Before the Arbiter for Financial Services

Case ASF 075/2021

ZN (The Complainant)

vs

MIB Insurance Agency Ltd (C 42111)

Lloyds Malta Ltd (C 24264)

(MIB, Lloyds, Service Provider/s)

Sitting of the 27 July 2022

The Arbiter,

Having seen the Complaint[1] whereby the Complainant states that during April 2021 he noted that the water in the well was escaping. He noticed that although there was rain that season, and he also brought water by means of a bowser, the water level was getting shallower. He immediately asked his assistant to seek the services of a 'professional well handler' to identify the problem.

Once the water leak was detected, pressure was made on workmen to finish repairing the well as soon as possible so as to avoid more loss of water and more damage to the foundations of the property especially since it was the winter season.

The Complainant explains that his efforts were all focused on having the damage repaired. He was away on business, and it was only upon his return that he informed his assistant that they were covered by a buildings insurance. It was at this stage that they made the claim.

[1] P. 3-4

The Service Provider refuted the claim because it stated that the Complainant should have contacted an architect prior to fixing the well.

The Complainant is asking to be compensated for €2626.68 which is the sum he paid to repair the well.

Having seen the reply by the Service Provider[2] whereby it submits that:

ZN is insured under the HSBC Buildings block policy placed with Lloyds Insurance Company S.A. wherein MIB (Malta) Ltd are the cover holders. MIB Management Services Ltd act as the Third-Party claims administrator cover holders as appointed by the insurer to deal with claims on their behalf. This was confirmed to ZN during our initial correspondence (as per attached email). This reply is also being sent for and on behalf of Lloyds Malta Ltd. (Dr Cassar Pullicino in copy).

On the 12/04/2021 we were notified of a potential claim by Ms XX obo ZN. On the same day we emailed XX and asked her to submit the following documentation in order for us to start reviewing the claim:

1. ID card copy of policyholder;
2. Architect's report;
3. Photos of the sustained damages.

Two days later, a copy of the policy was requested and same was sent to XX.

On the 17/04/2021, XX submitted a quotation dated 14/03/2021 together with a completed claim form. We reminded XX to submit the remaining documentation. Eventually, we received a typed and signed statement by Mr Charles Muscat dated 17/04/2021 confirming the damages in the well and that cause was due to movement. Mr Muscat is the person who was commissioned to carry out the repairs. In view that the quotation was dated in March, i.e., prior to the claim notification, we asked XX to confirm whether repairs had already been carried out, to which she confirmed.

At that stage, it was no longer possible to obtain an architect's report to confirm the cause of damage, hence, why the statement was issued by Mr Muscat.

[2] P. 106-107

We informed Underwriters of the claim and advised that we were not in a position to appoint a loss adjuster or assess the claim as repairs had already been carried out. The insured was clearly in breach of the policy condition stating:

QUOTE

In the event of a claim or a possible claim under this insurance

- *you must notify us as soon as reasonably possible giving full details of what happened and you must provide us with written details of what has happened within 7 days of the event occurring and provide any other information we may reasonably require.*

  IMPORTANT: If you fail to comply with any of the above duties this insurance may become invalid.

UNQUOTE

Underwriters confirmed that claim was to be declined in view that their position was prejudiced, and the insured did not abide with the policy conditions.

May we point out that we had specifically asked for an architect's report in view that on the claim form (attached) ZN had advised that the cause was due to movement following two episodes of earthquakes in 2020. Normally such events are disastrous in their nature and effect hence why we requested that this is confirmed by an appropriate professional which in this case would be an architect.

Having heard the parties and seen all the documents submitted,

Considers

The Arbiter decides the case by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.[3]

[3] Chapter 555 of the Laws of Malta, Art. 19(3)(b)

The Service Provider submits that it could not honour the claim because it should have been advised prior to the works being carried out. The fact that the works were carried out prior to the notification of the claim was in breach of the policy which states that:

'*In the event of a claim or a possible claim under this insurance*

- *You must notify us as soon as reasonably possible giving full details of what happened and you must provide us with written details of what has happened within 7 days of the event occurring and provide any other information we may reasonably require.*

Important: If you fail to comply with any of the above duties this insurance may become invalid.'

The Arbiter has to decide whether the refusal by the Service Provider is **fair, equitable and reasonable** in the **particular circumstances of this case.**

The Juridical Context

Traditionally, our jurisprudence on insurance disputes is based on the decisions of English Courts. Our Courts have over time followed British jurisprudence and established important principles which have in reality substituted the lack of legislation regulating the substantive elements of the insurance contract. Apart from a few definitions in Chapter 403 of the Laws of Malta,[4] which have helped our Courts in defining the insurance contract, the 'insured', 'the insurer' and a few other concepts, our Courts have in general followed British judgements based on common law concepts and practice.

However, both in England and Wales; in Scotland and also in other Commonwealth Countries like Canada and Australia (and now New Zealand), there have been huge statutory developments to equitably balance the rights and obligations of the insured and the insurer.

The emergence of Consumer Insurance Contracts,[5] as distinguished from pure Commercial Insurance Contracts, have established a level playing field and a

[4] The Insurance Business Act and the Insurance Intermediaries Act respectively are the local legal instruments governing Insurance Law in Malta. They are basically of a regulatory nature.
[5] For example, in England and Wales; Scotland, and Ireland

more equitable balance in the rights and duties of the parties to an insurance contract.

There is the need in the local context for legal innovation to reflect the developments already in place in other countries, including Britain, which we have followed for such a long time.

Mere Conditions and Conditions Precedent

As John Birds[6] points out, there are basically two different types of conditions: *mere conditions*, the non-observance of which does not invalidate the policy and serves the insurer no basis to repudiate a claim; and *conditions precedent* which in normal circumstances lead to the repudiation of a claim and also may invalidate the policy.

The question whether a condition in a policy document is considered as a condition precedent has over the years been a subject of debate. The traditional view taken by insurers that nearly all conditions in a policy could be translated into conditions precedent has changed considerably. Whereas a breach of a condition precedent by the insured is still considered to void the contract, and the insurer is absolved of liability to pay the claim, **other conditions do not invalidate the contract.**

In the question of late notification of a claim, there is still an ongoing debate whether the infringement of this condition would justify the repudiation of the claim. However, in recent years, the inception of '*consumer insurance contracts*' and a general view that in observing the basic rule of *uberrima fides* the insurer should give the benefit of the doubt to the insured, has gained ground. The recent modern practice is for the insurer to find ways to approve rather than refute a claim and there has been a movement in the direction that a *condition precedent* **should be spelt out** in a consumer insurance contract.

Birds points out that:

'If there is no reference to the sorts of condition in question being precedent to the insurer's liability, then it is clear that a breach does not entitle the insurer to repudiate liability.'

[6] Birds Modern Insurance Law, (Sweet and Maxwell, tenth edition), p. 184

Quoting the decision of the Court of Appeal in *Friends Provident Life & Pensions Ltd vs Sirius International Insurance* which overturned previous jurisprudence, the principle established in this quoted decision is that '*it is easy for insurers to spell out the effect of a condition if they want to make performance of it precedent to their liability.'*[7]

In the United States, in the majority of States, the Courts have taken the same position that a condition precedent, because of its draconian effect of invalidating the policy, **has to be spelled out as such**. Moreover, provisions leading to the forfeiture of cover has found disfavour in Illinois where one Court held that[8] '*insurance forfeitures are not favored, as insurance serves important purposes in contemporary society, and courts should be quick to find facts which support coverage'.* Then in *Rice v. AAA Aerostar, Inc.,*[9] *'Not every breach of a policy condition by the insured will allow the insurer to avoid payment under the policy*'.

Late notification of a claim

The prevalent position in many US states is that late notification can only lead to the repudiation of the claim if the insurer **proves** (1) **the late notification, and** (2) that late notification has led to an **actual prejudice to the insurer**. For instance, it has long been established in Californian law that notice given by an insured to an insurer after any required time period does not excuse the insurer's obligations under the policy, unless it can show **actual prejudice** from the delay.[10]

The Nevada Supreme Court joined the majority of states in adopting the **notice-prejudice rule** and held that an insurer who denies coverage of a claim because of an insured's failure to provide timely notice must prove that the notice was late and that the insurer was prejudiced by the late notice.[11]

Moreover, under Californian law it is well established that the burden is on the insurer to prove that it **suffered actual prejudice** as a result of the insured's late

[7] *Op cit.* p. 185-186
[8] *A.D. Desmond Co. v. Jackson Nat'l Life Ins. Co.,* 585 N.E.2d 1120, 1122 (Ill. App. Ct. 1992)
[9] 690 N.E.2d 1067, 1071 (Ill. App. Ct. 1998)
[10] *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303, 308 (Cal. Ct. App. 1963)
[11] *Coregis Ins. Co.* at 965.

notice, and not merely **a possibility** of prejudice.[12] To establish **actual prejudice**, the insurer must show a substantial likelihood that, with timely notice, and notwithstanding its denial of coverage or reservation of rights, it would have settled the claim for less, or taken steps that would have reduced or eliminated the insured's liability.[13]

In addition, speculation regarding how the insurer might have investigated the loss had it received timely notice is irrelevant to the issue of prejudice.[14]

The insurer must prove actual prejudice.

The application of these principles to the case in question

The Arbiter is conscious of the fact that these established principles cannot be applied in a vacuum but have to relate to the facts of the case. Article 19 of Chapter 555 stipulates that the Arbiter has to decide the case with reference to what, in his opinion, is **fair, equitable and reasonable in the particular circumstances of the case.**

The Service Provider has refused the claim on the basis of the section of the policy titled '*Claims, Conditions and Procedures*' and specifically where it states that:

> *'In the event of a claim or a possible claim under the insurance*
>
> - *You must notify us as soon as possible giving full details of what happened and you must provide us with written details of what has happened within 7 days of the event occurring and provide any other information we may reasonably require.*
>
> *Important: if you fail to comply with any of the above duties this insurance may become invalid.'*

[12] *Northwestern Title Sec. Co. v. Flak*, 6 Cal. App. 3d 134, 141-42 (Cal. Ct. App. 1970, and *Colonial Gas Energy System v. Unigard Mut. Ins. Co.,* 441 F. Supp. 765, 768-769 (N.D. Cal. 1977)

[13] *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 763 (Cal. Ct. App. 1993); *Safeco Ins. Co. of America v. Parks*, 170 Cal. App. 4th 992, 1004 (Cal. Ct. App. 2009).

[14] *Colonial Gas Energy System v. Unigard Mut. Ins. Co.,* 441 F. Supp. 765, 768-769 (N.D. Cal. 1977). December 1, 1977.

The insurer insists that since the Complainant was late in notifying it about the damage and repairs, it had the automatic right not to honour the claim. In view of the established principles quoted above, to which the Arbiter adheres (because, in his opinion and discretion, believes to be fair, equitable and reasonable), the Arbiter believes that the insurer did not have the automatic right to refuse the claim. It is true that in the policy section quoted above the insurer added that '*this insurance* ***may***[15] *be invalid'*. However, it did not specifically state that it 'will or shall' be invalid. Where the insurer wanted to categorically invalidate the policy, it stated so.

For instance, under '*fraudulent claims'* the policy specifically states:

'*If you or anyone acting on your behalf makes a claim knowing it to be false or fraudulent in amount or in any other respect this insurance* ***shall***[16] *be invalid and all claims* ***shall***[17] *be forfeited.'*

The distinction is clear and had the Service Provider wanted to refute the claim for late notification, it should have specifically stated it in the policy document as it had done regarding fraudulent claims.

Moreover, the condition regarding late notification was not specifically stated that it is a condition precedent and is bundled up with 'claims' and 'procedures'. As has already been explained above in this decision, the modern and fairer view regarding conditions precedent is that they should be *specifically stated to be such*, so that the policyholder would clearly understand that failure to abide by those conditions would necessarily invalidate the policy or entitle the service provider not to honour a claim.

Therefore, on the basis of what has been stated above, the Arbiter does not consider it to be fair, equitable and reasonable for the Service Provider to consider the condition relating to late notification as one that could **automatically** entitle the insurer to refute the claim *ab initio*, as it did.

The Arbiter firmly believes that in order to decide fairly, equitably and reasonably, he would subscribe to the modern and recent line of thought that

[15] Arbiter's emphasis
[16] Arbiter's emphasis
[17] Arbiter's emphasis

in order for the Service Provider to refute the claim on the basis of late notification, it has to prove that (1) there was in fact a late notification *and* (2) it suffered actual prejudice by the delay. The Service Provider must prove both eventualities.

Late notification

From the facts of the case, there is no doubt that the Complainant was late in notifying the Service Provider about the claim. However, he also explained that at the time of the seeping of water from his well, he was abroad on business and since he did not want to allow the water to seep under the building foundations, his concentration was more on repairing the damage as soon as possible rather than on his insurance cover.

This case is dissimilar to other cases where late notification was the result of carelessness or negligence.

The Arbiter considers the Complainant's error as a genuine mistake.

Actual Prejudice

On the strength of the jurisprudence quoted above, and on the basis of fairness, equity and reasonableness, the Arbiter is of the strong opinion that the Service Provider failed in its duty of care and of treating the claim fairly.

The reason brought forward by the Service Provider was that since it was not notified within the period established in the policy, it could not verify the damage sustained by the insured and insisted on an architect's report.

The Arbiter cannot subscribe to this line of reasoning.

Considering the facts of this case, it results that the insured had provided the insurance with a report with photographs of the damage to his well as it was **prior to the performance of the repair.**

In the Arbiter's opinion, from the photos and the explanation given in the report supplied by the insured, the Service Provider was in a position to appoint its own experts and evaluate the nature and extent of the damage and reach the conclusion whether the cause of the damage was an insured peril or not. It was

also in a position to quantify the damages. However, the Service Provider took the short cut of refuting the claim without even trying to evaluate it.

Moreover, during the proceedings, the Service Provider did not even try to prove that it suffered an **actual and substantial prejudice** due to the late notification and repairs. The Service Provider did not bring forward any witness or any other evidence to prove that it **had** suffered any prejudice.

The Service Provider did not even cross-examine the Complainant or his witness.

On the strength of the above-quoted jurisprudence, the mere *possibility* of a prejudice is not enough to refute the claim.

Therefore, the Service Provider's claim that it could not evaluate the damage is hypothetical. The Arbiter is convinced that with the information supplied by the insured, it could have evaluated the cause of the damage and its extent and also determine the cost of repair.

The careful examination of a claim

It has long been established that the contract of insurance is one based on the utmost good faith of the parties to the insurance contract. Utmost good faith, or *uberimae fidei,* should subsist not only in the pre-contractual stage but also during the subsistence of the insurance contract.

In order to act fairly and respect its obligations of utmost good faith, the insurer is expected to deal with the claim in an honest and fair manner.

Therefore, in dealing with a claim the insurer must:

1. Consider the insured's interests with the same consideration it gives its own interests. This means that the insurer must give the policy holder the benefit of the doubt.

2. Look for reasons to find coverage, not for reasons to deny coverage. The insurer should be looking for reasons to pay the claim, not reasons to deny it.

3. Not view the process as insurance company versus policy holder but as honest partners to the same contract.

4. Promptly and fairly investigate every claim.
5. Promptly pay the claim if payment is owed.
6. Give an adequate explanation to the policy holder if the claim is denied.

From the facts of this case, the insurer did not give the benefit of the doubt to the insured; it did not look for reasons for cover; it did not investigate the claim fairly and objectively but promptly denied the claim without any investigation.

As has already been stated above in this decision, the Service Provider could have investigated the claim even on the basis of the information supplied by the insured. It could have reached a different conclusion from that reached by the insured but, in this case, it did not even try to examine the facts leading to the claim. In this way, it did not adhere to its obligations of good faith in dealing with a claim.

Decision

For the above stated reasons, the Arbiter finds that the Complaint is fair, equitable and reasonable and is accepting it in so far as it is compatible with this decision.

Compensation

The only version the Arbiter has regarding the cost of damages is the proof of the Complainant. The Complainant stated that he paid the sum of €2626.68.[18] This is also corroborated by the person who made the repairs and the accompanying quotation.

Therefore, in virtue of Article 26(3)(c)(iv) of Chapter 555 of the Laws of Malta, the Arbiter orders MIB Insurance Agency Ltd and Lloyds Malta Ltd to pay the Complainant the sum of €2,626.68.

With legal interest from the date of this decision until the date of effective payment.

The costs of these proceedings are to be borne the Service Providers.

[18] P. 4, 24, 96

Dr Reno Borg
Arbiter for Financial Services