Insurance - Switzerland

Insurance fraud through omission – qualified duty to act required

Contributed by **BADERTSCHER Rechtsanwälte AG**

July 15 2014

In a recently published decision(1) the Federal Supreme Court quashed a criminal verdict of the Supreme Court of the Canton of Basel-Country and held that insurance fraud by omission requires a qualified duty of the perpetrator to act. According to the Federal Supreme Court, statutory or contractual duties of a recipient of insurance benefits (eg, information duties regarding changes in personal circumstances that might affect the amount of insurance benefits) do not create such qualified duty.

Facts

The appellant, a motor mechanic, had a traffic accident in Summer 1996, which resulted in reduced earning capacity. Consequently, he received insurance benefits from the state accident and invalidity insurers, as well as from a private life insurance company, until the insurers brought a criminal complaint against him for alleged insurance fraud.

From April 2005 the appellant participated in several car races. From June 30 2006 until July 28 2006, his garage was kept under surveillance by the police, who recorded him working.

The criminal prosecutor accused the appellant of fraud and systematic deception of doctors and insurers regarding the true status of his health, by giving false statements and concealing information about his improved health in order to obtain insurance benefits to which he was not entitled.

The Canton of Basel-Country Criminal Court convicted the appellant on several counts of fraud. This verdict was subsequently upheld by the Canton of Basel-Country Supreme Court.

The appellant appealed to the Federal Supreme Court, requesting full acquittal. He argued that the decision was based on an erroneous application and interpretation of Article 146 of the Criminal Code. In particular, he asserted that the insurers knew that he was working to the extent of his remaining ability to work, and that they had all the facts to assess his earning capacity. He denied any act of wilful deceit.

Considerations

The crime of fraud, according to Article 146 of the Criminal Code, is fulfilled by anyone who, with a view to securing an unlawful gain for himself or herself or another party, wilfully induces an erroneous belief in another party by false pretenses or concealment of the truth, or wilfully reinforces an erroneous belief and thus causes that party to act to the prejudice of its own or another's financial interests.

Fraud by omission is considered a crime only under particular circumstances and hence can be committed only by a perpetrator who is under a qualified, affirmative legal obligation to act towards and in order to protect the aggrieved person.

The Federal Supreme Court held that the appellant's actions with regard to the insurers were limited to the violation of statutory and contractual reporting obligations. Under these obligations, the appellant was obliged to inform the insurers of his improved state of health. Instead of doing so, he continued to collect the insurance benefits (which were originally rightly granted to him), despite his improved state of health. The court ruled that the appellant did not deceive the insurers in the sense of Article 146 by providing incorrect information or through other active conduct. The court held that continued collection of insurance benefits does not qualify as an act of (active and malicious) deception. By doing so, the appellant also did not implicitly express that his health issues subsisted. The case would be different only if the insurers had specifically enquired about his state of health and the appellant had remained silent (known as 'qualified silence'). In this case, no such enquiries were established.

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The court thus concluded that only fraud by omission could be considered, which requires a specific duty of care. It considered whether the information duty of the appellant represented a qualified affirmative legal obligation with the purpose of protecting the insurers' assets.

The duty of an insured to report any substantial change in circumstances to the insurer is statutorily (social security) or contractually (private insurers) regulated. In either case, the duty to report changes is based on the principle of good faith. Duties which arise from the principle of good faith are insufficient to constitute a qualified affirmative legal obligation to act. Therefore, the court held that the appellant's reporting obligation did not entail a duty to protect the insurers' assets. It was solely the insurers' responsibility to protect their assets. The insurers could have easily made enquiries which would have prompted the appellant to provide the requisite information about his health. If the appellant concealed his improved health status, such behaviour would no longer have qualified as omission, but as active deceit.

The court concluded that violation of the duty to inform can have diverse consequences. Besides a reduction in benefits or a civil claim to return unduly received benefits, the insured may face a fine (eg, based on statutory regulations of social insurance) insofar as he or she has violated the duty to inform. Because of such special law provisions, the mere violation of a duty to inform cannot be considered fraud by omission according to Article 146. In light of its elaborations, the court acquitted the appellant of all fraud charges.

Comment

The court upheld its previous jurisprudence with a narrow interpretation of the circumstances under which insurance fraud can be committed by omission pursuant to Article 146. An insured who collects insurance benefits does not commit fraud by wilfully not informing the insurers of changes regarding his or her state of health. The ruling makes it clear that insurers should enquire regularly into (potential) changes in insureds' circumstances. By continuing payment of insurance benefits without enquiry, an insurer cannot hold an insured criminally liable for fraud.

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Endnotes

(1) Decision 6B_750/2012, November 12 2013, BGE 140 IV 11.