

## MIS- OR NON-DISCLOSURE : RECONSTRUCTING THE POLICY\*

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### Stating the problem

A life insured obtains a whole life policy with disability cover. What he failed to disclose at the time of his application for insurance was that he had previously consulted a psychiatrist on three separate occasions for major depression. He is subsequently badly injured in a motor vehicle accident in circumstances that had nothing to do with his depression. The insurer nevertheless declines his claim and rescinds the contract but, having done so, acknowledges to our office pursuant to a complaint by the life insured, that had it been informed about the depression at the time, it would have offered cover but not at standard rates.

Is that approach fair to the complainant?

Before looking at the problem in particular it is necessary to say something about non-disclosure in general.

\* This article appeared in the November 2006 issue of COVER (Volume 20 Number 6) 26-32 with the following editorial comment at p1,

*“Judge Nienaber and Professor Reinecke wrote a paper for COVER on miss- and non-disclosure. A large number of cases reported to the Ombudsman relate to non-payment of claims due to non-disclosure. One of the ways to start changing the image of the industry and regaining trust, is to manage the expectations of clients. Clear principles on dealing with non- and mis-disclosure will go a long way to ensuring that clients have certainty about the effects of their disclosure or lack thereof. It is interesting to see how Nienaber and Reinecke apply their test to determine whether it would be appropriate to rescind a contract or to apply a different remedy, such as a pro rate adjustment of the benefit.*

*I look forward to receiving comments from readers on the above two very important aspects affecting both the long- and short-term industry”*

and p32,

*“The above article is rather longer than we usually run, but due to its nature we found it important to publish for readers’ information. We omitted the cross references, and if any reader would like the article with all cross-references, please email your query to [andrew@cover.co.za](mailto:andrew@cover.co.za)”.*

### **Non-disclosure in general**

Insurance being a contract of chance, insurers need as much information as possible to assess the risk they are asked to assume. Hence applicants are usually required to answer a series of questions on the circumstances pertaining to the risk. These questions must naturally be correctly answered. Moreover, since the facts affecting risk are more often than not within the peculiar knowledge of the proposer for insurance, the law imposes a special duty on them to disclose material facts known to them.<sup>1</sup> Proposers for insurance are not always fully appreciative of the fact that they are subject to the duty to volunteer all the pertinent information of which they are aware and that it is not enough simply to respond literally to the questions asked by the insurer. The information may relate to their medical condition, their occupation, their lifestyle or to any other circumstance that may be relevant to an assessment of the risk. In this respect there is no difference in principle between a false answer and a failure to answer. A false answer is a mis-disclosure; a failure to answer is a non-disclosure. A non-disclosure is thus a false statement by default. Both are misrepresentations.<sup>2</sup> This is one instance where honesty, not being a complete defence, is not necessarily the best policy.<sup>3</sup> Mere failure to disclose material information cannot of course be equated to fraud on the part of the applicant although some insurers appear to

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<sup>1</sup> This has sometimes been said to be a manifestation of the “duty of utmost good faith” but after the decision in *Mutual and Federal Insurance Co Ltd v Oudtshoorn Municipality* 1985 1 SA 419 (A) 433 “utmost good faith” can no longer be said to be the rationale for the doctrine of non-disclosure. The duty of disclosure is not peculiar to insurance law but is subsumed in the general “duty to speak” in circumstances where it would be inimical to the conventions and convictions of the community to remain silent. See, in general, on the “duty to speak”: Christie, *The Law of Contract*, 5<sup>th</sup> ed 276 et seq; Reinecke et al, *General Principles of Insurance Law* par 175, 193.

<sup>2</sup> Reinecke et al op cit par 192.

<sup>3</sup> It is a matter for debate whether the doctrine of non-disclosure requires reconsideration. See, for instance, the incisive remarks by Van Niekerk *Goodbye to the Duty of Disclosure in Insurance Law* (2005) SA Merc LJ 150-159, and 323-339.

think so.<sup>4</sup> As far as the Office of the Ombudsman for Long-term Insurance is concerned mis- or non-disclosure is the major cause for avoiding contracts of insurance<sup>5</sup>.

### **Causal and incidental misrepresentation**

A proposed contract of insurance may conceivably be adversely affected by an applicant's mis- or non-disclosure in one of two ways. In serious cases the effect of the mis- or non-disclosure might be that the insurer would not have entered into the contract at all had it known the true facts. This is sometimes referred to as *causal* misrepresentation. In less serious cases of mis- or non-disclosure, as in the case described in the opening paragraph, the insurer may still have entered into the contract but on terms different to those on which the parties in fact agreed. Such instances of misrepresentation are usually referred to as *incidental* misrepresentations.

### **Materiality**

Section 59(1)(b) of the *Long-term Insurance Act 52 of 1998* (as amended) ("the Act") makes provision for certain remedies for an insurer which had been misled by a false representation.

Section 59(1) (a) of the Act provides:

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<sup>4</sup> Fraud is not an element of the defence of non-disclosure; it would be an additional cause of action for a claim for damages. See further the paragraph below on "Pre-contractual fraud".

<sup>5</sup> 225 out of a total of 4853 cases finalised in 2004 (5%) were non-disclosure complaints; the corresponding figures for 2005 are 203 out of a total of 5478, i.e. 3%.

*“Notwithstanding anything to the contrary contained in a long-term policy, whether entered into before or after the commencement of this Act, but subject to subsection (2)-*

- (i) the policy shall not be invalidated;*
- (ii) the obligation of the long-term insurer thereunder shall not be excluded or limited: and*
- (iii) the obligations of the policyholder shall not be increased, on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless that representation or non-disclosure is such as to be likely to have materially affected the assessment of the risk under the policy concerned at the time of its issue or at the time of any variation thereof.”*

Section 59(1)(b) of the Act elaborates on the last four lines of Section 59

(1) (a):

*“The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk.”*

To be actionable the non-disclosure must be material. To be material it must, as a matter of probability, affect the assessment of the risk. It is the underwriter who assesses the risk. But there is this qualification: non-disclosure, whether embellished as a warranty or not, will not be actionable if a reasonable prudent person would not have disclosed the non-disclosed information. But who is the “reasonable prudent person”? Is it the reasonable person standing in the shoes of the underwriter – as in jurisdictions such as the UK or New Zealand? Or is it a reasonable person standing in the shoes of the proposer? That is the situation in Australia. In South Africa there is no case law directly in point as to the interpretation of the sub-section. It

distinguishes conceptually between “a reasonable prudent person” and “the insurer”. Our office has accordingly interpreted this to mean that the reasonable prudent person is neither the actual applicant nor the actual underwriter but a hypothetical person standing in the shoes of the insurance proposer with the knowledge and appreciation that such a reasonable person would possess of the factors an underwriter would take into account in assessing the risk.<sup>6</sup>

In effect it is an integrated qualified objective test which boils down to the common knowledge and common sense of the common consumer as to what he believes an underwriter would regard as crucial to the assessment of the risk.

This is admittedly a somewhat contorted and convoluted test which is designed to be more generous to the insured than the postulate of a reasonable underwriter. It would exclude matters that the insurer might regard as important (e.g. underwriting or actuarial considerations and pricing policies) but that the insured would not consider to be immediately relevant.<sup>7</sup>

### **The modification of the duty of disclosure**

The duty of disclosure is *displaced* when no questions are asked of the prospective policyholder and no underwriting occurs (as, for instance, in the

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<sup>6</sup> Cf Reinecke et al op cit para 199 200 570.

<sup>7</sup> So, for example, a visit to a neurologist because of severe headaches should normally be disclosed whereas a visit to a gynaecologist for a routine check-up need not be disclosed even if, in both instances, the results were negative at the time but the claim was afterwards made for a stroke or cervical cancer, as the case may be.

case of group risk policies and direct and across-the-counter marketing of less sophisticated types of insurance, such as funeral policies).

Insurers protect themselves amongst other things by inserting waiting periods and exclusion clauses. So, for example, in a funeral policy, a claim in respect of death for natural causes can be made subject to a six month waiting period whereas a claim in respect of accidental death could be excluded if it was self-inflicted.

In the case of an exclusion clause (unlike in the case of non-disclosure) a causal connection must be established between the excluded circumstance (e.g. a medical condition or suicide) and the insured event (death or disability).

The reason is clear: non-disclosure is directed at the conclusion of the contract; an exclusion clause is directed at limiting the extent of cover. Any material non-disclosure should therefore entitle the insurer to rescind the entire contract, regardless of the factual cause for the claim being made. In the case of an exclusion the onus would, however, rest on the insurer to establish that the claim made was excluded by the exclusion clause – hence that there was a causal link between the factual cause for the claim and the event that was excluded.

The duty of disclosure may be *curtailed* when specific questions are asked of the proposer. Specific questions may imply, not as a matter of law but as a matter of fact, a waiver of disclosures falling outside the scope of the

questions posed. The issue in each case would be whether a specific question refines or nullifies the duty of disclosure.

A similar situation arises when the proposer, in answering questions posed, leaves questions blank or incomplete or furnishes patently inadequate responses and the insurer fails to react thereto in issuing the policy concerned. In those circumstances a waiver of the required information may be implied.<sup>8</sup>

### **Rescission : an all or nothing approach?**

The usual remedy for mis- or non-disclosure is rescission. Rescission is available not only when the insured committed fraud<sup>9</sup> but also where the mis- or non-disclosure was negligently or even innocently made. A fraudulent mis- or non-disclosure can, in addition, give rise to a claim for damages but in the context of insurance a claim for damages would be exceptional.

To revert to the problem stated in the opening paragraph: is an insurer entitled to rescind a contract even though, as a matter of probability, it would still have entered into the agreement with the insured albeit on terms less favourable to the insured?

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<sup>8</sup>Poor underwriting at contract stage encourages what is sometimes described as "underwriting at claim's stage". Some insurers, anxious to generate additional business, are sometimes inclined to issue policies without meticulous underwriting at the time. When there is no claim, well and good. But if there is a claim the claimant's pre-policy history is then vigorously investigated with a view to discovering a cause for disputing liability on the grounds of non-disclosure. Better underwriting would minimise the opportunity for contriving an escape from liability on this basis.

<sup>9</sup> See the paragraph below on "Pre-contractual fraud".

There can be no doubt that an incidental misrepresentation can be material for “[i]t has always been taken for granted ...that the enquiry into materiality normally covers both the innate acceptability of the risk and its bearing on the calculation of the premium”<sup>10</sup> But should the extreme remedy of rescission not be restricted to the more extreme instances of causal misrepresentation?

This question, which is not peculiar to insurance contracts but can arise with other types of contract such as a sale, has as yet not been squarely faced in our case law. The main argument raised against permitting rescission in cases of incidental misrepresentation is that rescission would leave the innocent party, the insurer, in a better position than that in which he would have been had he not been misled. In that event he would still have been liable in terms of his contract, regardless of the misrepresentation. Such a result would be contrary to the avowed purpose of the remedies for misrepresentation, namely to put the innocent party in the same but not a better position than the position he would otherwise have occupied. The insurer should after all not derive a benefit from the insured's misrepresentation.

A counter-argument in favour of the innocent insurer, is that an insurer which had been misled by the insured may rightly not be anxious to remain locked in an ongoing contractual relationship albeit on more favourable terms.<sup>11</sup>

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<sup>10</sup> *Pillay v South African Life Assurance Co Ltd*, 1991 1 SA 363 (D) 370 per Didcott J.

<sup>11</sup> This argument is perhaps more appropriate in cases of fraud. See the paragraph below on “Pre-contractual fraud”.

### **The Pillay case**

The question of how one should address the consequences of incidental misrepresentation inducing a contract of long-term insurance, was touched upon in the case *Pillay v South African Life Assurance Co Ltd* supra. The insured committed a breach of warranty by not supplying correct answers to certain questions in the proposal form. From the evidence it appeared that had the insurer not been misled, it would still have accepted the risk but at a higher premium. Didcott J opined that in these circumstances the cancellation of the contract in toto would be unjust. According to him the insurer should be restricted to recovering the additional premiums it would have charged had it not been misled.

The Court in *Pillay* had to deal with a breach of warranty. Provided a warranty pertained to a material fact, an insurer was entitled, as the law then stood<sup>12</sup> to cancel the contract in the event of a breach of warranty. The Court in *Pillay's* case therefore had no option but to uphold the insurer's reliance on the breach of warranty but it nevertheless recommended that the law should be reformed to prevent an insurer from cancelling the contract on the grounds of an incidental misrepresentation, whether warranted or not.

### **The problem of proof**

An objection sometimes voiced to what may be termed the *Didcott* principle is that it cannot be postulated that a contract would necessarily have ensued on the alleged different terms. This, however, is a matter for evidence and the probabilities. By way of analogy the Appellate Division had no difficulty, where an applicant sought compensation (though not rescission) on the grounds of

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<sup>12</sup> See now section 59 (1) (b) of the Act, quoted above.

fraudulent misrepresentation inducing a sale, to assess the damages with reference to the difference between what the party misled paid and the amount he would have paid had he not been misled.<sup>13</sup>

The difficulty to prove whether a contract would have ensued in the absence of the misrepresentation is therefore not insurmountable. Thus if the premium the insurer would have charged had it been correctly informed would have been market related and not excessive, it can fairly be assumed that a contract would have resulted on those terms. The insured after all experienced a need for such cover and he selected the particular insurer to provide this cover.

### **Pre-contractual Fraud**

Should similar reasoning apply where the mis- or non-disclosure was fraudulent?<sup>14</sup>

The law frowns on fraud and will always be reluctant to come to the assistance of fraudsters. Moreover, the nature, severity and extent of the fraud may be such as to justify an insurer in distancing itself, for the future, from an insured who is shown to have defrauded it in the past. Fraud, like acid, is likely to corrode any relationship, be it personal, professional or commercial.

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<sup>13</sup> See, for instance, *Ranger v Wykerd* 1977 2 SA 976 (A).

<sup>14</sup> Fraud occurs when mis- or non-disclosure is knowingly or recklessly made to mislead the insurer. As such it can be a form of anti-selection where insurance is taken out in the confident expectation that the event insured against is about to happen and that the deceit, on the happening of the event, will either not be discovered or will not readily be capable of proof.

The point of departure is therefore that an insurer will not be required to countenance and accommodate fraud by the insured, if established.

The practical difficulty, however, is that a mere allegation or suspicion of fraud will not suffice. To pre-empt a reconstruction of the policy on the basis discussed above it would be necessary for the insurer to prove fraud on a balance of probabilities.<sup>15</sup>

### **Other jurisdictions**

The view that an insurer may freely rescind a contract in the case of incidental misrepresentation is not universally favoured. One solution is the *causation approach* followed in German law. According to this approach the misrepresentation is irrelevant if the incorrect information had no influence on the eventual loss. Thus if an applicant non-disclosed his condition of cancer but he eventually dies in a motor vehicle accident the insurer cannot avoid liability. This approach produces the same result as an exclusion from the risk and it would probably find favour with most insured.

Another approach is the French *proportionality approach* in terms of which the insured may claim pro rata to the premium he paid. The insurer must therefore pay to the insured the proportion of the proved claim which the actual premium bears to the premium it would have charged.<sup>16</sup>

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<sup>15</sup> See, too footnote 17 below.

<sup>16</sup> Section 59 (2) of the Long-term Insurance Act 52 of 1998, dealing with a misstatement as to the age of the insured, is based on precisely this principle.

The Australian *Insurance Contracts Act* 1984 (as amended) is a prime example of the proportionality approach. The test for non-disclosure is that of the reasonable insured (as opposed to the reasonable underwriter) which is basically the same test as our own. But the remedy for non-disclosure is more flexible than our own. The insurer is not given the right to avoid the contract where the non-disclosure, if revealed at the time, would not have prevented the conclusion of the contract albeit on different terms. In those circumstances, depending on the nature of the contract, the insured's claim or benefit is proportionately reduced.

Separate provision is made where the mis- or non-disclosure was fraudulent.<sup>17</sup>

### **The experience of the office**

Several of the major insurers in South Africa of their own accord adopt an approach in line with the *Didcott* principle. Thus in a recent complaint the insured failed to disclose that he had suffered from a venereal disease. The insured died when he was assaulted. The insurer eventually offered to pay the death claim but it deducted from the proceeds an amount to allow for a 100% loading of the premium. This represented the premium it would have charged

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<sup>17</sup>The Act allows the courts to temper the strict application of the general approach that a contract may always be avoided if fraud can be established. In terms of section 31 (1) of the Act a court may, if it would be harsh and unfair not to do so, disregard the avoidance and, if it does so, allow the insured to recover the whole or such part as the court thinks just and equitable in the circumstances of the amount that would have been payable if the contract had not been avoided. In terms of section 31 (2) that power may only be exercised if the court is of the opinion that the insurer has not been prejudiced by the failure or misrepresentation or that the prejudice is minimal or insignificant. Subsection 31 (3) provides that "in exercising the power conferred by subsection (1) the court: (a) shall have regard to the need to deter fraudulent conduct in relation to insurance; and (b) shall weigh the extent of the culpability of the insured in the fraudulent conduct against the magnitude of the loss that would be suffered by the insured if the avoidance were not disregarded; but may also have regard to any other deliberate matter." See too, sections 56 (2) and 56 (3).

had the insured disclosed his disease at the time of the contract. This, in our view, was an eminently fair solution to the problem.

Our office has engaged with the LOA in an attempt to persuade all its members to adopt the proportionately approach as a voluntary industry norm. We shall similarly canvass the FSB and the Law Commission but it would be unrealistic to say that the prospects are favourable for legislative intervention within the foreseeable future along the lines of the Australian model.

### **Conclusion**

A conclusion that rescission of a contract of insurance on the grounds of innocent or negligent misrepresentation (whether by way of mis- or non-disclosure) is available only if the insurer would not have entered into the contract at all, would, we believe, be fair to both parties. Such an approach would be fully justifiable in the exercise of the equity jurisdiction conferred on our office in terms of our Rules. If the insurer would have entered into the contract but on different terms, an appropriate remedy must be made available to address the detrimental consequences of the misrepresentation. Such a remedy may take various forms, for instance to treat the matter as if an exclusion clause had been inserted in the contract, with a pro rata adjustment of the benefits or a corresponding increase in the premium or some other appropriate measure to balance the position.

We have been able in the past, as an office, to persuade insurers to settle claims in accordance with the above approach and we shall continue to endeavour to do so in the future – but the time may come where a ruling will have to be made if persuasion fails.

