ABI Guidance

Non-Disclosure and Treating Customers Fairly

Claims For

Long-Term Protection Insurance Products

January 2008

1 Scope

1.1 This ABI guidance covers the continuing fair treatment of claims for UK life, critical illness, income protection and other long-term protection insurance contracts in the light of evolving industry practice, FSA regulations and the treating customers fairly (TCF) regime and experience.

1.2 For the purposes of this ABI guidance, any reference to non-disclosure includes both the omission and misrepresentation of material information that the insurer has asked for.

1.3 This guidance covers the fair treatment of non-disclosure occurring during the application process and discovered at the point of claim.

1.4 This guidance replaces previous guidance issued by ABI dealing with non-disclosure discovered at the point of claim.

1.5 ABI believes that this guidance goes beyond the current legal position in many aspects. However, insurers should note that it does not purport in any way to replace the Law.

2 The three categories of non-disclosure and associated outcomes

2.1 The three high level categories of non-disclosure and outcomes are set out in the table below.

Category	Explanation	Outcome
Innocent	• The customer has acted honestly and reasonably in all of the circumstances, including the customer's individual circumstances but only where these were known to the insurer. • In the circumstances, a reasonable person would have considered that the information was not relevant to the insurer. • The non-disclosure would have resulted in a different underwriting outcome.	Pay the claim in full
Negligent	• Applies where the non-disclosure resulted from insufficient care – the failure to exercise reasonable care. This includes anything from an understandable oversight or an inadvertent mistake to serious negligence. • In the circumstances, a reasonable person would have known that the information given was incorrect and was relevant to the insurer. • The non-disclosure would have resulted in a different underwriting outcome.	Apply a proportionate remedy
Deliberate or without any care	• Only applies where the non-disclosure was deliberate or without any care. • In the circumstances, on the balance of probabilities, the customer knew, or must have known, that the information given was both incorrect and relevant to the insurer, or the customer acted without any care as to whether it was either correct or relevant to the insurer. • The non-disclosure would have resulted in a different underwriting outcome.	Avoid the policy (decline the claim and cancel the policy from inception)

2.2 The overall principle is that the severe remedy of avoiding a policy from outset should be confined to the most serious cases of non-disclosure. See section 8 below.

3 Assessing Claims

3.1 Customers cannot be expected to provide information that they are unaware of. In these circumstances, there is no lack of utmost good faith and therefore no non-disclosure.

3.2 In assessing claims, insurers should consider all of the circumstances, including:

3.2.1 How clear and concise the relevant questions were. Where the insurer has asked a clear question, there will be a presumption that the customer realised that it would be relevant to the insurer. Insurers can expect customers to answer clear questions carefully, accurately and to the best of their knowledge and belief. However, not much weight should be given to 'catch all' or 'memory test questions'.

3.2.2 The sales process and its effect on the customer – for example:

3.2.2.1 Whether or not an intermediary was involved (see 3.4 below).

3.2.2.2 Whether or not the customer had the opportunity to check their answers.

3.2.3 The warnings given and whether these were adequately prominent.

3.3 As far as possible, insurers should always try to understand the reasons for non-disclosure. Where possible, insurers should ask the customer (or the potential beneficiary) about the reasons why the information was incomplete or incorrect before making any judgement about the category of non-disclosure.

Intermediated sales

3.4 Insurers should always try to establish the facts and credibility of allegations that non-disclosure arose as a consequence of failures during the sales process and their effect on the customer, paying special regard to those parts of the process for which the insurer, or those acting for the insurer, is responsible. In particular, where the allegations are supported by credible evidence:

3.4.1 If the intermediary was acting on behalf of the insurer, and information was properly disclosed to that intermediary, then the insurer cannot claim that the information was not disclosed to it.

3.4.2 Whether an intermediary was acting as an insurer's agent in a transaction will depend on the facts and circumstances in each case.

3.4.3 The insurer will always benefit from being able to provide an audit trail – regardless of whether the sale was intermediated – to show that clear questions were asked and understood, and that the customer had the opportunity to check and confirm the accuracy of their answers.

3.4.4 If the intermediary was clearly acting on behalf of the customer, for example, an independent financial adviser, the intermediary (as opposed to the insurer) should be accountable for any non-disclosure resulting directly from the intermediary's action or omission.

Collecting medical information

3.5 Insurers are fully entitled to ask for any medical or other information needed to properly assess a claim.

3.6 However, insurers should have a legitimate reason for requesting medical information at the point of claim and should apply the principles set out in the joint BMA/ABI guidance, 'Medical Information and Insurance', on gathering medical information at the point of claim.

3.7 Accordingly, insurers should only ask for medical information beyond that needed to assess whether the insured event has occurred, or to case manage a disability claim, to the extent that the

circumstances of the claim reasonably prompt the insurer to believe that there might have been non-disclosure by the customer. In particular, insurers should:

3.7.1 Keep an audit trail of the reasons for requesting medical records (the Financial Ombudsman Service, FOS, will be concerned at the use of medical evidence clearly obtained without an appropriate reason).

3.7.2 Note that an early claim is not a reason by itself (although it may be a relevant supporting factor).

3.7.3 Carefully consider the time period for which it is appropriate to request information and the relevant areas that should be investigated.

3.7.4 Ensure that claims investigations are consistent with the timely collation of evidence and the need to make claims decisions promptly.

See Annex, example cases 1 to 5 – asking for appropriate medical information

4 A proportionate remedy

4.1 A proportionate remedy means that, as far as possible, the insurer will seek to put the customer back to the same position as an identical customer who had accurately disclosed the omitted information and who paid the same premium for the same type of policy.

4.2 The outcome will therefore depend on what the underwriting decision would have been if the omitted information had been accurately disclosed at the time the customer took out the policy, as follows:

4.2.1 **The premium would have been rated** – the insurer will work out how much cover the total premium paid by the customer would have bought, and pay that amount.

See Annex, example case 6 – applying a proportionate remedy where the premium would have been rated

4.2.2 **An exclusion would have been applied to the cover** – in this case, the insurer will assess the claim as though the exclusion had been applied when the cover started. If the exclusion applies to the claim, no payment will be made. If the exclusion does not apply to the claim, a payment will be made (note: the amount paid may still be less than the full sum assured in cases where a premium rating would also have applied as above).

4.2.3 **The term would have been restricted** – in this case, the claim will be paid only if it arose within the restricted term (note: the amount paid may still be less than the full sum assured in cases where a premium rating would also have applied as above).

4.2.4 **The application would have been declined** – in this case, had the information been disclosed, there would have been no policy at all so the claim will result in no payment. However, the premiums will be returned.

4.2.5 **The underwriting decision would have been deferred** – In cases where the underwriting decision would have been deferred, or where the decision to defer the cover would have been made. As far as possible, insurers should try to determine what the ultimate underwriting decision would have been (that is, at the end of the deferred period or when the investigation was complete) and apply the appropriate remedy as above. If it is not possible to work out whether the insurer would have offered any cover, or if the deferral decision would have required the customer to re-apply at a future date, then this should be treated as a decline in 4.2.4 above.

See Annex, example cases 7 to 9 – deferred decisions

4.3 Important considerations:

4.3.1 In applying a proportionate remedy, in principle, no customer should be better off than any other customer who had disclosed all the requested information.

4.3.2 For the purpose of determining the appropriate amount to pay when a higher premium would have applied, proportionality applies at the policy level, for example where the policy covers more than one person or multiple types of benefit.

> See Annex, example case 10 – applying a proportionate remedy to a multi-benefit policy
>
> For a joint life policy see Annex, example case 6 – applying a proportionate remedy where the premium would have been rated

5 Non-disclosure and inducement

5.1 For the purposes of this section, 1.2 above and for the rest of this guidance, material information means that, if it had been disclosed, the omitted information would have induced the insurer at the time the cover started to have applied a different underwriting outcome. For example:

5.1.1 A higher premium would have applied to the policy for the same sum assured;

5.1.2 A lower sum assured would have applied to the policy for the same premium;

5.1.3 Part of the cover would have been excluded for the relevant life assured;

5.1.4 The term of the policy would have been restricted;

5.1.5 The application would have been deferred, for example, pending the outcome of a medical investigation; or

5.1.6 The application would have been declined.

6 Menu and multi-benefit policies – severable benefits and non-disclosure that is deliberate or without any care

6.1 Insurers may not decline a claim as a result of non-disclosure if the omitted information was material only to a severable benefit which is not the subject of the claim.

6.2 For this purpose, for combinations of critical illness and/or income protection and/or life cover benefits in a single policy, the severable benefit types are limited to Total Permanent Disability and Waiver of Premium Benefit.

> See Annex, example case 11 – a claim with non-disclosure that relates only to a severable benefit

6.3 When considering non-disclosure, insurers should take into account the risk warnings given and whether these were adequately prominent – see section 3.2.3 above.

7 Notes on innocent non-disclosure or misrepresentation

7.1 Typical characteristics:

7.1.1 The question was not clear enough – any ambiguous wording should be construed in favour of the customer.

7.1.2 The question did not apply clearly to the facts in question.

7.1.3 It was reasonable for the customer to have overlooked the omitted information – for example, a minor childhood ailment.

7.2 It is irrelevant whether or not there is a link between the non-disclosure and the cause of the claim.

8 Notes on non-disclosure that is deliberate or without any care

8.1 The overall principle is that the severe remedy of avoiding a policy from outset should be confined to the most serious cases of non-disclosure.

8.2 The insurer has the initial burden of establishing whether any case falls into this category on the balance of probabilities. Accordingly, insurers need clear evidence to show this applies.

8.3 This category does not apply where:

8.3.1 Having investigated the matter, the customer has a credible explanation supported by the facts for having omitted information and/or there are other credible mitigating circumstances.

8.3.2 The degree of materiality associated with the non-disclosure is relatively low and, in cases where a premium rating would have applied, the underlying risk premium rating resulting from the non-disclosed information in aggregate would not have been more than +50% (or £1/mil) for the applicable life assured.

8.4 Typical characteristics:

8.4.1 **Deliberate** – in the circumstances, the customer knew, or must have known, that the representation they made in answer to a question was incorrect, and knew, or must have known, that the information was relevant to the insurer (that is, they intended to omit the information).

8.4.2 **Without any care** – it is clear that the customer had a complete disregard for the question or the accuracy of the answer when completing the application and must have understood that the information was relevant to the insurer.

8.4.3 **Medical information** – in cases where the omitted information was about the customer's medical history or family medical history (as opposed to, for example, about occupation, time spent abroad, the use of tobacco products, alcohol or drugs) insurers should take into account that in some circumstances consumers may not have a full understanding of their medical history. Accordingly, this category is more likely to apply in the following situations:

8.4.3.1 The omitted information is widely known by consumers to be important to the risk of a claim being made (for example, cancer, heart disease, diabetes or, for income protection, periods of time off work as a result of incapacity).

8.4.3.2 The omitted information concerns recent or ongoing treatment, specialist consultations and/or medical investigations about matters that a reasonable consumer would have understood to be important to their health.

8.4.3.3 The customer has specialist knowledge – for example, someone in the medical profession or relevant parts of the insurance industry.

See Annex, example cases 12 & 13 – non-disclosure of medical information

8.4.4 **Lifestyle information** – since lifestyle information is usually more familiar and easier for customers to understand, it follows that customers will need to give a particularly credible and convincing explanation for clearly evidenced non-disclosure not to be classified as deliberate or without any care.

See Annex, example cases 14 & 15 – where smoking is not disclosed

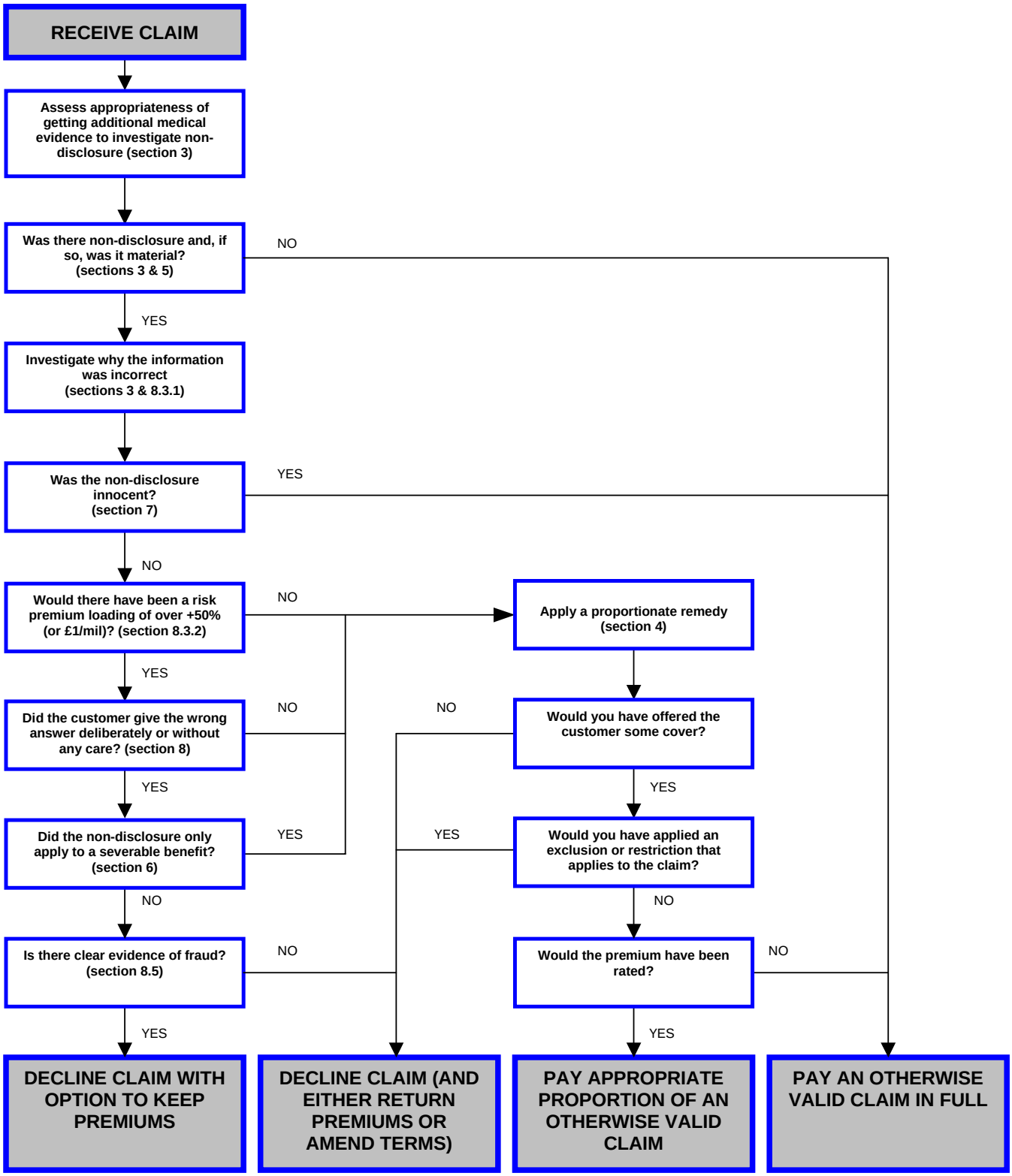
8.4.5 **Continuing duty of disclosure** – insurers will need to have a particularly robust case for classifying non-disclosure occurring after the application was completed as deliberate or without any care (that is, when the non-disclosure results from a change of health or other circumstances after the application was completed but before the cover starts).

8.5 **Returning premiums** – when avoiding a policy, insurers will normally return the premiums paid. Insurer will only keep the premiums in cases where there is clear evidence of fraud, or if the non-disclosure has been proved fraudulent in a court of law.

9 Notes on negligent non-disclosure or misrepresentation

9.1 Includes all cases between innocent and deliberate or without any care.

10 Flowchart for assessing non-disclosure discovered at the point of claim



Annex – Illustrative Examples

Case 1 – asking for appropriate medical information for a benign brain tumour claim

A 42 year old woman makes a critical illness insurance claim for a benign brain tumour after her policy has been in force for a year. The insurer's medical advice is that there is a reasonable likelihood that the woman experienced related symptoms before the policy started.

In addition to asking for all the details relating to the need to assess whether the benign brain tumour definition is met, the insurer asks her GP for a report that includes details of all consultations concerning neurological and related symptoms in the two years before the woman took out the policy. The insurer explains that it is interested in all relevant symptoms including loss of coordination or motor control, hemiparesis, numbness, speech difficulties, hearing loss, impairment of vision, intellectual impairment, headache, epilepsy, vomiting. The insurer makes it clear that it wants a copy of the original medical records, referral letters, etc that relate to any such consultations. This is so that it can get the most accurate picture of what underwriting terms, if any, it would have offered.

If the claim had been for cancer, depending on the site, the potential early symptoms might be too wide in scope for the insurer to list for the GP. Therefore, it would be appropriate for the insurer to ask for a copy of the original medical records over a time period appropriate to the likely onset of the cancer.

Case 2 – asking for appropriate medical information in an accidental death claim

A man takes out life insurance and dies less than two years later. The information on the interim certificate of the fact of death leaves the insurer with reason to believe that the customer might have committed suicide, been the victim of an unlawful killing, suffered an accident with no contributory medical factor or suffered an accident with a contributory medical factor. The insurer is at first unable to get further credible information from the Coroner or other sources.

The insurer is keen to avoid delaying settlement of the claim. It wishes to avoid repeated requests for additional information or evidence; especially for evidence that the customer could reasonably say that the insurer was able to ask for earlier in its consideration of the claim.

In some of the potential scenarios, it is likely that the customer would have experienced undisclosed symptoms of a contributing medical condition before the policy started. However, this could involve a wide range of relevant medical conditions or symptoms. In these circumstances, it is therefore reasonable for the insurer to request from the GP sight of the medical records over a time period appropriate to the medical conditions that it has reason to believe may have existed.

Before receiving this medical information, and before the Inquest has been held, the Coroner is able to inform the insurer that there is no evidence to suggest anything other than that the customer was the innocent victim of a road traffic collision and the customer had no contributory medical condition. The insurer should pay the claim and inform the GP that it no longer needs sight of the medical information.

Case 3 – asking for appropriate medical information in an accidental death claim with an underlying medical cause

A man takes out life insurance and dies less than a year later. The circumstances of his death are such that the insurer believes that he has died in a road traffic collision. The Coroner and post-mortem indicate that the man suffered a heart attack at the wheel of his car.

The insurer therefore has reason to believe that not all questions about the customer's cardiovascular history, and related factors such as family history, weight and smoking history were correctly answered. This includes coronary heart disease, congenital and valvular heart disease, cardiac arrhythmias,

hypertension and other circulatory disorders, and their related symptoms, tests and treatment. The insurer writes accordingly to the GP.

The information received from the GP shows that the customer did not disclose a history of angina, related treatment and a relevant family history. However, the information doesn't enable the insurer to determine whether the non-disclosure was deliberate or precisely what terms it might have offered if there had been full disclosure at outset. Accordingly, the insurer asks the doctor for further clarification of the matters that were not disclosed.

Case 4 – asking for appropriate additional medical information for an income protection claim

A 40 year old woman makes a claim for chronic fatigue syndrome under her income protection policy which she took out six years ago. The insurer asks her GP and her Consultant Neurologist for the full medical reports on her current condition.

The GP report confirms that she is currently incapacitated. The Consultant's report suggests that a neurological investigation revealed no adverse findings. However, this report also refers to episodes of anxiety and depression when she was in her late 20's and early 30's. These episodes were not disclosed when she took out the policy, despite being the subject of clear questions in the application.

The insurer therefore asks the GP for a copy of her medical records since the age of 25. These records show recurrent episodes of depression, irritable bowel syndrome, stress at work, reports of being tired all the time, treatment with fluoxetine and prozac, as well as time off work for depression in the year before she took out the policy.

Accordingly, the insurer asks her why she did not disclose this information as the next first step in assessing her claim.

Case 5 – asking for appropriate medical information for a death claim caused by liver failure

A man dies of liver failure three years after taking out life insurance. The circumstances are such that the insurer has reason to suspect that the claim might be related to a history of heavy alcohol consumption or drug use that started before the policy was taken out, but was not disclosed.

Accordingly, the insurer asks the customer's GP for information, including a copy of the original medical records, relating to the use of alcohol and drugs in the period before the policy started, together with details of any history of liver disorder such as hepatitis or cirrhosis, or of any metabolic disorder. The insurer also asks for details of any consultations and treatment regarding the customer's mental health. The time period asked about is appropriate to the development of the conditions that the insurer has reason to be concerned about.

Case 6 – applying a proportionate remedy where the premium would have been rated

When assessing a man's critical illness claim, an insurer finds that he had incorrectly answered a question about his medical history when he took out the policy, jointly with his wife, several years before. They paid a premium of £50 a month for joint cover of £100,000. The insurer assesses the non-disclosure in accordance with this guidance and concludes that he had been negligent.

If he had given the correct information, using the premium rates that applied when the policy was taken out, the insurer works out that the premium of £50 a month would only have bought joint cover of £75,000.

As the claim is otherwise valid and a proportionate remedy is appropriate, the insurer pays out £75,000.

Case 7 – where the underwriting decision would have been deferred pending an investigation

A man takes out critical illness insurance and subsequently claims for cancer. In assessing the claim, the insurer discovers that when he took out the policy he failed to disclose that he was waiting for the results of a test for the malignancy of a mole. The insurer assesses the non-disclosure in accordance with this guidance and concludes that he had been negligent.

If the insurer had known about this, it would have deferred the underwriting decision until the result of the test was known. However, on this occasion the test showed that the mole was perfectly normal with no signs of malignancy. In these circumstances, the insurer would have accepted the application on standard terms. Accordingly, in applying a proportionate remedy, the insurer pays the claim in full.

Case 8 – where the underwriting decision would have been deferred subject to a fresh application at an unspecified time in the future

A woman takes out life insurance and subsequently dies of a heart attack. In assessing the claim, the insurer discovers that she failed to disclose that, shortly before she took out the policy, she had made a failed suicide attempt after a significant life event and she was taking treatment for depression. The insurer assesses the non-disclosure in accordance with this guidance and concludes that she had been negligent.

If the insurer had known this, it would have deferred the underwriting decision indefinitely, but would have been prepared to consider a new application for life insurance when she has been free from treatment for at least a year.

In these circumstances, the insurer would not have offered any cover at all at the time of her application, nor in the foreseeable future. Accordingly, the insurer applies a proportionate remedy meaning that it declines the claim, cancels the policy from inception and returns her premiums in full.

Case 9 – where the insurer would have asked for specific tests

A man takes out life insurance and subsequently dies in the early years of the policy. In assessing the claim, the insurer discovers that he failed to disclose GP consultations six months before he took out the policy. At these consultations he reported alcohol-related symptoms, including early morning tremors and a jaundiced appearance. However, there is no evidence that shows the amount of alcohol he was consuming in the period immediately before he took out the policy, nor can the insurer establish with certainty that he was advised to stop or reduce his drinking on medical grounds. The insurer assesses the non-disclosure in accordance with this guidance and concludes that he had been negligent. If the insurer had known about these GP consultations, it would have deferred the underwriting decision until he had taken a liver function test.

Depending on what the outcome of the liver function test would have been (if one had been performed) the underwriting decision might have been any of the following:

- Application accepted at normal rates.
- Application accepted with a higher premium (where the amount of the extra premium would have depended on the actual test result).
- Application declined.

In a case where his medical history while the policy was in-force is consistent with continuing excessive alcohol consumption (for example, death from liver cirrhosis), the insurer concludes that the most likely result of the liver function test would have meant that using the underwriting guidelines applicable at that time they would not have offered insurance when he applied for the policy. In these circumstances, the insurer

would have declined his application and, accordingly, in applying a proportionate remedy the insurer declines the claim.

However, in a case where there is evidence of only moderate alcohol consumption after the initial GP consultations, the insurer might conclude on the balance of probabilities that the test result would have allowed the insurer to accept the case on rated terms. Accordingly, in these circumstances, in applying a proportionate remedy the insurer will apply their expert judgement as to the terms that are most likely to have been offered and makes the appropriate payment.

Case 10 – applying a proportionate remedy to a multi-benefit policy

A man takes out a multi-benefit policy with £100,000 critical illness insurance (CI) and £1000 a month income protection (IP). The premium he pays is £80 a month. When he took out the policy he incorrectly answered a specific question about his occupation.

Some time later, he makes an otherwise valid critical illness claim for testicular cancer. After a review of the circumstances of the non-disclosure, the insurer concludes that the misrepresentation was negligent and applies a proportionate remedy.

Using the premium rates that would have applied at the time the policy was taken out, the insurer works out that, if he had correctly disclosed his occupation, the premium for the whole policy would have been £100 a month. By applying the same proportion to all benefits, a premium of £80 a month would have provided £80,000 CI and £800 a month IP. As the CI claim is otherwise valid, the insurer pays out £80,000.

Under the terms of the policy, cover for CI ends with the payment of a claim, and the premium for this part of the cover stops. However, as IP is a continuing benefit, the insurer reduces the ongoing IP cover to £800 a month and notifies the customer.

Case 11 – a claim with non-disclosure that relates only to a severable benefit

A woman takes out a policy for critical illness insurance (CI) with total permanent disability (TPD) benefit where cover for one of the benefits continues after a successful claim on the other. When she took out the policy she knowingly answered a specific question incorrectly, deliberately concealing an ongoing history of serious back problems. She then makes an otherwise valid CI claim for breast cancer.

The insurer does not decline the claim because the outcome of the underwriting would only have changed the terms offered for TPD, and not for the main CI benefit being claimed for.

If the back problems had been disclosed, the insurer would have issued the policy at standard premium rates but with an exclusion for back problems for TPD. As this exclusion does not apply to breast cancer, the insurer pays the CI claim in full.

However, as there was deliberate non-disclosure relating to TPD, the insurer avoids the remaining TPD benefit.

Case 12 – finding out why medical information was not disclosed

A man aged 42 takes out a critical illness (CI) policy for £100,000 for a premium of £40 a month. Some time later he makes a claim for a heart attack.

In assessing the claim, the insurer finds that when he took out the policy he had for several years been taking tablets daily to control hypertension. However, he incorrectly answered a clear question about

high blood pressure and a clear question about ongoing treatment. He answered the remaining questions in the application correctly. If he had disclosed his high blood pressure and treatment, the insurer would have charged a premium of £80 a month.

The insurer asks him why he wrongly answered the questions. He explains that he did not consider himself to have had high blood pressure as his pills were effectively controlling it. Further, his doctor had told him that the treatment was "routine" and that his condition was very common for a man of his age and that it was "nothing to worry about". He did not therefore consider this to be relevant.

The insurer decides that his explanation for the incorrect answer is credible because it fits his medical records and the other circumstances of the case. However, the representation was incorrect and the omission was material.

Taking into account all the circumstances, the insurer gives him the benefit of the doubt. That is, on the balance of probabilities, although he must have known about his condition and treatment, the insurer cannot say that he must have known that his condition was relevant to the insurer or that he acted with complete disregard to the truth of his answers. Accordingly, the insurer does not classify the non-disclosure as deliberate or without any care.

Given the questions asked, the insurer concludes that a reasonable person ought to have known that the representation given was relevant to the insurer. In the circumstances, the customer' s answer to the question about ongoing treatment was not reasonable. Accordingly, the insurer treats his misrepresentation as negligent having concluded that it was not innocent.

Using the premium rates that applied when the policy started, the insurer works out that a premium of £40 a month would have provided cover of £48,500. As a proportionate remedy applies and the claim is otherwise valid, the insurer pays out £48,500.

Case 13 – where non-disclosure of medical information is deliberate or without any care

A man aged 47 takes out critical illness insurance for £100,000. Two years later he makes a claim for a heart attack.

In assessing the claim, the insurer finds out that when he took out the policy, for a continuous period of three years he had been taking a combination of three types of medication for hypertension. His medical records show that, despite the treatment, his blood pressure had been significantly raised during this period and that he had been to see his doctor at regular intervals to monitor his blood pressure and renew his prescription for treatment. However, he wrongly answered two clear questions in the application about high blood pressure and ongoing treatment. If he had disclosed his high blood pressure and treatment, using the underwriting manual applicable when he took out the policy, the insurer would have applied a risk premium rating of +100%.

The insurer asks him why his answers to the questions were incorrect. He explains that, because he had been taking treatment for many years, he did not consider his condition or the treatment to be important, and that his blood pressure was controlled by the treatment.

However, contrary to his explanation, the evidence in his medical records shows that his GP had repeatedly warned him about his uncontrolled high blood pressure. Therefore, the insurer concludes that:

- he must have known that his answers were incorrect; and
- he must have known they were relevant to the insurer.

If he had correctly disclosed his condition and treatment, the underwriting outcome would have been a risk premium rating of more than +50%. Accordingly, the insurer classifies the non-disclosure as deliberate or without any care. The insurer therefore avoids the policy and refunds the premiums.

Case 14 – where smoking is negligently not disclosed

A woman takes out a combined (accelerated) life and critical illness insurance policy and declares that she is a non-smoker. Following an otherwise valid claim for cancer, the insurer finds that her medical records show that she was a smoker six months before she took out the policy, and she was also a smoker at the time of the claim.

The insurer asks her why she declared herself to be a non-smoker. She explained that her reason for buying the policy was because she was starting a family. She said she had given up smoking since finding out she was pregnant which was when she took out the policy. The evidence supports this. Her adviser, an employee of the insurer, filled in her application on-line. She recalls that her adviser had only asked her if she was a smoker and not whether she had used tobacco within the preceding 12 months as asked in the application. She accepted that she should have been more careful in checking the copy of the completed application sent to her to review.

In the circumstances, the insurer accepts her explanation as credible given the evidence of the pregnancy as mitigating circumstances and does not avoid the policy. It therefore treats the non-disclosure as negligent (as opposed to deliberate or without any care) and applies a proportionate remedy. Based on the smoker rates that applied when she took out the policy, the insurer works out how much cover her premium would have provided and pays that amount.

If she had not been asked to check the application, as she answered the question asked by the adviser (acting on behalf of the insurer) to the best of her knowledge and belief, there would have been no non-disclosure and the claim should be paid in full.

Case 15 – where smoking is deliberately not disclosed

A man applies for critical illness insurance and declares that he is a non-smoker. Following a claim for cancer, the insurer finds that his medical records show that he was a heavy smoker three months before he took out the policy and also after the start of the policy.

The insurer asks why he had declared himself to be a non-smoker but he fails to offer any plausible mitigating explanation. In the circumstances, the insurer concludes that either:

- he must have known that he was a smoker and, given the question in the application, must have known that this was relevant; or
- he showed no care at all in answering the question about whether he had smoked.

Accordingly, on the balance of probabilities, the insurer concludes that the non-disclosure was deliberate or without any care. The insurer therefore avoids the policy and refunds the premiums.