Guidance on claims handling procedures under the Insurance (Conduct of Business) (Long Term Business) Code 2018

1. Introduction

This guidance is issued to supplement the requirements of paragraph 24 of the Insurance (Conduct of Business) (Long Term Business) Code 2018 ("the Code"). It covers the Authority's expectations for the fair treatment of customers in circumstances of non-disclosure or misrepresentation occurring during the insurance application, servicing and claims process.

The Financial Services Authority ("the Authority") issues guidance for various purposes, including to illustrate best practice, to assist regulated entities to comply with legislation and to provide examples or illustrations. This guidance is, by its nature, not law, however it is persuasive. Where a person follows guidance this would tend to indicate compliance with the legislative provisions, and vice versa.

2. General Principles

The Authority expects insurers to ask clear questions about facts they consider material as part of the application and renewal process.

Where an insurer has asked a clear question, it is reasonable to assume that the policyholder realised that the information would be relevant to the insurer.

Insurers should also expect customers to answer such questions carefully, accurately and to the best of their knowledge or belief.

However, customers cannot be expected to provide information that they are not asked for.

3. Categories of Non-Disclosure / Misrepresentation

When considering non-disclosure for the purpose of assessing a claim, the failure of policyholder to disclose material information that an insurer has asked for may be considered under the following groupings:

- Innocent – where it is apparent that the customer has acted honestly and reasonably;
- Negligent – applies in circumstances where a policyholder has failed to exercise reasonable care in providing material information requested by an insurer;
- Deliberate, reckless or without any care – where it is evident, on the balance of probabilities, that a policyholder knew or must have known that the information was

incorrect and relevant to the insurer, or that the policyholder did not care whether it was or not.

4. Assessment of claims

In assessing claims, insurers should -

- rely only on the answers given or withheld;
- consider the circumstances of the non-disclosure or misrepresentation and in particular whether it was deliberate, negligent or innocent as described above. Before making any judgement, the insurer should ask the policyholder why the information was incomplete or incorrect. A credible explanation might indicate to the insurer that the policyholder was not acting deliberately or without care.
- consider whether the information omitted or misrepresented was material to the claim, in that it would have induced the insurer to make a different underwriting decision.

If the customer has a credible explanation and/or there are other credible mitigating circumstances, or if the information omitted or misrepresented was relatively unimportant, consideration should be given to whether a proportionate remedy could be proposed based on what would have happened if the information had been disclosed correctly.

The Authority considers that rejecting or avoiding a policyholder’s claim should be limited to circumstances where the non-disclosure or misrepresentation can be demonstrated to have been deliberate or reckless.