctors, not simply generalised symptoms.
- ***The test in Laurence,*** [8] in relation to mental health conditions.
- ***The test in Jnfrapulse* and *Kausar,*** [9] which provide guidance as to change of circumstances disclosure, in particular timing requirements and rejecting a notion of immediate notification.
- **Onerous terms** if not fully included within unfair contractual terms under the Fair Trading Act.
- **Reasonable care** across various cases, and included clarity of whether the test is subject, objective or mixed. This varies across jurisdictions.

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[5] *Versloot Dredging BV and another (Appellants) v HD/ Gerling lndustrie Versicherung AG and others (Respondents)* [2016] UKSC 45

[6] *Percy v Sovereign* [2014] NZHC 1573 at [4]:

[7] *Cook v Financial Insurance Company Ltd* [1998] UKHL42; 1998 1 WLR 1765

[8] *Royal & Sun Alliance Life and Disability (New Zealand) Ltd v Laurence* (1999} 10 ANZ Insurance Cases ,J61-434

[9] *Infrapulse Distributors New Zealand Ltd v State Insurance Ltd* [2000] OCR 170; *Kausar v Eagle Star Insurance Co Ltd* [2000] Lloyd's Law Reports IR 154

52. Are there other areas of law where the interface with insurance contract law needs to be considered? If so, please outline what these are and what the issues are.

We see some cross-over with privacy and medical disclosure issues, due to disclosure obligations both during the insurance purchasing process and dispute resolution. It would be helpful if this was included as part of the review.

53. Is there anything further the government should consider when seeking to consolidate the six Acts into one?

Whatever changes are made should be carefully considered to ensure they meet the reform recommended by the Law Commission and reflect more recent changes made in the UK and Australia, with a focus on drafting legislation in plain English to ensure accessibility.

I hope our comments are of assistance to the Review and encourage you to contact us if further case studies are required, or any clarification is needed of the submissions made by the IFSO Scheme.

s 9(2)(a)

Karen Stevens
Insurance & Financial Services Ombudsman

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