INSURANCE FRAUD GUIDELINES FOR THE FINANCIAL OMBUDSMAN SERVICE CASES

The Financial Ombudsman Service (FOS) is an independent, impartial dispute resolution organisation. It is regulated under the *Financial Services and Markets Act 2000*[1] and the *Consumer Credit Act 2006*. Rules under these Acts set out the way the FOS should handle complaints about financial services and products. These rules form part of the FSA handbook in the section *Dispute Resolution: Complaints*.[2]

The following briefing summarises discussions between the FOS and insurers in a number of forums. It is intended to provide a guide to FOS thinking on a range of issues, where there have areas of misunderstanding. However, all cases are unique and whilst the guidelines aim to steer behaviour, they should not be regarded as a definitive statement of policy, either from the FOS or from the ABI.

The FOS has reported that most companies meet the standards contained in this note. This note is intended to aid companies who are not familiar with the FOS to achieve a level of industry good practice.

FOS AND THE LAW

The FOS applies the standards and tests that have been laid down by civil and criminal law as they relate to fraud. However, the civil standard of proof 'on the balance of probabilities' applies in FOS cases. The FOS has stressed that it takes a tough stance on fraud. Any proven case of material fraud, whether it is exaggeration of a genuine claim or the invention of a claim, will result in the FOS upholding a decision by an insurer to reject a claim.

In some cases, particularly cases that are likely to require evidence from a third party or where cross-examination would be beneficial in resolving the conflict, the FOS will recommend that the matter be placed before the Courts or will decline to adjudicate.

Case Study

There was a fire claim and evidence of county court judgements and several previous accidental damage claims over a short period of time. The insured's 2 witness statements gave varying accounts of the alleged circumstances.

[1] A complaint is to be determined by reference to what it is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case – s228 (2).
[2] In considering what is fair and reasonable in all circumstances of the case, the ombudsman will take into account all the relevant law, regulations, regulators' rules and guidance and standards, relevant codes of practice and, where appropriate, what he considers to have been good industry practice at the relevant time – DISP 3.8.1(2).

Furthermore, the policy was only incepted 2 days before the fire and there was no previous cover for 3 years. Hearsay evidence was given from neighbours that the insured said he was 'gonna torch the joint.' The insured was evasive in response to the FOS enquiries.

FOS Decision: The complaint was dismissed without considering its merits as the ombudsman 'considered it would be more suitable for the matter to be dealt with by the courts.' There were too many unexplained discrepancies, third party evidence and serious allegations of fraud.

MAKING AN ACCUSATION OF FRAUD

Fraud is a serious allegation, and one that must be properly evidenced. When insurers seek to reject a claim or avoid a policy on the basis of fraud, the FOS has indicated that it is essential the insurer makes this clear at a stage in the process that allows the insured to respond to the allegation. The FOS follows due process in all of its decisions and will ensure that both parties have the chance to respond to issues, facts or allegations that are raised by the other party and which affect the Ombudsman's judgement

A number of cases reach the FOS where an insurer is unwilling to cite fraud as the reason for voiding the claim. In this situation the FOS has indicated that it will not make a finding of fraud if a) no allegation is made and/or b) if no evidence is submitted showing that the policyholder was given the opportunity to respond to the assertion of fraud.

The FOS recognises the obligation on insurers to make a disclosure under the Proceeds of Crime Act (POCA) and the concern regarding the tipping off policyholders. If the FOS is informed that this concern may affect the insurer's handling of the claim and/or its involvement in the FOS process then it will make due allowance. However, the FOS expects insurers to make a disclosure under POCA and to not leave it up to the FOS to do so.

DOES THE FRAUD AFFECT LIABILITY?

Following the case of Mercandian Continent the FOS has based its decisions by taking the approach that a fraudulent act or omission must make a difference to the insurer's ultimate liability under the terms of the policy. For example, if, when asked to provide proof of ownership, an insured forges a receipt for the actual purchase price in panic, this falsification may not affect the insurer's ultimate liability to indemnify, where the loss is genuine and the amount claimed is correct.

However, if the FOS is satisfied that a complainant has perpetrated a fraud, with the intention of dishonestly obtaining a financial advantage to which they

are not entitled, then the FOS will reject their complaint.[3] The following case studies provide some illustration of these principles.

Case Study

The insured claimed for the theft of a Rolex watch. The insurer sought certificates/receipts for proof of purchase. The insured reported that he had lost the certificate in moving house and therefore got his friend to forge a copy. The insurer's experts spotted this immediately and the policy is forfeited for fraud. However, the insured then found the genuine certificate and receipt.

FOS Decision: Compliant was upheld and the *Mercandian Continent* test was applied and the insurer accepted that the loss was genuine and that the insured acted stupidly out of panic rather than dishonesty. The main rule to come from this was: there was no intent to gain that to which he was not entitled to and therefore the firm's ultimate liability was unaffected.

Case Study

There was a £10,000 claim for stolen jewellery and the insurer asked for proof of purchase/ownership. The insured had no photos, valuations, receipts etc, but eventually found a 1979 purchase receipt. The insurer examined this receipt and concluded it was false as there was a 1990's telephone code on it. The insured responded to this by saying it was a duplicate of the original. The insurer voided ab initio, rejected the claim and sought recovery of previous claims settlements.

FOS Decision: Complaint was rejected as the receipt was proven to be false and it was material to the firm's ultimate liability – there was an intention to gain more than the insured was entitled to (therefore the *Mercandian* test would not apply). However, the insurer could only forfeit the policy from the date of the fraud and not avoid ab initio, therefore the earlier claims could stand.

AVOIDING THE POLICY

Insurers may propose that a policyholder's fraud amounts to a breach of their duty of utmost good faith, thereby allowing the insurer to 'avoid' the policy from its inception. Insurers may also try and recover any monies previously paid out under the policy, even for genuine claims.

The FOS has indicated that it takes the same approach as the Courts and will look at when the fraud occurred. If a policyholder breaches their duty of utmost good faith during the course of making a claim (ie by submitting forged

[3] Ombudsman News, November 2004

receipts) the insurer cannot avoid the policy from its inception, rather from the date of breach. However, it is clear in law as well as in the FOS decisions that not all breaches of the duty of utmost good faith amount to fraud. Insurers will need to be aware of this distinction otherwise their own failures to act with utmost good faith (e.g. by making low offers to settle claims) might be construed as fraudulent.

The insurer is not obliged to pay a fraudulent claim but they cannot cancel the policy retrospectively and seek to recover monies previously paid out for genuine claims.[4]

EXAGGERATION AND MATERIALITY

There is no *de minimus* monetary amount applied by the FOS, as to what constitutes a material fraud. All fraud is treated as fraud.

WHAT IS FRAUD?

Key to this is the principle of intent to gain a pecuniary advantage or to cause a loss to the insurer. The FOS applies the same two-stage test that the law requires. Firstly, was the action of the insured something that would be regarded as dishonest by ordinary standards? Secondly, did the insured know that his/her actions would be so regarded? This legal test is known as the Ghosh test.

This test is most commonly applied (and misunderstood) in the case of fraudulent exaggeration. The FOS has indicated that it will not find fraud in cases where the insured or loss adjuster genuinely believed that an exaggerated claim or a ‘low ball’ offer represented part of the “normal” bargaining process surrounding a claim. For example, in the case of a burglary, the FOS has made a distinction between a claimant who invents items that he/she knew were never owned, from the claimant who inflates the value of items “expecting that the claim will be knocked down from whatever position is started from”. In other words, if the claimant’s intention is to achieve a fair settlement, neither the Courts nor the FOS are likely to regard initial exaggeration as a fraud.

[4] Agapitos v Agnew