

# BURROWES and Company



Barristers and Solicitors

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**Michael Burrowes**  
Principal

## Burrowes and Company

Level 2  
111 Customhouse Quay  
P O Box 24515  
Wellington 6142

Phone: 04 473 7733  
Fax: 04 471 1121

mrb@burrowes.co.nz  
www.burrowes.co.nz

## HUMAN RIGHTS COMMISSION INSURANCE GUIDELINES

The Human Rights Commission Insurance Guidelines, originally issued in 1997, have recently been updated. The Guidelines follow the Commission's aim to assist the insurance industry and the public in understanding the relationship between the Human Rights Act 1993 and insurance companies, and their rights and responsibilities in complying with the anti-discrimination provisions of the 1993 Act.

The new Guidelines have been published since the review process was completed with no dramatic differences from the previous guidelines. Some minor alterations have occurred to reflect changes in New Zealand society since the Guidelines were first published. These changes are due to factors such as the rapid advancement in the knowledge of human genetics, the increase in reported mental illness and a greater demand for mortgage protection insurance. The Human Rights Commission,

through the experience of the practical application of the Human Rights Act 1993, has identified several key issues including; lawful and unlawful discrimination, obtaining medical advice and the exclusions and pre-existing conditions that lead to a refusal to insure.

The Guidelines emphasise the fact that insurers cannot refuse to provide insurance to people, or treat people less favourably when providing insurance, due to the grounds laid out in section 21 of the Human Rights Act 1993. However, insurance companies can offer policies on different terms and conditions, including restricting coverage of insurance in relation to sex, health, family history and age. This is allowed due to an exception in the Human Rights Act that states the distinctions between people must be rationally related to insurance underwriting criteria.

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## "CAUSED BY" v "ARISING FROM"

**In *CIR v Bhanabhai [2007]* the Courts considered the difference between the phrases "caused by" and "arising from" in a policy exclusion clause.**

When Golden Gate Holdings purchased a commercial property in Auckland, their solicitor, Mr Bhanabhai, gave an undertaking that GST would be paid. When court proceedings were initiated to recover the GST, Mr Bhanabhai claimed under his professional indemnity policy with Vero Insurance.

Vero argued that no claim was possible, as the policy wording excluded claims "arising from a trading ... liability incurred by a business managed or carried on by the Insured." They said that there was an underlying liability at law for the company to pay its GST, and that the undertaking arose from this, and was therefore excluded from the policy.

Vero submitted that for liability to "arise

from" something, there must be a causal link between those two things. The Court held, referring to authorities, "that 'arising from' is less demanding of proximity than 'caused by' but still requires some causal link albeit that other factors may be operative."

In this instance, an undertaking had been given that the GST component of the sale would be paid. The claims brought by the Commissioner of Inland Revenue were based on this undertaking, which had not been met. Vero was required to pay out the claim.

The point from this case is that the courts will deem the causative link required for loss "arising from" some event to be of a lower threshold than if the words "caused by" were used.

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# LIABILITY FOR ADDITIONAL LOSS WHEN A VALID CLAIM ISN'T PAID

***Brescia v QBE [2007]* demonstrates that if an insurer does not pay a valid claim, or takes an unreasonably long time to decide a claim, it may be liable to pay compensation for any consequential losses suffered by the insured due to the insurer's failure to pay or pay promptly.**

Brescia imported furniture and home furnishings for retail sale. Brescia had a policy with QBE and another insurer that provided property damage and business interruption cover with an indemnity period of 12 months.

A fire destroyed Brescia's showroom and warehouse and Brescia claimed under the policy. The insurers did not indemnify and the building was not rebuilt.

The insurers claimed that Brescia failed to take reasonable measures to prevent any damages to the property and that Brescia's claims for stock loss and business interruption were fraudulent.

Brescia sued the insurers for breach of contract. Brescia claimed benefits payable under the policy and also losses suffered because the insurers did not admit indemnity. In this case they claimed the loss of profits from the estimated date at which the building would have been re-opened, had the policy been paid.

The Judge held that the insured took reasonable precautions to prevent damages and had not purposely courted any fire risk.

The Judge also held the insurers had breached the insurance contract by failing to admit indemnity within a reasonable time. Because of this, the insurers were instructed

to compensate Brescia for the loss of profits in the period where the insurers did not indemnify.

The Judge awarded Brescia \$17,305,275 as benefits payable under the policy.

The Judge dismissed one of the arguments by the insurers that where the insurance contract remains on foot consequential losses are not available.

The damages were assessed using ordinary contract law principles. The Judge followed the principle in *Hadley v Baxendale* "The breach by an insurer to meet its obligations to indemnify is no different to a breach by any other citizen of a contract".

This decision outlines the difficulty for an insurer to deny indemnity on the grounds of an insured's failure to comply with the contractual condition to take reasonable measures to avoid damages. The test of whether the insured deliberately courted risk often relies on witnesses.

This case shows how damages can be awarded outside the policy limits if indemnity is wrongfully refused. This highlights that insurers will want to think twice about what additional losses the insured could suffer if the claim is not paid in a timely manner and whether that loss may lead to compensation.

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## HUMAN RIGHTS COMMISSION INSURANCE GUIDELINES

*From page 1*

In the Guidelines, importance is placed on the interaction between the company and applicant. When constructing a proposal form, insurance companies need to take care to comply with the Act as particular patterns of questioning may indicate an intention to discriminate. Obviously, sometimes an insurer will need more information to understand an applicant's situation to carry out further assessment. While charging for a cost of assessment is permissible it should not act as a deterrent or be perceived as a refusal to insure.

In relation to mental disability, the Guidelines point out that although it may appear difficult to quantify the risk, it should be done, using reputable medical, psychiatric and actuarial advice as guidance.

Reinsurers are exempt from the Human Rights Act as the service they offer is to insurance companies, not individuals, but its result is that on occasion New Zealand insurers will have to offer insurance to individuals, even though they cannot be reinsured.

There has been a change to the complaints process for unlawful discrimination as a result of the Human Rights Amendment Act 2001 which introduced a new system. The previous system required a written complaint to the Human Rights Commission. The new process is modelled on the disputes resolution process set out in the Employment Relations Act 2000, and aims to resolve complaints without cost or legal representation, in a timely and informal manner.

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# REPUDIATION OF POLICY LEADS TO SIGNIFICANT DAMAGES

**In *Bottrell v National Mutual Life [2007]* the avoidance of an income protection policy amounted to a repudiation. Damages were awarded so as to reinstate the insured into the position he would have been in if not for the wrongful repudiation. The case highlights two important issues: non-disclosure and misrepresentation; and the consequences of repudiation.**

## BACKGROUND FACTS

The insured (Bottrell) was a qualified chiropractor and in 1995 an opportunity arose to buy his own practise. In May 2005 Bottrell first met with Mr Brown, an insurance advisor, to discuss income protection insurance.

In September 1995 Bottrell injured his right arm in a car accident. Subsequently, his proposed purchase of the practice was delayed until February 1996. The treatment for his injury was minor.

In November 1995 Bottrell met again with Mr Brown. Bottrell dictated his policy application to Mr Brown and relied on him to write his answers. He did not read the policy application form before signing it. The policy was issued in January 1996.

In June 1998 Bottrell injured his wrist which led him to cease work from November. He claimed under his policy and was paid out until September 2004. The insurer then purported to avoid the policy due to fraudulent misrepresentation and non-disclosure.

Bottrell sought damages for the benefits he would have received if not for the insurer's alleged repudiation. The terms of the policy were as follows:

The insurer contracted to pay, for the "life-time" of the insured, a monthly benefit of \$5,000 whilst the insured was TD. Total disablement was defined as occurring where "because of an injury or sickness, the insured is unable to perform *at least one* income producing duty of his or her occupation; not working; and under the regular care and attendance of a medical practitioner."

The policy also covers where the insured is partially disabled. In this instance the amount of benefit paid out is the full amount less any income earned by the insured. There is no requirement for the insured to work in part-time employment. In fact there is a distinct disincentive for the insured to work part-time because the money earned in work would be deducted out of the insurance payments.

The insurance company argued that Bottrell significantly over-inflated his income figure as well as misrepresenting his medical history (making material non-disclosures regarding the accident in September 1995).

## JUDGES' DECISION

The crux of the fraudulent misrepresentation relates to the meeting between Bottrell and Mr Brown in November 1995. The Judge concluded that Bottrell had made a number of honest mistakes and that there had been a certain level of misunderstanding between Bottrell and Mr Brown during the application process. There was insufficient evidence to prove fraud.

After determining that there was no misrepresentation or non-disclosure the conclusion was made that the insurer had wrongfully cancelled the contract. The Judge stated that he found Bottrell's work ethic to be slack and that the reason he has been receiving payments was "by choice, not necessity" - however, this was allowed under the terms of the policy.

Because the contract was wrongly avoided by the insurance company, they were liable to pay to Bottrell the amount required to place him in the position he would have been in had the contract been performed.

The Judge commented that there is also another duty of law for a plaintiff in those circumstances to mitigate his loss. However, as this was not alluded to at trial the Judge did not consider it. Instead, the Judge found that in terms of the policy, not having to work until reaching the age of 65 was one of the benefits of the policy.

The Judge therefore concluded that Bottrell was entitled to payments until age 65, if he had been totally disabled for at least 14 days and did not work in any occupation whatsoever.

The figure totalled approximately AU\$1.4 million.

## ISSUES FOR INSURERS TO CONSIDER

- Partial disablement clauses should be thoroughly examined;
- Cases regarding fraudulent misrepresentation are hard to prove;
- Agents must be careful to record policy information accurately; and
- Wrongful avoidance of a policy can result in repudiation and payment of the insured's entitlement to future damages.

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## A TIME TO DECLINE

*Davis v Westpac Life Insurance Services Limited [2007]* concerns an income protection policy and non-disclosure issues. In August 2001 Mr Davis completed a policy application. In November his GP referred him to a specialist for sleep apnoea treatment. The specialist told the GP he had arranged for further tests to confirm diagnosis of what he thought "will almost certainly turn out to be sleep apnoea". None of this information was disclosed to the insurer before the inception of the policy a week later on 12 November 2001. The subsequent tests did reveal that Mr Davis suffered from sleep apnoea, at the rate of 94 respiratory events an hour.

After an injury in June 2003, Mr Davis sought to recover under the policy. Westpac Life avoided the policy in January 2004 due to Mr Davis's non-disclosure of his sleep apnoea. The policy avoidance letter stated: "Had Westpac Life ... been aware of this referral we would not have accepted your application for Income Protection Policy for that risk on any terms and your application would not have been considered until results for those test results were known to us..."

At trial Mr Davis's lawyers conceded the non-disclosure issue and that if he had complied with his duty of disclosure Westpac would not have entered into the policy. The issue became the time at which Westpac would not have been prepared to enter into a life insurance contract with Mr Davis.

The main thrust of Mr Davis's argument was that the letter from Westpac constituted a deferral, and that a deferral is not declinature. In other words Westpac would not have immediately rejected the proposal but would have waited to see the outcome of the treatment.

In this way they argued that the policy could not be avoided because even if the non-disclosed information had been disclosed Westpac would not have declined cover, they would merely have waited. At trial 2 underwriters from Westpac gave evidence. They said if they knew of Mr Davis's sleep apnoea they would have deferred writing the policy until after the test results. Given the high rate that the tests showed they would have further deferred cover for 12 months to see if the sleep apnoea could be treated. They said if there had been no successful treatment they would not have entered into a contract of life insurance with Mr Davis.

The issue is the time that Westpac are entitled to make their decision whether they will insure Mr Davis and consequently, what information they are allowed to take into account.

The Court found that an insurer is entitled to take into account any subsequent information it discovers as a result of the non-disclosure in order to decide whether it would have entered into the policy in the first place.

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## PROOF OF INDUCEMENT FOR NON-DISCLOSURE

In investigations of non-disclosure cases in the past, the ISO was primarily concerned with the materiality of the non-disclosed information. However, recently the case of *Jagger v Lyttelton Marina Holdings Ltd (In Receivership) [2006]* has now emphasised the requirement of inducement.

In his decision, Panckhurst J quoted from *Assicurazioni Generali v Arab Insurance Group [2003]* as follows:

In all the circumstances I would summarise the relevant principles of inducement in this context in this way:

1 In order to be entitled to avoid a contract of insurance or reinsurance, an insurer or reinsurer must prove on the balance of probabilities that he was induced to enter into the contract by a material non-disclosure or by a material misrepresentation.

2 There is no presumption of law that an insurer or reinsurer is induced to enter in the contract by a material non-disclosure or misrepresentation.

3 The facts may, however, be such that it is to be inferred that the particular insurer or reinsurer was so induced even in the absence [of] evidence from him.

4 In order to prove inducement the insurer or reinsurer must show that the non-disclosure or misrepresentation was an effective cause of his entering into the contract on the terms on which he did.

*He must therefore show at least that but for the relevant nondisclosure or misrepresentation, he would not have entered into the contract on those terms.*

However, he does not have to show that it was the sole effective cause of his doing so.

In summary, insurers have to prove the materiality of information not disclosed and also show that they were induced (due to the non-disclosure) into offering insurance to the insured. Evidence of inducement is usually provided by way of an underwriter's opinion before the avoidance of the policy by the insurer.

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