EXTRA-CONTRACT RECOVERY IN INSURANCE LAW

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Every person or business has one or more insurance policies covering all kinds of risks; for instance, fire, household contents, loss of profits, or professional negligence. What all policies have in common is their form, the style of language used, their conditions, warranties and exclusions, and centuries of insurance case-law based upon "doctrines" such as non-disclosure and good faith. A surprising fact is these "doctrines" when in issue appear to have been breached or not observed always by the insured and never by the insurer. Insurers are generally large corporate bodies against which an insured person lacks any real bargaining power. Insurance settlements can often contain elements of injustice and as a response to this, and to the hard bargaining tactics of American insurers in general, American courts are attempting to redress the respective contractual positions of insured and insurer by allowing for recovery of extra-contract damages of various kinds against insurers. The author reviews these developments and relates them to current Australian complaints statistics and practice. The author advocates a return to the "doctrine" of good faith on the part of the insurer as advanced by one of the founding fathers of modern insurance law, Lord Mansfield, in setting out the principle of the mutuality of good faith (in Carter *v.* Boehm *(1766) 3 Burr. 1905, 1909, 97 E.R. 1162, 1164) in the insurance contract.*

I INTRODUCTION

An insurance policy is a contract whereby one person, the insurer, undertakes, in return for the agreed consideration, the premium, to pay another person, the insured, a sum of money or its equivalent on the happening of a specified event.[1] Behind this simple definition lie centuries of dispute and doubt in the context of disputed insurance claims. The apparent simplicity of the agreement entered into underlies a deeper reality, namely, the imbalance in the respective positions of insurer and insured. The insurer assumes the corporate form with an expertise in legal and insurance matters and with some centuries of insurance experience on which to draw. The insured, even if a large corporation, can never be sufficiently privy to the state of the mind of

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[1] E. Ivamy, *General Principles of Insurance Law* (4th ed. 1979) 3.

the insurer in view of the scope of insurance law decided in favour of insurers over the centuries.

Any study of insurance case-law, reinforced by annual reports of Consumer Affairs Bureaux, indicates that insurers have at their disposal numerous defences to a valid claim which can be raised if the insurer has any doubts as to the validity of that claim. This has been described as the insurer being both judge and jury in its own cause,[2] and the use of these defences becomes even more objectionable because their use is not necessarily limited to doubtful claims. They can be used at any time. This is not to suggest that insurers are in the habit of consistently rejecting claims. Experience shows this not to be the case. Indeed, on the conservative assumption that each person in Australia has at least one policy of any description, the number of actual reported cases is small in the context of a very conservative estimate of the 14 million current policies in this country. However, the problem lies in the real possibilities for abuse insurance law gives insurers. The cases and instances of abuse are enough to raise the question of what can be done to reverse existing case-law trends in favour of insurers.

The intention of this article is to consider recent American initiatives in redressing the balance between insurer and insured because of the traditionally heavy imbalance in the insurance contract. These initiatives take three forms. First, extra-contract recovery for damage arising from delay in settlement on the part of the insurer, if based on the foreseeability test, is now providing a remedy for the insured in the face of an immovable insurance company. Where extra-contract damage is caused by a delayed settlement and has led to such matters as foreclosure by a mortgagee or winding up of a business the scope of damage arising naturally must be substantial. Secondly, American tort law is adapting its tried and tested remedies of fraud and infliction of nervous shock to the insurance context. The latter is one of the matters against which insurance is designed to provide cover. A delayed insurance settlement, at times of stress, must be as emotionally draining as any of the better known situations involving invasions of personal security in tort law. American courts have evolved a tort remedy from the implied-in-law duty in contract to act in good faith, now known as the tort of bad faith. Finally, permeating the insurance contract is the third area considered in this article: a doctrine by which legal effect is given to the reasonable expectations of the insured as to the purpose and effect of his contract of insurance.

Although an insurance contract may involve the undertaking of an insurer to pay compensation on the happening of a specified event, the insurer does not necessarily enter the contract without the knowledge that the contract may involve no liability on its part. Devices for

[2] *E.g. per* Stephen J. in *Deaves* v. *C.M.L. Fire and General Insurance Co. Ltd* (1979) 53 A.L.J.R. 382, 391.

ascertaining and controlling risk have existed since the origin of insurance and to that extent, an insurance contract is far less than a contract of chance if the actuarial and statistical material of the insurer is correct.[3] However, the devices that can be relied on by an insurer today are largely those from an earlier pre-actuarial and pre-computer processing period. Namely, the devices found in the insurance contract called variously non-disclosure, representations, warranties, conditions and exceptions.[4] By requiring compliance with non-disclosure and warranty rules, the risks of the insurer have been diminished by overcoming, to some extent, the unknowns involved in the contract. However, by requiring compliance with conditions in the contract, and by specifically limiting liability with various exceptions, the position of the insurer has been further fortified. The insurer has been thereby placed in a firm position (in view of its actuarial and experiential evidence) to estimate risks and to define limits. Moreover, these devices even require the insured to keep the insurer fully in view by notifying immediately any change in circumstances affecting the risk. All this has taken place in the context of an insurance market that was and still is largely unregulated.[5]

The problem facing law reformers is to balance the rights of the respective parties to the insurance contract. In its early days, insurance law and practice was clear to and understood by all parties to the transaction. It can be argued that the development of insurance law has been marked by the application in later times of principles evolved for quite different purposes. The shipowners and the underwriters of the 18th century were the formulators of principles now applied to insurances as different as multinational reinsurance treaties and the first motor vehicle policy of an 18 year-old. Expressions used in insurance negotiations and documents were clear in meaning and subject to no strained

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[3] "When you buy health insurance, you are saying 'I bet I get sick', and the company is saying 'I bet you won't'. Just in case you do, however, the company is making the same bet with thousands of other people": R. Swagler, *Caveat Emptor! An Introductory Analysis of Consumer Problems* (1975) 71. See generally S. Caffin, *A Technical Basis for General Insurance* (1975) 3: "A survey of the general insurance industry shows that major companies carrying on general insurance businesses in U.S.A., Canada and Europe recognise that the application of properly developed mathematical and actuarial techniques and the compilation of well-designed forms of statistical tabulation, are necessary for continued profitability."

[4] W. Vance, *Handbook on the Law of Insurance* (3rd ed. 1951 B. Anderson) 365.

[5] Australian Law Reform Commission Discussion Paper No. 7, *Insurance Contracts* (1978) para. 6. Australian federal legislation sets minimum solvency ratios and is administered by, in the case of general insurance (which operates under the Insurance Act 1973 (Cth) (as amended)), the Insurance Commissioner. Beyond administrative control and supervision of solvency ratios, there is nothing in the way of a fund to protect policy-holders as in the United Kingdom under the Policyholders Protection Act 1975 (U.K.). State legislation has provided for some alteration in common law insurance contract provisions on such matters as the effect of incorrect statements in documents (as noted at note 37 *infra*) arbitration and suicide.

interpretations. However, developments in mercantile society hand-in-hand with insurance law have led to such a rapid growth that legal concepts developed in a period before insurance became such a powerful institution and influence can be said to be inadequate in the current environment; inadequate if only because of their evolution in another time and another place. As has been argued, modern insurance practice witnesses the application of "like rules in unlike cases".[6]

What remedies are available to the insured for the wrongful refusal of an insurer to honour a claim? Apart from a common law action for failure to indemnify under the contract, the insured is in a relatively weak position. In other words, apart from legal proceedings that may be slow, expensive and unsatisfactory, the insured may have no recourse but to entrust himself to the insurer's claims department. American decisions demonstrate an insurer may delay settlement. The insurer may by its very inertia create barriers of all kinds to genuine claims. In view of the nature of an insurer, which is like any "giant-sized organisation run . . . either by clerks or by computers [where] [n]either the clerks nor the computers care a tinker's damn",[7] the insured will be left to deal with that void presented by the "great, sluggish robot".[8]

Dilatory tactics available to an insurer are numerous.[9] American decisions demonstrate insurers refusing to accept liability for a valid claim even after assessors and legal advisers have given advice to do so;[10] delaying settlements and investigations;[11] forcing an insured to arbitration in the hope that the insured's claim will be settled;[12] contending that claim forms or other documentation were not received;[13] requesting unnecessary and superfluous medical reports;[14] unreasonably accusing the insured of non-disclosure or misrepresentation with the view of forcing a settlement;[15] fabricating defences;[16] instigating, without any real foundation, criminal proceedings;[17] repeatedly requesting

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[6] W. Vance, note 4 *supra*, 100 n.

[7] P. Clyne, *How Not to Pay Your Debts* (1974) 25.

[8] *Ibid.*

[9] See generally, Note, "First Party Torts—Extra-Contractual Liability of Insurers Who Violate the Duty of Good Faith and Fair Dealing" (1976) 25 *Drake L. Rev.* 900, 909-910.

[10] *Kinder* v. *Western Pioneer Insurance Co.* 231 Cal. App. 2d 894, 42 Cal. Rptr 394 (1965); *Garner* v. *American Mutual Liability Insurance Co.* 31 Cal. App. 3d 843, 107 Cal. Rptr 604 (1973).

[11] *Baque* v. *Pan-American Life Insurance Co.* 313 So. 2d 293 (1975).

[12] *Gruenberg* v. *Aetna Insurance Co.* 9 Cal. 3d 566, 510 P. 2d 1032, 108 Cal. Rptr 480 (1973).

[13] *Humphries* v. *Puritan Life Insurance Co.* 311 So. 2d 534, 539 (1975).

[14] *Id.*, 537.

[15] *Fletcher* v. *Western National Mutual Life Insurance Co.* 10 Cal. App. 3d 376, 89 Cal. Rptr 78 (1970).

[16] *Gruenberg* note 12 *supra; Davenport* v. *Mutual Benefit Health & Accident Association* 325 F. 2d 785 (1964).

[17] *Gruenberg* note 12 *supra.*

identical information[18] or simply forcing an insured person to litigation to enforce a valid claim.[19] Australian practitioners know that it may take the threat of proceedings or the issuing of a writ to stir an insurer into action.

What of the situation where the insurer fails to seek a third medical opinion where there is a conflict between reports of the physicians of insured and insurer? Or where the insurer accepts premiums knowing that the policy issued does not cover the risks that the insured believed to be covered?[20] These instances can be cited despite far more rigid American legislative control over standardisation of insurance contracts.[21] American state control varies from allowance of free negotiation between insurer and insured to the extremes of statutory prescription. The extremes are couched in that distinctive American style: "An act requiring insurance policies to be written in a form that can be easily understood".[22] That particular Act requires an insurance policy form to be filed with and approved by the Insurance Commissioner, to comply with typographical requirements and to achieve a minimum Flesch scale readability score of fifty (on a scale of zero to one hundred, where the former indicates that the passage is almost incomprehensible and the latter that the passage would be easily understood by a young child).[23] In addition to such controls, American developments show a balancing of the rights of insurer and insured with the development of the "bad faith" doctrine. This could be described perhaps as requirement of a duty of good faith on the part of the insurer.

Australian evidence indicates that the examples of American insurers considered in this article are not unique to the United States. So many Anglo-Australian insurance cases purport to be decided according to the terms of the policy. However, a second look indicates that the insured (whether an honest householder or a large corporation) was usually quite unaware of the "right" being exercised by the insurer in its favour. One obvious reason for this lies in the form and evolution of insurance policies themselves. Even in 1786, Park was able to observe that the "antiquity [of the insurance policy] cannot preserve it from censure, it being very irregular and composed, and frequently ambiguous

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[18] *Merrin Jewelry Co.* v. *St Paul Fire & Marine Insurance Co.* 301 F. Supp. 479, 484 (1969).

[19] *Kirk* v. *Safeco Insurance Co.* 28 Ohio Misc. 44, 273 N.E. 2d 919 (1972).

[20] *Michel* v. *Washington National Insurance Co.* 315 So. 2d 863 (1975).

[21] R. Keeton, *Basic Text on Insurance Law* (1971) sec. 2.10(b).

[22] *E.g.* New York General Obligations Law (McKinney) ch. 23-A §5-702. Requirements for use of plain language in consumer transactions: "Every written agreement . . . to which a consumer is a party . . . must be 1. Written in a clear and coherent manner using words with common and every day meanings . . .".

[23] On the Flesch readability scale, see P. Latimer *Cases and Text on Insurance Law—Australia and New Zealand* (1977) 204; G. Lyons and J. Tanner, "Legal Documents—Can Anyone Understand Them?" (1977) 2 *Legal Service Bulletin* 283; R. Flesch, *The Art of Readable Writing* (25th ed. 1974).

from making use of the same words in different senses".[24] In more recent days this point has been reiterated in the High Court when Mason J. noted in passing that the policy in question was "made up of a jumble of ill-associated documents expressed in that distinctive style which insurance companies have made their own".[25] In other words, one initial criticism is that insurers have the benefit of their experience, and a document of sand upon which the protection paid for is to be built. Many of the leading insurance contract cases which have been decided against the insured are indefensible on the grounds of either fair dealing or common sense. How was the insured in *Dawsons Ltd* v. *Bonnin*[26] supposed to know that if the insured truck was not garaged where it was stated in the policy to be garaged, the insurance would be void? How was the insured in *Macaura* v. *Northern Assurance Co. Ltd*[27] supposed to know that even though he was the man behind the one-man company which owned the insured timber, the policy would be void on the basis that because it was in his name, he could not have a so-called insurable interest in the property which was owned in the name of the company? How was the illiterate Afghan camel driver supposed to know that representations made by "his" agent were not made on behalf of the insurer and therefore did not bind the insurer?[28] How was the former criminal supposed to know that insurance law placed on him a duty to disclose his criminal convictions of twelve years earlier even though no question on this point was printed in the proposal or raised by the broker through whom he arranged his insurance?[29]

Most cases of bad faith tactics on the part of insurers do not get to court. Thus, it is necessary to examine statistics compiled by the Consumer Affairs Bureau of each jurisdiction for evidence of such bad faith tactics.[30] The essence of the complaints lies in the unexpected or

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[24] J. Park, *System of the Law of Marine Insurers* (8th ed. 1786) 15. See early criticism also in *e.g. Brough* v. *Whitmore* (1791) 4 T.R. 206, 210, 100 E.R. 976, 978; *Marsden* v. *Reid* (1803) 3 East 572, 578-579, 102 E.R. 716, 718-719.

[25] *Guardian Assurance Co. Ltd* v. *Underwood Constructions Pty Ltd* (1974) 48 A.L.J.R. 307, 308.

[26] [1922] 2 A.C. 413.

[27] [1925] A.C. 619.

[28] *Jumna Khan* v. *The Bankers and Traders Insurance Co. Ltd* (1925) 37 C.L.R. 451. See also text accompanying note 46 *infra* and note 159 *infra*.

[29] *Woolcott* v. *Sun Alliance and London Insurance Ltd* [1978] 1 All E.R. 1253, [1978] 1 W.L.R. 493. See also Commercial Law Note, "Avoidance of Insurance Policies for Non-Disclosure of Material Facts" (1978) 52 *A.L.J.* 645. However, the insured did succeed against his broker: *Woolcott* v. *Excess Insurance Co. Ltd* [1978] 1 Lloyd's Rep. 633; noted 53 *A.L.J.* 146.

[30] Insurance complaint statistics: Victoria 395 (Ministry of Consumer Affairs, *Annual Report* (1977-1978) 131); N.S.W. 374 (Consumer Affairs Bureau, *Annual Report* (1975-1976) 97); Queensland 81 (Commissioner for Consumer Affairs, *Ninth Annual Report* (1978-1979) 12); S.A. 339 (Report for the Commissioner for Consumer Affairs, *Annual Report* (1977-1978) 30); Tasmania 103 (Consumer Affairs Council, *Seventh Annual Report* (1976-1977) 34); A.C.T. 74 (Consumer Affairs Council, *Sixth Annual Report* (1978-1979) 31).

even unfair result confronting the consumer caused by such matters as failure (on the part of the insured) to increase property insurance to keep abreast of inflation, averaging of property claims or the real effect of an excess clause.[31] A number of complaints received by the Victorian Consumer Affairs Bureau are attributable to one surprising fact: the insured had never been issued with a copy of the policy and was therefore unable to comply with policy requirements.[32] The Bureau was able to conclude in 1975-1976 that "[b]y far the majority of complaints arise because the consumer was not aware of the conditions under which his property is insured, especially in relation to any exclusion clauses. Consumers should obtain a copy of an insurance policy and read it before they take insurance; if the contract does not give the cover they want they should go elsewhere. If the company cannot or will not supply a copy of the policy for examination, go elsewhere for insurance; it is *too* late to read a policy after a claim arises".[33] In 1977-1978 the Bureau was able to note that a "large number [of insurance complaints] referred to disputes arising out of exclusion clauses contained in the policies. Consumers complained that they were not aware of such clauses or that they had attributed to them a different interpretation to that of the company. In some cases the company's interpretation was most one-sided in their favour and rendered the policy virtually useless to the consumer when a claim was made".[34] The A.C.T. Consumer Affairs Council was able to note in its 1978-1979 Annual Report that:

* Most insurance policies oblige insurance companies to notify cancellation or modifications of policies by ordinary rather than registered or certified mail. As a direct result, the person insured may be unaware of cancellation or modification.
* Insurance companies are permitted to furnish "specimen" rather than original policies to persons insured, thus increasing the possibility that the insured is not aware of the precise terms of his cover.
* Many insurance companies give only limited information on notices of renewal, failing to make full disclosure of information which might have substantial influence on the insured person's decision to accept or reject a renewal.[35]

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[31] Consumer Affairs Bureau (Vic.), *Annual Report* (1976-1977) paras 6.2.1-6.4.2. See also Consumer Affairs Bureau (Vic.), *Annual Report* (1978-1979) paras 4.1.1-4.9.2.

[32] *Id.*, para. 6.5. At the Life Underwriters' Association annual conference held at Monash University in February 1978, the author as one main platform speaker put this question to the 600 or so insurance agents and personnel present in the form of a straw vote. Less than half could claim to even have the printed policy present when discussing insurance with a proponent, let alone taking time in their "presentations" to analyse and explain policy terms.

[33] *Id.*, para. 6.5.4.

[34] Ministry of Consumer Affairs (Vic.), *Annual Report* (1977-1978) paras 4.1.1-4.1.2.

[35] Consumer Affairs Council (A.C.T.), *Sixth Annual Report* (1978-1979) 24.

The Bureaux do report on the strictness with which some insurers enforce their contractual rights in rejecting claims on the basis of non-disclosure of material facts (such as a previous driving record) or actions on the part of the insured which are considered to have prejudiced the company.[36] This is despite legislative action at the State level. New South Wales followed the 1936 lead of Victoria in 1974 by amending its insurance legislation: a new section 18 was inserted preventing an insurer unfairly relying on a technicality to defeat a genuine claim.[37]

It is true that there is no evidence of widespread rejection of claims, but the possibility is ever present for an insurer to be a judge in its own cause if it so chooses. It is often said that the reason a claim is rejected is because the insurer had reason to suspect foul play on the part of the insured but for reasons of evidence and ease chose the device of non-disclosure to reject a claim. This may be so, but if an insurer is justified in rejecting a claim the reasons should be clearly stated rather than masked behind doctrines of good faith and non-disclosure.

Proposals for unconscionability legislation include the insurance contract as one of the contracts able to be re-opened or re-written by the courts in the light of evidence of inequality and inequity derived from the relative positions of the parties to the contract. The New South Wales *Report on Harsh and Unconscionable Contracts*[38] specifically included insurance contracts in the same class as real estate, building and door-to-door sales contracts as examples of contracts of special concern to the State Consumer Affairs Bureau. In the resulting Act the Contracts Review Act 1980 (N.S.W.) the court is empowered to (in effect) rewrite contracts (as widely defined) found to have been harsh, oppressive, unconscionable or unjust at the time of being made.[39] This does not provide the restriction it would appear to. This is because section 9(4) extends the operation of the Act to any injustices arising from the operation of the contract which were reasonably foreseeable at the time the contract was made. This means that an insurer's contention that an insurance contract was clear and unobjectionable at the time it was made would be of no effect if in reality the effect of the fine print, exclusions and excess technicalities were not revealed until the time that a genuine insurance claim was made. The powers of the court are wide

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[36] *E.g.*, Consumer Affairs Council (Tas.), *Seventh Annual Report* (1976-1977) 14-15.

[37] Insurance Act 1902 (N.S.W.) s. 18 (added in 1974); Instruments Act 1958 (Vic.) s. 25. See *e.g.* Consumer Affairs Bureau (N.S.W.), *Annual Report* (1975-1976) 50-54. See also Life Insurance Act 1945 (Cth) (as amended) ss. 83, 84; Insurance Law Reform Act 1977 (N.Z.) s. 6; Illinois Insurance Code s. 766; Ontario Insurance Act (R.S. Ont. 1914 c. 183) s. 198; recommended for Western Australia by the Law Reform Committee (W.A.) *Motor Vehicle Insurance* (1972) 7 ff.

[38] J. Peden, *Harsh and Unconscionable Contracts* (Report to the N.S.W. Minister for Consumer Affairs and Co-operative Societies and the Attorney-General for N.S.W., 1976); noted (1977) 51 *A.L.J.* 232.

[39] Contracts Review Act 1980 (N.S.W.) s. 7.

in relation to the relief that can be granted. The court is empowered to make an order for *inter alia* the supply of services (which must include services under an insurance contract).[40] It was necessary to overcome the problems faced by the courts with equivalent sections in the Money-lenders and Hire-purchase legislation.[41] In that legislation the sections have been largely by-passed by the courts. Accordingly a shopping list of "matters to which the court shall have regard"[42] has been added to the Act to assist a court to determine whether a contract or a provision in a contract is unjust.[43] Some of these "matters" seem ready made for insurance contract law. For instance, the question of whether the contract was subject to negotiation (standard form insurance contracts never are);[44] the ease by which conditions could be complied with (insurance conditions are often difficult to comply with);[45] whether any representations were made by any person "not reasonably able to protect the interests of any party whom he represented" (the contractual position of insurance agents has often proved difficult);[46] and even the physical form and intelligibility of the documentation.[47] Perhaps the major objection will be the Act's exclusion of non-consumers from its purview. It is true, a large business organisation will or should have the best insurance and legal advice available, however the Act excludes small businesses and no business contract will be reviewable.[48] It is unfortunate that this limitation was imposed[49] because many of the leading insurance cases have involved what may be called small business cases as indicated by the frequency with which a proprietary company appears as a claimant in insurance cases. However, in general terms, unconscionability legislation is a fact of life in many jurisdictions made necessary by the complexities of the mass production society.[50] Such legislation provides

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[40] *Id.*, Schedule 1, Ancillary Relief, 1(e).

[41] Note 50 *infra.*

[42] Note 39 *supra*, s. 9(2)(1).

[43] S. Einfeld, Second Reading Speech, *Parliamentary Debates* (N.S.W.) 19 March 1980, 5534.

[44] Contracts Review Act 1980 (N.S.W.) s. 9(2)(b).

[45] *Id.*, s.9(2)(d). See *e.g. Deaves* v. *C.M.L. Fire and General Insurance Co. Ltd* (1979) 53 A.L.J.R. 382 and *Woolcott* v. *Sun Alliance and London Insurance Ltd* [1978] 1 All E.R. 1253, [1978] 1 W.L.R. 493.

[46] *Id.*, s. 9(2)(e). An expansive reading could conceivably include cases such as *Jumna Khan* v. *The Bankers and Traders Insurance Co. Ltd* note 28 *supra.*

[47] *Id.*, s. 9(2)(g).

[48] *Id.*, s. 6(2).

[49] See the difficulties in the definition of "consumer" canvassed by the Trade Practices Act Review Committee, *Report to the Minister for Business and Consumer Affairs* (1976) paras 9.38-9.45.

[50] *E.g.* U.S. Uniform Commercial Code U.C.C. §2-302; Uniform Consumer Credit Code §5-108; Trade Practices Act 1979 (British Columbia) s. 3. In Australia see *e.g.* Money Lenders Act 1958 (Vic.) s. 28; Money Lending Act 1941 (N.S.W.) s. 30 and equivalents; Hire-Purchase Act 1959 (Vic.) s. 24; Hire Purchase Act 1960 (N.S.W.) s. 32 and equivalents; Industrial Arbitration Act 1940 (N.S.W.) s. 88F.

one means of putting some equality back into the notion of contract as evidence of agreement.

The Federal Government takes or has taken action in a number of ways. For a start, the annual reports published by the Insurance Commissioner and the Life Insurance Commissioner under the Insurance Act 1973 (Cth) (as amended) and the Life Insurance Act 1945 (Cth) (as amended) contain, in addition to very full statistics on solvency and financial matters, comments on complaints and inquiries received by the Commissioners. In this area there is the spectre of growth. For example, the Life Insurance Commissioner noted in 1976 that

> [t]he number of inquiries and complaints received in 1976 again showed a significant increase over the number received in previous years. The trend is expected to continue in the future with the current emphasis on consumer interests and the establishment of consumer protection authorities which are referring an increasing number of complaints to my Office. There are indications that members of the public are becoming more aware that the Act contains provisions for the protection of policies and are approaching my Office to ensure that their entitlements in regard to those policies are being met.[51]

The relevant statistics, as quoted by the Life Insurance Commissioner[52] indicate a substantial increase in reported complaints from 303 in 1976 to 401 in 1977. This steep increase is attributable to a number of factors. One factor must be the increased consumer consciousness in the economy. This trend can be expected to increase with the heightening of the level of outrage caused by the recognition of bad faith tactics.

One imponderable in this area is the question of whether poor financial performance on the part of the insurance industry in general can be correlated with the level of rejection or delay of claims. The general insurance industry in Australia underwent severe losses in 1973-1974 and 1974-1975.[53] Modest returns in 1975-1976 were not expected to be sustained. Indeed, stiff competition and rate cutting have been blamed by the Insurance Commissioner for the expectation of a decline of underwriting profits in 1977-1978 and 1978-1979.[54] Massive rate cutting leading to insurers chasing the available business, the loss of tariff protection following action by the Trade Practices Tribunal in 1977,[55] stiff competition between insurers, and now the effect of the technological revolution leading to staff retrenchments must all play

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[51] Life Insurance Commissioner, *Thirty-first Annual Report* (1977) para. 9. Sentiments repeated in *Thirty-second Annual Report* (1978) para. 10.

[52] *Thirty-second Annual Report* para. 9.

[53] Insurance Commissioner, *Third Annual Report* (1976-1977) 20.

[54] Insurance Commissioner, *Fourth Annual Report* (1977-1978) 18.

[55] *The City Mutual Life Assurance Society Ltd* (1978) 2 A.T.P.R. 17,631; "TPC Shatters Life Insurance Industry" *Financial Review*, 13 October 1977, 1.

their part in affecting the capacity of insurers to pay.[56] Such a financial exercise must be outside the scope of this article.

The Federal Attorney-General's reference on insurance contracts in 1977 to the Australian Law Reform Commission has been well publicised with extensive media coverage given to the reference, nationally held insurance seminars,[57] the publication of two research reports,[58] the publication of the lengthy Treasury Submission to the Law Reform Commission,[59] and a shortly expected final report with draft legislation.

The other major Federal Government initiative in the insurance area, the scheme proposed in 1974 for national compensation and rehabilitation, came to a quick end. The plan of the scheme was to bypass the existing remedies for injury and to replace them with a universal and comprehensive no-fault liability scheme. The scheme would have operated to the exclusion of the private insurers, which would in turn have faced substantial winding down of operations, enforced sale of assets and retrenchment of staff. Such a scheme was bound to attract widespread opposition from insurers and it disappeared with its sponsoring government in 1975. Consideration of this alternative to insurance is another topic in itself and has been considered elsewhere.[60]

Finally, law reform commissions in other jurisdictions have actively assessed the operation of insurance contracts with new legislation in both New Zealand and the United Kingdom. The Insurance Law Reform Act 1977 (N.Z.) and the Policyholders Protection Act 1975 (U.K.) both make moves to redress the imbalance of the insurance contract.

However, it is through the evolution of case law that major initiatives have been taken in the development of American insurance law. In view of the frequency with which Australian law follows American developments[61] (often with a time-lag of some decades) the American developments are presented with a warning.

II RECOVERY IN CONTRACT

The full range of contractual remedies (insurance forming one specialised area of contract law) will be available to the insured.

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[56] *E.g.* "Insurance Industry in State of Upheaval" The *Weekend Australian*, 19-20 April 1980, 15.

[57] During November 1978 in association with the Australian Insurance Institute.

[58] Australian Law Reform Commission Issues Paper No. 2, *Insurance Contracts* (1977); Australian Law Reform Commission Discussion Paper No. 7, *Insurance Contracts* (1978).

[59] *Treasury Submission to the Law Reform Commission* (1979).

[60] *E.g.* H. Luntz, *Compensation and Rehabilitation* (1974); K. Marks, "A First in National No-Fault" (1973) 47 *A.L.J.* 516 (the New Zealand scheme); Current Topic, "Report of National Committee of Inquiry into Compensation and Rehabilitation in Australia" (1974) 48 *A.L.J.* 413; M. Vennell, "The Scope of National No-Fault Accident Compensation in Australia and New Zealand" (1975) 49 *A.L.J.* 22; Report from the Senate Standing Committee on Constitutional and Legal Affairs, *Clauses of the National Compensation Bill 1974* (1975).

[61] *E.g.* Trade Practices legislation and product liability case law.

Although compensation will be the intention of an action in damages, the question is whether it can adequately cover possible consequences of a delayed insurance settlement such as financial hardship of the insured, his bankruptcy or the winding up of his business. According to the *Hadley* v. *Baxendale* rule,[62] damages are limited to those arising "according to the usual course of things"[63] or to those that were in the contemplation of the parties as the possible result of the breach. It is suggested that such circumstances must have been in the contemplation of the insurer at the time the insurance was effected. Why would the insured have wanted cover if not to provide security against risk, and all that must flow from it if the risk occurs? Foreseeability as a test for damages does not always benefit the insured. There may be the assumption or hope that the insurer will be alerted to the effect of failure to settle. However, insurers have not yet been held responsible for the full consequences of failure to settle. Surely, therefore, narrow definitions of foreseeability do fail to take fully into account the position of the insured; even though to the "reasonable man" it must be obvious that an insured party whose claim is delayed may suffer economic loss. Indeed, he may also suffer physical hardship; in one American case, the wheelchair of the insured victim in a personal accident claim was repossessed;[64] in another case, an insured party fell into arrears in house mortgage payments and his house was repossessed.[65] Such specific consequences of delay by an insurer may not be (or probably are not) foreseeable and will arguably not be recoverable in an action for damages by the insured.

Modern statements of the *Hadley* v. *Baxendale* rule could perhaps come to the assistance of the insured. For example, in the *Victoria Laundry* case,[66] damages were still tied to what was at the time foreseeable and this was said to still depend on knowledge "possessed by the parties or, at all events, by the party who later commits the breach".[67] Is the insurer not expected to know that the reason for the effecting of insurance in the first place is to provide cover against risk? However, *Victoria Laundry* can be further applied to assist the insured. Damages were sought for delay in delivery of a boiler for a laundry. Loss of profits were claimed for the loss of new customers as a result of inability to contract and for the loss of a special contract with the Ministry of Supply. It was held that the defendant could have foreseen that delay on its part must lead to loss of profits. If loss of profits is recognised, as

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[62] (1854) 9 Exch. 341.

[63] *Id.*, 354.

[64] *Silberg* v. *California Life Insurance Company* 11 Cal. 3d 452, 521 P. 2d 1103 (1974), 113 Cal. Rptr 711 (1974).

[65] *Leonard* v. *Firemen's Insurance Co.* 100 Ga. App. 434, 436, 111 S.E. 2d 773, 775 (1959).

[66] *Victoria Laundry (Windsor) Ld.* v. *Newman Industries Ltd* [1949] 2 K.B. 528.

[67] *Id.*, 539.

indeed it is,[68] there would have to be some remedy available to an insured claimant for dilatory tactics by an insurer.

This could be illustrated by reference to *Reichert* v. *General Insurance Co. Of America.*[69] In that case the insurer's delay in settlement of a fire claim in respect of a heavily mortgaged motel forced the insured into bankruptcy five months after the fire because of his inability to meet mortgage repayments. It was held that damages for this consequential loss were recoverable as being reasonably within the contemplation of the parties and that breach of contract by the insurer was not limited to the amount specified in the policy.[70] This was because the main reason for the purchase of fire insurance in the first place was to provide protection against an eventuality such as this: "[i]nsurers are, of course, chargeable with knowledge of the basic reasons why fire insurance is purchased, and of the likelihood that an improper delay in payment may result in the very injuries for which the insured sought protection by purchasing the policies".[71]

In another American case,[72] it was held that lost rents could be recovered if proximately caused by, or if flowing naturally and expectedly from, the defendant's breach and if they were within the contemplation of the parties at the time the contract of insurance was entered into. In other words, consequential damages will be awarded if they are foreseeable even though it would mean recovery over and above the limit of the policy itself. This case must, incidentally, indicate the "consumer" nature of some insurance. *Reichert's* case[73] concerned a 325 unit motel worth $1.5 million (perhaps the insurance should have been effected through a broker with all the professionalism, advice and legal liabilities that such entails) whereas *Asher's* case[74] concerned a fire policy worth $14,000 with an annual premium of $78.00. Decisions such as these graphically illustrate the variables involved in insurance and the difficulties of making generalisations on insurance law favouring either insured or insurer. Possibly it is the insurer who needs protection against a $1-1.5 million policy in view of the risk run. It may be asked why the same rules apply to each class of policy.

What damages will be available in contract beyond those under the foreseeability test? Punitive, vindictive or exemplary damages in contract

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[68] *Cory* v. *Thames Ironworks & Shipbuilding Co. Ltd* (1868) L.R. 3 Q.B. 181; *In re Trent and Humber; ex parte Cambrian Steam Packet Co.* (1868) L.R. Ch. App. 112; *Steam Herring Fleet* v. *Richards Co. (Ltd)* (1901) 17 T.L.R. 731.

[69] 428 P. 2d 860 (1967), 59 Cal. Rptr 724 (1967).

[70] This decision was reversed upon rehearing by the Californian Supreme Court on the basis of a technicality not material in the present context—that the plaintiff did not have a right to recover because recovery had vested with the trustee in bankruptcy. However, there are many authorities for the proposition that consequential damages will be recoverable. See *e.g.* J. Parks and R. Heil, note 147 *infra.*

[71] Note 69 *supra,* 864, 728.

[72] *Asher* v. *Reliance Insurance Co.* 308 F. Supp. 847 (1970).

[73] Note 69 *supra.*

[74] Note 72 *supra.*

in Anglo-Australian law were limited until 1964 to an action for breach of promise of marriage. Injured feelings in themselves have not grounded an award of exemplary damages.[75] The 1964 decision of the House of Lords in *Rookes* v. *Barnard*[76] may have opened the gate for exemplary damages in tort in three limited circumstances[77] but did not provide the same scope for the recovery of exemplary damages in contract.[78] Therefore, as authority for exemplary damages in contract one would be either forced to turn to old authorities[79] or else view the damages under another name: aggravated damages for non-pecuniary loss as upheld by Lord Denning M.R. in *Jarvis* v. *Swans Tours Ltd.*[80] The plight of the solicitor employed by the local authority at Barking during his 1969 annual holidays is by now well known; how everything went wrong from the start with the 12 day Swiss house party holiday which he had booked through Swans Tours. When the solicitor sued for damages for breach of contract, he was awarded half of the tour cost by the judge at first instance. However, on appeal the previously upheld common law limitations on the right to recover damages in contract for mental distress were abandoned. Lord Denning stated that

> [i]n a proper case damages for mental distress can be recovered in contract, just as damages for shock can be recovered in tort . . . If the contracting party breaks his contract, damages can be given for the disappointment, the distress, the upset and frustration caused by the breach . . . The right measure of damages is to compensate [the plaintiff] for the loss of entertainment and enjoyment which he was promised, and which he did not get.[81]

Punitive damages under that head are not generally available therefore in an action in contract regardless of the degree of wilfulness, malice or fraud leading to the breach.

Some American jurisdictions have allowed for some years recovery of punitive damages in contract situations involving fraud. For example, in South Carolina[82] the principle became firmly established in a number of insurance cases where it was held that policies had been breached by

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[75] *Addis* v. *Gramophone Co. Ltd* [1909] A.C. 488; *Groom* v. *Crocker* [1939] 1 K.B. 194.

[76] [1964] A.C. 1129.

[77] *Australian Consolidated Press* v. *Uren* [1969] 1 A.C. 590.

[78] *Viz.*, in cases of oppressive, arbitrary and unconstitutional acts of Government servants; in cases where the tortfeasor's conduct has been calculated to make a profit exceeding compensation payable to the plaintiff.

[79] *Sondes* v. *Fletcher* (1882) 5 B & A 835; *Smith* v. *Woodfine* (1857) 1 C.B. (N.S.) 659; *Berry* v. *Da Costa* (1866) L.R. 1 C.P. 331; *Finlay* v. *Chirney* (1888) 20 Q.B.D. 494; *Maw* v. *Jones* (1890) 25 Q.B.D. 107.

[80] [1973] 1 Q.B. 233.

[81] *Id.*, 237-238.

[82] H. Summerhall, "Punitive Damages for Breach of Contract in South Carolina" (1958) 10 *S. Carolina L.Q.* 444; see also J. Esler, "Bad Faith and Punitive Damages" (1977) 652 *Ins. L.J.* 285.

insurers in the committing of fraudulent acts.[83] There have been many different fact situations giving rise to punitive damages in the South Carolina jurisdiction. There have been cases of the insurer making fraudulent representations, gaining possession of the policy and, when a claim is sought, refusing to return the policy.[84] On the other hand there are cases involving the fraudulent inducement of settlements of claim.[85] Some cases have involved fraudulent omissions by the insurer or an agent to collect premiums with the view to cancellation or lapsing of the insurance.[86] Other cases where punitive damages in contract have been awarded have involved such matters as an insurer's interfering with arbitration proceedings to secure a finding favourable to the insurer,[87] forgery by an insurance agent[88] or even stand over tactics by an insurer where cancellation was attempted by the insurer unless the insured would accede to retrospective exclusion of ailments recently acquired by the insured's wife.[89]

Punitive damages in tort have been more readily awarded in the United States.[90] Almost any conduct by an insurer in refusing to settle a valid claim has been categorised as unreasonable. Such factors as the refusal of an insurer to follow its own legal advice to settle,[91] or refusal to disclose policy limits to the insured's legal advisers,[92] or even an arbitrary refusal to enter settlement negotiations[93] have been held to constitute bad faith situations for which punitive damages may be awarded.

In jurisdictions where punitive damages in contract are not available, the words of Lord Collins in dissent in *Addis* v. *Gramophone Co. Ltd*[94] have special meaning. Namely, that the power of the jury to award punitive damages should not be curtailed because it is "a salutory power, which has justified itself in practical experience, to redress wrongs

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[83] *McLoud* v. *Metropolitan Life Insurance Co.* 166 S.E. 343 (1932); *Wilkes* v. *Carolina Life Insurance Co.* 165 S.E. 188 (1932); *Derrick* v. *North Carolina Mutual Life Insurance Co.* 166 S.E. 502 (1932).

[84] *Henderson* v. *Capital Life and Health Insurance Co.* 18 S.E. 2d 605 (1942); H. Summerhall, note 82 *supra*, 467 n. 114.

[85] *Bailey* v. *North Carolina Mutual Life Insurance Co.* 175 S.E. 73 (1934); H. Summerhall, note 82 *supra*, 468-469.

[86] *Bradley* v. *Washington Fidelity National Insurance Co.* 171 S.E. 243 (1933); H. Summerhall, note 82 *supra*, 469-473.

[87] *Smith* v. *Home Insurance Co.* 183 S.E. 166 (1936); H. Summerhall, note 82 *supra*, 473-476.

[88] *West* v. *Service Life and Health Insurance Co.* 220 S.C. 198, 66 S.E. 2d 816 (1951).

[89] *Yarborough* v. *Bankers Life and Casualty Co.* 225 S.C. 236, 81 S.E. 2d 359 (1954).

[90] See text accompanying footnotes 176-186 *infra.*

[91] *Kinder* v. *Western Pioneer Insurance Co.* 231 Cal. App. 2d 894, 42 Cal. Rptr 394 (1965).

[92] *Coppage* v. *Fireman's Fund Insurance Co.* 379 F. 2d 621 (1967).

[93] *Young* v. *American Casualty Co.* 416 F. 2d 906 (1969).

[94] Note 75 *supra.*

for which there may be . . . no other remedy".[95] Thus, the proposition being advanced is to break the restriction against an award of punitive damages in a contract action. In addition to the South Carolina precedents, and the authority of Lord Collins in *Addis*,[96] an award of punitive damages in tort in the Anglo-Australian context,[97] and in the American context[98] indicate that redress for the insured in a form over and above compensation (that is, punishment) could be recognised by the law depending on how the damages being awarded are characterised. Under the name of aggravated damages for non-pecuniary loss the foreseeability test must be satisfied. Because Anglo-Australian courts cannot add an amount for punishment and can only compensate, real restrictions are added to the apparent scope of *Jarvis* v. *Swans Tours Ltd.*[99] For example, in *Cook* v. *Swinfen*[100] an action against a solicitor in contract included a claim for damages for the client's anxiety state. The restrictions of *Addis* v. *Gramophone Co. Ltd*[101] were again stated: namely, that even though it could be foreseen that there may be injured feelings, mental distress, anger or annoyance, damages cannot be awarded because they are too remote. In other words remoteness is still the test. It was suggested by Lord Denning M.R. that if the solicitor had known beforehand of the client's highly strung nature, the claim may have succeeded. This certainly raises possibilities, as advanced in *Jarvis'* case,[102] but as was noted in another recent case denying damages in contract for inconvenience and mental distress, "[t]here may be signs of some judicial thaw, but spring is yet to come".[103]

Consider the beneficial effects of such a trend. It could be suggested that the insurer's duty of good faith could be refined by the knowledge of an action involving possible punitive damages. It has been further suggested that insurers have been able to pay less regard to their legal responsibilities because any damages that may be awarded in threatened litigation can be reasonably accurately calculated with no threat of the unknown factor of punitive damages.[104] Would this not be sufficient to justify the courts giving credence to an award of excess damages?

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[95] *Id.*, 500.
[96] Note 75 *supra.*
[97] *Ibid.*
[98] See text accompanying footnotes 176-186 *infra.*
[99] Note 80 *supra.*
[100] [1967] 1 W.L.R. 457 (C.A.).
[101] Note 75 *supra.*
[102] Note 80 *supra.*
[103] *Falko* v. *James McEwan & Co. Pty Ltd* [1977] V.R. 447, 452.
[104] This happened in the U.S.A.: *Scottish Union and National Insurance Co.* v. *Bejey* 201 F. 2d 163, 166 (1953). See T. Light, "Damages Assessed Against Insurers for Wrongful Failure to Pay" (1968) 10 *Wm & Mary L. Rev.* 466, 475. Where breach of contract and fraud have been pleaded in the U.S. punitive damages have been recoverable: *Ward* v. *Taggart* 336 P. 2d 534 (1954); *Wetherbee* v. *United Insurance Co. of America* 265 Cal. App. 2d 921, 927-929, 71 Cal. Rptr 764, 770-771 (1968); *Fletcher* v. *Western National Life Insurance Co.* 10 Cal. App. 3d 376, 404, 89 Cal. Rptr 78, 95 (1970); *Engel* v. *Vernon* 215 N.W. 2d

III RECOVERY IN TORT

1. *Deceit*

Typically, in effecting insurance the insured places reliance upon what he is told by an agent or what he reads in promotional literature. What has been said, or what has failed to have been said, can lead to a situation where loss may be suffered and where relief will, as a result, be sought.

Tortious recovery in fraud or deceit in Anglo-Australian law goes back to at least the time of *Pasley* v. *Freeman*.[105] It was there established that A will be liable in tort to B if A knowingly or recklessly, not caring whether it be true or false, makes a false statement to B with intent that it be acted upon by B who does so act and who suffers damage as a result. The need to prove intent to defraud may not be easy in the insurance context; moreover, the insurer's intent not to honour the policy may only arise, or become manifest, at the time of the claim. Indeed, in the leading authority of *Derry* v. *Peek*[106] it was said by the House of Lords that an honest (although perhaps blundering) belief in an allegation cannot be deceit.

American courts have recognised two classes of fraud in the insurance context. First, there have been reported cases indicating fraud on the part of the insurer at the time of the issuing of the policy. This is sometimes called fraud in the inducement. Secondly, other fraud cases have involved fraudulent conduct on the part of the insurer in settling an insurance claim or fraudulent breach of contract.

(a) *Fraud in the Inducement*

To prove fraud in this situation, there must be evidence that the promisor never had any intention of maintaining his promise. If this can be shown, there will be the false statement upon which action in fraud can be based. It has been held in the United States that the issuing of a policy of insurance includes an implied, if not an express promise to perform the contract and to honour claims made under it. Moreover, it has been held that if such a promise is made with a present intent not to perform, this can amount to a fraudulent misrepresentation.[107]

Circumstantial evidence may furnish evidence of fraud. For example, misrepresentation made by the insurer's agent may provide such evidence. Moreover, there have been reported American decisions where it has been proved that the insurer in fact never intended to fulfill

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506, 516-517 (1974); *Physicians Mutual Insurance Co.* v. *Savage* 296 N.E. 2d 165 (1973); *Sharp* v. *Automobile Club of Southern California* 225 Cal. App. 2d 648, 37 Cal. Rptr 585 (1964).

[105] (1789) 3 T.R. 51, 100 E.R. 450. See W. Prosser, J. Wade and V. Schwartz, *Cases and Materials on Torts* (6th ed. 1976) 886.

[106] (1889) 14 App. Cas. 337.

[107] *Old Southern Life Insurance Co.* v. *Woodhall* 326 So. 2d 726 (1976).

its representations or the representations of its agent. In this situation, the plaintiff's need to show that he was induced to pay premiums in reliance upon a representation which the insurer knew to be false (or which he never intended to fulfil) will be easier. This is illustrated by *Sharp* v. *Automobile Club of Southern California*.[108] In that case the insured was informed by an insurance agent that the policy would cover medical expenses whether or not the insured held other insurance. Undisclosed at the time of negotiation was the fact the insurer had previously ceased to pay claims if other such indemnity insurance was held by an insured. The insured sued upon the refusal of a claim and recovered substantial punitive damages for fraud, oppression and malice on the part of the insurer in inducing the plaintiff to enter the contract of insurance.

In fraud in the inducement cases, it must be proved that the insurer "never intended to insure the plaintiff in the amount of $[X] and thus misled plaintiff into signing a contract of insurance therefor".[109] It can be proved when an agent delivers a policy which is different to the earlier made agreement with the insured. It can also be proved in the simpler situation of the agent inducing the insured to buy insurance.[110] Indeed, it is this requirement of intention which distinguishes deceit from the more nebulous tort of negligence.

The nature of the representation itself raises the next issue. There must be a false representation of fact (as opposed to promise) made by the defendant. Can the contents of a policy document constitute the required actionable representation? Until 1976 a representation had to have been made by the insurer separate to anything contained in the policy itself. This requirement was abandoned with *Miller* v. *National American Life Insurance Co*.[111] where such an assertion was said to be without merit. The Court noted inducement if made by way of representation may be more blatant although "it is no less apparent where, as here, it is found in the very contractual promises that constitute the consideration for which the insured enters the agreement and exchanges his premium payments".[112] The insurer's contention that this rule would lead to an action in fraud for any "erroneous denial of coverage"[113] was not upheld by the Court by restating first principles. That is, to prove fraud the insured must show that the insurer did not intend to fulfil its representations as to coverage at the time the contract was entered into,

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[108] 225 Cal. App. 2d 648, 37 Cal. Rptr 585 (1964). For further authorities see *Asher* v. *Reliance Insurance Co.* 308 F. Supp. 847; W. Prosser *et al* note 105 *supra*, 886-887.

[109] *Asher* v. *Reliance Insurance Co.* note 108 *supra*, 849.

[110] For an example under the Trade Practices Act 1974 (Cth) see *De Jong* v. *Prudential Assurance Co. Ltd* (1977) 2 T.P.C. 1.

[111] 54 Cal. App. 3d 331, 126 Cal. Rptr 731 (1976).

[112] *Id.*, 338, 734.

[113] *Ibid.*

a quite different matter to denial of coverage.[114] In other words, the terms and conditions of the policy are more than statements of intention by the insurer. The policy will state emphatically that "[t]he company agrees that if . . ." and this can be held to constitute a promise or statement of fact by the insurer.

With the proof of the requirements of the tort of deceit (a misrepresentation of fact, the requisite intention, and the requisite intended reliance) compensatory damages, being the gist of actionable deceit, could be awarded. If the intent of an award of damages is to give the plaintiff "the benefit of the bargain",[115] (as opposed to his "out of pocket" loss) to what will the plaintiff-insured be entitled? The plaintiff is entitled to be put in the position he would have found himself if the fraudulent statement had not been made. A plaintiff in deceit cannot normally recover for expected prospective gains[116] but rather it is reparation for actual losses flowing from the deceit for which the plaintiff can expect recovery. Moreover, in one recent American case, in addition to allowing the insured rescission of a policy for misrepresentation made by the insurer's agent as to the nature and character of the policy, it was said that it was not necessary that the insured restore value to the insurer for cover provided prior to the rescission.[117] In addition to these damages, recovery of all consequential loss flowing directly from fraud has been allowed if the directness criterion can be shown.[118]

Recovery in deceit would appear to provide a fruitful remedy for recovery in insurance law. Too often instances of exaggeration or misrepresentation (whether by intent or by ignorance) by insurance agents are reported. If intent to defraud cannot be proved (and such would be generally unlikely in the insurance context) developments such as in *Miller's* case[119] where "any erroneous denial of coverage" was held to constitute evidence of deceit indicate the direction this body of law can take.

(b) *Fraudulent Breach of Contract*

Some American jurisdictions have evolved an alternative remedy in fraud which has proved of assistance in the insurance context. Where an insurer has used fraudulent or deceitful methods to settle or to repudiate an otherwise valid claim, courts have been prepared to provide a remedy often accompanied with punitive damages. Action for fraudulent breach of contract is based directly on conduct causing the losses complained of. In South Carolina, a jurisdiction where this tort

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[114] *Id.*, 338, 734 n. 4.
[115] J. Fleming, *The Law of Torts* (5th ed. 1977) 624.
[116] *McConnel* v. *Wright* [1903] 1 Ch. 546, 554-555 *per* Collins M.R.
[117] *Dreiling* v. *Home State Life Insurance Co.* 213 Kan. 137, 515 P. 2d 757 (1973).
[118] *Doyle* v. *Olby (Ironmongers) Ltd* [1969] 2 Q.B. 158.
[119] *Miller* v. *National American Life Insurance Co.* note 111 *supra.*

is well established, wrongful activity beyond mere non-payment must be proved. In other words, there must be a fraudulent act.[120] Action for fraudulent breach of contract is to be distinguished from the cases considered above of "fraud in the inducement". Fraudulent breach of contract is based directly on the conduct of the insurer which gives rise to the insured's complaint such as misrepresentations made by an insurer as to the amounts due under a life policy on the life of the plaintiff's husband.[121] In another case, misrepresentations made by the insurer's agent on the effect of an exclusion in a motor vehicle policy in the event of intoxication have been held to be actionable.[122]

In fraudulent breach of contract a wrongful action is required by the insurer in addition to non-payment as considered for instance in *Miller* v. *National American Life Insurance Co.*[123] In the South Carolina leading case, *Welborn* v. *Dixon*,[124] it was said that punitive as well as compensatory damages would be awarded where a breach of contract had been accompanied with a fraudulent act. South Carolina courts have expanded this principle to award punitive damages in this context if breach of contract was accompanied by (*cf.* with)[125] a fraudulent act; or accompanied by an intent to defraud the other party to the contract;[126] or in circumstances giving rise to a cause of action for fraud; or in circumstances where the plaintiff must show that the breach was accomplished with a fraudulent intention and was accompanied by a fraudulent act;[127] as the final statement of the rule allowing for recovery of punitive damages is that a fraudulent breach of contract is a tort in itself.[128]

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[120] *Gavin* v. *North Carolina Mutual Insurance Co.* 217 S.E. 2d 591 (1975). See *e.g.* H. Summerhall, note 82 *supra.*

[121] *Corley* v. *Coastal States Life Insurance Co.* 135 S.E. 2d 316 (1964).

[122] *Physicians Mutual Insurance Co.* v. *Savage* 296 N.E. 2d 165 (1973) (damages on the contract $10,000; punitive damages $50,000). See also *Davenport* v. *Mutual Benefit Health & Guidance Association* 325 F. 2d 785 (1963): representations by insurer's "claims agents" that the insured's condition was neither sickness or accident and would not come within the cover of the policy. Conduct of the insurer held to constitute fraudulent breach of an insurance contract because at the time the insurer was found to know that the plaintiff/insured's condition was within the policy coverage.

[123] Note 111 *supra.* See also *Wetherbee* v. *United Insurance Co. of America* note 104 *supra*, where the insurer cancelled disability cover two years after the insured's total and permanent disablement on the basis the insured was not permanently house confined. The insurer had assured the insured, at the time of issuing the policy, that the policy could not be terminated. The insured succeeded in a six-figure extra-contract recovery (punitive damages) for the insurer's fraudulent conduct.

[124] 70 S.C. 108, 49 S.E. 232, 3 Ann. Cas. 407 (1904).

[125] *Givens* v. *North Augusta Electric & Improvement Co.* 91 S.C. 417, 74 S.E. 1067 (1912).

[126] *Reaves* v. *Western Union Telegraph Co.* 110 S.C. 233, 96 S.E. 295 (1918).

[127] *Williams* v. *Metropolitan Life Insurance Co.* 176 S.E. 340 (1934).

[128] *Dyson* v. *Commonwealth Life Insurance Co.* 180 S.E. 475 (1935).

This contract remedy in the United States is heading towards tort law and the measure of damages in tort. Moreover, a rule is being established allowing recovery in tort for breach of contract. In other words, the law is recognising a breach of duty (that is, a breach of the duty of good faith) by the insurer to constitute a tort and to allow the injured party to sue in contract or in tort where there is an element of public duty. Instances of this public duty supporting recovery in tort have been held to include contractual relations between attorney and client, physician and patient, and other such situations.[129] However, of recent development has been the application of this principle to insurance, despite earlier reservation,[130] because it too involves a contract affected by public duty and public policy.

2. *Intentional Infliction of Nervous Shock*

Whether what is being inflicted is called nervous shock, emotional distress or mental distress, this area of tort liability laid down in *Wilkinson* v. *Downton*[131] presents a widely defined remedy available to insurance claimants seeking damages in excess of policy limits. Extreme conduct of the insurer, with intent, or reckless disregard to the probability of causing physical harm through emotional distress has already provided the basis of litigation in the United States.[132] The law in fact recognises a legal right to personal safety,[133] which can be invaded either intentionally, recklessly or negligently. In other words, there need not be an intention on the part of the defendant to inflict nervous shock so long as the conduct of the defendant (the defendant's outrageous conduct, as the Americans call it) was the actual and proximate cause of the plaintiff's emotional distress.[134]

In *Fletcher* v. *Western National Life Insurance Co.*[135] the facts showed that the insurer had embarked upon a concerted course of conduct to

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[129] *Leonard* v. *Fireman's Insurance Co.* 100 Ga. App. 434, 435; 111 S.E. 2d 773, 775 (1959).

[130] *Merrin Jewelry Co.* v. *St Paul Fire and Marine Insurance Co.* 301 F. Supp. 479, 481 (1969).

[131] [1897] 2 Q.B. 57.

[132] *Fletcher* v. *Western National Life Insurance Co.* 10 Cal. App. 3d 376, 89 Cal. Rptr 78 (1970); approved and applied in *Eckenrode* v. *Life of America Insurance Co.* 470 F. 2d 1 (1972).

[133] *Wilkinson* v. *Downton* note 131 *supra*, 58 *per* Wright J.; *Janvier* v. *Sweeney* [1919] 2 K.B. 316; *Hambrook* v. *Stokes Bros* [1925] 1 K.B. 141; *Owens* v. *Liverpool Corporation* [1939] 1 K.B. 394; *Bourhill* v. *Young* [1943] A.C. 92.

[134] *Fletcher* v. *Western National Life Insurance Co.*, note 132 *supra*, 394, 88; *Eckenrode* v. *Life of America Insurance*, note 132 *supra*, 4. See also W. Prosser, *Law of Torts* (4th ed. 1971) 56; *Restatement of the Law of Torts* (2nd ed. 1965), i, s. 46. For legal literature see A. Keenan, "The Insurer and the Tort of Intentional Infliction of Mental Distress" (1972) 39 *Ins. Counsel J.* 335; *State Rubbish Collectors Association* v. *Siliznoff* 240 P. 2d 282 (1952); *Crisci* v. *Security Insurance Co.* 426 P. 2d 173, 58 Cal. Rptr 13 (1967), 2d 173 (1970). J. Holinka, "Damages for Mental Suffering Caused by Insurers: Recent Developments of the Law of Tort and Contrat" (1973) 48 *Notre Dame Law.* 1303.

[135] Note 132 *supra.*

induce the plaintiff to surrender his policy or to enter into a disadvantageous "settlement" of a non-existent dispute. An intention to cause emotional distress was inferred from the conduct of the insurer in attempting to misuse its position of power. That is, the insurer was seeking to promote its own economic interests over those of the plaintiff. The insurer was also held to be aware of the susceptibility of the plaintiff to emotional distress. That is, aware that he was a 41 year old unskilled worker with a family of eight children barely able to support them with his insurance cover, and that he never expected to be able to return to work.

However, the liability of the insurer was confirmed for yet another reason. The legal relationship under the contract of insurance was held, in itself, to place on the insurer a duty to protect the interests of the insured. It was said that

> [a]n insurer owes to its insured an implied-in-law duty of good faith and fair dealing that it will do nothing to deprive the insured of the benefits of the policy . . . Included within this duty in the case of a liability insurance policy is the duty to act reasonably and in good faith to settle claims against the insured by a third person . . . We think that, similarly, the implied-in-law duty of good faith and fair dealing imposes on a disability insurer a duty not to threaten to withhold or actually withhold payments, malicious and without probable cause, for the purpose of injuring its insured by depriving him of the benefits of the policy.[136]

In the second recent American decision on nervous shock, *Eckenrode* v. *Life of America Insurance Company*,[137] *Fletcher's* case was approved. In *Eckenrode* compensation was allowed for the coercive tactics of the insurance adjusters seeking to force a settlement on the plaintiff that was favourable to the insurer. The high pressure methods were employed on the plaintiff (a beneficiary under a life insurance policy) at a time when she was both emotionally and financially distressed. Thus, the conduct of the insurer occurred at a time of crisis and at a time when the plaintiff was peculiarly susceptible to emotional distress.[138] Interestingly, the requirements of good faith and fair dealing (the insurer's duty of good faith) were not highlighted beyond a statement to the effect that "insurance contracts are subject to the same implied conditions of good faith and fair dealing as are other contracts. We think it is clear

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[136] *Id.*, 401, 93.

[137] 470 F. 2d 1 (1972).

[138] See also *Amsden* v. *Grinnell Mutual Reinsurance Co.* 203 N.W. 2d 252 (1972); *Meyer* v. *Nottger* 241 N.W. 2d 911 (1976); *World Insurance Company* v. *Wright* 308 So. 2d 612 (1975). In an analogous situation, recovery was allowed for mental distress when an insurer was sued for trespass by its agent when the agent visited the home of the insured and verbally abused him knowing him to be ill: *Continental Casualty Co.* v. *Garrett* 173 Miss. 676, 161 So. 753 (1953).

that an action of the type involved here sounds both in contract and in tort".[139]

Anglo-Australian law has recognised a claim for damages for intentional infliction of nervous shock in cases where conduct likely to produce the effect of "terror or shock" has been inflicted. Case law shows recovery having been allowed under this head for the effect of a practical joker falsely telling a woman that her husband had been severely injured in an accident[140] or for the effect of threats made by private detectives.[141] There must be intention on the part of the defendant to alarm the plaintiff and the act must be either of a kind reasonably capable of so terrifying a normal person or was known, or ought to have been known, to the defendant to be likely to terrify.[142]

Can intention be imputed to an insurer? In the American cases where the insurer has sought to bluff the insured into settlement or compromise of a valid claim, it could be suggested that the insurer's conduct was designed to cause alarm (or to frighten for an ultimate purpose) in circumstances little different to those in the leading cases. The duty resting on any person (or insurer) is to refrain from doing an act which he (or it) must realise to be fraught with risk of causing physical injury to some particular person or class of persons whom he (or it) realises or ought to realise are likely to be exposed to the consequences of the act.[143] Accordingly, damages would have been allowed in the situation where severe shock was maintained by a mother at the recovery of her dead drowned son from a trench by Evatt J. in his distinguished dissent in *Chester* v. *Waverley Corporation*: "[a] man who strikes another ought to foresee that his victim may be suffering from some weakness".[144] Negligent infliction of injury or nervous shock will surely provide the insured with a remedy in trying times: "[t]he law's protection against negligent interference with an individual's personal security is today subject to few limitations".[145] The scope of recovery in this area is wide. Therefore, abusive settlement tactics by an insurer leading to infliction of emotional distress or nervous shock will ground an action in tort as it has in the United States. Its scope in Australia remains ready for trial.

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[139] Note 137 *supra*, 5.

[140] *Wilkinson* v. *Downton* note 131 *supra*.

[141] *Janvier* v. *Sweeney* note 132 *supra*.

[142] *Bunyan* v. *Jordan* (1936) 36 S.R. (N.S.W.) 350, 353 *per* Jordan C.J.

[143] "It is recognised that the outrageous character of a person's conduct may arise from an abuse by that person of a position which gives him power to affect the interests of another; and that in this sense the extreme 'bullying tactics' and other high pressure methods of insurance adjusters seeking to force compromises or settlements may constitute outrageous conduct": *Eckenrode* v. *Life of America Insurance Co.* 470 F. 2d 1, 4 (1972).

[144] (1939) 62 C.L.R. 1, 26 citing A. Goodhart, *Essays in Jurisprudence and the Common Law* (1931) 126, 127.

[145] J. Fleming, note 115 *supra*, 152.

3. *The Tort of Bad Faith*

This is the biggest growth centre of application of the insurer's duty of good faith. One recent article is entitled "Insurers Beware: 'Bad Faith is in Full Bloom' " and it commences, "[t]he California Supreme Court, in *Gruenberg* v. *Aetna Insurance Company*[146] has declared open season on the insurance industry by confirming that the theory of bad faith is the primary weapon in a policyholder's arsenal against insurance companies".[147]

The duty of good faith and fair dealing that must permeate every contractual relation is strained by the imbalance between the might of the insurer and the insured. Inequities and bad faith have been revealed in insurance judgments from the beginning and courts in all jurisdictions (English, American and Australian) have, although only in more recent years, begun to give greater protection to insured parties against insurance practices. However, the duty of good faith expected of insurers is now being expressed clearly:

> The law in this state is that in every liability insurance policy there is an implied covenant of good faith and fair dealing which includes the duty to accept settlement offers under certain conditions. The insurer is required to concern itself with the interests and welfare of the insured as well as its own interests and welfare, and in so doing must carefully and realistically assess the case against the insured as to the issue of liability and as to the potential magnitude of possible damage awards, to determine the financial risk to each party resulting from failure to settle or attempt to settle.[148]

The High Court of Australia has recently referred to this principle on two occasions.[149] The first obiter came in the context of construing policy conditions requiring the insured not to make any admission *etc.* without the consent of the insurer on the one hand and giving the right to the insurer to take over conduct of proceedings on the other. The dilemma facing the insured was recognised because if the insured reached settlement without consent of the insurer, the insurer could rely on breach of the former condition in excusing itself from liability to indemnify the insured under the policy. Stephen J. referred to Aus-

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[146] 9 Cal. 3d 566, 510 P. 2d 1032, 108 Cal. Rptr 480 (1973).

[147] J. Parks and R. Heil, (1973) 9 *Forum* 63. This is now a well documented area of insurance law. See *e.g.* J. Parks and R. Heil, "The Tort of Bad Faith—the Impact of *Gruenberg* v. *Aetna Insurance Company*" (1974) 24 *Ins. Counsel Q.* 3. See also Note, "First Party Torts—Extra-Contractual Liability of Insurers Who Violate the Duty of Good Faith and Fair Dealing" (1976) 25 *Drake L. Rev.* 900, 909-910.

[148] *Carner* v. *American Mutual Liability Insurance Co.* 31 Cal. App. 3d 843, 847, 107 Cal. Rptr 604, 607; see also *Fireman's Fund Insurance Co.* v. *Security Insurance Co.* 72 N.J. 63, 367 A. 2d 864 (1976); *Isadore Rosen & Sons Inc.* v. *Security Mutual Insurance Co.* 31 N.Y. 2d 343, 291 N.E. 2d 380 (1972).

[149] *Distiller's Company Bio-Chemicals (Aust.) Pty Ltd* v. *Ajax Insurance Co. Ltd* (1974) 130 C.L.R. 1; *Deaves* v. *C.M.L. Fire and General Insurance Co. Ltd* (1979) 53 A.L.J.R. 382.

tralian,[150] British[151] and American[152] authorities for the proposition that an insurer's failure to settle may create liability in fraud or for bad faith. He referred to one of the more recent cases[153] in which the insurer's duty of good faith and fair dealing was referred to as having been closely analysed in the judgments and concluded:

> This duty of good faith and fair dealing must, I think, not only control the actions of an insurer who has taken over its insured's defence but will apply equally to the insurer's exercise of its power of granting or withholding consent to the making of admissions etc. even if it elects not to take over the defence.[154]

Such words are relatively new in Anglo-Australian insurance law. Compliance clearly requires of the insurer similar matters required of the insured, namely, the exercise of good faith. This requirement can be compared with, for example, the duty owed by a mortgagee to a mortgagor in the exercise of the power of sale.[155]

None of the other judges adverted to this principle in the *Distillers Company* case, and its obiter nature was confirmed in the second recent insurance case considered by the High Court.[156] Murphy J. was the only member of the Court to grapple with his new insurance principle of good faith. The majority of the Court indicated that technical defences would not be available for the benefit of one of the insurers concerned. The *Deaves* case concerned what may be called "consumer" insurance, namely the problems faced by a "layman" in seeking to claim under a small policy. The layman was a Queensland country service station owner, and the problem concerned the mix-up that followed his attempt to cancel his first fire policy (Policy A) and replace it with a second policy for a higher amount with another insurer (Policy B). The conditions of Policy B required that notice of any other insurance over the property be given. This is a normal condition which has been often litigated.[157] The reason the insured answered the question incorrectly was because he believed that he had effectively cancelled Policy A even though this step had not been formally completed because Insurer A was still awaiting his mortgagee's consent to the cancellation of Policy A (which of course also covered the mortgagee's interest). When the service station was destroyed by fire, the insured lodged claims with

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[150] *Club Motor Insurance Agency Pty Ltd* v. *Swann* [1954] V.L.R. 754.

[151] *General Omnibus Co. Ltd* v. *London General Insurance Co. Ltd* [1936] I.R. 596.

[152] *Best Building Co.* v. *Employer's Liability Assurance Corporation* 247 N.Y. 451; Annot. 40 A.L.R. 2d 168.

[153] *Gordon* v. *Nationwide Mutual Insurance Co.* 30 N.Y. 2d 427 (1972).

[154] *Distiller's Company* case, note 149 *supra*, 31 *per* Stephen J.

[155] *Forsyth* v. *Blundell* (1973) 129 C.L.R. 477.

[156] *Deaves* v. *C.M.L. Fire and General Insurance Co. Ltd* (1979) 53 A.L.J.R. 382.

[157] *Steadfast Insurance Co. Ltd* v. *F. & B. Trading Co. Ltd* (1971) 125 C.L.R. 578.

each insurer, and three defences were raised by Insurer B: first, that "N/A" inserted in the proposal by the (second insurer's) agent in answer to the other insurance question constituted breach of warranty; secondly, that there was non-disclosure of two material circumstances, namely, that the property was the subject of another insurance policy and that the property was mortgaged; and thirdly, that the other insurance clause was breached.

In the final outcome, it was held that the claim on Policy B failed because of the continued existence of Policy A which had not been effectively cancelled. In the context of the present article, it is the discussion on each of Insurer B's arguments that indicate the attitude of the High Court to insurance technicalities, especially in the context of a small "consumer" claim.

The first and third contentions of Insurer B carry some weight, as the principle (just or unjust) is well established that failure to answer can be deemed non-disclosure at the insurer's pleasure.[158] Clearly, to state that there was no other insurance in force and that the question on this point was not applicable was an incorrect answer if the insured knew of the hold-up in the cancellation of Policy A. However, in this case he did not know of the cancellation delay. The fairness or otherwise of this conclusion is debatable, but it was the second contention (a reasonably normal defence) which was rejected by the court four to one (Mason J. dissenting). The facts indicated that far from there being any non-disclosure on the part of the insured, he and Insurer B's representative went out of their way to thrust upon Insurer B the relevant facts. All the majority judges were prepared to impute the agent's knowledge of the existence of Policy A to the insurer, and earlier authorities[159] were thereby not followed in favour of the insured. The existence of the mortgage as an example of non-disclosure was also decided in favour of the insured: in the words of Stephen J., if the proposal does not raise the importance of this as a question, and if the insured is not asked for any such details, "the existence of a mortgage does not appear of itself to be a fact calling for unsolicited disclosure[160] by an applicant for fire insurance".[161] However, it was the words of Murphy J. which clearly placed insurance law in a modern context by moving in the direction of the recognition of duties of good faith and fair dealing as requirements of both insured and insurer. These are brave new words for an Australian judge and deserve to be cited in full:[162]

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[158] *MacGillivray and Parkington on Insurance Law* (6th ed. 1975) para. 689.

[159] *E.g. Jumna Khan* v. *Bankers and Traders Insurance Co. Ltd* (1925) 37 C.L.R. 451, mentioned at text accompanying notes 28 and 46 *supra; Biggar* v. *Rock Life Assurance Co.* [1902] 1 K.B. 516.

[160] *Cf.* a criminal conviction: *Woolcott* v. *Sun Alliance and London Insurance Ltd* [1978] 1 All E.R. 1253, [1978] 1 W.L.R. 493. See also text accompanying notes 29 and 45 *supra.*

[161] Note 156 *supra,* 393.

[162] *Id.,* 402.

> Duties of disclosure arise from the doctrine of uberrima fides. The duty to act in the utmost good faith is not confined to the insured or proposed insured, it applies also to the insurer or proposed insurer (see *The Distillers Company Bio-Chemicals (Australia) Pty Limited* v. *Ajax Insurance Company Limited* (1974), 48 A.L.J.R. 136, per Stephen J. at pp. 146-148; *Halsbury's Laws of England*, (3rd ed.), Vol. 22, pp. 110, 185 and 193-4). If not disclosing a mortgage when no question is asked about it and there is no deliberate concealment enables an insurer to escape liability, then the protection for which many innocent consumers pay premiums is destroyed. If there is a breach of faith, then it is on the part of the insurance company in denying liability on such a point (see, R. A. Hasson, *The Doctrine of Uberrima Fides in Insurance Law—A Critical Evaluation*, 32 Mod.L.R. 615). *MacGillivray and Parkington on Insurance Law* (6th ed., 1975), p. 783 suggests there is no substance in the point . . .
>
> The respondent insurer appears to have taken every possible point to avoid paying this modest claim although there is no suggestion that the appellants have acted other than reasonably and honestly with it. The existing state of insurance law is so favourable to insurers that any insurance company can easily frame its proposal forms and policy in such a way that only an extremely wary proponent will be able to recover. This has been tolerable only because, in general, insurers have not taken advantage of their superior position. If they have drafted documents to the disadvantage of the proponent, they have in practice generally refrained from insisting on their strict legal rights where the proponent has acted reasonably and honestly.
>
> This case shows that the ordinary person cannot always rely upon this practice, even when dealing with a large reputable insurance company. If the course taken in this case becomes common, every householder and small business man will need to be guided at every step of even a modest insurance transaction by an expert insurance consultant or counsel.
>
> Elsewhere, insurance law has developed to give much more protection to the consumer (see Keeton, *Basic Test on Insurance Law*, 1973). In Australia, legislative intervention seems desirable to redress the balance. . . .

One further question must however, be considered: is there in any case a doctrine of good faith in contract law? For insurance is always described as involving a contract of good faith that *uberrima fides* is required by both sides to the contract. It must be considered whether this requirement is unique to insurance, or whether there is a wider concept of good faith in contract law. After all, the law enforces bargains struck between parties; it enforces bargains and preserves sanctity of contract. A contract usually refers to the written document which enshrines the agreement of the parties because correspondence or conversation leading up to the contract is generally not admissible in

evidence. However, does the law recognise a moral need in the parties to the contract to keep faith? Does it recognise the spirit of a contract? In other words, where there is a "layman" insured and an unseen corporate insurer, and where a policy has been sold on the basis of a particular coverage, is there any place in the common law for recognition of good faith on the part of the insurer, or what the Americans now call the reasonable expectations of the insured?[163] The Americans do recognise an implied-in-law duty in contract to act in good faith.[164] However, at common law the answer must at the moment be in the negative. As Lord Devlin put it:

> [T]he common law is very reluctant to allow a contract that looks good to be vitiated by a flaw in the making of it. It does not require full disclosure and caveat emptor is the general rule.[165]

In *Bell* v. *Lever Bros*,[166] Lever Bros contended that the contract in question was voidable because Bell had failed to disclose misconduct. In other words, the claim was based on the contention that contract law imposed a duty of disclosure, and that in default of disclosure the contract would be voidable. This contention was firmly rejected: "[t]he principle of caveat emptor applies outside contracts of sale".[167] The only exceptions were stated to consist of contracts of three classes only: fiduciary relationships, contracts for partnerships, and contracts of insurance. Nevertheless, the duty was expressed not to arise from the contract but separate to it. No doctrine of good faith can therefore apply in contract law. This is unfortunate and must clearly await legislative intervention.[168] Hence the problem confronted in this article: is there a duty of good faith (arising outside the contract of insurance) in Anglo-Australian law? American cases provide guidance. Indeed, there are instances of the application of an objective good faith (the standards of the reasonable man) in the interpretations of documents or in the implication of terms in a contract. However, there is no overriding positive duty of good faith imposed by the common law on the parties to a contract.[169]

By way of contrast, and to indicate how far ahead insurance law is moving, consider the leading American case of *Gruenberg*.[170] The facts provide the model instance of delaying tactics by the insurer and illustrate the scope available to the insurer to place hurdles in the path of any claimant. The insured brought an action against the insurers for

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[163] See text accompanying notes 187-202 *infra*.
[164] W. Jaeger, *Williston on Contracts* (3rd ed. 1961) §670, 159-160.
[165] P. Devlin, *The Enforcement of Morals* (1965) 44.
[166] [1932] A.C. 161.
[167] *Id.*, 227 *per* Lord Atkin.
[168] As in the consumer law area of contract: Trade Practices Act 1974 (Cth) and diverse state legislation.
[169] R. Powell, "Good Faith in Contracts" (1956) 9 *C.L.P.* 16, 25.
[170] *Gruenburg* v. *Aetna Insurance Co.* 9 Cal. 3d 566, 510 P. 2d 1032, 108 Cal. Rptr 480 (1973).

infliction of nervous shock and sought damages resulting from alleged bad faith and outrageous conduct in denying payment under the relevant policies. The insured alleged severe economic damage, severe emotional distress, loss of earnings and sought compensatory and punitive damages. The Supreme Court of California held that an action for bad faith did not require outrageous conduct:

> [I]n every insurance contract there is an implied covenant of good faith and fair dealing . . . [W]hen the insurer unreasonably and in bad faith withholds payment of the claim of the insured, it is subject to liability in tort.[171]

Failure of the insurer to meet its implied duty of good faith and fair dealing has thus been recognised as a tort in itself, even though it may also constitute breach of contract. In other words, the implied-in-law duty of good faith (as the Americans call it) which permeates all contracts has been treated as a tort in itself in addition to being an ingredient of every contract.

Therefore, to establish the tort of bad faith two elements must be shown. First, that there is the absence of a reasonable basis on which to deny benefits. It has been submitted in the United States that the court will use the objective reasonable man test to determine this,[172] instead of the subjective test whether the insurer *thought* that it had a reasonable basis. To establish an unreasonable basis for denial of benefits considerations as to whether there had been a proper investigation and evaluation of a claim would be relevant. Secondly, to establish bad faith the insurer's denial of benefits under the policy must be with knowledge or in reckless disregard of the fact that it had no reasonable basis so to refuse. Establishing that there was no such reasonable basis is another problem. Are there standardised tests that can be resorted to in order to establish that the actions of the insurer were in good faith, or is the argument that the insurer acted reasonably, and if so, "has any jury ever heard of a reasonable insurance company?"[173]

What defences would be available to an insurer? Common practice in the industry has been rejected by the American Courts on the basis that under no circumstances will unreasonable conduct by the insurer be condoned.[174] A second defence attempted, that the insurer genuinely believed the policy would not provide cover, has also been rejected on the application of the *contra proferentem* rule, namely, an ambiguity will be construed against an insurer.[175]

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[171] *Id.*, 575, 1038, 486.

[172] *Crisci* v. *Security Insurance Co.* 426 P. 2d 173, 58 Cal. Rptr 13 (1967).

[173] J. Parks and R. Heil, "Insurers Beware: 'Bad Faith is in Full Bloom' " (1973) 9 *Forum* 63, 68.

[174] *Silberg* v. *Californian Life Insurance Co.* 11 Cal. 3d 452, 521 P. 2d 1103, 113 Cal. Rptr 711 (1974).

[175] *Id.*, 464, 1111, 719.

4. *Punitive Damages in Tort*

Punitive or exemplary damages seek to punish and deter and would appear to provide a natural remedy to be used against an insurer whose conduct can be described as dilatory.[176] However, as noted above, the House of Lords in *Rookes* v. *Barnard* did renounce exemplary damages on the basis of their incompatibility with the compensatory nature of tort remedies. The House of Lords stated that there were three situations where exemplary damages could be awarded: in cases of oppressive, arbitrary or unconstitutional acts of government servants; in cases where the defendant's conduct had been calculated by him to make a profit for himself which might well exceed compensation payable to the plaintiff; and in cases expressly authorised by statute.[177] The third exception could be applied in the insurance context by parliamentary action, as could the first (in the context of government insurance corporations) and possibly even the second. In any case, the High Court of Australia has expressly rejected the limitation enunciated in *Rookes* v. *Barnard*.[178] Therefore, there is scope for exemplary damages in Australian tort law in litigation against insurers.

Would there be scope in Anglo-Australian insurance law for the award of exemplary damages against an insurer? Although Lord Devlin restricted his first exception to action by servants of the government, and although he specifically said he was not prepared to extend the category to oppressive action by private corporations or individuals, his words are surely ready-made for the insurance bad faith examples given: "[w]here one man is more powerful than another, it is inevitable that he will try to use his power to gain his ends; and if his power is much greater than the other's, he might, perhaps, be said to be using it oppressively".[179] A distinction was purportedly made with government servants who were said to be servants of the people and whose "use of . . . power must always be subordinate to their duty of service".[180] Is not a duty of service the hallmark of insurance?

American courts see little in the way of limitation in this area. Punitive damages are well established in tort cases involving what has been described as "outrageous high handedness"[181] by insurers dealing with claims unethically.[182] American authority provides for an award of punitive damages depending on malice, moral turpitude, wantonness or

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[176] Discussed above at text accompanying notes 75-103 *supra* relating to punitive damages in contract. For punitive damages in tort, see *e.g.* G. Du Bois and E. Bronson, "The Spectre of Punitive Damages in First Party Actions" (1973) 40 *Ins. Counsel J.* 290.

[177] [1964] A.C. 1129, 1226, 1227.

[178] *Australian Consolidated Press* v. *Uren* [1969] 1 A.C. 590.

[179] *Rookes* v. *Barnard* note 177 *supra*, 1226.

[180] *Ibid.*

[181] *Campbell* v. *Government Employees Insurance Co.* 306 So. 2d 525, 531 (1974).

[182] *Fletcher* v. *Western National Life Insurance Co.* 10 Cal. App. 3d 376, 89

outrageousness and such an award is made as a deterrent.[183] For example, in *Campbell's* case[184] a public liability insurer which misrepresented the severity of a claim against the insured and which therefore failed to settle a claim against the insured within policy limits was "guilty" of bad faith. The insured was entitled to recover punitive damages: "[t]here has been a recent spate of cases . . . that vividly underscore the point that insurance companies are vulnerable to punitive damages suits by their policyholders when carriers attempt to deal with their insureds unethically".[185] In another recent American case,[186] the insurer's conduct, involving at the most perfunctory consideration of advice to settle as well as the deliberate choice not to make an honest and good faith evaluation of the insured's claim, was held to constitute evidence of bad faith for which punitive damages could be awarded. Such conduct, in other words, was held to amount to a repudiation of the obligation owed by an insurer to the insured.

IV THE REASONABLE EXPECTATIONS DOCTRINE

Insurance law is governed by traditional contract principles which assume an equal meeting of minds. Agreement, consideration and the forces of the market are assumed to guarantee the sanctity of the bargain struck. Whether effecting insurance takes place under such conditions should not be seriously maintained. Being a contract of adhesion, in a form largely unchanged over decades (if not centuries), the insured is so often in a position of taking what is offered or not insuring. As Keeton picturesquely states:

> The typical purchaser of insurance takes a packaged product. Like the purchaser of an automobile, he knows the general purpose of the product and the needs he wants it to serve . . . But he is content to leave to specialists all concern about the detailed structure of his purchase.[187]

Policy conditions, terms, warranties and exclusions (the distinction is not always so clear) are the result of many years of evolution and experience on the part of the insurer.

American courts are recognising the difficulties facing the insured in the usual insurance situation and are overriding in some cases the literal effects of insurance documentation if the reasonable expectations of

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Cal. Rptr 78 (1970); *Wetherbee* v. *United Insurance Co. of America* 265 Cal. App. 2d 921, 71 Cal. Rptr 764 (1968).

[183] *Dr P. Phillips & Sons* v. *Kilgore* 12 So. 2d 465 (1943).

[184] Note 181 *supra.*

[185] *Id.*, 531.

[186] *Fireman's Fund Insurance Co.* v. *Security Insurance Co.* 367 A. 2d 864 (1976).

[187] R. Keeton, *Basic Text on Insurance Law* (1971) 68.

the insured are not fulfilled.[188] Anglo-Australian law recognises devices to be applied in the event of ambiguities—the *contra proferentem* rule, the *noscitur a sociis* rule and other such devices. However, the courts in recent times have not taken a firm stand on overriding literal readings of insurance documentation to uphold the "reasonable expectations" of the insured. This attitude, incidentally, is in marked contrast to the view of Park in 1786:

> A policy of insurance, being a contract of indemnity, and being only considered as a simple contract, must always be construed, as nearly as possible, according to the intention of the contracting parties; and not according to the strict and literal meaning of the words.[189]

Park noted that policies were taken out for the benefit of the insured, as well as for the advancement of trade, and that policies must therefore be construed to attain those ends.[190]

In the United States, the reasonable expectations doctrine has been defined as

> [t]he objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honoured even though painstaking study of the policy provisions would have negated those expectations.[191]

One of the first cases where the doctrine was enunciated was *Kievit* v. *Loyal Protection Life Insurance Company*.[192] In that case a policy provided protection against loss "resulting directly and independently of all other causes from accidental bodily injuries" and excluding disability "resulting from or contributed to by any disease or ailment". The insured was injured but the symptoms displayed were said to result from pre-existing but latent Parkinson's disease which developed simultaneously with the accident. It could have been argued that the policy expressly excluded recovery in these circumstances because the disability had at least been contributed to by "any disease or ailment". Clear statements were made by the court on the interpretation to be given to the policy in such circumstances:

> When members of the public purchase policies of insurance they are entitled to the broad measure of protection necessary to fulfill

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[188] Journal literature is voluminous. See *e.g.* F. Gardner, "Reasonable Expectations: Evolution Completed or Revolution Begun?" (1978) 669 *Ins. L.J.* 573. R. Keeton, "Reasonable Expectations in the Second Decade" (1976) 12 *Forum* 275.

[189] J. Park, *System of the Law of Marine Insurers* (8th ed. 1786) 46.

[190] However, it must not be overlooked that these words begin a chapter headed "Of the Construction of the Policy" containing details of construction of various technicalities. The chapter concludes by reference to usage of trade as well as the intention of the parties to give meaning to a policy: *id.*, 135.

[191] R. Keeton, note 187 *supra*, 351; R. Keeton, "Insurance Law Rights at Variance with Policy Provisions" (1970) 83 *Harv. L. Rev.* 961, 966.

[192] 34 N.J. 475, 170 A. 2d 22 (1961).

> their reasonable expectations . . . Where particular provisions, if read literally, would largely nullify the insurance, they will be severely restricted so as to enable fair fulfillment of the stated policy objective.[193]

It cannot be claimed that such a reading has been given in all recent American insurance cases involving ambiguity, but it does indicate a direction in which American insurance law is moving.[194] This trend could be traced to various possible causes. First, there would be the traditional *contra proferentem* rule, whereby ambiguities in a document are to be read against the person who drafted it; secondly, it could be based upon the nebulous ground of public policy; thirdly, it could be influenced by the unconscionability doctrine in American contract law.[195] Whatever the actual cause, it is the effect that is of more importance, namely, the readiness of American courts to override the various risk-limiting devices (for example exclusions, limitations, or warranties) traditionally at the call of insurers.

Consider some of the many Anglo-Australian cases where unexpected results have occurred because of the courts' insistence on technicalities. In *London and Lancashire Fire Insurance* v. *Bolands*,[196] the policy in issue was to provide indemnity against burglary, housebreaking or theft of cash provided that it did not happen "in consequence of . . . riot, strikes, civil commotions . . .". The insured's premises were burgled by four armed men. Instead of allowing recovery according to the "obvious" meaning of the policy, it was held that the theft itself constituted a "riot" at law[197] and recovery was thereby denied. On this reading the policy could never have any effect. Most texts on insurance law contain a chapter headed "Construction of the Policy"[198] which include many other examples of this same method of interpretation. It is submitted the problem is that the fate of a genuine claim of an insured may have to rely on legalistic interpretations of a policy that should clearly provide for indemnity or compensation on the occurrence of an event insured against. Insurance cases are marked by narrow and technical judgments of what should be read broadly in the light of the purpose of the policy.

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[193] *Id.*, 482-483, 26.

[194] See R. Keeton, note 187 *supra*, 354-356 for other recent examples. See also F. Gardner, note 188 *supra*.

[195] Uniform Commercial Code U.C.C. §2-302; for Australian developments see P. Clark, "Unequal Bargaining Power in the Law of Contract" (1975) 49 *A.L.J.* 229; Working Party on Consumer Protection Laws of the A.C.T., "Memorandum Relating to Harsh and Unconscionable Contracts Ordinance for the A.C.T." (1975).

[196] J. Peden, *Harsh and Unconscionable Contracts*, note 38 *supra*.

[197] The word "riot" has an express legal meaning. See definition in W. Hawkins, *Pleas of the Crown* (1973) i, 155.

[198] *E.g.* E. Ivamy, *General Principles of Insurance Law* (4th ed. 1979) ch. 35. P. Latimer, *Cases and Text on Insurance Law—Australia and New Zealand* (1977) ch. 3.

English courts are perhaps showing some signs of giving effect to a doctrine analogous to the American reasonable expectations doctrine. In at least one recent case,[199] Lord Denning M.R. has taken the view that "[w]e must so construe the exemption clause as to give effect to the main object and intent of the policy".[200] Shipowners chartered a ship on a time charter and took out insurance against loss of hire. The purpose of the insurance was to cover themselves against loss of hire owing to perils, including breakdown of machinery or stranding. The peril occurred and loss was suffered. The question in issue was the construction to be applied to a clause exempting liability in respect of "any claim consequent on the loss of time whether arising from a peril of the sea or otherwise" in a policy. A claim was rejected by the insurer; the rejection of the claim would surely lead to the conclusion that the insurance could never cover the insured perils. In applying his "new equity"[201] in a further attempt to keep the law up to date with social necessities and social opinion, Lord Denning M.R. put it thus:

> The court will, if necessary, "reject words, indeed whole provisions, if they are inconsistent with what one assumes to be the main purpose of the contract". It will, in any case, limit and modify the words to the extent necessary to enable effect to be given to the main object and intent of the contract.[202]

These are important words in giving effect to an Anglo-Australian doctrine of reasonable expectations. If the contention of the insurers had been upheld, the very purpose of the insurance would have been a policy providing for no cover. Due to the options open to an insurer under a policy, Anglo-Australian law must move in the direction of providing a legislative balance in the insurance contract under the banner of "the insurer's duty of good faith".

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[199] *Naviera de Canarias S.A.* v. *Nacional Hispanica Aseguradora S.A.* [1976] 3 All E.R. 167, [1976] 3 W.L.R. 45.

[200] *Id.*, 172, 51.

[201] Sir Alfred Denning, "The Need for a New Equity" (1952) 5 *C.L.P.* 1.

[202] Note 199 *supra*, 170, 49; citing *Glyn* v. *Margetson and Co.* [1893] A.C. 351, 357 and *Sze Hai Tong Bank Ltd* v. *Rambler Cycle Co. Ltd* [1959] A.C. 576, 587 (P.C.).