Aspects of Fraud in Marine Insurance

Fraud at Inception

Marine contracts of insurance are subject to the principle of utmost good faith.

That principle of utmost good faith has subsequently been confirmed in Section 17 of the Marine Insurance Act 1906. That section says:

“A contract for marine insurance is a contract based upon the utmost good faith, and if the utmost good faith be not observed by either party, the contract may be avoided by the other party”.

The statutory requirement of good faith extends into Section 18 which requires the assured to disclose to the insurer, before the contract is made, every material circumstance which is known to the insured.

The consequence of non-disclosure by the assured is that the insurer may avoid the contract.

A failure to disclose is not, of itself, necessarily fraudulent. Non-disclosure may be fraudulent or it may be innocent. The classic definition of fraud was defined in 1889 in the case of Derry v Peek. The Court concluded that fraud was proven when it could be shown as a false representation had been made by the assured knowingly or without believing in its truth or recklessly without caring whether the statement is true or false. Essentially it is the element of deliberate misrepresentation and deliberate concealment that define fraud.

Misrepresentation at the inception of the policy can occur deliberately or inadvertently. If it is deliberate it is fraudulent. If it is inadvertent, even if it is careless or negligent, then it is not fraudulent.

Fraud on the part of the assured at the inception of the policy may involve the fraudulent withholding of information. The insurer may rely upon fraudulent non-disclosure by the assured to avoid a policy if he can show three things:

1) The fact that was not disclosed was material to the risk.
2) The fact was within the knowledge of the insured; and
3) The fact was not communicated to the insurer.

Perhaps the classic example of fraudulent withholding of information is that of overvaluation of the property to be insured. Overvaluation is commonly associated with the deliberate destruction of the insured property, so that in fact there may be a double fraud. In non-marine policies, overvaluation of property is most commonly associated with arson and in marine policies over valuation is most commonly associated with scuttling. Indeed it is often the realisation of an overvaluation that prompts investigation into the cause of the loss.

The 2004 case of the Game Boy is a fine example of the type. The insured, having recently acquired the vessel, insured her for 1.8 million dollars and then moved her to a dockyard supposedly to carry out maintenance repairs. Whilst in the dockyard the vessel was severely damaged by an explosive device. Faced with a substantial claim the insurer was prompted to look more closely at the valuation given by the insured and the documents tendered in support of that valuation. The investigations eventually proved that the vessel was actually worth less than 10% of the value for which the insured had insured her, and that most of the documents provided to prove that value had been forged.

The Court agreed that the insurers were entitled to avoid the contract for fraudulent overvaluation by the assured. It was unnecessary in the circumstances for any conclusion to be reached as to how the loss had occurred although, given the Court’s findings as to the wide extent of fraudulent document creation and deliberate overvaluation, that result would probably have been a foregone conclusion.
Fraud at the inception of the policy entitles the insurer to avoid the contract *ab initio*. The Courts recognise that he should never have been required to take on the risk and all claims made are rendered void.

**The Fraudulent Claim**

Fraudulent claims occur in several forms.

The most extreme perhaps is the situation where the assured deliberately causes the loss with a view to making an illicit profit. In a marine context that will involve, in most cases, a deliberate scuttling or a deliberate fire or explosion. It may include the deliberate causing of damage to machinery with the intention of covering failure actually caused by ordinary wear and tear.

Not surprisingly, there is an underlying presumption in law that as a matter of construction of any policy, there can be no recovery where an assured has deliberately caused damage to his own property because as a matter of construction the insurers cannot have agreed to cover intended loss.

In fact of course most policies contain terms specifically dealing with fraudulent claims and excludes them.

That kind of contractual provision has had longstanding support both from case law and from statute.

In 1866 in the case of *Britton v Royal Insurance Company* the Courts said that;

> “It is common practice in fire policies conditions that they shall be void in the event of a fraudulent claim. Such a condition is only in accord with legal principle”.

And of course as everybody knows section 17 of the Marine Insurance Act says that;

> “A contract of marine insurance is a contract based upon the utmost good faith, and if the utmost good faith be not observed by either party, the contract may be avoided by the other party”.

So it is clear then, by policy terms, by case law and by statute a fraudulent claim allows the insurer to avoid the policy.

Or does it?

Exaggerated or excessively padded claims have long been the bane of the insurance industry. They have caused the Courts considerable concern, albeit for different reasons. Judges are reluctant to draw an inference of fraud notwithstanding a clear finding of over-valuation or exaggeration. This is an understandable attitude for the Courts to adopt in circumstances where the valuation of the subject matter of the claim is difficult to ascertain, and that can, for example, be the case where an insured cargo is destined for a speculative market.

In some cases however the fraudulent nature of the claim must be self evident. One example is frequently held up as a case in point. In 1994 a Mr Orakpo sued Barclays and Commercial Union Assurance plc for damage to his property and for loss of income. The property in question was a large house which had been divided up into 13 bedsits. It had been insured for loss or damage caused by fire, storm, flood or vandalism. The property suffered several mishaps. Frost damage to pipes caused flooding and ceilings fell down. Storm damage to the roof created several larges holes. The damage was severe enough to cause the last of the tenants to move out and when that happened, the vandals moved in. Eventually vandals set fire to the building and destroyed it. Mr Orakpo brought a claim for the total loss of the building and his claim included a claim for loss of rental income from the 13 bedsits. During the course of investigations into the losses, however, the insurers discovered that the building had already been in a substantially deteriorated condition, such that extensive repairs would have been required, before the various mishaps occurred which allowed a claim against the insurers. They also found that whilst a claim was made for the loss of income from 13 bedsits, the rundown...
condition of the house had driven out 10 of the tenants and only three bedsits were actually tenanted. The insurers asserted that the claim was fraudulent since it was put forward in an amount, and on a basis, which the insured could not possibly have believed was genuine.

The Court acknowledged that in property damage cases, a degree of exaggeration was to be expected. Lord Justice Staughton said that “if I examined a sample of insurance claims on household contents, I doubt if one would find many which stated the loss with absolute truth”.

The court, however, concluded that in this particular instance the gross exaggeration of Mr Orakpo’s claim went beyond anything that could be condoned or overlooked. Mr Orakpo’s claim failed.

His entire claim failed. Not just the part of the claim that was fraudulent, but his entire claim, the good parts as well as the bad.

The Court in fact, took a tentative step further. It said that fraud in the making of a claim should be treated with no less severity than fraud at the inception of the policy, so that the insurer could avoid the whole contract, recovering any monies it might already have paid out on valid claims. This was a majority verdict: Lord Staughton was not happy with it. In his view the whole of the current claim should be forfeit but there should be no retrospective effect on the policy.

Nevertheless, at this particular point in time a loud warning bell had been rung that would warn the insured property owner of the potentially dire consequences of his making a fraudulent exaggerated claim.

However, a cautionary note was sounded in a 1998 case, when Commercial Union again found themselves facing a claim which they considered to be fraudulently exaggerated. The Judge said that in that case that;

“If a claim is fraudulent inflated so that the claim is made in an amount which the plaintiff clearly knows he has not suffered that will amount to a fraudulent claim”.

So far so good, but the Judge went on to say that;

“In my view, very clear evidence of fraud will be required because one has to accept as a matter of commercial reality that people will often put forward a claim that is more than they believe that they will recover. That is because they expect to engage in some form of horse-trading or other negotiations”.

And, a particularly poor decision, from the insurer’s point of view, was that given in the case of Ewer v. National Employers Mutual General Assurance Association Limited where a claim was put forward for the cost of new goods where the goods actually destroyed in the fire had in fact been second-hand. The insurers argued that the claim was patently false and fraudulent. The Judge, however, rejected the argument of fraud and said that in his view “the plaintiff knew the claim would be discussed and probably drastically criticised by the assessors. He had been asked for invoices and he started the bargaining with them by putting down the cost price of his articles as if they were new. Though I admit that the resulting figure is preposterously extravagant, I do not think there was any fraud in putting it forward”.

That creates something of a dilemma for insurers. Without knowing what is going on in the insured’s mind, how will they know whether the insured intends the deliberate falsification of a claim which he might expect the insurers to accept, unless they happen to know of the falsification, or whether he is merely optimistically putting forward a figure which he confidently expects the insurers to turn down but which will stand as a basis for further negotiation. The rationale put forward by the Court was that if the claim was deliberately inflated by the insured for the purposes of negotiation and as a bargaining device with his insurers, then the claim ought not to be categorised as fraudulent. It has to be said that that attitude may set a dangerous precedent. The assumption that the insured is merely embarking upon a bargaining process fails to take into account the possibility that the insurer may
simply rely upon the information contained in the assured’s claim and make payment of the claim as presented and, a consequence, may pay a claim greatly in excess of the loss actually suffered. This sort of decision also raises difficult questions of motive. How does one demonstrate, bearing in mind that the onus of proof is put on the insurer, that the insured was putting forward the gross over valuation as a deliberate intent to defraud rather than as a basis for negotiation.

The guiding principle for the Courts, in fact, seems to be one simply of honesty.

In the case of Galloway v GRE, Mr Galloway was suing for losses which he suffered when his house was burgled. His claim was for about £18,000. During investigations by the insurers, it turned out that one of his claims was for the loss of a computer which he valued at about £2,000. In fact, Mr Galloway had never owned a computer and he had produced a forged receipt to support the claim. At trial is was accepted that his claim for £2,000 wasn’t genuine, but Mr Galloway pressed on with his claim for the remaining £16,000, all of which seemed to be genuine. Mr Galloway argued that although he had tried to deceive his insurers his claim was not fraudulent to a very substantial extent, and therefore he should not suffer the severe penalty of losing his entire claim.

Lord Woolf’s answer to this was to say that:

“If an instance of fraudulent non disclosure to the insurer proved not to be material then dire consequences would not follow for the claim as whole. The claim as a whole would fail only if the fraud was material.”

In terms of the Galloway claim Lord Woolf said that:

“If you have a claim where the part which is fraudulent amounts to about 10% of the whole, that is an amount which is substantial and therefore an amount which taints the whole claim”.

So Mr Galloway lost his entire claim, because it was considered that he had been guilty of a material fraud.

Lord Woolf’s mention of a “10%” figure might suggest that there is some sort of threshold test. That when the fraudulent part of a claim reaches a certain proportion or percentage, then it become substantial and material and likely to invalidate the entire claim. But in fact that appears not to be the case.

It has been observed by Lord Justice Millett that that notion of a threshold test “would lead to the absurd conclusion that the greater the genuine loss the larger the fraudulent claim which may be made at the same time without penalty”.

Lord Justice Millett said that the right approach was to consider the fraudulent claim as if it were the only claim and then to consider whether, taken in isolation, the making of that claim by the assured is sufficiently serious to justify stigmatising it as a breach of the insured’s duty of good faith so as to entitle the insurer to avoid the claim and the policy.

So, in terms of the Galloway claim, where Mr Galloway made a claim for the loss of a £2,000 computer which turned out not to exist, that, the Court decided, was a sufficiently serious breach of his duty of good faith, to amount to fraud. Never mind whether that particular claim formed part of a £20,000 claim or part of a £200,000 claim. The issue should simply be whether the fraud was substantial in it’s own right.

And it looks as though the test here is that a fraudulent claim is considered to be sufficiently substantial to justify the objection of the claim if the fraud is not so small as to be “de minimis”. On the face of it therefore any claim of any significant size, put forward by an insured which the insured knows to be wholly unwarranted, must be a claim which is fraudulent.
That still, of course, leaves the problem of the exaggerated claim in a position of some uncertainty. In that sense the Galloway case might seem to be fairly obvious. The computer did not exist. It could not be claimed for. But what if the computer had existed but was not really a model worth £2,000? The Ewer case would suggest that Mr Galloway could perhaps legitimately overvalue the computer if he had an expectation that the assessors would whittle his claim down in negotiation.

In the Mercandian Continent case, and in the Star Sea case, both heard in 2001, the Court expressed doubt that the presentation of a fraudulent claim would entitle the insurer to avoid the policy ab initio. In each of those cases, however, the Court remained much more comfortable with the idea that avoidance for fraud in the claim process would operate prospectively, so that the forfeiture suffered by the assured should only be in respect of matters arising from the moment the fraud was attempted. In effect, what this means is that the insurer will be able to avoid the claim but the insurer would not, upon discovering the fraudulent claim, be entitled to avoid the policy retrospectively, so that previously paid valid claims would still stand. On the face of it, this would seem to conflict with section 17 of the Marine Insurance Act which says that “if utmost good faith is not observed by either party, the contract may be avoided by the other party”. The lodging of a fraudulent claim is, at least on the face of it, a clear breach of the duty of good faith but in the case of Agapitos v. Agnew Lord Justice Mance suggested that the way in which the Court should view the situation is to treat the common-law rules governing the making of a fraudulent claim as falling outside the scope of section 17, so that no question of avoidance of a policy can then arise. That view was confirmed in the case of Axa General Insurance Limited v. Gottlieb.

We have moved some little distance away from the comparative severity of the Orakpo decision, but nevertheless the potential consequences of the presentation of a fraudulent claim as part of an essentially sound claim are still serious. The insured puts at risk his whole claim. He may find himself without insurance subsequently.

**Fraudulent Devices**

Here we are looking at a different aspect of fraud and one that has caused more problems, for insurers and for their lawyers, and created more recent litigation, than the conventional fraud situation.

This is the situation where the assured believes that he has suffered a genuine loss and is entitled to claim under his policy of insurance, but tries to embellish or improve his claim by a lie or by falsified evidence.

Currently the leading case on this subject is Agapitos against Agnew.

A passenger ferry was lost by fire on 19 February 1996. The vessel belong to Mr Agapitos and he had the vessel insured for hull and machinery port risks for a six-month period under a policy which contained a warranty by endorsement that an LSA certificate had to be in place before hot work was commenced. A fire broke out some weeks after and the vessel was lost.

The insured asserted that no hot works had been carried out prior to the endorsement of the policy but, during proceedings evidence was disclosed that suggested that the insured had in fact not told the truth. It appeared possible that hot works had in fact commenced earlier than the policy endorsement. The insurer then asked the Court to allow it to amend their defence to include a pleading of fraud in the presentation of the claim.

The Court decided, however, ultimately not to allow the insurers to plead fraud. The Court concluded that the assertion by the assured that hot works commenced only after the relevant date was made only during the course of the Court proceedings and the Judge decided that that fact removed the assertion by the assured from the scope of the fraudulent claims principle. As the Judge put it:

“The case simply becomes one where a litigant is alleged to have lied in support of his case. It a litigant did lie that is reprehensible and the fact that he thought it necessary to lie obviously causes one to suspect that his case… may not be a good one. But it is not the law that if his case is a
good one after all, the fact that he lied in support of it is itself a ground from judgment being given against him”.

In reaching this decision the Court acknowledged that, as the Judge put it, any lie which directly related to the claim and which was intended to significantly improve the insured’s prospects of obtaining a settlement, or a better settlement, was prospectively to be regarded as a subspecies of making a fraudulent claim.

Nevertheless the Court refused the insurers the remedy of avoidance for fraud which the insurers were seeking. In reaching that decision the Court concluded that it had to place limitations upon the application of the duty of good faith recognised under section 17 of the Marine Insurance Act. The Court acknowledged the principle that section 17 sets out. It acknowledged that if the utmost good faith was not observed by either party then in principle the contract could be avoided by the other party. But the Court identified what it considered to be an important distinction between a fraudulent claim, where the result would be that the entire claim, both the genuine elements and the fraudulent elements could be rejected, and the use of a fraudulent device to promote what otherwise would be a good claim. Additionally the Court decided that it had to impose a dividing line beyond which concealment or misstatement by the assured would not fall to be considered as potentially a fraudulent device.

The Court looked first at the Mercandian Continent case. Here the insured had concocted a document that was intended to raise a jurisdiction defence to a claim brought against the insured by a third party. The Court observed that the assured’s deceit was not clearly intended to defraud the insurers. The Court concluded that the fraud by the assured was not relevant to the insurers’ liability to pay. The fraud was designed to defeat a third party claim against the insured and the Court concluded therefore that in those circumstances there were no grounds upon which the insurers might be entitled to avoid the policy.

The Court went on to say that the words of section 17 of the Marine Insurance Act were required to be restricted in circumstances of post contract bad faith and that the section 17 sanction of avoidance should only be applied where the fraud would have an effect on the insurers ultimate liability and where the seriousness of the fraud was such that the underwriters could in any case terminate for breach of contract.

So, stopping there, one immediate distinction between a fraudulent claim which necessarily impacts upon the liability of the insurer, and a fraudulent device which may, or may not, affect the insurers liability, was highlighted. An element of fraud within a larger genuine claim may result in the loss of the entire claim. A fraudulent *device* within a larger claim will not have the same affect unless the fraud was a serious one and would have substantial impact upon the insurers’ ultimate liability to the insured.

In fairness, one can see the logic of that. If the embellishments created by the insured do not actually operate as a fraud upon the insurer, it might be thought very harsh to impose the serious penalties which attach to fraud. A fraudulent *device* produced to insurers therefore is not necessarily fraud in the context of the policy.

The Court then went on to look at the Star Sea case. In that particular case the insurers faced a claim for total loss of the vessel following a fire. The insurers had rejected the claim on the basis that the vessel was known by the insured to be unseaworthy before she set sail but during the course of the trial the insurers became aware that the assured possessed information that dampers (part of the fire suppression system) had not been in proper operating condition. That information, however, was contained in reports which were privileged from disclosure under the disclosure Rules of the High Court. The Court concluded that in circumstances where disclosure of that particular factual material was not required by the Rules of Court, it could not be said that the assured was acting fraudulently in concealing that information from the insurers. The Court found that the section 17 duty of good faith ended once proceedings were commenced and the High Court Rules of disclosure took over.

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The insurers’ defence of a fraudulent device in the Star Sea case therefore failed.

Returning now to the Agapitos case. The judges, having considered the previous authorities, decided that if it turned out that the assertions made by the insured during the course of the proceedings, as to when the hot works were carried out, proved not to be true, the insurers would not be allowed to avoid the claim on grounds of fraud. The Court summed it up in this fashion.

If the insurers’ statement that hot works did not commence until 12 February had been made to the insurers in the course of pre-litigation discussions and the negotiations about the policy claim then that statement, if it was a lie, would entitle the insurers to raise a defence of fraud. However in circumstances where the statement was made in a pleading in the course of litigation, or raised in witness evidence disclosed in litigation, then those circumstances removed it from the ambit of the fraudulent claims principle. In short, dishonesty during the course of proceedings would not amount to an attempt at fraud against the insurers.

This may not be an entirely satisfactory situation for insurers.

As matters stand where a claim is accompanied by a fraudulent device it seems that the insurers will have a defence only if they can show that the false statement or document a) directly related to the claim, b) was intended to improve the insured’s prospects of settlement or of winning any litigation against the insurers and c) would, if successful give a significant improvement of getting such a settlement or success in litigation.

Deceitful conduct or misleading statements made by the insured without these ingredients would not entitle the insurer to resist the claim, and deceitful conduct or misleading statements made by the insured during litigation with the insurers would not count as fraud at all.

Having said that, the relevance of the defence of fraudulent devices still stands. A claim, prospectively sound, which is enhanced by forged documents or untruthful statements delivered to the insurers before any proceedings are commenced, will be rendered unrecoverable against the insurer, if there is clear intent to defraud the insurer to a significant degree.

Fraud lets the insurer avoid the policy ab initio only when that fraud occurs right at the beginning of the policy. Where the insured makes a fraudulent claim the insurer can reject the claim of course, and the judges in the Star Sea and Orakpo cases considered that he could terminate the policy from that point on.

The problem for the insurer is to prove that fraud has taken place. The Court of Appeal in the Icarian Reefer case in 1995 said, in connection with fraud cases that:

“On this issue the burden of proof rests unequivocally on the insurers and that degree of standard of proof which the law requires makes the burden heavier than that which rests upon the shipowners. Although the same balance of probabilities test applies, the standard of proof required is commensurate with the gravity of the allegation made… the burden of proof is not discharged in our judgment if the evidence fails to exclude the substantial possibility that the loss was accidental”.

If insurers are going to plead a fraud defence, they have to be sure of getting it right. If fraud is pleaded and the pleading of fraud is maintained when it should not have been, the insurer may be exposed to indemnity costs and in some instances the insurers’ lawyers may be exposed to a wasted costs order.

Does the insurer have alternatives?

At the inception of the policy the insured has a positive duty under section 17 of the Marine Insurance Act to disclose to the insurers all material circumstances concerning the proposed insurance. The sanction available to the insurer where this duty of disclosure is breached by the insured when the insurance contract is made is avoidance of the entire insurance contract ab initio. So the insurer has
no liability in respect of any current claims or any future claims, and can recover from the insured any claims which he has already paid before giving notice of avoidance. The insurer does have to return the premium to the insured, but non disclosure looks like an attractive remedy for the insurer.

There are, however, two requirements which the insurer needs to meet if he wishes to run this particular defence. First he has to meet the objective test of demonstrating that the matter which was not disclosed to him was one which would influence the judgment of a prudent insurer in fixing the premium or deciding whether he would take the risk. Inevitably this involves arguments of expert opinion. Secondly the insurer has to meet the subjective test of establishing that the particular non disclosure had induced this particular underwriter to write the risk on the terms that he did.

The non disclosure defence operates primarily in the area of pre contract disclosure. The decisions in the Mercandian Continent and the Star Sea suggest that innocent non disclosure in the presentation of a claim won’t defeat that claim. That being the case, it seems that if insurers wish to reject a claim on grounds of the insured’s failure to observe the utmost good faith in disclosing matters which were relevant to the claim, as opposed to the making of the insurance contract, then they must demonstrate that the failure was intentional and fraudulent. So here we are drawn back again to fraud.

Non disclosure has its own problems, however.

The non disclosure at inception defence will usually be met by an argument by the insured that he has disclosed everything material regarding the specific questions asked of him in, for example, the proposal form. The more specific the questions put in the proposal form, the more limited may be the extent of the information to be provided by the insured. If an insured answers a detailed proposal form and discloses everything material regarding the specific questions put, the insurer may well be held to have waived the insurers’ duty to disclose any further information. So an insured’s defence of waiver may arise when an insurer complains of non disclosure.

An insured may also answer an insurers’ objection of non-disclosure with the response that the insurer has affirmed the contract. Where waiver negatives the duty of disclosure, affirmation occurs where there is a duty of disclosure, where there is then a breach by the assured but where the subsequent conduct of the insurer may cause him to lose his right to avoid the contract.

Case law indicates a threefold test on affirmation.

1) That the insurer has now obtained actual knowledge of the facts that were not disclosed to him when the contract was made;

2) that the insurer has had an opportunity to consider whether or not he wishes to exercise his right to avoid the contract; and

3) That he acts, by words or conduct, so as to tell the insured that the insurer has decided to maintain the contract notwithstanding the non-disclosure.

Now this might seem fairly clear in theory but the reality has been that the insurer has to exercise great caution in how he acts once he is put on notice of possible non-disclosure. Paying any part of the claim, accepting any future premium, exercising the contractual right to inspect documents or to conduct litigation, in the absence of a strict reservation of rights may all count as affirmation and cost the insurer the loss of his right to avoid the policy.

Affirmation is frequently raised in answer to an insurers’ argument of non-disclosure. Affirmation can also be an insured’s answer to a fraud defence but case law indicates that the courts will be fairly generous in giving to the insurer a substantial amount of latitude whilst the insurer investigates what turns out to be a fraudulent claim.

In the 1997 case of ICCI against McHugh the court was looking at what turned out to be a quite complex and well concealed fraud. The insured argued that the insurers’ failure to allege fraud at an
early date and their continuation of a relationship with the insured amounted to affirmation. The court rejected that argument. The judge said;

“The reality is that insurers were at all times very suspicious but did not have any sufficient factual basis to justify what they rightly regarded as the extreme step of alleging fraud and avoiding cover. In the circumstances I have seen no basis upon which insurers are to be treated as having affirmed the insurance by not alleging fraud or pursuing matters further. In my judgement there was no affirmation.”

So non disclosure is a useful remedy but it has its weak points. The insurer may have a stronger position if he can prove fraud.

Of course, there’s another remedy which might be available to insurers in circumstances where they are unhappy with the insured’s conduct. In the Agapitos case, the insurers wanted to amend their defence to plead an argument that the insured had fraudulently misrepresented the date on which hot works were carried out on board the vessel. The insurers failed to persuade the Court to allow them to amend and plead fraud, but, the circumstances of that case were such that if the insurers were able to prove that hot works had commenced on the vessel at a date which constituted a breach of the endorsement warranty, that no hot works would be commenced until the appropriate certificate was in place and all recommendations complied with, then the insured’s claim would fail in any event for breach of warranty. Similarly in the case of the Game Boy. The Court found clear evidence of fraud, but the Court also found that the circumstances in which the fraud was carried out involved breaches of warranty by the insured and concluded that on these grounds the insurer was entitled to refuse the claim in any event.

A warranty may refer to the future – a promise that a particular thing shall be done or not done or it may apply to the past or to the present, with the insured promising that a certain state of affairs does or does not exist.

Warranties must be exactly complied with and if they are not then the insurer is not obliged to pay any claims that arise after the breach of warranty. As the law stands at present – although this is under scrutiny – it may not matter that the breach of any warranty is unconnected with the loss. Breach of warranty may therefore be a more useful and effective defence to a claim than is non disclosure.

There are however, certain disadvantages involved with a defence of breach of warranty.

The insurers are discharged from all liability from the date when the breach of warranty occurs, so prior claims still stand.

The defences of waiver and affirmation apply to warranties in the same way that they apply to non disclosure. So the same weak points exist.

So where does that leave us? The insurers may have remedies other than a defence of fraud. Those other remedies, principally of non disclosure and of breach of warranty, may provide them with the means of avoiding a claim. Those remedies may require an easier burden of proof than does fraud. But there are arguments which can be raised against those other remedies and sometimes, despite the evidential difficulties, the insurers may be better off if they can put up a persuasive argument of fraud.