The AFCA Approach to non-disclosure and misrepresentation – General insurance

We have created a series of AFCA Approach documents, such as this one, to help consumers and financial firms better understand how we reach decisions about key issues.

These documents explain the way we approach some common issues and complaint types that we see at AFCA. However, it is important to understand that each complaint that comes to us is unique, so this information is a guide only. No determination (decision) can be seen as a precedent for future cases, and no AFCA Approach document can cover everything you might want to know about key issues.

1 Executive summary

1.1 AFCA's purpose

AFCA is the independent external dispute resolution (EDR) scheme for the financial services sector. AFCA's purpose is to provide fair, independent, and effective solutions for financial disputes. We do this by providing fair dispute resolution services. We also work with financial firms to improve their processes and standards of service to minimise future complaints. In addition to resolving financial complaints, AFCA identifies, resolves, and reports on systemic issues and serious contraventions of the law.

1.2 About AFCA's Approach documents

The purpose of AFCA's Approach documents is to explain how we look at common issues and complaint types. Approach documents provide greater clarity around what to expect from AFCA processes, explain how we investigate complaints and how we make decisions.

1.3 The purpose of this Approach and when it applies

This document explains AFCA's approach to complaints involving the duty of disclosure or not to make a misrepresentation in general insurance.

This Approach document applies to:

- complaints about general insurance policies entered into or renewed prior to 5 October 2021, and
- complaints about general insurance policies which are not consumer insurance contracts that were entered into or renewed on or after 5 October 2021 (known as 'Other contracts').

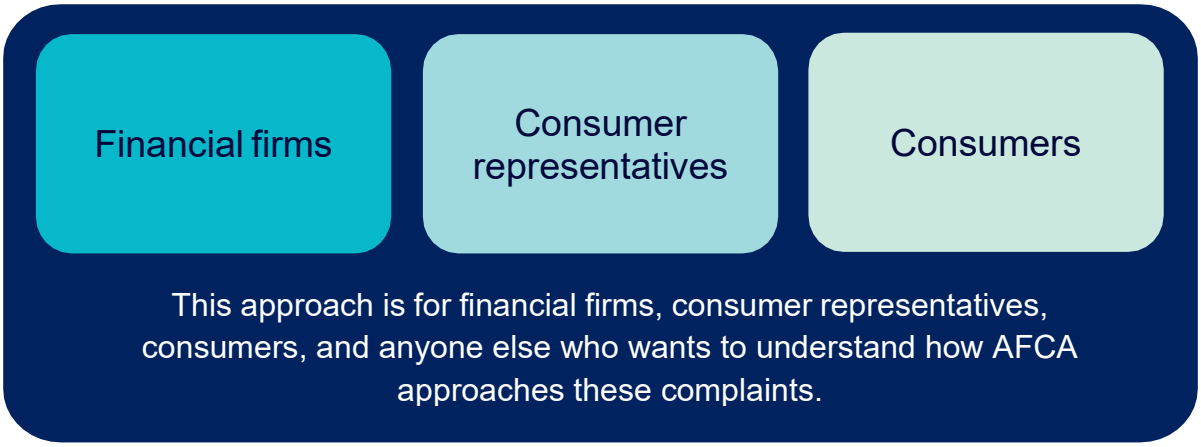
This Approach document does not apply to:

- consumer insurance contracts as defined by the *Insurance Contracts Act* 1984 (Cth) (the Act) (see *AFCA Approach to take reasonable care not to make a misrepresentation – general insurance)* [this is a new Approach document currently under consultation. Link to be provided following publication]
- complaints about life insurance policies (see AFCA Approach to take reasonable care not to make a misrepresentation – life insurance or *AFCA Approach to non-disclosure or misrepresentation – life insurance)* [these are new Approach documents due for consultation later in the year. Links to be provided following publication]
- superannuation insurance complaints covered under AFCA's superannuation jurisdiction.

This Approach document will explain how we consider complaints where issues about non-disclosure or misrepresentation are raised, including:

- which general insurance contracts are covered
- how we assess complaints about non-disclosure or misrepresentation, and
- how we consider all the circumstances to determine an outcome that is fair to all of the parties.

1.4 Who should read this Approach?



1.5 Complaints about non-disclosure or misrepresentation in general insurance

Insurers and consumers have obligations under the Act when entering into, renewing, varying, reinstating or extending a contract of insurance.

The Act sets out the obligations in relation to:

- the duty of disclosure (Part IV Division 1), and
- misrepresentations by the insured (Part IV Division 2).

These obligations apply to:

- general insurance contracts entered into or renewed prior to 1 January 2021, and
- any general insurance contracts that are not a 'consumer insurance contract'.

For innocent non-disclosure, AFCA will consider:

- Has the insurer clearly informed the complainant of their duty of disclosure?
- Has the complainant failed to comply with their duty of disclosure?
- Can the insurer show the extent of its prejudice?

For innocent misrepresentation, AFCA will consider:

- Has the complainant made a misrepresentation?
- Did the complainant, or a reasonable person in their circumstances, know their misrepresentation was relevant to the insurer's decision to accept the risk?

- Can the insurer show the extent of its prejudice?

A misrepresentation or non-disclosure will be considered fraudulent if the person did so knowingly, without belief in its truth, or recklessly. This will require clear and cogent evidence in support.

Where there has been a misrepresentation or non-disclosure, the Act provides remedies for insurers under section 28. These remedies include:

- avoiding a policy which means the policy never existed – this can only occur if the misrepresentation or non-disclosure is fraudulent
- denying or reducing liability on a claim.

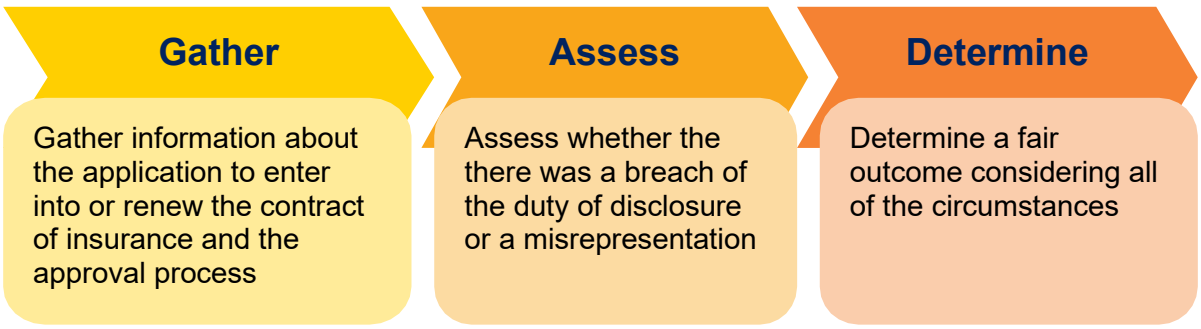
AFCA will also consider other relevant factors to ensure the outcome is fair, including whether:

- the complainant provided an obviously incomplete or irrelevant answer
- the complainant genuinely believed the answer they provided was true, or
- avoiding the policy would be unfair.

2 How AFCA assesses complaints about non-disclosure or misrepresentation

2.1 AFCA's process to assess complaints about non-disclosure or misrepresentation

Our process to consider complaints about non-disclosure or misrepresentation is:



Investigation steps

When we investigate a complaint about non-disclosure or misrepresentation in general insurance complaints, we consider whether the insurer and complainant complied with their obligations under the Act.

To do this, we usually take the following steps:

1. Ask the parties to provide information about the alleged non-disclosure or misrepresentation, the remedies applied and any claim information
2. Ask the parties to provide their views about each other's conduct prior to and at the time the contract of insurance was entered into
3. Review whether the insurer has established a breach has occurred and the remedy is applicable and fair

Seeking information to provide a fair resolution

We will often ask for relevant information at an early stage of our investigation process to help us understand the complaint and help explore possible resolutions.

When we consider appropriate remedies, we seek to provide a clear pathway for the parties. We aim to minimise the requirement for the parties to undertake further negotiations or other processes after the AFCA complaint is closed. We also attempt to avoid the need for the parties to return to AFCA later.

Under our Rules, parties are generally required to comply with AFCA's information requests.

Insurers should provide us with the information showing the alleged non-disclosure(s) or misrepresentation(s), the basis for the remedy applied and any claim information.

Examples of what AFCA may ask the insurer to provide include:

- The application to enter into the insurance cover including correspondence, notes, application forms completed and/or recordings of telephone applications
- The Product Disclosure Statement (PDS) and Certificate of insurance, Renewal Certificate issued to the applicant for insurance
- Proof of dispatch
- Information which the insurer says supports the alleged non-disclosure(s) or misrepresentation(s)
- All correspondence and information exchanged if the policy has been avoided or varied including "procedural fairness" letters
- Underwriting evidence showing what the insurer would have done had the alleged breach not occurred – this would include a statutory declaration from the underwriter and relevant underwriting guidelines (or extracts of) at the time the

insurance application was accepted. If the original underwriter cannot be located, an experienced underwriter can provide the underwriting statutory declaration.

- Any claim information and decision made on the claim
- Submissions addressing the alleged non-disclosure(s) and/or misrepresentation(s) having regard to the obligations set out in the Act
- Submissions explaining why the insurer has applied the remedy
- Submissions on why the claim has been declined or would otherwise have been declined.

Complainants can provide information explaining why there was no misrepresentation or non-disclosure, the reasons why the insurer's remedy should not be applied and why any claim should be accepted.

Examples of what AFCA may ask the complainant to provide include:

- An explanation of how the insurance policy was taken out:
  - Did they read the documents?
  - Did they purchase the policy online, over the phone, at a branch?
- Did the complainant complete and/or sign a form? If so, do they have a copy of the form?
- Does the complainant recall being asked the specific question in dispute? If so, do they recall how they responded?
- Did the complainant receive the policy documents (Product Disclosure Statement and Certificate of insurance, renewal certificate)?
- If the complainant did receive the policy documents:
  - Did they read the documents?
  - Did they notice any error? If yes, did they attempt to correct this with the insurer?
- Any submissions on why the insurer has not complied with its obligations.
- Any claim information and submissions on why the insurer should accept the claim.

3 When does the duty of disclosure or misrepresentation by an insured apply?

3.1 Applies to non-consumer contracts and contracts prior to 1 January 2021

The duty of disclosure or not to make a misrepresentation applies to:

- All general insurance contracts entered into or renewed prior to 1 January 2021
- Any general insurance contracts that are not a 'consumer insurance contract'.

A contract of insurance is a 'consumer insurance contract' if:

- it is entered into or renewed on or after 5 October 2021, and is predominantly for personal domestic, or household purpose of the insured, or
- it is a contract for new business entered on or after 1 January 2021 and the insurer gives written notice that the contract is a consumer insurance contract before it is entered into
- it is a renewal entered on or after 1 January 2021 and the insurer gives written notice that the contract is a consumer insurance contract

We will need to look at the contract of insurance and the date it was entered into to confirm whether the contract of insurance is:

- a consumer insurance contract to which the duty to take reasonable care applies (Division 1A of the Act) (see *Approach to take reasonable care not to make a misrepresentation – general insurance*)
- a contract of insurance to which the duty of disclosure or misrepresentation by an insured applies (Division 1 and 2 of the Act).

For example, Jim applied for a motor vehicle insurance policy on 4 April 2021 which the insurer agreed to accept on the same day. The insurer did not give prior written notice that the contract was a consumer insurance contract. Jim's application was subject to the duty of disclosure not to make a misrepresentation. This is because:

- the motor vehicle insurance policy was entered into prior to 5 October 2021, and
- there was no written prior notice by the insurer that it was a consumer insurance contract.

Jim renewed the motor vehicle insurance policy on 4 April 2022. When renewing the policy, the duty to take reasonable care applied. This is because the renewed policy is a consumer insurance contract given:

- every renewal is considered a separate contract of insurance
- this contract of insurance was for Jim's personal use, and
- it renewed after 5 October 2021.

4 How we decide whether there has been a breach of the duty of disclosure or a misrepresentation

4.1 Has there been an innocent non-disclosure?

This applies to complaints where the insurer says the complainant failed to disclose a matter but does not allege this was done fraudulently.

For the sake of convenience, this approach presumes the complainant is the insured.

Sections 21, 21A, 21B, 22 and 28 of the Act apply to contracts entered into or renewed prior to 5 October 2021 that are an 'eligible contract of insurance[1]'

Sections 21, 22 and 28 of the Act apply to policies entered into or renewed:

- on or after 5 October 2021 that are non-consumer insurance contracts.
- on or before 5 October 2021 that are not eligible contracts of insurance ('Other Contracts').

To refuse payment of a claim on the basis of an innocent non-disclosure, the insurer must show:

- The complainant was clearly informed of the general nature and effect of their duty of disclosure before the relevant policy was issued – the relevant policy is the one that would respond to the claim
- if the policy was an 'eligible contract of insurance' entered into or renewed prior to 1 January 2021:
  - The insurer asked the complainant a specific question (if the non-disclosure relates to when the policy was first issued); or
  - The insurer (if the non-disclosure relates to the policy being renewed) either:
    - asked the complainant a specific question; and/or
    - gave the complainant a copy of the matters previously disclosed and asked the complainant to inform it of any change
  - The complainant did not accurately respond to the question or update the information previously given
  - The complainant knew the correct answer and a reasonable person in their circumstances would have disclosed this information
- if the policy is either 'Other contracts' or was not an 'eligible contract of insurance' entered into or renewed prior to 1 January 2021:
  - The complainant knew about the information
  - The complainant, or a reasonable person in their circumstances, knew this information was relevant to the insurer's decision to accept the risk

[1] These are policies for motor vehicle, home building, home contents, travel, consumer credit or personal accident and sickness

- The complainant did not disclose this correct information

- The extent of the insurer's prejudice by the complainant's failure to disclose this information.

Generally, the insurer establishes prejudice if it can show it would not have issued a policy or would have issued the policy on different terms that would have resulted in a different outcome (e.g. an exclusion would have been imposed that would have applied to the claim).

Even if the insurer can establish those matters, AFCA will consider any other aspect of the Act that may be relevant. For example, if the complainant provided an obviously incomplete or irrelevant answer (section 21(3)) or the insurer already knew about the matter (section 21(2)(b)).

Other considerations

AFCA may also consider other matters it believes are relevant. For example, if the complainant was in a vulnerable situation (e.g. had minimal literacy skills, or limited understanding of English) and the insurer was aware of this.

AFCA considers this approach to be fair because:

- it is consistent with the purpose of the Act, which was designed to ensure a fairer application compared to the previous common law
- it provides sufficient flexibility to take into account the circumstances of the matter.

4.2 Has there been an innocent misrepresentation?

This applies to disputes where the insurer says the complainant made a misrepresentation but does not allege this was done fraudulently. Often this issue will arise alongside non-disclosure.

This is because the same set of facts can give rise to both grounds.

Sections 23, 24, 26, 27 and 28 of the Act apply.

To decline a claim on this basis, the insurer must show:

- The complainant made a statement before the contract was entered into
- This statement was either a:
  - statement of fact that was untrue;
  - statement of opinion that was not the subject of an honestly held belief; or
  - statement of intent that never existed at the time provided.
- The complainant knew the statement was relevant to the insurer's decision to accept the risk, or a reasonable person in the circumstances could be expected to know the matter was so relevant

- The extent of the insurer's prejudice by the misrepresentation.

This part of the approach is the same as for innocent non-disclosure. That is, the insurer would generally need to show it would not have issued the policy if the misrepresentation had not been made, or would have issued the policy on different terms that would have resulted in a different outcome (e.g. an exclusion would have been imposed that would have applied to the claim).

Even if the insurer can establish all this, AFCA will consider any other provision of the Act that may be relevant. For example, if the complainant genuinely believed the answer to be true, and a reasonable person in their circumstances would have formed the same belief (section 26(1)), or the insurer's question was ambiguous (section 23).

Other considerations

AFCA may also consider other matters it believes are relevant. Such as, if the complainant was in a vulnerable situation (e.g. had minimal literacy skills, or limited understanding of English) and the insurer was aware of this.

AFCA considers this approach to be fair because:

- It is consistent with the purpose of the Act, which was designed to ensure a fairer application compared to the previous common law
- It provides sufficient flexibility to consider the specific circumstances of a matter.

4.3 Fraudulent misrepresentation and fraudulent non-disclosure

There are times when an insurer says the misrepresentation or non-disclosure was fraudulent.

A misrepresentation or non-disclosure is fraudulent when the person did so knowingly, without belief in its truth or recklessly (not caring whether it is true or false). If it was made negligently or carelessly, this is not fraud.

Given the seriousness of the allegation, AFCA would expect the insurer to provide clear and cogent evidence to establish this.

4.4 What other things may be relevant?

A person is only required to disclose what they know

That is, they need to disclose something that was subject to a true belief, held with sufficient assurance to justify the term 'known'. It means considerably more than suspects or strongly suspects.

Therefore, if a person disclosed something they believed was the truth (i.e. held with sufficient assurance to justify the term 'known'), then there is no non-disclosure even if that belief was wrong. However, if they disclosed something they have not

'known' (i.e. they guessed or suspected the answer), then they have not complied with their duty of disclosure.

Most general insurance policies operate for one year and are renewable

Each renewal is a separate contract of insurance. Therefore, it is important to identify which period of insurance is relevant to the alleged breach. This includes ensuring the relevant misrepresentation is continuing, operative or applicable to the relevant period.

For example, a person may have made a misrepresentation about a licence suspension they had in the past 5 years when the policy was first issued. However, if by the next renewal that suspension is more than 5 years old, it is no longer continuing, operative or applicable for that renewal.

An insurer is not legally required to clearly inform the complainant of their duty of disclosure at each renewal

This is because if the insurer has done so once, then effectively they have been deemed to do so at each subsequent renewal (section 11 of the Act).

However, AFCA may consider it unfair if the information was provided by the insurer a long time ago.

'A reasonable person in the circumstances'

The phrase used in the Act – 'a reasonable person in the circumstances' – is generally an objective test although a degree of subjectivity must be applied. It is a matter of considering a reasonable person in the same circumstances as the complainant.

5 How we determine fair outcomes

Important note: AFCA makes decisions based on what is fair in all the circumstances. As a result, it is not possible to set out a definitive approach that will apply to all scenarios. This section of the document sets out common approaches applied in some typical scenarios. It is indicative only and will not apply in all complaints.

5.1 Overview of AFCA's approach to determining fair outcomes

The AFCA Rules and delivering fair outcomes

AFCA aims to provide a remedy that is fair in all the circumstances of the complaint.

Under the AFCA Rules, we may decide that a financial firm must compensate a complainant for the loss its errors cause them, including:

- direct financial loss
- indirect financial loss
- non-financial loss.

There are compensation caps in our Rules that limit the amount of compensation we can require a financial firm to pay to a complainant.

We may also decide a financial firm is required to take, or not take, particular actions to remedy the practical impact of its error.

The focus of AFCA's outcomes is to compensate the complainant for the loss the financial firm's error caused them. AFCA does not award compensation to 'punish' an error or breach and we do not impose fines or sanctions.

5.2 How AFCA decides remedies for non-disclosure or misrepresentation

Section 28 of the Act provides remedies for insurers

The insurer must show the extent of its prejudice under section 28 of the Act (if the breach is not fraudulent). Generally, the insurer establishes prejudice where it can show that if the breach had not occurred:

- it would not have issued the policy, or
- it would have issued the policy on different terms that would have resulted in a different outcome (for example, an exclusion would have been imposed that would have applied to the claim).

If the non-disclosure or misrepresentation is fraudulent, the insurer can generally avoid the contract.

Loss may be recovered in limited cases for fraudulent misrepresentation and fraudulent non-disclosure

In limited cases, avoiding the policy may not be fair. This may be when the information not disclosed made little difference to the insurer's position. For example, the insurer would have simply charged a slightly higher premium or imposed a condition that made no difference to its liability.

In those cases, AFCA will consider whether it is fair in all the circumstances for the claim to be denied. This requires consideration of at least the following factors:

- the extent of prejudice the non-disclosure or misrepresentation had on the insurer's position
- the requirement to deter fraudulent conduct
- whether the impact extends beyond the person who perpetuated the fraud (e.g. an innocent co-insured).

This is also consistent with section 31 of the Act. Whilst AFCA is not a court, it is required to do what is fair in all the circumstances. AFCA considers it is appropriate to have regard to this provision given it aligns closely to our purpose.

Premium refunds

If the insurer has shown it would not have offered a policy if the complainant did not breach the duty of disclosure, we generally expect the insurer to refund the premiums paid for the relevant insurance periods (i.e. from when the insurer would have first gone off risk – this may be from inception in some cases).

A refund may not be required in certain cases. For example, if the complainant had a claim accepted and paid during the insurance period.

AFCA may decide on reinstatement of a contract

Where there has not been a breach of the non-disclosure or misrepresentation provisions, or the insurer has not shown it is entitled to avoid the policy or deny the claim, AFCA may decide the insurer must reinstate the contract.

AFCA may also decide the contract should be reinstated if it is fair in all of the circumstances.

Where AFCA decides the contract of insurance must be reinstated, AFCA may require the parties to do any of the following:

- the insurer to reinstate the contract of insurance
- the insurer to remove any unfounded allegation of fraud or breach from its records
- the complainant to pay any outstanding premiums from the date the contract was avoided or cancelled (or have those premiums deducted from any claim payout).

AFCA may decide the claim

Where there has not been a breach of the non-disclosure or misrepresentation provisions, or the insurer has not shown it is entitled to avoid the policy or deny the claim, AFCA may decide the insurer is to pay the claim. This may occur when it is apparent the claim is payable under the contract or the insurer has not raised any other possible grounds.

If we decide the claim is payable, we may also award interest based on section 57 of the Act.

In some instances, AFCA may decide there is insufficient information to make a fair decision on the claim. If that is the case, AFCA may give directions to be taken for the assessment of the claim after the complaint is closed.

Awarding compensation for non-financial loss

AFCA may require an insurer to pay compensation for non-financial loss, subject to the monetary limits in our Rules.

When determining the appropriate amount of non-financial loss, AFCA will consider the factors outlined in '*The AFCA Approach to non-financial loss claims'*.

6 Case studies

Case study 1 – A case of criminal acts

The complainant lodged a claim on 1 November 2016 for fire damage to his home. The insurer denied the claim due to non-disclosure.

The insurer said the complainant failed to disclose a criminal charge when altering the policy in late 2015. If the complainant had done so, the insurer would not have continued to cover the property.

When the policy was altered, the complainant was asked to verify that the following information was still correct:

> You or anyone to be insured under this policy has NOT committed any criminal acts in relation to Fraud, Theft or Burglary, Drugs, Arson, Criminal, Malicious and/or Wilful damage.

On 12 June 2015, the complainant was charged with criminal offences, including the cultivation of a prohibited substance. Later, he pleaded guilty to this offence. This plea was made some time after the policy alteration.

The insurer said that the complainant should have disclosed the criminal charge in response to the above statement. The AFCA panel which made the decision disagreed.

The panel considered a reasonable person may interpret this phrase as referring to criminal convictions, as the complainant did. The question that the insurer asked the complainant to respond to is, at the least, ambiguous as to whether it refers to a charge rather than a conviction.

This view is consistent with the presumption of innocence in criminal law. It is also unreasonable to expect a person to admit to an insurer a matter which could prejudice their legal defence in criminal proceedings.

Therefore, the panel was not satisfied the complainant was required to disclose his criminal charge in response to the above.

Further, even if it could be said the complainant should have disclosed his criminal charge, the panel was not persuaded the insurer would have refused to cover the property based on the following:

- On 9 November 2016 the complainant disclosed his criminal charges (yet to be convicted) to the insurer's investigator
- Eight days later the insurer renewed the complainant's home and contents policy for another property
- On 20 April 2017 the insurer issued an amended certificate of insurance after the complainant altered the home building policy for the destroyed insured property
- On or around 25 October 2017 the insurer issued a policy renewal for the destroyed property.

Further:

- The insurer's underwriting guidelines refer to a person's criminal history, not charges
- The insurer's underwriter was unclear as to whether they referred to charges or convictions when saying the insurer would not have offered any policy
- The insurer did not provide any examples where they refused to provide cover by reference to a charge rather than a conviction.

Given this, the panel was not satisfied the insurer showed they suffered any prejudice by the complainant's failure to disclose the charge and therefore, the insurer was liable to accept the claim.

Case study 2 – A case of context and risk

The complainant held a contents policy with the insurer. He lodged a claim for storm damage to contents at his place of residence.

The insurer denied the claim on the basis the complainant failed to disclose his claims history. The complainant's claims history showed he had lodged five claims in the past five years.

The insurer says if the complainant had disclosed this history, it would not have renewed the policy. This is because the underwriting guidelines say they will not issue a policy to a person who has lodged more than three claims in the last five years.

The relevant question asked by the insurer in the renewal was:

> In the last 5 years has the insured or any household member had any thefts, burglaries or made any insurance claims for home and/or contents?

There is no dispute the complainant did not disclose any claim in response to this question.
The complainant had numerous investment properties. At least two of these claims involved his investment properties. The issue was whether he had to disclose his claims for the investment properties when asked about 'any insurance claims for home and/or contents?'.

The ombudsman concluded he did not need to disclose these claims for the following reasons:

- The policy defined 'home' as the complainant's current place of residence. This did not help the insurer because none of the claims involved this property.
- Both Macquarie and Oxford dictionaries refer to 'home' as a person's place of residence.

Given this, the ombudsman concluded that a reasonable person in the complainant's circumstances would have only disclosed their claims history about their place of residence (or their contents). This is consistent with:

- the ordinary and natural meaning of the word 'home'; and
- the risk being insured – that is, the complainant's contents at his home.

Therefore, the complainant did not need to disclose claims for his investment properties. This meant the insurer could not show it was prejudiced to the full extent of the claim, as the insurer's underwriting guidelines do not exclude people with only three claims.

Therefore, the insurer had to accept the claim subject to any additional premium that may have been charged if the claims history involving the complainant's home had been disclosed.

Case study 3 – A case of underwriting

The complainant lodged a claim for hail damage to his commercial property with his insurer.

The insurer denied the claim on the basis the complainant failed to disclose the correct age and condition of the property. The insurer says that if the complainant had done so, it would not have issued the policy.

The available information showed that the complainant purchased the policy through a broker. The broker had disclosed that the property was built in 1970. However, there was no dispute the property was built around 1925.

Therefore, the complainant had failed to comply with his duty of disclosure. There was no dispute this was innocent. The issue became whether the insurer could show its prejudice.

In support of its position, the insurer provided a statutory declaration from the national underwriting manager. This underwriter said a policy would not have been issued if it was disclosed:

- The property was constructed between 1898-1900; and/or
- The condition of the property was as outlined in two reports provided by two experts (IB and CD).

The panel reviewed the underwriting guidelines and noted:

- They related to a home building – this was a commercial property
- They did not refer to the age of the property
- They only required the property to be actively cared for, water-tight, well-maintained, structurally sound and secure, and likely to withstand natural peril.

Various reports were provided about the property. In analysing these reports, the panel noted:

- The insurer's loss adjuster (C) said the property appeared to be well-maintained
- Expert (CD) said the building has been maintained in a satisfactory condition given the age and method of construction
- Expert (IB) said the roof was in average to good condition and the maintenance related issues repaired.

These reports also noted the previous maintenance work and that the roof was structurally sound and water-tight. There was no information implying that the roof could not withstand natural peril. There was also no suggestion the complainant had actual knowledge of any issues with the roof.

The panel also noted the insurer had previously insured the property (with a previous owner), with a build date disclosed as 1905.

The complainant had also submitted that:

- A new roof was fitted in the last 10-30 years
- All circuit boards had been updated in the past 3 years
- The previous owner had undertaken electrical rewiring; and
- Licenced tradespersons were employed to maintain the roof.

The insurer did not refute any of this information.

When considering this evidence, the panel was not satisfied the insurer could show that it would not have insured the property. This meant the insurer could not establish the extent of its prejudice.

Therefore, the insurer was liable to accept the claim.

7 Appendix

7.1 Appendix 1

Complaints AFCA can consider

It is important to understand that each AFCA complaint has a unique set of facts and this information is a guide only. We will always consider the nature, size and scale of a complaint and the impact of issues on all parties.

AFCA can consider complaints against financial firms that are members of AFCA, provided the complaints meet the other requirements in our Rules (for example Rule A.4 – Complaints AFCA can consider).

If a complaint is not resolved by agreement, negotiation or conciliation, we make a decision. Our decision reflects what is fair in all the circumstances having regard to legal principles, applicable industry codes or guidance, good industry practice and previous decisions of AFCA or predecessor schemes (which are not binding).

Complaints not covered in this approach

This approach document does not apply to:

- complaints about general insurance policies which are consumer insurance contracts (see *AFCA Approach to take reasonable care not to make a misrepresentation – general insurance* *[this is a new Approach document currently under consultation. Link to be provided following publication]*
- complaints about life insurance policies (see *AFCA Approach to the duty to take reasonable care not to make a misrepresentation – life insurance* or *AFCA Approach to non-disclosure or misrepresentation – life insurance)* *[these are new Approach documents due for consultation later in the year. Links to be provided following publication]*
- superannuation insurance complaints covered under AFCA's superannuation jurisdiction.

AFCA's fairness jurisdiction

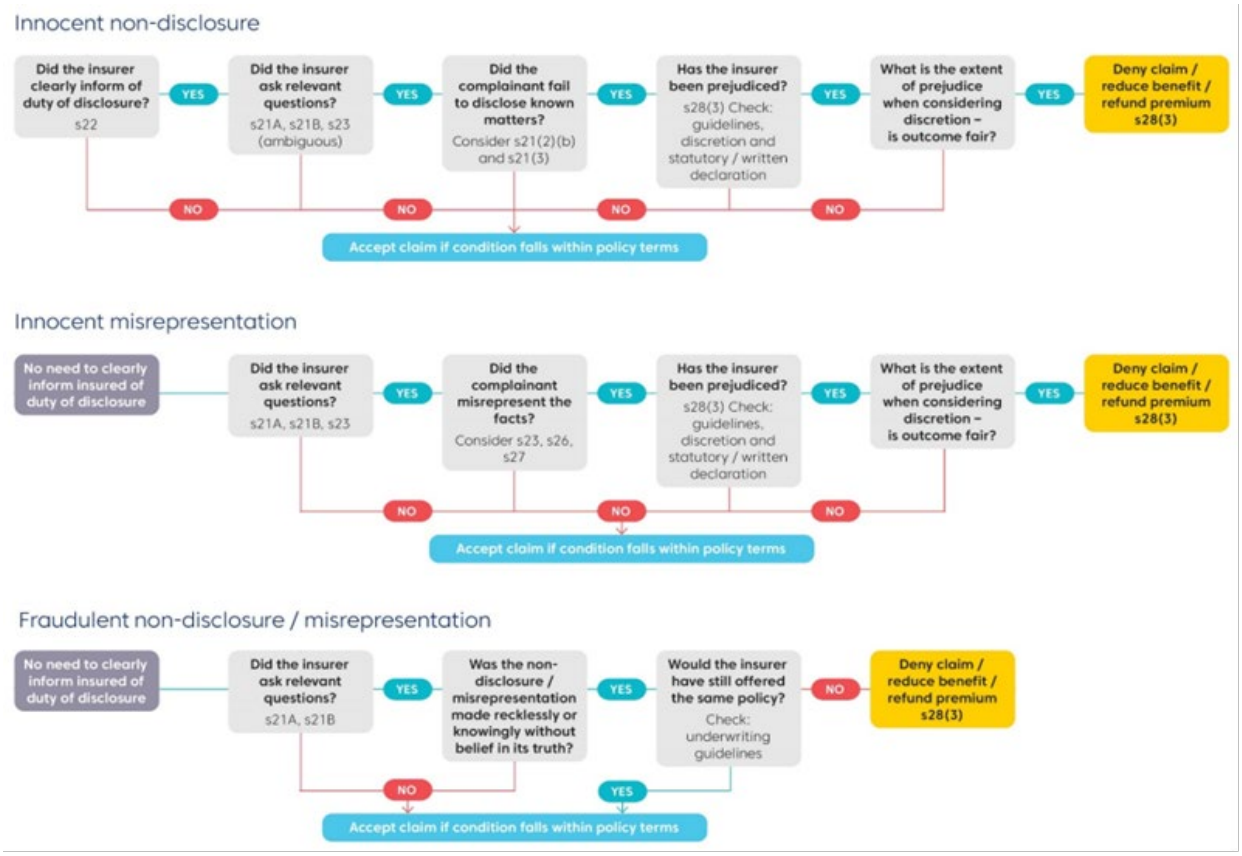
Our decisions are intended to reflect what is fair in the circumstances of each complaint. This includes providing a fair outcome where we find the financial firm made an error or breached an obligation to the complainant.

In assessing what is fair, we apply a standard of fairness which focuses on concepts such as fair dealing, fair treatment and fair service. We may consider the conduct of both parties when determining a fair outcome, and we will consider all the circumstances to determine an outcome that is fair to the parties.


Law
Regulatory guidance
Good industry practice and industry codes
Past decisions
Fair in all the circumstance

7.2 Appendix 2

Innocent / fraudulent non-disclosure and misrepresentation decision guide



References

Term	Definition
Complainant	A person who has lodged a complaint with AFCA. Also, this approach document presumes the complainant is the insured under the policy.
Financial firm	A financial firm such as an insurer, who is a member of AFCA.
Insured	A party to the insurance contract. They are normally noted in the policy schedule as an insured.

Useful links

Document type	Title / Link
Insurance Contracts Act	This Commonwealth statute can be found here: legislation.gov.au/Details/C2019C00115
Austlii	Austlii is a free resource that contains a full extract of most of the judgments issued in Australia austlii.edu.au

Document control

Version	Date	Approved by
1	July 2020	Lead Ombudsman, General Insurance
2	November 2024 [DRAFT]	Lead Ombudsman, General Insurance