Banking Ombudsman Scheme

Ministry of Business, Innovation and Employment
By email: insurancereview@mbie.govt.nz.

13 July 2018

Dear Sir/Madam

Submission on insurance contract law review

Thank you for the opportunity to comment on the Issues Paper: Insurance Contract Law review.

It is important that the legal framework delivers on the community's expectations and the legal framework supports fair, efficient and transparent interactions for both consumers and insurers. We are aware that reform has been planned for many years and New Zealand's regulatory framework has slipped behind other comparable jurisdictions.

We commend the Ministry for Business, Innovation and Employment for progressing this review, and agree that it is sensible to begin with considering what is working well and what is not. We support the focus of the review on disclosure obligations, conduct, unfair contracts, processes and complaints at a high level.

We have focused this submission on describing the types of cases we see in those areas so you can see how those issues impact consumers. We look forward to commenting on the policy options in the second consultation document later in 2018.

We strongly support reforms that seek to ensure consumers are adequately informed about insurance products and their rights, and are confident in enforcing them, and that insurers are informed about the liability they are taking on in transactions.

BOS jurisdiction on insurance cases

The Banking Ombudsman Scheme (BOS) was established in July 1992 as an independent dispute resolution scheme. It is an approved dispute resolution scheme under the Financial Service Providers (Registration and Dispute Resolution) Act 2008. BOS is governed by a board of consumer and industry representatives, with an independent chair.

BOS helps customers sort out problems with registered banks, and related companies, and non-bank deposit takers that meet BOS participation criteria (referred to in this submission as 'banks'). BOS is independent of banking service providers, customers, and the government. Its services are free of charge to customers, and funded by a levy on scheme participants.

BOS can consider all complaints about the sale of insurance products by banks, regardless of whether the products are provided by their own insurance divisions or by external providers.

BOS can also consider complaints about the way a claim has been assessed, or the fact it has been declined, but only if the bank itself has provided the policy. If the complaint is about a claim on another company's policy, the complaint is outside our jurisdiction.

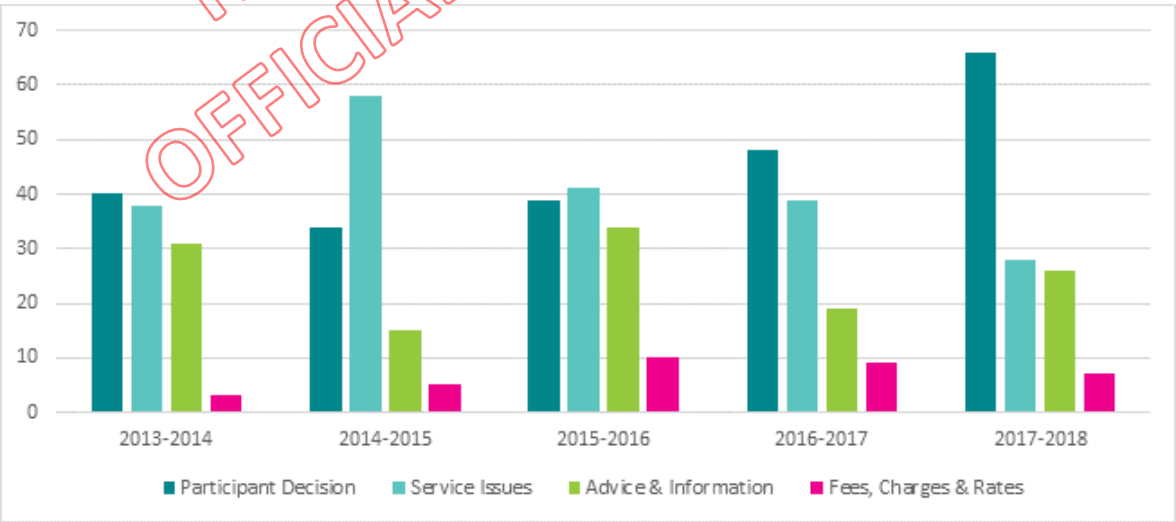
Themes in our insurance cases

We categorise our cases as complaints, disputes and enquiries:

- a complaint is any expression of dissatisfaction about a bank which requires a response
- a dispute is any case that has been considered by the bank, but there has been no resolution and the customer has requested we investigate
- an enquiry is any other contact, such as a general query about banking.

Insurance disputes over last five years

In the last five financial years we have considered 120 insurance-related disputes (11% of all disputes). Our top insurance problem categories are shown in the graph below:



The most common insurance products under dispute were:

- life insurance (41)
- loan protection insurance (30)
- home and contents insurance (17); and
- income protection insurance (16).

The most common reason for a dispute was a decision by the bank to reject a claim due to alleged non-disclosure. We received 52 disputes on this issue. You will note there has been a recent increase in these cases.

We also received 39 disputes about the advice and information given by the bank. These cases tend to involve allegations that the bank gave the customer incorrect or mistaken advice and information, missold the insurance product or that the insurance product was not in the best interests of the customer.

We recommended compensation in 44 out of the 120 disputes. This means that in 37% of our insurance disputes, we recommended the bank pays compensation. The most common elements of the compensation were reimbursement of premiums and compensation for inconvenience and stress.

We see low numbers of cases relating to health insurance, vehicle insurance and travel insurance.

Insurance cases this year

In the financial year ending 30 June 2018, we received 148 cases involving insurance. There were 98 complaints, 21 disputes and 29 enquiries. This means 14% of insurance related cases we received resulted in a dispute.

Compensation for loss in insurance disputes was $63,935, and inconvenience was $2700. This was spread across three cases, with one case representing a large amount ($58,307). Insurance compensation amounted to 23% of all compensation awarded.

These statistics from our cases confirm that the review is focused on the right issues – disputes arising from a mismatch of expectations around disclosure and the exchange of information that is needed so that customers receive the right products.

Our Quick Guide on insurance policies is on our website. We have also attached it to this submission.

Cases about nondisclosure

Many of our cases are based on material non-disclosure of pre-existing health conditions including previous injuries, mental health issues, sleep apnoea, anxiety, high blood pressure, history of stroke, and previous surgery.

There are also cases where the timing of a diagnosis was an issue. The customer may not have had the diagnosis at the time when the application was completed, but the medical evidence suggests that the condition would have been present or the customer was under a duty to let the insurer know of the subsequent diagnosis.

We have attached the following cases by way of example:

1. Non-disclosure of surgery 20 years prior to claim meant application denied. Customer did not know she should have disclosed the surgery. (43255)
2. Pre-existing high blood pressure was not diagnosed at time of application. Complainant died one year later. Insurer refused payment because insured had been diagnosed with heart condition, and was on medication since completing the application, but had failed to disclose relevant information. (32539)
3. Pre-existing condition not diagnosed at the time policy was taken out. Customer visited doctor during 90 day wait period. Melanoma was diagnosed three days after wait period expired. While the bank may not have intended cover to be provided for conditions that came to light during the wait period but were not formally diagnosed, the policy did not clearly spell this out. (29414)
4. Customer did not disclose pre-existing medical conditions and subsequently suffered a heart attack. Customer alleged bank had said it would obtain doctor's notes but there was no record of that conversation. Doctor's notes not on file. Case on our website as well as attached (41082).
5. Customer diagnosed with cancer within one month of taking out life and loan protection. Bank claimed a three month stand down applied but policy was not clear on stand down period for critical care benefit. (8670)
6. Customer mistakenly filled out her weight at 155 lb instead of 155 kg. A customer has a duty to make sure they are not reckless when filling out application form. (50836)

Cases about information and advice

Cases about information and advice tend to involve mismatched expectations between the customer and the bank, either about whether insurance is in place or the scope of cover. Customers often allege the policy is not what they believe they bought when the time comes to make a claim.

For example:

1. Customer cancelled contents insurance and attempted to reinstate it 18 months later. Accidentally cut off during call. Customer assumed it would be arranged. Burgled three weeks later – was not covered. Bank did not make it clear that insurance could not simply be reinstated. However, complainant should have followed up. 60:40 split favouring customer. (9029)

2. Home and contents insurance for rental property – claim for a water leak. Customer alleged he was sold the wrong type of policy. Policy suitable for rental property but did not cover gradual damage. (31975)
3. Customer did not include measurements of deck and garage when policy taken out as she believed bank had said this was not required – no record of that agreement. (40134)
4. Complainant said he disclosed previous back injury in insurance application, but the bank incorrectly recorded his answer. When the customer suffered a subsequent injury in a motorbike accident, the claim was declined. The bank said it would have granted limited cover if the previous injury had been disclosed. Case settled on the basis that the bank refunded premiums paid to date. (32675)

Some of our cases also illustrate a lack of consumer understanding about how insurance products work. For example, customers not being aware that premiums increase over time, funeral policies stop at 65, policies have expiry dates and are not perpetual, critical care may require a separate product to health insurance.

Conclusion

BOS is supportive of the review and its objectives of enabling customers and insurers to transact fairly and with confidence at all points in the lifecycle of an insurance policy. We would welcome the opportunity to discuss any specific proposals further.

Yours sincerely

s 9(2)(a)

Nicola Sladden
Banking Ombudsman

Insurance policies

Banks sell insurance policies. We outline common complaints about their sale and how we investigate them. We also look at switching policies and common misunderstandings with some policies.

Some banks sell policies provided by their own insurance divisions, and other banks sell policies supplied by separate companies. We can consider all complaints about the selling process by banks, regardless of whether banks sold an internally or externally provided policy.

We can also consider complaints about the way a claim has been assessed, or the fact it has been declined, but only if the bank itself has provided the policy. If the complaint is about a claim on another company's policy, we cannot consider the complaint, but will help you find who can.

Our approach

Bank officers have a duty to take care when giving customers information and advice about financial and insurance products. The exact nature and extent of that duty will depend on each case. We can look at whether they met that obligation.

For instance, one bank might simply give a customer information about a policy, but no advice or recommendation. In that situation, we would look at whether the customer received information that was clear and also sufficient to enable the customer to make an informed decision about whether the policy was the right choice.

In other situations, a bank might assess a customer's insurance needs and then give advice and a recommendation. In that situation, we would look at whether the bank took adequate steps to ensure the recommended policy suited the customer's needs.

We sometimes get complaints from people who say the policy is not what they believe they bought when the time comes to make a claim:

- A bank led a complainant to believe a policy was compulsory, and having learned it was not, the complainant wanted reimbursement of all premiums.
- A bank failed to advise that a policy would not provide cover for the event claimed for, despite being aware of the complainant's circumstances.
- A bank failed to provide a copy of a policy, so the complainant could not check whether it met his or her needs.

We also sometimes get complaints about the failure to disclose information, such as:

- A bank did not record all the details of a complainant's health on a policy application form, and a claim was subsequently declined for either a failure to provide important information or supplying incorrect information.
- A complainant told a bank about a health condition and the bank said it was so minor there was no need to put it on the application.
- A bank declined a complainant's claim because of a pre-existing condition – despite advising that the policy would cover all health matters.
- In looking at a complaint about the sales process, we consider:
- the information the bank had about the customer's insurance requirements
- the information or advice the bank gave to the customer about the insurance policy

- whether the customer was eligible for the policy (some travel insurance policies, for example, don't cover those over a certain age)
- whether any policy exclusions or limitations made the policy unsuitable for the customer (such as a pre-existing medical condition)
- what written disclosure was made to the customer about the policy.

To help us make a decision, we will often look at:

- the application form, bank diary notes about the sale (including any records of a needs analysis and any customer notes) and phone recordings
- what the bank officer and complainant remember about the sale
- the bank's policies on insurance products and any sales scripts bank staff use when selling policies
- relevant law, codes of practice and regulatory guidelines.

If we find the sales process was flawed, we may recommend the bank pay the customer's claim, or some proportion of it. In other situations, we may recommend the bank reimburse the premiums, and/or pay compensation for the inconvenience arising from the sales process.

Switching policies

Advisers need to take special care when recommending a customer take out a different policy because of the risk the customer may lose some of the cover offered by the existing policy. We use a Financial Markets Authority guide when looking at complaints in this area. The guide says advisers comparing a customer's existing policy with a replacement must:

- be familiar with the terms of the existing product
- make a clear, reasonable and balanced comparison
- point out the disadvantages as well as the advantages of switching policies.

A bank should make clear the limited scope of the service it is providing if it is not giving advice or making a recommendation about a different policy. It should point out that no comparison has been made, and it should explain the risks of changing policies and the nature of these risks, which may include:

- reduced cover (for example, a change to the date from which pre-existing medical conditions will be excluded)
- fees for cancelling a policy
- a specific period of reduced cover (for example, redundancy cover will not be available for the first three months).

Specific policies

Critical care cover

Also known as trauma cover, this is often an option added to life insurance policies. It usually offers a lump sum payment on diagnosis of a terminal illness that will soon end in death. It can also include very specific conditions, such as loss of a limb, certain cancers and certain types of heart disease.

It is commonly believed – including by some bank officers – that critical care cover is a cheap alternative to disability cover. However, it is often so narrowly defined that it excludes most types of disability. Nor is it a substitute for a loan protection or income protection policy. There are clear differences, which banks should explain to customers.

Loan protection policies

Also called mortgage protection policies or loan repayment policies, they offer loan repayments when a borrower cannot meet his or her commitments because of temporary disability or redundancy. Or they repay the loan in full in case of permanent disability or death. Loan protection policies pay out to the lender rather than to the insured (or his or her estate), as happens with life insurance policies.

Loan protection policies are sometimes confused with lender's insurance. The latter protects the bank (for example, if there is a shortfall after a mortgagee sale), not the borrower, even though the borrower pays the premiums – which is why some borrowers assume the policy is in place for their protection. It is not. If the insurer pays out on a claim, it has the right to recover the money from the borrower.

Complaints about loan protection policies sometimes stem from this confusion. We check whether the bank properly explained that the premium paid was for the bank's lender's insurance

Banks don't have to offer customers a loan protection policy when arranging a loan, but it is a good idea for borrowers to think about insurance cover when taking out a loan.

Sometimes, when a customer's borrowing amount is increased, the existing loan will be repaid and a new loan made at the higher amount. In the process, loan protection insurance on the old loan can sometimes be automatically cancelled – a fact missed by customers and sometimes not pointed out by banks. Banks should advise customers of this and check what insurance they may want.

When a customer borrows more money, the cover may continue for the original loan, but not for the extra lending. It is good practice for banks, if they have sold the original policy, to check whether the customer requires insurance cover for all the lending.

A standard loan protection policy may not be of much value to part-time workers or the self-employed. Part-timers may not qualify for disability or redundancy cover, and the self-employed cannot get redundancy cover and may not be covered for loss of contracts.

Buying insurance over the phone

Telemarketing of insurance policies is becoming more common. Legally, an insurance contract doesn't have to be in writing, so acceptance of an offer of insurance over the phone is binding. However, banks should make sure customers are sent a copy of the policy, and advised to read it, because the full terms and conditions of the policy won't have been disclosed in the phone call.

Case - 43255

2014 – 2015

Insurance – life insurance

Ms G was diagnosed with terminal cancer and made a claim on life insurance taken out 15 years earlier.

To assess her claim, her bank requested her medical history and discovered she had had serious surgery 20 years prior. It said it would have charged higher premiums had it known about the surgery and was only prepared to approve a $15,000 payout, not the $70,000 she had claimed for.

Ms G didn't know she should have disclosed the surgery, and still wanted the full $70,000, or at least a refund of the $40,000-worth of premium payments she paid over 15 years. The bank maintained it could keep her premiums because of her non-disclosure.

There is a general principle customers must disclose all information impacting a decision to provide insurance. It was clear Ms G had not done this. Generally speaking, if material information is not disclosed, the parties are restored to the position they would be in before the insurance was taken out. This usually means a bank refunds premiums, declines all claims and cancels the insurance policy.

We asked the bank why it had not done this because we could find no basis for the bank's position but did not get a satisfactory answer. In the meantime, Ms G's health was declining. The bank decided to reimburse the premiums (minus the $15,000 it had already paid her) as a goodwill gesture but maintained it didn't have to. Ms G accepted the bank's offer and the complaint was resolved.

Case - 32539

2012-2013

Insurance - Life insurance

Mr L applied for a term life policy from his bank. As part of the application process, he was asked a series of questions over the phone about his health and lifestyle. Mr L said he was currently having medical tests for high blood pressure. The bank officer asked whether he had received the results of the tests and whether he had been diagnosed with high blood pressure. Mr L said he did not have the test results and no diagnosis had been made.

The bank provided Mr L with a life policy.

Four years later, Mr L died suddenly of a heart condition.

Mr L's partner lodged a claim under the policy. The bank declined the claim because Mr L had not disclosed the full extent of medical investigations being carried out when he applied for insurance. It also said he had not disclosed a diagnosis of a heart condition. Mr L's partner complained to us.

The medical information showed Mr L had visited his GP for high blood pressure and chest pain two months before applying for the insurance. Mr L was referred to a specialist to investigate a possible heart condition. Over the following two months, Mr L had a range of appointments and tests. There was also a record of a heart condition diagnosis. Over this period, Mr L's doctors discussed his high blood pressure and the appropriate medication.

The bank advised it would not have offered a policy if it had known all the medical information.

Mr L's partner said when Mr L applied for the insurance, he did not know he was being investigated for anything other than high blood pressure. He had not been diagnosed with a heart condition at this point. He attempted to answer the bank officer's questions to the best of his knowledge, and told the bank he was undergoing tests. The bank did not accept Mr L did not know he was being investigated for a heart condition.

Reviewing the information, we believed Mr L did not have the heart condition diagnosis at the time of his insurance application. He did not receive the results of a echocardiogram until after the policy had been granted. However, we did decide he had answered several of the other health questions incorrectly.

We looked at whether Mr L had given the bank officer sufficient information to alert it to his health status. A person is required to disclose enough information for an insurer to know more information can be provided.

When considering this, we presented three underwriters with the telephone transcript of the call between Mr L and the bank (with identifying details omitted), and asked if they would have undertaken any further enquiries. All three said a prudent insurer would have contacted the insured's doctors before making a decision on the application. They also noted apparent inconsistencies in Mr L's answers were not followed up. On the basis of the underwriters'

responses, we felt a prudent insurer would not have finalised a decision on the application without making further enquiries.

We then asked the bank whether it was willing to reconsider its position. The bank did so, and made an offer to pay 75% of the claim on a “without prejudice” basis. Mr L’s partner accepted the offer, and the file was closed on this basis.

Case – 29414

2010-2011

Insurance – Health

Ms D applied for a term life policy with her bank, with optional critical condition cover. The bank approved the application and a policy was issued. The policy had a wait period which meant that the bank wouldn't pay out if Ms D was diagnosed with a critical condition within 90 days of the policy being approved.

Before the end of the wait period, Ms D visited her GP about a lesion on her leg which had been knocked and had started bleeding. Her GP referred her to a specialist. The specialist saw Ms D within three weeks and a biopsy was carried out seven days later.

Two weeks later, the wait period expired. Three days after this, the pathology report was issued, which diagnosed a melanoma above 1.5mm Breslow thickness. Ms D's policy excluded cover for melanoma below 1.5mm Breslow thickness.

Ms D lodged a claim under the policy. The bank declined the claim on the basis that Ms D had been diagnosed with melanoma within the wait period.

Ms D complained to us about the bank's decision to decline the claim. She submitted that her melanoma had only been diagnosed when the pathologist's report was issued, which was after the wait period had ended. Without a pathology investigation, a melanoma could not be diagnosed. Ms D did not believe that the medical staffs' suspicions constituted "diagnosis" in terms of the policy.

The bank claimed that Ms D's GP, the specialist, and the surgeon who carried out the biopsy all suspected melanoma. It also noted that Ms M couldn't have reasonably believed that it would provide cover for a condition that came to light during the wait period.

We considered all of the available medical evidence, including further information from Ms D's GP. We also reviewed the wording of the policy. We formed the view that:

- without a pathology investigation, we were not convinced that malignancy could be diagnosed or that the Breslow thickness could be established
- in this case, the trigger for the bank's liability under the policy was "diagnosis" of a specific critical condition. The policy did not specify the diagnostic technique to be used, nor did it define "diagnosis"
- a diagnosis occurs when a condition has been identified with sufficient precision to allow decisions to be made about treatment and, in relevant cases, information given about prognosis. In Ms D's case, after receiving the pathology report, her specialist explained the necessary future treatment
- while some conditions can be formally diagnosed by a clinical investigation rather than a pathological investigation, given the level of specificity of the condition described in the policy, a pathological investigation seemed necessary to make the diagnosis.
- in its plain, ordinary usage in the context of the policy, the word "diagnosis" could reasonably be interpreted as Ms D contended, that is, a diagnosis from the results of the pathology investigation.

While the bank may not have intended cover to be provided for conditions that came to light during the wait period but were not formally diagnosed, the policy did not clearly spell this out.

The bank was responsible for drafting the policy documents and as such, should have clearly explained the cover it was providing, particularly when dealing with how liability is triggered under the critical condition benefit. Under other parts of the policy it does just that, excluding cover where an insured person knows or suspects a condition to exist.

We recommended that the bank pay Ms D the critical condition benefit under the policy of $50,000. Both parties accepted the recommendation.

Case – 41082

2015-2016

Insurance – other insurance

The facts

Tani wanted to switch life insurance provider and applied to her bank for life insurance with critical care cover. When she was told her application was successful, she cancelled her existing insurance. Six months later, Tani suffered a heart attack and claimed for critical care under her new policy.

But the bank declined the claim and cancelled her insurance because she hadn't disclosed information about her medical history, which included high blood pressure, diabetes and weight problems. It said it would have declined her application if she had disclosed this information.

Our investigation

Tani complained to us that the bank hadn't asked any medical history questions and told her it would contact her doctor for information before approving her application. She said she had lost the opportunity to be paid out under her previous insurance's critical care cover.

We looked at Tani's completed and signed insurance application, along with medical notes supplied when she made her policy claim. There was nothing to suggest she was told her doctor would be contacted before her insurance was approved. The application form had made clear she had to disclose all relevant medical history. It clearly recorded that she had been asked whether she had received medical advice on a range of different medical issues, to which she answered "no".

Tani's medical records showed she had a significant medical history (and family medical history) and should have answered "yes" to many of the questions in the application form. We concluded there was no evidence that the bank was responsible for Tani's non-disclosure. It had also sought a medical review, which showed it would have declined her application if made aware of her medical history.

We also found that Tani hadn't disclosed her medical history when applying for her previous insurance, and that it was likely any claim under it would also have been declined and the policy cancelled. We could not, therefore accept her complaint that she would have been better off under the previous policy.

Outcome

We told Tani there was no evidence for us to take further action on her complaint, which she withdrew.

Case – 8670

2004-2005

Insurance – Life insurance

In April 2004 Ms W took out a life and loan protection insurance policy with her bank.

About a month later she was diagnosed with cancer. Her bank manager suggested that she make a claim under the critical care provision of her policy which provided for a payment of 25% of the total sum insured ($62,000 in Ms W's case) if the insured was diagnosed with a critical condition, including cancer.

The bank's insurance division told Ms W that it would not pay the critical care benefit because it was subject to a three-month stand down period. In other words, because Ms W had been diagnosed with her critical condition within three months of taking out the policy, a policy exclusion applied and the benefit would not be paid.

Ms W then checked the brochure that she had been given when she purchased the policy. She noticed that there was nothing in the brochure to say that there was a three-month stand down period in respect of the critical care benefit. She complained to the bank.

After some negotiation the bank's insurance division told Ms W that it would make her an ex gratia payment of $50,000. The total sum for which Ms W was insured would then be reduced by $50,000.

Ms W was not satisfied with this offer, and complained to my office. The complaint was then referred to the bank's specialist complaints department. Further discussions and negotiation took place between the bank's complaints department, Ms W and my office, resulting in the bank agreeing to pay Ms W the full amount to which she would have been entitled under the critical care benefit, which is the sum of $62,000.

The bank accepted that, while the stand-down period was mentioned in the context of other benefits under the policy (e.g. the redundancy benefit), there was no mention in its brochure of a three-month stand down period applying to the critical care benefit (although the policy document did refer to a three-month stand down period). The bank was therefore to change the wording of its brochure to ensure that it properly represented the terms of the policy and to properly inform its customers of all exclusions to the policy. The bank also said that it would be undertaking some staff training because its enquiries showed that its branch staff were also unaware of the three-month stand down period in respect of critical care benefits.

Ms W was very satisfied with the outcome of her complaint.

Case - 50836

2016 - 2017

Insurance – life insurance

Ms U took out life insurance through her bank. The policy would pay $50,000 if she suffered a permanent disability and $500,000 when she died. She completed a form seeking personal and medical information. The form asked for height in centimeters and weight in kilograms, but Ms U wrote “1.6” and “119”, above which she wrote “m” and “lbs”. The bank approved her request for insurance based on this information.

Five years later, Ms U was diagnosed with cancer and claimed the disability benefit on her policy. The bank sought information about the cancer and discovered Ms U was much heavier than it previously thought. She had said she was 119 pounds (54 kilograms) when she was in fact 119kgs. The bank declined her claim and cancelled her policy, saying it would not have offered her insurance if it had known her correct weight. However, it offered to refund her premiums – totalling about $5,000 – out of sympathy for her situation.

Ms U declined the offer and complained to us that the bank should have known her correct weight and should accept her claim. We didn’t agree that the bank should have known the weight stated on the form was incorrect because it was her responsibility to ensure she supplied correct information, and the bank was entitled to rely on the information she gave. We then considered whether the bank had the right to refuse to honour the policy. We concluded it did because:

- Her stated weight was incorrect by a substantial margin – 54kg was normal, 119kg was obese.
- Her weight was material to the decision about whether to provide insurance cover – knowing her true weight, the bank would not have offered her disability cover and would have required a higher premium for the life cover.
- Ms U either knew 119lbs was incorrect or was reckless about whether this was correct when she filled in the form.

The bank then offered a further payment of compensation in addition to refunding the premiums. Ms U accepted the offer.

Case – 9029

2005-2006

Insurance – Home and contents

Ms H held a contents insurance policy with a bank. In July 2003 she called the bank to suspend the policy, as she could no longer afford to continue to pay the premiums. She told the bank that she intended to reinstate the policy in the future.

On 21 December 2004, Ms H telephoned the bank's call centre and spoke to a customer services adviser. She explained that she wanted to have her policy reinstated with immediate effect, and they discussed the amount of cover she required. She was accidentally cut off when the customer adviser tried to verify her identity. Ms H immediately called back and spoke to another staff member who was unable to access the underwriting software. This second staff member offered to email the previous customer services adviser to get him to call Ms H back to complete the arrangements for her insurance cover. When Ms H heard nothing further she assumed that cover had been arranged, as she had already provided the bank with all the information necessary to arrange the insurance and had previously held an insurance policy with it.

About three weeks later, on 10 January 2005, Ms H's home was burgled. When she realised that she had received no formal confirmation of her policy, she called the bank, only to discover that the policy had not been reinstated, and that she was uninsured. The bank then insured her with immediate effect, but refused to compensate her for the loss sustained in the burglary because, in its view, she had not been covered when the burglary took place. The bank offered an ex gratia payment representing a refund of one year's premium, but Ms H was not satisfied and lodged a complaint with my office.

The bank said that Ms H's original policy had been cancelled and explained that, once a policy has been cancelled, it cannot be reinstated, as a full assessment of risk must be completed. If a policy is accepted by the bank's underwriter, the insured person will normally be formally advised of this within three to five days of the risk being accepted, together with full details of the policy and payment arrangements. The bank could find no evidence that it had offered to provide Ms H with contents insurance on 21 December 2004. However, the customer services adviser in the call centre who first spoke to Ms H was aware of what she wanted when her call was disconnected, but did not have her contact information, and had not started the insurance sales process. He was busy on the day in question and had a backlog of calls, so although he received the email, Ms H's second call was not followed up.

I found that, while the bank made it clear to me that a policy may not be reinstated once it has been cancelled and that a full assessment of risk has to be undertaken before a new policy can be arranged, there was nothing to suggest that this process had ever been made equally clear to Ms H, who firmly believed that it was possible to reinstate the old policy without further ado. I concluded that the bank had been at fault in not making it clear that a new policy would have to be arranged and that this would necessarily involve a risk assessment. Also, the bank should have contacted Ms H to follow up on her second telephone call. However, I felt that Ms H had to share some responsibility for the fact that she remained uninsured from 21 December 2004 until 10 January 2005, during which time she suffered a loss through burglary. I felt that a careful person, such as Ms H appeared to be, should have sought confirmation from the bank that her policy had been reinstated.

I accordingly proposed that responsibility for the direct loss suffered by Ms H should be shared between her and the bank, with the bank assuming responsibility for 60% of the established loss, and the complainant 40%. In addition, in recognition of the stress and inconvenience suffered by Ms H when she discovered the bank had failed to arrange contents insurance for her, I proposed that the bank should pay her compensation in an amount of $500. The bank and Ms H both accepted the proposed recommendation, and the complaint was resolved on that basis.

Case – 31975

2011-12

Insurance – Home and contents

Mr M had his home lending and home and contents insurance with the bank. A couple of years later he bought a rental property and again arranged the lending and insurance through the bank. A copy of the policy document was sent to Mr M and he was asked to check it to make sure the insurance met his needs.

A few years later the rental property was damaged by a leak from an internal water pipe. Mr M made an insurance claim for the damage. The insurer declined the claim because the policy only covered gradual damage caused by a water leak if Mr M had been personally living in the home.

Mr M complained first to his bank and then to us. He said the bank knew the property was a rental investment property and that the insurance policy supplied to him was not suitable for his needs. He considered the bank had breached the Consumer Guarantees Act 1993 by recommending an unsuitable policy.

The bank accepted that it knew the property was a rental investment property but maintained that the policy was suitable. The bank had sent Mr M the policy and considered it his responsibility to check it was suitable for his needs.

We reviewed the complaint and were satisfied that although the policy excludes cover for gradual damage to rental properties it was a suitable product for rental properties. Gradual damage was the only event that the rental property was not insured for: it did cover accidental or sudden loss to the property. None of the bank's insurance policies would have covered gradual damage to a rental property.

There was no suggestion Mr M had asked the bank for an insurance policy that would cover gradual damage to his rental property, or that he had asked for insurance that would provide cover identical to his home.

All insurance policies have limitations. The standard policy was posted to Mr M, he was advised to check it and the gradual damage limitation was not hidden in the fine print. Mr M therefore had the opportunity to make alternative arrangements if the policy did not suit his needs.

We recommended the complaint be not upheld.

Case – 40134

2014 – 2015

Insurance – Home and contents insurance

Some years ago Mrs R arranged house insurance for a Christchurch property she intended to buy. The insurance policy was arranged by a banking consultant. Mrs R provided the consultant with the house floor measurements. When asked about other areas on the property to be insured, Mrs R said she did not know the measurements.

Mrs R said the banking consultant advised it was unnecessary to record the measurement of the detached single garage, carport or deck because these could be obtained in the event of a claim. It was only important the house size was recorded correctly.

Mrs R signed the Home Cover Schedule which stated the 'Other area' square metre value was '0'. When she received annual renewal notices, Mrs R did not think she needed to update this because of the banking consultant's advice.

Following the Canterbury earthquakes, Mrs R's property was deemed a total loss. She then discovered her garage, carport and deck were ineligible for cover, and felt the bank was responsible for her financial loss.

The bank did not agree as customers have an obligation to ensure insurance policy details are correct. Any incorrect initial advice provided in 2001 should have been corrected by the customer upon receipt of subsequent communications via the insurance policy, annual renewal notices and annual policy schedules. Mrs R asked our office to investigate.

We explained to Mrs R that if a banking consultant provides advice, that advice should be accurate. If a bank provides incorrect advice, it may be liable to the customer for the consequences of this. However, to determine whether poor advice was provided, we require sufficient information to support such an allegation.

We considered it would be difficult to hold the bank responsible for the under-insurance position given:

- there was no information available to corroborate the conversation that took place when the insurance application was made
- the policy document, plus annual renewal notices and annual policy schedules were sent to and received by Mrs R; the documentation made it clear Mrs R was required to check the policy for accuracy, and
- the policy details explicitly noted the insured floor area of undeveloped outbuildings including carports and decks was "0". Therefore, it appeared that these areas were not insured.

Mrs R understood the difficulties in upholding her complaint and decided to withdraw it.

Case – 32675

2011-12

Insurance – Loan

Mr S wanted to buy his first car. While his mother could afford to lend him the money, she thought it would a good experience for him to borrow money from his bank. She encouraged him to get insurance to cover the loan repayments if he was unable to work for any reason. Mr S's bank approved his lending application and Mr S and his mother went to the bank to discuss insurance.

Mr S's mother claims that when Mr S was asked if he had suffered any injury to his back within the last five years he answered "yes". Both of them were very aware of a motorbike accident he had had only two years earlier in which Mr S injured his back. The bank recorded the answer to the question about any injury to Mr S's back as "no" and his insurance application was accepted.

Mr S later had a car accident and injured his back to the extent he was unable to work. When he submitted an insurance claim his previous injury was discovered and the insurance company declined his claim. Mr S and his mother complained to the bank. The bank did not agree it had incorrectly recorded the answer to the question, but had some sympathy for their situation and offered a goodwill payment of $1,000.

Mr S and his mother then complained to us saying the bank wrongly recorded the answer to the question about his previous back injury. They believed that the bank should honour the terms of the insurance policy and pay the loan repayments for Mr S. Mr S authorised his mother to discuss his complaint with us.

We discussed what would have happened if the bank had correctly recorded the answer to the question. The bank had previously explained that its insurers would have insured Mr S, but excluded any cover for a back injury. Mr S's mother said that if he had been offered limited cover, her son would not have proceeded with either the loan or the insurance and she would have lent the money as an informal family loan. She said the money she would have loaned him remained on term deposit and she could access it to repay Mr S's debt if necessary. It appeared that if the question had been answered correctly, he would not have gone ahead with the insurance, therefore the only loss to Mr S was the insurance premiums he had paid.

We contacted the bank and asked how much Mr S had paid in insurance premiums, and whether it would offer to reimburse him for this loss. The bank calculated Mr S had paid $1,300 in insurance premiums, but would increase its settlement offer to $1,500. Mr S accepted this offer.