INSURANCE - SWITZERLAND

Insurers' contractual obligations in case of fraudulent claims

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In a recent decision, the Federal Supreme Court considered whether insurers are bound to contracts if an insured party submits a fraudulent claim (Decision 4A_20/2018 of 29 May 2018).

Facts

The plaintiff was a self-employed naturopath who suffered a traffic accident on 8 March 2013. She was hospitalised from 8 to 15 March 2013 with:

- a concussion;
- pain in both hands and spinal cord nerves; and
- a slipped disc with narrowing of the spinal canal on both sides.

She was diagnosed with acute post-traumatic stress disorder and suffered panic attacks, flashbacks and depression. The defendant insurer paid a daily allowance from the eighth day after the accident based on her full incapacity to work.

From 27 May to 10 June 2013 the plaintiff stayed in a clinic for treatment and displayed no signs of abnormality in neuropsychological tests. Further, she received treatment in a specialised psychiatric-psychological private clinic from 8 to 15 August 2013 due to her trauma. Here she was diagnosed with an adaptation disorder mixed with anxiety and depressive reaction and a slipped disk. It was noted that the criteria for post-traumatic stress disorder were only partially met.

While the doctors continued to assess the plaintiff as fully incapable of work, she underwent an MRI scan on 29 October 2013 and a neurological examination on 25 November 2013 at the request of the insurer. Based on this, a consultant insurance physician concluded that the consequences of the accident probably no longer played a role in her capacity to work.

From January to March 2014 the insurer monitored the plaintiff on various occasions. Based on these video recordings, the insurer found no concrete evidence of impairment. In June 2014 the insurer sought an interdisciplinary medical opinion.

In its 23 January 2015 letter, the insurer declared that the insurance claim was based on fraudulent grounds under Article 40 of the Insurance Contract Act and therefore:

- withdrew from the individual daily allowance insurance contract with retroactive effect; and
- requested reimbursement of the paid daily allowances.

The insurer eventually filed a legal action against the insured party.

In its 14 November 2017 decision, the first-instance court approved the claim and awarded the

insurer Sfr92,575 (ie, to cover daily allowance payments, expert fees and observation costs).

Insurance Contract Act

Under Article 40 of the Insurance Contract Act, insurers are not bound by a contract if, for deception purposes, the insured party incorrectly notifies or conceals facts from the insurer which would exclude or reduce the insurer's obligation to provide indemnification. Insurers can therefore refuse payment and withdraw from such contracts.

Article 40 covers, among other things, insurance fraud by misrepresenting a major loss. In particular, this includes the aggravation of health disorders. Further, the insured party must have acted with fraudulent intent (ie, it must make false statements with knowledge and willingness in order to achieve a pecuniary advantage). Since the fraudulent justification of an insurance claim is detrimental to the insured party, the insurer must provide evidence which satifies the balance of probability standard.

Decision

In its decision, the Federal Supreme Court reiterated that insurance claims are fraudulent if the insured party presents false information which is significant to the insurance claim and acts in a way that can objectively mislead the insurer.

The interdisciplinary medical opinion of June 2014 had found that the plaintiff had acquired a 50% ability to perform light or medium physical activity three months after the accident and was fully capable of work six months after the accident. According to the court, her ability to work proved that she had acted with fraudulent intent.

Article 40 of the Insurance Contract Act is fulfilled if the insured party knowingly makes false statements regarding their physical capacity. This is true even if an insured party does not make the statements directly to the insurer, but rather to a medical doctor who confirms their inability to work.

If the insured party objectively provides incorrect or incomplete information – such as concealing health improvements – medical assessments will almost inevitably be false. Therefore, it is clear that the insured party has at least concealed facts which are likely to remove or reduce the insurer's obligations.

The intent to deceive is demonstrated if the insured party is aware of the insurer's misconception or takes advantage of its error by not disclosing the facts of the case or intentionally provides information too late.

According to the Federal Supreme Court, the lower-instance court had therefore correctly judged that the insurer could withdraw from the contract based on Article 40 and confirmed that the plaintiff must reimburse the paid daily allowance benefits from the respective point in time from which, according to the expert opinion, she was partially or fully able to work.

The Federal Supreme Court also ruled that Article 40 may serve as legal grounds for reimbursing expert fees and observation costs.

Comment

This decision confirms that in the event of fraudulent justification in an insurance claim, insurers are not bound by the contract. Withdrawal from a contract is sufficiently justified if the insured party knowingly acted in a way that could have misled the insurer.

If a contract expires due to the insurer's withdrawal, the insured party owes the negative contractual interest; in particular, the insured party must reimburse the insurer as if the contractual relationship between the parties had never existed.

In the present case, had the insurer not concluded the insurance contract, it would not have been

necessary to examine and observe the plaintiff, who was rightly suspected of providing fraudulent grounds for her insurance claim.

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