Australian Financial Complaints Authority

The AFCA Approach to Duty to take reasonable care not to make a 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 to take reasonable care not to make a misrepresentation in general insurance.

This Approach document applies to complaints about general insurance policies which are consumer insurance contracts.

This approach document does not apply to complaints about general insurance policies which:

- were entered into or renewed before 5 October 2021
- are non-consumer insurance contracts entered into or renewed on or after 5 October 2021 (see *AFCA Approach to non-disclosure or misrepresentation – general insurance* [this Approach document is currently under consultation. Link to be updated following publication of amended Approach document]
- are complaints about life insurance policies (see AFCA Approach to non-disclosure or misrepresentation- life insurance or AFCA Approach to take reasonable care not to make a misrepresentation – life insurance [these are new Approach documents due for consultation later in the year. Links to be provided following publication]
- are superannuation insurance complaints covered under AFCA's superannuation jurisdiction.

This approach document will explain how we consider complaints about the duty to take reasonable care not to make a misrepresentation in general insurance, including:

- which general insurance contracts are covered under the duty to take reasonable care not to make a misrepresentation
- when the duty applies
- how we assess complaints about the duty to take reasonable care not to make a misrepresentation
- 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 the duty to take reasonable care in general insurance

Insurers and consumers have obligations under the Insurance Contracts Act 1984 (Cth) (the Act) when entering into, renewing, varying, reinstating or extending a contract of insurance.

The Act was amended to include the duty to take reasonable care not to make a misrepresentation for consumer insurance contracts (the Duty) (sections 20A to 20C). This duty took compulsory effect on 5 October 2021.

Where there has been a breach of the Duty, the Act provides remedies for insurers under section 28 of the Act.

If an insurer seeks to apply a remedy for an alleged breach of the Duty, the insurer must be able to show all of the following:

- The insurance contract is a 'consumer insurance contract'
- The complainant made a misrepresentation
- In doing so the complainant failed to take reasonable care
- It can avoid a policy, deny the claim or reduce its liability on the claim pursuant to section 28 of the Act.

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

- the complainant provided an obviously incomplete or irrelevant answer

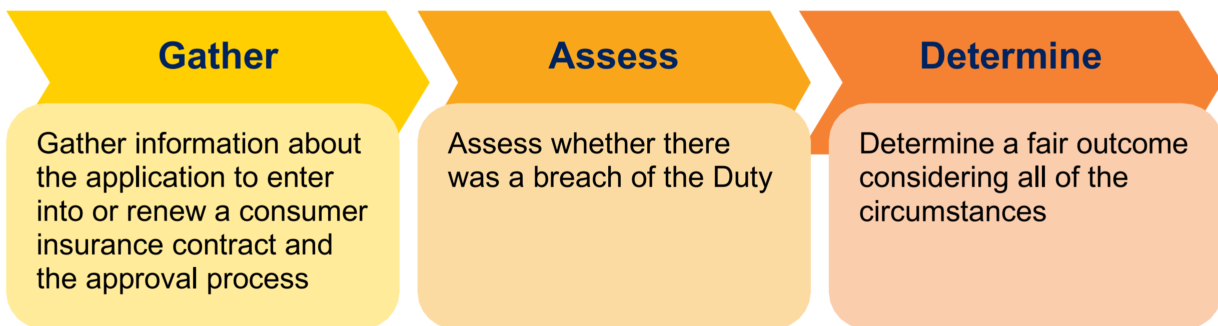
- the complainant genuinely believed the answer they provided was true, or
- avoiding the policy would be unfair.

Throughout this approach, AFCA uses 'Duty' to describe the duty to take reasonable care not to make a misrepresentation.

2. How AFCA assesses complaints about the Duty

2.1 AFCA's process to assess complaints involving the Duty

The Duty provides obligations to both insurers and consumers. Our process to consider complaints about the new duty is:



Investigation steps

When we investigate a complaint involving the Duty, 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 breach of the Duty, the remedies applied and any claim information
2. Ask the parties to provide their views about each other's conduct before and at the time the relevant 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 assist in exploring 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 breach of the Duty, information supporting the basis for the remedy applied and any claim information.

Examples of what AFCA may ask the insurer to provide:

- The application to enter into the insurance contract including correspondence, notes, application forms completed and/or recordings of telephone applications
- The Product Disclosure Statement and Certificate of Insurance and/or Renewal Certificate issued to the applicant
- Proof of dispatch
- Information which the insurer says supports the alleged breach of the Duty
- 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 cover was entered into, renewed, varied, reinstated or extended. 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 breach of the Duty (having regard to section 20B of 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 breach of the Duty, 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:

- 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, have they got 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 apply?

3.1 Duty only applies to 'consumer insurance contracts'

The Duty only applies to 'consumer insurance contracts' as defined under section 11AB of the Act.

A 'consumer insurance contract' is insurance that is obtained wholly or predominantly for the personal, domestic or household purposes of the insured and is entered into or renewed on or after 5 October 2021.

A 'consumer insurance contract' also:

- applies from 1 January 2021 if the insurer says the contract is a consumer insurance contract before the contract was entered into, or
- it is for new business and the insurer gives written notice saying the contract is a consumer insurance contract

We must be satisfied the insurance contract is a 'consumer insurance contract'. Otherwise, the Duty does not apply.

3.2 Separate duties apply to non-consumer insurance contracts

For contracts that are not consumer insurance contracts, sections 20E to 27 of the Act apply. Those sections of the Act refer to the duty of disclosure and misrepresentations by the insured. Importantly, those sections do not apply when considering the Duty.

Further information about the duty of disclosure and not to make a misrepresentation can be found in the '*AFCA Approach to non-disclosure and misrepresentation – general insurance*' [please note this Approach document is under consultation. Link to be provided following publication of amended Approach document].

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 before 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 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 if there has been a breach of the Duty?

4.1 Has there been a breach of the Duty?

Insurer must show at least two things

The Duty only applies before the contract of insurance was entered into, renewed, reinstated or varied (but only to the extent of the variation).

The insurer has the onus to show there has been a breach of the Duty. To do so, it must at least show:

- the complainant made a misrepresentation, and
- the complainant failed to take reasonable care when making the misrepresentation.

There must be a misrepresentation

A misrepresentation is typically a statement of:

- fact that was untrue
- opinion that was not the subject of an honestly held belief, or intent that never existed at the time it was provided.

A misrepresentation would ordinarily be limited to statements that induced the insurer into issuing the policy. This would typically be the complainant's incorrect answers to the insurer's questions when applying for the policy. It can also apply to answers previously made which the complainant failed to correct (e.g. in a renewal notice).

A mere failure to answer a question, or providing an obviously incomplete or irrelevant answer to a question, will not be a misrepresentation or a breach of the Duty.

If a complainant made a misrepresentation, AFCA will consider whether the complainant did so by failing to take reasonable care.

4.2 How does AFCA assess 'taking reasonable care'?

Factors which can be considered in assessing 'taking reasonable care'

Whether a person has taken reasonable care is mostly a subjective test. This will be informed by the various factors of a particular case.

There is no limit to the range of factors to be considered. AFCA must have regard to all the relevant circumstances when considering whether the complainant breached the Duty.

Section 20B(3) of the Act sets out the following matters that may be relevant when determining whether the complainant breached the Duty:

- The type of consumer insurance contract in question and its target market
- Explanatory material or publicity produced or authorised by the insurer
- How clear and specific the insurer's questions are
- How clearly the insurer communicated to the insured the importance of answering the questions and the possible consequences of failing to do so
- Whether or not an agent was acting for the complainant
- If the policy was a new contract or was being renewed, extended, varied or reinstated.

Section 20B(4) says the complainant's particular characteristics or circumstances must be considered if the insurer was aware of them, or ought to have been aware of them. For example, if the insurer knew (or ought to have known) the complainant had limited literacy skills or poor understanding of English.

It is important to note the following:

- the list of factors in the Act are not exhaustive
- other factors should be taken into account when relevant, and the Act does not say all these factors must be considered.

Certain factors are likely to be relevant in most cases

The factors in section 20B(3) of the Act that are likely to be relevant in most cases are:

- how clear and specific the insurer's questions are
- how clearly the insurer communicated to the insured the importance of answering the questions and the possible consequences of failing to do so.

This is because a consumer should clearly understand the Duty, the consequences of failing to comply with that Duty and the information the insurer requires to assess the risk.

To the extent the insurer does not do these things, this would likely lower the standard and potentially result in the insurer failing to show the complainant breached the Duty.

The other factors set out in section 20B(3) will be considered if relevant depending on the case.

Fraudulent misrepresentation

There are times when an insurer says the misrepresentation was fraudulent.

A misrepresentation 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.

If the misrepresentation is fraudulent, this will be enough to show the complainant breached the Duty.

4.3 What other things may be relevant?

How the Duty may apply to general insurance renewals

Each renewal of a general insurance policy is typically a separate contract of insurance. AFCA's expectation is that insurers will either:

- ask the insured specific questions relevant to the insurer's assessment of the risk, or
- provide information previously disclosed in the renewal offer and ask the insured to let them know if there are any changes.

If an insurer does neither, but simply relies on a misrepresentation made in a previous policy, it is unlikely AFCA will find the complainant breached the Duty.

This is because AFCA will not consider a complainant should be expected to remember what they may have previously represented as still being relevant to the insurer's assessment of the risk for that renewal.

Misrepresentation must be continuing, operative or applicable

General insurance contract renewals are typically separate contracts of insurance. Therefore, it is important to identify which period of insurance is relevant to the 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.

Misrepresentations based on genuinely held beliefs

If a complainant represented something they genuinely believed was the truth, then it is unlikely that AFCA will find they have breached the Duty.

However, if the complainant misrepresented something they did not 'know' (i.e. they guessed or suspected the answer), then it is possible they may have breached the Duty depending on all the other circumstances.

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 caused 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 in complaints about a breach of the Duty

Section 28 of the Act applies for breaches of the Duty

Unless the misrepresentation is fraudulent, an insurer cannot deny a claim under a general insurance policy simply because there has been a breach of the Duty. The insurer must also show the extent of its prejudice under section 28 of the Act (if the breach is not fraudulent).

Generally, the insurer establishes prejudice if it can show that if the breach had not occurred:

- it would not have issued insurance, 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 breach of Duty is fraudulent, the insurer can generally avoid the contract.

An insurer cannot always avoid the contract for fraudulent misrepresentation

In limited cases, avoiding a contract of insurance because of a fraudulent misrepresentation may not be fair. This may be when the information not disclosed made little difference to the insurer's position. For example, it 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 policy to be avoided and the claim 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. While 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 section of the Act 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, we generally expect the insurer to refund the premiums paid for the relevant insurance periods (i.e. from when it 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, 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 Duty or the insurer has not shown it is entitled to avoid the policy or deny the claim, AFCA may decide the insurer should reinstate the contract.

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 remove any unfounded allegation of fraud or breach of the Duty 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 Duty 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 in accordance with 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 about 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 – Complainant breached the Duty at renewal

The insurer declined the complainant's claim saying she breached the Duty. This was in relation to her disclosure of her claims history on renewal of the policy.

The insurer had sent a renewal offer. The renewal notice asked if any drivers of the insured vehicle had claims, accidents, thefts or losses in the last 5 years.

The answers to this, and other questions, were pre-completed by the insurer. This was based on information previously provided by the complainant. There were three claims disclosed in a box headed "Claims/Loss".

Following the claim, the insurer identified further claims that were not disclosed. This included two that had occurred in the preceding 12 months.

The Ombudsman was satisfied a breach of the Duty occurred noting the following:

- there was no dispute the complainant received the relevant policy documents
- the policy documents clearly explained the new Duty
- it is reasonable for the insurer to expect the complainant to read the renewal offer
- it is reasonable to expect any additional claims history would be included given the information provided
- in failing to notify the insurer of any changes, the complainant effectively represented the information in the renewal offer was accurate – this was a misrepresentation.

Further, as the insurer showed it would not have renewed the policy if the complainant had complied with the Duty, the insurer could deny the claim under section 28 of the Act. This was subject to refunding the premium for the renewal.

Case study 2 – No breach due to minor hail dents

The insurer denied a motor vehicle claim. The insurer did so saying the complainant breached the Duty by answering 'no' to this question:

Does your car have any existing damage or rust?

Minor scratches as well as general wear and tear
aren't considered existing damage

The complainant's car had unrepaired dents which they did not disclose. As the hail dents were neither 'minor scratches' nor 'general wear and tear', the complainant's answer was incorrect and likely a misrepresentation.

However, the Ombudsman did not accept this proved the complainant failed to take reasonable care when making the misrepresentation because:

- having considered the photos, and other information, the hail dents were minor, barely visible and did not need to be repaired.
- the complainant believed the hail dents were minor
- the insurer's question said he did not need to disclose minor scratches – given this, the complainant could have concluded that minor hail dents did not need to be disclosed either

Case study 3 – Conviction did not clearly fall within question

The complainant applied for a comprehensive motor vehicle insurance policy by phone. The insurer relevantly asked him:

> In the past 10 years have you, or anyone to be covered under this policy, committed any criminal act relating to fraud, theft, dishonesty, arson or malicious damage?

The complainant answered no.

In September 2022, the complainant lodged a claim following the theft of his car. In assessing the claim, the complainant's criminal history check showed that in 2020 he was convicted of 'unlawfully destroy or injure any property'. He had no convictions relating to fraud, theft, dishonesty or arson.

The insurer denied the claim and cancelled the policy. It said the complainant breached the Duty as he did not disclose the above conviction.

The Ombudsman did not accept a breach of the Duty occurred noting the following:

- The complainant was a tradesman whose answers during the policy inception call indicated he had limited sophistication with law and financial services.
- The insurer's question could reasonably be understood by the complainant to be asking about a particular subset of property damage such as a more serious charge of malicious damage, for which he did not have a conviction.
- The complainant says he answered what he believed to be true. He says that his offence is a minor or summary offence. He says he understood malicious damage to be a much more serious offence than his conviction for which he received a $500 fine
- The insurer did not define what it considered malicious damage to be.

AFCA's determination was in favour of the complainant.

7. Appendix

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).

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 on AFCA).

Complaints not covered in this approach

This approach document does not generally cover:

- complaints about general insurance policies which:
  - were entered into or renewed before 5 October 2021
  - are non-consumer insurance contracts entered into or renewed on or after 5 October 2021 (see AFCA Approach to non-disclosure or misrepresentation – general insurance) [this Approach document is currently under consultation. Link to be updated following publication of amended Approach document]
- complaints about life insurance policies (see AFCA Approach to non-disclosure or misrepresentation – life insurance or AFCA Approach to take reasonable care not to make a 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 circumstances

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

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1	November 2024	Lead Ombudsman, General Insurance