Case No: CLAIM NO G64YX685

IN THE COUNTY COURT AT MIDDLESBROUGH

Teesside Combined Court

Centre Square

Middlesbrough TS1 2AE

Date: Double-click to add Judgment date

Before :

HH JUDGE MARK GARGAN

- -

Between :

CAROL KRAMARCZYK

Appellant

- and -

INTER PARTNER ASSISTANCE (S.A)

Respondent

- -

- -

Adam Gould (instructed by **Watson Woodhouse, Middlesbrough**) for the **Appellant**

Christopher Fleming (instructed by) for the **Respondent**

Hearing dates: **1st June 2022**

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

....

HH JUDGE MARK GARGAN

HH Judge Mark Gargan:

(1) Introduction

1. This is an appeal by the claimant from the decision of Deputy District Judge Swann on 15 April 2021 dismissing her claim for an indemnity under a travel insurance policy issued by the respondent/defendant.

2. I shall refer to the appellant and respondent as claimant and defendant respectively.

3. I am grateful to both counsel, Mr Gould and Mr Fleming, for their clear Skeleton Arguments and their helpful oral submissions.

(2) Background

4. In June 2017, the claimant and her husband took out a "one-off" travel insurance policy with the defendant for a trip to New York. The contract was arranged online via Money Supermarket and the premium was £22.21.

5. While she was in New York, the claimant suffered a myocardial infarction and required medical/hospital treatment which cost over $100,000. The claimant and her husband also incurred further incidental expenses.

6. The defendant refused to indemnify the claimant and argued that it was entitled to avoid the insurance policy on the basis that the claimant had failed to make proper disclosure before the policy was taken out.

7. The only loss quantified in the pleadings was a claim for $4,203.12 made up as follows (i) $3,195.03 for the hotel expenses; (ii) $761.98 for the rearranged flights and (iii) $246.11 for additional pharmacy costs. [At the hearing before the Deputy District Judge counsel agreed the quantified loss, subject to liability, at £3,337.15 after deduction of the £50 excess].

8. However, the claimant also claimed "*an injunction ordering the defendant to pay to the claimant or on the claimant's behalf, the hospital fees or such alternative or additional costs and expenses as the claimant may otherwise be liable to pay to the hospital ".* [Mr Gould accepted that this would have been better phrased as a claim for an indemnity.] As the pleadings failed to mention the potential sum due pursuant to any such indemnity, the claim was allocated to the Small Claims Track, where it remained without any objection from the parties.

9. In its defence the defendant relied upon the claimant's answer "*No"* to the first part of "*The Second Question"* which stated:

> "***Important Information***

Please note that the policy you have selected is not designed to cover claims arising from pre-existing medical conditions. If you can answer "no" to the following questions, please select "I Agree" to proceed

(1) Within the last 5 years have you or anyone you wish to insure on this policy suffered any medical condition that has required prescribed medication and/or treatment including surgery, tests or investigations?

(2) Are you or anyone you wish to insure on this policy:

a. awaiting a diagnosis, surgery, treatment, tests or investigations (or their results) for any medical condition, or suffering symptoms that have not yet been discussed with a doctor? Or

b. aware of any circumstances, including the health of relatives or other third party, which may cause the cancellation, cutting short of a trip or result in a claim?"

10. The defendant contended that the claimant's answer was false because she had:

10.1 suffered a back injury in June 2016 when lifting a patient in the course of her employment as a nurse;

10.2 consulted her GP about her symptoms and been prescribed naproxen and codeine;

10.3 been off work for at least 1 week and been examined by an osteopath-although no treatment was required;

10.4 therefore, suffered from a medical condition which had required medication and/or treatment within (1) of The Second Question.

11. The claimant contends that her answer to The Second Question was accurate and, even if it was not accurate, it was not careless.

(3) The law

12. The policy was a "*consumer insurance contract*" within the meaning of section 1 of the Consumer Insurance (Disclosure and Representations) Act 2012. (All references to section numbers in the judgment are to the appropriate section numbers of this Act).

13. Section 2 replaces the common law rule that a consumer insurance contract is one of "*utmost good faith*" and provides that:

(1) This section makes provision about disclosure and representations by a consumer to an insurer before a consumer insurance contract is entered into or varied.

(2) It is the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer.

(3) … .

(4) The duty set out in subsection (2) replaces any duty relating to disclosure or representations by a consumer to an insurer which existed in the same circumstances before this Act applied.

(5) … .

14. Section 3 provides guidance as to the way in which the court should determine whether the consumer has taken reasonable care. The appropriate test is whether the consumer has exercised the care to be expected of a reasonable consumer:

> (1) Whether or not a consumer has taken reasonable care not to make a misrepresentation is to be determined in the light of all the relevant circumstances.
>
> (2) The following are examples of things which may need to be taken into account in making a determination under subsection (1):
>
> a. the type of consumer insurance contract in question, and its target market,
>
> b. any relevant explanatory material or publicity produced or authorised by the insurer,
>
> c. how clear, and how specific, the insurer's questions were,
>
> d. in the case of a failure to respond to the insurer's questions in connection with the renewal or variation of a consumer insurance contract, how clearly the insurer communicated the importance of answering those questions (or the possible consequences of failing to do so),
>
> e. whether or not an agent was acting for the consumer.
>
> (3) The standard of care required is that of a reasonable consumer: but this is subject to subsections (4) and (5).
>
> (4) If the insurer was, or ought to have been, aware of any particular characteristics or circumstances of the actual consumer, those are to be taken into account.
>
> (5) A misrepresentation made dishonestly is always to be taken as showing lack of reasonable care.

15. Section 4 limits the circumstances in which an insurer has a remedy against a consumer for misrepresentation. Such a remedy is available only where there is a *qualifying misrepresentation* which is defined in section 4(1). Further, this section provides that an insurer which has established a *qualifying misrepresentation* is only entitled to the remedies set out in Schedule 1:

> (1) An insurer has a remedy against a consumer for a misrepresentation made by the consumer before a consumer insurance contract was entered into or varied only if—
>
> a. the consumer made the misrepresentation in breach of the duty set out in section 2(2), and
>
> b. the insurer shows that without the misrepresentation, that insurer would not have entered into the contract (or agreed to the variation) at all, or would have done so only on different terms.

> (2) A misrepresentation for which the insurer has a remedy against the consumer is referred to in this Act as a "qualifying misrepresentation".
>
> (3) The only such remedies available are set out in Schedule 1.

16. Section 5 distinguishes between representations which are deliberate or reckless and those which are merely careless. It also deals with the burden of proof. I set the section out in full. However, the defendant's pleaded case is that the claimant's answer amounted only to a careless misrepresentation:

> (1) For the purposes of this Act, a qualifying misrepresentation (see section 4(2)) is either—
>
> a. deliberate or reckless, or
>
> b. careless.
>
> (2) A qualifying misrepresentation is deliberate or reckless if the consumer—
>
> a. knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and
>
> b. knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.
>
> (3) A qualifying misrepresentation is careless if it is not deliberate or reckless.
>
> (4) It is for the insurer to show that a qualifying misrepresentation was deliberate or reckless.
>
> (5) But it is to be presumed, unless the contrary is shown—
>
> a. that the consumer had the knowledge of a reasonable consumer, and
>
> b. that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer.

17. If the defendant establishes that the claimant's answer to *The Second Question* was (i) a qualifying representation and (ii) made carelessly then its remedies are prescribed in paragraphs 4 to 8 of Schedule 1.

18. Pursuant to paragraph 4, the insurer's remedies depend upon what it would have done if the consumer had complied with the duty set out in section 2(2). Assuming that the claimant's answer to the *Second Question* was both inaccurate and careless, the defendant's remedy depends upon what it would have done if the claimant had answered the question accurately.

19. Paragraphs 5 to 8 provide as follows:

> 5.
>
> If the insurer would not have entered into the consumer insurance contract on any terms, the insurer may avoid the contract and refuse all claims, but must return the premiums paid.
>
> 6.
>
> If the insurer would have entered into the consumer insurance contract, but on different terms (excluding terms relating to the premium), the contract is to be treated as if it had been entered into on those different terms if the insurer so requires.
>
> 7.
>
> In addition, if the insurer would have entered into the consumer insurance contract (whether the terms relating to matters other than the premium would have been the same or different), but would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim.
>
> 8.
>
> "Reduce proportionately" means that the insurer need pay on the claim only X% of what it would otherwise have been under an obligation to pay under the terms of the contract (or, if applicable, under the different terms provided for by virtue of paragraph 6), where—
>
> $$X = \frac{\text{Premium actually charged}}{\text{Higher premium}} \times 100$$

(4) The decision at first instance

20. The issues for determination at trial were:

20.1 Did the claimant answer the *Second Question* accurately.

20.2 If the claimant's answer to the *Second Question* was not accurate, did she breach the duty under section 2(2) in giving that answer;

20.3 If the claimant was in breach of her duty under section 2(2), was the careless misrepresentation a *qualifying misrepresentation;*

20.4 If there was a *qualifying misrepresentation*, what relief was the defendant entitled to under Schedule 1.

21. The claimant argued that *The Second Question* was ambiguous or unclear. In support of that argument Mr Gould drew the court's attention to the previous question (the *First Question)* which asked:

> "Does any person to be insured have a pre-existing condition?
>
> To ensure you have the right cover for your trip it is important you tell us about your medical history. If you do not declare medical conditions this

> could invalidate your policy. Examples include diabetes, high blood pressure, depression and respiratory conditions (including asthma)"

22. Mr Gould argued that the *Second Question* did not define the term *medical condition* and that the back pain the claimant suffered in June 2016 was only a symptom caused by a lifting injury and was not a "*condition*" as that was something which should be equated to the type of illness identified by way of example in the First Question such as *diabetes*, *high blood pressure* etc. Further, Mr Gould argued that the context in which the question was asked would have led a reasonable consumer to assume that transient symptoms caused by a one-off incident were irrelevant. The reasonable consumer would have assumed that the insurer was asking about the type of illness which might require treatment whilst abroad and covered by the policy, rather than symptoms from a time limited injury.

23. The Deputy District Judge first directed himself that the Second Question should be construed objectively: see paragraph 10. Applying that test, the Deputy District Judge rejected Mr Gould's submission that the Second Question was ambiguous. The claimant had consulted a doctor and had been prescribed medication. The Deputy District Judge held that the injury and the symptoms which kept the claimant off work for four weeks would objectively and reasonably have been considered to be a medical condition: see paragraphs 12 and 14 of the judgement. He, therefore, held that the claimant's answer to the *Second Question* was inaccurate.

24. Although the *Second Question* had to be construed objectively, Mr Gould argued that the claimants had not acted carelessly even if they had given an inaccurate answer. Mr Kramarczyk gave evidence that he found the Second Question confusing and had asked the claimant for her advice. After a discussion, they decided that the *Second Question* was just asking "*the same question again and looking for further confirmation*". Mr Kramarczyk acknowledged that the claimant had suffered a back injury but asserted that it was not a condition, but an injury caused by a single act. The claimant and Mr Kramarczyk then agreed that they would answer no to the *Second Question*.

25. Mr Gould rightly argued that the court must determine whether the consumer had taken reasonable care "*in the light of all the relevant circumstances*": see section 3 (1). He further referred to the factors identified in section 3(2)(a)-(c) of the Act. Mr Gould argued that the claimant and her husband had acted reasonably because they had read the questions in detail and given some thought to them, discussed them and then reached a conclusion as to the appropriate answer which was not unreasonable given: (i) the limited information available to them, (ii) the absence of any definition of the term "medical condition", (iii) the apparent absence of any contact telephone number where they could seek advice and (iv) the likely level of diligence to be expected of someone filling in such a questionnaire online.

26. The Deputy District Judge rejected Mr Gould's argument and held that the claimant was careless in completing the form. He pointed out that there was an opportunity to make enquiries if the claimant had any doubts as to how the question should be answered: see paragraph 13. As he put it at paragraph 15:

> If you had been so minded, you could have made further enquiry, or even if you had doubts you could have terminated the application for the policy until you knew fully what was being requested of you.

27. The court should then have considered whether the claimant's careless misrepresentation amounted to a qualifying misrepresentation for the purposes of section 4(1). The court did not do so expressly. However, it follows from the court's findings on the first two issues that the claimant had made a misrepresentation in breach of the duty set out in section 2(2). Therefore section 4(1)(a) was satisfied. In order to satisfy the condition in section 4(1)(b) the defendant had to prove that, but for the misrepresentation, it would not have entered into the contract at all or would have done so only on different terms.

28. The defendant relied upon the evidence of Tracy Richards. [As far as I can see from the transcript Ms Richards was employed by a company as operations director for the company responsible for the management of the website rather than the defendant insurer. However, this does not appear to affect matters]. Ms Richards explained that the defendant offered the *Coverwise Silver Policy* to those consumers who answered "No" to the relevant questions about previous conditions. This was a standard form policy which would not be available to any consumer who had answered "Yes" to those questions. However, at paragraph 14 of her witness statement, Ms Richards explained that:

> Coverwise also offers a "Select" product, which is a higher risk product available to policyholders who declare pre-existing medical history in the inception process

29. In her oral evidence Ms Richards explained that a consumer who disclosed a pre-existing medical condition would not necessarily have been referred to a policy by the same provider. Customers would be presented with a "*completely new list of insurers, which they would have then had the opportunity to start the selection process from again*". Ms Richards confirmed that neither she nor her colleague, Ruth, who investigated the claim considered the claimant's details and that of her husband against the policy requirements of the defendant's other products.

30. On the face of this evidence, I consider it clear that the defendant would not have entered into the policy on the same terms had the claimant answered the Second Question accurately. Therefore, the claimant's answer was a *qualifying misrepresentation.*

31. In submissions before the Deputy District Judge, Mr Gould appears to have accepted that the defendant would not have offered the policy on the same terms had the Second Question been answered "Yes" and moved straight to the final issue, namely whether the defendant would have contracted with the claimant on any terms: see [60-61] (of the appeal bundle).

32. Mr Gould took the Deputy District Judge to paragraphs 4 to 8 of Schedule 1 and argued that the defendant had failed to establish that it would not have issued a policy on any terms given the evidence of Ms Richards.

33. Mr Fleming replied that the legislation required the insurer to show that:

> … the insurer would not have contracted on any terms on the specific insurance policy that is provided, rather than on any insurance policy at all which is what my learned friend seems to have been implying.
>
> The purpose-taking a step back and looking at the purpose of this test-is clearly one of causation. It's for the court to be able to determine-well they-and look at things practically and

the issue of causation, and to determine whether if a customer were to provide careless information, would they have been provided with a policy in any event, and-rather than, it cannot have been the purpose of the legislation to impose such a high burden on the insurers, that they would only be able to avoid an agreement if they had not been able to provide an insurance policy at all to the claimant on any possible terms. That's simply too high-to high threshold. In that event, any claim in which the consumer could have been offered a policy at a higher price if they had not made a careless statement, would not be voidable. And that simply cannot have been the purpose of the legislation

34. The Deputy District Judge dealt with the final issue in paragraph 16 of his judgement. He stated:

> This can be a complex matter on its analysis. In my judgement it does not have to be.... I have decided your claim is dismissed simply on the basis that you did not comply with the requirement of disclosure to the insurance company before it issued its policy.... That (the pre-existing condition/treatment) needs to be disclosed, and unfortunately that was not disclosed. And this insurer is, therefore, in my judgement, entitled to avoid the policy, to say we are not insuring you because you did not meet our terms and conditions; you did not disclose information to us which we could validly and properly assess the risk... The £22 in payment bears no relevance whatsoever to the potential loss as in this case. That does not matter because the insurer takes on the risk, it takes the risk, and if it has to pay out so it does. But not where, given the additional pieces of information or pieces of information, it could have decided not to ensure or insure elsewhere a different policy. That is my judgement today.

(5) Permission to appeal on paper

35. In the Appellant's Notice the claimant relied upon three grounds of appeal arguing that the Deputy District Judge failed:

35.1 properly to construe the term "*condition*" in the *Second Question*;

35.2 to give any or any adequate weight to a series of allegedly relevant considerations when determining whether the claimant had been careless;

35.3 properly to apply paragraphs 4 to 8 of schedule 1, and in particular erred in allowing the defendant to avoid the policy.

36. By an order drawn the 27 October 2021 I refused permission to appeal on Grounds 1 and 2 but granted permission to appeal on Ground 3.

37. The claimant indicated that she would make a renewed oral application for permission to appeal in relation to grounds 1 and 2.

38. I directed that any renewed oral application for permission to appeal be heard at the same time as the appeal in relation to Ground 3.

(6) The renewed oral application for permission to appeal

(6)(a) Ground 1: Construction

39. It was agreed that that Second Question must be construed objectively and that the following dicta of Lord Hoffman in **Investors Compensation Scheme Ltd v West Bromwich Building Society** [1997] UKHL 28 were helpful:

> "Interpretation is the ascertainment of the meaning which the document would convey to a reasonable person having all the background knowledge which would reasonably have been available to the parties in the situation in which they were at the time of the contract."

40. It was also agreed that the Deputy District Judge had applied an objective test when construing the *Second Question*.

41. Therefore, in order to obtain permission to appeal the claimant had to show that there was a real prospect of successfully establishing that the learned judge:
41.1 failed to take into account material factors; or
41.2 took into account immaterial factors; or
41.3 Reached a conclusion not open to a reasonable tribunal on the evidence.

42. I do not accept Mr Gould's submission that the term "*condition*" in the Second Question was ambiguous-whether because of the examples given in the *First Question* or at all.

43. The term "*condition*" must be read in its context as part of the *Second Question*. This requires a consumer/potential customer to answer whether *"within the last 5 years have you … suffered any medical condition that has required prescribed medication and/or treatment …".* In my judgment it is quite clear that the term "*conditio*n" is not limited to the examples used in the First Question but applies to any medical condition for which treatment was received or medication prescribed.

44. Equally, in my judgment, it is quite clear that a back injury sustained at work which caused problems which led a patient to consult their GP and receive a prescription for analgesic medication falls squarely within that question

45. I do not think that this was a particularly onerous term as suggested by Mr Gould. It was a simple question which required a simple answer. Further, it is not relevant whether the claimant took the medication. The question asks whether it was prescribed. Equally it is not material to the meaning of the question that the claimant's injury was modest and that she made a good recovery. She had an injury which caused symptoms and for that condition she consulted her GP and was prescribed medication.

46. I do not consider it arguable that the *Second Question* could have any other meaning. Further, it is certainly not arguable that the Deputy District Judge erred in reaching his conclusion as to the appropriate construction of the *Second Question*. The claimant has no real prospect of success on Ground 1 and permission to appeal on Ground 1 is refused.

(6)(b) Ground 2: Reasonable care

47. Mr Gould argued that that Deputy District Judge's decision was predicated solely on his conclusion that the *Second Question* was unambiguous. In the circumstances Mr Gould argued that the Deputy District Judge failed properly to take into account that the claimant (and her husband) was (were) confused by the question and failed to give any or any adequate weight to the following:

47.1 When selling insurance online the defendant must be taken to accept:

   .1 The limited amount of information a consumer is reasonably going to take into account;

   .2 The level of diligence exercised by its target audience;

47.2 The claimant and her husband were confused by the question;

47.3 The failure of the site to define the term "*medical condition*";

47.4 The claimant and her husband could not recall seeing a contact telephone number to seek advice.

48. I reject Mr Gould's argument.

49. First the Deputy District Judge did not base his conclusion that the claimant had been careless only on the fact that she had inaccurately answered an objectively unambiguous question. He expressly recorded that the claimant and her husband had doubts about the meaning of the question and discussed it: see para 13. He found that the claimant and her husband could (and implicitly, should) have made further enquiry or terminated the application until they were clear about what was being asked: see paragraph 14.

50. Further, the assertion that the Kramarczyks did not recall seeing a telephone number does not accurately reflect their evidence. The claimant's reply when asked in cross-examination whether she had checked the website for a contact number was that "*My husband did that".* However, Mr Kramarczyk stated that he had not looked for a telephone number stating "*Well, no. The questions that they asked me in good faith. So why would I look for a telephone number to check something that I just…".*

51. The learned judge was entitled to find that the claimant had failed to exercise the care to be expected of the reasonable consumer in:

51.1 Giving adequate thought to her answer to the Second Question which was unambiguous and clear; and

51.2 Failing to investigate what the answer should be if she remained confused as to the meaning of the question.

52. I do not consider that the claimant has any real prospect of success in this argument. Therefore, I refuse the renewed oral application for permission to appeal on Ground 2.

(7) The Appeal: Ground 3

(7)(a) Introduction

53. Given my conclusions in relation to Grounds 1 and 2 it is clear that the claimant's answer to the Second Question was a *qualifying misrepresentation.*

54. It follows from that finding that the provisions of Schedule 1 were engaged.

55. Unfortunately, the Deputy District Judge did not analyse the defendant's right to avoid the contract through the prism of Schedule 1. In my judgement his analysis comes closer to the common law approach to material non-disclosure which applied before the Act came into force. In the circumstances the Respondent, (rightly) accepted that this analysis cannot stand.

56. The claimant argues that there is a "lacuna" in the defendant's case because Ms Richards' evidence establishes only that, but for the misrepresentation, it would not have contracted on the *Coverwise Silver Policy*. It does not establish that the defendant would not have contracted on any terms at all. Further, having failed to produce evidence of any alternative basis upon which it would have contracted the defendant cannot claim a reduction in the amount by which it has to indemnify the claimant under the policy proportionate to the relationship between the premium in fact paid and the premium which would have been due under the policy that would have been issued had proper disclosure been made in accordance with the calculation at paragraph 8 of the Schedule.

57. The Respondent contends that on a proper analysis the appeal should be dismissed and that the decision can and should be upheld on the basis that:

57.1 The claimant should not be entitled to argue that the defendant has failed to prove that it would not have entered into the contract on any terms because that claim was not pleaded. Although this argument was advanced before the Deputy District Judge, it was first made clear in Mr Gould's Skeleton Argument served 3 days before the trial;

57.2 In any event the court should find that the defendant is entitled to avoid the policy as it can show that, but for the misrepresentation, it would not have entered into the same type of insurance policy with the claimant because it is clear that it would not have entered into the *Coverwise Silver Policy*. Properly construed, the Schedule does not require the defendant to establish that it would not have entered into the *Coverwise Silver Select* policy;

57.3 In any event, if I am against the defendant on these two issues, I should remit the matter for rehearing and allow the defendant to adduce further evidence as to whether it would have entered into a policy on any terms and, if so, the extent of any premium increase.

(7)(b) The pleading point

58. In my judgment the starting point is to look at the Act which now governs the circumstances in which an insurer can obtain any remedy against a consumer who makes a qualifying misrepresentation when entering into a consumer insurance contract: see paragraph 4(1).

59. In order to obtain any remedy there must be a qualifying misrepresentation. The claimant asserted that she had answered the Second Question (a) accurately and (b) in any event, carefully. In the circumstances, in my judgment, it was for the defendant to plead and prove that there was a qualifying misrepresentation so as to show it was entitled to the remedies prescribed by Schedule 1.

60. Paragraph 5 provides that the insurer may avoid the contract *If the insurer would not have entered into the consumer contract on any terms.*

61. Paragraphs 6 and 7 of Schedule identify what is to happen *If the insurer would have entered into the consumer insurance contract **but*** … on different terms and/or at a higher premium.

62. The paragraphs do not identify which party must prove that the relevant condition must be satisfied.

63. However, in my judgment, this burden must rest on the insurer. I reach that conclusion for the following reasons:

63.1 The only party who can properly answer whether the relevant condition is satisfied is the insurer. No consumer can be expected to know whether the insurer would have accepted or rejected the policy and/or what other terms it would have imposed and/or what increase in premium it might have demanded. These matters are potentially commercially sensitive and within the sole knowledge of the particular insurer which may have different practices from its competitors such that even expert evidence could not provide a conclusive answer;

63.2 There may be cases where it is appropriate for a consumer to obtain expert evidence to challenge an insurer's claim that it would not have entered into the policy. For example, it might have been proportionate to do so in this case given its value. However, in most consumer insurance contracts it would be disproportionate to incur such costs. If the burden to plead and prove that the defendant would not have entered into the consumer insurance contract on any terms lay on the claimant such evidence would be needed from the outset;

63.3 I do not consider that such a construction is consistent with the purpose of the Act which is designed to provide additional protection to the consumer and to ameliorate the effects of the traditional rules on material non-disclosure;

64. In the circumstances, I consider that it is for the defendant to plead and prove that:

64.1 The claimant was guilty of a qualifying misrepresentation; and

64.2 It is entitled to avoid the policy completely pursuant to paragraph 5 because it would not have entered into the consumer insurance contract on any terms; and/or

64.3 It would have entered into the policy on different terms; and/or

64.4 It would have charged a higher premium.

65. Looking at the pleadings:

65.1 The particulars of claim assert that the claimant had answered the *Second Question* accurately and, in any event, honestly and reasonably: see paragraph 18. The claimant then asserts that the defendant is in breach of contract in failing to indemnify her;

65.2 The Defence identifies the claimant's answer to the *Second Question* and asserts that:

.1 It was a *defined misrepresentation* under the Act;

.2 If the questions had been answered accurately, the defendant would not have entered into the *Coverwise Silver Policy*;

.3 Had the claimant answered the Questions accurately it would not have entered into the insurance contract on any terms;

.4 Once it identified the careless misrepresentation, the defendant had invoked its remedy under Schedule 1 to avoid the contract and return the premium;

.5 In the circumstances the contract had been "cancelled"

.6 See paragraph 7(iv) to (viii).

65.3 There was no Reply.

66. In my judgment, the defendant correctly identified that it must plead and prove that it was entitled to avoid the contract pursuant to paragraph 5 of Schedule 1. However, it did not seek to put forward an alternative case on the basis that it would have entered into such a policy albeit on different terms and/or at a higher premium.

67. Where no Reply is served, the claimant is deemed to join issue with all matters in the Defence (save in so far as it consists of admissions). I do not consider that it was for the claimant to put in a Reply asserting that the defendant would have entered into such a policy and identify the terms/premium on which it would have done so. The claimant is deemed to have joined issue with the assertion that the defendant would not have advanced a policy on any terms. It was for the defendant to prove that and, if it could not, to claim relief under paragraphs 6 to 8 of the Schedule.

68. In the circumstances, I do not consider that there was any failure on the part of the claimant to plead her case. The claimant was entitled to advance the arguments upon which Mr Gould relied at trial (and to which Mr Fleming made no objection at that stage). Further, the claimant is entitled to take the point on appeal.

(7)(c) Construing Schedule 1

69. Mr Fleming argues that it is significant that paragraph 5 uses the definite article "the" when referring to the insurance contract:

> If the insurer would not have entered into **the** consumer insurance contract on any terms, the insurer may avoid the contract and refusal claims, but must return the premiums paid.

70. He submits that "the" contract means the same type of insurance contract which would have been entered into by the insured and not any contract of insurance which may have been offered by the insurer. If the legislation had intended to cover any prospective agreement between the insurer and the consumer it would have referred to "a" or "any" consumer insurance contract.

71. Whilst paragraph 6 and 7 provide for cases where the insurers might have entered into the contract on different terms, both provisions specifically refer to possible variations of "the" consumer insurance contract that was entered into. In this case the defendant would not have varied its standard form *Coverwise Silver Policy* at all. If this is "the" contract, then even if the defendant had been prepared to enter into a *Coverwise Silver Select Policy* contract of insurance that would have been a wholly different contract and not "the" consumer insurance contract (*Coverwise Silver Policy*) on different terms.

72. In making his submissions Mr Fleming emphasised that insurers providing policies through comparison websites would be at a significant commercial disadvantage if the court adopted the construction for which the claimant contends and that they would no longer be able to offer such attractive premiums.

73. In my judgment, the purpose of the Act is to put the insurers and careless consumers in the position which would have applied if the careless consumer answered all pre-contractual enquiries accurately. If the insurer can show that it would not have insured the consumer,

then it can avoid the policy. If the insurer can show that it would have included additional terms-for example, an exclusion clause relating to any recurrence of the pre-existing condition-then the insurer can benefit from that clause. If the insurer would have offered cover but charged a higher premium, then the claimant cannot expect to receive a full indemnity in return for paying the additional premium. Such a course would encourage consumers to be careless as they would only have to pay in full where they had a claim. The Act allows insurers to reduce the extent of their indemnity in proportion to the relationship between the premium paid and that which should have been due. It is clearly intended that these provisions should replace the old rules on material non-disclosure which allowed the insurer to avoid the policy and return the premium. In the circumstances the Act is intended to prevent insurers enjoying a "windfall" benefit where careless non-disclosure of an issue which did not relate directly to the claim might otherwise have allowed them to avoid the policy in full.

74. The difficulty with Mr Fleming's argument is that it is not clear in what circumstances he would accept that a policy in which a term was changed remained "the" policy so as to be caught by paragraphs 5 to 8 of the Schedule. In practice his approach would limit the application of the Act to bespoke policies which are individually negotiated and where individual terms can be altered. It would exclude those policies which are based on an insurer's non-negotiable standard terms and conditions where the insurer would still provide cover but subject to a different set of standard terms with a different marketing title. There is no evidence before the court as to the proportion of consumer insurance contracts that are individually negotiated and which are on insurers' standard terms. I suspect that the vast majority of consumer insurance contracts are on standard terms, However, I do not think I can make such a finding in the absence of evidence. However, in my judgment, I can take judicial notice that a substantial proportion of consumer insurance contracts are incepted online on insurers' standard terms. Mr Fleming's approach would exclude these insurance contracts from the reforms introduced by the Act. I do not consider that this was the purpose behind the Act or that it should be construed in such a way.

75. In my judgment Mr Fleming is placing far too much weight on the use of the definite article. Even without adopting a purposive construction, the natural and obvious meaning of paragraphs 5 to 8 is that, in this case, "the consumer insurance policy" is the travel insurance policy. The court must ask whether the defendant has shown that, but for the misrepresentation, it would not have offered the claimant a travel insurance policy albeit on different terms or at a different premium from those which applied to the *Coverwise Silver Policy*. Reassuringly, such a construction is entirely consistent with the purpose and effective operation of the Act.

(7)(d) Applying the Act properly construed.

76. I accept that the defendant established that it would not have offered the claimant a *Crosswise Silver Policy*.

77. However, there was no evidence that the relevant insurer would not have contracted on any terms. Ms Richards expressly stated that the defendant offered a *Crosswise Silver Select Policy* for those consumers who had pre-existing conditions. The defendant's evidence that the proposal would have gone back to a medical panel and that this would have generated a

range of policies for consideration by the claimant is not sufficient to establish that the defendant would not have entered into a travel insurance policy on any terms given the pre-existing condition. On the contrary it suggests that the defendant would have been one of a number of insurers who offered a policy to the claimant which she could have accepted if she wished, a decision which is likely to have depended upon how competitive it was.

78. It follows that, in my judgment, on the evidence before the Deputy District Judge, the defendant has not satisfied paragraph 5 of Schedule 1. On that basis it is not entitled to avoid the policy but remains bound by its terms. Further, on the evidence before the Deputy District Judge, the defendant would not be entitled to rely on any exclusion that might have been included in the policy nor would it have been entitled to a proportionate reduction in the level of indemnity having failed to put forward any evidence on the issue.

79. Therefore, the claimant is entitled to succeed unless the matter should be remitted to a District Judge and the defendant allowed to call further evidence as Mr Fleming submits.

(7)(e) Remitting the matter for a further hearing

80. In my judgment it is not appropriate to remit the matter for a further hearing.

81. Given my finding on the pleading issue, it was for the defendant to plead and prove its case. The defendant made a choice that it would not seek to argue in the alternative that it would have offered a consumer insurance contract on different terms and/or at a higher premium. There are many potential explanations for that decision. It may have reflected the defendant's confidence that it would win on the construction issue. It could have been a deliberate tactical decision to avoid providing the court with a way of "middling" the case which might have detracted from its primary argument that it would not have entered into a policy on any terms. However, all those were issues for the defendant to consider. It was open to it to have pleaded its case on the construction issue and argued that, if the court reached a different conclusion as to the way the Act operated it would, for example, have offered an alternative policy at a significantly higher premium. The defendant chose not to take that course.

82. The matter came before Deputy District Judge Swan for trial. It was for the parties to have all relevant material ready for that trial.

83. In my judgment to remit the matter for a further hearing and allow the defendant to adduce further evidence would be to allow it a second bite of the cherry. I do not consider that such a course is consistent with the overriding objective or the need for finality in litigation.

84. Therefore, I am not prepared to remit the matter.

(8) Conclusion

85. It follows that the Appeal is allowed, and the claimant is entitled to an indemnity under the policy.

86. The quantified claim in the pleadings was agreed at £3,337.15 after deduction of the £50 excess. There must be judgment for this sum.

87. Further, the claimant is entitled to some order in relation to the hospital costs as identified in paragraph (4) of the prayer. That order is better expressed as an indemnity rather than an injunction. I will leave it to the parties to agree an appropriate formula.

20th July 2022

HH Judge Mark Gargan