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Submissions - Insurance contract law reform 2018

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Our submissions are informed by our role as an independent dispute resolution scheme, which investigates complaints across a broad spectrum of financial advice and products (except banking).

In the year ended 30 June 2018, we investigated 108 complaints concerning insurance. These complaints include both complaints about fire and general insurers, and complaints about insurance brokers and advisers. FSCL does not investigate complaints about life insurance companies. The majority of the complaints centred around travel insurance {65 complaints), although FSCL also investigated complaints about:

- Motor vehicle insurance (10 complaints)
- Life and trauma insurance (7 complaints)
- Pet insurance (6 complaints)
- Material damage insurance (4 complaints)
- Health insurance (4 complaints)
- Business interruption insurance (4 complaints)
- Home and contents insurance (3 complaints)
- Income protection insurance (3 complaints), and
- Mechanical breakdown insurance (2 complaints).

As part of our submissions, we have attached a number of case notes to this letter. FSCL prepares these case notes after completing a complaint investigation. The case notes (which have all identifying information removed) detail the events leading up to each complaint, the positions of the parties, and the steps taken by FSCL to resolve the complaint. The case notes are referenced throughout this letter, wherever they are particularly relevant to a discussion point raised in MBIE's issues paper.

1. **Disclosure obligations and remedies for non-disclosure**

Q3. *Are consumers aware of their duty of disclosure?*

We find consumers are generally unaware of their duty of disclosure. While consumers understand they must not give any false information when purchasing an insurance policy, very few consumers understand that they are required to volunteer all relevant information for the insurer.

We find the lack of understanding is most obvious in the case of credit card travel insurance policies. Premium credit cards often come with free travel insurance, which is triggered when a consumer purchases half their travel using the credit card (or meets other activation requirements). The insurer will usually post or email a disclosure document to the consumer, describing the consumer's disclosure obligations. However, we find consumers often do not read their disclosure documents (which can be quite lengthy). It will never occur to some consumers that they should contact their insurer and disclose their existing medical conditions and risk factors. We find that many consumers will learn about their duty of disclosure only when they go to make a claim to their insurer, and find they have been declined.

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Case notes

"Insurance cancelled for failing to disclose a heart attack" (p 2): A consumer purchased a life insurance policy, and failed to disclose a heart attack. 4 years later, after some prompting by his daughter, the consumer advised his insurer of the heart attack. The insurer responded by cancelling the insured's policy. If not for his daughter's comments, it is likely the insured would never have considered his disclosure obligations.

"Replacement cover; replacement knee" (p 3): A couple approached their insurance adviser about changing insurers, in order to secure a lower premium. The adviser recommended the consumers switch to a new insurer. At the time these arrangements were being made, one of the consumers was consulting a doctor about knee pain. After the consumer's original policy was cancelled, the consumer discovered he would need replacement knee surgery, at a cost of $20,000. The consumer had not disclosed the knee injury, so the surgery was not covered by the new insurance policy. It seems the consumer did not even consider disclosing his injury when signing up for the new policy.

"Left high and dry" (p 5): A consumer booked a trip to Hawaii for herself and her partner. The consumer had taken out a credit card travel insurance policy. Shortly before the trip, the consumer suffered an adverse reaction to a change in her regular medication, and had to cancel the trip. The medication was taken to treat the consumer's dry mouth/lack of saliva, and was changed due to a new diagnosis for another condition. The insurer declined the consumer's claim for cancellation costs, as the cancellation was related to an undisclosed pre-existing medical condition. The consumer had not thought to disclose her dry mouth to the insurer beforehand.

Q4. *Do consumers understand that their duty of disclosure goes beyond the questions that an insurer may ask?*

No. Consumers will regularly assume that if an insurer needs information, the insurer will ask for it. Consumers will usually rely on their insurer's questionnaires and forms, and their adviser's questions, to prompt disclosure of the information that the insurer might need.

We find this is particularly true when it comes to medical records. We have seen a number of complaints where, as part of the insurance purchasing process, an insurer has required a consumer to sign a waiver, allowing the insurer to request the consumer's medical records. The consumer (wrongly) assumes the purpose of the waiver is to allow the insurer to request the medical records before the policy is underwritten. The consumer will conclude that they do not need to disclose any details from their medical records, as the insurer will be acquiring the details as a matter of course.

In reality, the insurer will usually only acquire a consumer's medical records after the consumer has made a claim. The medical records may reveal signs, symptoms, or other information relating to an illness which is relevant to the consumer's policy and risk. The consumer's failure to disclose these details means the insurer can void the policy, and the consumer, having paid insurance premiums, is left with no cover for the loss they have suffered and may have their policy voided altogether. This seems a disproportionately harsh effect for the consumer, which results directly from a poor understanding of the duty of disclosure.

We suggest that it be considered whether insurers should be required to obtain a consumer's medical records before a policy is accepted. We acknowledge that this requirement will increase administrative costs for insurers, and could lead to increased premiums. However, we consider consumers would be willing to pay higher premiums with the assurance they will have cover for pre-existing medical conditions. Further, costs may be reduced as medical records are increasingly digitised and centralised.

We also suggest that it be considered whether insurers should be required to underwrite policies at the time a policy is purchased, rather than the time a claim is made. This will encourage insurers to appropriately investigate and account for the risk associated with each policy before it is purchased. The requirement will help to ensure that consumers receive appropriate insurance, rather than discovering their policy is void after they make a claim. Again, this will increase administrative costs and premiums, but may result in better consumer outcomes.

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> **Case notes**
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> **"Getting to the heart of the matter by way of a heart to heart"** (p 7): A consumer, on the advice of their new insurance adviser, switched their life insurance policy to a new insurer. When they switched to the new policy, the consumer failed to disclose a recent heart issue. The consumer had assumed, based on signing a form saying their new adviser would examine their insurance, that the new adviser would seek a copy of their full medical records and information from their old insurer and put anything relevant on the application form. The issue was picked up by the new insurer which cancelled the consumer's cover. However, the consumer had now lost cover he would have had with his old insurer.
>
> **"Best practice when advising on replacement health insurance"** (p 10): On the recommendation of their insurance adviser, a couple moved to a new health insurer. After the consumers made a claim to the new insurer, the insurer reviewed their medical records, and discovered several serious conditions. As a response, the insurer added significant exclusions to the consumers' policies. The consumers made a complaint against their adviser, as they had assumed that the adviser would pass their medical records on to the insurer, and the insurer would take their medical history into account when entering into the policy.

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Q5. *Can consumers accurately assess what a prudent underwriter considers to be a material risk?*

No. In our view, most consumers are unaware of which facts might constitute a material risk to an insurer or prudent underwriter.
Consumers are particularly unaware of the need to disclose symptoms and signs of illnesses, rather than just illnesses where they have already received a diagnosis. We have seen a number of complaints where a consumer has had a claim declined due to a failure to disclose relatively benign symptoms (excessive tiredness, night sweats etc), which have later turned out to be indicators of a serious illness. In these cases, insurers will treat the symptoms as evidence of a pre-existing medical condition, and decline the claim. This is a disproportionately harsh result for what may be considered an understandable, and usually innocent, non-disclosure.

Another common issue is consumers being unaware of the need to disclose 'propensity conditions'. Propensity conditions are medical conditions which do not present a health risk on their own, and have not yet led to any injury or serious illness, but which put the consumer at an increased risk of suffering an injury or illness in the future. An example is a consumer who is taking medication for high blood pressure. The consumer has not suffered any blood pressure related illnesses yet, and their medication is simply a preventative measure prescribed by their doctor, which keeps their blood pressure well-regulated. However, the high blood pressure may put them at increased risk of heart disease and other serious

conditions. The high blood pressure is clearly a medical condition which the consumer needs to disclose. However, the consumer thinks that because their medication is effectively managing their high blood pressure, the condition does not pose any material risk, and they do not need to disclose it. Again, this failure to disclose can lead to the insurer declining a consumer's claim, and cancelling their policy, and declining to refund premiums already paid. This appears to be a disproportionately harsh consequence for misunderstanding their disclosure requirements.

We consider that consumers' understanding of relevant information and material risks may further deteriorate in the future. Insurers use complex algorithms to assess risk, which are incomprehensible to the average consumer. We do not consider it is reasonable for a consumer to know, for example, that their above-average meat consumption could increase their risk of bowel cancer, or that their office-work increases their risk of RSI and back strain. Insurers are the parties with the expert knowledge of the risk factors which affect their decision as to whether or not to insure a person and on what terms. We consider the responsibility for collecting relevant information should rest with the insurer.

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Case notes

A hard lump to swallow (p 14): A consumer, on the recommendation of his adviser, switched his health insurance policy to a new insurer. When taking out the new policy, the consumer did not disclose a recent visit to his doctor, where he discussed a lump on his neck and night sweats. His doctor ran tests which showed no problems. The consumer decided not disclose these issues as there had been no firm diagnosis, so the consumer assumed there was no health issue, and nothing to disclose. Months later, the consumer was diagnosed with cancer. The insurer declined his claim, as the lump and night sweats were symptoms of cancer, so the consumer had breached his duty of disclosure.

(lack of) Iron-man (p 17): A consumer purchased travel insurance for a trip to Rarotonga. Shortly before purchasing the insurance, the consumer had visited a doctor to discuss physical and emotional exhaustion. During this visit, the doctor discussed the consumer's history of anaemia. The day before the trip, the consumer cancelled his flights, as he was too exhausted to travel. A doctor confirmed this. The insurer declined the consumer's claim for cancellation costs, as the costs were caused by an undisclosed pre-existing medical condition, the consumer's anaemia. The consumer did not feel the insurer had done enough to inquire into his pre-existing medical conditions, or to assess whether any medical issues could make the insurance inappropriate.

"Neck on the line" (p 19): A consumer took out income protection insurance, and disclosed a 'shoulder injury'. Later, the consumer injured his spine, and it was discovered that the injury was, in fact, a neck injury, not a shoulder injury. The insurer cancelled the policy and declined the claim due to the material non-disclosure. The consumer had been under the impression that his disclosure had been sufficient.

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Q6. *Do consumers understand the potential consequences of breaching the duty of disclosure?*

We find that consumers rarely understand the potential impact of their failure to disclose. The effects of non-disclosure are usually described in an insurer's product disclosure statement or policy wording. However, these documents are often long and difficult to digest. We find consumers rarely read the disclosure statements thoroughly, and usually *do* not understand the consequences of non-disclosure.

Q7. *Does the consumer always know more about their own risks than the insurer? In what circumstances might they not? How might advances in technology affect this?*

Although consumers will have more knowledge about their individual circumstances, they usually have little understanding about what details will be relevant *to* the insurer. We consider it is better for the insurer to be responsible for asking for all relevant information, rather than the consumer bearing sole responsibility for

making full disclosure. Please refer to our answer to question 5 (above) for more detail.

Q8. *Are there examples where a breach of the duty of disclosure has led to disproportionate consequences for the consumer? Please give specific examples if you are aware of them.*

We find that breaches of disclosure requirements often lead to disproportionately harsh consequences for consumers. For examples, please refer to the following case notes.

Case notes

"I never said I'd pay for it, I thought you did!" (p 22): A 78 year-old consumer took out travel insurance before a holiday in the US. Before purchasing the policy, the consumer disclosed that she had high blood pressure, and had been treated for heart problems in the past. The insurer asked a number of follow-up questions, including whether the consumer had ever suffered from angina. The consumer incorrectly said she had not, as she thought her past heart problems were caused by high blood pressure. While in the US, the consumer suffered from a tight chest, and had to undergo treatment for angina, at a cost of US $50,000. Due to the consumer's incorrect disclosure, the claim was declined, and the consumer was forced to bear the $50,000 cost.

"Whose responsibility is disclosure when an adviser (or another intermediary) is involved?" (p 25): A consumer was hit in the head by a cricket ball during a game of indoor cricket, causing post-concussion syndrome which left him unable to work. The consumer made a claim to his income protection insurer, but the claim was declined in its entirety, as the consumer had failed to adequately disclose a history of mental illness and alcohol abuse. The injury was likely unrelated to the non-disclosure, and the non-disclosure was likely innocent, but the claim was still declined, and the consumer's policy was cancelled.

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Q9. *Should unintentional non-disclosure (i.e. a mistake or ignorance) be treated differently from intentional non-disclosure (i.e. fraud)? If so, how could this practically be done?*

Yes. If, as we suggest, an insurer is prevented from cancelling a policy due to an innocent non-disclosure, there must be a distinction between innocent and fraudulent non-disclosure. If an insurer cannot cancel a policy following deliberate non-disclosure, this creates a perverse incentive for consumers to deliberately and consistently withhold information from their insurer. Further, we do not consider cancellation of a policy is a disproportionately harsh consequence where a consumer *deliberately* chooses not to disclose relevant information to their insurer.

We consider the Australian legislation deals with the distinction between innocent and fraudulent non-disclosure appropriately. Where an insured makes an innocent non-disclosure, the Australian legislation only allows the insurer to cancel the insurance contract where the undisclosed information would have caused the insurer to reject the risk entirely. In the case of a deliberate or fraudulent non-disclosure, the Australian legislation allows the insurer to cancel the policy, except where the deliberate non-disclosure is insignificant, and non-payment would be a disproportionate response. We consider this approach is fair and reasonable.

Q10. *Should the remedy available to the insurer be more proportionate to the harm suffered by the insurer?*

Yes. For the insured to fully comply with their disclosure requirements, currently they need an understanding of fairly arcane legal concepts, and a full knowledge of the risks which a 'prudent insurer' would consider relevant. These are subjects which an insurer is in a far better position to assess and understand than a consumer. Accordingly, it makes sense to place an onus on the insurer to prompt disclosure, and to request any information they may reasonably require.

Accordingly, we are of the view that New Zealand should consider adopting the restrictions on the duty of disclosure in place in the United Kingdom. Placing a legal onus on the insurer to request information and to ask specific questions of the consumer will help to minimise innocent non-disclosure, and prevent the unreasonably harsh consequences of non-disclosure for many consumers.

We also consider an insurer's remedies for innocent non-disclosure should be restricted. The current legislation, which allows an insurer to cancel a contract for innocent non-disclosure, can often lead to extremely harsh and disproportionate outcomes for consumers. For examples and further detail, please refer to Q8 above. New Zealand should consider adopting the Australian approach to remedies for non-disclosure. An insurer should not be able to reject a claim or cancel a policy for innocent non-disclosure, unless the innocent non-disclosure would have caused the insurer to reject the risk at the time of contract formation.

We consider it important, if the Australian approach is adopted, that the onus should be on the insurer to prove that it would have rejected a risk at the time of contract formation if the insurer wishes to cancel a contract. If an insurer wishes to cancel a contract it should be able to prove to the satisfaction of a court or dispute resolution scheme that it would never have accepted the relevant risk had the relevant information been disclosed.

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Q11. *Should non-disclosure be treated any differently from misrepresentation?*

No. We do not consider there needs to be any distinction between non-disclosure and misrepresentation. We think a distinction between deliberate and innocent non-disclosure would adequately respond to the differences between non-disclosure and misrepresentation.

2. Conduct and supervision

Paragraph 71.

We question where MBIE sourced the figures listed in this paragraph. You have said that of the complaints against insurers in 2016, only 14 were upheld. This may be the total number of complaints formally upheld, but we do not think this represents the number of complaints resolved in the consumer's favour. If FSCL issues an initial, informal view, we find insurers will often agree with the view, and accept a settlement of the complaint. This will often mean the complaint is resolved entirely or partially in the consumer's favour, even if the complaint is not formally upheld. In the year ended 30 June 2018, FSCL investigated 108 complaints relating to insurance, and 38% of complaints were upheld, partly upheld, or settled.

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

We often find that after a claim is made, an insurer will immediately turn to the exclusion clauses in a contract. If an exclusion clause applies, the insurer stops its investigation, without first considering whether the insuring clause applies. This can lead to frustration for consumers if they spend time and effort disputing the application of the exclusion clause, only to discover later that they do not qualify under the base insuring clause. The reverse is also true - where an insurer discovers an insured does not meet an insuring clause, they will often not consider whether any exclusions apply. A more comprehensive assessment, combined with a clear articulation of the insurer's reasons for declining a claim, could avoid stress for consumers and reduce complaints.

We acknowledge that this is a problem which may be difficult to address through regulation.

Case notes

Is an unforeseen pregnancy unforeseeable? (p 27): Shortly before a planned trip to Africa, a consumer discovered she was (unexpectedly) pregnant. She was advised not to travel due to the risk of contracting the Zika virus, which could affect the unborn child. Her travel insurer declined her claim for cancellation costs, saying the policy excluded claims for pregnancy or childbirth. The consumer, of her own volition, correctly argued that the claim did not fall under the exclusion, as the claim was for cancellation costs, not for pregnancy or childbirth. The insurer responded that, even so, the claim did not meet the insuring clause, as the pregnancy was not objectively unforeseen or unforeseeable. FSCL did not accept this argument, because the insurer had written in correspondence to the consumer that the pregnancy was both unforeseen and unforeseeable. Although the claim was eventually paid, having to deal with these multiple arguments was a protracted and frustrating experience for the consumer.

One man's variation is another man's vandalism (p 29): A consumer had insurance cover for their tenanted commercial property. When the consumer examined the property at the expiry of the lease, they discovered the tenants had made extensive unauthorised additions to the building, including kitchen alterations, installation of a leaky vent in the roof, and a mezzanine floor for the purposes of cultivating illegal drugs. When the insurer made a claim for the cost of repairs to the insurer, the insurer took an unfairly narrow view of the policy wording. The insurer decided the repairs were not covered, as the alterations had not adversely affected the value of the property. FSCL overturned the decision, holding that the alterations did, in fact, damage the property, and the consumer was entitled to have the alterations repaired. The insurer's adoption of an unnecessarily narrow definition, and its refusal to take a common-sense approach, caused unnecessary inconvenience and delay for the consumer.

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Q18. *What has your experience been of the claims handling process? Please comment particularly on:*

- *timeliness the information from the claims handler about:*
  - *timeframes and updates on timeframes*
  - *reasons for declining the claim (if relevant)*
  - *how you can complain if declined*
- *The handling of complaints (if relevant)*

Delay can be an issue for insurers' internal complaints processes ("ICPs"). Insurers often have a two-stage ICP, involving two separate and lengthy assessments of each complaint. Further, the two-stage ICP process is usually only started once a claim has been through a claims assessment process, and has been declined. We find it can be frustrating for consumers to undergo three time-consuming internal processes, before their complaint can progress to an external dispute resolution process or to

the courts. We also find that the decisions of the second or third tier internal complaints process is unlikely to change from the insurer's initial claim declinature, making the lengthy process stressful for the consumer.

We recommend that stricter time limits be put in place for complaints and claims handling. We also recommend that insurers should provide no more than a two-level level internal complaints process.

Case notes

How long is too long to repair a flooded building? (p 31): A consumer owned a cafe in a small town, which was flooded in June 2015. The consumer held material damage and business interruption insurance. The insurer took responsibility for the repairs, which were not completed until a year and a half later. In the meantime, the consumer's business interruption insurance had lapsed, as it was only for a period of 12 months. FSCL found that the insurer had failed to adequately communicate with the consumer, leading to a breakdown in communications, and drawing out the repairs process.

Insured wants compensation for insurer's breach of its policy duty (p 34): A tenant leased premises from the insured. The premises was damaged in the 2010 Christchurch earthquakes, although the damage was not discovered until June 2011. In June 2011, the insured made a claim to their material damage insurer. The insurer's claims assessment took nearly 2 years, and repairs did not begin until November 2013. The tenant, worried the repairs would interfere with his business, cancelled their lease of the premises. The insured made a complaint against the insurer, saying if the insurer had performed the repairs in a reasonable timeframe, the lease would not have been cancelled, and they would still be receiving the rental income. FSCL upheld the insured's complaint, and awarded $12,000 in lost rental income and $7,000 in legal costs to the landlord.

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Q21. *What evidence is there of insurers or insurance intermediaries mis-selling unsuitable insurance products in New Zealand.*

We find issues arising with replacement insurance. In some cases we have investigated, an insurance adviser will recommend a consumer moves to a new insurer, usually based on the new insurer's lower premiums. If the adviser does not make enough inquiries about the consumer's position, or if the adviser does not perform a thorough risk comparison between the old and the new insurer, the new policy can lead to a significant decrease in the consumer's potential cover. This is because the consumer may develop an injury or illness which may have been covered by the consumer's original policy, but will be excluded under the new policy. If the injury or illness is not properly disclosed, the consumer will only realise their coverage is reduced after their original policy is cancelled.

We also see examples of travel insurance that comes as a benefit with a bank's credit card, where the travel insurance is not fit for purpose or has more restrictive cover than other travel insurance policies. Consumers often give little thought as to whether their credit card travel insurance is suitable for their trip, and due to the automatic nature of the transaction, they will not be prompted to consider whether there are any exclusions which might apply. We consider that banks, who are acting in a similar role to an intermediary, could do more to remind their customers of the limits that apply to travel insurance offered with a credit card.

Case notes

Having to sit down during the stand down (p 36): A consumer approached his insurance adviser about reducing his premiums on his life insurance. The adviser found a similar product for a lower premium. The consumer made full disclosure to the new insurer, however, the new policy included a 90-day stand down period - the policy would exclude any claims relating to symptoms arising during the stand down period. The consumer cancelled their old policy and entered into a contract with the new insurer. Unfortunately, 60 days into the stand down period, the consumer experienced tightness in his chest, breathlessness, and dizziness. He was diagnosed with cardiomyopathy, and was hospitalised. The claim would have entitled the consumer to a pay-out of $55,000 under his accelerated trauma policy, except the symptoms had arisen in the stand down period. This loss could have been avoided, if the adviser had advised the consumer not to cancel his old insurance until the stand down period had expired.

Ch-ch-ch-ch-changes (p 38): On the advice of her insurance adviser, a consumer switched insurers, largely based on lower premiums. The consumer had previous abnormal cervical smears, and her original insurance excluded cover for treatments related to abnormal cervical smears. The new insurance policy contained a much broader exclusion, which excluded any issues relating to the 'Female Genital Tract'. A year and a half later, the consumer was diagnosed with endometriosis, and the costs of her treatment were declined by the insurer. FSCL arranged a settlement with the insurance adviser, but expressed concerns that the consumer had not been properly advised on the differences between the policies.

Around the world in 35 ... 37 days (p 40): A couple planned a 37-day trip to Rome. The consumer used their credit card to purchase the flights, triggering their credit card insurance. However, the credit card insurance only covered trips up to 35 days in length. When one of the consumers was injured, and had to cancel the trip, their claim to the insurer was declined.

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Q22. *Are sales incentives causing poor outcomes for purchasers of insurance? Please provide examples if possible.*

We do consider there is a serious risk that sales incentives contribute to poor outcomes for consumers. Financial advisers earn higher commissions by switching consumers to new policies, compared to consumers staying with an existing policy. This may result in advisers being incentivised to switch consumers to new insurers, regardless of whether a new policy will be in the consumer's best interests. We are of the view that all commissions, including soft commissions, and brokerage earned should be clearly disclosed to consumers.

It is difficult for us to provide specific examples of the effect of sales incentives, as during our investigations, we do not generally request information about the commissions paid to advisers. However, please refer to the case notes under Q21 (above), for examples of poor advice regarding replacement policies. While we cannot confirm that these examples were the result of sales incentives, they are good examples of the outcomes which inappropriate sales incentives can promote.

3. Unfair contract terms exceptions in the Fair Trading Act 1986

Q24. *Are you aware of instances where the current exceptions for insurance contracts from the unfair contract terms provisions under the Fair Trading Act are causing problems for consumers? if so, please give examples.*

We do not consider the current exceptions to the Fair Trading Act (FTA) are causing any significant issues (subject to the exception we discuss at Q25, below). Insurance contracts necessarily need to distinguish between categories of consumers, in order for insurers to be able to effectively manage their risk. These distinctions (such as distinctions based on age or gender) might be unfair in other contracts, but they are necessary for the effective functioning of the insurance industry. We consider the FTA exception for insurance contracts is reasonable.

Q25. *More generally, are there terms in insurance contracts that you consider to be unfair? If so, why do you consider them to be unfair?*

We raise an issue concerning a common clause in travel insurance policies which excludes all losses caused by mental health issues. We understand these clauses are usually included due to the difficulty of conclusively proving a mental illness. It is also difficult to prove a mental illness has caused a consumer to suffer a loss, or that a mental illness has left a consumer unable to continue their travel. However, we have found that these broad exclusion clauses can exclude very legitimate claims, and as was found in *Ingram v QBE Insurance (Australia) Ltd* [2015] VCAT 1936, the exclusions are not usually supported by actuarial data. With the growing recognition

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of mental health issues as serious illnesses, we consider it is unfair that travel insurers should be allowed to exclude all mental health-related claims, at least without statistical proofthat the exclusions are necessary to manage the insurer's risk.

Case notes

Why is my insurance punishing me for being a good mother? (p 41): A couple purchased a trip to Australia. Shortly before they were due to depart, their 21 year-old son suffered a large cut to his head while drinking. After the accident, the son was very despondent and anxious, and refused to talk about what had happened. The son was tentatively (though not formally) diagnosed with depression. The couple cancelled their trip, and made a claim to their insurer. The insurer declined the claim, as the policy had a blanket exclusion for any claims relating to anxiety or depression.

Unexpected tragedy (p 43): A consumer had to curtail her trip to Australia when her brother committed suicide. Her claim to her travel insurer was declined, due to an exclusion for any claims arising out of suicide. FSCL held that the insurer was entitled to decline the claim, but noted that this may be an appropriate issue for the Human Rights Commission to address.

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4. Exclusions that have no causal link to Joss

Q40. *Do you consider the operation of section 11 of the Insurance Law Reform Act 1977 {ILRA) to be problematic? if so, why and what has been the consequence of this?*

We do not consider the operation of section 11 is problematic. We appreciate the section makes it difficult for insurers to manage their risk. However, we find the section operates *to* provide fair outcomes in individual circumstances. Restricting section 11 may allow insurers *to* charge lower premiums, but we do not think the benefit of lower premiums outweighs the very harsh consequences for consumers should s 11 not apply. Ins 11 cases, the error on the part of the consumer is usually minor (eg driving with the wrong licence), while the costs are large (eg vehicle repair costs or medical bills).

For examples where we consider section 11 has provided a fair outcome, please refer to the case notes below.

Case notes

Going downhill fast (p 44): A consumer was riding a motorcycle in Thailand when his brakes failed. The consumer saw a grassy field on the side of the road, and decided it was the safest place to stop the out-of-control bike. When the consumer drove the bike into the field, he was able to jump clear of the bike, but fell and hit his head on a rock hidden in the grass. The consumer was hospitalised with minor brain damage, incurring over $20,000 in medical expenses. The consumer's insurer declined a claim for the expenses, as the consumer's policy excluded any injuries sustained while driving a motorcycle over 200cc (the consumer's bike was 250cc) or without a valid licence (the consumer did not hold an NZ or Thai motorcycle licence). FSCL founds 11 applied, as the consumer was not travelling at an excessive speed when the brakes failed (so the size of the engine did not contribute to the crash), and the consumer was an experienced motor-cross rider (so the lack of a valid licence did not contribute to the crash). Neither of the excluded circumstances caused or contributed to the crash, sos 11 applied, and the insurer could not rely on the exclusions.

"A suspended claim" (p 47): A consumer had her partner drive her home from the airport in the consumer's car. The consumer did not realise her partner's licence had been suspended 4 years ago, so he would be excluded from the consumer's motor vehicle insurance policy. On the way home, a third party crashed into the car. The consumer's partner was not at fault in the accident. FSCL found that the partner's licence suspension did not cause the crash, sos 11 applied, and the insurer could not rely on the exclusion.

"What if I'm breaking the rules when I crash, but breaking those rules didn't cause the crash?" (p 49): A consumer crashed his car while driving in heavy rain. One of the conditions of the consumer's drivers licence was that he must be accompanied by a supervisor while driving, but he was not accompanied by a consumer at the time of the crash. The consumer's motor vehicle insurance policy excluded claims where the insured was not complying with the conditions of their licence, so the insurer declined his claim for the damage to the vehicle. In this case FSCL decided that s11 applied, and the insurer could not rely on the exclusion, as a supervisor's presence in the car would likely not have prevented the crash. The cause of the crash was the extremely poor road conditions, not the lack of a supervisor.

Thank you for the opportunity to make a submission. If you have any questions about our submissions, please contact us.

Yours sincerely

s 9(2)(a)

Susan Taylor
Chief Executive Officer

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