The Insurer's Duty to Contract – The Norwegian model

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1 Introduction and Overview

The topic for this article is the rules on duty to contract in the Norwegian Insurance Contract Act 1989/69 (ICA) § 3-10 and § 12-12.[1] Duty to contract may be absolute or partial. Absolute duty to contract means that the insurer has a duty to offer insurance to all or some groups of customers. Partial duty to contract means that the insurer may only reject an application for insurance if there is a just cause for the denial. The regulation in ICA is based on the principle of partial duty to contract.

The Norwegian regulation on duty to contract was enacted in 2009 by an amendment in the ICA after a long discussion in the market on the right to reject application for insurance because of inter alia failure to pay premium, payment remarks, high casualty frequency and different types of health problems. There are no similar rules in Denmark and Finland although the issue has been discussed in Denmark concerning inter alia natural disasters/water damage caused by extensive rain/flooding. On the contrary, the Swedish Consumer Insurance Contract Act contain rules on duty to contract. [2] It may therefore be of interest to give a presentation of the Norwegian model of these rules with a side view to the Swedish rules when convenient to outline similarities and differences. In particular, it may be of interest to see how the regulation is interpreted by the Norwegian Financial Institutions Complaint Board as the Swedish regulation today lacks a reference to such out of court dispute solution system. Further, it is of interest to see the Norwegian rules in the light of the recent evaluation of the Swedish regulation for personal insurance and the points for improvements identified in this review.[3]

In the following, chapter 2 will provide an overview of the regulation and the relevant legal sources for the presentation. Thereafter the rules are presented in chapter 3 and some reflections given in chapter 4.

2 Overview of the Legal Sources

The Norwegian ICA is divided into two parts. Part A regulates casualty insurance,[4] whereas Part B provides rules on personal insurance.[5] Part A and Part B contain identical rules on duty to contract in ICA § 3-10 and § 12-12:

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1 For a more detailed presentation of the Norwegian regulation, se Trine-Lise Wilhelmsen, Forsikringsselskapenes kontraheringsplikt –Nye regler eller keiserens nye klær, Tidsskrift for erstatningsrett, forsikringsrett og trygderett, 1/2018.

2 Insurance Contract Act (Försäkringsavtalslag) (2005:104) 3 ch. 1 § for consumer insurance and 11 kap. 1 § for personal insurance (Swedish ICA).

3 SOU 2016:37 (SOU).

4 ICA § 1-1.

5 ICA § 11-1.

> "The Insurer may not without just cause deny anyone insurance cover on ordinary terms which the Insurer otherwise offers to the general public.
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> Circumstances which constitute a special risk shall be deemed to be just cause for denial provided there is a reasonable connection between the special risk and the rejection of the application. Other special circumstances shall constitute just cause when they entail that the rejection cannot be deemed to be unreasonable in respect of the person in question.
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> Matters which it is prohibited by a provision laid down in or pursuant to statute to attach importance to in insurance risk assessments cannot constitute just cause. The same applies to information which the Insurer by a provision laid down in or pursuant to statute is barred from requiring from the person effecting the insurance or theAssured.
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> The insurance applicant shall without undue delay be notified in writing of the rejection and the grounds for it. This also applies to oral enquiries to the Insurer. The grounds shall indicate the various factors on which the rejection is based, including any individual risk assessments that may have been carried out. The grounds shall also indicate any company practice, industry norms, statutes or regulations that may enable the insurance applicant to apply for the insurance in question after a certain period of time or altered circumstances without being rejected on similar grounds. The notification of the rejection shall contain information about the rules for bringing disputes regarding the insurance contract before an appeals board, cf. section 20-1 and information about the time limit stated in the sixth paragraph.
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> An insurance applicant who wishes to plead an unlawful denial of insurance cover must notify the Insurer in writing of this or bring the case before an appeals board as stated in the fifth paragraph within six months after the insurance applicant received written notification of the rejection".

The rules were included in the ICA by an amendment in 2008 and enacted in 2009. The preparatory works consist of two main documents. The first is the public report, NOU 2000:23 Forsikringsselskapers innhenting, bruk og lagring av helseopplysninger (NOU), which is written by the Legal Committee that wrote the proposal for the regulation. The second is the Proposition to the Odelsting, Ot.Prp. nr. 41 (2007-2008) Om lov om endringer i lov 16. juni 1989 nr. 68 om forsikringsavtaler m.m. (Prp), which is written by the Ministry of Justice in preparation for the political treatment of the legislation. In general, a characteristic feature of these documents is that they are well written and provide valuable information on the existing rules in the area of legislation, similar regulation in other countries, and relevant policy considerations. The preparatory works therefore provide guidelines for the interpretation of the legislation and information about its purpose, and they define the legal policy behind the rules. There will therefore be extensive references to the preparatory works in this article.

There is limited court practice that may shed light over the regulation.[6] However, there are several decisions from the Financial Complaints Board concerning the rules.[7] A decision from the Financial Complaints Board is according to Agreement on the Financial Complaints Board between Forbrukerrådet, Næringslivets Hovedorganisasjon, Finans Norge, Finansieringsselskapenes Forening and Verdipapirfondenes Forening, sec. 3 no. 11, advisory. An insurance company who does not want to accept the decision must however, give notice about this within a certain time limit and normally cover the trial costs for the customer if he wants to bring the matter before the court.[8] The decision is not binding for other companies. Nevertheless, if an insurer denies insurance and the customer brings the case before the Financial Complaints Board, the Board will normally follow its own practice. This means that the decisions serve as guiding lines for the state of the law until a customer brings the case before the court and the court reaches another result. Case law demonstrates that practice from the Financial Complaints Board is a relevant legal source, but that the weight attributed to the decisions varies substantially. It is therefore difficult to say how much weight such decisions will have in a court case.[9] Even so, an analysis of the Board's practice shed light over the problems that arise in practice and how the Board interpret and apply the rules. Compared to the Swedish regulation it is also interesting to see how the Board handle such cases.

3 Duty to Contract According to ICA § 3-10 and § 12-12

3.1 The Framework in Subparagraph 1

According to §§ 3-10 and 12-12 subparagraph 1 the insurer may not without just cause deny anyone insurance cover on ordinary terms which the insurer otherwise offers to the general public. This part of the regulation is similar to the Swedish rules. The rules state that insurance can be denied with just cause, which means that the duty to contract is partial, and not absolute.[10]

The provisions regulate the relationship between the insurer and customers who address the insurer to effect insurance. It does not require the insurer to

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6 For casualty insurance see LB-2014-150000 Appeal Court, for personal insurance see TOSLO-2010-131138 City Court.

7 4 cases on casualty insurance and 35 cases on personal insurance under the new rules. Both the cases referred to in note 5 had been through the Board system, and the conclusion by the court followed the conclusion by the Board.

8 http://www.finansklagenemnda.no/assets/avt_sign.pdf See § 3-10/§ 12-12 subparagraph 4 on the right to bring denial in for an appeal board.

9 Hans Jacob Bull, *Forsikringsrett*, Oslo 2008 (Bull) pp. 53–54 with references.

10 Prp. p. 98. Absolute duty to contract may however have a legal basis in other regimes, for instance in the mandatory traffic accident insurance, FOR-1974-04-01-3 Forskrift om trafikktrygd m.v. § 3.

make a general offer of insurance to all potential customers.[11] This means that the insurer is under no duty to develop certain insurance products even if this would be beneficial for the society in general.

The limitation on the right to deny insurance without just cause applies to "anyone".[12] The concept of "anyone" has different content in casualty insurance than in personal insurance. ICA Part A on casualty insurance applies to both consumer insurance and professional insurance. ICA § 3-10 therefore applies to both consumers and professionals.[13] However, ICA is not mandatory for so-called "qualified" professional insurance, that is entities of a certain size, and there is thus no duty to contract for this category of insurance customers.[14] ICA Part B on the contrary only applies to personal insurance. There is no question of denial for professionals. The rules in ch. 12 applies for collective insurance to the extent they are suitable, cf. § 19-1, but here the duty to contract is limited through other provisions, see below.[15] The Financial Complaints Board for personal insurance has decided that a duty to contract similar to the regulation in § 12-12 cannot be established on no statutory grounds for insurance offered to commercial activity.[16] This conforms to the Swedish ICA 11 ch. 1 § subparagraph 2 for personal insurance.

The duty to contract applies to "ordinary terms". This expression refers primarily to the insurance conditions that the insurer normally offers for the relevant product.[17] The applicant must therefore accept the exclusions from liability, safety regulations and deductibles that the insurer normally includes in his contract.[18] Nevertheless, the word "term" includes according to the preparatory works also more general criteria, requests and guiding lines used by the insurer when contracting for insurance.[19]

Interpreted widely the word "term" includes calculation of premium, but according to the preparatory works the rule does not apply to the insurer's ordinary premium calculations.[20] Calculation of premium is regulated by the Insurance Company Act[21] § 3-3 paragraph 5 and § 7-5 subparagraph 4 stating that the insurer when calculating the premium shall ensure that the premium is in reasonable proportion to the risk taken over and the services provided, and is sufficient to secure the economic duties according to the contracts. The

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11 Prp. p. 98.

12 Swedish ICA 3 ch. 1 § is addressed to any consumer.

13 Prp. p. 36-37.

14 Norwegian ICA § 1-3 paragraph 4 cf. paragraph2, Bull p. 127.

15 Prp. p. 37.

16 FinKN 2013-297, cf. also FinKN 2015-423.

17 Prp. p. 98, Bull p. 127.

18 Bull p. 127.

19 Prp. p. 98, see also Bull s. 127.

20 Prp. p. 35 and p. 98, Bull p. 127.

21 LOV-2005-06-10-44 om forsikringsvirksomhet (forsikringsvirksomhetsloven).

premium must therefore be proportional to the risk for harm and the extent of harm if the risk materializes. This is outside the scope of the regulation in §§ 3-10 and 12-12.[22]

Since the premium tariffs are outside the scope of the requirement of just cause, it is possible for the companies to avoid the duty to contract through the calculation of premium. If the risk for harm or probable extent of the harm is especially extensive, the insurer may calculate a premium that is far above what ordinary customers have to pay and the actual applicant is willing to pay. This approach will be contrary to the rules in the Insurance Company Act on proportionality between premium and risk, but the customer cannot invoke these rules against the insurer. According to the preparatory works, however, the rules on duty to contract shall also apply if the insurer tries to circumvent the rules.[23]

The duty to contract applies to insurance cover which the insurer otherwise offers to the public. The provision does not require the insurer to market an insurance product he normally does not offer. The insurer may therefore limit the market he wishes to operate in by choosing to offer personal insurance only or limit his products to professional insurance.[24] The insurer may also limit his product specter if he finds that the risk for certain products is too extensive. In earlier Board practice, there are examples that the insurer draws back insurance products because they mean that the risk for the product has changed significantly.[25] In such cases, they cannot be required to enter into new contracts. Lastly, the insurer may limit their group of customers for instance to insure only members of certain organizations. This means that collective insurance is outside the scope of the regulation.[26] The Financial Complaints Board for Personal Insurance has however noted that if the refusal of insurance concerns a member of the group the collective insurance is meant to cover, it may be reasonable to apply the conditions in ICA § 12-12.[27]

3.2 Reservations in Personal Insurance

Personal insurance is often offered with "reservations" for certain illnesses or weaknesses, which means that these illnesses are not covered by the insurance. Such reservations are used in insurance against disability and critical illness.

ICA § 12-12 is silent on reservations, and if the insurer as a general policy offers disability insurance with reservations for certain illnesses it can be

22 See FinKN 2011-376.

23 Prp. p. 35 and p. 56, Bull p. 127. See also FinKN 2011-376. For examples on circumvention for mandatory insurance, see FSN 5707 and 5551.

24 Prp. p. 99.

25 FSN 6710, FSN 2011-12.

26 Prp. p. 99, see also LB-2014-15000.

27 See FinKN 2017-13 and FinKN 2015-423 with reference to FinKN 2013-297 cf. FinKN 2014-361. See also Bull p. 127.

argued that this is outside the scope of the duty to contract. However, it follows clearly from the preparatory works[28] that insurance with reservations constitutes partial denial of insurance and that the regulation is meant to include this situation. The Financial Complaints Board has also applied the requirement of just cause for reservations in a series of cases.[29]

The Nordic life insurance market does not apply reservations for insurance against the risk of death. The reason is that it may be difficult to prove causation between the illness that the policy reserves against and the death and that such reservations would be contrary to the interests of the bereaved and mortgagees.[30] This attitude was accepted in FinKN 2014-340, where the Board accepted that life-insurance could not be effected with a reservation against alcoholism. As an insurance not offered in the market is not an insurance offered to the public, the refusal is outside the scope of § 12-12 subparagraph 1.[31]

On the contrary, the Board has not accepted a limitation in the number of reservations that is given a just cause if the insurance is offered with reservations.[32] It may be argued that this is a question of the insurer's policy that is outside the scope of the regulation.

Reservations concern illness etc. that the customer has at the point in time when he applies for insurance. The question is therefore if the insurer has a duty to re-evaluate the reservation after a certain period. This issue is not touched upon in the preparatory works, but the Board has presumed that the insurer has a duty to look into the matter at a later stage depending on medical research.[33]

3.3 Just Cause for Denial

3.3.1 Introduction

ICA §§ 3-10 and 12-12 subparagraph 2 defines further the content of "just cause":

> "Circumstances which constitute a special risk shall be deemed to be just cause for denial provided there is a reasonable connection between the special risk and the rejection of the application. Other special circumstances shall constitute just cause when they entail that the

28 Prp. s. 34-35.

29 See inter alia FinKN 2017-479, FinKN 2016-156, FinKN 2015-210, FinKN 2014-340, FinKN 2012-523, FinKN 2011-378.

30 FinKN 2014-340.

31 Similar SOU p. 214-217 on the interpretation of Swedish ICA 11 kap. 1 §.

32 FinKN 2015-210.

33 FinKN 2017-479.

> rejection cannot be deemed to be unreasonable in respect of the person in question".

According to this provision, there are two types of "just cause": First, if there is a circumstance which constitutes a special risk and there is a reasonable connection between the special risk and the rejection of the application, and second if there is a special circumstance and the rejection cannot be deemed to be unreasonable in respect of the person in question.

The Swedish ICA has a somewhat different regulation on this issue.[34] Consumer insurance and personal insurance may not be denied unless there is a "special ground" when the risk for future insured events, the type of insurance and any other circumstance is taken into consideration. For consumer insurance an added consideration is the extent of potential damage. Even so there are clear similarities in the rules as the risk for a future insured event and the extent of damage are key features of the concept of "special risk". Nevertheless, the Norwegian approach is somewhat clearer as the assessment is divided between a risk related approach and other "circumstances", whereas the Swedish regulation calls for an overall assessment in all cases.

The Swedish evaluation does not suggest to amend the grounds for denial. The investigations made demonstrate that 96,8 % of all applications for child insurance, 93 % of all applications for accident and sickness insurance and 95 % of sickness insurance for adults was accepted.[35]

3.2.2 "Special risk" as just cause

3.2.2.1 What constitutes a "special risk"?

The concept of "special risk" refers to a risk assessment. The concept must be seen in conjunction with the concept of insurance, which in short means to take over risk against a premium.[36] The concept of risk is based on probability for a negative outcome and varies between 0 and 100 %. If the insured event has already occurred, there is no longer a risk involved and we are outside the concept of insurance. It is a fundamental principle in insurance law that you cannot effect insurance for a casualty that has already occurred. There is no duty to contract insurance in this situation.[37]

The concept "special" means that there must be a departure from the normal risk, but the quality or the quantity of the departure is not further described. The preparatory works here point out two elements. The first element relates to the risk factor and is that ordinary circumstances that applies to substantial groups of the population, for instance which part of the country one lives in, do

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34 Swedish ICA 3 ch. § 1 and 11 ch. 1 §.

35 SOU p. 24-25 and ch. 11.

36 Bull p. 24.

37 Prp. p. 99 and FinKN 2014-341.

not constitute a "special risk".[38] A practical example of a risk factor that cannot be used as a reason for denial is the gender of the customer, but this follows from separate legislation.[39] Apart from this, it is difficult to say how far this presumption reaches. It is for instance clear that age is a risk factor that applies to big groups of the population, but at the same time it is clear that age is a significant risk factor in personal insurance[40] and can also be one in casualty insurance.[41]

Risk factors as grounds for denial of insurance must also be seen in conjunction with the rules on duty of disclosure and the question of what kind of information the insurer may ask for, cf. above and §§ 3-10 and 12-12 subparagraph 4 on circumstances the insurer may not ask about. If the insurer may ask about a risk factor, he may also use that risk factor as a reason to deny insurance.[42] Typical examples of risk factors that may constitute grounds for denial are misuse of alcohol or tobacco, but also other circumstances such as extensive traveling to risky areas or extreme sports activities may provide a reason to deny insurance if this constitutes a "special risk".[43]

The second element is the extent or significance of the risk. The extent of the risk will depend on the probability for the casualty to incur and the extent of the loss presuming the casualty does incur. The expression "special risk" can therefore either refer to an unexpected high frequency for the casualty or an unexpected high loss if the casualty does occur. The insurer operates normally with statistics where expected losses in a big group of customers provide a basis for calculation of the premium. The concept "special" risk means that there must be a deviation from this expected value, but the concept does not define how extensive the deviation must be. The preparatory works state that it is not sufficient with "any little increase of the risk" compared to the normal risk and that the increase must be more "pronounced".[44] A more "pronounced" increase in the risk is however less than a "substantial" increase in the risk.[45] The legislator discussed whether a substantial risk increase should be required for the insurer to deny, but recommended against this for two reasons.[46] The first reason was that a duty to contract unless there was a substantial risk increase could have negative influence on the market because the insurers would hesitate to offer products with a very varied risk profile. The second was

38 Prp. p. 99.

39 Act relating to equality and a prohibition against discrimination (Equality and Anti-Discrimination Act). https://lovdata.no/ dokument/NLE/lov/2017-06-16-51 ch. 2, Prp. ch. 4.6.1.2.

40 FinKN 2015-423.

41 FinKN 2014-109.

42 NOU 2000:23 p. 75 ff., FinKN 2014-340.

43 NOU 2000:23 p. 75 ff..

44 Prp. p. 99.

45 Prp. p. 99 and ch. 453, Bull p. 128.

46 Prp. p. 44-45.

that a duty to effect insurance also in case of substantial risk increase could result in adverse selection because customers constituting a low risk would refuse to pay the high premium necessary to cover the customers that constitute a substantial risk.[47] The result could be that the insurer would end up with an increasing number of high risk customers leading to increasing losses and a potential close down.[48] The attitude of the legislator was therefore that the insurer also under the new regime should be allowed to refuse disability insurance for persons with a risk for disability.[49]

Accordingly, the Financial Complaints Board for Personal Insurance has accepted denial of insurance in several cases. Examples are refusal of disability insurance due to breast cancer (FinKN 2017-479), depression and back/neck problems (FinKN 2016-156),[50] Asperger syndrome (FinKN 2015-362), psychological problems due to a difficult life situation (FinKN 2015-162), pain syndrome (FinKN 2015-160), headache, dizziness and neck problems (FinKN 2012-524) and learning and behavioral problems (FinKN 2011-379). Further, the Board has accepted alcoholism (FinKN 2014-340) and diabetes (FKN 2010-41) as just cause for denial of life-insurance.

The distinction between pronounced and substantial increase in risk is however difficult and will depend on statistical or individual risk assessments. The Board's authority to overrule the concrete risk assessments made by the insurers is also limited.[51] It is not possible to define the increase in premium required for the insurer to deny insurance. The Board has accepted an increase of 500 %[52] and 600 %[53] as ground for denial, but not 100 %.[54]

In cases where the premium is calculated based on general statistics, the concept of "special risk" may be measured against the calculated expected risk. However, in many cases such general statistics do not exist, and more individual risk assessments must be accepted.[55] The concept of "special risk" will also depend on the kind of product and the scope of cover.[56] A reference to the type of risk is given especially in the Swedish regulation, but is clearly also relevant in a risk assessment without special emphasis. A product with a large group of customers can carry a more varied risk profile than a product for fewer

47 Prp. p. 45-46, NOU 2000:23 ch. 4.1.3 p. 19. See also SOU p. 87.

48 Prp. p. 46.

49 Prp. p. 99.

50 See also FinKN 2011-378 and FinKN 2010-42.

51 Prp. s. 44-45 og kapittel 7.

52 FinKN 2016-35, see also FinKN 2017-711 and FinKN 2017-710 (increase of 400 % as ground for refusal to renew)

53 FinKN 2014-342.

54 FinKN 2017-653.

55 See for instance LB-2014-15000.

56 Prp. p. 99, FinKN 2014-361, Bull p. 128.

customers, and for products without individual calculation adjustment of premium due to individual risk factors is more difficult.[57]

The insurer has the burden to prove the existence of a special risk. The insurer must submit a statistical analysis as ground for denial or at least a proper risk assessment.[58] To the extent such risk assessment is submitted, however, the Board does not have authority to overrule the assessment.

In personal insurance it is not uncommon that the insurer deny due to medical probability for relapse. This must however be tied to the risk for the insured event to occur. [59]

4.3.2.2 What is "reasonable connection"

The insurer may only deny insurance "provided there is a reasonable connection between the special risk and the rejection of the application". The reason for this is that the permission to refuse shall not be wider than that indicated by the «special risk».[60] Persons suffering from particular illnesses, weaknesses or syndromes may thus not be refused accident insurance or casualty insurance based on their health condition. Further, in order to ensure that there is a reasonable connection the insurer must assess whether it is possible to limit against the special risk through more limited measures than refusal to contract, typically through exclusions in the scope of cover. [61]

In personal-insurance the Financial Complaints Board has emphasized the option to contract insurance with reservations tied to illness caused by the health problems that constitute the reason for the refusal.[62] The Board therefore treats reservations partly as partial refusal of insurance where the Board assesses whether the reservation is based on a just cause, partly as an insurance alternative to avoid special risk. As already mentioned, the Board does not accept an unreasoned limitation in the number of reservations,[63] and neither does it accept wider reservations than accounted for through the illness statistics that the insurer put forward.[64] But the Board has accepted that certain sufferings indicate a risk for so many health problems that a reservation is difficult to construct.[65]

The insured risk is normally defined through statistics based on loss history. The requirement of "connection" between the special risk and the denial means

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57 FinKN 2014-361.

58 Prp. p. 99.

59 See for instance FinKN 2014-343.

60 Prp. p. 44.

61 Prp. s. 44 and p. 99.

62 FinKN-2017-653, FinKN 2017-479, FinKN 2017-184, FinKN 2016-156.

63 FinKN 2015-210.

64 FinKN 2014-342.

65 FinKN 2015-160, FinKN 2012-524, FinKN 2011-379.

that there must be connection between the statistical basis for the risk assessment and the risk that is the ground for denial. It is not required that the denial is reasonable concerning the actual customer. According to the preparatory works, this is not relevant.[66] It is outside the role of the insurer to consider the customers individual need for insurance.

Further, the regulation does not require direct causation between the circumstances that provide the basis for the statistics and the special risk.[67] Statistics tied directly to a certain illness or suffering can therefore provide a cause for refusal without an individual risk evaluation tied to the actual customer. The insurer does not have to evaluate the concrete health risk of each individual customer. [68] The individual medical prognosis is therefore not relevant if the customer represent a special risk for the insured event to occur due to his past illness.

The Swedish regulation seems to be different concerning this issue. The evaluation points out that the insurers do not always satisfy the requirement that each customer shall be assessed individually.[69] The evaluation therefore suggests a duty for the insurer to undertake an individual assessment of the circumstances in the concrete situation before the application may be refused.[70]

The connection between the special risk and the refusal will depend on how relevant the statistics used are in relation to the application.[71] The use of statistics is in particular difficult where the statistics are not tied directly to the actual risk factor, but rather indicate that there is a risk factor. The preparatory works point to the situation where the customers have been in contact with a psychologist or a similar service. In such cases an individual assessment of the causes of the treatment may be necessary.[72] This however, raises difficult questions on the Boards authority to overrule medical assessments.[73]

The requirement of reasonable connection also means that the statistics used must have a sufficient professional level and be updated and timely according to medical research.[74]

If there are no statistics available for the relevant insurance, the insurer may build on medical and insurance-medical assessment and experience.[75]

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66 Prp. p. 100 and p. 45.

67 Prp. p. 44.

68 Prp. p. 99, FinKN 2017-479, FinKN 2015-362.

69 SOU p. 26.

70 SOU p. 35.

71 Prp. p. 99.

72 Prp. p. 100.

73 FinKN 2011-379, FinKN 2011-378, FinKN 2010-42, FinKN 2012-523.

74 Prp. p. 45, FinKN 2017-479.

75 FinKN 2012-524.

3.3.3 Other "special circumstances"

In addition to "special risk", other "special circumstances" shall constitute just cause when they entail that the rejection cannot be deemed to be unreasonable in respect of the person in question.

The expression "circumstances" is wide and indicate that any circumstance that is relevant for the insurer's assessment on whether or not they want to accept the insurance may give a reason for denial. Since risk as ground for denial is regulated in the first sentence, "circumstances" must include factors that is not necessarily relevant for a risk assessment. At the same time, it follows from the regulation that risk factors is regulated in first sentence and that circumstances therefore must be something different. A risk factor which in itself is not sufficient to constitute a "special risk" may therefore not constitute "other circumstances" unless it is combined with other factors.[76] Further, the circumstance must be "special", which means that it must deviate from that of the normal customer.

The expression other special circumstances is also used in relation to the insurer's right to cancel the insurance during the insurance period, and the preparatory works refer to these rules for relevant grounds for denial.[77] According to the ICA, the insurer may cancel the insurance if the person effecting the insurance gives wrong or insufficient answers to the questions asked by the insurer.[78] In such cases, the insurer must also have a right to deny future insurance contracts for the same product.[79] If the person effecting the insurance has acted fraudulently, the insurer may cancel all insurance contracts in the same company,[80] and must be allowed a similar right of denial of future contracts.

Previous casualty history may provide a ground for denial according to §§ 3-10 and 12-12 subparagraph 1 first sentence if the casualties constitute part of the statistics that provide the ground for the insurer's denial. This will particularly be relevant for professional insurance with individual risk assessments.[81] In other cases previous casualties must constitute a special circumstance to justify denial. The purpose of insurance is to give financial cover for casualties, and the starting point must therefore be that previous casualties may not constitute a "special circumstance". This is also supported by the preparatory works.[82]

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76 FinKN 2017-653.

77 Prp. p. 100 cf. ch. 4.2.1.

78 ICA § 4-3 first sentence and § 13-3 first sentence.

79 FinKN 2011-381.

80 ICA § 4-3 subparagraph 1 first sentence and § 13-3 subparagraph 1 third sentence, cf. Prp. p. 100.

81 LB-2014-15000I.

82 Prp. p. 100 and p. 25.

However, if previous casualty history departs so far from normal expectations that this in itself create a breach of trust between the insurer and the customer, the situation may be different.[83] It is not possible to define how many casualties this will be. Insurance contracts often contain conditions stating that the insurer may cancel the insurance if the assured sustains three or more casualties during the insurance period, but the Financial Complaints Board has decided that it is not reasonable to cancel the insurance based on this reason only.[84] A combination of a high number of casualties and breach of the duties of the assured may however make the cancellation "reasonable".[85] The same is true for high compensation amounts[86] or if the assured has participated in fraud or given wrong information in the settlement.[87]

Before the rules on duty to contract were enacted, payment default was used as a reason to deny insurance. This is no longer acceptable.[88] The insurer may however deny entering into a new contract if premium for a previous period is not paid.[89]

3.4 Matters that may not be Taken Into Consideration

According to §§ 3-10 and 12-12 subparagraph 3, certain matters may not constitute just cause:

> "Matters which it is prohibited by a provision laid down in or pursuant to statute to attach importance to in insurance risk assessments cannot constitute just cause. The same applies to information which the Insurer by a provision laid down in or pursuant to statute is barred from requiring from the person effecting the insurance or the Assured".

The first group of information that may not constitute just cause is "matters which it is prohibited by a provision laid down in or pursuant to statute to attach importance to in insurance risk assessments". This concerns primarily protection of privacy and discrimination.[90] Credit reports may not be used as a ground for denial. The same is true for matters that result in discrimination of gender, pregnancy, leave in connection with childbirth or adoption, care responsibilities, ethnicity, religion, belief, disability, sexual orientation, gender identity, gender expression, age or other significant characteristics of a

83 Prp. p. 100 cf. ch. 4.2.1.

84 FSN 2014-143, 2013-063, 6851, 6850, 5309, 4522, 4168, 3706, 2622.

85 I FSN 4922, FSN 4515.

86 FSN 1812.

87 Prp. p. 100 and p. 25, see also FSN 2578.

88 Prp. p. 100 and p. 42-43.

89 Prp. p. 100.

90 Prp. p. 100.

person.[91] However, differential treatment may constitute a just cause for denial if it is legal, that is if it has an objective purpose, is necessary to achieve the purpose, and does not have a disproportionate negative impact on the person or persons subject to the differential treatment.[92] The preparatory works mention as an example that life insurance is denied for members of a religious suicide cult.[93] Age may also constitute a just cause for denial for insurance products where age is a central risk factor.

The other group of information which may not constitute just cause is matters which the insurer by a provision laid down in or pursuant to statute is barred from requiring from the person effecting the insurance or the assured. This refers primarily to genetic information as regulated in the Biotechnology Act.[94] According to the Act § 5-8 it is prohibited to request, receive, be in possession of or use information on another person obtained through genetic testing that comes within the scope of section 5-1, second paragraph, litra b, or by systematic surveys of hereditary disease within a family.

This means that the insurer may not use this information in their risk assessments, and may not deny insurance based on such information.

3.5 The Insurer Must Provide Grounds for the Rejection

According to § 3-10 and § 12-12 subparagraph 4 denial shall be made in writing and the insurer must also provide the justification for the rejection. The justification shall indicate the various factors on which the rejection is based, including any individual risk assessments that may have been carried out. It follows from the provision that the justification shall be given to the assured together with the denial. It is not sufficient that the insurer gives the applicant the justification after the denial is brought into the Financial Complaints System.[95] However, the provision does not say that failure to provide justification means that the denial may not be invoked. The approach in the preparatory works is that a failure to justify the denial will give the applicant a basis for complaint to the Financial Complaint Board, and if the insurer during the treatment there does not provide a justification for the rejection, the requirement of just cause is not met. Insurance may in this case not be refused.[96] It is therefore a close connection between the requirement of just cause and the duty to justify this cause because a failure to provide a valid

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91 Act relating to equality and a prohibition against discrimination (Equality and Anti-Discrimination Act) § 6.

92 Equality and Anti-Discrimination Act § 9.

93 Prp. s. 47.

94 Act of 5 December 2003 No. 100 relating to the application of biotechnology in human medicine, etc.

95 FinKN 2015-161, FinKN 2015-160, FinKN 2012-524, FinKN 2012-523.

96 Prp. p. 54 and for instance FinKN 2017-653.

reason means that just cause is not documented. At the same time the justification may be provided both during the treatment in the Board and also later in a court case.[97] This cannot be a convenient sharing of work between the Board system and the insurers. When the insurers have a duty to justify the denial, there is no reason why the Board system shall have to deal with unsatisfactory grounds and make efforts to get more information before the decision is made.

In personal insurance, the insurers often obtain an assessment from the Board for health assessments (NHV).[98] NHV is established by the life insurers to assess how matters of health may influence the risk for the applicant's death, disability or illness. NHV gives recommendations for evaluations of applications for insurance that are of a particularly difficult character. The insurer's denial often builds on NHV's evaluation, but this evaluation is not binding for the Financial Complaint Board.[99]

The insurers often refer to investigations made by Nav and statistics tied to disability.[100] Nav's statistics are however general, and if they use such statistics the insurer must demonstrate that the information is relevant for the actual applicant.[101] If the statistics are less relevant, the insurer must demonstrate that he has assessed the information in the concrete case.[102]

The insurers internal guiding lines for the definition of special risk are not accepted it they do not build on statistics or other foundations to document the increased risk.[103]

4 Some Reflections

The rules on duty to contract insurance reflects a difficult balance between fundamental principles for an insurance market based on risk equalization and a reasonable relationship between risk and premium and the individual's need for financial security through insurance. If it is accepted that the framework for the insurance market as established in the insurance company regulation shall continue, it is difficult to see how insurance may be offered to groups whose insurable interests constitute a pronounced increase in the risk compared to the normal risk. Within this framework it is therefore natural to refer more

97 LB-2014-15000.

98 https://www.finansnorge.no/tema/liv-og-pensjon/nemnda-for-helsevurdering/ cf. FinKN 2017-479, FinKN 2017-13, FinKN 2015-362, FinKN 2015-160, FinKN 2015-161, FinKN 2014-340, FinKN 2012-524, FinKN 2012-523.

99 FinKN 2017-479, FinKN 2015-161 and FinKN 2012-523.

100 Se f.eks. FinKN 2015-362, FinKN 2015-162, FinKN 2012-523.

101 FinKN 2017-479, FinKN 2012-523.

102 FinKN 2012-523.

103 FinKN 2017-653, FinKN 2015-210.

pronounced risks either to the public well fare system or to the customer's own financing. A duty to contract unless there is a substantial risk increase could easily destroy the market and reduce the insurance products offered to persons representing a more normal risk. Both the Norwegian and Swedish regulation builds on this starting-point and the Swedish evaluation does not suggest to change the threshold for denial.

However, even within this framework, customer groups with substantial health problems can be helped through the use of reservations. This contractual tool was not given much attention by the legislator and is complicated because reservations are both a mechanism to avoid total denial and represent a part denial which must have a just cause. Board practice indicates that the insurers are not always willing to make a full use of this tool. A more detailed regulation on this issue would be beneficial.

There has been few cases on denial in casualty insurance. This may indicate that the regulation functions according to its purpose and that the insurers are careful not to deny insurance without just cause. The Norwegian Bank Law Commision has suggested a risk equalization scheme for certain risks for consumers.[104] The provision was never enacted and is not included in the new regulation for insurance companies. According to this analysis there is no need for such rule.[105]

Compared to the Swedish regulation it is a clear advantage that the Norwegian rules state that the insurer has to justify the denial. This is a necessary condition for the board to be able to control the decision process performed by the insurers. The Norwegian board practice demonstrates that the Swedish suggestion to include similar rules is beneficial.[106]

At the same time it is unfortunate that the failure to justify the denial does not have any other effect that the denial is without just cause. Practice demonstrate that the insurers now can provide their grounds through several rounds with first an insufficient justification in the denial and then a more detailed one when the denial is claimed into the Financial Claims Board or the court system. The result of this is unnecessary double work which is not convenient in an overworked dispute solution system.

Compared to the Swedish regulation it is a clear advantage that a denial may be tried before the Financial Complaint Board. At the same time, it is clear that the regulation is complicated and raise several difficult questions relating to risk assessments in general and medical risk assessment in particular. It can be discussed whether a board system with written main hearings is the best way to settle disputes on such issues. On the other hand, the number of cases tried before the board indicates that there is a need for a cost efficient dispute system. The number of cases that has been tried in the Norwegian board system

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104 Prop. 134 L (2009- 2010) Endringer i forsikringsvirksomhetsloven (skadeforsikring), see the proposal § 12-17.

105 See further Hans Jacob Bull: Rett til forsikring – fra ikke-problem til «overkill», Kart og Plan, Vol 70, p. 151-155.

106 SOU 2016:37 p. 27, p. 35-36.

since the regulation was enacted indicates clearly that the Swedish suggestion to implement similar conflict solutions for personal insurance has some merit.