



INSURANCE:
SOLVING SOME
ALCOHOL
PROBLEMS AND
CAUSING OTHERS

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Please note that the views expressed in this paper are those of the author and do not represent the views of the Institute of Alcohol Studies

INSURANCE: SOLVING SOME ALCOHOL PROBLEMS AND CAUSING OTHERS

By Jonathan Goodliffe, solicitor

Introduction

Problem drinking may lead to financial problems for the drinker and those affected by his behaviour. In England 21% of adults have an alcohol use disorder likely to cause problems for them. 3.6% of adults are alcohol dependent (i.e. in common language they might be labelled "alcoholics")¹.

Alcohol is a proven factor often causing or contributing to the occurrence of many risks against which insurance is commonly taken out. These include, for instance, death and ill health², crime³, accidents (including motor accidents)⁴ and fire⁵. There are other risks in relation to which a link with problem drinking has been suggested but has yet to be scientifically established. These include professional negligence⁶ and marine collisions⁷.

Insurance can sometimes pay for treatment for the effect of alcohol misuse. It can help to meet the cost of alcohol related harm. Sometimes the insured may be encouraged to avoid alcohol problems, by risk management procedures required by the insurer or by the prospect of paying higher premiums if those procedures are not adopted.

Often alcohol related risks may be excluded from the scope of the cover. Sometimes the non-payment of an insurance claim is an alcohol problem in its own right. Non-disclosure of (among other things) problem drinking by the person applying for cover ("the proposer") may invalidate the insurance. Insurance can also be problematic when it contributes to dangerous behaviour by protecting people from the consequences, as when an alcoholic makes a suicide attempt believing that his family will be able to claim on his insurance.

This paper focuses on the non-disclosure issues whilst also touching other aspects of insurance's relationship with alcohol related risk. I hope to show that there are areas of common interest between the field of alcohol studies on the one hand and of insurance on the other. Focus on common ground may lead to the development of more constructive policies for the reduction of alcohol related harm, for the management of alcohol related risk and for the development of fairer sales techniques.

A case study⁸

Mr. John Smith died in June 2002 aged 42. Three years earlier he had taken out a £105,000 life assurance policy. He did not mention his drinking problem on the proposal form, so the policy was issued at a standard premium rating. The stated cause of death was not alcohol-related. The insurer, however, refused to pay out on the policy to his widow, Mrs Smith. She sued the insurance company but her suit was dismissed by the judge, Mr. Justice Lindsay.

It emerged after Mr. Smith's death that he had consulted his doctor about his drinking problem. The doctor had taken full notes and arranged liver function tests which had to some extent been abnormal. The doctor's notes in 1997, for instance, had recorded

that his patient was drinking half a bottle of spirits a day, that he was binge drinking, had had counselling at work and that there had been a discussion as to his being referred to a local alcohol counselling service.

The proposal form required Mr. Smith to indicate how many units of alcohol he consumed every week. His answer was "8". He also indicated that it had never been substantially higher than that. His counsel pointed out that he was a binge drinker, but the judge commented:

"I suspect that the question as to units a week is deliberately left vague, but I cannot think it is open to an applicant to reduce his figure by reference to an average arrived at over a long period which includes long spells of abstinence. To take an extreme example, it would surely be absurd if an applicant at age 50 who had abstained until he was 45, but who had thereafter drunk a litre of whisky a day, would be able to supply an average arrived at over the whole of his adult life and not expect avoidance of his policy, even if the latter part of the question – has consumption ever been substantially higher? – had not been raised."

At the trial Mrs Smith testified to the effect that her husband's drinking was always at normal levels. The judge commented: "She was not merely an unreliable witness but thoroughly lacking in credibility and all too willing to give false evidence." His comments about the evidence given by Mrs Smith's daughter were only slightly less scathing.

The insurance market and alcohol

The term life assurance taken out by Mr. Smith is only one of a number of insurance products in relation to which a proposer is required to make medical declarations. Other examples of long term (i.e. life related) assurance include mortgage endowment and mortgage protection policies which may pay off a mortgage if the insured dies and critical illness insurance, which pays benefits if the insured suffers from a specified illness. In the field of general insurance (i.e. insurance which is usually renewed – with a new medical declaration - every year) examples include private medical insurance which pays for the cost of private treatment and motor insurance which, among other things, may indemnify the victims of drink driving.

When people take out these insurance policies they are usually asked to complete a medical declaration which may be more or less extensive depending on the type of insurance. Medical declaration forms used in connection with life cover will usually ask questions targeted at, among other things, alcohol consumption. Often there will be a passage in the policy, as there was in Mr. Smith's case, worded to the following effect:

"All material facts must be disclosed to the Insurer. If you fail to do so, the Insurer will make your policy void and reject any claim. If you are in doubt as to whether any fact is material you should disclose it. I/we declare that I/we the proposed life/lives insured am/are in good health and that all statements in the declaration and to any medical examiner appointed by the company, whether in my/our handwriting or not, are to the best of my/our knowledge and belief true and complete."

If the proposal form discloses no serious problems the policy will usually be issued at standard premium rates with no further enquiry. If medical problems are disclosed, the insurer may require a higher premium, a report from the proposer's doctor, or a full medical examination. Some insurers employ medically trained professionals (usually nurses) to help proposers over the telephone to fill in the life insurance proposal forms correctly.

Such declarations will, however, normally be dispensed with when insurance is taken out by an employer for its employees as part of a benefits package. Under such "group policies" the insurer "takes the rough with the smooth" as regards the state of health of the workforce.

Alcohol is not just an issue for the insurer as regards whether it is willing to give cover and if so at what price. There may also be exclusions which are either specific to alcohol problems or to problems which are often (although not invariably) alcohol related. So life assurance may exclude cover for suicide either entirely or during the initial years of the policy. Critical illness cover may exclude treatment for self-harm, for mental illness or for alcohol dependence. It may also more widely exclude treatment for any condition arising directly or indirectly from "inappropriate" alcohol consumption. On a literal reading this exclusion could be held to apply to, for instance, cancer, liver and heart problems, or depression. Accident insurance may also exclude accidents arising when the insured is under the influence of alcohol. Where it does not it may be debatable whether alcohol related injury arises from an "accident" if, for instance, the insured chokes on his own vomit.

Most private medical insurance in the UK also excludes treatment for self-harm, alcohol problems, and sometimes more widely for any condition which is related directly or indirectly to "inappropriate" drinking. A few insurers do, however, offer such cover within the more expensive options. Some insurers only offer this cover to employers under "group policies".

By contrast, in the USA such exclusions may be ineffective in law under the Americans with Disabilities Act. Even in Europe, the more widely worded exclusions may fall foul of the rules in the Unfair Terms in Consumer Contracts Directive⁹, especially when they are buried in small print.

Non-disclosure of alcohol problems

Mr. Smith's case was an extreme example of non-disclosure and misrepresentation inducing an insurer to issue insurance. An insurer underwriting term life assurance has a legitimate interest in establishing whether the proposer has a drink problem. In some cases death may be obviously linked to alcohol consumption, such as from alcoholic liver disease. In other cases, alcohol may be one contributory factor where, for instance, heavy drinking and heavy smoking in combination have an enhanced carcinogenic effect. The link may be difficult to prove. The link between alcohol and some medical conditions may be the subject of research which has yet to arrive at firm conclusions but may be taken into account in underwriting practice.

Sometimes, however, non disclosure may arise from the wrong questions being asked rather than from the wrong answers to legitimate questions.

If one accepts that it was wrong for a heavy binge drinker like Mr. Smith to average out his alcohol consumption at 8 units a week, then what answer should he have given? And if the proposer is asked, for instance, whether his doctor has given him advice about his drinking can he just answer "no"? Or should he mention that he has, for instance, received this advice from his wife, employer, alcohol counsellor or fellow member of Alcoholics Anonymous? And can the insurer avoid answers which are economical with the truth by asking questions in very general terms, such as "is your drinking causing you problems".

These issues, are not, of course, entirely specific to alcohol problems as opposed to other medical conditions. An irrational attitude towards drinking and its consequences, is, however, inherent in the diagnostic criteria for alcohol dependence and abuse¹⁰. This is often referred to as "denial": the drinker cannot face up to the consequences of his actions. Apart from this, heavy drinking may lead to long or short term cognitive impairment, which can further affect people's insight into the implications of their behaviour and ability to rehabilitate themselves.

Dr Dominique Lannes, medical director of French reinsurer, SCOR, put it more bluntly¹¹ by saying "It should be recognised that alcoholics are usually dishonest about their actual alcohol intake". The evidence in the Smith case illustrates how the alcoholic's irrationality concerning his problems can affect his family, although the prospect of financial gain may also have been a significant factor.

A study by the Norwich Union, the UK's largest insurer, the results of which were published in December 2006, identified five main conditions that people fail to disclose when completing insurance application forms. These included "smoking status, alcohol consumption or advised to reduce alcohol consumption."¹²

The law on medical declarations

The law governing the formation of contracts of insurance is bewildering in its complexity, even for specialised lawyers. Traditionally the rule has been that people who take out insurance should disclose all material facts, whether the insurer asks for them or not. Where a proposer provides only slightly inaccurate answers to the insurer's questions, the policy may allow the insurer to repudiate the cover in its entirety.

The severity of these rules has, however, been mitigated in the consumer market by industry standards published by the Association of British Insurers ("ABI"), by rules adopted by the Financial Services Authority ("FSA"), the UK insurance regulator, and by the influence of the Financial Ombudsman Service.

The Law Commission has recently been undertaking a fundamental review of insurance law. If this bears fruit and is translated into legislation, it may require insurers to take more responsibility for making enquiries about people's medical condition at the proposal stage. This will be achieved by, among other things, making it more difficult for insurers to repudiate liability at the later claim stage.

The Financial Ombudsman Service ("FOS")

FOS provides an informal dispute resolution service. It resolves claims by consumers and some small businesses against firms regulated under the Financial Services and Markets Act 2000 ("FSMA"). It has jurisdiction where the value of the claim is no more than £100,000. Some insurers follow its recommendations even when the amount in issue is more than that figure.

FOS is not required to follow the law in arriving at a "fair and reasonable outcome" to the disputes it resolves¹³. The practice it has developed in mitigating the rigours of insurance law is likely to be followed by the Law Commission in its recommendations for reform of the law.

In one case resolved by FOS¹⁴, the policyholder took out critical illness insurance. In September 1997 his doctor had recorded his consumption of alcohol as 80 units a week. This was recorded as having reduced to 40 units a week by February 1998. In his proposal in November 1998 he declared his consumption to be 35 units a week. The insurer repudiated his claim. It contended that he was probably drinking far more than this. FOS considered, however, that there was no evidence to support the insurer's suspicions and upheld the claim. If the claim had gone to trial in the civil courts (which was more likely to have happened if the amount in issue had been significantly more than £100,000) the claimant would have been submitted to the full rigours of cross-examination. This might possibly have affected the outcome, although from a medical perspective the difference between 35 and 40 units a week is of minor significance. Both levels are in the "hazardous" range.

In a more recent case¹⁵ a woman completed a proposal for life assurance in 2002 and died a few years later. FOS held that she had been entitled to answer "No" to the question "Do you consume alcoholic drinks?" when she had recently stopped drinking and had started attending Alcoholics Anonymous meetings. It did not accept, however, that she had been entitled to answer "No" to the questions "Are you currently receiving any medical treatment or attention?" and "Have you ever sought or been given medical advice to reduce the level of your drinking?" The lawyers representing her estate had sought to justify these answers on the basis that her doctor did not consider that her drinking problem was medical and that she had been advised not to reduce her drinking, but to stop altogether.

FOS therefore concluded that the insurers' refusal to pay on the life assurance had been justified.

The FSA's work on the regulation of critical illness insurance

The FSA is the UK regulator for a wide range of financial services, including insurance. In the exercise of its functions, it seeks to achieve four statutory objectives set out in section 2 FSMA, namely (a) market confidence, (b) public awareness, (c) the protection of consumers; and (d) the reduction of financial crime. It has adopted rules regulating the sale of insurance. Some of these follow the ABI standards and FOS practice in mitigating the rigours of the law of insurance¹⁶. One of the most important of the FSA's rules is the requirement that a regulated firm "must pay due regard to the interests of its customers and treat them fairly"¹⁷.

Apart from its work in regulating insurance in general, the FSA focuses its resources on dealing with financial products (including insurance) which give rise to particular problems and threats to its statutory objectives. These often arise because the products may be subject to hard sell or misleading marketing techniques, or because a high proportion of claims on such insurance is rejected.

Critical illness insurance is one such "priority" product. Term life assurance and mortgage protection insurance are not the subject of the same degree of regulatory focus. This may be partly because medical conditions, including problem drinking, which are not fully disclosed are more likely, in the short term at any rate, to lead to illness than to death. In any event critical illness, life and/or mortgage protection insurance are often sold together, usually at the same time as the proposer buys a house and takes out a mortgage.

The FSA published the results of its research into the sale of critical illness insurance in May 2006¹⁸. A number of its comments are worth noting. The emphasis is on getting insurers and their intermediaries to take more responsibility for ensuring that customers understand their responsibilities as well as their rights:

"The other main reason [apart from customers not understanding the nature of the product] why claims are rejected is that customers do not fully disclose information about their medical history. We know that there are cases where customers deliberately mislead the insurer, but in most cases, consumers simply do not understand what is required of them. The fact that dishonest consumers think they can hide information and still make a claim shows how little they understand their obligations and the consequences of not disclosing. This, in turn, is a telling indicator of how effectively firms¹⁹ explain about the need to disclose relevant information."

"We recognise that sales staff are not health experts and so may not be equipped to make judgements about the significance of medical information. But advisers and insurers have an important role to play in making sure consumers disclose the right information. Possible ways that disclosure could be improved include:

- insurers making it clearer in their literature and particularly application forms what they consider to be material – too many application forms are a memory test;
- insurers and intermediaries looking at ways to support advisers and consumers where there are doubts about the materiality of a condition;
- greater consistency across insurers over what information is material; and
- insurers seeking information from GPs more often at the application phase (rather than when claims are made)."

"As critical illness is often a secondary or tertiary purchase (after a mortgage and term assurance) and it has some complex features, firms have trouble getting customers to take enough interest in understanding what they are buying. Of

the high level of claims that are rejected (over 25% in some cases) about half are because customers fail fully to disclose their personal circumstances. So it is important for firms to overcome this problem."

Too little information, or too much?

There is, however, a tension between this aspect of FSA policy and the need to avoid "information overload". There is only so much technical material that people can be expected to read and understand even when they are intelligent and sober. The FSA published a paper in December 2005²⁰ which addressed this information overload problem. Its focus was on how insurers should compose "policy summaries". These summaries, in contrast to the small print of the full policy itself, are actually supposed to be read by customers. One of the FSA's suggestions was that, when preparing policy summaries, for private medical insurance, payment protection insurance and travel insurance, firms should consider omitting reference to the fact that self-inflicted injury and claims, loss or treatment as a result of misuse of drugs or alcohol are excluded from the cover.

Andrew McNeill, of the Institute of Alcohol Studies commented²¹:

"The national alcohol strategy shows that heavy drinking is common, with around a quarter of the population exceeding the recommended maximum limits. Estimates for alcohol dependence are five per cent to seven per cent of men and about two per cent of women (but these proportions will be higher in the population of working age). The strategy also contains a recommendation to develop workplace policies and responses. I would have thought these engage directly with the terms of private health insurance policies. So if the customer concerned is a corporate body, coverage of alcohol misuse will or should influence the decision to buy, partly because the problems are not that infrequent. Employees should also know whether the condition is covered. In any case, even an infrequent condition could be highly problematic and disruptive when it does occur, so frequency is not the only consideration. I question, therefore, whether what is proposed is consistent with the aims of the national alcohol strategy."

Some research might also perhaps be worthwhile into how exclusions for self-harm and suicide in insurance policies influence the behaviour of policyholders. It cannot be assumed that there is no such influence.

Doctor Guy Ratcliffe, Medical Director of the Medical Council on Alcohol, has suggested that in this context policy summaries should be tailored to the individual. If, for instance, the proposer under a critical illness policy has divulged an alcohol history which is likely to result in loaded premiums the summary might highlight any exclusions for alcohol related conditions.

A similar issue may arise in motor insurance. An insurance policy may require the insured to refrain from drinking and driving. If he ignores this and injures someone and is convicted of driving while over the limit, the insurer must indemnify the victim. It may, however, be entitled to recover its outlay from the policyholder if there is a clause in the policy to that effect²². Should this also go into the policy summary? Or is this

something which is more effectively highlighted in, for instance, a government publicity campaign or a television drama documentary²³?

The Law Commission insurance law project

The Law Commissions of England and Wales and Scotland have responsibility for making recommendations to the UK government for reform of the law, particularly in areas which are not politically controversial. They are currently consulting on reforms to insurance law. Many of these are likely to be aimed at redressing the balance in the protection of the often conflicting interests of insurers and insureds, especially in the retail market.

The Law Commission has suggested²⁴, for instance, a rule restricting the ability of insurers to rely on non-fraudulent misrepresentations in consumer life policies. One option is to exclude any such reliance after the policy has been in force for three years.

Long term harmful alcohol consumption often leads to severe financial problems. In extreme cases, the drinker may lose his livelihood, he may be seriously in debt and the equity in his home may have been entirely mortgaged away. If he then dies the insurance policy on his life may be the only asset in his estate of any value. So the rule proposed by the Law Commission might give his family some protection.

Such a rule might, however, also result in a significant reduction in the availability of, and increase in the cost of, insurance cover.

An insurer can, of course, defend an insurance claim on the grounds that a medical declaration is not only inaccurate but fraudulent. That is to say the proposer knew that it was untrue, or was reckless as to whether it was true or false. It is, however, difficult to prove fraud in the courts or in claims to FOS, particularly in regard to something as subjective as problematic drinking. FOS expects fraud to be proved "beyond reasonable doubt"²⁵.

The causes of insurance fraud and misrepresentation

The FSA's perspective on problematical medical declarations, as expressed in its paper on critical illness insurance, is in a sense at the opposite extreme from that of Dr Lannes of SCOR. Dr Lannes highlights the dishonesty of the "alcoholic". Research into alcohol related problems shows, however, that "the population sum of lesser and preventable problems may in some circumstances exceed the sum of large and manifest problems which are of lower occurrence"²⁶. It is not only alcoholics who have drink problems and a faulty perspective into their significance and how they arise.

In contrast to Doctor Lannes, the FSA sees the belief on the part of some consumers that they can get away with insurance fraud, as being a consequence of the failure of its regulated firms to give adequate explanations to consumers as to their responsibilities. This makes no allowance for the cognitive symptoms associated with problem drinking and many other medical conditions. It is also difficult to reconcile with the FSA's statutory duty to have regard to "the general principle that consumers should take responsibility for their decisions"²⁷. It might be argued that this principle should also extend to taking responsibility for the consequences of their drinking²⁸.

The FSA's analysis assumes that the consumer's belief that he can get away with fraud is wrong. This is far from obviously the case, given the difficulty of proving misrepresentation, much less fraud. A cynical perspective might be that there is no harm in making a fraudulent medical declaration as to your drinking habits, particularly if you do not take your doctor into your confidence. The insurer will probably not be able to prove fraud or misrepresentation. Even if it does, you are unlikely to be prosecuted (although you may find it difficult to get insurance in the future – if you are still alive). On the one hand the FSA encourages regulated firms to take effective measures against insurance fraud²⁹. On the other hand insurers have been accused by FOS³⁰ of creating the problem by adopting "stonewalling" defence tactics where fraud is suspected.

There are, however, arguably many reasons, in addition to those put forward by the FSA, as to why medical declarations are often misleading (particularly as to the existence of medical problems with significant psychological symptoms and social stigma). Alternative explanations for why people are untruthful are also worthy of research. They might include long term cognitive impairment arising from alcohol misuse, short term memory loss, including alcoholic blackouts, normal memory loss, arrogance and wishful thinking.

Even a proposer making a genuine effort to be honest may include inaccurate information. The information and advice which doctors give to their patients about their condition may be aimed at helping them to recover rather than enabling them to give accurate descriptions of their medical condition. Sometimes doctors may even deliberately withhold relevant information, as to, for instance, the first evidence of cancer or of Wernicke's encephalopathy³¹, if they consider that revealing it might be traumatic for the patient or might provoke an aggressive reaction. Moreover, most doctors receive limited training on the consequences of harmful alcohol consumption and its treatment. They may also have little interest in addiction and its treatment. Their expertise, if any, in this area depends on any know-how that they pick up in the course of their practice.

The role of doctors

Most proposal forms require the proposer to consent to the insurer approaching his doctor for further information. In most cases this will not be done. Even if the proposer discloses obvious minor medical problems, these can be provided for simply by quoting a higher premium. ABI guidelines suggest that proposal forms should mention the possibility of the proposer consulting his doctor before completing the form, but this suggestion is not always communicated.

Some insurers employ nurses to help people to complete the form. This is likely to produce a better outcome than, for instance, leaving the proposer to complete the form over the internet where it is all too easy to "tick the box" without thinking through the consequences. Another advantage for the insurer of using nurses in this way may be that it helps to ensure that the form does eventually get completed (thus achieving sales targets) and is not just abandoned half way through. The nurse does not, however, have access to the proposer's medical records, so the "garbage in, garbage out" principle may sometimes apply.

Best practice may be, however, for the proposer to discuss the completion of the form with his doctor, especially if there are a number of medical problems to disclose. If there is an alcohol problem, the doctor may say to his patient: "perhaps you should do something about your drinking before applying for insurance". Such "brief interventions" are an established and often successful way of encouraging people to stop or reduce their drinking³². Where the proposer does disclose significant problems in most cases underwriting practice will alert him to the need for medical advice. The need for this to happen could perhaps be more clearly highlighted, for instance in the ABI's Statement of Best Practice for Critical Illness Cover³³.

There may, however, be a legal impediment restricting the extent to which doctors can advise patients on how to complete medical declarations for insurance cover. Such advice, if carried on "by way of business", may amount to an "insurance mediation activity"³⁴. The doctor may either require FSA authorisation or to establish that he is exempt by law from the requirement for such authorisation. It is not entirely clear whether any exemption applies.

These regulatory issues would probably not arise if the doctor could show that he is receiving no remuneration (either directly or indirectly) for the advice. The same would apply if he confines the advice which he gives to his patient to information about the latter's medical condition, rather than to suggestions as to how the declaration might be completed. Sometimes the line between these concepts may be difficult to draw. Nurses employed by insurers or intermediaries are unlikely, of course, to be similarly constrained in the advice they can give.

Both the FSA and the Law Commission have remarked that people who complete these medical declarations often assume (if they do not read the small print) that the insurer will contact their doctor for further information. The Law Commission has tentatively proposed³⁵ that an insurer who has indicated that it may obtain information from a third party (by, for example asking the insured for consent to obtain it) should not be allowed to rely on a non-fraudulent misrepresentation if the insured reasonably thought that the insurer would check with the third party.

Alternative possible approaches to the problem

Dishonesty, or untruthfulness falling short of dishonesty, is a common consequence of alcohol and drug misuse. This untruthfulness may be apparent in other business and social contexts, including, for instance, employment, marriage and the professions. Alcoholic lawyers commonly steal money from their clients or get involved in moneylaundering transactions³⁶. Medical conditions other than alcohol and drug misuse may also lead to cognitive impairment and thus untruthfulness. One of these, also identified in the Norwich Union study, is depression, which, is often co-morbid with alcohol dependence. People suffering from terminal neuro-degenerative conditions may have difficulty accepting that they are dying and that life or illness insurance at any reasonable price is unlikely to be a realistic option for them.

From this perspective there may be ways of raising the standard of disclosure in medical questionnaires apart from simply encouraging regulated firms to try ever harder to explain things to people. Anything that helps people to get a better insight into their condition can contribute to the process of recovery from alcohol dependence as well as the likelihood of their medical declaration being honestly completed.

One possible starting point may be better communication between the insurance industry and professionals in the addiction field, especially doctors in general practice. Scientific research and practical lessons arising from experience with patients and clients can feed into underwriting practice.

Equally, underwriting and claims experience such as that published by Norwich Union can inform scientific research. Diversified multinational insurance groups such as Aviva (of which Norwich Union is a member), Swiss Re, SCOR and others are particularly well placed to identify common trends in alcohol related risk across different product lines and national frontiers.

There are indications that this process does take place, at least to some extent. The initiative is most obviously coming from the insurance industry. Leading reinsurer Swiss Re, for instance, has brought its underwriting practices in connection with alcohol related risks into line with recent clinical studies and modern terminology arising from the International Classification of Diseases and the Diagnostic and Statistical Manual³⁷. Dr Lannes' paper³⁸ for reinsurer SCOR recommends the use, in appropriate cases, of scientific tests for identifying harmful alcohol consumption³⁹ and full medical examinations when the sum insured justifies the expense.

In many if not most cases, however, tests such as these may actively discourage new business. Increasingly, people expect to be able to buy insurance as they might buy a new television. This belief is at least partly fostered by the insurance industry. In addition, there must be many people, particularly in their teens and early twenties, who can honestly complete a medical declaration without answering "yes" to any of the questions, although others may already be drinking beyond safe levels.

One possible way of encouraging people to be more truthful is to combine the message about the need for accuracy in medical declarations with a more positive message that insurance may be available even for people who are not in the best of health or who have a personal history (and/or a family history) of serious problems from which they can prove they have recovered⁴⁰.

Insurance for people within this category is available from some insurers⁴¹, and some intermediaries even specialise in it and are already conveying this message to their customers, although the UK market lags far behind the USA. Other firms may not be willing to offer it at any price, but might be encouraged, (or if necessary compelled) to mention the availability of cover from other firms. Some people, however, with a recent history of very serious problems may be uninsurable for some risks. Mr. Smith, for instance, might have been uninsurable for life cover, although the woman in the second FOS case referred to above might perhaps not have been, if she had made a more forthcoming medical declaration.

So considerable care is appropriate in composing an appropriate message and conveying it – possibly in doctors' surgeries as well as in the offices of independent financial advisers and on the Internet. It might be best conveyed in a formula agreed between, on the one hand, the insurance industry and, on the other, the medical profession and specialists in the addiction field. In some cases people may need to have medical or other professional help to get to the position where an honestly prepared medical declaration will secure insurance at a fair or any price.

There will be other ways of encouraging people to take fuller responsibility for their medical and financial health. There is scope for the field of addiction to take more interest in financial problems arising from alcohol misuse. The insurance industry and its regulator may be able to contribute, financially and otherwise, to the learning process.

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- ⁷ The captains or pilots of a number of vessels involved in collisions have been shown to have been drinking at hazardous levels. Examples include the collision between the ferry "George Prince" and the Norwegian Tanker "SS Frosta" in the Mississippi river in 1976 and the collision between the "Lady Brittany" and "Cape Light II" off Prince Edward Island in 1996.
- ⁸ Neutral Citation Number: [2005] EWHC 2678. "Smith" is a pseudonym for the name of the deceased in this case.
- ⁹ Transposed into UK law by the Unfair Terms in Consumer Contracts Regulations 1999.
- ¹⁰ as described in the International Classification of Diseases and the Diagnostic and Statistical Manual of the American Psychiatric Association.
- ¹¹ "Alcoholism and Life Insurance", SCOR Technical Newsletter published March 2002.
- ¹² <http://www.aviva.com:80/index.asp?PageID=104&year=&newsid=2932&filter=UKGENERAL%20UKLIFE%20MORLEYFM>. Other conditions mentioned include depression, multiple sclerosis, double vision, numbness or giddiness.
- ¹³ FSMA section 228(1) and rule 3.8.1R of the FSA's Dispute Resolution Sourcebook.
- ¹⁴ "Ombudsman News" issue 48, August 2005, <http://www.financial-ombudsman.org.uk/publications/ombudsman-news/48/insurance-non-disclosure.htm>.
- ¹⁵ "Ombudsman News" April 2007, issue 61, <http://www.financial-ombudsman.org.uk/publications/ombudsman-news/61/61-insurance.htm>
- ¹⁶ For instance rule 7.3.6R of its Insurance Conduct of Business Rules provides: "An insurer must not: (1) unreasonably reject a claim made by a customer; (2) except where there is evidence of fraud, refuse to meet a claim made by a retail customer on the grounds: (a) of non-disclosure of a fact material to the risk that the retail customer who took out the policy could not reasonably be expected to have disclosed; (b) of misrepresentation of a fact material to the risk, unless the misrepresentation is negligent ..."
- ¹⁷ Principle 6 of the FSA's "Principles for Businesses" <http://fsahandbook.info/FSA/html/handbook/PRIN/2/1>
- ¹⁸ http://www.fsa.gov.uk/pubs/other/critical_illness.pdf.
- ¹⁹ i.e. insurers or intermediaries selling their products.
- ²⁰ http://www.fsa.gov.uk/pubs/ceo/gi_disclosure.pdf.
- ²¹ See Goodliffe, J, "Policy summary: throwing the baby out with the bathwater", www.complinet.com, 13 December 2005.
- ²² Section 148(4) of the Road Traffic Act 1988

²³ Attempts were once made by the insurance industry to discourage people from travelling as passengers of drunken drivers by excluding liability to such passengers. This initiative was, however, frustrated by Article 4 of the 5th EC Motor Insurance Directive 2005/14/EC (see also section 149 of the Road Traffic Act 1988).

²⁴ "Insurance Contract Law, Issues Paper 1: Misrepresentation and NonDisclosure", http://www.lawcom.gov.uk/docs/insurance_contact_law_issues_paper_1.pdf, paragraph 6.126.

²⁵ "Ombudsman News", issue 42, December 2004/January 2005 http://www.financial-ombudsman.org.uk/publications/ombudsman-news/42/42_ins_fraud.htm. FOS' approach to the burden of proving insurance fraud is slightly different to that of the civil courts. See "The Grecia Express" [2002] EWHC 203

²⁶ Edward, G et al. "Alcohol Policy and the Public Good" (1994).

²⁷ FSMA Section 5(1)(d).

²⁸ See, for instance, The Alcoholics Anonymous "Big Book", 4th edition, Chapter 10 "To employers" http://www.aa.org/BIGBOOKONLINE/en_BigBook_chapt10.pdf

²⁹ <http://www.fsa.gov.uk/pages/Library/Communication/PR/2006/014.shtml>.

³⁰ Ombudsman News issue 41, November 2004 http://www.financial-ombudsman.org.uk/publications/ombudsman-news/41/41_aspects_ins.htm.

³¹ i.e. loss of short term memory which may arise, among other things, from vitamin deficiency caused by heavy drinking.

³² Edwards, G et al (1994) op. cit. pages 187 to 196.

³³ [http://www.abi.org.uk/BookShop/ResearchReports/SoBP%20for%20CI%202006%20\(Final\).pdf](http://www.abi.org.uk/BookShop/ResearchReports/SoBP%20for%20CI%202006%20(Final).pdf)

³⁴ See chapter 5 of the FSA's "Perimeter Guidance Manual"

<http://fsahandbook.info/FSA/html/handbook/PERG>.

³⁵ Op.cit. para 6.117.

³⁶ Goodliffe, J. and Brooke, D. "Alcoholism in the Legal Profession" New Law Journal, January 1996.

³⁷ <http://www.swissre.com/INTERNET/pwswpspr.nsf/vwallbyidkeylu/SHAY-6TNHUS>

³⁸ Op. cit. See also Bean, P. et al. "A new century approach for alcohol screen in the insurance industry", Journal of Insurance Medicine, Vol 33, No 2, page 188

³⁹ Carbohydrate-deficient transferrin (CDT), gamma-glutamyl transferase (GGT) and Mean Corpuscular Volume (MCV)

⁴⁰ No such message appears on, for instance, the FSA web site. See

http://www.moneymadeclear.fsa.gov.uk/products_explained/types_of_insurance.html.

⁴¹ "Insurance Dilemmas", Dee Kenwyn, Addiction Counselling World, September/October 1996.