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RECENT DEVELOPMENTS IN THE LAW RELATING TO CHANGES MATERIAL TO THE RISK

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DUTY OF DISCLOSURE

The relationship of insurer and insured is unique in the law of contracts. An insurance contract is one of *uberrima fides* or of utmost good faith. This principle applies to all types of insurance and to both the insurer and the insured. In *Lee v. Canadian Northern Shield Insurance Co.*[1] the Court recently discussed this principle and stated:

> The legal principles governing insurance policies are well settled. It was established in Carter v. Boehem (1766), Burr. 1905 (K.B.) that the principle of utmost good faith applies to contracts of insurance. An insured has the obligation to make full and accurate disclosure of all information which is relevant to the proposed insurance coverage. The insurance underwriter must trust those representations in order to determine if it wishes to underwrite the risk and if so, to accurately assess the risk. If the insured fails to disclose information or keeps information back through intention or mistake, the policy is void. In other words, the basis of an insurance policy is that the insurer understand the risk involved and intend to assume it; it therefore must know all the relevant information to assess the risk.

While commercial contracts can be terminated if induced by mistake, misrepresentation or breach of condition, an insurer can also be relieved of its contractual obligation to indemnify if the insured does not fully and completely disclose all material facts. As discussed in *Lee,* non-disclosure which renders an insurance policy void may result from the insured's either intentional or accidental failure to communicate facts which are within its knowledge. Such facts are those which are not known to the insurer *and* which are calculated to induce the insurer either to enter into a contract of insurance, or, not to bargain for a higher premium. The insured's obligation to make disclosure of all material facts existed at common law prior to implementation of the *Insurance Act*.[2]

The duty of disclosure, which existed at common law, is largely unaffected by the *Insurance Act*. Section 13 and various other sections in the *Insurance Act*[3] simply codifies the common law duty. Section 13 of the *Insurance Act* states:

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1 2007 CarswellBC 516 (S.C.).

2 R.S.B.C. 1996, c. 226 (the "*Insurance Act*").

3 See *Insurance Act, supra*, note 2 - *Accident and Sickness Insurance*, section 97, *Life Insurance*, section 41, *Fire Insurance*, section 126, Statutory Condition #1, Automobile *Insurance*, section 137, section 18 and 19 of the *Insurance (Marine)Act*, R.S.B.C. 1996, c. 230.

Misrepresentation and nondisclosure

> 13(1) A contract is not rendered void or voidable by reason of any misrepresentation, or any failure to disclose on the part of the insured in the application or proposal for the insurance or otherwise, unless the misrepresentation or failure to disclose is material to the contract.
>
> (2) The question of materiality is a question of fact.[4]

Only in respect of policies covered by Part 5 of the *Insurance Act*,[5] (fire insurance or policies in which fire is a specified peril), are there important differences from the common law duty. What makes fire insurance unique is Statutory Condition #1 which provides:

> 1. If any person applying for insurance falsely describes the property to the prejudice of the insurer, or misrepresents or fraudulently omits to communicate any circumstance which is material to be made known to the insurer in order to enable it to judge of the risk to be undertaken, the contract shall be void as to any property in relation to which the misrepresentation or omission is material.

Statutory Condition #1 narrows the duty to disclose which existed at common law. Statutory Condition #1, which regulates pre-contract disclosure, requires proof of a *fraudulent* omission to communicate a material circumstance in order to render the contract voidable. Generally, a misrepresentation which nullifies an insurance policy need only be material, and not necessarily fraudulent. For this reason in respect of fire insurance it is always advantageous to utilize an extensive questionnaire. Eliciting a definite answer from an insured avoids the need to prove that his failure to disclose a material fact was undertaken with a fraudulent intent.

In fire insurance contracts the requirement of continuing disclosure after formation of the insurance contract is governed by Statutory Condition #4, which will be discussed later in this paper. Statutory Condition #4 provides:

> "4. Any change material to the risk and within the control and knowledge of the insured avoids the contract as to the part affected by the change, unless the change is promptly notified in writing to the insurer or its local agent; and the insurer when so notified may return the unearned portion, if any, of the premium paid and

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4 See Ontario *Insurance Act*, section 124(6); Alberta *Insurance Act*, section 513(8); Saskatchewan *Insurance Act*, section 103(6), Manitoba *Insurance Act*, section 117, New Brunswick *Insurance Act*, section 98(6), Nova Scotia, *Insurance Act*, section 86, Newfoundland *Insurance Contracts Act*, section 5(6).

5 *Supra*, note 2.

> cancel the contract, or may notify the insured in writing that, if the insured desires the contract to continue in force, he must, within 15 days of the receipt of the notice, pay to the insurer an additional premium; and in default of such payment the contract is no longer be in force and the insurer shall return the unearned portion, if any, of the premium paid."

The duty of disclosure has significant consequences for insureds if this duty is breached. The consequence of non-disclosure or misrepresentation by the insured is a loss of coverage as the insurer is entitled to render the contract void.[6]

The principle accounts for a large number of cases which proceed to court. Many of these cases involve an insured's failure to disclose material facts or a failure to disclose in combination with material misrepresentations. Since this area of the law accounts for so many reported cases it is important for those on both the underwriting and claims side of the industry to understand the consequences of an insured's failure to disclose. Equally important is an understanding of when and to what extent the insured can overcome an apparent failure to disclose on his part. The purpose of this paper is to identify the dominant trends which have emerged over the past five years, with particular emphasis on problem areas for an insurer. The paper is divided into four sections:

(a) Non-disclosure and the "standard" mortgage clause;

(b) Non-disclosure and the utilization of a questionnaire as part of the insured's application;

(c) Non-disclosure and morality; and

(d) Non-disclosure and the insurer's obligation to investigate suspicious circumstances.

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6 *Lloyd's London, Non- Marine Underwriters v. National Armoured Ltd.*, [2000] I.L.R. I-3751 (Ont. C.A.).

NON-DISCLOSURE AND THE "STANDARD" MORTGAGE CLAUSE

One of the most perplexing issues an insurer confronts is whether an insured's failure to make disclosure of material facts permits the insurer to deny coverage to a lending institution which claims indemnity through a "standard" mortgage clause. Historically, judges acknowledged that a "standard" mortgage clause confers upon a mortgagee greater rights than the insured party itself and may, in some circumstances, permit the mortgagee to recover on the policy even though the insured may not be entitled to recover.

Lenders have taken the position that the insured's wrongful conduct including acts of arson, misrepresentation or failure to disclose should not be attributed to an entirely "innocent" lender who is relying on the "standard" mortgage clause as a form of collateral security in the event of loss. There is no question that many lenders stipulate for insurance as an absolute condition of any loan to the insured, and would not agree to lend without insurance protection. On the other hand, insurers have argued that the lender's position ought to be no better than that of the insured, and that to permit the lender to recover in the face of the insured's default merely provides the lender with a financial incentive to remain wilfully blind to a statutory or policy breach by the insured. Further, insurers have fairly pointed out that the lender is not a party to the insurance contract and consequently has not provided any legal consideration or value to the insurer so as to create contractual rights over and above the contractual rights of the insured.

This issue was squarely addressed in *Canadian Imperial Bank of Commerce v. Dominion of Canada General Insurance Co. et al*,[7] a decision of the British Columbia Supreme Court. The insured owned a hotel near Kamloops which was financed by a loan that included as a term "fire insurance and appropriate liability insurance loss payable to the Bank".

The insurer contended, in the aftermath of a fire loss, that the lender could not recover on the strength of the "standard" mortgage clause (approved by the Insurance Bureau of Canada) which stated:

> "IT IS HEREBY PROVIDED AND AGREED THAT:
>
> Breach of conditions by mortgagor, owner or occupant. This insurance and every documented renewal thereof - AS TO THE INTEREST OF THE MORTGAGEE ONLY THEREIN - is and shall be in force notwithstanding any act, neglect, omission or misrepresentation attributable to the mortgagor, owner or occupant of the property insured, including transfer of interest, any vacancy or non-occupancy

[7] (1987), 29 C.C.L.I. 313.

> or the occupation of the property for purposes more hazardous than specified in the description of the risk."

The insured had fraudulently failed to disclose prior fire losses at the hotel in breach of Statutory Condition #1. The insurer advanced two arguments in resisting the mortgagee's claims:

(a) a breach of Statutory Condition #1 meant the policy had never been validly entered into (void ab initio) so that neither the insured nor the mortgagee could claim any rights; and

(b) even if the insured's breach did not render the policy void, there was no "consideration" flowing from the lender to the insurer so as to justify recovery (consideration being a benefit received by one party to an agreement).

The Court rejected both arguments. Addressing the first issue, the Court stated that the effect of a mortgage clause is to create in the mortgagee an interest distinct from that of the insured and that the insured's failure to make disclosure did not render void the mortgagee's *separate and distinct contractual right* to recover under the policy. Addressing the insurer's second argument, that there existed no legal consideration, the Court noted the economic reality that underlies the "three way" nature of the policy and the fact that insurers appreciate that they could not sell such policies without a "standard" mortgage clause.

The "three-way" contract that exists between insured, insurer and lender therefore gives rise to rights and responsibilities enforceable directly between insurer and mortgagee. From a claims' standpoint it is critical that insurers recognize that:

(a) to some degree the tripartite nature of an insurance contract which contains a mortgage clause imposes on a lender a continuing obligation to make disclosure of any change material to the risk which is within the lenders' knowledge and control; and

(b) the inclusion of a "standard" mortgage clause in a policy constitutes the mortgagee as an insured, and imposes on an insurer a duty of good faith owed to the lender. Failure by the insurer to properly fulfil that duty can give rise to liability at the suit of the lender.

The lender's continuing duty of disclosure following issuance of the policy has been the focus of several decisions. It is critical to recognize that the "standard" mortgage clause, by its terms, obligates the lender to notify

> "... (if known) of any vacancy or non-occupancy extending beyond 30 consecutive days, or of any transfer of interest or *increased hazard that shall come to his knowledge*".

Recently, the Supreme Court of Canada determined that there was a conflict between Statutory Condition #4 and the standard mortgage clause resulting in the lender prevailing over the insurer. In *Royal Bank v. State Farm*,[8] fire destroyed a house. By the time of the fire, the insured had vacated the house and was controlled by the mortgagees. The mortgagees then made a claim pursuant to the standard mortgage clause in the State Farm homeowner's policy (the "Policy"). State Farm denied the claim because the mortgagee did not advise State Farm that the house was vacant. State Farm argued that the vacancy was a 'change material to the risk and within the control and knowledge of the mortgagees' and that under Statutory Condition no. 4 it was entitled to void the coverage. The mortgagees sued State Farm alleging breach of the Policy.

The trial Court concluded that although Statutory Condition 4 did not conflict with the mortgage clause it was not applicable to the case and as such State Farm had to indemnify the insured. The Court of Appeal reversed the trial decision and granted judgment in favour of the insurer.

In *Royal Bank*, *supra*, the Mortgage Clause stated:

> the mortgagee's coverage shall remain in force despite *any* act of the mortgagor...including, necessarily, an act causing a 'change material to the risk' - and that the mortgagee shall pay for any resulting '*increase of hazard...during the continuance*' *of the coverage.*

The SCC concluded that there was a conflict between Statutory Condition 4 and the Mortgage Clause given that the 'change material to the risk' within the control and knowledge of the insured alleged by the insurer arises from the fact of the insureds vacating the house. However, the Mortgage Clause says the insured's coverage shall remain in force notwithstanding any vacancy or non-occupancy attributable to the mortgagor (i.e. the insured). As such, State Farm had to indemnify Royal Bank.

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8 (2005), 23 C.C.L.I. (4th) 1 (S.C.C.).

NON-DISCLOSURE AND THE UTILIZATION OF A QUESTIONNAIRE AS PART OF THE INSURED'S APPLICATION

A reader would reasonably think that a principle predicated on a positive duty to disclose material facts, regardless of what is specifically asked for by an insurer, should provide the insurer protection if a loss arises and adequate disclosure has not been made. However, recent decisions illustrate the need for a precise and detailed questionnaire in support of the insured's application for coverage. It is imperative that the terms used in questions in the application are carefully defined. In *Ouimet Estate v. Co-operators Life Insurance Co.*,[9] the deceased insured had completed an application for travel insurance. The deceased insured had a pre-application medical incident involving the mixing of alcohol and dental painkillers (the "Medical Incident"). She also had a history of alcohol abuse. The insured signed an application with a condition precedent agreeing to the following:

> I am in good health and know of no reason to seek medical attention. I am aware that, if I have a medical condition affecting my health, that claims relating to this condition may be excluded under this policy.[10]

The insured collapsed while on a trip and was rushed to the hospital. The insured's condition deteriorated and she eventually died from major organ failure. The insurer denied coverage under the policy based on the deceased insured's statement that she was in good health at the time she signed the application. In allowing the action, the Court concluded that the term "in good health" was vague and ambiguous:

> The phrase "in good health", as it is used in the Declaration Form, would have no precise meaning to the reasonable lay person. Therefore, that person would interpret it in the light of the phrase that follows: "know[s] of no reason to seek medical attention". The reasonable lay person would rely on that latter phrase for some indication of what is meant by the former phrase. The latter phrase suggests that the insurer is interested only in health conditions serious enough to warrant medical attention. Looking at that phrase in context, a reasonable lay person, purchasing travel insurance for emergency hospital and medical expenses would conclude that "medical attention" refers to something more than routine or nonemergency medical treatment. Therefore, looking at the clause as a whole, and in its context, a reasonable lay person would conclude that a prospective insured is not "in good health, if he or she has a health condition for which he or she should seek non-routine or emergency medical attention.

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9 (2006), 38 C.C.L.I. (4th) 76 (S.C.).

10 *Supra*, at page 5.

After analyzing the term "in good health" the Court concluded that the deceased insured's pre-application Medical Incident was an isolated incident and as such, it could not be concluded that she misrepresented her health status.

An insurer is better protected if the non-disclosure can be portrayed as an actual misrepresentation given in answer to a specific written question. This is true for two reasons:

The insurer has the burden of proving that a fact is material to the risk. The fact the question is elicited in a questionnaire allows the insurer to contend that *prima facie* the answer is material; otherwise the question would not have been asked. This can shift the evidentiary burden to the insured to demonstrate that the inaccurate answer is not material.

On policies to which Part 5 of the *Insurance Act*[11] applies, it is essential that "mere silence" be converted into a misrepresentation. Simple non-disclosure must be evidenced by a fraudulent intent to conceal, which is always difficult to prove. A false answer provided in a questionnaire amounts to a misrepresentation and for the purpose of fire insurance policies, the misrepresentation need only be an inaccurate fact unaccompanied by a fraudulent intent. This is easier to prove.

There have been a number of British Columbia cases that serve to remind the insurance industry of the critical role a questionnaire can play in successfully denying a claim. Claims personnel have encountered arguments that an insured made disclosure of material facts to an agent who was authorized to bind the insurer and that the agent's knowledge ought to be imputed to the insurer. Such reasoning can prevent an insurer from relying upon non-disclosure of material facts as a bar to recovery of an indemnity.

It appears that a "basis clause", contained in the application questionnaire is effective in preventing the insured from imputing to the insurer knowledge of facts disclosed to the insurer's agent and which facts are not disclosed in the application reviewed by the underwriting staff.

In the leading case of *Van Schilt* v. *Gore Mutual Insurance Co.*[12] the insured claimed on a fire policy. A burglary occurred at the insured's home. The insured had attended at his broker's office and in the course of his conversation with the broker had made known that he needed coverage in light of a prior insurer's "unsatisfactory handling" of a loss on the

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11 *Supra*, note 2.

12 (1987), 25 C.C.L.I. 267 (B.C.S.C.); aff'd (1988), 29 C.C.L.I. 181 (B.C.C.A.).

same premises. The agent must have known of a prior loss since her file notes indicated that she had not contacted several insurers as none would provide coverage in view of the prior loss. Notwithstanding these discussions the agent filled out a form that provided:

> "Have any claims been paid (or outstanding) in the last 3 years?"

to which the "No" box was ticked. The application read:

> "All statements in this application are true and the applicant hereby applies for a contract of personal property insurance based on the truth of those statements"

The British Columbia Court of Appeal was of the view that the real issue was not who was responsible for the mistaken answer, or whether, assuming that the insured gave a true answer to the agent, the insurer could be imputed with knowledge of the true answer. Instead, the Court treated the "basis clause" as severing the conduct both of the agent and the insured from the insurer, as the "basis clause" amounted to a representation that all the answers were true. In effect, by using a properly worded questionnaire the insurer was insulated from careless errors made by its own agent since the Court insisted that the insured read over the answers in the questionnaire to ensure the correctness of the answers. As Mr. Justice Carrothers stated:

> "As to the law, the general rule is that an insured who has signed a basis clause as in this case; is bound by his answers and the onus of proof is on him to establish that despite the actual working of the application form, he did not, in fact, give the answer written down and attributed to him."

When the underwriting personnel review the insured's detailed questionnaire to assess the risk it is critical that any unanswered questions be re-submitted for complete answers. It had long been accepted that a "blank" in answer to a specific question was tantamount to not answering a question. If the insurer accepts the risk without requiring an answer to the question the insured's omission is treated as amounting to a waiver of the answer by the insurer.[13] It will not make a difference if an accurate response to the unanswered question would have prompted the insurer to refuse the risk, or to seek a greater premium.

While the insurance industry has tended to treat a slash mark, or, a stroke across an answer as amounting to a definite "no" in answer, the validity of that assumption is doubtful in light of *Hanzeh et al v. Safeco Insurance Co. of America et al*.[14] The insured in that

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13 *Gabel v. Howick Farmers Mutual Fire Insurance Co.* (1917), 38 D.L.R. 139 (Ont. H.C.).

14 (1988), 32 C.C.L.I. 83 (Alta. Q.B.).

case was claiming on a homeowner's policy for the value of stolen jewellery. When applying for insurance the insured was asked (and answered with a slashline):

> How many losses have occurred during the last 3 years to the insured's home or personal possessions at this or another location (such as fire, theft, glass, wind, cigarette burns, liability, water damage, freezing, etc.)?

The insured had filed prior insurance claims, and revelation of that fact was the basis for denying coverage. At trial the insurer led evidence that within the industry a slash line is treated as a no " answer, so the insured's response had been regarded as non-disclosure or a misrepresentation. Nonetheless, the Court treated the "slash" as falling within the *Gabel* decision, necessitating clarification of the answer, in default of which the insurer was treated as having waived the answer. *Hanzeh*, *supra*, makes clear that any ambiguities must be resolved before acceptance of the risk notwithstanding that such procedures increase the paper flow from an underwriting standpoint.

Insureds have increasingly relied on either their own illiteracy or their inability to understand application questions to avoid the unfavourable results that might flow from non-disclosure or an untruthful answer. Arguments based on such reliance have met with little success, and the Courts continue to adhere to the view that if the question is found to be confusing to the insured the onus is on the insured to seek clarification. It is no answer for the insured to say that he misunderstood the nature of the question.

This is illustrated by the recent decision in *Sandhu Estate et al v. Fidelity Life_Insurance Company*.[15] The surviving wife of the insured was claiming on a policy of life insurance issued by Fidelity Life. The insured had answered "no" to a very specific question concerning whether the insured suffered from any disorder of the heart, lungs, kidneys, liver and digestive or nervous system. The insured had been seeing a doctor for a number of years for treatment of alcoholism and the effects of alcohol on his liver. The evidence at trial established that the deceased was virtually illiterate and had little or no comprehension of the English language. It was argued that the deceased's limited education and level of intelligence prevented him from diagnosing his own complaints constituting a justification for giving negative answers. The Court rejected this argument, ruling that if the insured did not understand the questions he should have said so. However, if the form of the question in the questionnaire gives rise to an ambiguity the insured will gain the benefit of any uncertainty. In *Gore Mutual Insurance Company* v. *Emms et al*[16] the insurer denied coverage following a fire loss after having learned that at

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15 (1987), 28 C.C.L.I. 108 (B.C.S.C.).

16 (1987), 25 C.C.L.I. 274 (B.C.S.C.).

the time of application the insured was being sued for negligence by the victim of a dog attack. The insured stated "No" to the question:

> "Have any claims been paid (or outstanding in the last three years)?"

Mr. Justice Meredith of the B.C. Supreme Court held that the answer did not amount to a misrepresentation, as the reasonable interpretation of the word "claims" was *insurance claims* as opposed to *tort claims*. The judgment suggests that if the insurer wished to elicit information about tort claims the form of question would have to be directed to that concern as the insured would naturally contemplate that "claims" referred to fire claims as opposed to occupier liability claims.

The Courts are more likely to uphold the insurer's position if a case is truly marked by fraud. In the field of life as well as accident and sickness insurance it is not uncommon for the insurer to include an incontestability provision that stipulates that after the policy has been in force for a defined period the policy is incontestable as to the statements contained in the insured's application form. These provisions are often more extensive than Section 98 of the *Insurance Act*[17], which stipulates for incontestability after the policy has been in force for two years. Traditionally, such a provision has barred the insurer from raising an allegation of fraud upon the expiry of the incontestability clause. A recent British Columbia decision would suggest that a clear case of fraud will not protect the insured in such circumstances. In *McLean v. Paul Revere Life Insurance Company*[18] the insurer issued an accident and sickness policy that contained the following clause:

> "After this policy has been in force for two years during the lifetime of the insured, it shall become incontestable as to the statements contained in the application."

The insured had received disability benefits for seven years, at which time the insurer learned that there had been a material misrepresentation and cancelled the policy.

The Court held that proof of fraud permitted the insurer to deny coverage on the basis of its newly acquired information; fraud rendered the contract void *ab initio* that is, from the very inception of coverage. The result was that the insured could not rely on a contractual incontestability provision. For all practical purposes the only incontestability provision that will ultimately assist the insured is Section 98 of the *Insurance Act*, R.S.B.C.

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17 *Supra*, note 2.

18 (1988), 33 C.C.L.I. 165 (B.C.S.C.).

NON-DISCLOSURE AND MORALITY

Non-disclosure voids a policy if the non-disclosure concerns a material fact. In the 1970's it was not uncommon for many insurers to argue that failure to disclose a moral risk was material and should void coverage. In many cases the denial was predicated on a perception of a "moral hazard" of concern to a *particular* insurer which might not necessarily be consistent with the views of a *reasonable* insurer. In these circumstances the Courts were not willing to uphold the insurer's denial of coverage.

The earlier view is reflected in the decision of *Ryan v. Citadel General Insurance Company*.[19] The insured had a fire policy on the contents of his home which he occupied as a tenant together with his wife and child. The wife and son left the matrimonial home and the insured and two male friends moved in. A fire occurred and the insured claimed for loss of contents. The insurer argued that it was entitled to deny the claim on the basis that the change in household members had altered the character of the residence and had thereby materially changed the risk. Mr. Justice Smith of the Ontario Supreme Court rejected that argument stating:

> "I am not persuaded that a reasonable insurer would or should consider occupancy more hazardous when a man and women are in a common-law relationship for instance or for that matter when two males or two females with or without sexual content in their relationship occupy a single family dwelling together. It would be straining the concept of reasonableness to define the risk in those terms given today's societal attitudes. The materiality of a change along the lines just described is not self-evident. In fact it is not at all certain that an insurer would want to discriminate in that fashion or would be entitled to do so."

A similar approach is evident in recent decisions such as *Lewandowski v. The Waterloo Mutual Insurance Company*.[20] The insured premises had been left in the hands of the alcoholic husband of the policyholder. The insured decided to leave the marriage because of the husband's abusive character and the insurer suggested that leaving the spouse on the premises, incapacitated by illness and alcoholism, was material to the "moral risk". While as a matter of common sense many people might share that view, the Court was not prepared to treat the change as being material to the insurer's risk, in the absence of evidence that the husband was not able to manage his own affairs or look after the farm.

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19 (1983) 2 C.C.L.I. (Ont. H.C.).

20 [1985] I.L.R.-1-1933

NON-DISCLOSURE AND THE INSURER'S OBLIGATION TO INVESTIGATE SUSPICIOUS CIRCUMSTANCES

Many insured persons, having failed to make the required disclosure, argue that the insurer is prevented from raising that fact by reason of its own failure to make inquiries. Often, the insured will argue that the insurer, by reason of his own investigations, ought to have been suspicious and engaged in more detailed investigations which would have ultimately disclosed the true state of affairs. The Courts have been unwilling to accept these arguments.

In *Ford v. Dominion of Canada General Insurance Company*[21] the insured did disclose on an application that he had one previous loss and one previous cancellation, but did not make disclosure of a second loss and a second cancellation. At trial it was evident that the insurer failed to perform cursory internal checks including consulting with the Insurance Bureau of Canada, and requesting a Dunn & Bradstreet report. If these rudimentary checks had been undertaken the insurer would have learned of the insured's previous claims history. The insurer admitted that it failed to follow its routine investigations and that the application had "fallen through the cracks". Notwithstanding laxity in the insurer's procedures the Court decided that the policy was voidable notwithstanding the insured's suggestion that the insurer had failed to perform certain investigations which would have disclosed his previous claims history. The result was based entirely on a lack of evidence:

> "In the absence of an evidentiary foundation, I do not think it is the role of this Court to question whether ... (the insurer or agent) were under a duty to make further enquiries."

The clear implication from this statement is that there will be cases where a proper evidentiary foundation will create a duty upon the insurer to make further enquiries. If the insurance company does not make further enquiries in such cases, it may well be that the insurer will be prevented from relying upon non-disclosure (perhaps even fraudulent non-disclosure) if the further investigations would have revealed the truth.

An example occurred in the case of *Coronation Insurance Co. v. Taku Air Transport Ltd.*[22] Taku was a commercial air carrier which had obtained insurance from Coronation in 1978. After the first policy year, the insurer declined to renew coverage because Taku had had three accidents during that year. Taku then obtained coverage from other

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21 (1988), 34 C.C.L.I. 224 (Man.Q.B.); rev'd (1989), 40 C.C.L.I. 313 (C.A.); rev'd [1991] 1 SCR 136.

22 (1991), 48 CCLI 160 (S.C.C.).

insurers and had other accidents. When its coverage was terminated in 1986, Taku again applied to Coronation. Although the agent recalled Taku from the past, he did not check the insurer's files. Rather, he relied on Taku's statement that it had had only one accident in the previous 10 years. On the basis of that false statement, the insurer issued coverage without any investigation and without consulting its own records. When an accident happened, the Court refused to allow the insurer to deny coverage on the basis of non-disclosure of previous accidents. The Court stated that the insurer was obliged to take basic steps to investigate the flying record of an air carrier applying for insurance. This was especially so because the insurance policy, was primarily for the benefit of members of the flying public and not just the insured. The Court decided that the insurer was presumed to know publicly-available information, and information available in its own files, concerning Taku's accident record. As a result, the insurer could not escape liability on the ground of the insured's non-disclosure.

Although the Court restricted its comments to situations like aviation insurance (where the beneficiaries of the insurance were likely to be members of the public as opposed to the insured), it is conceivable that future cases will apply the same principle to any case where the insurer or its agent has the true information in its own files or could have discovered the truth if it had undertaken a simple investigation.

CONCLUSION

In reviewing recent decisions, it is apparent that a number of trends have emerged in the area of non-disclosure:

a. an insurer cannot successfully resist a mortgagee's claim on the basis of the insured's default, unless it can be determined that the mortgagee had knowledge of and control over the material changes which is the basis for the breach;

b. detailed questionnaire that includes a "basis clause" is an important ingredient in the successful defence of non-disclosure and misrepresentation cases;

c. it is important that the questionnaire contain clear and unambiguous questions;

d. any unanswered question or ambiguous answer should be resubmitted for clarification;

e. the insured may be able to succeed if she can establish that the agent was responsible for the false statement in the application form; and

f. the insured may be able to succeed if she can establish that the insurer could have discovered the truth if it had undertaken a simple investigation.