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FAIR PRESENTATION OF THE RISK BEFORE WAIVER

Life insurers avoid contracts of insurance based on fraudulent misrepresentation and fraudulent non-disclosure

On 26 June 2015 the Supreme Court of Victoria handed down its decision in *Montclare v Metlife Insurance Ltd* [2015] VSC 306 (***Montclare***) and on 30 June 2015 the Supreme Court of New South Wales handed down the decision of *Hitchens v Zurich Australian Ltd* [2015] NSWSC 825 (***Hitchens***). In both matters, the insurers successfully avoided life insurance contracts based on fraudulent misrepresentation and fraudulent breach of the duty of disclosure. The New South Wales decision of *Hitchens* is discussed below.

Hitchens

The claim

In December 2004 the plaintiff took out two life insurance policies with the defendant. The first was an income replacement policy, which provided income protection cover to the plaintiff if, as a result of Sickness[1] or Injury[2], he was unable to generate at least 80% of his pre-disability income through personal exertion in his usual occupation and was required to be under the regular care, and following the advice, of a Medical Practitioner.

The second policy was a life insurance policy that covered the plaintiff and his wife in the event of death or Total and Permanent Disablement[3].

On 9 September 2007 the plaintiff was injured at home whilst using a power saw. The plaintiff severed three of his fingers and a small section of his thumb on his right hand. As a result, the plaintiff made a claim for income protection payments under the first policy and the Total and Permanent Disablement benefit under the second policy.

Although the defendant initially made fortnightly payments under the income protection policy, on 19 August 2010 it purportedly avoided both policies on grounds of misrepresentation and non-disclosure. In response, the plaintiff commenced a claim for damages that would compensate him for the amounts that would be payable under the policies, if they responded to his claim. The total amount claimed was just over $4 million.

Medical history

The plaintiff, who was born in 1969, had a somewhat extraordinary and complex medical history, commencing with an operation to remove a melanoma from his left calf in 1984. In 1989, lymph nodes were removed from the plaintiff's groin because the cancer had metastasised. As a result, the plaintiff suffered from lymphedema and cellulitis, which caused his left leg to swell. Flare ups of this condition persisted on an ongoing basis, often requiring hospitalisation in order to administer antibiotics intravenously.

In 1996 the plaintiff injured his right knee, neck and elbows in a motor vehicle accident (**MVA**). The plaintiff succumbed to a right knee reconstruction later that year and diagnoses of reactive depression and acute stress disorder as a result of the MVA were also made. The

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[1] Defined in the policy to mean 'sickness or disease which first manifests itself after the Policy began', excluding 'any sickness or disease that is the direct or indirect result of elective or donor transplant surgery…'

[2] Defined in the policy to mean 'an accidental injury caused by an event external to the body, occurring while the Policy is in force', excluding 'any injury that is the direct or indirect result of elective or donor transplant surgery…'

[3] Defined in the policy as 'the life insured is 'Unable to Work' through Sickness or Injury', that is, 'has been absent from active employment solely as a result of Sickness or Injury for an uninterrupted period of six consecutive months…'

plaintiff commenced taking Valium, Endone and Prozac. He also underwent cognitive behavioural therapy.

In October 1997 the plaintiff was considered to be addicted to Endone and other pain management drugs. In 1998 the plaintiff attended a three week pain management program at Royal North Shore Hospital. At the end of this program, anxiety was considered to be a barrier to the plaintiff's ability to return to work and medications were stated to be nil. Advice was given not to recommence the ceased medications. A short time later, however, the plaintiff obtained prescriptions for antibiotics and Endone from a medical centre. Initially, these prescriptions were written reluctantly, but then written on a regular basis for the remainder of 1998 and 1999.

In 2000 the number of Endone prescriptions spiked at 30 (up from 9 in 1999). In 2001 38 scripts were written. The increase in prescriptions since 2000 appeared to be the result of the plaintiff frequenting a number of different medical centres, without telling any of them that he'd been to another clinic for the same prescription. By 2004 the plaintiff's use of Endone had reduced again, to seven scripts in 2004. By this time, however, the Endone was being supplemented with Tramal, with 20 scripts for Tramal written in 2002, 26 in 2003 and 18 in 2004.

By 2003 the plaintiff had apparently become addicted to Tramal. Although some medical centres refused to prescribe Endone further, unbeknown to them the plaintiff obtained scripts for Endone elsewhere. On 5 January 2004 the plaintiff was referred to Royal North Shore Hospital pain clinic but did not attend. In May 2004 the plaintiff had further surgery to his right knee.

The application for insurance

The application for insurance was completed by the plaintiff on 8 August 2004. The duty of disclosure, which is a continuing duty up until entry into the insurance policies, extended from 8 August 2004 to 1 December 2004, when the policies were issued.

The application contained a series of questions about the plaintiff's medical history. Question 1 required the plaintiff to state whether he had a 'usual doctor' and if yes, to provide that doctor's details. The plaintiff answered 'No', he did not have a usual doctor and left the section asking for details blank. This 'No' answer required the plaintiff to provide details of the doctor he 'usually visit[s]' or 'last ... attended' and to provide details of his last consultation. The plaintiff left this section blank, that is, he provided no details regarding the last doctor he attended. Relevantly, however, the plaintiff had attended Strathfield Medical Centre on 18 occasions in the 12 months prior to 8 August 2004, far more often than he had visited other medical centres in that period. Strathfield Medical Centre was arguably, the medical centre the plaintiff 'usually' visited.

Question 2 of the application asked whether the plaintiff had 'reason to visit any other doctor in the last two years. The plaintiff answered 'Yes'. The form then asked for the date(s) of consultation(s) but the plaintiff left this section blank.

The plaintiff was then asked, also at question 2, to provide names and addresses of 'any other doctor [visited] in the last two years', the reason for the visits, the results of the visits and the degree of recovery. The plaintiff answered:

> *'Name: Medical centre*
>
> *Address: Numerous*
>
> *Reason - stiches/antibiotics'*

The stated reason, however, was not the principal reason for the 'numerous' attendances. The principal reason was to obtain prescriptions for strong pain relief for lymphedema and cellulitis.

Question 5 asked about personal habits, including whether the plaintiff took medication or drugs, or had done so in the last five years. The plaintiff answered 'Yes'. The disclosed details, however, were limited to 'pain medication- result of motor vehicle accident'.

Elsewhere in the application, in answer to other questions about his medical history, the plaintiff's disclosure was limited to disclosure of:

- neck and knee injuries from the MVA resulting in 12 months off work, with the last consultation for same being in 1998 and which currently had 'no other impact to current lifestyle apart from odd headache' and 'no other impact to working commitments'; and
- cancer in 1989 requiring three months treatment with no impact to work and with 'no other conditions apart from [occasional] mild lymphedema left leg', which did not cause 'any impact to work commitment'.

The underwriter's assessment of the application

Montclare serves as a useful and timely reminder at [725 to 727] that:

- if an insurer seeks to establish a right to avoid a contract of insurance, the onus is on the insurer to produce evidence;
- the absence of evidence from the insurer will be perilous;
- an underwriter's evidence will be closely scrutinised, given its self serving nature; and
- the Court will determine whether the evidence is to be given weight in light of the experience and qualifications of the insurer answering the questions.

Having (understandably) no specific recollection of the subject application, the underwriter's evidence in *Hitchens* was largely evidence of usual practice that the application would have been read, the disclosures made noted and the following factors considered as relevant:

- there had been no recurrence of the malignant melanoma since 1989;
- treatment for lymphedema appeared to have been successful and the plaintiff suffered from only the odd lymphedema;
- the effects of the MVA appeared to have resolved, with no time needed off work since 1997; and
- the plaintiff was not continuing to receive medical treatment in respect of the disclosed medical conditions.

The underwriter also speculated, in the absence of specific recollection, that she would have taken the reference to 'pain medication' to mean occasional painkillers such as aspirin or paracetamol. She then gave evidence that she would have declined the plaintiff's application, had she been aware of his true medical history. This evidence was supported by the written underwriting guidelines of the defendant's reinsurer, which included that income protection cover is to be declined if there is a history of drug dependence or evidence of an anxiety disorder, severe depression, or depression associated with drug abuse. Evidence of underwriting practices, such as written guidelines and manuals, will often be the most crucial evidence. As noted in *Montclare* at [727] without this, an underwriter's evidence might be considered to be nothing more than 'unsubstantiated hindsight', which would carry little weight.

The underwriter in *Hitchens* went on to give evidence that had full disclosure of the plaintiff's medical history been made she would have noted that the plaintiff obtained regular scripts for Endone and Tramal, sometimes within days of his last script, which would have indicated a high need for pain relief. The history would also have raised the prospect of 'doctor shopping' and hence the prospect of having developed a dependency on these medications. The underwriter also would have noted the history of depression, including acute stress disorder and severe reactive depression. These are matters all excluded under the reinsurer's guidelines.

The underwriter's usual practice and hindsight evidence was not challenged. Instead, the cross examination was limited to establishing there had been sufficient disclosure such that a reasonably prudent underwriter would have required provision of further information from the plaintiff's doctors and, as such inquiry was not made, the defendant had waived compliance with the duty of disclosure.

The findings of misrepresentation and non-disclosure

The court found, inter alia, that the plaintiff had failed to comply with his duty of disclosure in the following respects:

- his statement in answer to question 2 that the reason for his visits to numerous medical centres for the previous two years was for 'stitches/antibiotics" was substantially false, given the principal reason was to obtain strong pain relief for lymphedema and cellulitis;
- his statement that he suffered mild/odd lymphedema misrepresented the extent of this condition and concealed the extent of pain relief he was receiving;
- his statement that he had never had depression, stress, or anxiety was false[4];
- his failure to disclose ongoing use of Endone and Tramal and his habit of 'doctor shopping' for these prescriptions.

Waiver

Having made these findings of misrepresentation and non-disclosure the Court then considered the extent to which the defendant had waived the duty of disclosure (if at all) by failing to make further enquiries in circumstances where the plaintiff had, in parts of the application:

- given no answer;
- given incomplete answers; and
- (on the plaintiff's case) had provided answers that should have aroused suspicion in the insurer's mind that there might be further material facts relevant to the risk that should be explored.

The plaintiff pleaded that the information he had disclosed put the defendant on notice that there was a history of:

- cancer;
- injuries in an MVA;
- lymphedema and cellulitis;
- use of pain killers; and
- 'numerous' attendances at medical centres in the past two years.

In circumstances where the defendant had failed to make further inquiry about the disclosed conditions or the pain killers being used and had not made inquiries of the medical centres, the plaintiff argued that the defendant had waived disclosure in relation to these matters.

The plaintiff relied on sections 21(2)(d), 21(3) and 27 of the *Insurance Contracts Act 1984* (Cth) (***ICA***) in relation to wavier.

S21(2)(d) of the *ICA* provides that the duty of disclosure in s21 does not require disclosure of a matter as to which compliance with the duty of disclosure is waived by the insurer.

S21(3) of the *ICA* provides that compliance with the duty of disclosure is deemed to have been waived where an insured failed to answer or gave an obviously incomplete or irrelevant answer to a question in a proposal form.

S27 of the *ICA* provides that an insured shall not be taken to have made a misrepresentation by reason only that they failed to answer a question included in a proposal form or gave an obviously incomplete or irrelevant answer to such a question.

Although ultimately not critical to the particular facts in *Hitchens*, the issue for consideration was whether the correct application of the principle of waiver is:

- a waiver must be an intentional act with knowledge, as held in *Claude R Ogden & Co Pty Ltd v Reliance Fire Sprinkler Co Pty Ltd* [1973] 2 NSWLR 7; or

[4] Waiver was not relevant to the plaintiff's denial of any history of depression, anxiety or stress, as the 'No' answer he had given was a complete, but untrue, answer to that question.

- the broader test propounded in *Jaggar v QBE Insurance International Ltd* [2007] 2 NZLR 336 (***Jaggar***) which substitutes the requirement that a waiver be an intentional act with knowledge with a requirement that it be an intentional act (issue of the policy) with knowledge or reasonable notice of the possibility that the duty to disclose material facts has not been complied with.

The plaintiff argued for this wider application of the principle of waiver by submitting that where the insured discloses facts and circumstances which reasonably indicate the possible existence of further material facts, the insurer will have waived disclosure if it fails to make further inquiry. The plaintiff argued that the facts he disclosed were sufficient to indicate to the defendant the possible existence of further material facts and that by failing to make further inquiries in these circumstances, the defendant had waived compliance with the duty of disclosure.

Ultimately, the Court concluded that the correct test requires waiver to be an intentional act with knowledge and thus, there could be no waiver by the insurer of its right to avoid a policy on grounds of material non-disclosure, unless the insurer knew there had been such non-disclosure, or that it had the right to avoid the policy. The Court said at [128]:

> *'the question is whether the insurer waives its right to insist on compliance with the duty of disclosure, that is, waives its right to material information. Unless the insurer knows that the information it knows has not been provided is information that should be provided if the duty of disclosure were to be complied with, it could not intentionally and with knowledge waive its right to material information by issuing a policy without ascertaining what the information is'.*

In reaching this conclusion the Court had regard to the Court of Appeal of England decision in *WISE Underwriting Agency Ltd v Grupo Nacional Provincial SA* [2004] EWCA Civ 962; [2004] 2 All ER (Comm) 613; [2004] 2 Lloyd's Law Rep 483 (**WISE**), and noted at [136] that this *'decision requires that in insurance law, before a question of waiver arises, there must be a fair presentation of the risk'*.

The Court went on to say at [137] that:

> *'if there has been a fair presentation of the risk to the insurer and the insurer receives information which, either on its own or in conjunction with other facts known to the insurer or which the insurer is presumed to know, would prompt a reasonably careful insurer to make further inquiries, then, if the insurer does not make the inquiry, assuming it could be simply made, it will be taken to have waived disclosure of the material fact which that inquiry would necessarily have revealed'.*

The Court endorsed the following test in WISE:

> *'So the question becomes: (a) was there a fair presentation of the risk: And (b) was the insurer in the course of that presentation ... put on enquiry by the disclosure of facts which would raise in the mind of a reasonable insurer at least a suspicion that there were other circumstances which would or might vitiate the presentation?'*

The Court also endorsed at [139] the conclusion of Rix LJ in WISE that:

> *'The test has to be applied by reference to a reasonably careful insurer rather than the actual insurer, and not merely by reference to what such an insurer is told in the assured's actual presentation but also by reference to what he knows or ought to know ... The reasonably careful underwriter is neither a detective on the one hand nor lacking in common sense on the other hand. Mere possibilities will not put him on inquiry, and very little if anything can make up for nondisclosure of the unusual or special. Overriding all, however, is the notion of fairness and that applies mutually to both parties, even if the presentation starts with the would-be assured'.*

The plaintiff's expert underwriter accepted at [141] that the plaintiff had not given a fair presentation of the risk and had been 'inconsistent with his disclosures, particularly the depth of his disclosures'. However, the plaintiff's position was that the matters that he did disclose should have called to the attention of the defendant the possibility of other material facts relevant to the risk.

The Court agreed at [143 and 144] with previous Court approval of the passage in MacGillivray on Insurance Law, 7th ed that:

> *'Assuming that there is a material fact apt to be disclosed, the rule is satisfied if he assured discloses sufficient to call the attention of the insurers in such a matter that they can see if they require further information they ought to ask for it. So, if reasonably sufficient information has been placed before them they cannot take advantage of failure to follow it up'.*

However, the Court considered the facts in *Hitchens* to be distinguishable in that the specific matters not disclosed by the plaintiff were unusual. Putting this into context, the Court pointed out at [145] that in *Asfar & Co v Blundell* [1896], QB 123 (***Asfar***), which applied the MacGillivray test, the alleged non-disclosure was the failure to disclose a usual term in a charter party. The charter party was disclosed for the purposes of insurance for chartered freight. The insurer was asked to insure the difference between the chartered freight payable by the assured to the ship owner, and the bill of lading freights which they were to obtain from the consignees of the goods. They did not, however, tell the insurer whether the chartered freight was lump sum or tonnage freight. The Court held, however, that it was almost certain to be lump sum and that:

> *'if the insurer wanted to be sure on the point, they could have immediately acquired the knowledge by asking the question; the position ought to have been present in their minds'.*

Therefore, sufficient disclosure was made by the insured in *Asfar*. It was observed, however, that if the charter party contained an unusual clause, impacting the risk, it would not be sufficient to simply disclose the existence of the charter party.

The court considered at [147] *Asfar* (where there was a finding of waiver because the term not disclosed was a usual term) to be:

> *'consistent with the principle that the question of waiver of the duty of disclosure does not arise unless the insurer has been informed of facts which fairly indicate to a prudent insurer that there are other facts that may materially affect its decision to underwrite the risk, or the terms on which it might do so, that have not been disclosed'.*

In *Hitchens*, the plaintiff disclosed he was using pain medication but did not disclose the nature or frequency of the pain mediation he had been taking or of his concealment from doctors that he was obtaining prescriptions for the same drugs from other doctors. Unlike *Asfar*, the Court concluded at [156] that these were unusual matters that were not revealed by the application form and therefore, there had not been a fair presentation of the risk, as the insurer *'was not put on notice that there were material matters relevant to its decision whether or not to accept the risk relating to [the plaintiff's] use of pain medication'*. As such, it was held that the defendant had not waived the duty of disclosure.

There was expert evidence from an underwriter to the effect that a prudent underwriter would have followed up on the use of pain medication by asking for more details, such as the type of medication and frequency of use. However, the Court considered this to be largely irrelevant, as the question was not whether the insurer exercised reasonable care in making its decision to issue the policies. The question was whether, in the first instance, there had been a fair presentation of the risk.

Whilst the Court clearly held that unless there has been a fair presentation of the risk, the question of waiver does not arise, it went on to state the conclusions it would make, if it was wrong about the application of the principle of wavier and instead, the principle in *Jaggar* applies. That is, whether the insurer should be taken to have waived disclosure by not making further inquiry because the plaintiff had disclosed matters that indicated the possible existence of further material facts.

The two matters disclosed that might have indicated possible additional risk were the melanoma in 1989 and the MVA in 1996. However, given statements in the proposal form that there had been a complete groin dissection, that the plaintiff had 'fully recovered' and required 'no other treatment' the Court at [161] held that it could be inferred that the melanoma had not recurred or spread. Similarly, the plaintiff had expressed in the proposal form that he had fully recovered from the MVA, was receiving no ongoing treatment and had last seen a doctor in 1998 in relation to this accident. Based on these matters the Court at [170] did not accept that a prudent underwriter, acting reasonably, was required to make further enquiries.

However, the court accepted at [172] that a prudent underwriter would have sought more information regarding the numerous attendances at medical centres in the last two years and the taking of pain medication but considered that there likely would be some delay in obtaining further information. The Court said at [176] that if the duty of disclosure and:

> *'the consequence of a false answer can be waived by an insurer not making an inquiry that a prudent insurer would make, and if that is so irrespective of the fairness of the presentation of the risk and the delay that would attend such an inquiry then I would accept that by not making*

> *further inquiries in relation to the answer to question 2, the insurer waived the consequence of the false answer'.*

However, this was ultimately of no consequence, not only because the Court did not consider *Jaggar* to be the correct test but also because the Court did not accept at [177] that further enquiries would have necessarily revealed the extent of the plaintiff's use of Endone and Tramal or his habit of doctor-shopping for these prescriptions.

The Court concluded at [178] that *'on any view, an underwriter is not required to be a detective'* and that:

> *'even if the doctrine of waiver could have the expansive operation for which [the plaintiff] contended [it] would not conclude that the doctrine could affect the consequence of the description of [the plaintiff's] lymphedema, nor his failure to disclose that he was in the habit of [doctor-shopping]'.*

Pursuant to s29 of the ICA the defendant was not entitled to avoid the policies on grounds of non-disclosure or misrepresentation unless the non-disclosure or misrepresentation was fraudulent, as more than 3 years had passed since the contracts of insurance were entered into (ICA s29(2) and (3)). However, the Court held that the non-disclosure and misrepresentations were fraudulent, entitling the defendant to avoid the policies.

Useful lessons from *Hitchens* (and *Montclare*)

Hitchens provides a useful and very detailed analysis of the law on waiver of the duty of disclosure.

Waiver will apply if a prospective insured provides no answer, or an obviously incomplete answer, and the insurer makes no further inquiry. However, there will often be an issue in situations where there has been what might be called partial disclosure of certain facts that may hint at something more sinister.

In these circumstances, *Hitchens* requires that the first question is whether there has been a fair presentation of the risk. If the answer is no, waiver does not arise. If the answer is yes, then the question becomes whether, in making that presentation, the disclosed facts would raise in the mind of a reasonable insurer the possibility that there were other circumstances which would, or might, vitiate the presentation.

However, the reasonable insurer does not need to be a detective. Mere possibilities will not be sufficient to put the insurer on inquiry. Put simply, the issue is whether the complaint of non-disclosure is something usual that could arise from the disclosed facts, or whether the matters are unusual. If it is something usual, and the insurer considers it relevant to its decision whether to accept the risk, then further inquiry should be made. If further inquiry is not made, the insurer risks waiving compliance with the duty of disclosure.

Lastly, it is always useful to remember to ensure that underwriting practices are applied consistently, and supported by written guidelines and manuals. In most cases (as in *Hitchens)*, an underwriter's evidence will be limited to evidence of usual practice. Given the sheer number of applications life insurers are required to deal with on a day to day basis, an instance of an underwriter having an actual recollection of their assessment of a specific application many years later, when the dispute arises, will be rare. Documentary evidence in the form of written guidelines and manuals will go a long way to strengthen the oral evidence of an underwriter's usual practice.

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