FRAUD & INSURANCE

1 As insurers often tell us, insurance fraud costs us all. The Insurance Council estimates that about 10% of all claims and costs are fraudulent and that it costs the insurance industry approximately two billion dollars each year. Having said that, on an individual case by case basis, whatever the cost to an insurer of paying a fraudulent claim or losing a case involving fraud, it can safely be stated that the consequences of a finding of fraud against an insured are much more significant. The reality of a finding of fraud against an individual is that, not only does he or she lose the benefit sought under the Policy and become liable to pay costs or other sums to an insurer, but the person is tainted on a long term basis. The individual may lose the right to protect himself or herself against the contingencies of life, both on a personal and business level, on a long term basis. Reputational damage is also very high.

2 A very recent example of all of that is *Sharma v Insurance Australia Limited t/as NRMA*[1]. Mr Sharma owned an investment property. It was damaged by fire. The insurer alleged that Mr Sharma organised his friend to start the fire. This was accepted on a hearing in the District Court. Mr Sharma appealed (which is always surprising in a case of this nature because the plaintiff may voluntarily turn a loss into a very big loss). He lost in the Court of Appeal. The next day the case was reported in the Daily Telegraph with some very adverse comments about Mr Sharma. The case against him was built on circumstantial evidence which was accepted by the Court. Prior to the loss Mr Sharma was a successful businessman with no history or record of undertaking such acts. He was well off and could have sold the property. The only motive identified by the insurer was that he could make a claim on an Insurance Policy. The point of his story at this time is that between the time of the fire and the end of the litigation, being the Court of Appeal case, Mr Sharma had gone on to be involved in a number of activities which must involve complete honesty and the trust of the community. Setting fire to his

[1] [2017] NSWCA 307

own investment property for financial gain did not make sense. The reputational damage which Mr Sharma must have suffered as a result of the publicity about his case must have been significant.

3 That is the risk that insureds take if they challenge an insurer's decision to deny a claim on the grounds of fraud. Of course, it must also be said that, particularly having regard to the prevalence of fraud across the spectrum of insurance claims, particularly in the context of statutory claims, it must be that many people consider that the benefit is worth the risk.

What is Fraud?

4 There has been little change in the definition of "fraud" for many years. "Fraud" is a dishonest act or omission with an intention to deceive so as to obtain a material benefit or advantage[2].

5 When an insurer asserts fraud, the onus shifts to the insurer to prove that the claimant was involved in or knew of the fraudulent event or activity. The test to be applied in determining whether an insurer has discharged its onus of proof was conveniently set down by the High Court in *Neat Holdings Pty Limited v Karajan Holdings Pty Limited*[3] as follows:

> "The ordinary standard of proof required of a party who bears the onus in civil litigation in this Country is proof on the balance of probabilities. That remains so even where the matter to be proved involves criminal conduct or fraud. On the other hand, the strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what is sought to prove. Thus, authoritative statements had often been made to the effect that clear or cogent or strict proof is necessary where so serious a matter as fraud is to be found. Statements to the facts should not, however, be understood as directed at the standard of proof. Rather they should be understood as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or

[2] *William Derry v William Henry Peake* (1989) 14 AC 337
[3] (1992) 110 ALR 449

> criminal conduct and a judicial approach of the Court should not lightly make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct. As Dixon J commented in *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362 - the seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description or the gravity of the consequences flowing from the particular finding are considerations which must affect the answer to the question whether the issue has been proved …"

6 Fraud may occur at three times during the transaction:

(i) pre-contractual fraud;

(ii) fraud in the event;

(iii) fraud in the claim.

7 Depending on what is established in terms of fraud, the consequences in respect of the claim and the Policy may be different depending on when the fraud occurs.

8 Pre contractual fraud

9 Pre-contractual fraud, i.e. non-disclosure and misrepresentation, allows the insurer to avoid the contract of insurance, both in respect of a general and life contract (s28(2) and s29(2) ICA).

10 As set out in s28(2) ICA, if the failure to disclose was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract. Contracts of life insurance are governed by s29 ICA. As set out in s29(2), if the failure was fraudulent or the misrepresentation was made fraudulently the insurer may similarly avoid the contract.

11 One of the difficulties for a life insurer is that s29 ICA affords the insurer little by way of remedy in respect of a non-disclosure which occurred more than 3 years prior to the claim, unless that non-disclosure or misrepresentation was fraudulent.

12 It is often difficult to establish that a non-disclosure or representation was fraudulently made. The reality is, an insurer will not succeed until it convinces the Court not to accept the insured. This may be the fundamental issue in all fraud cases. Is the evidence to be adduced by the insurer so compelling that the Court will reject the evidence of the insured? Insurers are often unsuccessful because, despite the insurer having contradictory material from apparently objective honest witnesses, the Court accepts the insured's explanation.

13 In the life context, cases such as *Bottrell v National Mutual Life*[4] and *Muggleston v National Mutual Life Association of Australasia Limited*[5] demonstrate the difficulties in convincing the Court to find that apparently ordinary honest citizens without any sort of dishonest background have deliberately attempted to deceive an insurer. Both those cases involved a failure to disclose pre-existing medical problems. In both cases the Court accepted the insureds' explanations. For example, in *Muggleston* the Court accepted that the insured provided the information to the agent, even though the agent, who was actually a friend of the insured at the time, denied this.

14 These cases should be contrasted with two other cases involving fraudulent non-disclosure in the life insurance field, being *Dr Gregory Moore v National Mutual Life Association of Australasia Limited*[6] and *Hitchens v Zurich Australia Limited*[7].

15 In *Moore*, the plaintiff was a doctor. The only problem was that he had a pethidine abuse habit and he had been deregistered on more than one occasion for incidents involving pethidine abuse. Suffice to say that he managed to talk his way into a job in a hospital in Tasmania. His problem re-emerged and he subsequently made a claim for payment of income protection benefits. In his evidence in the Supreme Court he endeavoured to provide an explanation for his failure to mention any of these earlier problems and issues when completing the application for income protection insurance, essentially

[4] (2007) NSWSC 458
[5] (2004) NSWSC 913
[6] (2011) NSWSC 416
[7] [2015] NSWSC 825

trying to resist the factual propositions being put to him but, having regard to the number of pre-inception inconsistent contemporaneous documents suggesting that that which the plaintiff was suggesting in the witness box would not be true, he failed.

16 In *Hitchens* the Court accepted that the plaintiff had been fraudulent in failing to disclose his complex and longstanding pre-existing medical history. *Hitchens* is unusual in that initially the insurer did not consider that it had sufficient evidence to plead fraud. Only once it obtained that evidence was it prepared to plead fraud. It made an application to amend but its application was resisted on the basis of evidence from his solicitor that on doctors' advice the plaintiff would not be capable of providing any instructions to meet the defence. Perhaps surprisingly, the Court at first instance declined to allow the amendment. On appeal the Court allowed the amendment to be made. As it turns out, Mr Hitchens was quite able to give extensive evidence about why he had failed to disclose only up to about 50 matters that might have required disclosure, mainly relating to his ongoing consumption of Endone and Tramal and the fact that he had been and was in the habit of obtaining prescriptions for those drugs from different doctors, without advising one that he was getting a prescription for the drugs from another. Despite the plaintiff's attempts to rely on waiver and the questions being ambiguous and incomplete answers, Mr Hitchens lost.

17 The evidence of Dr Moore and Mr Hitchens was not accepted by the Court. This is because they were not telling the truth.

18 *Stealth Enterprises v Calliden Insurance*[8] was a non-disclosure case but was not a fraud case. It was not necessary for the insurer to establish that the non-disclosure was fraudulent because it relied on underwriting evidence to the effect that if it had known that the Director and Manager of the brothel were members of the Comancheros it would not have accepted the risk at all. As such, it would have been entitled to rely on s28(3) ICA to reduce its liability to nil. The Court of Appeal did not accept the fundamental premise of the insurer's defence.

[8] 2017 NSWCA 71

19 Pre-inception fraud is often difficult to prove. As set out in s21 ICA, it is necessary for an insurer to establish that the insured knew of a relevant matter and then either that the insured knew it would be relevant to the decision of the insurer whether to accept the risk or a reasonable person in the position of the insured would have known it to be so relevant. In some cases the application form or proposal might be completed by an agent. It might be wrong but, if it has been completed by the agent, then the insured might maintain that the answers given were based on the questions asked by the agent or that the agent paraphrased in some way. It is always more difficult to establish fraud on the part of an insured when an intermediary is involved. It is often necessary to adduce evidence from the intermediary, although most insurance intermediaries would rather not be involved in such a dispute.

20 Fraud in the event

21 The second type of fraud, being fraud in the event, is of course the most common type of fraud. Fraud in the event includes fraudulent motor accident claims, alleging an accident occurred when it did not occur, or alleging that a loss occurred when it did not occur. The most common type of fraud in the event involves first party insurance, in the sense that it involves an insured person fraudulently claiming in respect of a loss which the insured person had caused, i.e. deliberately damaging his or her own property. Fraudulent personal injury claims are reportedly rife but there are in fact not many cases in which fraud is alleged in the personal injury context,.

22 The most common type of fraud in the event is motor vehicle fraud and there are always cases being pursued in the Local Court between insurers and insureds involving motor vehicles. One of the key issues in these types of cases is who bears the onus of proof. There is no doubt that an insurer bears the onus of proving that the insured was guilty of fraud and that the Court will apply the *Briginshaw* standard of proof. However, particularly under defined event Policies there will often be an obligation on the insured to prove that the loss was accidental. The onus does not shift to the insurer to prove that the claim is fraudulent until the insured proves that the loss was caused by the

defined event, e.g. an accidental fire. The benefit to insurers in forcing the insured to prove that the loss was accidental is that in most cases the insured person will need to enter the witness box to do so.

23 Cases such as *Hammoud Bros od v NRMA*[9] and *Simon v NRMA* demonstrate the effectiveness of putting the insured to proof on establishing that the defined event happened. If the Court does not accept the insured as a witness of truth, then it cannot accept that the evident happened as the insured maintains. Irrespective of any evidentiary burden imposed upon the insurer to prove fraud, the insured might simply fail because the Court does not accept its version of events. If may be a fine distinction but it has proved to be successful in a number of cases.

24 However, there has been some controversy on interpretation of defined event Policies and who bears the onus. This was best demonstrated in *McLennan v IAG*[10]. Ms McLennan represented herself for two weeks in District Court proceedings in Orange. She claimed that whilst she was away in the Blue Mountains her house had burned down. The fire had been deliberately lit. She could offer no real explanation as to who might have lit the fire. She did not know. She was not there. She made a claim under her Home and Contents Policy. NRMA denied the claim on the grounds that her claim was fraudulent and further that she bore the onus of proving that the fire was not started deliberately by her or someone she knew. The insurer did not establish that she was fraudulent. However, it did through various means successfully discredit her, in the sense that the Trial Judge did not accept that she was telling the truth. It relied heavily on her refusal to provide Tax Returns and other financial records, despite the requests of the insurer to do so. It might be said that it could have been suggested that if she was properly represented it might have been suggested that Tax Returns could not be relevant to an assessment of the value of a house, they could only go to her credibility and documents that only go to credibility are not discoverable. Be that as it may, the Trial Judge determined that the onus was on Ms McLennan to establish, in effect, who lit the fire because of His Honour's acceptance of the insurer's

[9] 2004NSWCA 1
[10] 2104 NSWCA300

interpretation of its own Policy. The Court of Appeal disagreed. Although there may have been many issues on appeal, the appeal case was determined on the question of onus. The insurer accepted in the Court of Appeal that, if it bore the onus, it had not discharged it.

25 *Sharma* presents as another interesting case in the sense that there were no signs of forced entry, there was no motive and it seemed unlikely that Mr Sharma would have done it. However, the circumstantial evidence presented by the insurer turned out to be persuasive, particularly because Mr Sharma gave evidence and was found not to be truthful in that evidence.

26 There are onus of proof issues in both *McLennan* and *Sharma*. It is always important to consider the terms of the Policy in determining a strategy for a fraud case. It must be remembered that the onus of the insured is only to bring the claim within the insuring clause of the Policy and satisfy the conditions. The insurer must satisfy the factual matters necessary to rely on an exclusion. The task of an insured in a fraud case would not be difficult in a broadform type of coverage such as the very general wording in an ISR Policy. On the other hand, in a Motor Vehicle Policy or Home and Contents Policy coverage will only be available if certain defined circumstances exist. The insurer will not have to establish fraud until such time as the insured discharges its onus.

27 S56 ICA determines the insurer's response to a fraudulent claim. Where a claim under a contract of insurance is made fraudulently, the insurer may not avoid the contract but may refuse payment of the claim.

28 Further, s56(2) provides the Court with a discretion in response to a fraudulent claim. In any proceedings in relation to a fraudulent claim the Court may, if only a minimal or insignificant part of the claim is made fraudulently and non-payment of the remainder of the claim would he harsh or unfair, order the insured to pay in relation to the claim such amount, if any, as is just and equitable in all the circumstances.

29 The discretion must be exercised having regard to the need to deter fraudulent conduct in relation to insurance but the Court may also have regard to any other relevant matter (s56(3)).

30 S56 may be of little relevance in most claims arising out of fraud in the event. If the subject matter of the Policy is destroyed as a result of fraud in the event and a claim is made for payment of the value, then it would not matter whether the insurer can void or merely refuse to pay the claim and s56(2) will not assist the insured.

31 An insurer's remedy in respect of the fraudulent claim is thus to refuse to pay the claim.

32 The remedy for the insured may not be limited merely to the amount payable under the Policy. The refusal to pay a claim is a breach of the contract. The general principle remains that the innocent party is entitled to be put back in the position, as far as money can do it, with respect to damages if the contract has not been performed.

33 All of these cases generally turn on known facts and onus of proof issues. Perhaps one of the more famous cases from some years ago involved the Bankstown Football Club[11]. The Club was damaged as a result of fire. The insurer declined to pay on the grounds of fraud. The insured did not have the capacity to repair independently of payment from the insurer. The Club was boarded up in its damaged state until the hearing. Between the date of the first fire and the hearing there were two subsequent fires in the building leading to the Club being destroyed.

34 At first instance the Supreme Court rejected the insurer's defence of fraud. Whilst there was no challenge to that finding in the Court of Appeal, the case progressed to the Court of Appeal and the High Court on damages and policy related issues. As the insurer had declined to pay the claim on the grounds of fraud, it did not send out the statutory renewal notice pursuant to s58 ICA. This left it exposed to further damage to the property as a result of the two

[11] *Bankstown Football Club Limited v CIC Insurance Limited* (1998) 2 ANZIC 61-406

other fires on the grounds that there was a statutory Policy in place at the time of the further damage. The end result was that, having declined to pay for an approximately $300,000 loss, the insurer ended up exposed to a $3 million Judgment.

Fraud in the Claim

35 This is generally constituted by the provision of false information to the insurer as part of the claim, although not every false statement made as part of the claim would be considered fraud.

36 Examples of fraud in the claim including:

(i) claiming reimbursement in respect of a loss of property which did not exist;

(ii) in some circumstances overstatement of the amount of the loss;

(iii) provision of false information in an attempt to substantiate the loss;

(iv) provision of false information in progress claim forms in seeking payment on an income protection policy.

37 Fraud in the claim was considered in *Brescia v. QBE*[12].

38 The insured's property was destroyed by fire. A claim was made under an ISR policy in respect of property damage and consequential loss of profits. QBE declined indemnity on the basis of a failure to take reasonable precautions and on the basis that the insured's claim for loss of stock and business interruption was fraudulent.

39 Although Brescia pursued a claim, QBE refused to acknowledge indemnity and pay under the policy. At that same time Brescia did not purport to terminate the policy for breach or repudiation by QBE. The Court accepted that the failure by QBE to pay or an unreasonable delay in payment or admission of liability would be a breach of contract and thus that Brescia's claim was for breach of contract.

[12] (2007) NSWSC 598

40 QBE did not suggest that the fire was deliberately lit or that the event was fraudulent. Rather, it merely relied on a breach of condition 14.2 in relation to the failure to take reasonable precautions to prevent damage and s.56(1) ICA in respect of the quantification of the stock losses and business interruption claim.

41 Brescia pursued a claim for stock loss in the sum of $3,900,000. Again, there was no issue that the fire destroyed the stock. QBE maintained that Brescia grossly overstated the value of the stock such that its claim should be considered as fraudulent. If it was a fraudulent claim QBE may refuse to pay the claim it said pursuant to s.56.

42 The Court held that the approach should be:

(i) Brescia must establish the value of the stock as part of its damages claim;

(ii) if the value is less than Brescia's claim for its loss then:

(a) an issue arises as to whether the entirety or the stock loss component of the claim which Brescia makes is a claim made under a contract of insurance within the meaning of s.56;

(b) whether the claim is fraudulent; and

(c) whether the difference is only minimal and insignificant such as to give rise to s.56(2).

43 QBE's defence relied upon a detailed and complex analysis of the accounts and inconsistencies in financial documents. It is not necessary for the purposes of this paper to review the findings except to say that the Court accepted the claim for stock loss in its entirety. Further, it held that even if the stock value had not been established there would be no finding of fraud because the evidence did not establish any fraudulent intent on the part of the principals. Whilst this meant it was not strictly necessary to consider the meaning of s.56, Hammerschlag J commented on the meaning of s.56 in the following terms:

> "It is, however, noteworthy that these proceedings started out life as a claim for a declaration that Brescias were entitled to indemnity. The claim for stock loss is a claim for damages made in proceeding in this Court which was manifestly always going to be the subject of close scrutiny. In my view a claim contemplated by section 56(1) is a claim made extra curially by an insured on an insurer with dishonest intent to induce a false belief in the insurer for the purpose of obtaining payment or some other benefit under the policy. Section 56(2) talks of proceedings in relation to such a claim which, in my view, indicates a distinction between a claim and proceedings in relation to it. The prosecution of the cause of action in these proceedings for damages after refusal by the defendants of indemnity is not, in my view, a claim under an insurance contract for the purpose of section 56(1) of the Act. It follows, in my view, that even if I had found that the stock loss claim was inflated to the knowledge of the Brescia, the defendants would not have had the benefit of section 56(1)."

44 The refusal to pay the claim was a breach of the contract. QBE's fraud defence was unsuccessful. The insured sought damages for consequential loss. QBE relied on the principle[13] that if an insured elects to accept an insurer's wrongful repudiation damages may be awarded in accordance with *Hadley v. Baxendale* but if an insured does not accept the repudiation the contract remains on foot leaving the insured only entitled to cover in accordance with the terms of the policy.

45 Hammerschlag J did not accept that the failure by an insured to terminate the contract based on a repudiation of the insurer precluded payment of any damages over and above the amount payable under the policy. Referring to *CIC Insurance v. Bankstown Football Club* and *Motor Accident Mutual Insurance v. Kelly*[14], His Honour held that the breach by an insurer to meet its obligations to indemnify should be no different to a breach by any other citizens of a contract. Damages are payable and the insured should be put in

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[13] set out in *Russell Young Abalone Pty Limited v. Traders Prudent Insurance Company Limited* (1993) 7 ANZIC 61-182

[14] (1998) 10 ANZIC 61-420

the position that he would have been if the contract had been performed. If the contract remains on foot damages may still be assessed in accordance with the rule in *Hadley v. Baxendale* but on the basis that the contract remains on foot. If the contract is terminated damages are assessed on the basis that the bargain has been lost.

46 This led to a finding that Brescia was entitled to the loss of trading profits suffered by the delay in reopening the building (due to the refusal of QBE to pay the claim).

47 *Brescia v. QBE* dealt with a claim under an ISR policy where the subject matter of the insurance was destroyed. Further, as the Court held that s.56 did not apply to that part of the claim for damages for overvaluation of stock, the Court did not consider s.56(2).

48 In *Entwells Pty Limited v. National & General Insurance Co Limited*[15], Ipp J of the Western Australian Supreme Court found that a stock claim was inflated. Yet he found that the fraudulent part of the claim was relatively small and considered that non-payment of the entire amount of the claim would be harsh and unfair. His Honour applied s.56(2) and indicated that he took into account the need to deter fraudulent conduct as required by the Act. It is not clear how His Honour took this factor into account.

49 The remedy available to an insurer in respect of a fraudulent claim is thus to refuse to pay the claim. The insurer may not avoid the policy and as such the policy remains on foot. In some circumstances the refusal to pay a claim on the grounds of fraud may be a repudiation such as to entitle an insured to elect whether to keep the policy on foot or terminate for breach. In *Brescia v. QBE* Hammerschlag J held that the right to damages for consequential loss was not dependent upon whether the insured elected to terminate the contract. Rather, the wrongful refusal to pay a claim should be treated as an ordinary breach giving rise to damages. If an insured suffered damages over and above the amount payable under the policy and if it is necessary to compensate the insured by way of payment of those damages to restore the

[15] (1991) 6 WAR 68

insured to the position that it would have been if the claim had been paid, then the insured would be entitled to such damages.

50 In the context of life insurance, a refusal to pay a claim, for example, under an income protection policy on the grounds of fraud, may not operate as a repudiation of the contract having regard to decisions such as *Bottrell* and *Green v. AMP Life Limited*, an income protection insurer may face a particularly thorny issue if it refuses to pay based on fraud in the claim. If the Court accepts that such a refusal to pay was a repudiation and the insured elects to accept the repudiation and terminate, then the policy does not remain on foot at the time of the hearing. The insured would be entitled to damages based on the approach set out in *Bottrell* - that is damages equivalent to the amount of benefits that would have been recovered by the insured for the life of the policy.

Conclusion

51 A pleading of fraud has significant consequences for both the insured the insurer. A very high onus is placed on the insurer to establish fraud. The seriousness of the allegations require compelling proof. Mere suspicion and establishing of a motive is insufficient. Most often, fraud cases fail not on the basis that the factual assertions underpinning the allegation of fraud are not established but rather on the basis that the insurer does not establish the requisite intent or recklessness. It will always be difficult to establish fraud when the Court accepts the insured. The key to establishing fraud must be to adduce compelling independent evidence which the Court will have difficulty rejecting. Whether that come from the doctor who told the insured about his pre-existing medical condition (in a life insurance case) or from independent lay persons able to substantiate a version of events inconsistent with the insured’s claim, the key to a successful fraud defence remains being able to convince the Court that the insured should be rejected as a witness of truth.