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Serious Illness Insurance Coverage: An Applicant Hides His True Health Condition in Order to Deceive the Insurer

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Authors

Judith Rochette

Partner, Lawyer

Pierre-Olivier Tremblay-Simard

Lawyer

Recently,[1] Justice Isabelle Germain of Quebec's Superior Court ruled on a case involving insurance fraud in the matter of *Paul-Hus v. Sun Life Canada, compagnie d'assurance-vie*[2]. This ruling illustrates that applicants must answer the insurer's questions honestly; should an applicant try to mislead the insurer, he will have to face the consequences.

In this case, the plaintiff Daniel Paul-Hus (Paul-Hus) claimed an amount of $150,000 from Sun Life Canada by way of benefits as set out in the serious illness insurance policy taken out by his company (of which he was the sole shareholder and director) in 2015, along with $50,000 for the trouble and inconvenience caused by Sun Life's refusal to honour its contractual undertakings.

Paul-Hus claimed that he suffered from amyotrophic lateral sclerosis (ALS) diagnosed on February 1, 2018. The claim form was submitted by him on August 16, 2018. Sun Life refused his claim since an assessment of his medical records revealed that his prior medical history was inconsistent with the information he had provided during a telephone interview on March 17, 2015.

Sun Life considered the contract null and void due to Paul-Hus's false declarations while filling out the questionnaire he was required to complete when taking out the policy. Essentially, it was Sun Life's position that Paul-Hus had not answered certain questions correctly in the questionnaire and that, if he had, the insurer would not have issued the serious illness policy.

It was brought into evidence that, during the telephone interview of March 17, 2015, Paul-Hus had to answer questions on his lifestyle habits, his current health condition and his prior medical history. Some of the questions in Sun Life's medical questionnaire sought to ascertain whether Paul-Hus felt

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weakness in his arm and whether a doctor had ever recommended any tests or if he was awaiting any test results. These questions were answered in the negative by Paul-Hus.

However, a review of the file reveals that these answers were inaccurate. The insurance policy was issued on March 17, 2015, while the evidence indicated that Paul-Hus had consulted his neurologist a few weeks before, on February 24, 2015, due to weakness in his left hand, the symptoms having appeared progressively since August 2013. At that time, additional tests were prescribed (cervical and brain imaging, magnetic resonance imaging and numerous blood tests). Nonetheless, in his Originating Application, Paul-Hus asserts that, at the time the policy was issued, he had not noticed or suspected any symptoms of disease and contends that, according to the doctors, the disease had developed suddenly.

In her judgment, Justice Germain reiterated the principles governing declarations of risk in the insurance sector, pointing out that false declarations can result in the nullification of the contract.[3] However, in this case, the policy had been in force for over two years at the time of the claim for indemnification, so that the insurer was required to prove fraud in order to nullify the contract[4] (Paul-Hus's intention to hide his true health condition).

Justice Germain found that Sun Life had discharged the burden of demonstrating Paul-Hus's fraudulent dealings. In addition to his medical records, Sun Life produced a recording of the telephone interview held on March 17, 2015, as well as a transcription of the interview. In the Court's view, it was clear that Paul-Hus was under neurological investigation due to weakness in his left arm at the time he was completing the questionnaire. Although in his testimony at trial,[5] he claimed not to know that this information could have had an impact on the insurer's decision, Justice Germain did not side with this version. For Justice Germain, the evidence presented by the insurer demonstrated that it had been Paul-Hus's intention to deceive Sun Life.

This being said, in accordance with the requirements of article 2408 C.C.Q., Sun Life had to demonstrate not only that it would not have covered this risk had it been aware of the new information resulting from the claim, based on its own underwriting standards, but that any reasonable insurer would have refused to issue the serious illness insurance policy under the circumstances. Sun Life also discharged this burden and completed this "evidence of materiality" by presenting the testimony of an underwriting expert.

Finally, and in addition to the above, Paul-Hus claimed that he had been diagnosed with amyotrophic lateral sclerosis (ALS), which he was unable to support with evidence. Under cross-examination, Paul-Hus admitted that he had never received any such diagnosis. Instead, he suffered from a lower motoneuron disease, which did not qualify as a "serious illness" under the policy.

In conclusion, in the Court's opinion, the policyholder knowingly misled the insurer and falsified his risk assessment in order to obtain coverage. Moreover, given that Paul-Hus was not insurable for serious illness coverage in the eyes of a reasonable insurer, the Court concluded that the contract should be nullified *ab initio* and terminated.

This decision reminds us of how important it is for policyholders to answer insurers' questionnaires honestly when making their initial declaration of risk :

> [TRANSLATION] [55] In the Court's opinion, Paul-Hus failed to answer the questionnaire sincerely. He did not act as would have a reasonable insured. He was aware of the importance of giving honest answers to the questions asked during the telephone interview. An insurance contract is one requiring the utmost good faith, particularly as far as the assessment of risk is concerned.

It is of interest that in this matter, Paul-Hus gave his testimony at the hearing by way of

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videoconference, which Justice Germain comments as follows:

> [TRANSLATION] [49] One notes that, while giving his testimony via videoconference at the hearing, Paul-Hus referred to a document, which would be obtained and filed by Sun Life. The document is Sun Life's letter of refusal of December 28, 2018, which he annotated with the words "good faith" and "answered no in all good faith I was not awaiting anything no results". It seems odd, to say the least, that he should make the effort to write down these words as a reminder and should feel the need to repeat them several times during his testimony and when cross-examined.
>
> [50] However, it is not enough to repeat that one acted in good faith to justify such omissions.

Paul-Hus appealed Justice Germain's decision. Sun Life filed a Motion to Dismiss the appeal, which was dismissed on January 15th, 2024[6]. We will therefore have to wait and see what happens before the Court of appeal.

To sum up…

Insurance contracts are essentially characterized by the risks they cover and by what risks the insurer is willing to tolerate for a given premium. The *Civil Code of Québec* recognizes two specific instances in which the actual declaration of risk is fundamental: the initial declaration of risk before the contract is drawn up[7] and any increase in the risk level during the term of the contract.[8]

The declaration of risk is essential to the insurer when it comes to accurately determining the extent of the risk and the premium that will be charged if the insurer agrees to provide coverage. As a general rule, the policyholder's utmost good faith should be in evidence during the initial declaration stage given that this declaration paves the way for the prospective contractual relationship and its various terms and conditions. A policyholder will be deemed to have properly met their obligation "if the representations are such as a normally provident insured would make, if they were made without material concealment and if the facts are substantially as represented."[9]

Since Policyholders are responsible for informing the insurer about any relevant factors that might change its risk assessment, i.e., a positive disclosure requirement, it stands to reason that the Civil Code sets out consequences in the event that this requirement is not fulfilled by the policyholder. A policyholder who makes false statements can therefore see his insurance contract nullified *ab initio.*[10] In other words, the contract would be deemed to have never existed because the basis on which it rests, the initial declaration of risk, was flawed. It should also be noted that nullification will only be relative and that the insurer may elect not to assert it. Consequently, the Court, after having heard the evidence, cannot rule *ex officio* that the contract is null and void.

The insurer has two (2) years after the effective date of the contract to request nullification *ab initio* based on false statements or unwillingness to fully disclose risk.[11] Set against that backdrop, the insurer's burden of proof amounts to demonstrating that the policyholder made false statements or concealed relevant facts.

Insurance fraud

Once the two (2) year window of opportunity has closed, the insurer faces an additional burden of proof: it must also demonstrate that the policyholder committed fraud.[12]

Fraud is distinguished from false declarations or concealment. Among other things, it results from the misrepresentation or omission of a fact in the knowledge that, if the truth were disclosed, the insurer would not issue the policy under the negotiated conditions. Therefore, the policyholder must

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have intentionally deceived the insurer in order to obtain an advantage that would not have otherwise been obtained.

Insurers, therefore, have a heavy burden of proof if the two-year threshold has been crossed. This is because fraud cannot be presumed; it must be established on the balance of probabilities.

Burden of proof

Whether or not the two (2) year period is still running, the insurer must **(1)** demonstrate that it would not have entered into the contract based on its own underwriting criteria; and **(2)** that a reasonable insurer in the same circumstances (i.e., dealing with false declarations, concealment or fraud) would have also declined to issue coverage.[13]

To recap, **before the expiry** of the two (2) year period, insurers seeking a contract's nullification *ab initio* must prove that:

1. The policyholder made false declarations or concealed information when making the initial declaration of risk.
2. The insurer would not have entered into the contract based on its own underwriting criteria if it had been apprised of the concealed information.
3. A reasonable insurer in the same circumstances would have also declined to take on the risk.

After the expiry of the two (2) year period following the effective date of the policy, insurers requesting the contract's nullification *ab initio* must prove that:

1. The policyholder made false declarations or concealed information when making the initial declaration of risk **AND** intended to deceive the insurer.
2. The insurer would not have entered into the contract based on its own underwriting criteria if it had been apprised of the concealed information.
3. A reasonable insurer in the same circumstances would have also declined to take on the risk.

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1. Judgment handed down on October 3, 2023; the hearing was held on May 25 and 26, 2023.
2. 2023 QCCS 3890; this ruling was appealed from (200-09-010693-239) and the appeal was dismissed on January 16, 2025 (2025 QCCA 41).
3. Art. 2410 C.C.Q.
4. Art. 2424 C.C.Q.
5. Via videoconference.
6. Paul-Hus v. Sun Life Canada, compagnie d'assurance-vie, 2024 QCCA 46
7. Arts. 2408 and 2409 C.C.Q.
8. Arts. 2466 et seq. C.C.Q.
9. Art. 2409 C.C.Q.
10. If the false statement deals exclusively with the policyholder's age, the contract cannot be declared null and void (art. 2410 C.C.Q.) unless the policyholder's actual age is outside the insurable range established by the insurer (art. 2411 C.C.Q.).
11. Art. 2424 C.C.Q.
12. Civil Code, art. 2424, para. 1 C.C.Q.
13. CGU compagnie d'assurance du Canada v. Paul, 2005 QCCA 315, para. 2 and art. 2408 C.C.Q.

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