

CLYDE & CO

Insurance Act 2015  
Shaking up a century of insurance law

CB  
1892

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# Introduction

The Insurance Act received Royal Assent by Parliament on 12th February 2015, and will come into force on 12th August 2016. This represents the most significant reform of UK insurance law since the Marine Insurance Act of 1906. All contracts of insurance, reinsurance and retrocession made after 12th August 2016 (or variations to contracts which are made after 12th August 2016) will be governed by the Act.

The Act is the product of a process of law reform which was instigated by the Law Commissions in 2006. The Act is intended materially to change the way in which insurance business is conducted, and is designed to modernise and clarify the law.

To the "casual observer" it might be surprising that the UK's insurance law regime has for so long been based on a statute that is more than 100 years old and which was originally designed only to address marine insurance. And yet, the business of insurance in the UK has thrived and the UK legal system, based upon a combination of statutory codification and judicial precedent, has, to a significant extent, shaped the international insurance markets and the development of insurance law during the century since the 1906 Act. But as market practices have developed the legal regime needed to be updated to reflect changing demands and bring it into line with other jurisdictions.

With the enactment date now looming, it is important to focus on how the Act will work and the steps that insurers will need to take to ensure they are ready to deal with these changes. In this guide we have focused on how the key provisions of the Act will operate, offering guidance on best practice for insurers as they implement the provisions

of the Act, and assessing the practical implications of the Act across all lines of insurance business. Some of the more controversial provisions of the Act, such as the removal of the basis of contract clauses, have already been widely implemented by the market, other provisions have gradually been introduced by insurers as they have sought to ready themselves for the Act. Nevertheless, it is important to note that all contracts of insurance after 12th August 2016 will be formed under a new regime and insurers must take careful note as they are drafting contracts of the potential implications of the Act.

During the process of law reform, the Law Commissions looked at other jurisdictions where similar provisions had already been implemented, and in part eight of this report we have considered how the new UK regime for insurance law measures up against the other major insurance markets.

Like all new statutes, the full impact of the Act will not be appreciated until some of the provisions are interpreted by judicial precedent, and we expect that over the coming years we will see further definition of the Act as it is put into practice.

We hope that this report will add valuable insight for insurers as they move into the new regime.



**Simon Konsta**  
Global Head of Insurance  
June 2016

# The case for insurance contract law reform

The Insurance Act 2015 received Royal Assent on 12 February 2015 and is due to come into force on 12 August 2016. It will amend certain key sections of the Marine Insurance Act 1906, although the 1906 Act has not been repealed. It applies to England, Wales, Scotland and Northern Ireland.

The road to this point has not been straightforward; and the case for reform has been discussed for many years. As early as 1957, there were calls for change, and various attempts since then to kick-start the process of reform.

Current UK insurance law stems from the 1906 Act, which codified common law principles that had been developed in the eighteenth and nineteenth centuries, largely from marine cases, most notably, the case of *Carter v Boehm* (1766) which established the duty of utmost good faith. Over the years its provisions have been applied to marine and non-marine cases alike and there were increasing concerns that the clear bright language of the 1906 Act restrained the judiciary and was not able to keep up with the changing market practice of the industry in both the consumer and business sectors. No longer was insurance arranged between a few men face-to-face; no longer was the range of products limited and focussed on marine insurance; no longer was it difficult to store and process information.

As the Law Commissions put it:

“The law has failed to keep pace with these changes. The law does not reflect the diversity of the modern insurance market or the changes in the way people communicate, store and analyse information. Nor does it reflect developments in other areas of commercial contract and consumer law.”

The call for reform got louder at the turn of the new century and, following a convincing BILA report, the Law Commissions of England and Scotland produced a scoping paper in January 2006 examining the current state of insurance law to ascertain where reform was needed. The Law Commissions examined how insurance law operated in other jurisdictions noting that the 1906 Act had provided the global insurance market and legal profession with a framework that became a model for codification in many common law jurisdictions, with the UK judiciary's interpretation of the 1906 Act being instructive to other jurisdictions and its principles often applied. However, over the years many of these same jurisdictions had reformed their laws resulting in the UK lagging behind and out of step with international markets.

Following publication of their joint scoping paper in January 2006, the Law Commissions published several issues papers and detailed consultations. It was decided that consumer and business insurance reform should be treated separately. The reviews culminated in the adoption of three new Acts of Parliament:

- The Third Parties (Rights against Insurers) Act 2010 (coming into force 1 August 2016)
- The Consumer Insurance (Disclosure and Representation) Act 2012 (which came into force on 6 April 2013)
- The Insurance Act 2015 (coming into force 12 August 2016)

In relation to business insurance, the Law Commissions had presented their Report and Draft Bill on 15 July 2014 to the Government, proposing a default regime in respect of:

- The duty of disclosure in business and other non-consumer insurance
- The law of insurance warranties
- Insurer's remedies for fraudulent claims
- Late payment of insurance claims

The majority of the Law Commissions proposals were enacted in the Insurance Act 2015. The provisions for late payment of insurance claims were not included in the Bill, enabling it to follow the uncontroversial bills route through Parliament. However, these provisions were subsequently reintroduced in the Enterprise Act 2016 which received Royal Assent on 4 May 2016 and will come into force on 7 May 2017.

The process of insurance law reform is not yet complete. Still on the Law Commissions' agenda is to clarify and amend the law in relation to insurable interest: their argument, in essence, is that insurance contracts should be void, not illegal, unless the policy-holder had an interest at the time of contract or had reasonable prospects of obtaining one during the contract. If the contract is void, there is no obligation to pay premium or, if it has been paid, premium must be refunded.

The Law Commissions published their Draft Insurable Interest Bill in April 2016 and intend to publish a joint report in the second half of 2016, setting out their recommendations following consultations which took place in 2008, 2011 and 2015 and 2016.

“ The changes introduced by the Act have largely been welcomed; many insurers have already been following the provisions of the Act.

The Law Commissions also published proposals on the following, though currently these items have been shelved:

- Whether the need for a formal insurance policy in marine insurance (under the 1906 Act) should be abolished. Consultees said no
- Whether the broker should remain liable for premium under section 53 of the 1906 Act – if a broker goes out of business, the insurer is left out of funds and cannot recover from the insured but must still pay the claim if there is a loss. There was a radical split in response with brokers agreeing with the Law Commissions and the underwriters disagreeing

The changes introduced by the Act have largely been welcomed; many insurers have already been following the provisions of the Act.



# Law reform: a timeline

**JUL  
1930**

Third Parties (Rights Against Insurers) Act 1930 in force

**1980**

The Law Commission publishes its report: Insurance Law: Non-disclosure and Breach of Warranty

**MAR  
2001**

Lord Justice Longmore gives the Pat Saxton Memorial Lecture and calls for "An Insurance Contracts Act for a new century"

**2006**

**Jan 2006**  
The Law Commissions' joint scoping paper is produced

**Sept 2006**  
Issues Paper 1: Misrepresentation and non-disclosure

**Nov 2006**  
Issue Paper 2: Warranties

**JUL  
2007**

Consultation: Misrepresentation, non-disclosure and breach of warranty by the insured

**APR  
2009**

Issues Paper 5: Micro-businesses – should micro-businesses be treated like consumers for the purposes of pre-contractual information and unfair terms

**DEC  
2009**

Report: consumer insurance law: pre-contract disclosure and misrepresentation

**JAN  
1907**

Marine Insurance Act 1906 in force

**1957**

The Law Reform Committee recommends reform of insurance law

**FEB  
1986**

The Department of Trade and Industry tells Parliament that insurers' willingness to strengthen the voluntary "statements of insurance practice" makes legislation unnecessary, and that self-regulation is preferable

**2002**

The British Insurance Law Association (BILA) publishes a report declaring that it is "satisfied there is a need for reform"

**MAR  
2007**

Issues Paper 3: Intermediaries and pre-contract information

**JAN  
2008**

Issues Paper 4: Insurable interest

**NOV  
2009**

Third Parties (Rights Against Insurers) Bill introduced to Parliament

**MAR  
2010**

Issues Paper 6: Damages for late payment  
Third Parties (Rights Against Insurers) Act 2010 receives Royal Assent

JUL  
2010

Issues Paper 7:  
The insured's  
post-contract  
duty of good  
faith

Issues Paper 8:  
The Broker's  
Liability for  
Premiums  
(Section 53)

MAY  
2011

The  
Consumer  
Insurance  
(Disclosure  
and  
Representations)  
Bill is  
introduced to  
Parliament

MAR  
2012

Consumer  
Insurance  
(Disclosure  
and Representations)  
Act 2012  
receives  
Royal Assent

APR  
2013

Consumer  
Insurance  
(Disclosure  
and Representations)  
Act 2012 in  
force

FEB-  
MAR  
2015

Insurance Act  
2015 receives  
Royal Assent

Issues Paper  
10: Insurable  
interest

4/MAY  
2016

Enterprise Act  
2016 receives  
Royal Assent

12/  
AUG  
2016

Insurance Act  
2015 in force

OCT  
2010

Issues  
Paper 9: The  
Requirement  
for a Formal  
Marine  
Policy: Should  
Section 22 Be  
Repealed?

DEC  
2011

Consultation:  
insurance  
contract  
law: post  
contractual  
duties and  
other issues

JUN  
2012

Consultation:  
insurance  
contract law:  
the business  
insured's duty  
of disclosure  
and the law  
of warranties

JUL  
2014

Report:  
insurance  
contract law:  
business  
disclosure;  
warranties;  
insurers'  
remedies for  
fraudulent  
claims; and  
late payment

Insurance Bill  
introduced to  
Parliament

SEP  
2015

Enterprise  
Bill (including  
provisions  
relating to  
damages for  
the late pay-  
ment if insur-  
ance  
claims) is  
introduced to  
parliament

1/AUG  
2016

Third Parties  
(Rights  
Against  
Insurers) Act  
2010 in force

7/MAY  
2017

Enterprise  
Act 2016  
provisions  
relating to  
damages for  
late payment  
in force

# Part one:

## Key changes introduced by the Act

The most significant changes introduced by the Act are summarised below. Note that the provisions in relation to utmost good faith and non-disclosure only apply to non-consumer insurance, consumer insurance having already been dealt with in this regard by the Consumer Insurance (Disclosure and Representations) Act 2012.

### Utmost good faith/Non-disclosure

#### Fair presentation of the risk – Section 3 of the Act

The duty to volunteer information is being retained (unlike for consumer policies). An insured has to disclose all material facts or make a fair presentation, which will include putting a prudent insurer “on notice” that it needs to make further enquiries (and so falls short of requiring the insured to disclose every material circumstance). Material information must not be deliberately withheld.

The Law Commissions criticised the practice of convoluted presentations and “data dumping”: “A lack of structuring, indexing and signposting may mean that a presentation is not fair”. Hence, disclosure must be “in a manner which would be reasonably clear and accessible to a prudent underwriter”. Section 7 provides guidance on what to include in a fair presentation.

#### Knowledge of Insured – Section 4 of the Act

When deciding what an insured knows, it is the knowledge of senior management (which will include the board of directors but also those who play significant roles in the making of decisions about how the insured’s activities are to be managed or organised) and of those responsible for arranging the insurance which matters (and blind-eye knowledge is included).

An insured must now carry out a reasonable search for information, and what is reasonable will depend on the size, nature and complexity of the business.

“ Disclosure must be “in a manner which would be reasonably clear and accessible to a prudent underwriter”.

The insured will be deemed to know what “should reasonably have been revealed by a reasonable search” and so information held by non-senior management (but by those who, say, perform a managerial role) may still be imputed to the insured. Information/knowledge held by any other person with relevant information (even those outside the company, such as the company’s agents or beneficiaries of cover) will also be imputed to the insured if a reasonable search should have revealed that information.

However, the insured’s knowledge does not include confidential information acquired by the insured’s agent (eg its broker) through a business relationship with someone other than the insured who is not connected with the insurance.

#### Knowledge of Insurer – Section 5 of the Act

The Act also creates a positive duty of inquiry for the insurer. An insurer “ought reasonably to know” something if it is known to an employee/agent who ought reasonably to have passed it on, or relevant information which is readily available and held by the insurer.

An insurer will also be presumed to know things which are common knowledge, or which an insurer offering insurance of the class in question to insureds in the field of activity in question would be expected to know in the ordinary course of business.

#### Remedies – Section 8 and Schedule 1 of the Act

The remedies for material non-disclosure or misrepresentation will change as follows:

1. It will be possible to avoid a policy and keep the premium only where the misrepresentation or non-disclosure was deliberate or reckless.
2. In all other cases (even where the insured is innocent), a scheme of proportionate remedies will apply, as follows:
  - a. where the insurer would have declined the risk altogether, the policy can be avoided with a return of premium
  - b. where the insurer would have accepted the risk but included a contractual term, the contract should be treated as if it included that term (irrespective of whether the insured would have accepted that term); and
  - c. where the insurer would have charged a greater premium, the claim should be scaled down proportionately (for example, if the insurer would have charged double the premium, it need only pay half the claim). This contrasts with some other jurisdictions, where only the additional amount of premium is payable to the insurer. The Law Commissions have explained that this is because it was felt the insured should have something to lose (ie more than just paying the amount of premium they should have paid in the first place)



The proportionate remedies can work together or as sole remedies.

The test of what the insurer would have done had it known the true facts is entirely subjective. In practice, it may be hard for insureds to disprove that, for example, a particular insurer would have viewed a certain breach as so serious that he/she would not have written the risk at all. The issue will become one of credibility. The keeping of thorough and comprehensive underwriting records (both of risks which are accepted and risks which are not) will be important.

In order to have any remedy at all under the Act for non-disclosure or misrepresentation (even a relatively modest one, eg a 20% reduction of the claim), the insurer will have to meet the same burden of proof that is currently required for avoidance of the policy. However it may be that judges and arbitrators will be more willing to conclude that the threshold has been met once they are able to grant a remedy that is proportionate to the degree of mischief.

## Warranties and other policy terms

### Basis of contract clauses – Section 9 of the Act

Basis of contract clauses will be prohibited (as is already the case for consumer contracts) and it will not be possible for business insurers to contract out of this particular change (section 9 of the Act). Thus any provision in a proposal form which purports to convert answers in the proposal form into a warranty will be ineffective though it is still possible to have warranties in the policy itself.

“Basis of contract clauses will be prohibited and it will not be possible for business insurers to contract out of this particular change.

### Breach of warranty – Section 10 of the Act

All warranties will become “suspensive conditions” (section 10 of the Act). This means that an insurer will be liable for losses that take place after a breach of warranty has been remedied, assuming this is possible and provided that the loss is not “attributable to something happening” before the breach.

Thus, for example, if an insured breaches a warranty that an alarm system will be inspected every six months, that breach will be “remedied” if the system is inspected after seven months, and so coverage will be suspended for only one month in such circumstances.

### Terms not relevant to the actual loss – Section 11 of the Act

A new provision has been introduced for any term (not just a warranty) designed to reduce the risk of a particular type of loss, or of loss at a particular time or in a particular place. It will not apply to terms which define the risk as a whole (eg a requirement that a property will not be used commercially).

Where there is non-compliance with such a term, insurers will not be able to rely on that non-compliance as a defence if the insured can demonstrate that such non-compliance could not potentially have increased the risk of the loss which actually occurred in the circumstances in which it occurred.

So, for example, where there is a requirement to install a burglar alarm, and that is not done, insurers will not be able to refuse an indemnity on that ground for flood loss.

### Fraudulent claims

Currently, an insurer is not liable to pay a fraudulent claim and can recover any sums already paid in respect of it. It is not clear whether an insurer can refuse to pay genuine claims for losses suffered after the fraudulent act but before discovery/termination of the policy.

Under section 12 of the Act, an insurer will also have the option of terminating the contract from the date of the fraudulent act (not the discovery of it), without any return of premium. The Law Commissions believed that insurers would want this option, rather than an automatic remedy, because it allows them more commercial flexibility. The insurer can then refuse to pay any claims from that point onwards (but will remain liable for legitimate losses before the fraud).

The Act does not seek to define a fraudulent claim, so there is no distinction between someone who presents a completely fraudulent claim (ie claims for something that never happened) and someone who has genuinely suffered a loss but has used a fraudulent device to increase his chance of being paid. There is also nothing in the Act concerning whether the fraud must be substantive.

The Act also provides, at section 13 of the Act, that, in the case of a group insurance policy, where a fraudulent claim is made by one of the beneficiaries to the policy (who is not a party to the policy), the insurer may treat cover for the fraudulent beneficiary only as having been terminated at the time of the fraudulent act (and cover will remain in place for the other “innocent” beneficiaries).

The explanatory notes to the Act explain that this clause applies not just to, for example, employment group policies, but potentially also to insurance arranged by one company for a group of companies (if that is how the policy is structured). In a non-consumer context, the Act also now makes it clear that if an insurer wants to contract out of this provision, it must comply with the transparency requirements in section 17 to bring that to the attention of the group company beneficiary.

“ The option of terminating the contract from the date of the fraudulent act allows more commercial flexibility.

### Damages for late payment of claims

The Law Commissions' proposal relating to damages for late/non-payment of claims was dropped from the Insurance bill and was not included in the version of the Act which received Royal Assent on 12th February 2015. That was, in the main, because the bill was following the Law Commissions' uncontroversial bills route and strong opposition to the inclusion of the provision by insurance bodies meant that the bill could not be categorised as "uncontroversial" without the removal of the provision. However, there had been some support for the provision in the House of Commons and the Law Commissions remained keen to re-introduce it at a later stage.

In a surprise move, the Law Commissions announced on 17th September 2015 that a section on damages for late payment had been included in the Enterprise Bill introduced by the House of Lords and laid before Parliament the day before. The bill received Royal Assent on 4 May 2016, becoming the Enterprise Act 2016 and the provisions in relation to damages for late payment will come into force on 7 May 2017.

The Enterprise Act inserts a further clause into the Act (section 13A of the Act). This new clause provides that it is an implied term of every insurance contract that an insurer must pay any sums due in respect of a claim made by the insured "within a reasonable time" (which will include a "reasonable time" to investigate and assess the claim).

Reasonableness will depend on all the relevant circumstances, including the size and complexity of the claim, the type of insurance and factors outside of the insurer's control.

The new section will also provide that where an insurer can show that there were reasonable grounds for disputing the claim (either in full or as to quantum), the insurer will not

breach the new implied term "merely by failing to pay the claim...while the dispute is continuing, but the conduct of the insurer in handling the claim may be a relevant factor in deciding whether that term was breached and, if so, when". Thus, in principle, an insurer might breach the implied term even though it had reasonable grounds for contesting a claim (which is subsequently proved to be valid) – where, for example, the insurer has conducted the investigation unreasonably slowly, or has been slow to change its position when new facts come to light.

The remedies for breach of the new implied term are said to include damages (in addition to having the claim paid and interest). As the bill progressed through Parliament a further provision was included that claims by insureds for damages for late payment must be brought within one year of an insured receiving payment of the insurance claim. This will be reflected in an amendment to the Limitation Act 1980. The new section 16A does envisage that insurers will be able to contract out of these changes (although not for consumer insurance). However, contracting out will not be valid where there has been a deliberate or reckless breach by the insurer. Recklessness in this context means where the insurer did not care whether or not it was in breach. The general contracting out rules set out in the Act will apply to terms in non-consumer policies relating to non-deliberate/reckless breaches.

The new section will not apply to settlement contracts.

“ In principle, an insurer might breach the implied term even though it had reasonable grounds for contesting a claim.

### Good faith and contracting out

#### Good faith – Section 14 of the Act

The remedy of avoidance for a breach of the duty of utmost good faith is abolished under section 14 of the Act (although, as mentioned above, the ability to avoid will be retained in some cases where the insured breaches the duty in relation to disclosure/misrepresentation). The Law Commissions did not suggest a remedy of damages instead (despite contemplating introducing that remedy at one point); rather, they suggested that the courts will allow good faith to be used as "a shield rather than a sword", ie insurers may be prevented from exercising an apparent right if they have not exercised it in good faith. It is perhaps unclear, however, how a legitimate right can be exercised in a manner which amounts to bad faith (and the Law Commissions acknowledged that there is conflicting case law on how far the courts will recognise this concept).

### **Contracting out – Section 16 of the Act**

The changes being introduced by the Act are intended only to be a “default regime” for non-consumer insurance. While the Law Commissions have previously indicated that they wish to discourage boiler-plate clauses which opt-out of the default regime as a matter of routine, particularly in the context of mainstream business insurance, they add that: “In sophisticated markets including the marine insurance market, we expect contracting out will be more widespread”.

In other words, business insurers cannot expect to restore the current position and carry on “business as normal” simply by inserting a clause into a policy to the effect that the changes in the Act (when it comes into effect) do not apply. Instead, insurers will need to identify each and every change which they do not intend to apply and cater for an opt-out for that change separately in the policy. It will probably be best if insurers focus on what is truly important to them, and set out the consequences of breach of any policy terms. Accordingly, very careful consideration will have to be given to the drafting of business insurance policies in the future.

Where insurers do intend to opt out under sections 16 or 16A (and hence include a “disadvantageous term”), they must take sufficient steps to draw that to the insured’s attention before the contract is entered into and the disadvantageous term must be “clear and unambiguous as to its effect”. These are known as the “transparency requirements”, found in section 17 of the Act.

The Act also provides that “...the characteristics of insured persons of the kind in question, and the circumstances of the transaction, are to be taken into account”.

Guidance from the Law Commissions explained that additional steps by the insurer would be needed where a small business purchases insurance online but, conversely, more leniency will be allowed where a sophisticated insurance buyer purchases cover at Lloyd’s (“This is a fast-paced market, and we would not want to interfere unnecessarily with its operation”). The more lenient approach applies where a broker is involved, even if the insurance buyer is unsophisticated.

For both consumer and non-consumer insureds, the contracting-out provisions will not apply to settlement agreements (and hence an insured will still be able to enter into a settlement on less favourable terms than the default rules).

Finally, as mentioned above, it will not be possible for business insurers to contract out of the prohibition for basis of contract clauses (although they can still specifically agree a warranty in respect of any particular matter in the policy).



# Part two:

## The Act in practice

As with any major new law, there will be uncertainty as to how the provisions will be applied and interpreted by the Courts. It will take some time to fully understand the implications of the changes made by the Act and where practice needs to develop to ensure that disputes are kept to a minimum.

From our review of the Act and its impact on various individual business lines, we anticipate that the following will be the areas with the potential for the most “sting”.

Insurers of non-consumer risks can, of course, contract out of the provisions of the Act, with the exception of the prohibition on basis clauses. However, such attempts may prove fruitless in the current soft market.

### Fair presentation of the risk

There are two limbs to the obligation of ‘fair presentation’. Under one of the limbs, an insured can discharge its duty by providing “sufficient information to put a prudent insurer on notice that it needs to make further enquiries”. A key issue will be what amounts to “sufficient information”. To say that the insured has to give “sufficient information” puts the onus onto the insurer to ask the right questions. There is the potential that this test could turn into a lower threshold whereby we start to see a minimum level of disclosure that the insured has to meet, potentially with insureds beginning to disclose less and less.

“ We anticipate that this may be an area for disputes in the future.

The concept of utmost good faith remains an interpretative principle for this duty and, therefore, the courts may exercise caution when allowing an insured to use this alternative limb for sharp practice. The obligation on the insured to present information in a reasonable manner should also preclude an insured concealing issues in a lengthy submission.

It will be interesting to see how the courts will interpret this issue; we anticipate that this may be an area for disputes in the future.

The new general rule that an agent’s knowledge is imputed to the insured now better reflects the ordinary principles of agency. Where there is a change of broker in the course of dealing with the insurer, the knowledge of the first broker is still relevant (following *Blackburn v Haslam* (1888) 21 QBD 144).

### Proposal forms

The key with proposal forms is striking the appropriate balance between asking the right questions in order to elicit the necessary information whilst avoiding being too prescriptive. Under the new regime, it is likely that some insurers’ proposal forms will become longer in an effort to capture everything that is important to those writing the risk. If too many questions are asked, then there is a risk that an insurer may not be able to rely on non-disclosure of an item which it did not ask a question about. A form which is too prescriptive runs the risk of the courts finding that what was asked in the form included all the information that the insurer considered was relevant to the risk, thus an insurer’s argument may be limited.

When looking at other jurisdictions: Australia, the United States, France and the United Arab Emirates tend towards fuller proposal forms. In the United States, for example, the insured has no duty to disclose information unless the insurer makes specific enquiry into these areas. The insurer can then rely on any representations from the insured without further enquiry; however, there is still a continuing obligation on the insured to correct any wrong answers or answers that become incorrect at a later date. It is therefore incumbent on the insurer to ask everything it needs at the outset in order to fully assess the risk.

Similarly, in France, the insured only has a duty to answer the question that has been asked correctly and accurately; vague questions can result in a vague answer so it is therefore important for an insurer to formulate their questions accurately. Unlike the United States, an insurer in France must follow up with any queries.

South Africa, Canada and Hong Kong tend towards briefer less prescriptive forms; there is no absolute right or wrong and it very much depends on how the obligations for the insured and the insurer are set out and interpreted in each jurisdiction. Insurers would be wise to review how they approach their proposal forms (see our ‘Practical Tips’ section), bearing in mind the issue of “sufficient information”. It may be that, unless the risk is to be 100% written by an insurer or the risk is on the small, medium enterprise (SME) level, in practice the market will generally use the broker’s proposal form on which the insurer may have little input. However, differences in the substantive law on disclosure will have to be taken into account.

## Proportionate remedies

The Act brings in proportionate remedies in the event of non-disclosure; gone is the draconian “all or nothing” remedy of avoidance in all instances except for deliberate or reckless non-disclosure and where the insurer would not have written the policy at all if it had been aware of all the facts.

The benefit to insurers is that they can invoke the remedy without severely damaging business relationships in the event of an actionable non-disclosure. In some areas, such as medical malpractice, where competition is strong and the relationship with the insured is paramount, these remedies may allow insurers to raise non-disclosure points without risk of damaging the relationship (as avoidance may well have done previously). Insurers will need to carefully assess when to run such arguments based on the circumstances at hand.

Should a non-disclosure dispute go to trial, the courts may be more willing to find non-disclosure when the prescribed remedy is a more palatable solution than avoidance.

However, it is conceivable that the existence of proportionate remedies may make some insureds less willing to settle the case at an early stage as they do not face the risk of losing everything if the matter goes to court.

We can see that there may be some circumstances where the insured has made an honest deliberate non-disclosure ie where there was no intention to deceive but the insured honestly felt that the insurer did not need to know something. It may be that such situations may not be classified as deliberate non-disclosures in the context of applying proportionate remedies.

### Application of proportionate remedies

Applying proportionate remedies in practice raises a number of questions. For example, where an insurer states that, had the issue in question been disclosed to it, it would have charged a higher premium, the remedy would be that the cover is reduced proportionately ie if it would have charged three times the premium; the position that an insurer will only have to pay a third of the claim is relatively straightforward. A potentially more complicated question is how this would play out in a tower of indemnity in these circumstances ie at which point will the next layer’s obligation to pay be triggered? In this situation, in our view, it is as if the insurer’s line on the risk is one third of what was actually written – so the insurer pays one third of what it would have paid, up to one third of the limit. On that basis the attachment point of the excess layer is unaffected (assuming of course that they were not themselves misled) – the insured bears the two thirds of the loss that would otherwise have been paid by primary insurers.

## Establishing evidence of the difference in terms or premiums

The main difficulty with the proportionate remedy regime is establishing evidence of the difference in terms or premiums. While non-disclosure of true operating revenues can easily be translated into a premium increase based on rates, it is much more difficult when dealing with other types of non-disclosure. For example, if a circumstance has not been mentioned in a proposal form, will insurers be able to say that the correct proportionate remedy would be that the claim that arises from it is not covered by the terms of the policy? This would be sensible if insurers can provide evidence that had they been notified of the fact in issue, they would have underwritten an exclusion into the policy for such a claim.

In addition, it is likely that insureds may contend that the insurers’ current position is coloured by hindsight and not representative of the situation at the time. The importance of good records is obvious here.

“ If a circumstance has not been mentioned in a proposal form, will insurers be able to say that the correct proportionate remedy would be that the claim that arises from it is not covered by the terms of the policy? ”

### Reinsurance position

Currently, it is not possible to draw a firm conclusion as to what would happen in the situation where a misrepresentation is made to the insurer and this is passed on to reinsurers (only relevant in facultative reinsurance) in circumstances where the reinsurer then raises an argument that had there been no misrepresentation, it would also have changed its position but on different terms to what the insurer would have done.

Taking it logically, the insurer would advance its case first against the insured and seek the appropriate adjustment to the policy, for example, carrying on the example above, reduce the cover to one third on the basis that it would have charged three times the premium. If successful, the claim (and indeed the cover) will therefore be scaled down. Even if the reinsurer does nothing further, it will receive the benefit of the action taken by the insurer. Does the reinsurer, therefore, still need a remedy of its own? This is an area we can only theorise on at this stage and we can see that there is potential for disputes between the layers. However, as insurers/reinsurers are not pursuing these points regularly in the current soft market it may prove in reality to be limited to a point of academic interest.

### Subscription market issues

How proportionate remedies will be handled in the subscription market is a key issue. As each insurer has technically entered into a separate contract with the insured, what will happen if they all have different views on what they would have done differently had there been effective disclosure? Will the lead be truly followed? If in fact the followers were given abbreviated presentations and largely followed the lead's decision then there would be a compelling case for saying that they all have the same remedy as the lead. However, if there is no leader, with the broker filling the slip by approaching several insurers, then theoretically each individual insurer would be entitled to run separate arguments as to what they would have done had they had a fair presentation. These may prove difficult to resolve and assess.

A solution may be that insurers can deal with this on a contractual basis between themselves ie set out expressly that the following market is to follow the lead in regard to proportionate remedies.

### Subsequent losses

We think it is clear beyond argument that the proportionate remedies will apply to subsequent losses under the same policy. The whole policy will be reformulated if a proportionate remedy is applied. As such, it would apply even to a subsequent claim which does not relate to the non-disclosure in question.

This conclusion is supported by the position in France where proportionate remedies are applied to the policy, not the loss. Therefore, if there are further losses on the same policy, the proportionate remedy would also apply to the subsequent losses under the policy. There has been little case law in France on how this would affect the excess layer; we do not expect the courts would be sympathetic to an argument by an excess layer insurer that a primary layer had not been theoretically exhausted.

“ Proportionate remedies will apply to subsequent losses under the same policy.

### Reinstatement

On reinstatement the cover will be reinstated on the basis of the reconfigured policy following the application of the proportionate remedy.

### Claims control

It has been suggested that proportionate remedies may also cause issues with claims control clauses; can the insurer control the claim where it is not paying the full amount?

It is likely that the courts will take the view that the reinsured has conceded claims control and is the author of its own misfortune for failing to make an adequate presentation. Therefore, if the indemnity is scaled down as a result of a proportionate remedy being applied, then the reinsured has to face the consequences. Claims control clauses are contractual terms and there is no reason why they should be edited out.

### Evidential difficulties

Experience from other jurisdictions with a proportionate remedy regime suggests that insurers may face evidential difficulties when attempting to argue what they would have done if a fair presentation had been made.

In Quebec the proportionate remedies system has been codified. The code is very specific – there is either full avoidance or reduction of the underlying indemnity. Unlike the UK Act, the law in Quebec does not allow for other provisions such as exclusions to be written into the contract. The courts in Quebec and elsewhere in Canada in general treat the testimony of an underwriter with scepticism when they say what they would have done, so coverage disputes in more complex cases (such as FI and D&O) become a battle of the experts.

The system is similar in France. Avoidance is only permitted where there is fraud. If insurers would have increased the premium, then a proportionate remedy is applied, however, this proportionate remedy is not applied much in practice for evidential reasons. In France, any expert will be appointed by the court and it is likely that an attempt will be made to use any existing underwriting guidelines to evidence how the insurer would have viewed the risk if it had had a fair presentation of the risk. However these do not tend to exist for sophisticated products.

A useful tool for tackling this problem, therefore, could be wider publication of underwriting guidelines and literature to assist the underwriters in proving that their approach to the risk in question would have differed had a fair presentation been made. Indeed, in Australia, which also applies proportionate remedies, underwriting guidelines are becoming a regular feature. If an insurer has guidelines, these should be reviewed and insurers should make sure that any departure from the guidelines is properly documented, explained and authorised. It is

likely that if an insurer has not consistently applied its guidelines, the broker in any coverage dispute will draw this to the attention of the insured.

These are all areas that can cause disputes and only time will tell how they will be dealt with in practice. The current law, whilst draconian, imposes clear bright line tests whereas the new law is fact specific and therefore ripe for dispute. However, as the law has now been brought into line with current market practice in a number of areas, coupled with the soft market conditions and the increasing importance of preserving commercial relationships, this may mean that, in reality, litigation will be limited.

“ The courts in Quebec and elsewhere in Canada in general treat the testimony of an underwriter with scepticism when they say what they would have done, so coverage disputes in more complex cases become a battle of the experts.

#### **Additional premium**

We understand that some insurers are considering inserting an additional premium clause into policies, which provides for additional premium to be paid in the event of non-disclosure if, had a fair presentation been made, the insurer would have charged a higher premium. The insurer can, at its sole discretion, elect to charge the additional premium or scale down the claim. If the former, the insurer cannot scale down any subsequent claims, having already received a remedy. This clause may be seen as contracting out of the Act so insurers should ensure the transparency requirements are met.

#### **Tension between layers – interaction with damages for late payment**

As we have set out above, there is potential for tension between layers in the application of proportionate remedies. Not only can this be disruptive and costly for insurers but with the introduction of damages for late payment, there is the risk that such tensions may expose insurers to claims for late payment. It is highly unlikely that the Courts would consider disputes between layers to be a “reasonable” reason for delay in payment of the claim.



## Damages for late payment

As discussed above, section 13A implies a term into the insurance contract that an insurer must pay sums due in respect of a claim within a reasonable time. If an insurer is in breach of the duty, the insured will be able to claim damages in addition to the right to be indemnified under the policy and interest.

The section is a response to arguments that the pre-Act rule under English law, as represented by the case of *Sprung v Royal Insurance (UK) Ltd*, is an anomaly which places England and Wales out of step with many other jurisdictions (including Scotland).

This rule is based on a legal fiction that an insurer's primary obligation under an indemnity insurance contract is to "hold the indemnified person harmless against a specified loss or expense" (see Lord Goff's speech in *The Fanti*) – in other words to prevent the event that is insured against from happening. Accordingly, insurance payments were not debts due under a contract but were instead damages for breach of contract, and English law did not recognise a claim for damages for the late payment of damages.

This rule has been widely criticised. This new clause in the Act will bring the law into line with other jurisdictions and with general contract law principles.

When the insurer pays late without denial of the claim, the focus is simply on the length of time taken to pay and section 13A(3) provides guidance in this regard.

**“ This new clause in the Act will bring the law into line with other jurisdictions and with general contract law principles.**

It is unclear what would be considered “reasonable” by the courts when determining whether insurers were unreasonable in declining to pay a claim. The phrase used clearly suggests that an objective test will be applied and it is likely to be fact specific. It has been suggested that the courts will look at applying a standard somewhere between surviving an application for summary judgment and proving you were right at trial on the balance of probabilities. However, it might be worth noting that the FOS (which hears complaints from consumers and micro-businesses) already applies a remedy of damages for late payment, with broad acceptance from the industry. Consumers and micro-businesses are, in any event, far more likely to sustain losses as a result of late or non-payment of a claim than larger businesses, which in general will have better cash flows to cope with delayed insurance claims.

## “Reasonable” test in contested claims

There is no guidance in the new section 13A for what is “reasonable” in contested claims. Here, the main issue will be whether or not there were reasonable grounds for denying the claim, taking into account the conduct of the insurer, even if the objective test above is met. Examples of conduct could include:

- Conducting investigations slowly
- Refusal to engage in ADR
- Failure to make interim payments, especially where the whole claim is not in dispute
- Breaches of the CPR which cause delay

The scope of conduct under scrutiny is unclear as the Enterprise Bill does not state whether it is the insurer's conduct in denying the claim or its conduct in the litigation or both.

## How will damages be assessed?

Normal contractual principles will be applied, namely, that the purpose of contractual damages under English law is to put the innocent party in the position in which it would have been had the relevant contract not been breached. In order to prove its damages, a party must demonstrate that its loss was reasonably foreseeable at the time the relevant contract was entered into (not at the date of breach). Questions to be resolved include how much the severity of the insurer's conduct will impact on damages given, and how foreseeable it was that the insured would suffer the losses claimed. A key point is whether the insurer was aware that the insured would be relying on the insurance monies to reinstate its facilities and resume normal production. However, on the issue of consequential damages, we anticipate that the courts will likely be insurer-friendly.

## Practice in other jurisdictions

Experience from other jurisdictions that already have a similar system for damages for late payment indicates that it is not often used in practice. In Australia, for example, the court can award damages to compensate for loss of use of money that a party has paid out as a result of the other party's breach. However, we understand that despite its availability, there has not been a flood of claims in this area. The mechanism is already available in, amongst others, Scotland, Ireland, France and Canada and it is rarely utilised in those jurisdictions. In Canada, the vast majority of cases relate to consumer contracts and we anticipate that the impact in England will be similar on the basis that large companies/firms can more readily obtain a suitable line of credit.



Under Scots law, the obligation to pay only arises once the loss has occurred, the insured has made a valid claim and the insurer has had an opportunity to investigate the soundness of the claim. Claims for damages for late payment are rarely brought and while there is awareness that such a remedy is possible, it is not seen as a particular concern to insurers. Actions challenging an insurer's wrongful repudiation of a claim are not uncommon.

### **Areas where damages for late payment could have an impact**

The impact on the property and business interruption ("BI") insurance sector could be more significant. SMEs or sole traders, for example, may not have the ability to take out significant lines of credit to cover them until the insurance pays out. A typical scenario might be an SME or sole trader with weak cash flow who suffers a catastrophic fire at its premises. The insurer suspects arson given the known financial difficulties. As a result, there is a long investigation and, in the meantime, the business collapses. If the claim was genuine then the insurer will be exposed to a claim for damages for late payment. A similar scenario arises in relation to one ship companies where the insurer suspects that the ship has been scuttled. These types of cases are notoriously difficult to prove and, as such, may take a long time to resolve and expose insurers to damages for late payment claims.

“ The impact on the property and business interruption ("BI") insurance sector could be more significant.

Perhaps more straightforward is the application of the late payment damages provisions to a typical BI cover scenario: if the insurer had paid the property loss promptly, the insured would have been able to rebuild its facilities and resume normal production within, say, nine months; due to the delay in payment, it took 18 months so the insured may seek damages for the six months of BI that fell outside the 12 month maximum indemnity period. The energy sector, where claims are often very complex in nature and can take a considerable amount of time to investigate and adjust, may also be more vulnerable to claims for damages; these are commonly seen in other jurisdictions where this line is written. This will only be a concern where the insured actually suffers foreseeable consequential loss.

Claimant lawyers may seek to push these types of claims and vexatious litigants are also a potential concern. The Law Commissions have said they expect vexatious litigation claims to cost GBP 375,000 (USD 541,670) per year over the next ten years.

It is, therefore, not an area that should be readily dismissed.

In a positive development for the insurance industry, upon the third reading of the Enterprise Bill (which will insert the section into the Act), the House of Lords introduced a one-year limitation period to bring a claim through the addition of section 5A of the Limitation Act 1980.

Some practical points to consider:

- Drawing upon our experience of bad faith claims in the US, whilst insureds in the UK may not issue late payment damages claims regularly, the threat of such an action could be raised by the insured to increase its bargaining power in negotiations
- If the question of whether an insurer has dealt with the coverage issue within a reasonable time is in issue, then the court may want the claims file to be disclosed in order to assess reasonableness. The insured may also seek the coverage files, including privileged legal reports to insurers. We do not think that the courts would be willing to accept by way of submissions without evidence, that the insurer received legal advice that it had a good defence so it was therefore reasonable in delaying payment. This is something to be wary of and to assess carefully should the need arise
- How will the remedy be applied in the subscription market if, for example, one insurer is the cause of the delay? If all but one of the insurers are prepared to pay, but they all wait for the one follower to agree then that would surely be unreasonable delay by all of them and they will all be exposed to a claim for damages for late payment. If only one insurer delays payment, then it may be that contractual principles apply and the insurers are all held to be jointly liable for the damages on the basis that the following market is bound by the leader so should pay if the leader pays. In reality this situation is likely to be rare. It is also questionable whether delay of paying a small amount of the claim (for example, if it is only a 5% line that has not paid) would result in causing the insured significant loss such as to justify damages

## Section 11 difficulties

Section 11 is intended to prevent an insurer from relying on breach of a term by the insured if that breach is not connected with the actual loss suffered by the insured.

Section 11 is potentially fraught with difficulties. It applies to a term of a contract of insurance, other than a term defining the risk as a whole, if compliance with it would tend to reduce the risk of loss of a particular kind, at a particular location or at a particular time. Section 11 goes on to provide:

“If a loss occurs, and the term has not been complied with, the insurer may not rely on the non-compliance to exclude, limit or discharge its liability under the contract for the loss if the insured satisfies subsection (3).

[Subsection (3)] The insured satisfies this subsection if it shows that the non-compliance with the term could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred.”

Disputes as to which terms fall within the section and which do not are likely, although the accepted view is that post-loss terms, such as notification clauses, will not be caught by the section (they are not about risk mitigation).

The oft-cited example is where the insurer attempts to rely on breach of a burglar alarm warranty where the loss resulted from a fire; in this situation the insurer will now not be permitted to rely on non-compliance with that term to defend a claim if the insured can show that its non-compliance “could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred”. However, there are likely to be grey areas here (eg where a flood might have triggered the burglar alarm and so the emergency services might have arrived on the scene sooner) and so, in order to limit the scope for dispute, it would be advisable for insurers to specify in their policies what requirements they wish to impose, what risk of loss that requirement is intended to address and what consequence non-compliance will have.

The Law Commissions’ July 2014 report stated that section 11 “does not introduce a causal element about whether compliance would have prevented the loss, or whether the breach caused or contributed to it. It is simply whether compliance might usually be thought to reduce the chances of the particular type of loss being suffered.” However, given that there will inevitably be questions and disputes as to whether a term falls within the section and whether or not the non-compliance increased the chance of the loss occurring, it may well be necessary for the courts to examine the terms closely and consider the law of

causation. In certain circumstances, such as complex medical malpractice cases, expert evidence may be required to assist the court in determining the issues, thus increasing the length of the case and the costs involved.

“ There will inevitably be questions and disputes as to whether a term falls within the section and whether or not the non-compliance increased the chance of the loss occurring.

As section 11 does not apply to terms “defining the risk as a whole”, an exercise to determine which terms define the risk as a whole and a term which would reduce the risk of a specific type is required. An example, given by the Law Commissions in their July 2014 paper, is a warranty that a ship will remain in class (in marine insurance). They also have suggested that the following may qualify as terms which define the risk as a whole (and are therefore not subject to section 11):

- Terms that define the age, identity, qualifications or experience of a driver of a vehicle, a pilot of an aircraft, or an operator of a chattel
- Terms that define the geographical area in which a loss must occur if the insurer is to be liable to indemnify the insurer
- Terms that exclude loss that occurs while a vehicle, aircraft or other chattel is being used for commercial purposes other than those permitted by the contract of insurance

Whilst these examples are illustrative of what may be considered terms which define the risk as whole, the situation is not clear-cut.

It may be that the courts will look at the complete cover provided under the policy in determining whether section 11 applies to the term in question. So, if the cover provided is limited to a specific risk, for example, flood risks, then it may be that section 11 will not apply as it defines the risk as a whole. However, terms under a policy that is provided to cover a number of risks may be caught by section 11 as, logically, the term applies only to part of the cover so does not define the risk as a whole.

There is no doubt that section 11 is a potential source of future disputes. Experience from Australia where section 54 of the Insurance Contracts Act 1984, similar in scope to section 11 has been the source of much litigation supports this conclusion.



# Part three:

## In practice – how to comply with the Act

Reform	The Act provides:	Practical tips for claims and underwriting specialists
<b>Duty of fair presentation</b>	Insured can discharge duty by providing “sufficient information to put a prudent insurer on notice that it needs to make further enquiries”	<ul style="list-style-type: none"> <li>– Be proactive in reviewing/processing material received</li> <li>– Ensure all information is carefully read</li> <li>– Data dumping by the insured is prohibited so question material received in this way (it must be presented to you in a “clear and accessible manner”)</li> <li>– Question any blank spaces/incomplete answers promptly</li> <li>– Check all queries raised are fully answered</li> <li>– Check have received answers in relation to any subsidiary entities also being insured</li> <li>– Give same level of scrutiny to renewals</li> </ul> <p><b>In relation to proposal forms:</b></p> <ul style="list-style-type: none"> <li>– Review and amend as necessary to include questions that will produce the information required to assess and write the risk</li> <li>– Draft in a non-ambiguous manner eg do you have risk management procedures <u>and</u> are they implemented?</li> <li>– Be careful not to be too prescriptive – a form which is too prescriptive runs the risk of the courts finding that what was asked was all an insurer wanted to know, thus an insurer’s argument may be limited</li> </ul> <p><b>In relation to underwriting guidelines:</b></p> <ul style="list-style-type: none"> <li>– Consider producing underwriting guidelines setting out what insurers will accept, minimum premium levels etc to demonstrate that a proportionate remedy should be applied if there is a non-disclosure and to ensure consistency across the company</li> <li>– Be careful not to be too prescriptive – guidelines which are too prescriptive run the risk of the courts finding that factors in the guidelines were exhaustive in relation to what an insurer wanted to know, thus an insurer’s future argument/defence (in the event of a dispute) may be limited</li> <li>– Keep a record of any departures from the guidelines with reasons for the departure</li> </ul>
<b>Reasonable search</b>	“an insured ought to know what should reasonably have been revealed by a reasonable search of information available to the insured”	<ul style="list-style-type: none"> <li>– Insureds may try to agree in advance what comprises a “reasonable search” – consider carefully whether such an agreement may limit your rights</li> <li>– Consider setting out what you do not require sight of</li> <li>– Be careful that the defined scope of the search is not wider than the scope of the Act (if it is, consider contracting out of the Act in this regard, bearing in mind the transparency rules)</li> </ul>
<b>Knowledge – what an insurer “ought to know”</b>	“an insurer ought to know something only if (a) an employee or agent of the insurer knows it, and ought reasonably to have passed on the relevant information to an individual [who decides on behalf of the insurer to write the risk] and (b) the relevant information is held by the insurer and is readily available to [such] an individual”	<ul style="list-style-type: none"> <li>– Ensure everyone clearly knows who is responsible for deciding to write the risks and that they are up to date with personnel changes</li> <li>– Ensure all information from other departments is passed to underwriters in a timely fashion, including claims history and details regarding ongoing claims</li> <li>– Have systems in place to make information held off-site “readily available” for underwriters</li> <li>– Check all information from brokers, loss adjusters and any other agents used has been passed to the underwriter</li> </ul>

Reform	The Act provides:	Practical tips for claims and underwriting specialists
<b>Knowledge – what an insurer is “presumed to know”</b>	“an insurer is presumed to know (a) things which are common knowledge, and (b) things which an insurer offering insurance of the class in question to insureds in the field of activity in question would reasonably be expected to know in the ordinary course of business”	<ul style="list-style-type: none"> <li>– Continued education needs to be provided to all individuals regarding developments in the class of business in question</li> <li>– Consider methods of sharing sector knowledge and market information, for example – a weekly email or newsletter rounding up the week’s news and developments in the field in question</li> </ul>
<b>Proportionate remedies</b>	No longer “all or nothing” approach to non-disclosure	<ul style="list-style-type: none"> <li>– Keep good records of underwriting decisions including reasons, notes of unusual factors, questions raised, answers to queries</li> <li>– Keep copy of broker presentation if possible</li> </ul>
<b>Warranties</b>	Warranties are now “suspensive conditions”	<ul style="list-style-type: none"> <li>– Review wordings carefully</li> <li>– If there is something you absolutely do not want to cover then consider putting in as an express exclusion clause in the policy (applies to warranties and terms currently expressed as condition precedents)</li> </ul>
<b>Basis clauses</b>	These are now prohibited – not possible to contract out of section	<ul style="list-style-type: none"> <li>– Review wordings to ensure these are removed</li> </ul>
<b>Section 11</b>	<p>Where there is non-compliance with a term that is designed to reduce the risk of loss, insurers will not be able to rely on that non-compliance where the insured can show that such non-compliance “could not potentially have increased the risk of the loss which actually occurred in the circumstances in which it occurred”.</p> <p>For example, where there is a requirement to install a burglar alarm, and that is not done, insurers will not be able to refuse an indemnity on that ground for flood loss.</p>	<ul style="list-style-type: none"> <li>– Consider carefully which terms are important</li> <li>– Avoid uncertainty by making clear express provision for the consequences of breaching particular terms</li> <li>– Consider opting out of section 11 altogether (subject to considerations in Contracting Out section below)</li> </ul>
<b>Damages for late payment</b>	<p>Implied term in every insurance contract that insurer will pay claim within a reasonable time</p> <ul style="list-style-type: none"> <li>– Reasonable time includes reasonable time to investigate and assess the claim</li> <li>– Reasonableness depends on all the circumstances</li> </ul>	<ul style="list-style-type: none"> <li>– Deal with claims as promptly as possible</li> <li>– Have written record showing how the claim is being progressed</li> <li>– Be mindful that disputes between layers will likely not be considered a reasonable reason why payment was delayed</li> <li>– Be aware that it may be necessary to disclose underwriting files – in order to establish reasonableness in subsequent proceedings</li> <li>– Be aware that you may need to waive privilege in respect of legal advice received to demonstrate reasonableness</li> <li>– Consider partial payment on uncontroversial element of claim under reservation of rights for the disputed element</li> </ul>
<b>Contracting out</b>	<ul style="list-style-type: none"> <li>– Cannot contract out in consumer policies</li> <li>– Cannot contract out of prohibition on basis clauses</li> <li>– Damages for late payment – in a non-consumer policy you can contract out, providing transparency requirements are met. However, the term will be void if it puts the insured in a worse position as a result of “deliberate or reckless breaches” of the implied term</li> </ul>	<ul style="list-style-type: none"> <li>– You must take sufficient steps to draw any disadvantageous term to the insured’s attention before the contract is entered into or the variation agreed</li> <li>– The disadvantageous term must be clear and unambiguous as to its effect</li> <li>– If the above “transparency requirements” are not fulfilled, the term will not be upheld</li> <li>– Consider wordings carefully and assess whether you may be inadvertently contracting out of sections of the Act. If you are in effect contracting out, then the transparency requirements in section 17 will have to be met in the normal way</li> <li>– Need to show to the FCA that you are treating customers fairly</li> </ul>

# Part four:

## International reach – choice of law and the application of the Act

When considering whether the Act will apply, the starting point is that it will apply to all (re) insurance contracts written on or after 12 August 2016 which are governed by English law.

This is obvious in policies that contain an express choice of law clause. However, what is the position where there is no such express provision? Will English law govern the policy so that it will be subject to the Act? If, after applying the relevant test (which is set out below), the law to be applied to the policy is English law, then the Act will apply to it.

### What are the choice of law rules?

The general position is that if there is an express choice of law in the contract, that is almost always honoured by the English courts. In the absence of an express clause, the English courts will determine whether a choice of law can be implied. Failing that, the rules on choice of law will determine the law that will apply to the policy. In relation to contracts entered into after 17 December 2009, EU Regulation 593/2008 (“Rome I”) will apply.

Rome I applies to insurance of large risks wherever the risk is situated and to all other insurance wherever the risk is situated (ie it applies to all insurance). The only difference is that for non-large risks situated outside the EEA, Article 7 does not apply.

The parties to an insurance of a large risk (wherever situated) or of a non-large risk which is situated outside the EEA retain freedom to choose the applicable law (Article 7.2). “Large risks” includes most commercial insurance such as marine, aviation and transport as well as some forms of liability insurance and certain other risks where the insured meets specified criteria relating to turnover, balance sheet or employee numbers (see Article 5(d) of the First Non-Life Directive 72/239/EEC).

If no choice of law is made, the insurance contract for a large risk will be governed by the law where the insurer has its habitual residence (generally that will be the insurer’s place of central administration (see Article 19), but a branch or agency involved in the making of the contract will suffice). But if it is clear from all the circumstances that the contract is manifestly more closely connected with another country, the law of that country will apply (Article 7.2).

In the recent case of *Molton Street Capital LLP v (1) Shooters Hill Capital Partners LLP (2) Odeon Capital Group LLC* (2015) the court considered what “manifestly more closely connected with another country” meant and held that it required that the cumulative weight of the factors connecting the contract to another country had to clearly and decisively outweigh the need for certainty in applying the habitual residence test. Whilst *Molton* is not an insurance case, the same principles applies. Briefly, the facts of this case are as follows: the English

broker claimant had negotiated with the first defendant (D1), who was also an English broker, to buy bonds held by a New York hedge fund. Whilst a firm offer from D1 was accepted it was necessary, for regulatory reasons, for the contract to be entered into with D2, a company based in New York. The transaction was approved and the claimant requested a trade ticket which contained a disclaimer that a trade could not be considered a good trade without the express consent of D2’s principals. The claimant contracted to sell the bonds before receiving them and when D2 was notified that the bonds would not be delivered, it cancelled the contract. The claimant sought damages and an indemnity against liability to its purchaser. What law to apply became an issue in the proceedings. The Court considered the facts and held that New York law rather than English law would apply to the contract as the bonds were essentially New York instruments; the issuing entity was a bank headquartered in New York; performance would take place in New York; the price was in USD, and the substantive rights attaching to the bonds were represented by a book entry in New York. The fact that negotiations had been between two English companies carried little weight.

“ The Act will apply to all (re)insurance contracts written on or after 12 August 2016 which are governed by English law.

As such, if on the facts the insurance policy is manifestly more closely connected with England, then English law will apply and the policy will be subject to the Act.

For completeness, the parties to all other insurance contracts have a more limited choice of law (Article 7.3). They can choose (a) the law of any member state where the risk is situated at the time the contract is entered into, or (b) the law of the country where the policyholder has his habitual residence (although see the Article for some further options in specific cases). In the case of commercial or professional insurance covering risks situated in two or more member states, the parties can choose the law of any of them, or the law of the policyholder’s habitual residence (Article 7.3(e)).

If the parties have not chosen a governing law in accordance with this Article, the governing law will be that of the Member State in which the risk is situated at the time the contract is concluded. Note that for consumer insurance policies Rome I applies whether the risk is situated inside or outside the EU.

# Part five:

## Insolvent insureds: Third Parties (Rights Against Insurers) Act 2010

The Act made various amendments to the Third Parties (Rights Against Insurers) Act 2010 (the “2010 Act”) aimed at rectifying the failure to include certain insolvency circumstances in the original 2010 Act.

These defects in the original 2010 Act resulted in it languishing on the statute books without coming into force. On 25 February 2016, the Third Parties (Rights Against Insurers) Regulations 2016 were laid before Parliament, together with an explanatory memorandum, enabling the 2010 Act to finally come into force; the date is set for 1 August 2016.

The 2010 Act makes it easier for third parties to bring claims against insolvent insureds, as it provides a simpler procedure for doing so than under the existing Third Parties (Rights against Insurers) Act 1930 (“the “1930 Act”).

The main changes are:

1. Claims may now be brought directly against the insurer without the need to establish liability against the insured
2. Third parties may obtain information regarding the policy prior to the issuing of proceedings (at the cost of the insurer)
3. The rights of the insolvent insured against the insurers are automatically transferred to the third party claimant when the insured enters into a formal insolvency process (there is no longer the requirement for the claimant to sue the insured in the first instance so there is also no longer the need for a dissolved company to be restored to the register of companies)

“ The 2010 Act makes it easier for third parties to bring claims against insolvent insureds, as.

### Pros and cons of the 2010 Act for insurers

On the one hand insurers must bear the cost and inconvenience of responding, at short notice, to information requests. This may mean that there is potential for third parties to frame their claim so as best to ensure that the policy responds and/or to determine the amount of their claim once they know how much is “in the pot”. On the other hand, this information may serve to reduce speculative or unmeritorious claims.

Liability policies confer rights on the insurer, once notified, to defend the claim and participate in any proceedings. The insured is also usually required not to admit liability or compromise the claims without consent. However, where the insured is insolvent, it often has little interest in complying with policy terms to notify or in defending claims from third parties. Under the 1930 Act, an insurer

may have been faced with the unattractive proposition of being presented with a demand for the immediate settlement of a final judgment award, where they have had no opportunity to dispute the claim and it is only the possible existence of policy defences which presents any barrier to payment. Whilst the fact that the process under the 2010 Act of claiming against insurers will be quicker, simpler and cheaper may mean that more meritorious claims are brought, if they are, the insurer may take a direct participatory role in any proceedings if it chooses to do so and will be able to raise substantive liability arguments against the claimant, as well as policy defences.

As such, on balance, the 2010 Act may, overall, be beneficial to insurers.

### The 2010 Act and Latent Damage cases

Currently, a claimant establishes liability against the insured by first restoring the insured to the Companies Register. The time limit for restoring a company is 6 years from the date of dissolution. Since this may be too short a time period for latent damage cases, section 1030 of the Companies Act 2006 provides that an application to restore can be made “at any time for the purpose of bringing proceedings against the company for damages for personal injury”. However, there is no extension of the 6 year deadline for the purpose of bringing a claim on behalf of the company. This presents a problem for insurers who may wish to pursue a claim, on behalf of the company, against other tortfeasors or insurers, following the introduction of the 2010 Act.

The problem is of particular importance for mesothelioma claims where, because of section 3 of the Compensation Act 2006, a mesothelioma claimant can recover in full from a single tortfeasor (and now, under the 2010 Act, from that tortfeasor’s insurer). However, for the reason stated above, that insurer will not be able to bring a contribution claim against other tortfeasors/insurers in the name of the insured if the insured was dissolved more than 6 years ago. Nor will it be able to rely on the claimant having restored the company itself in order to bring its claim (since the insured no longer needs to do that).

One possible solution to this problem is to require a claimant, when entering into a settlement of its direct claim against the insurer under the 2010 Act, to assign to that insurer its direct right of action against any other insurers who may also be liable.

# Part six:

## Law reform in the consumer context

The process of insurance contract law reform has followed two paths, with law reform in the consumer context being addressed in the Consumer Insurance (Disclosure and Representations) Act 2012 (“CIDRA”). The position in relation to consumer insurance is summarised below.

CIDRA was the first act to come out of the Law Commissions review of Insurance Contract Law. It received royal assent on 8 March 2012 and it came into force on 6 April 2013. This one-year gap was intended to allow insurers time to adapt their internal procedures and to re-draft proposal forms, as appropriate.

Its passage through Parliament was quick because it was described as uncontroversial. It essentially codified the position adopted by the Financial Ombudsman Service (“FOS”). Most insurance-related cases go to the FOS (which has the advantage of being free, and is perceived to be more consumer-friendly than the courts). A claim to the FOS must be worth no more than GBP 150,000. A consumer can still go to court if they disagree with the FOS’s decision.

CIDRA only applies to consumer insurance contracts (ie contracts entered into by insureds who are individuals and for purposes which are wholly or mainly unrelated to their trade, business or profession). Small businesses are not dealt with.

It is not possible to contract out of CIDRA, insofar as any contract term purports to put the consumer into a worse position than he or she would be under the act. These are the main provisions in CIDRA:

1. Consumer insurance contracts are no longer contracts of utmost good faith and there is no requirement for the consumer to volunteer information to the insurer. Consumers cannot know what insurers want to know, or what they think is material.
2. Nevertheless, CIDRA provides that the consumer must take reasonable care when answering the insurer’s questions (or when choosing to volunteer information). There is no duty after the contract is entered into. There can be a breach of duty by failing to respond to a renewal letter asking if the previous particulars are still correct.
3. There are three types of remedy for misrepresentation:
  - a. If a consumer has taken reasonable care but has still made a misrepresentation, there can be no avoidance, and any claim must be paid (ie there is no remedy at all for the insurer)
  - b. If the consumer makes a careless misrepresentation, or the answer is misleadingly incomplete (but if the consumer clearly refuses to answer a question, and the insurer provides cover, then that is not a misrepresentation), the insurer’s remedy will be based on what it would have done had the consumer not breached its duty. This idea of a proportionate remedy was new at the time. It may result in the insurer being able to avoid the contract (with a return of premiums) or to impose different terms (which might exclude the loss event), or to reduce proportionately the payment to the consumer (because a higher premium would have been charged). A calculation for this reduction is set out in CIDRA. There is no need to show a causal connection
  - c. If the misrepresentation was deliberate or reckless, the insurer can avoid the contract. A “deliberate or reckless” misrepresentation is a misrepresentation made in circumstances where the consumer:
    - i. knew that the representation was untrue or misleading, or did not care whether or not it was untrue or misleading, and
    - ii. knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer



4. Furthermore, it is to be presumed, unless the contrary is shown (ie the consumer has the burden of proving):
  - a. that the consumer had the knowledge of a reasonable consumer, and
  - b. that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer
5. A representation made by a consumer in connection with a proposed consumer insurance contract (or in connection with a proposed variation to a consumer insurance contract) will not be capable of amounting to a warranty. As a result, the “basis of the contract” clause which commonly appears at the end of a proposal form must be deleted from consumer insurance contracts.
6. The act also provides rules for determining whether a broker (or other agent) is acting as the agent for the consumer or for the insurer. This is relevant because consumers could say that the broker never advised them to disclose, which could possibly lead to more broker claims.
7. Finally, the act makes provision for group insurance. Broadly, where a contract of insurance is entered into by a person (“A”) in order to provide cover for another person (“C”), and C is not a party to the contract, C’s disclosure and representations to the insurer will be treated as if they were made by a party to the contract.





# Aviation

## Part seven: The Act in focus - each class of business discussed

In the chapters that follow, the potential impact of the Act is assessed, with particular reference to each class of insurance business.

The Act is not entirely welcomed by the Aviation sector as it brings with it a degree of uncertainty and additional burdens for insurers. Whether the contracting out provisions will be used remains under active consideration and will be determined over the longer term.

### Fair presentation of the risk

For an insured to fulfil its duty of fair presentation, it must disclose all material information known to it or provide enough information to put a prudent insurer on notice that further enquiries are required. For example, in an aviation scenario, if an insured discloses that it is under investigation by the European Aviation Safety Authority (“EASA”), but does not state the nature of the investigation, it will arguably have fulfilled its duty of fair presentation because a prudent insurer would be on notice that, before writing the risk, further enquiries into that investigation should be made.

An insured will, under the Act, be regarded as knowing that which “should reasonably have been revealed by a reasonable search of information available to the insured”. Bearing this in mind, insurers may wish to indicate to the insured the minimum avenues of enquiry that it should pursue or recommend that it instructs a professional risk assessment analyst. In high-tech, high-value industries and those where there is a risk of loss of life, such as aviation, this may be a particularly sensible course for an insurer to take. However, in doing so insurers should be wary of either waiving the insured’s duty of fair presentation or too readily expanding the insured’s duty of enquiry, which could be regarded as contracting out of the Act (in which case the transparency requirements need to be met).

Aviation insurance policies, as with many commercial insurance policies, often contain multiple insureds within the same group. For example:

“Ruritania Airlines and/or Ruritania Maintenance Inc and/or Rurtania Catering Inc and/or their respective subsidiaries and/or associate and/or affiliated companies.”

In such a case, each insured is considered to be independent and therefore bears its own duty of fair presentation. However it is likely that even if information is only disclosed about the airline, and not the other insureds, the insurer will still be put on notice that it needs to make further enquiries.

The situation will be different where additional insureds can be added automatically. AVN 67B and 67C provide:

“The Contract Party(ies) included as Additional Insured(s).”

On the face of it, each additional insured should be under its own duty of fair presentation. However, policies frequently contain words to the effect that:

- i. finance/lease contracts subject to AVN 67B insured under the expiring policy are “automatically included” in the renewing policy, and
- ii. any new finance/lease contract subject to AVN 67B which are concluded during the currency of the policy in question are “automatically included” under that policy

When the term “automatic” or an equivalent is used, it is arguable that the insurer is thereby bound to accept the lease/finance contract and the contracting parties in question and, as a consequence, has effectively waived its underwriting discretion. Accordingly, in such scenarios, it is arguable that the contracting parties would have no duty of disclosure either under the existing law or the Act.

An insured does not have a duty to disclose facts which ought to be known to the insurer. An insurer will be taken to know something if it is known to one or more of the people participating in the underwriting decision. The knowledge of the insurer will include:

- i. information held by an employee or agent of the insurer that should have been passed on
- ii. information that is held by the insurer and is readily available to the people making the underwriting decision (for example: records of previous insurance for the insured in question)
- iii. things that are common knowledge (for example: battery defects on a particular type of aircraft), and
- iv. things that should have been picked up in the ordinary course of business (for example: the fact that Iran is subject to certain trade sanctions)

### Warranties and other policy terms

In relation to section 11 of the Act, an example from an aviation policy might be a warranty that a hangar has a fire suppressant system which is fully operational 24/7. Under the current law, if that warranty is broken, then the insurer has no liability for any losses even though a functional fire suppressant system would not have prevented a different type of loss, such as burglary. Under the Act, cover would be suspended, but the effect of section 11 would be that, on the face of it, if the loss is caused by a burglary the warranty would be of no effect.

“ In practice, courts may take a common sense approach to looking at exclusions.

Now take the example of a warranty that the hangar has a working burglar alarm. The warranty is breached, an intruder gains entry to the hangar and causes a fire, which is put out by the fire suppressant system but not before it causes a certain amount of damage. The warranty relating to the burglar alarm is not, on the face of it, directed at reducing the risk of a fire occurring: does the breach take the insurer off cover? The answer would appear to be yes. Compliance with the burglar alarm warranty would have reduced the risk of the loss that actually occurred in the circumstances in which it occurred. It would have reduced the risk of any sort of damage caused by intruders.

Whether this rule will apply to exclusions is unclear. On the face of it section 11 applies to all terms including exclusions. However, it might be argued that exclusions fall into the exception as a “term that defines the risk as a whole”. An exclusion does not in the strict sense place an obligation on an insured; rather, it places a limit on the extent of the insuring clause from the inception of cover. So an insured can never really be said to have either complied or not complied with an exclusion. Having said that, it is possible to argue that certain exclusions do tend to reduce the risk of loss. For example, it may be that the General Exclusion in AVN 1C/D, excluding cover when the aircraft is operated by an unauthorised pilot, will not exclude cover under the new law if the pilot was nevertheless fully qualified. In practice, courts may take a common sense approach to looking at exclusions so that if an exclusion does not explicitly state that it is directed at avoiding certain risks but that is its clear purpose then, in broad terms, an insurer will be off cover where the subject matter of the exclusion is relevant to the risk.

#### Contributors

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# Construction and engineering

The Act has the potential to have a significant effect on construction policies. It is not uncommon to take non-disclosure points in relation to such policies, and where insurers do so they will have to get to grips with, practically speaking, how to evidence the underwriting decision that would have been taken had there been no non-disclosure or misrepresentation, so that the new proportionate remedies are available to them.

## Fair presentation of the risk

One of the key changes in the Act is the new duty of fair presentation of the risk. The insured is required to disclose material circumstances which it knows or to give insurers sufficient information to put a prudent insurer on notice that it needs to make further enquiries. What an insured "knows" will include what should have been reasonably revealed by a search of information available to the insured. Both of these aspects of the Act have the potential to cause difficulties for a large construction insured. It is currently unclear what the extent of a reasonable search would be, but it would appear to be drawn very widely and to include agents. Therefore, it may be necessary for an insured to seek information, for example, from architects or engineers who are not employees of the insured.

There is a presumption that insurers know what an insurer in that class of insurance would know and so there is no need to disclose that in the absence of an express question. The potential here is for insurers and insureds to agree what should generally be disclosed as part of a fair presentation. However, it may often be difficult for such information to be agreed, given the nature of large construction companies which often have an international aspect. For example, a Contractors All Risk ("CAR") policy could perhaps require disclosure of all large construction contracts in the last five years in order that insurers can assess the good standing of sub-contractors, the likelihood of claims and potential for subrogated recovery. This information may be needed in order for the insurer to fully assess the risk and the level at which to set the premium. This could mean that a large insured may need to disclose contracts undertaken by subsidiaries, the level of fees paid to sub-contractors and sub-consultants and any contractual limitations of liability agreed with designers, which is a tall order for a large insured.

In addition, as the Act seeks to avoid "data dumping" of disclosure in favour of clear and accessible disclosure which may place a heavy burden on a company that has a large amount of low value claims or that has many subsidiaries that have a large amount of low value claims. Further, if the company obtains annual cover on behalf of itself and its subsidiaries, this may also result in a lot of information to be collated and organised.

Typically insureds and their brokers simply refer underwriters to their website for information. This will no longer be sufficient.

## Proportionate remedies

The application of the new regime of proportionate remedies can be demonstrated by the recent case of *Brit v F&B Trenchless Solutions* (in which Clyde & Co acted for the successful insurers, Brit), which was, of course, decided before the Act. The facts of the case are, briefly, that the insurer avoided a contractors' combined liability policy that it had entered into with FBTS on 19 August 2013. FBTS was a specialist tunnelling contractor constructing micro-tunnels. Between June and 9 July 2013, FBTS carried out work to install a micro-tunnel beneath a railway and level crossing at Stoke Lane, Gedling. On 27 August 2013 a freight train derailed when passing over the level crossing, the cause of which was severe settlement due to a void in the ground underneath. FBTS faced a claim of GBP 2.67 million in respect of remedial works carried out and potential further claims that it sought cover for under the policy.

Insurers sought to avoid the policy on the basis that FBTS failed to disclose material information prior to policy inception regarding substantial and progressive earth settlement at the site and the existence of a void which had occurred. FBTS challenged the insurers' position and insurers sought a declaration that the policy had been validly avoided.

The High Court found in favour of the insurers, holding that there had been material non-disclosure by FBTS which had induced the insurers to write the risk on the terms that it did. The underwriter gave evidence that had he been told about the settlement he would have excluded the site from the policy and asked FBTS what it intended to do to prevent any similar issues arising in the future.

Insurers also sought to avoid on a separate ground that FBTS made a misrepresentation prior to conclusion of the policy that it did not carry out, and would not in the future carry out, tunnelling works on railways that were active. The Court also found that there had been material misrepresentation which had induced the underwriter. The underwriter's evidence was that tunnelling under active railway lines would have attracted a higher excess or premium, as it creates a more hazardous risk and that more questions

would have been asked. The Court again found in favour of the insurer that there had been a material misrepresentation. Therefore the policy had been validly avoided.

Had the Act applied then the position would have been different as regards the remedies that would have applied. Applying the Act to the findings of the Court, it appears likely that the policy would have remained in existence. However, the derailment claim would not have been covered as the policy would have been varied so that there was an exclusion in respect of the Stoke Lane site (assuming, of course, that the underwriter was satisfied with the insured's answers to questions as to what they might do to avoid such issues in the future). This would mean that any other hypothetical claims made under the policy would be covered.

“ It will now be more important than ever to keep records of matters relevant to the underwriting decision, answers to questions from the insured, method for calculating the premium and so forth.

In addition, if it were not for the misrepresentation regarding tunnelling under active railway lines then insurers would have charged a higher premium and, therefore, cover for any other claims under the policy would be reduced proportionately.

Obviously, in these circumstances, the court would have needed to consider further evidence in order to make a finding in respect of these issues such as: the questions that might have been asked by the insurer; the response given; the likely outcome of any discussions; and the exact amount of excess and premium that would have been charged.

As can be seen from the illustration above, and in common with other business lines, the courts will have to reach a more nuanced conclusion under the Act than presently. As avoidance is now only a remedy for deliberate or reckless non-disclosure or in circumstances where the insurer would not have entered into the contract at all on any terms if it had been given a fair presentation, the court would need strong evidence to conclude that the policy should be avoided.

In these circumstances the evidence that insurers can present will be key. It is not uncommon in relation to construction insurance for insurers to not have necessarily made full notes in relation to an underwriting decision. It will now be more important than ever to keep records of matters relevant to the underwriting decision, answers to questions from the insured, method for calculating the premium and so forth.

## Warranties and other policy terms

Basis of contract clauses are not common in construction policies and so the prohibition on including such clauses is unlikely to be of much effect.

Warranties are sometimes included, for example, in relation to hot works. The Act means that such warranties will now be suspensory, rather than acting as a once and for all breach. For example, if time periods for regular fire safety checks are no longer complied with, then insurers will come back on cover if a check is carried out late.

Of course, section 11 of the Act would also apply to such warranties so that the insurer will not be able to rely on the non-compliance with the warranty in defence of a claim where the insured can show the non-compliance could not have increased the loss that occurred in the circumstances in which it occurred.

## Third Parties (Rights Against Insurers) Act 2010

In recent years, we have seen a number of small to medium construction companies involved in losses occurring on construction sites; often thereafter entering into administration or liquidation as a result of economic pressures. Given that the loss is often caused by subcontractors down the contractual chain, it has been very important for our insurer clients to first indemnify the loss above (ie the employer) and thereafter see whether a recovery can be made against the relevant subcontractor in due course. However, whether it is worth pursuing such claims in the first place will often depend on whether the subcontractor has any valid liability insurance in place.

The enactment of the 2010 Act will certainly assist CAR and liability insurers in this area by effectively removing all the red tape required to pursue liability insurers of insolvent companies. Claims will now be able to be made directly against the liability insurer and the right of the insolvent insured will be automatically transferred to the third party claimant when the insured enters into a formal insolvency process. Most importantly, insurers will be able to assess the risks of pursuing a recovery at an early stage given the new rights to obtain insurance information at the outset of any claim.

### Contributors

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A significant proportion of energy insurance policies placed in the London market are not subject to English law, given the global nature of the energy market. Accordingly, the provisions of the Act will not apply to the majority of such policies

### **Fair presentation of the risk**

Unlike some other lines of business, there is a huge amount of pre-risk information available in the energy market. Of particular importance in the energy insurance sector will be the degree to which insurers will be deemed to know something held on a database or written about in the trade press. The Act provides that an insurer is deemed to know relevant information if it is “held by the insurer and is readily available” to the particular underwriter.

Loss databases, such as the Willis energy loss database, are commonly relied upon by energy underwriters. In the pre-Act case of *Sea Glory Maritime v Al Sagr* [2013], the insured argued that even though certain information was not disclosed, it was available online and it was market practice for insurers to check that information. Reference was made to an established principle that there is no presumption of knowledge of the facts concerning particular ships merely on the ground that they have been published in the Lloyd’s List. However, the Court said that electronic databases should not be treated as equivalent to information in hard copy, such as newspapers: “an underwriter does not have to carry the information in an electronic database in his head. On-line information is available to be called up when required”. However, the judge agreed that the fact that information is available to an underwriter online does not necessarily give rise to a presumption of knowledge. Each case will turn on its particular facts.

“Of particular importance will be the degree to which insurers will be deemed to know something held on a database or written about in the trade press.

The Act also provides that insurers are deemed to know “things which an insurer offering insurance of the class in question to the insureds in the field of activity in question would reasonably be expected to know in the ordinary course of business”. In the upstream energy field, not only are details of losses available in the trade press, many large losses are reported in the national press too, and hence it might be difficult for insurers to deny knowledge of certain risks and losses.

For insureds, too, the Act could present challenges. For example, a risk manager of a global operator may not be given material information held by a local division overseas on a timely basis, and hence the risk of non-disclosure (albeit, not deliberately) could be hard to avoid for an insured.

In terms of proving the proportionate remedies, our experience is that energy underwriters already currently follow the practice of keeping details of risks that have been rejected, which will help support a future argument that a particular risk would not have been written at all had material information been disclosed. For commercial reasons, though, non-disclosure arguments tend not to be run in the current market.

### Warranties and other policy terms

Energy insurers have already adopted (some time ago) many of the reforms now being brought in by the Act. For example, in the important area of pre-risk surveys, the commonly used Joint Rig Committee Marine Warranty Survey wording provides that underwriters will not be liable for any loss “arising from or contributed to” by any breach of requirements issued by the Marine Warranty Surveyor. Thus, energy underwriters who adopt this form have already made it clear that a causative link is required between the breach of a warranty or non-compliance with the surveyor’s requirements and a loss to be established in order to decline a claim. Similarly, the Drilling Wells Reviews wording specifies the reviews which must be carried out in order to establish cover and, here again, there is a requirement for a link between a loss and a breach. Such wordings will therefore be Insurance Act-compliant, once the Act comes into force.

Although the Act does not remove the ability to use warranties, energy underwriters are reviewing other commonly used wordings to ensure that the warranty language used fulfils the function which they are intended to.

“ Until the courts consider the point in detail, uncertainty will remain as to how long insurers can take to investigate and settle a claim.

### Damages for late payment

The introduction of damages for late payment in the Act will be of concern to energy underwriters. Claims are often very complex in nature, the physical evidence is often not readily available for inspection and it can take a considerable amount of time to investigate and adjust a claim. Although the Act provides that the definition of a reasonable amount of time will depend (amongst other things) on the size and complexity of a claim and factors outside the insurer’s control, until the courts consider the point in detail, uncertainty will remain as to how long insurers can take to investigate and settle a claim. The concern is that, as a result and as is common in some other jurisdictions, almost every claim relating to an energy loss will now include a speculative claim for damages for late payment.

**Contributor**  
**Tim Taylor**

# Financial Institutions and D&O

Whilst FI and D&O claims and underwriting specialists need to get to grips with the changes brought in by the Act, its effect on this market is unlikely to be seismic. Existing market practices and the common inclusion of innocent non-disclosure clauses and non-attribution clauses mean that some of the changes introduced by the Act will either not require a change of approach or will have a diminished impact.

In addition, to the extent that the Act introduces uncertainty, this is likely to be mitigated by broking practice and express provisions in the relevant policies. However, there are still issues to consider, including whether to adopt the sliding scale of remedies for innocent/negligent non-disclosure, the challenges the Act brings for cover placed in the subscription market and in multi-layer programmes, and whether to contract out where this is permitted under the Act, bearing in mind the dynamics of the current soft market, where wordings are often broker driven.

“ Existing market practices and the common inclusion of innocent non-disclosure clauses and non-attribution clauses mean that some of the changes introduced by the Act will either not require a change of approach or will have a diminished impact.

## Application of the Act

The Act is predominantly concerned with what is termed non-consumer insurance contracts, the defining factor being whether the contract of insurance is taken out by an individual who enters into the contract wholly or mainly for purposes unrelated to the individual's trade, business or profession (the definition appears in the Consumer Insurance (Disclosure and Representations) Act 2012). For insurance policies which cover both private and some business use, one must look at the main purpose of the insurance to classify whether it falls under the consumer regime or the business regime. Although most FI policies will clearly be business insurance and fall under the Act, it will nonetheless be necessary to consider the position in respect of D&O cover. Generally speaking, D&O insurance will fall under the Act, but, as illustrated by the High Court's 2014 decision in *Bluefin v FOS*, it is possible that some insureds under a D&O policy will have an interest which does not derive from their trade, business or profession (for example, spouses). The practical impact of the distinction relates to the ability of the parties to contract out of certain provisions in the Act. Given generally soft market conditions, it is unlikely that the Insurers could impose tougher terms.

## Fair presentation of the risk

The Act introduces a slightly lower threshold for disclosure; the insured can satisfy the duty if it provides “sufficient information” to put a prudent insurer on notice that it needs to make further enquiries. So for example, if a financial institution discloses (in response to a request to give full details of any investigations into its activities) that it is under investigation by the FCA without more details, this might be sufficient to satisfy the duty of disclosure. Insurers who fail to ask questions do so at their own peril.

One practical point is the use in the Act of the term “material circumstance” in section 4 (a). In industry usage, “circumstance” refers to a situation which may lead to a claim; however in the Act, it will likely bear a broader meaning, akin to “fact”.

An insured is only required to disclose what it knows or ought to know. In the context of an entity, and of particular interest in the D&O market, the relevant test under the Act is what is known by “senior management”. This is likely to extend beyond the board of directors, especially for larger companies. The provisions are not that distinct from the principles of corporate attribution developed at common law although it is possible that the court will interpret “senior management” more restrictively to the common law tests of attribution, which focussed on the context to determine directing mind and will. Insurers may wish to consider the scope of any current wordings which specify the knowledge of who in the senior management will be imputed to the insured organisation.

The Act puts centre stage the question of what amounts to a “reasonable search” by the insured. In the FI market, as with others, issues of resources for smaller companies and oversight of global operations for larger entities are considerations. There is a potential for what is required in practice to become more onerous than current practice. We would expect to see, and in fact already do see, some insurers already prescribing to some extent what they consider to be a “reasonable search”. It will be interesting to see how this language develops in light of the Act. We do not think this will amount to contracting out of the Act unless the terms imposed are particularly onerous. There is also potential for more emphasis to be put upon detailed



proposal forms. Concurrently, Insurers will have to carefully review information provided to identify questions that ought to be asked, connected with the second limb.

Processes will also need to be tested to ensure that readily available information, including from the claims function, is available to underwriters, given the knowledge test applying to insurers under the Act.

### Proportionate remedies

As in other sophisticated and complex markets, the range of proportionate remedies for negligent and innocent non-disclosure which are based around subjective inducement ie what the underwriter in question would have done, present some challenges for FI and D&O insurers. The subscription market in place for FI policies also raises questions about what inducement needs to be shown by the following market, and the discussion in this area will be of relevance to FI and D&O policies, as is the analysis in relation to premium reduction and claims control issues. Reliance by co-insurers upon lead investigation may not be sufficient.

Proportionate remedies, common in civil law jurisdictions, are often difficult in application due to differing expert opinion as well as market conditions. Furthermore, many policies in common law jurisdictions have already incorporated some version of these remedies as a more commercially palatable alternative to rescission. The lack of case law on their application suggests they are little used.

### Warranties and other policy terms

Basis of contract clauses sometimes appear in FI and D&O wordings, often as a legacy issue, and there is a housekeeping exercise for the market here as these clauses will no longer be permitted. There may be ways around this provision of the Act if the truth of a particular representation is especially important, such as making the truth of the representation a condition precedent to liability or a warranty. These are still permitted in policies, although the effect of them is not certain given Section 11. The application of Section 11 of the Act is likely to raise a number of issues. It may be in certain cases that insurers will want to spell out the consequences of breaches of certain provisions to avoid some of these problems.

Warranties are not common in FI and D&O policies so this aspect is of limited relevance.

### Damages for late payment

Whilst the potential for damages for late payment may not be as much of an issue as in other areas (such as property) as large Financial Institutions are likely to be able to better manage their flow of capital, the late payment provisions may be a factor in the commercial D&O sector. However, most policies already contain contractual obligations to advance costs: in theory, failure by insurers to comply with such contractual provisions already permit claims for interest. The issues common to many complex risks placed in large programmes apply equally to FI claims, and any disputes between layers within a programme or as between lead and following market over questions of inducement or reduction of premium are unlikely to be regarded as extending the reasonable time to pay a claim, as are other common disputes between layers in FI programmes, such as how to apply a shaving of limits.

Whilst experience from other jurisdictions has shown that claims for late payment damages are not common in relation to complex risks, the potential for the insured to use the threat of such proceedings in negotiations is a real one.

In summary, the Act brings a number of opportunities and challenges for this market, and presents an fresh opportunity to look at best practice in areas where the market does not work so well such as in relation to disputes between layers. It is also important to remember that the Act only reflects part of the picture leaving common areas for dispute such as, aggregation, notification and the application of specific exclusions and triggers largely unaffected.

#### Contributors

James Cooper

Laura Cooke

# Marine



Non-disclosure points are rarely taken and basis of contract clauses are not generally used so some of the changes brought in by the Act may have a limited impact on this sector.

## Fair presentation of the risk

The duty of utmost good faith under current law, specifically the pre-contractual duty on an insured to disclose all material circumstances and not to make material misrepresentations – for which the remedy if broken is a right of avoidance ab initio on insurers' part – is replaced by a duty to make a fair presentation of the risk. The Act will bring in a new regime of proportionate remedies for breach of the duty of fair presentation instead of the current “all or nothing” avoidance remedy.

An example of how the Act might impact is provided by the recent High Court judgment in *Involnert Management Inc v Aprilgrange Limited* [2015]. A yacht was insured for EUR 13 million. Following a fire, the insured made a claim under the Policy, which insurers rejected on, inter alia, non-disclosure grounds. The insured had failed to advise insurers that (a) it had obtained a professional valuation, which valued the yacht at EUR 7 million and that (b) the yacht had been advertised for sale at an EUR 8 million asking price. The judge held that insurers were entitled to avoid the Policy on non-disclosure grounds, as a result of which insurers were able to avoid liability altogether.

The judge found that the non-disclosure was an accidental rather than deliberate non-disclosure. Under the Act and the proportionate remedy scheme, it would be for insurers to demonstrate what they would have done had a fair presentation of the risk been made. This creates an evidential burden for insurers – how, in practical terms, do insurers demonstrate what they would have done had they been given the full picture? On the facts of *Involnert* the probability is that the insurers would have been prepared to provide cover for a EUR 8 million insured value. As the judge commented “the just result in these circumstances would be to treat the insurance as valid in a reduced amount of EUR 8 million”.

At present insurers do not often seek to rely on a non-disclosure defence in part because the remedy of avoidance is so draconian. It remains to be seen whether with the more nuanced proportionate remedies provided for by the Act insurers may be more prepared to rely on insureds' breaches of the duty of fair presentation.

## Warranties and other policy terms

With warranties becoming suspensory under the Act, an insurer has no liability for a loss occurring or attributable to something happening after a breach of warranty but before the breach has been remedied.

The Act provides in identical terms to Section 34 of the Marine Insurance Act 1906 that compliance with a warranty is excused if: it ceases to be applicable due to a change of circumstances, compliance is rendered unlawful by any subsequent law, or the insurer waives the breach. In practice, waiver is by far the most important of these rules.

Section 11 of the Act provides that an insurer may not rely on a risk mitigation term (ie one that tends to reduce the risk of loss of a particular kind, at a particular location or at a particular time) if the insured can show the breach “could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred”.

Section 11 does not apply to a term “defining the risk as a whole”. That phrase is not defined in the Act. However, in the Explanatory Notes that accompanied the Insurance Bill that became the Act, an example of a term defining the risk as a whole is given as a “requirement that a property or vehicle is not to be used commercially”.

In a marine context, the judgment of the Hong Kong Court of Final Appeal in the *Ho Feng* No. 7 [2014] provides a useful example of how this phrase in the Act might apply. Hong Kong law in respect of warranties is based on current English law as contained in the Marine Insurance Act 1906.

Insurers provided a cargo policy to their cargo insured. The Policy provided “warranted vessel’s deadweight not less than 10,000 M/T”. There was a shipment of logs from Malaysia to China. The vessel sank in poor weather with total loss of cargo. Insurers relied upon a breach of the deadweight warranty – the vessel’s deadweight was less than 10,000 M/T. It is not evident from the Court of Final Appeal or lower court judgments that the breach of warranty had any causative effect, ie the vessel might well have sunk had she complied with the warranty and even if her deadweight had been 10,000 M/T or more. Insurers succeeded in their argument that they were off risk from the date of breach of warranty and so had no liability for the loss.

In a similar case under the Act, one can foresee an insured arguing that Section 11 applies and that in the absence of any clear evidence of a causative effect between the breach of the warranty and the loss itself, the insured should be

able to recover under the Policy. The contrary argument from an insurer’s perspective would be that the deadweight warranty “defines the risk as a whole” and so Section 11 does not apply – so as to allow insurers to rely upon the breach as a complete defence to the claim.

Another obvious example in a hull context is the “Class and Class maintained” warranty that one regularly sees. Again, one can anticipate arguments by insurers that this sort of warranty “defines the risk as a whole” ie insurers are only prepared to provide insurance on the basis that a vessel is Class and Class maintained. If, therefore, a vessel sinks whilst the insured is in breach, then insurers may well argue that they are not liable for the loss without having to prove that the loss was caused by or contributed to by the breach.

## Contracting out

The Act bans basis of contract clauses; clauses that convert pre-contractual representations of the insured into warranties. It is not possible to contract out of this prohibition. This provision has little relevance to marine insurance where basis of contract clauses are not generally used and where any “information” is commonly marked “information not limited or warranted”.

“ International Group P&I Clubs trading under English law have already indicated their clear intention to contract out of significant parts of the Act.

In non-consumer contracts the parties may generally contract out of the Act subject to the Act’s specific requirements. International Group P&I Clubs trading under English law have already indicated their clear intention to contract out of significant parts of the Act. How widespread contracting out will be in other commercial contexts at a time when the market is soft remains to be seen and, at the time of writing, there appears to be a “wait and see” approach being adopted.

### Contributor

Mike Roderick

# Medical malpractice

The Act is unlikely to make a fundamental practical difference to how insurers operate in this area. Proposal forms, already quite detailed, may become lengthier and more time-consuming and potentially more non-disclosure points will be taken in future, given the availability of proportionate remedies.

## Fair presentation of the risk

Insurers do not commonly seek to avoid a policy for non-disclosure given that insurers often tend to approach the decision from a commercial viewpoint, assessing the importance of the ongoing relationship, unless the loss is very large or the relationship has already deteriorated. Given the changes to remedies for non-disclosure, providing for proportionate remedies, it may well be the case that insurers take more of these points in future.

It would be prudent, therefore, for insurers to examine proposal forms and underwriting guidelines in order to ensure that the appropriate information is gathered to fully appreciate the risk being written. In addition, more time is likely to be required for the renewal process and insurers are likely to be more reliant on management information from advisers as a result. This is an industry where good data is key and where insurers are already proactively seeking out information to fully understand the risks they are writing. However, we envisage that even more information will be forthcoming as a result of the Act and that presents challenges as set out below.

From a practical point of view, information is most commonly presented by insureds in this sector via proposal forms and insurers are already used to sending out detailed forms. This is in addition to information gathered by insurers from the NHS Litigation Authority's data (and occasionally US data) on claims to try and predict trends and high risk areas and reviews of claims history and bordereaux.

However, as the insured can, under the Act, positively discharge its duty of disclosure by putting the insurer on notice that it needs to make enquiries on a matter, we consider that it is likely that proposal forms will get even longer. This could present an issue to insurers looking to underwrite novel/risky areas of medicine/healthcare due to the level of knowledge required to fully understand the risk. Whilst data dumping will be prohibited under the Act, given the level of knowledge required for this area, it may be difficult for insurers to process the increase in information and to identify if there are any gaps.

It is common for insurers to already have in place underwriting guidelines and premium manuals and they are, on the whole, followed. However, there is a disparity between content, with some insurers producing very detailed guidelines and others producing very basic guidelines. Insurers would do well to ensure that guidelines are in place to accurately reflect their intention when writing a risk, which may assist in any subsequent litigation. However, it is very important that insurers get the content right; if the guidelines are too prescriptive then the courts may just follow them to the letter which may not support the position taken on a particular case. This may be a difficult task to achieve in this sector where there are complex and novel risks being written.

“ Good data is key and where insurers are already proactively seeking out information to fully understand the risks they are writing.

Further, insureds will be required to undertake a reasonable search for information which could cause resourcing issues for the not for profit/charitable insureds that operate in this sector. We consider that it would be a good selling point for insurers to agree with insureds, in advance, guidelines for a reasonable search in order to make themselves more attractive to insureds/brokers. This is important in a sector where there are an increasing number of insurers writing the business and therefore a lot of competition and pressure on price. However, insurers should consider carefully how any of their rights are being limited by defining the scope of the search and that the way the scope is defined is not wider than what the Act provides for.

## Warranties and other policy terms

The changes made by the Act to warranties are unlikely to have much of an impact on this sector as insurers are often prepared to waive their rights in order to preserve the commercial relationship ie by not relying on warranties contained in the policy. However, as the remedy for a breach of a warranty is now suspensory in nature, it may be the case that insurers seek to rely on warranties more in the future.

Section 11 of the Act provides that where there is non-compliance with such a term, insurers will not be able to rely on that non-compliance as a coverage defence where the insured is able to show that such non-compliance with the term “could not potentially have increased the risk of the loss which actually occurred in the circumstances in which it occurred”.

Whilst the burden of proof is upon the insured in this respect, we foresee that insurers could face a large expense obtaining, for example, counter expert evidence exploring whether the breach by the insured made any difference in claims involving complicated medical causation issues.

In addition, it is worth noting that most coverage issues on medical malpractice policies relate to notification or interpretation of the policy, especially exclusion clauses. Whilst section 11 is not intended to extend to notification clauses, the Law Commissions July 2014 explanatory report did state that this section could apply to exclusion clauses. As such, insurers will need to consider carefully how the terms of the policy are formed and set out clearly the requirement and consequence for non-compliance.

### Contributors

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Erika Rainger



# Mining, industrials and power

Practical changes in the areas of mining, industrials and power insurance will be less noticeable than in other sectors. In these sectors, most of the Act's changes have been best practice for many years. Moreover, given the technical and high-value risks written, sufficient information is gathered and exchanged to make disputes over good faith rare.

## Fair presentation of the risk

The underwriting process for the mining, power and industrial sectors entails detailed investigations by the insurers as well as the presentation of information by the insured. Traditional proposal forms are not as heavily relied on as a result, but, rather, detailed engineering and technical reports are provided – including risk-mapping information, seismic data etc and calculations of potential loss scenarios.

Insurers often send their own engineers and, in the case of mining, geologists, to undertake risk assessment of projects, conduct on-site surveys and highlight required risk-mitigation measures. Continued site-visits to projects by insurers are a common occurrence, especially in the run-up to policy renewal. The insurer's investigations take some time and are as detailed as one would expect for complex engineering projects. Given this, avoidance for non-disclosure is infrequent.

One must also appreciate the commercial difficulty of avoiding mining, power or industrial policies for non-disclosure where risks are often financially significant and may be on a worldwide basis. Equally, because of the background summarised above many policies contain non-vitiating clauses in any event which water down the default position at law.

Accordingly, as a result of the introduction of proportionate remedies for non-disclosure, it may become more commercially acceptable and legally easier for insurers to exercise rights. Nevertheless, this may still be difficult giving the investigations referred to above. Indeed, in these sectors, disputes more often centre on policy exclusions and these are unaffected by the Act.

In conclusion, investigations by insurers and the commercial reality of the market therefore mean the Act's modification of the duty of good faith are unlikely to significantly impact these lines.

Nor does it seem the Act's "reasonable search" requirement will greatly affect mining, power and industrial insurance.

New projects will have comprehensive plans, projections and further documentation. Insurers will know that any contracts will be based on exhaustive negotiations. If there is anything worth knowing, it is likely the insurers will have seen it.

Once in operation, mines, power and industrial projects generate a slew of data. Amongst other things daily inspections, hourly reports and site-visits again suggest that anything worth knowing will be presented to the insurers.

Given this, it would be difficult to advance an argument that knowledge could have been uncovered by an insured's "reasonable search". A detailed search most likely occurred, and its finding most likely transmitted to the insurer.

“ One must also appreciate the commercial difficulty of avoiding mining, power or industrial policies for non-disclosure where risks are often financially significant and may be on a worldwide basis.

## Warranties

Warranties are often not contained in policies or, where they are, are not relied on by insurers. This is often for commercial reasons so the changes brought in by the Act will have very little effect.

## Damages for late payment

Claims are dealt with quickly and expeditiously given the total premiums these sectors generate – insurers could not afford to delay payment. In mining especially, there simply are not many companies who undertake mining globally. Therefore, insurers are keen to maintain a good relationship with their insureds by not delaying payment of claims. This is not to say that both parties do not allow for careful, often lengthy, investigation of a claim but given the complexity of the losses this would likely fall within the “reasonable time” requirement of the Act.

## Contracting out

Whilst no major legislative change will ever result in business as usual, it is submitted that the impacts of the Act will only be lightly felt in mining, power and industrial insurance. For these reasons, it would be surprising if insurers sought to opt-out of any of the Act’s provisions.

### Contributor

Lee Bacon



# Personal injury





The effect of the Act on this sector will be similar to other categories of liability insurance but with less immediate impact for the reasons set out below. However, the use of fraud clause wordings may need to be examined.

### Fair presentation of the risk

Personal injury policies are unlikely to be affected in any major way by the changes in the duties of disclosure and the introduction of proportionate remedies. Most casualty insurers, influenced by their personal lines and SME books, already apply the Financial Ombudsman Service ("FOS") principles across the board. Those who already apply the FOS principles will therefore notice no material change.

### Warranties and other policy terms

All warranties will now become "suspensive conditions", meaning that an insured is capable of remedying a breach and cover will continue thereafter. However, warranties and condition precedents are less widely used in casualty and healthcare policies than, for example, in property and business interruption covers. In compulsory insurance situations (motor and employers' liability) they are largely ineffective. In addition, the use of basis of contract clauses is not common in casualty policies.

For claims under the FOS jurisdiction, even if warranties are to be found in a policy, the ombudsman is unlikely to permit an insurer to rely on them.

As a result of the above, again, the effect of the Act will not be greatly felt.

“ For claims under the FOS jurisdiction, even if warranties are to be found in a policy, the ombudsman is unlikely to permit an insurer to rely on them.

### Fraudulent claims

Many casualty insurers employ broad "fraud clause" wordings, which arguably go beyond the remedies prescribed for by the Act. For example, in fraudulent claims, insurers may wish to seek to avoid the policy from the outset (as was the position under the Marine Insurance Act) which would result in the insurer having to return any payments made on genuine claims that had been made before the fraudulent claim. The position under the Act allows the insurers to avoid the policy from the date of the fraudulent act only and is therefore considered to be fairer to insureds.

“ It will be important for insurers to consider their fraud clause wordings, and if they wish to preserve contractual remedies which are broader than those prescribed by the Act, then they will need to bring that to the specific attention of insureds.

Insurers must therefore consider whether they wish to maintain the status quo and contract out. It will be important for insurers to consider their fraud clause wordings, and if they wish to preserve contractual remedies which are broader than those prescribed by the Act, then they will need to bring that to the specific attention of insureds at the inception of the policy. This is likely to be particularly relevant to commercial policies, where the previous robust fraud conditions will still be required to protect the insurer.

#### Contributors

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Danielle Singer

# Product liability and product recall

## Product liability

Some of the key areas addressed by the Act will not be of huge significance to product liability policies. For example, the use of basis of contract clauses, which will be prohibited by the Act, are not common in product liability policies in any event. Use of warranties is also not common. Many of the issues relevant to product liability, such as those relating to a reasonable search, insurers' knowledge and so forth are common to a number of business lines.

## Proportionate remedies

Although some product liability policies do contain non- invalidation clauses to restrict insurers' rights under the current law, subject to this, it is not uncommon for insurers to take non-disclosure points. A common scenario is where, during the course of the policy, the product manufacturer finds itself embroiled in litigation, often in the US, and the documents will show that it had known of the issue prior to policy inception. Whilst at present insurers may be seeking to avoid the policy, under the Act it will be a question of looking at the evidence as to what the underwriter would have done had they known of the issue. It may be that an exclusion would have been imposed in relation to the particular issue, in which case the policy will be treated as if it contained that exclusion. Or it may be a greater premium would have been charged, in which case any claims under the policy would be proportionately reduced.

## Policy terms

The interpretation of section 11 and its application to particular circumstances has the potential to cause uncertainties.

An example from the product liability field is in relation to the reasonable precautions clause commonly included in policies. This typically provides that the insured will take all reasonable precautions to prevent any occurrence/ loss/damage which may give rise to liability under the insurance and to prevent the sale and supply of goods that are defective. This clause will only exclude cover where the insured acts recklessly, rather than negligently. Previously, if the term was expressed as a condition precedent to liability it would not be necessary for it to be shown that there was any link between the recklessness and the claim being made under the policy for cover to be refused.

Pursuant to section 11 it will now be a defence for the insured to show that compliance with this term could not have increased the risk of loss which occurred in the circumstances in which it occurred. Although the Law Commissions did not intend section 11 to require a causal analysis, it seems likely that it will be necessary to carry out detailed factual enquiries and to consider issues of causation in this area.

## Product recall and contamination

Specialty product recall or contaminated products policies could see few, but significant, changes as a result of the Act.

“ The interpretation of section 11 and its application to particular circumstances has the potential to cause uncertainties. An example from the product liability field is in relation to the reasonable precautions clause commonly included in policies.

## Fair presentation of the risk

There is also potential for impact on the approach to disclosure, and related remedies. Regarding the requirement for a “reasonable search”, insurers may pay more attention to certain recurring loss themes, such as supply chain and manufacturing issues, and the extent to which senior management and insurance personnel should be aware of such issues. As with all business lines, the new approach to remedies will see an element of new focus on certain aspects of underwriting evidence, for example relating to the premium that would have been charged had the risk been fairly presented.

## Warranties and other policy terms

Basis of contract clauses are rare, as are warranties, other than those regarding payment of premium.

Risk mitigation terms in these policies are generally limited to provisions requiring “due diligence” or “reasonable precautions”, typically in manufacturing procedures. Often these are conditions precedent to insurers’ liability. Section 11 of the Act will change the position concerning conditions precedent, in that insurers will no longer be entitled to deny cover for breach if the insured demonstrates that non-compliance could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred. It remains to be seen whether there is any contracting-out of the Act in this respect and, if there is not, how the new provisions will be applied on a case-by-case basis.

### Contributors

Neil Beresford

Jason Mcnerlin



# Professional indemnity

The Act is likely to be of lesser impact in relation to professional indemnity insurance than in some other lines of business. In relation to the regulated professions, the existence of minimum mandatory terms and conditions of insurance already circumscribes the extent to which insurers can utilise remedies available under the current law of insurance.

Outside the regulated professions, good market practice has already addressed a number of the key changes introduced by the Act. For example, it has been common for some time to expressly limit insurers' remedies in relation to innocent non-disclosure within the operative policy wording, even where this is not required by a relevant regulatory regime.

There are also a number of aspects of the Act that are unlikely to have a major impact on professional indemnity policies. For example, warranties and basis of contract clauses are not common in professional indemnity policies. Although we sometimes come across the latter, they tend to be historic and not enforced in practice.

Many of the points in our Analysis and Financial Institutions and D&O sections, particularly those relating to issues arising on large programmes, tensions between layers, the evidential issues involved in applying proportionate remedies and the questions around the precise scope and operation of section 11 of the Act, apply also to professional indemnity covers and should be read in conjunction with this section of our report. In addition, many of the points raised in the Construction Liability section of our report in relation to fair presentation of the risk, will also equally apply to construction professional indemnity policies.

We do not consider here any issues arising under Broker's E&O as a result of failures under the Act as this is beyond the scope of the report.

“ In relation to the regulated professions, the existence of minimum mandatory terms and conditions of insurance already circumscribes the extent to which insurers can utilise remedies available under the current law of insurance.

## Minimum terms

Minimum terms of insurance are imposed in relation to a number of professions, most notably by the Solicitors Regulation Authority (SRA), the Royal Institute of Chartered Surveyors (RICS) and the Institute of Chartered Accountants of England & Wales (ICAEW). Where minimum terms apply, avoidance for non-disclosure has long been unavailable (either at all, in the case of solicitors, or absent fraud/intent to deceive or mislead in the case of accountants and surveyors).

The SRA has recently issued a consultation document seeking views on its proposed changes to the minimum terms to bring it into line with the Act. In short, it confirms that the minimum terms will not import the new proportionate remedies and the relevance will go instead to the operation of the insured reimbursement provisions (to ensure that clients remain protected where firms have breached a term or condition of the policy). In addition, the SRA proposes to make necessary consequential changes to the language used in clause 4.1 (the no avoidance or repudiation section) and clause 7.2 (reimbursement) to replace references to “non-disclosure” with “failure to make a fair presentation of the risk”. Finally, it proposes to adopt the non-consumer standard of non-disclosure on the basis that the contract between a firm and its insurer is a non-consumer contract; participating insurers are entitled to expect firms to meet a high standard when presenting the risk if they are unable to avoid cover; and the proposal will have a neutral impact on the overall level of consumer protection given that the only issue is the point at which the insurer's rights of reimbursement against the firm are triggered. It is worth noting that the SRA has mooted several times in recent years other potential amendments to its minimum terms, most recently, prior to the current consultation, in a discussion paper of July 2015 in which it consulted on removing restrictions on avoidance or repudiation in certain circumstances. These have not been included in the February 2016 consultation paper.

In our experience, insurers outside the MTC are already following the proportionate response now enshrined in the Act. For example, insurers are negotiating premium increases in place of avoiding. This is not driven by the Act but by the commercial realities and good market practice.

It remains to be seen to what extent the other professional regulators may be prepared to allow insurers to exercise some of the new remedies under the Act, given that the fundamental goal of consumer protection underpins the regulatory regimes, and to what extent the terms will be reviewed to remove any question marks over how they interact with the Act. The ICAEW and RICS minimum terms already contain their own forms of proportionate remedies for non-disclosure and a decision will need to be taken as to whether to align these with the Act. We understand that RICS are currently looking into whether any changes need to be made to their policies but, at the time of writing, the position has not been confirmed.

The ICAEW and RICS minimum terms also allow insurers to avoid the policy in respect of any insured who makes a claim knowing it to be false or fraudulent as regards the amount or otherwise. Clearly, these regulators will need to decide whether to adopt the default approach in the Act (which would mean that insurers could refuse to pay the fraudulent claim and give notice to terminate the contract but would remain liable in respect of genuine claims that pre-dated the fraud) or to opt out of the Act in this respect.

From our analysis of how the minimum terms will interact with the Act, it appears that whether the minimum terms or the Act are more favourable to the insured may sometimes be dependent on the precise circumstances.

Insurers should undertake a detailed review of their policies to identify where gaps and inconsistencies between them and the Act exist or may occur, and where steps need to be taken to opt out of the Act.

### **Fair presentation of the risk**

Our experience is that insurers and insureds in this field have worked hard to establish and maintain a good relationship. As such, processes are, in the majority of cases, already in place to ensure information is adequately collected and presented and these processes are reviewed regularly. For example, in the surveyors' market, surveyor insureds are generally very knowledgeable of their disclosure obligations so little will need to change.

Data dumping is prohibited under the Act so there is, in theory, an issue with this around the renewal date for solicitor's policies, which continues to be 1st October in the majority of cases despite this no longer being a requirement. The volume of renewals and submissions is always a stress on insurers' resources at that time of year. Given the heightened importance for insurers to review the information provided and identify issues that require further information, careful planning will be required. As mentioned above, robust procedures that gather information throughout the year, and not just at renewal, are likely already to be in place. In addition, given the relationship that most insureds enjoy with their insurer, insurers often take a common sense approach to information that strictly should have been disclosed prior to renewal.

The new provisions in respect of a reasonable search ostensibly benefit insureds but have the potential to be quite onerous for insureds. The Act puts centre stage the question of what amounts to a reasonable search by the insured, and in the PI market, as with others, issues of resources for smaller firms and oversight of global operations for larger entities are considerations. There is a potential for what is required in practice to become more onerous than previously.

Careful explanation of insurers' expectations in proposal forms will be important for establishing what is reasonable and what is not. In smaller partnerships, issues of the severability of policies will have to be considered, perhaps with clear guidance as to the search and questions to be asked of the partners by the partner responsible for disclosure.

We would expect that brokers and larger insureds will be seeking to agree with insurers the ambit of what constitutes a reasonable search. With global insureds this may be more of a problem. It will be necessary for insurers to make sure they have asked further questions if it is not clear from the proposal form that all relevant information from overseas offices has been collected, including circumstances or claims that have been notified to local policies.

The issue is potentially complicated in relation to insurers by the decision in *Law Society v Quinn*, which held that where the solicitor's obligation to notify circumstances under his insurance conflicts with his duty to keep his client's affairs confidential, the solicitor will have to breach his obligation to his insurer if necessary. Insureds need to give adequate consideration to the need, when notifying circumstances at placement or renewal, to anonymise information, therefore preserving client privilege/confidentiality. However, we understand that despite the significance of the case on its face, it is not in reality causing problems in practice.

### **Warranties and other policy terms**

We have dealt with warranties and basis of contract clauses and section 11 above, and in more detail elsewhere in this report. However, should section 11 be construed to cover notification clauses at some point in the future (the better view is that it will not), this will be a significant issue for professional indemnity insurers, as the application of notification clauses, such as whether a claim or circumstance has been notified on a timely basis, is commonly at issue in professional indemnity claims. Insurers may wish to consider whether to contract out of s11 of the Act in this regard in order to avoid any ambiguity.

### **Third Parties (Rights Against Insurers) Act 2010**

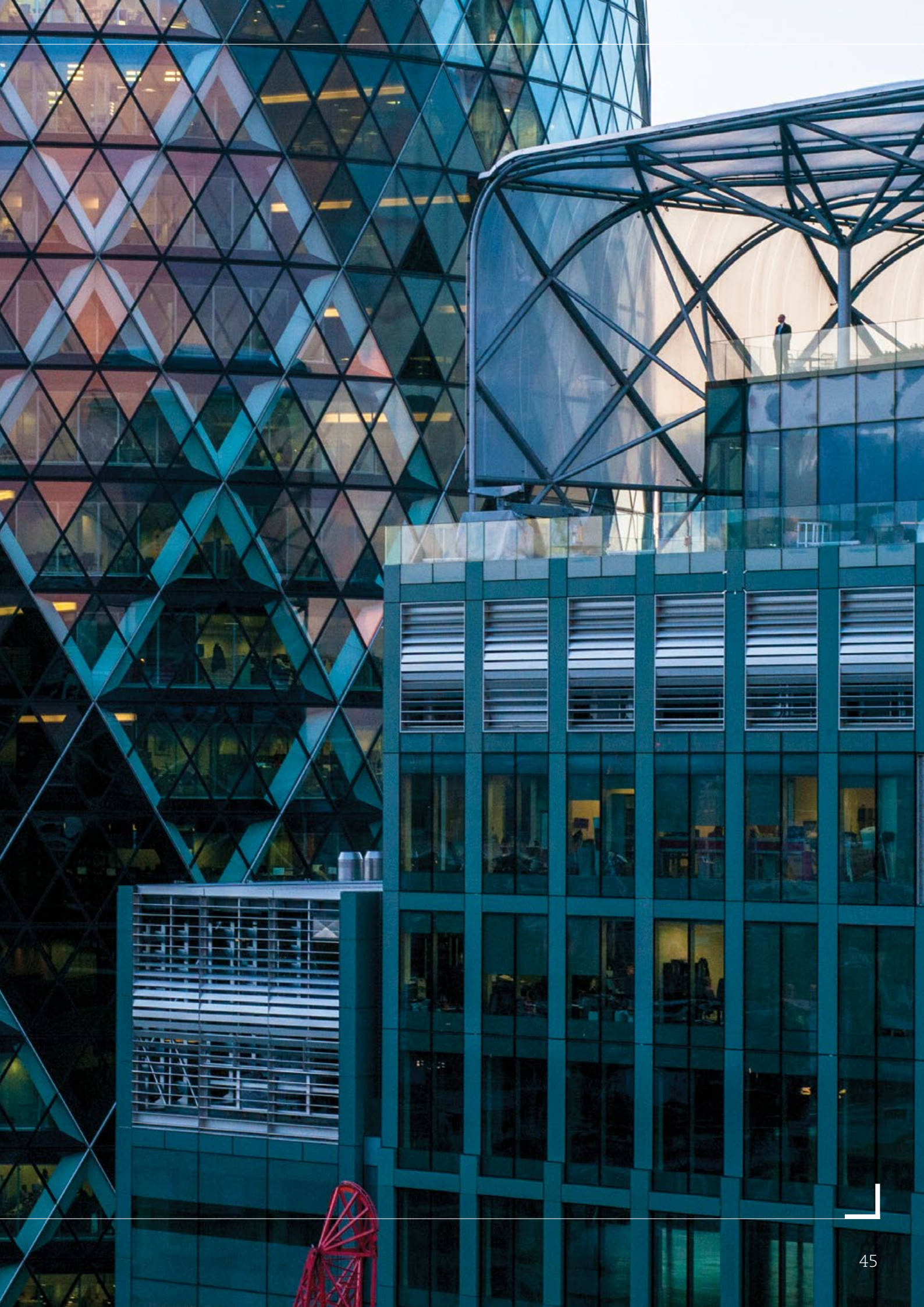
PI policies often contain an exclusion clause providing that insurers will not have any liability directly arising out of the insolvency of the insured and/or automatically cancelling the policy on such insolvency. For further details on the terms of the 2010 Act, the changes from the 1930 Act and its implications, please see the Third Parties section of this report.

### **Damages for late payment**

Although we do not expect it to be as significant as in other areas, such as property, the law on damages for late payment may impact on professional indemnity covers. This is particularly the case for smaller insureds where it is foreseeable that delaying payment could greatly impact the insured. Whilst the context is different, the situation is analogous with cases of under-insurance whereby a broker may be liable for an insured's losses if it is held that it was negligent in placing the insurance and it was foreseeable that the insured would suffer loss if it did not have adequate cover.

#### **Contributor**

**James Roberts**





Many of the reforms in the Act simply put existing best practice on a statutory footing. Few property insurers, under the present law, would wish to decline a claim for a technical breach of warranty entirely unconnected with the peril giving rise to the loss, absent some aggravating factor such as fraud.

Similarly, few insurers would rely upon a trivial and innocent non-disclosure that might have made only a minimal difference to the terms on which the policy was underwritten, in order to avoid the policy. Basis of contract clauses are now rarely relied upon in isolation to decline a claim. To this extent, many of the changes are more evolutionary than revolutionary when it comes to actual claims practice.

However, the re-shaping of the duty of disclosure, though in some ways subtle, is clearly intended to prompt a significant shift in market behaviour, requiring a more "scientific" approach to disclosure issues and their consequences. The need for clearer underwriting guides in order to demonstrate precisely what underwriting outcome would have followed from full disclosure of a certain issue has been much discussed and will not be repeated here.

Property insurance is likely to be an area in which the changes brought about by section 10 and section 11 of the Act have the greatest potential impact as these types of policies typically contain numerous warranties or conditions precedent.

### **Fair presentation of the risk**

It has been said that under the Act, proposal forms may become longer as insurers try to ensure that they are sufficiently detailed and capture all relevant information. However there is a limit to the size a proposal form can reach before it becomes unusable. In relation to a property risk, a one-size-fits-all proposal form is generally not appropriate because the type of information which will be relevant to, say, an unoccupied property will not be identical to the information which is relevant to an office or manufacturing risk or indeed to a residential property.

In advance of the Act, insurers may wish to review their proposal forms, and the proposal forms of the brokers which they deal with, to see whether they are fit for purpose. In the past, the property market has, at times, relied too readily on brokers' own proposal forms. Under the Act, insurers will be better placed to succeed in arguments on non-disclosure or misrepresentation if their proposal forms are more clearly tailored to their own underwriting guides.



In the case of large or complex risks, it is common for insurers to commission a risk survey report of the premises to be insured. The survey can take place before or after policy inception. The results of that survey will be information which the insurer ought to know for the purposes of section 3(5)(c) of the Act. However will the insurer be deemed to know information which was passed to the surveyor but not included in the report?

The answer will depend on whether the surveyor is an employee or agent of the insurer and, if so, whether information which the insured passed to the surveyor "ought reasonably" to have been passed on to the insurer. Whilst some insurers employ their own risk surveyors others use independent contractors, in relation to whom disputes will no doubt arise as to whether the surveyor is acting as an agent or not. In considering whether a surveyor ought reasonably to have passed on a particular piece of information, a court will no doubt take into account the purpose and scope of the surveyor's instructions.

“ Property insurance is likely to be an area in which the changes brought about by section 10 and section 11 of the Act have the greatest potential impact as these types of policies typically contain numerous warranties or conditions precedent.

It is not generally the responsibility of a surveyor to carry out an audit of the insured's proposal form answers or compliance with each and every policy term. The surveyor's responsibility is to identify risks at the insured premises and report back on these to the insurer. If, during the course of the inspection, the surveyor is provided with information which is at odds with an answer on the proposal form, he might not necessarily include this information in his risk survey report. However if he "ought reasonably" to have passed this information on, there is a risk that the insurer will be estopped from taking the associated coverage point at a later date. It will be interesting to see what approach the courts take to this issue.

Under the Act, insurers may seek to address and control this risk by clarifying to the insured the surveyor's status and role, in circumstances where this has often been left opaque in the past.

## Proportionate remedies

Property cover is often included as part of a broader commercial policy which could also include, for example, liability cover, business interruption cover and cover for plant, machinery and stock. In these circumstances it is important to understand whether the policy is to be treated under the Act as a single policy covering multiple risks or multiple contracts forming part of one document for convenience.

This is important because it can make a material difference to the insurer's entitlement to apply the new proportionate remedy. If the policy is treated as a single policy then the proportionate remedy arising from a misrepresentation or non-disclosure relating to a particular policy section is effectively diluted. For example, if the insured fails to disclose a material circumstance which related only to the property section of the policy, and this induced the insurer to charge half the premium for the property section than it would otherwise have charged, the overall effect on the total premium may not be especially significant once the effect on the total premium (including the various other sections) is calculated.

Conversely, an insured might find that a non-disclosure under the property or liability section of the policy impacts upon a claim under a separate section because of the effect of the proportionate remedy on all claims.

However if the policy is treated as multiple policies written on the same piece of paper, then these issues would not arise. No doubt the courts will be called upon to decide this issue in due course.

A similar issue is likely to arise in property policies where a schedule of properties is insured. Should a disclosure issue specific to one property impact upon a claim relating to another? This debate has often been had in connection with average under the old law but it will be of broader significance under the Act.

This may be an area that will be the focus of litigation as the consequences of the Act are fully worked out. Our view is that there could be an increasing willingness on the part of the courts to construe the separate sections of combined commercial policies as individual contracts if they were rated separately.

### **Business interruption**

It has been suggested that the new proportionate remedy may spell the end for declaration linked policies by reintroducing an average provision by the back door. We do not believe this is correct. Under a declaration linked policy an estimate of anticipated gross profit is likely to be viewed, both under the old law and under the Act, as a statement of expectation or belief and so will be regarded as true if honestly held. If a false declaration is made deliberately or recklessly, this will entitle the insurer to avoid the policy under the Act. If a statement as to expectation or belief is made innocently or negligently it is not, by definition, a misrepresentation and so the proportionate remedy is not available. There is, however, a risk that claims under Business Interruption sections of combined commercial policies may be reduced by the application of the proportionate remedy due to disclosure issues affecting other sections, for the reasons discussed above.

### **Warranties and other policy terms**

Property policies often contain a number of conditions precedent and warranties; they contain a ubiquitous obligation to keep the premises in a good state of repair, as well as warranties or conditions relating to security, fire safety and compliance with applicable legislation. Policies normally also contain additional warranties or conditions which are specific to the premises insured. For example, a policy covering premises used as a restaurant will normally include a warranty requiring the kitchen canopy and ducting to be professionally cleaned at periodic intervals.

Section 11 of the Act is a complicated provision which is likely to be a source of numerous disputes in the next few years.

It remains to be seen how broadly the courts will interpret the risks at which common policy conditions are addressed. For example, it is well-known that a burglar alarm can be activated by smoke and flames. What happens if there is an electrical fire and the insured has breached a policy condition requiring it to maintain a burglar alarm in full working order? Does section 11 entitle the insurer to decline the claim on the basis that the flames could have set off the burglar alarm and alerted the authorities and that the loss could have either been avoided or substantially diminished? Or would a court hold that the breach was connected solely to the arson and theft risks and so is irrelevant to an electrical fire? This will partly depend on the construction of the wording of the clause but it is certainly an area which we anticipate will be a source of debate in the future.

Under section 11(3) the burden of proof lies with the insured to show that non-compliance with a particular term "could not" have increased the risk of the loss which actually occurred in the circumstances in which it occurred. This is likely to be useful to property insurers as it is often impossible to determine precisely what caused a particular loss, especially in fire cases where the evidence is frequently destroyed or severely damaged.

However it is not clear precisely when the insured has satisfied section 11(3). If, for example, a fire has been caused by one of two competing causes, an electrical fault or arson for example, and the insured has breached a condition requiring the electrical installation to have been inspected and certified, what does the insured need to do to satisfy section 11(3)? If the insured establishes on the balance of probabilities that the fire was caused by arson, does the alternative cause fall away completely for the purposes of the section even though it might have been 40% likely that the breach caused the loss?

### **Contracting out**

We anticipate that most property insurers are unlikely to contract out of the Act in its entirety. In a soft market, this would be a commercially unattractive course of action. However we are aware that some insurers intend to contract out of section 10 of the Act in relation to the premium payment warranty. This seems sensible as it may not be in the interests of good administration to have the risk of a policy which has been lapsed for non-payment spring back into life several months later when the premium is paid.

### **Damages for late payment**

The new remedy of damages for late payment of an insurance claim introduced into the Act via the Enterprise Act 2016 should be of concern to property insurers. Commercial property claims often require complex and lengthy periods of investigation in order to gather evidence on the cause of a loss, conduct forensic examinations, obtain legal advice and so forth before a decision on policy coverage can be reached. Loss assessors acting on behalf of insureds already routinely complain to insurers about delays in reaching a decision and will no doubt use this new remedy to further pressure insurers into making policy decisions as quickly as possible.

Where the insurer has reasonable grounds for disputing a claim, the default position under the Act is that the insurer will not be liable for damages for late payment while the dispute remains unresolved. However the court

can nevertheless take the insurer's conduct into account in deciding whether to award damages for late payment. Accordingly if an insurer identifies any coverage concerns, it is particularly important to fully investigate these and reach a final decision on coverage without delay. There is also merit in issuing reservation of rights letters setting out any coverage concerns at an early stage in order to mitigate the risk of an adverse finding based on the insurer's conduct. In practical terms, this is not much different from what most insurance claims handlers do anyway. However it will now be especially important to co-ordinate loss adjusters, forensic experts, legal advisers and any other relevant parties at an early stage so that the roles and responsibilities are clear and that enquires are progressed without delay.

We anticipate that the new remedy will be very relevant to claims involving an element of business interruption where the insured business is at risk of collapse. In such cases, insurers already come under significant pressure to make interim payments and the risk of an insurer being held liable for the financial consequences of an insured business collapsing (which could easily exceed the policy limits) will further increase the pressure to make such payments. It is possible to make an interim payment without affirming the policy so long as careful language is used but it is not presently clear if a failure to make an interim payment within a reasonable time will give rise to a claim in damages under the Act. No doubt this will be addressed by the courts in due course. However this potential risk underlines the need for insurers to conduct their investigations promptly and follow up on any concerns identified as soon as possible.

#### Contributors

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# Reinsurance

The Act applies to contracts of reinsurance and retrocession in the same way as non-consumer insurance contracts (and variations to such contracts). This was confirmed by the Law Commissions when the Bill was presented to Parliament and is also included in the Explanatory Notes to the Act.

It is worth bearing in mind, however, that long-tail reinsurance business will be subject to the pre-Act position for many years. Further, in relation to delegated authority where the binding authority agreement was agreed before the Act but cessions/declarations are made post-Act, it depends on the type of reinsurance whether or not the Act applies:

1. If obligatory (cedant and reinsurer), there is no new contract on the cession so the Act does not apply
2. If facultative/obligatory (cedant option but reinsurer obliged to accept), the Act will apply but no fresh disclosure obligation as reinsurer has to accept
3. If facultative/facultative, the Act applies and fresh disclosure obligation arises

The Law Commissions considered and rejected the idea of referring specifically to reinsurance. We understand that Parliamentary Counsel advised that any specific reference could cause problems for other pieces of legislation which do not do this and which assume that insurance includes reinsurance, including the Marine Insurance Act 1906.

If explicit reference had been made to contracts of reinsurance it might also have caused confusion as to the lack of a specific reference to contracts of retrocession, or further contracts.

There is one express reference to reinsurance in the Act: the Act provides that a reinsured is not deemed to know confidential information known by its broker if information was acquired by the broker through a business relationship with a person not connected with the underlying insurance (“connected with” in this context means the insured and any other persons for whom cover is provided). This might cause difficulties in practice. For example, a broker might place liability reinsurance for the captives of two manufacturers, A and B. If the broker learns from A’s captive that A’s regulator is investigating its relationship with B and is considering charges, is B’s captive deemed to have the broker’s knowledge (even though it has no actual knowledge) of those matters?

## Fair presentation of the risk

The Act requires those seeking insurance to disclose matters known to their senior management; matters known to those involved in the process of procuring insurance; and

matters revealed by a “reasonable search”, that are material to the risk.

In the context of reinsurance, “senior management” is likely to include executive directors of the reinsured/managing agency but is unlikely to include claims directors, in-house lawyers or line managers below board level.

Those deemed to be involved in procuring reinsurance may include reinsurance managers, an underwriter buying facultative reinsurance, the reinsurance broker, and (potentially) those processing information.

In relation to the reasonable search, it will be important for a reinsured to make a record of the extent of its search. The record of the search should define the organisation, record who was asked, and record how the search was conducted, for example, enquiries and a review of files. The reinsured might want to ask the reinsurer to agree that the search it undertakes is reasonable.

One potential issue for reinsureds is the situation where the insured has made a fair presentation, disclosing sufficient information to put the reinsured on notice, but the reinsured unreasonably fails to investigate further. It could then be argued that the reinsured is deemed to know what a reasonable search would have revealed, and will breach its duty of a fair presentation to the reinsurer for failing to disclose it (and will not be able to claim against the reinsurer for any loss resulting therefrom, because the reinsured will have discharged its duty).

In the case of treaty reinsurance, where an event is covered by an expiring treaty and may eventually materialise, but the quantum is “to be assessed”, that will probably be something which should be disclosed. It is also sensible to clarify what has been done so that the reinsurer can ask further questions if necessary.

## Proportionate remedies

In terms of remedies under the Act, it is also worth noting that a reinsured and reinsurer may disagree as to what they would have done had there been no breach of the duty of fair presentation by the insured. That might cause practical difficulties where, for example, a reinsurer says it would not have taken on the risk at all if a fair presentation had been made, but the reinsured says that it would only have increased the premium. In such circumstances, the reinsurer may find that it is still

liable to pay the claim (and will not be able to contract out of the proportionate remedies at the underlying level). Where the insured's presentation fails to disclose, or misrepresents, a material fact, and the reinsured could not have discovered that falsity by conducting a reasonable search, and the same presentation is then made to the reinsurer, then there will be no remedy for the reinsurer against the reinsured, regardless of what it would have done had a fair presentation been made. Nor will the reinsurer be able to seek a remedy directly against the insured, since its presentation was made to the reinsured, and not the reinsurer. However, the reinsurer will benefit from the remedy which the reinsured is able to claim. So, for example, if the reinsured only has to pay a reduced amount for the claim (or ends up not having to pay at all), that will impact indirectly on the reinsurer too (but the reinsurer won't be able to say it would have acted differently had it been in the reinsured's position).

### Warranties and other policy terms

It is rare to find a true warranty in a reinsurance contract but warranties in the underlying contract can be incorporated into the reinsurance if the term is germane to the reinsurance; makes sense, subject to permissible "manipulation", in the context of the reinsurance; is consistent with the express terms of the reinsurance; and is apposite for inclusion in the reinsurance.

Often, warranties in a reinsurance contract relate to the type of business which can be ceded to the reinsurer, and it will not be possible to remedy the breach of such a warranty.

In relation to section 11, it is also worth noting that conditions precedent, exclusions and insuring clauses are rarely found in the reinsurance contract itself; instead the term will be incorporated from the underlying policy. For example, a policy may provide that the insured warrants that there is a working burglar alarm at the insured premises, and that the alarm shall be inspected every six months. This term is likely to be incorporated into the reinsurance and the reinsurer will be off cover if it is breached (subject to the terms of section 11), provided that the underlying policy is subject to English law.

### Contracting out

An example of a term taken from a reinsurance contract might read as follows:

"No Prior Knowledge

Underwriters shall not be exposed to liability under this Policy and the Reinsured shall have no rights hereunder unless:

(i) At the time of conclusion of this contract and the time of any amendment hereto, the Reinsured was not in breach of any common law duty in regard to non disclosure or misrepresentation, and further

(ii) [...]

Performance of these obligations shall be a necessary pre-requisite to cover under this Policy and in any proceedings by the Reinsured hereunder or between the parties hereto the burden shall in all circumstances be upon the Reinsured to establish that these obligation have been complied with."

Despite being of reasonable length, this term does almost nothing to alter the reinsured's duty of fair presentation. The term refers to the "common law duty in regard to non disclosure"; a court would most likely take this to mean the duty of fair presentation in the Act.

The reinsured's disclosure obligation is described as "a necessary pre-requisite to cover". This does not reflect the default position under the Act where there may be cover in spite of a non-disclosure depending on the seriousness of that non-disclosure. This term would probably be held to have contracted out of the Act. A reinsurer who wished to rely on it would have to bring it to the attention of the reinsured: the Act calls this the transparency requirement. The importance of the transparency requirement will depend on the sophistication of the insured: an insurer dealing with a sole trader would have to make sure that the meaning of the term is utterly clear to the insured; a reinsurer dealing with a sophisticated insurance entity will face much less stringent requirements. A court may be reluctant to hold that a large reinsured, buying insurance through a Lloyd's broker, had to be directed to terms in its policy.

A further issue may arise where a reinsurance contract expressly incorporates the terms of the original policy. If that policy contains a "disadvantageous term" which has not been drawn to the attention of the insured in accordance with the Act, then (assuming that both the reinsured and the reinsurer are aware of the term), this may be a situation where the reinsurance policy is not back-to-back with the insurance policy, as the insured will not be taken to be bound by the term, but the reinsured will be.

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# Specialty



## Accident and health

### Application

The Act predominantly impacts non-consumer contracts of insurance. Consumer contracts are subject to the Consumer Insurance (Disclosure and Representations) Act 2012 (“CIDRA”).

“ Certain products contain elements of both consumer and business insurance, particularly group policies which are specifically referenced in both CIDRA and the Act.

A&H policies are often purchased by both consumers and businesses, depending on the product. Certain products contain elements of both consumer and business insurance, particularly group policies which are specifically referenced in both CIDRA and the Act.

### Fair presentation of the risk

The Act requires the insured to ensure that a fair presentation of risk is given rather than a duty of utmost good faith to disclose all material facts. This is a slightly lower threshold with more restrictive remedies.

In the context of A&H policies, non-disclosure commonly relates to information concerning:

- i. Pre-existing medical conditions;
- ii. Relevant ages of personnel; and
- iii. Countries where exposure exists.

Where a group of high profile individuals is insured, such as professional sportsmen, medical underwriting will take place following detailed proposal forms regarding each individual. Elsewhere, information relating to each insured person in a general group policy context typically will be less detailed/comprehensive, where such information might be provided by way of a table/schedule.

It is important to consider whether the particular form of disclosure constitutes a fair representation of risk in each case, and where numerous individuals are covered, how much information insurers are entitled to expect or can request.

It is our view that where the named insured is a company, the obligations in the Act apply to the disclosure required, even if consumers are the ultimate beneficiaries of the policy.

Given that the insured’s duty of disclosure is now limited to providing a fair presentation of the risk, there is a greater burden on the insurer to ask the relevant questions of the insured, although this is less than the burden upon insurers

in the consumer context where the duty to volunteer information by way of disclosure has been abolished.

There is usually no obligation of disclosure placed upon individuals who benefit under group insurance. Insurers will need to make a specific request if information is required directly from individual insured persons.

In terms of the insurer’s knowledge, this includes actual knowledge but also anything insurers ought to know or are presumed to know. Insurers should take care to consider what knowledge is available to them, particularly through claims handling and general knowledge within the industry.

Where certain medical checks have been undertaken on the insured persons before applying for insurance it is likely that the results of those checks will be considered within the knowledge of the insured and useful information for a fair presentation of the risk.

However, as there are data protection rules surrounding the disclosure of medical information to a third party, an insured will not always be able to share that information. It would be prudent for insurers to discuss the level of medical disclosure they expect and the insured’s internal procedures for gathering such information (including securing DPA waivers for disclosure to insurers) rather than relying upon the duty on the insured under the Act.

“ Where the named insured is a company, the obligations in the Act apply to the disclosure required, even if consumers are the ultimate beneficiaries of the policy.

### Warranties and other policy terms

The Act contains important provisions regarding the application of terms in both consumer and non-consumer policies. It will therefore apply across a whole book of A&H business, where certain other elements only impact business insurance.

Breaches of condition (more than warranties) can be important when considering coverage in an A&H policy. Whilst it is usually necessary to establish a causal link between the breach and the loss in any event, it is worth noting that the provisions in the Act require that the term relied upon be one where compliance would have reduced the risk that the actual loss suffered would have occurred.

Insurers of non-consumer insurance may opt out of certain provisions of the Act (except for the prohibition on the basis of contract clauses), subject to a number of “transparency” requirements. However, no opt out is permitted for consumer insurance.

## Fraudulent claims

Section 13 of the Act, which relates to fraudulent claims, contains specific provisions in the context of group insurance policies.

This allows differential remedies in relation to various insured persons depending upon the character of the fraud. It includes permitting severing the insurance into an invalid portion and a portion which continues without adverse impact for “innocent” members of a group, the application of which will be fact specific.

There are similar “severing” provisions in CIDRA in relation to misrepresentations in the group policy context.

## Bloodstock

Bloodstock policies are unlikely to see any significant changes as a result of the Act although there are areas in which it could have an impact.

## Fair presentation of the risk

The majority of bloodstock policies are likely to be taken out by individual horse-owners. As such, pre-inception requirements will be governed by CIDRA and will not be impacted by the Act.

Where bloodstock policies are taken out in the course of a business, for example in connection with a stud operation, the Act will apply. The nature of bloodstock cover can vary, from mortality only to loss of use and more specialised policies, such as fertility insurance for a high value stud. The type of information to be provided will vary depending on the scope of the insurance but will be well understood by the insured and insurers and seems unlikely to give rise to disputes unless material is deliberately withheld. Questions such as the scope of a reasonable search also seem unlikely to have much application in this class of insurance.

The provisions spelling out the knowledge of the insurer are also unlikely to be relevant in practice, unless the request concerns an especially well-known horse, as insurers will not be in possession of information relating to particular animals.

## Proportionate remedies

The general measure of indemnity in a bloodstock policy is the value of the horse. For loss of use or other specialised policies, such as fertility, the Section 8 and Schedule 1 provisions regarding additional contractual terms may have some impact; if insurers were unaware that a horse had a particular health issue then they may successfully argue that they would have excluded that condition from cover. For a more “all or nothing” policy such as mortality, which operates in the event of humane destruction of the horse, the new proportionate remedies may have less impact.

## Warranties and other policy terms

The suspensory nature of warranties will be an interesting area in these policies. If, for example, the insured warrants that the horse will be subject to vetting every six months, and the insured fails to do this, the breach is technically capable of being remedied once the horse undergoes vetting. It is however possible that during that intervening period the horse has contracted a medical condition which will cause damage. If the damage does not manifest itself until some time after the breach has been remedied, there will be arguments as to whether the policy should respond.

Other common areas of dispute in bloodstock claims are (a) late notification; and (b) failure by the attending vet to follow proper procedures. In terms of (a), late notification in bloodstock policies is capable of causing prejudice to insurers, as prompt treatment can prevent a covered condition from developing. In terms of (b), clearly if a vet destroys a horse without consulting with insurers, in circumstances where the British Equine Veterinary Association guidelines require the vet to do so, this has increased the risk of loss; the horse has been destroyed when it might not have been appropriate to take this step. However, as these are post-loss provisions, it is the accepted view that Section 11 will not apply and that these provisions are instead aimed at mitigating the loss.

“ The suspensory nature of warranties will be an interesting area in these policies.



## Credit risk

### Fair presentation of the risk

There are sometimes express terms in a policy covering the insured's non-disclosure and utmost good faith duties.

For example, a policy might provide that it is exclusively the Transaction Team's knowledge and belief "after Customary Due Diligence" that counts as the insured's knowledge. Customary Due Diligence ("CDD") might in turn be defined as due diligence of a standard that would be expected of a top tier bank in the Insured's Country engaged in similar financing activity.

It might therefore be queried whether CDD is the same as a reasonable search ie would it require the Transaction Team to search for knowledge held within a different department of the bank regarding the borrower.

By referring only to what is known by the Transaction Team, this would seem to be a contracting out of the Act – which refers to senior management and those responsible for placing the insurance. It is a far narrower band of individuals – although in practice that may make no real difference if the Transaction Team searches the knowledge of others within the bank. The courts may view this as a contracting out of the Act, but since it isn't to the insured's disadvantage the transparency requirements would not apply.

A clause might also provide that, if the Transaction Team has disclosed all material facts and circumstances to the best of its knowledge and belief:

"the Insurer(s) agree that they will not seek to be entitled to avoid or rescind the Policy... or to reject any claim or be entitled to seek any other remedy or redress whatsoever on the grounds of a failure to disclose or to make truthful representations".

Accordingly, this goes further than the changes in the Act in the case of innocent misrepresentation and/or non-disclosure. What about a negligent misrepresentation or non-disclosure though? It is arguable that that couldn't really be said to be disclosure to the best of the Transaction Team's knowledge and belief (if something is forgotten). However, query whether it is likely to be negligent or innocent if the Transaction Team simply does not appreciate the relevance of something withheld from the insurer.

“ It might therefore be queried whether CDD is the same as a reasonable search.

## Warranties and other policy terms

A sample warranty might read as follows:

"Insured Payment(s): The Insured warrants that at the effective date of the Covered Transaction or, if later, the inception of this Policy, after legal Customary Due Diligence, the Insured Payment(s) constitute legally valid and enforceable obligations of the Obligor(s) in the Foreign Country(ies), subject only to the application of the bankruptcy laws of the Foreign Country(ies)".

Warranties are still permissible under the Act. Would the breach of this warranty be capable of remedy? This would seem unlikely – once a payment is invalid, it is probably always invalid, but in theory at least it might be capable of remedy and then the insurer would come back on cover.

What if the loan is legally enforceable at the date of inception but for some unforeseen reason becomes unenforceable at a later date? The insurer will be liable to cover a loss prior to the date of unenforceability. It might be that an insurer would want to contract out of section 10 in its entirety in order to avoid this issue, though careful consideration of the pros and cons need to be undertaken.

In terms of section 11, might it be said that this warranty defines the risk as a whole (ie non-repayment of the loan) or is it aimed at reducing the risk of a particular kind (ie non-repayment due only to the loan being invalid and unenforceable)? Arguably, it will be the latter, and so non-repayment due to a borrower simply refusing to repay would still be covered even if this term is breached.

A further example, this time of a condition precedent, might read as follows:

"No material change to Covered Transaction. It is a condition precedent to liability that the Insured shall not make any material change to, or waive any material breach under, the terms and conditions of the Covered Transaction without the prior written agreement of the Leading Insurer(s), such agreement not to unreasonably withheld or delayed."

However, a material change outside the control of the insured because of the majority lenders' approval will not constitute a breach of the condition precedent.

This probably goes to the risk as a whole and so will be unaffected by section 11. But could the insured argue that a material change such as altering the currency for repayment would tend to increase the risk of loss of a particular kind (ie loss due to currency fluctuations), and so the insurer would still be liable to pay for loss not relating to currency fluctuations?

Section 11 talks about a term “compliance with which would tend to reduce the risk of” eg loss of a particular kind. So the term doesn’t on its face have to say it is aimed at a particular risk – the question is whether it would “tend to” have that effect.

The safest option is to list exactly what risks the condition precedent is aimed at addressing – but that could end up being a straightjacket for the insurer, if there is a material change which the insurer did not foresee but would still not want to cover. So this is likely to be an area giving rise to some debate before the courts.

The same issues also apply to “bare conditions” (ie those conditions not expressed to be a condition precedent or having the nature of a condition precedent).

Section 11 applies to all policy terms – not just conditions but also, in theory at least, exclusions and insuring clauses, although it is difficult to see how the Act might impact on such clauses. For example, where a policy excludes cover for any loss arising from the insolvency of the insured, that is clearly aimed at loss of a particular kind (insolvency) but could not be relied on to exclude loss from anything else in any event.

**“ Once a payment is invalid, it is probably always invalid, but in theory at least it might be capable of remedy and then the insurer would come back on cover.**

The Act provides that representations made by the insured in connection with a proposed non-consumer insurance contract cannot be converted into a warranty by means of any provision of the policy. So basis of contract clauses are now invalid, not only if they appear in a proposal form but also if they are included in the policy itself.

Care should be taken where, for example, a policy provides that:

“all material information prepared by the Deal Team and provided to the Underwriters is true and correct in all material respects and no material information has been withheld”.

This term does not go so far to say that the information constitutes the basis of the contract, although it might be interpreted as such. Under the Act it will no longer be possible to argue that the information from the Deal Team amounts to warranties. It is not absolutely necessary to remove the term, but it will cease to have any effect, and so it would make sense to remove it.

### **Fine art**

Fine Art policies might include warranties as to storage, maintenance, transport and damage or theft prevention of the art work. The Act now requires a breach of warranty to be causative of the loss. If, for instance, an art work was damaged by fire but an insured was found to have been in breach of a warranty that required all entrances to the premises to be locked, that breach is a suspensory breach only and cannot be relied upon to deny cover as it did not cause the loss in question.

### **Political risk**

Political Risk policies cover a wide range of insured events, and it is likely that this class of business will be impacted by the changes in the Act.

### **Fair presentation of the risk**

The requirement for a fair presentation of the risk and, in particular, the requirement that the insured provide the information “in a manner which would be reasonably clear and accessible to a prudent underwriter” could be of benefit to underwriters in this class. Political risk underwriters are often confronted by vast quantities of documentation during the underwriting process, to the extent that a full review is impracticable. The need to provide data in a more structured way may go some way to removing this problem.

The “Knowledge of Insurer” provisions are possibly double-edged. One feature of political risk policies is that they provide cover for investments in countries which have well-publicised political problems. Often, there may be local indications prior to inception of potential problems to come. In the age of the internet, could it be said that issues reported in local news in the relevant country are “common knowledge”, or that they amount to information of which an underwriter offering political risk cover in that country should have been aware? To some extent this applies equally to the scope of the “reasonable search” to be carried out by the insured; to what extent is the insured required to make enquiries as to any local rumblings which might impact on the project? These “knowledge” areas could give rise to disputes when claims are submitted.

“ Political risk underwriters are often confronted by vast quantities of documentation during the underwriting process. The need to provide data in a more structured way may go some way to removing this problem.

### Proportionate remedies

The introduction of proportionate remedies may remove a longstanding issue in political risk policies. Often, an insured will take out a multi-jurisdictional policy to cover its investments worldwide. Under the old rules, if an insured was guilty of non-disclosure or misrepresentation in respect of an investment in one country, the remedy available was to avoid the whole policy. This left the insured without worldwide cover. Under the new regime, it will be easier for underwriters to say that they would have written the policy but would not have included cover for the country in question. This means that an innocent non-disclosure in respect of one country does not have the draconian remedy of removing cover across the globe.

“ An innocent non-disclosure in respect of one country does not have the draconian remedy of removing cover across the globe.

### Warranties and other policy terms

As with all classes of business, the suspensory nature of warranty breaches is likely to give rise to debate. If, for example, an insured warrants that it will comply with environmental regulations, and fails to do so, then the breach is “remedied” once the insured is again in compliance. The breach may, however, make it more likely that the foreign government will take action against the insured; if this action takes the form, for example, of nationalisation, once the cover is back in force, should the claim be covered? Time will tell.

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An aerial night photograph of a city, likely London, with its lights reflecting on the water. The image is used as a background for the text overlay.

## Part eight: International insurance cover – the Act compared

The business of insurance is increasingly global, and insurers increasingly need to be aware of the differences in the legal frameworks in which they operate.

When considering the law reform process, one consideration for the Law Commissions was that codified UK insurance law was perceived to have fallen behind other jurisdictions. The Law Commissions paid particular attention to the law reforms already introduced in other jurisdictions, and were to some extent guided by the experience in those regions where similar reforms had been in force.

In the following section we have compared the position of a number of key insurance law principles across a number of jurisdictions, with the responses from the UK reflecting the position under the new Act.



# Overall is the jurisdiction more insurer or insured friendly?

## United Kingdom

Certain aspects of the pre-Act insurance law regime in the UK has long been viewed as insurer friendly, such as the all or nothing remedy of avoidance of the policy following nondisclosure by the insured prior to policy inception, or the fact that a breach of warranty would allow the insurer to terminate the policy notwithstanding that a claim under the policy might be entirely unconnected to the breach.

Both CIDRA and the Act seek to redress this position to produce a more balanced regime.

## France

Overall, France is a rather pro-insured jurisdiction and the Insurance Code contains a number of mandatory provisions that are protective of the insured, even business insureds.

## South Africa

On balance the jurisdiction is probably relatively fair to both parties.

Although the jurisdiction maintains an all or nothing approach to the remedy of avoidance, many aspects of the law which were previously considered to favour the insurer have been ameliorated by legislative intervention and/or judicial interpretation.

As a general rule of interpretation, any ambiguous wording in a policy is interpreted against the insurer. Through legislative intervention, an affirmatory warranty provides no greater protection to an insurer than any other representation.

Similarly, no condition is elevated to condition precedent merely by virtue of it being described as such. Courts will ultimately determine whether it is fundamentally relevant to the operation of the policy.

## Australia

Generally the insurance law regime in Australia is considered insured friendly. This is largely a result of the operation of the Insurance Contracts Act 1984 (ICA). The ICA was brought in with the express intention of addressing the perceived imbalance in the positions of the insurer and insured which existed under the English common law system, which Australia had inherited. The ICA applies to all contracts of general insurance. Contracting out is not permitted (subject to a few limited exceptions). The ICA does not apply to marine or private health insurance (which are subject to separate regimes), or to reinsurance. Amongst other things, the ICA includes provisions which restrict insurers' rights to avoid contracts of insurance in instances of pre-contractual misrepresentation or non-disclosure and to refuse to pay claims as a result of post-contractual breaches of policy conditions.

## Canada

The jurisdiction is generally well balanced between Commonwealth and US influences. The trend currently favours insureds in terms of relief from forfeiture and interpretation of policies; there is also increasing resort to claims of "bad faith" although judgments remain rare. Quebec is a civil law jurisdiction with certain insurer friendly aspects.

## United States

Overall, the U.S. is considered more insured friendly, particularly in view of the availability of bad faith and statutory claims against insurers. State law governs insurance, however, and which of the 50 states' laws apply to the policy is important to a determination of the scope of coverage, as well as potential extra-contractual liability of the insurer. Certain states are considered more insured or insurer friendly than others. For example, some states have more developed case law on insurance and more sophisticated courts than others, but even in those states there may be a bias towards insurance companies. Also, federal courts may be viewed as a better venue for insurance companies than state courts.

## Hong Kong

In general, the insurance law regime in Hong Kong is relatively balanced for both parties. A number of aspects of the law – including the “all or nothing” approach to the remedy of avoidance of the policy based on non-disclosure – are more pro-insurer, while certain aspects are more protective to the insured, such as the C rule (ie if a clause in a policy appears ambiguous, it is to be interpreted against the insurer).

## Singapore

Overall, the jurisdiction is considered to be more insurer-friendly. An insurer will in general be entitled to avoid a policy for material pre-contractual non-disclosure or misrepresentation, as well as, to terminate a policy for breach of a warranty, even though a claim under the policy might be unconnected with the breach.

## Middle East

Overall, the courts in the UAE are pro-insured with clauses considered commonplace in other jurisdictions capable of being found to be void or unenforceable under UAE Law. For example:

- Pursuant to Article 1028(a) of the Civil Code, any clause which forfeits the right to insurance by reason of a breach of law is deemed void, unless such breach constitutes a deliberate felony
- Pursuant to Article 1028(c) of the Civil Code, any clause designed to release an insurer from liability in given circumstances, for example an exclusion clause, is void unless “shown conspicuously”. The Insurance Law provides that such clauses should be identified in bold or different fonts or colours. Though failure to meet the formatting requirements under the Insurance Law does not automatically void such clauses, these requirements should be followed in practice to ensure compliance with the “conspicuous” requirements of the Civil Code
- Pursuant to Article 1028(d) of the Civil Code, an arbitration clause is void, unless it is contained in a special agreement separate from the general printed conditions. It must also be signed by a party with specific authority to do so
- Pursuant to Article 1028(e) of the Civil Code, any clause considered “arbitrary”, in the sense that its breach has no effect on the occurrence of the insured peril, is void. The term “arbitrary” is not defined, but would, for example, apply to a warranty, or to conditions precedent, in circumstances where there is no causative link between a loss and the insured’s breach of the clause

# Is there a distinction between the law applying to consumer and business insurance?

## United Kingdom

The Consumer Insurance (Disclosure and Representations) Act 2012 applies to consumer insurance and the Insurance Act 2015 applies to both, with some sections only applying to business insurance. There is a mandatory regime in place with regard to consumer insurance but it will be possible for insurers to opt out of most of the business insurance regime.

## France

Although there are certain rules that are specific to consumers (especially in terms of information to be provided), most of the provisions are the same (for sake of completeness, one should note that certain specific areas are subject to more flexible rules such as marine insurance or credit/political risk).

## South Africa

The two principal Acts which govern the industry are the Long-term and Short-term Insurance Acts (Acts 52 and 53 of 1998 respectively). The Acts themselves apply equally to consumer and business insurance, as does the common law. However, since 2004 individual consumers have benefited from subordinate legislation in the form of the Policy Holder Protection Rules which, amongst other things, oblige insurers to comply with a variety of conditions once a claim is repudiated. For example, an insured must be given a 90 day grace period within which to make representations regarding any repudiation. In addition, onerous terms, like atypical policy exclusions and conditions, must be drawn to the attention of the insured. The industry now also has an obligation to word each consumer policy in plain language.

## Australia

There is a distinction between retail and wholesale clients from a corporate and regulatory perspective in Australia: however there is no such distinction for the purposes of the ICA. Certain types of contract of insurance, such as motor vehicle, home building & contents, sickness and accident, consumer credit and travel insurance are subject to specific consumer protection provisions, which are built into the ICA. The major piece of consumer protection legislation in Australia (the Australian Consumer Law) does not apply to insurance contracts which fall under the ICA.

## Canada

There is no general distinction. However, certain classes of insurance are specifically regulated and their content more closely controlled, notably automobile, accident and sickness, life, fire, livestock, hail and weather insurance.

## United States

Yes, separate state laws apply to commercial lines and personal lines insurance. Also, courts may apply different standards to interpreting coverage under personal lines and commercial lines policies. For example, a court may be more likely to apply the concept of contra preferentem to personal lines policies than commercial lines policies purchased by a business.

## Hong Kong

There is no general distinction. However, certain types of insurance such as motor vehicle, statutory and marine have their specific legal provisions/regulations.

## Singapore

The Insurance Act (Chapter 142) ("the IA") applies to both consumer and business insurance. However, in the case of insurance contracts entered into with consumers, the Consumer Protection (Fair Trading) Act (Chapter 52A) ("the CPA") applies. There are also specific pieces of legislation with provisions dealing with specific classes of insurance contracts, eg marine insurance, motor vehicle insurance and workplace injury insurance.

## Middle East

There is no clear distinction. In practice, court-appointed experts in insurance disputes will expect commercial entities to be able to protect their own interests to a much greater degree.



# Is there a distinction between the law applying to insurance and reinsurance?

## United Kingdom

The Act will apply to both insurance and reinsurance policies.

## France

Yes – reinsurance is not governed by the Insurance Code but only by the Civil Code (ie the general law of contract).

## South Africa

The Short-Term and Long Term Insurance Acts apply equally to insurance and reinsurance.

## Australia

The ICA applies to insurance but not, generally, to reinsurance. In Australia, contracts of reinsurance are largely governed by common law.

## Canada

Not specifically, although certain provisions of law and regulatory aspects apply to reinsurance exclusively.

## United States

Yes. There are separate bodies of common and statutory laws applicable to reinsurance and insurance.

## Hong Kong

There is no general distinction. The ICO and the Amendment Ordinance apply to both insurance and reinsurance policies. Otherwise, the regulatory regime is mainly based on common law.

## Singapore

Both insurance and reinsurance are governed by the IA.

## Middle East

There is no clear distinction in general, but many of the provisions cited above would not apply in a reinsurance context.

# What is the scope of the duty of disclosure prior to inception of the policy? What is the position with regard to representations?

## United Kingdom

The insured will be required to make a “fair presentation” of the risk. This is one that makes disclosure in a manner reasonably clear and accessible to a prudent insurer. Every material representation as to a matter of fact must be substantially correct and every material representation as to a matter of expectation or belief must be made in good faith. Disclosure is required of every material circumstance that the insured knows or ought to know or the insured may give the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries. Disclosure is not required of circumstances that diminish the risk; something the insurer knows, ought to know or is presumed to know; or something in respect of which the insurer waives information. The insurance contract remains one of the utmost good faith.

## France

In accordance with article L.113-2 of the Insurance Code, the duty of disclosure is limited to answering accurately the questions asked by the insurer, bearing in mind that when a question is deemed imprecise, the insured is entitled to give vague answers (provided they are accurate) and it is then up to the insurer to ask further questions.

As regards to representations that are made in the absence of a question from the insurer, there is always a potential debate as to the cases in which they can be relied upon. However, the insured’s representations obviously have to be true.

## South Africa

An insured is required to disclose information that a reasonable person would adjudge to materially affect an insurer’s assessment of the risk.

Even though the South African courts have jettisoned the notion of a contract of insurance being one of utmost good faith, it is accepted that when it comes to knowledge of risk, the insured sits in an advantageous position and will accordingly be expected to be proactive in making disclosure of a known material risk.

Although in the past positive misrepresentation and nondisclosure were treated differently, they are now treated in the same way when it comes to avoidance. Neither give rise to grounds for avoiding the policy unless the misrepresentation/non-disclosure is adjudged subjectively to have induced the policy, ie if, but for the misrepresentation/nondisclosure, the insurer would either have refrained from underwriting the risk or would have done so on different terms.

## Australia

Under the ICA, the insured has a duty to disclose to the insurer every matter that it knows, or which a reasonable person in the circumstances could be expected to know, to be relevant to the decision of the insurer whether to accept the risk, and if so, on what terms (s21 of the ICA). There is therefore both a subjective and objective element to the test.

The duty of disclosure does not extend to matters that diminish the risk, that are of common knowledge, that the insurer knows or ought to know in the ordinary course of its business, or in respect of which the insurer waives compliance with the duty of disclosure.

The ICA makes specific provision for what is and is not considered a misrepresentation.

Where a statement is untrue as a matter of fact, but is made on the basis of a belief that the person (a) actually and (b) reasonably held, that statement is not treated as a misrepresentation.

Equally, a statement is not treated as a misrepresentation unless the person who made it knew, or a reasonable person in the circumstances could be expected to have known, that it would have been relevant to the decision of the insurer whether to accept the risk and, if so, on what terms (s26 of the ICA).

A contract of insurance is a contract of the utmost good faith (s13 of the ICA).

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## Canada

Insurance policies are contracts of utmost good faith. The insured is obliged to advise of all material facts of the risk, even if not specifically asked, in his or her personal knowledge. However, information is not material simply because a question is asked by insurers.

## United States

An insured generally does not have an obligation to volunteer information that has not been requested by the insurer, but an insurer's specific question regarding a matter indicates that it deems the information to be material to the risk and such inquiry is not for the insured to "pass it over as trifling." Where an insurer asks about a fact, the insured is on notice that the insurer considers it material, and it therefore has a duty to inquire. Courts generally apply an objective standard when determining the insured's duties to investigate and disclose. More sophisticated insureds may be found to have a greater duty to conduct a thorough investigation. A court must consider whether the questions in an insurance application are so plain and intelligible that any applicant can readily comprehend them.

## Hong Kong

The duty of disclosure flows from the insured's duty of utmost good faith, at common law.

The insured has the duty to disclose, prior to entering into the insurance policy, every material circumstance which is known to the insured, and the insured is deemed to know every circumstance which, in the ordinary course of business, ought reasonably to be known by him/her.

The duty of disclosure does not extend to circumstances that diminish the risk; that is common knowledge; that is known or ought reasonably to be known by the insurer; or in respect of which the insurer waives the compliance with the duty of disclosure.

Representations are not treated differently. Every material representation made by the insured to the insurer before the policy is concluded must be true/accurate.

## Singapore

A contract of insurance is a contract of utmost good faith.

Therefore, in general, the insured is under a duty to disclose to the insurer every material circumstance which is known to the insured, and a circumstance is material if it would influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk. However, in the absence of inquiry, circumstances which diminish the risk, or which are known or presumed to be known to the insurer, or as to which information is waived by the insurer, or which it is superfluous to disclose by reason of any express or implied warranty need not be disclosed.

As for the position with regard to representations, every representation made by the insured to the insurer during the negotiation prior to the conclusion which is material must be true.

## Middle East

A contract of insurance is one of utmost good faith. Accordingly, under Article 1032 (b) of the Civil Code, the insured is under a duty to declare pre-inception, as well as during the period of the contract, all relevant matters relating to the risk being insured. Little guidance exists regarding the meaning of the words "all relevant matters", and accordingly what is "relevant" will be a question of fact in each case and determined by reference to the insured's duty of good faith.

As to misrepresentations, pursuant to Article 1033 of the Civil Code, where the insured acts in bad faith in concealing or misrepresenting any matters, or if the insured provides incorrect information, the insurer is entitled to cancel the insurance contract.

# What do an insured and an insurer know for the purposes of disclosure?

## United Kingdom

An insured who is an individual knows what is actually known to him (including “blind eye” knowledge) and what is known to individuals responsible for the insurance. The knowledge of a non-individual includes what is known to senior management or those responsible for the company’s insurance. In either case the insured will be deemed to know what should reasonably have been revealed by a reasonable search of information available to the insured.

An insurer knows what is known to any individual who participates in the underwriting decision (including “blind eye” knowledge). The insurer ought to know anything that an employee or agent of the insurer knows and ought reasonably have passed to the underwriter, and information held by the insurer that is readily available to the individual responsible for the decision. The insurer is presumed to know things which are common knowledge and things which an insurer offering insurance of the class in question to insureds in the field in question would reasonably be expected to know in the ordinary course of business.

## France

The assessment of the relevant knowledge of the insured is an issue of fact which is appreciated by the lower courts on a case-by-case basis and there is no test as such. The issue of knowledge is particularly critical for the purpose of establishing whether the non-disclosure or misrepresentation was made in bad faith (being one of the requirements for avoiding the policy). Although there is no published case on this point (as at September 2015), it is reasonable to focus on the knowledge of the senior management or those responsible for the company’s insurance.

The issue of the insurer’s knowledge is rarely at issue, but a French Court would presumably follow the same solution as the one applied under English law.

## South Africa

As far as the insured is concerned, the duty to make disclosure relates only to facts of which the insured has actual or constructive knowledge. Constructive knowledge of a fact is imputed to an insured if he ought, in the ordinary course of his business, to have known the fact; he would have ascertained the fact had he made such inquiries as reasonable business prudence required him to make; or his employee acquired actual knowledge of the fact in the course of his employment and was under a duty to communicate his knowledge to the insured.

The insurer is taken to know anything that is within the public domain. From an insured’s perspective this information needs not specifically be drawn to an insurer’s attention when proposing for cover.

The obligation to disclose material information resides with the insured who must act reasonably in making disclosure. The mere fact that a specific issue is not raised in a proposal form will not relieve the insured from the obligation of disclosure.

Of course, the more detailed the proposal form, the more likely that a court will decide that a failure to ask a particular question is suggestive of a lack of interest in that particular matter.

## Australia

The insured knows matters actually known to them (including in circumstances of wilful blindness). This does not include what the insured ‘believes’ or ‘strongly suspects’.

What an insured’s broker knows is not necessarily attributed to the insured in all cases.

In the case of a corporate insured, the insured will be deemed to have actual knowledge of matters within the knowledge of persons who are the directing mind and will of the insured, or known to persons who are employed or act for the insured in arranging the insurance.

The insured will also be deemed to know every matter that a reasonable person in the circumstances of the insured could be expected to know.

An insurer knows matters that are known to a responsible officer of the insurer who either appreciated the significance of the knowledge or should have appreciated its significance. This includes persons involved in the underwriting decision. Further, an insurer is deemed to know matters of common knowledge and of the risks associated with the ordinary trade of the insurer.

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## Canada

A proposer for insurance must disclose information he or she actually possesses or ought reasonably to know. An insurer is deemed to know matters in the public domain that are sufficiently notorious or relevant to the risk. For example, an insurer of aircraft risks is presumed to know of publically available air accident records (*Coronation Insurance v. Taku Ari Transport Ltd.*)

## United States

Courts have not outlined any particular duties for corporate applicants distinct from individual applicants. Presumably, rules of imputation and 'respondeat superior' will apply. Under the fundamental principle of agency, the misconduct of managers acting within the scope of their employment will normally be imputed to the corporation. The insurer may rely upon the insured's representations without conducting an investigation into the veracity or completeness of an insured's disclosure. However, an insurer cannot close its eyes to the obvious. The insurer has no duty to inquire, but the insured has a duty to investigate. Courts may find that more sophisticated insureds have a greater duty to conduct a thorough investigation when applying for coverage.

## Hong Kong

In the context of duty of disclosure, the insured knows matters that he/she actually knows (including the circumstances of wilful blindness). The insured will be deemed to know what should reasonably have been revealed by a reasonable search of information available to the insured in the ordinary course of business.

The insurer knows matters that are known to any individual involved in the underwriting decision (including the circumstances of wilful blindness). The insurer is presumed to know matters of common knowledge and what it would reasonably be expected to know in the ordinary course of business.

## Singapore

An insured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him. An insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of business, as such, ought to know.

## Middle East

A proposer for insurance must disclose all relevant matters relating to the risk being insured which he actually possesses or ought reasonably to know. There is little available guidance on what an insurer is deemed to know, but readily available public information is likely to be included in that.

# What is the position if an insurer fails to ask a question on a proposal form? Or if an insured fails to answer or gives an incomplete answer? For example: the insured leaves the question blank or answers “Yes” but fails to disclose that the procedures are not observed in practice.

## United Kingdom

Case law under the current regime suggests that the questions put in the proposal form may either enlarge or restrict the duty of disclosure, although the fact that particular questions are asked does not per se relieve an insured of the duty to disclose material facts. The phrasing of the questions may however limit the duty (eg if the insurer asks about particular matters but not others, or limits the time frame that is being asked about such as asking if there have been any claims in the last five years then the insurer may be taken to have waived information outside of these boundaries). Leaving the example question blank may arguably put an insurer on notice that it needs to make further enquiries under the new Act. Answering the example question “yes” without giving more information may amount to a non-disclosure/misrepresentation. Obviously this will depend on the facts and the context.

It is possible that questions that have been worded ambiguously in proposal forms will be construed more strictly against insurers under the Act.

## France

If the insurer fails to ask a question, it will not be able to raise a non-disclosure argument. In the event that the insured fails to give an answer or gives an incomplete answer, the interpretation will depend on the question asked. The basic rule is that the insured is entitled to give a vague answer to an unprecise question. The good practice is to ask follow up questions if an answer is incomplete or ambiguous.

## South Africa

Even though the duty of disclosure is not considered to be one that is on-going, policies typically require the insured to notify an insurer about any material changes in the risk during the currency of the policy. This has the effect of creating an on-going duty. The practice has become such common place that even some judges have recently assumed an on-going duty.

## Australia

In Australia, failure to ask a question on a proposal form can, in certain circumstances, constitute a waiver of the requirement for the insured to disclose its response to that particular answer. Much will depend on the nature of the insurance being taken out and the nature and context of the questions asked.

Under the ICA, where an insured fails to answer or gives an obviously incomplete or irrelevant answer to a question included on a proposal form, the insurer is deemed to have waived compliance with the duty of disclosure in relation to that matter (s21(3) of the ICA).

Where an insured fails to answer a question on a proposal form or gives an obviously incomplete or irrelevant answer they are not necessarily held to have made a misrepresentation (s27 of the ICA). The Courts will consider the answer (or absence of one) in context.

## Canada

Generally, it will be assumed that if a question was left unanswered by an insured, and the insurer did not draw attention to this, it will be assumed not to be material to the risk and not give rise to any remedies. However, any given answer must be full and accurate. If incomplete and/or misleading, remedies for non-disclosure apply.

### United States

The insured generally has no obligation to volunteer information which is not requested by the insurer. Some states, however, may permit rescission where the policyholder failed to disclose some circumstance that would have caused the insurer not to write the risk, and even though the insurer did not specifically inquire. An insurer's specific inquiry regarding a matter indicates that the insurer deems it material to the risk, and the insured is thereby on notice that the insurer considers it material and therefore the insured has a duty of inquiry. The insured has a positive duty to review the entire application and correct any incorrect or incomplete answers, and it cannot remain silent if its application contains misleading or incorrect information.

### Hong Kong

In general, not asking a particular question does not relieve the insured of his/her duty to disclose material facts. Nevertheless, the wording of questions in the proposal form may in certain circumstances limit the insured's duty of disclosure.

In the situation where an insured fails to answer a question or give an incomplete answer, it may, depending on the factual circumstances, still constitute non-disclosure/misrepresentation.

### Singapore

It is a matter of construction, depending on the context and wording of the proposal form, whether the questions in the proposal form are intended to be exhaustive, thus affecting the insurer's rights against the insured for non-disclosure.

Where a question in a proposal form is not answered, it is a matter of construction whether a reasonable inference can be drawn that the lack of an answer means that there is nothing to disclose. If so, then if there was a material circumstance which ought to have been disclosed in response to the question, the insurer may avoid the policy for non-disclosure or misrepresentation.

Where an incomplete answer is given which is materially misleading because of what is not stated (as in the example given), the insurer may have a remedy for misrepresentation. But if the incomplete answer was such as to reasonably put the insurer on inquiry, the insurer may be deemed to have waived its rights in respect of the incomplete answer.

### Middle East

If an insurer fails to ask a question on a proposal form, or fails to follow up on an incomplete answer given in a proposal form, a UAE court may not allow the Insurer to raise a non-disclosure argument. The UAE courts have been known to find that if a relevant question has not been asked, the Insurer cannot therefore demonstrate that such matters were material to the underwriting decision as the Insurer is in the best position to ask whatever questions are relevant to its underwriting decisions.

In the example given, a UAE court (or its appointed expert) would most likely find that the insurer has asked the wrong question and that it should have asked two questions, first do you have risk management processes and secondly do you follow them?

# Is there any ongoing obligation of disclosure during the policy term?

## United Kingdom

The general principle (unless the policy provides to the contrary) is that the duty of disclosure comes to an end when the insurance contract is entered into, so that there is no obligation on the insured to keep the insurer informed of matters affecting the risk. If the insured negotiates a variation in cover there may then be a duty of disclosure.

## France

Yes. The Insurance Code requires the insured must declare circumstances that aggravate or create new risks during the policy period, provided they render the answers to the questions in the proposal form inaccurate or obsolete.

## South Africa

Even though the duty of disclosure is not considered to be one that is on-going, policies typically require the insured to notify an insurer about any material changes in the risk during the currency of the policy. This has the effect of creating an on-going duty. The practice has become such common place that even some judges have recently assumed an on-going duty.

## Australia

The general principle is that the duty of disclosure ends when the policy is entered into, and that there is no obligation on an insured to keep the insurer informed of matters affecting the risk. However, this is subject to the terms of the policy and the ongoing duty of utmost good faith, which could be relevant in certain circumstances of post contractual non-disclosure.

## Canada

There is at common law and under statutory conditions an obligation to advise an insurer of any material changes to the risk that occur mid-term.



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### **United States**

The insured has a duty to supplement its application if an answer was incorrect or later becomes incorrect. Applications often include certifications that refer to the insured's obligation to inform the insurer of any alteration or addition to the statements or particulars made in the application which occur before or during the effective date of the policy.

### **Hong Kong**

The general principle is that the duty of disclosure comes to an end at the date on which the policy is concluded, and there is no ongoing obligation of disclosure during the policy term. Having said that, this is subject to the terms of the policy and the ongoing duty of utmost good faith which generally extends beyond the inception of the policy.

### **Singapore**

Subject to any specific contractual requirements to the contrary, there is no general on-going duty of disclosure during the policy term. However, a duty of disclosure arises in the event a variation to the policy is negotiated or where a renewal of the policy is proposed.

### **Middle East**

Yes, the duty of disclosure continues after inception. Pursuant to Article 1032 (c) of the UAE Civil Code, the Insured is obliged to "...notify the insurer of any matters occurring during the period of the contract which lead to such risks being increased".

# What test must insurers meet in order to prove nondisclosure/misrepresentation?

## United Kingdom

An insurer must demonstrate that but for the breach of duty of fair presentation the insurer would not have entered into the contract at all or would only have done so on different terms. The burden of proof in relation to non-disclosure/misrepresentation is on the insurer. It will be necessary to demonstrate that the circumstance which was not disclosed was material. A circumstance is material if it would influence the judgement of a prudent insurer in fixing the premium or in determining whether to take the risk. Expert evidence may be required on the issue of materiality.

## France

An insurer must demonstrate that the non-disclosure or misrepresentation “changes the subject-matter of the risk or alters the insurers’ opinion on that risk”. In practice, that essentially requires showing the materiality of the undisclosed fact on the opinion of a prudent insurer and its decision to underwrite the risks on the same terms and conditions.

## South Africa

A material representation (either in the form of non-disclosure or positive misrepresentation) that actually induces the contract will entitle an insurer to avoid a policy ab initio. There are a few ameliorating factors:

1. the materiality of the misrepresentation will be determined from the point of view of a reasonable person (ie neither an insured nor insurer)
2. the misrepresentation must actually induce the insurer. This two stage test was legislated in 1998 and has been the subject of two significant Supreme Court of Appeal decisions, including *Regent Insurance Company Ltd v King's Property Development t/a King's Prop* [2015] 2 All SA 137 (SCA) in which the insurer's rationale in underwriting of the risk came under significant scrutiny

## Australia

The insurer must demonstrate that the non-disclosure or misrepresentation was relevant to the decision of the insurer whether to accept the risk and, if so, on what terms.

The insurer must demonstrate that, but for the non-disclosure or misrepresentation, it would have declined the risk or accepted it on different terms. This is generally done by way of evidence from the relevant underwriter. Other evidence, such as underwriting guidelines, may also be referred to.

Further, where a statement is untrue as a matter of fact, but is made on the basis of a belief that the person (a) actually and (b) reasonably held, that statement is not treated as a misrepresentation. Equally, a statement is not treated as a misrepresentation unless the person who made it knew, or a reasonable person in the circumstances could be expected to have known, that it would have been relevant to the decision of the insurer whether to accept the risk and, if so, on what terms (s26 of the ICA).

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## Canada

Unless otherwise modified by the policy, the insurer must prove that the non-disclosure or misrepresented fact was both material to the risk (objective) and also would have been subjectively relevant to the underwriter in his or her appreciation of the risk.

## United States

The insurer seeking to rescind a policy has the burden to prove (i) a false statement or failure to disclose; and (ii) that the misrepresentation was material to the risk. A misrepresentation or concealment is material if it affects the underwriter's decision to issue the policy at all, or on the same terms or for the same premium. Generally, to prove materiality as a matter of law, an insurer must provide evidence regarding its underwriting practices to show that it would not have issued the policy if it had known the true facts. An insurer's specific inquiry regarding a matter indicates that the insurer deems it material to the risk, and the insured is therefore under a duty of inquiry with respect to that information. Depending on applicable state law, rescission may be available even if the misrepresentation was unintentional or in good faith. The majority view is that intent to deceive is not required to rescind a policy based on material misrepresentation. Some states, however, require a finding that the policyholder intended to deceive the insurer.

## Hong Kong

The insurer must show that the circumstance which was not disclosed was material, as well as, that the non-disclosure had induced the insurer into entering into the contract of insurance. As for misrepresentation, the insurer must show that the representation was material, that it was not substantially true, and that it induced him to enter into the contract of insurance.

## Singapore

The insurer must show that the circumstance which was not disclosed was material, as well as, that the non-disclosure had induced the insurer into entering into the contract of insurance. As for misrepresentation, the insurer must show that the representation was material, that it was not substantially true, and that it induced him to enter into the contract of insurance.

## Middle East

Although the duty of disclosure appears to be broad, in practice insurers must often prove that the insured acted in "bad faith" or fraudulently. Under UAE law, misrepresentation implies the existence of fraudulent means, which has led to the consent of the other party to enter into a transaction. UAE Courts do not commonly recognise negligent or innocent non-disclosure or misrepresentation. Accordingly, there must usually be an intention, deliberate action or inaction, to deceive by intentional/fraudulent means. The victim of misrepresentation therefore bears the burden of proof in establishing that (i) they were deceived by the misrepresentation and (ii) that the deception was intentional.

# What are insurers' remedies for non-disclosure/misrepresentation prior to policy inception? Is it an all or nothing regime or are there proportionate remedies?

## United Kingdom

Under the Act there are a range of proportionate remedies. Insurers can avoid the policy without return of the premium if the non-disclosure was deliberate or reckless. Otherwise the remedy will depend on what the underwriter would have done. If the underwriter would not have written the risk at all then the policy can be avoided with return of the premium. If the insurer would have written the risk on different terms then the contract of insurance will be treated as if it was written on those terms. If the insurer would have written the risk for a higher premium then the claim will be proportionately reduced.

## France

If the non-disclosure or misrepresentation was intentional or in bad faith, the insurer will be entitled to avoid the policy and keep the premium as "penalty". Otherwise, the insurer will be entitled to terminate or charge a higher premium if it is discovered prior to a loss. If the "innocent" misrepresentation or nondisclosure is discovered after a loss, a proportional remedy can be applied (provided the insurer can establish the premium that would have been applied had the risk been properly disclosed).

## South Africa

Provided the non-disclosure/misrepresentation is material and gives legal grounds for avoidance the remedy is all or nothing. We are however beginning to see proportionate remedies being included within the wording of some policies but this obviously depends on agreement between the parties.

## Australia

If the failure to disclose or misrepresentation is fraudulent, the insurer is entitled to avoid the contract.

In all other circumstances, the insurer is not entitled to avoid the contract, but liability may be reduced to the amount that would place the insurer in a position in which the insurer would have been if there had been no failure to disclose or misrepresentation (section 28 of the ICA).

## Canada

The default remedy at common law is reissue of the policy. This is frequently modified by the terms of the policy with proportionate remedies (or excluded altogether). Under Quebec law only proportional remedies are available.

## United States

A material misrepresentation or omission made in an application for insurance will void an insurer's obligation under the policy. The insurer may rescind the policy or deny future coverage if rescission is not allowed under certain circumstances (eg, pursuant to statute with respect to certain types of policies). When an insurance policy is void ab initio based on material misrepresentations in the application, it is as if the policy never came into existence, and an insured cannot create coverage by relying on the terms of a policy that never existed. Rescission usually requires the insurer to return the premium collected from the insured. In cases where an insurer defends against a claim for coverage on the ground that the insured made a misrepresentation in the application, the insurer is not required to tender the premium prior to trial in the action. Where the insurer makes an affirmative demand for rescission, the insurer is required to tender the premium. Unless there is a severability clause, most courts deem rescission effective to all insureds. Where there is a severability clause, the policy may remain in effect with respect to some insureds but not others.

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### **Hong Kong**

Where the insured has failed to disclose or misrepresented a material fact, the insurer's remedy is avoidance of the policy, and it is an all or nothing remedy. In the context of positive misrepresentation rather than a failure to disclose, the courts may in certain circumstances have the discretion to deny the remedy of avoidance and to substitute an award of damages.

According to the Code of Practice issued by the Hong Kong Federation of Insurers, it is stated that an insurer should not refuse a claim by an insured on the grounds of non-disclosure of a material fact which the insured could not reasonably have been expected to disclose; or on the grounds of misrepresentation unless this is a deliberate or negligent misrepresentation of a material fact. Although the Code of Practice does not have the force of law, insurers in Hong Kong are expected to follow it.

### **Singapore**

Subject to the terms of the contract, the remedy is all or nothing, and the insurer is entitled to avoid the contract of insurance ab initio.

### **Middle East**

Pursuant to Article 1033 of the Civil Code, an insurer may avoid (ab initio) a policy for breach of disclosure obligations under the contract, but can only retain the premium if the insured can be proved to have acted in "bad faith". There are no proportionate remedies.

# What are insurers' remedies in respect of breach of warranty? Are basis clauses permitted?

## United Kingdom

Under the Act, warranties will become suspensory conditions. The insurer will not be liable for losses whilst the insured is in breach of warranty, but if the breach is remedied the insurer will become liable for subsequent losses. Basis clauses will not be permitted.

## France

Warranties are not a recognised category of terms under French law. Depending on context, it will be treated either as a condition, or as an exclusion (which would presumably make it invalid) or as a general obligation (with uncertain sanctions for breach). Basis clauses would presumably not be given effect.

## South Africa

In terms of both Acts, affirmatory warranties are treated the same way as any other representation made during the course of disclosure. In other words, an insurer will only be entitled to avoid the policy if the misrepresentation is adjudged to have materially induced the policy, regardless of whether the representation amounted to a warranty or not. The consequence of the legislative intervention is that insurers may not repudiate a policy as a result of an inconsequential inaccuracy or trivial misstatement in a policy form.

## Australia

The remedies available in respect of breaches of warranty are limited by s54 of the ICA. A breach of a warranty is not treated differently to a breach of any other type of contractual term. The distinction between warranties, suspensive conditions and so on is largely illusory as a result of the operation of s54. Warranties of fact are treated as representations (s24 of the ICA) and can therefore form the basis of claim for misrepresentation if false. Basis of the contract clauses are not effective.

## Canada

Basis of contract clauses have (save for marine insurance generally) been precluded by statute. Subject to certain legislative requirements for special classes of insurance, warranties will generally be interpreted as conditions, the breach of which may lead to forfeiture of cover depending on the seriousness of the breach and nature of the condition.

## United States

An insurer may also decline coverage based on the insured's breach of a warranty in a policy application. An insured may still be able to recover despite having breached a warranty, unless the breach materially increases the risk of loss, damage or injury within the coverage. Basis clauses are generally permitted.

## Hong Kong

Any breach of warranty will result in the policy being discharged automatically, which means that an insurer is not liable for any claims arising after the breach. Basis clauses are not prohibited.

## Singapore

Subject to the terms of the contract, where there has been a breach of a warranty, the insurer's liability is discharged from the date of the breach of the warranty (unless the breach of warranty has been waived).

There is no general prohibition on the use of basis clauses so long as, on general principles of contractual interpretation, the basis clause can be reasonably construed to have elevated the answers in the proposal form to the level of contractual warranties. However, where the insured is a consumer, the CPA applies, and the insurer must ensure that the basis clause does not amount to an "unfair practice" under the CPA.

## Middle East

UAE law does not define "warranties" and there is no substantive law regarding "basis of contract" clauses. If a warranty incorporated into an insurance contract seeks to entitle insurers to avoid the contract, such avoidance will not likely be upheld unless the breach was causative of the loss.

# Is there a provision which means that insurers are unable to rely on breach of policy terms unless the breach is connected to or causative of the loss?

## United Kingdom

Section 11 provides that if a loss occurs then the insurer may not rely on non-compliance with the term to limit or exclude its liability if the insured can show that the non-compliance with the term could not have increased the risk of loss which actually occurred in the circumstances in which it occurred. Section 11 does not apply to terms defining the risk as a whole. Exactly how the term will apply is unclear, although the Law Commission has indicated that the term was not intended to require an analysis of causation.

## France

There is no such provision.

## South Africa

Following English law, the courts have historically held that to prove breach of a fundamental policy term, it is not necessary to establish that the breach was causally connected with the event insured against and hence that it caused or contributed to the occurrence of that event. The issue has not been the subject of judicial opinion for over a century and academic writers suggest that the approach may be out-moded given its lack of equity. Moreover, given the existence of Roman-Dutch authority to the contrary and the fact that English legislature has ameliorated its position leads us to speculate that the current approach will not survive judicial scrutiny.

## Australia

s54 of the ICA limits the circumstances in which an insurer can refuse to pay a claim on the basis of a breach of the terms of the policy. An insurer can refuse to pay a claim outright where post-contractual act or omission could reasonably be regarded as being capable of causing or contributing to a loss (s54(2) of the ICA). The insurer cannot rely on any post-contractual act or omission on the part of the insured which cannot reasonably be regarded as being causative of the loss to refuse to pay a claim outright, but “the insurer’s liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer’s interests were prejudiced as a result of that act.”

## Canada

Does not generally apply to insurance contracts but can be found for certain types of insurance in provincial insurance acts.

## United States

Generally, no. Under certain circumstances, statutory provisions or public policy interests may not allow an insurer to rescind a policy.

## Hong Kong

There is no such provision. According to the Code of Practice issued by the Hong Kong Federation of Insurers, it is stated that an insurer should not refuse a claim by an insured, in the absence of fraud by the insured, on the grounds of a breach of warranty or condition if the loss is unrelated to the breach. Although the Code of Practice does not have the force of law, insurers in Hong Kong are expected to follow it.

## Singapore

There is no such provision.

## Middle East

Yes. Article 1028(e) of the Civil Code provides: “Any of the following provisions appearing in a policy of insurance shall be void...any arbitrary condition breach of which has evidently had no effect on the occurrence of the incident insured against.” Unfortunately, little guidance exists regarding the meaning of the above provision and, in particular, what an “arbitrary” clause as referred to in Article 1028(e) is. It is our experience that the UAE Courts will interpret a condition imposed by an insurance contract (including an express warranty) as being arbitrary in nature if the breach of the clause/condition has no effect on the occurrence of the risk. The effect is that UAE Courts will generally only uphold warranties when there is a causative link between the breach and the loss.

# Is it possible to contract out of the general provisions that govern the terms of an insurance contract?

## United Kingdom

It is possible to contract out of the provisions of the Act in relation to business contracts, with the exception of the prohibition on basis clauses. However, transparency requirements apply where this would put the insured in a worse position than under the Act, and if these are not complied with then the attempt to contract out will be of no effect. A disadvantageous term must be drawn to the insured's attention before the contract is entered into or variation agreed, and the term must be clear and unambiguous as to its effect. The characteristics of insureds of the kind in question and the circumstances of the transaction will be taken into account in determining whether the requirements have been met.

## France

It is not possible to contract out of most of the provisions of the Insurance Code.

## South Africa

No.

## Australia

With a few limited exceptions, contracting out is not permitted (s52 of the ICA).

The exceptions to this rule include s67 of the ICA which deals with the distribution of funds recovered by way of subrogation.

## Canada

In general, parties cannot contract out of mandatory requirements of law, at least not to make the terms and conditions more onerous policy holders.



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### United States

Parties may choose which state law will govern the terms of the insurance contract. Policies often include choice of law provisions specifying applicable state law. Such clauses are presumptively valid and are usually enforceable. The Restatement of the Conflict of Laws, which has been adopted by a number of states, provides that the law of the state chosen by the parties to govern their contractual rights and duties will be applied if the particular issue is one which the parties could have resolved by an explicit provision in their agreement directed to that issue. Rescission, applicable coverage defences and the parties' other rights and obligations under the policy may be resolved by explicit provisions in a policy. If the parties could not have resolved a particular issue by an explicit provision in their agreement, the parties' chosen law will be applied unless the chosen state has no substantial relationship to the parties or the transaction and there is no reasonable basis for the parties' choice, or application of the chosen law would be contrary to a fundamental policy of the state whose law would apply under the most significant relationship test. State law may prohibit enforcement of an agreement that would offend a fundamental public policy.

### Hong Kong

In general, parties cannot contract out of mandatory requirements under the ICO. Having said that, in Hong Kong, the terms of an insurance policy are mainly governed by the common law. In certain circumstances, it is permissible for the parties to include a contract term that purports to limit or exclude their rights (eg the rights to avoid or to claim damages).

### Singapore

The duties imposed on an insurer under the IA carry with them criminal liabilities for breach of those duties. As such, it is not possible to contract out of them.

### Middle East

In theory, it is possible as the Commercial Code applies to insurance activities and affords primary status to the agreement of the parties, which should be paramount even if inconsistent with core provisions of the Civil Code (as described above). However, in practice, the parties will cite and the Courts will often apply the relevant Civil Code protections to favour the Insured, particularly where doing so avoids a harsh outcome.

# Are damages recoverable by an insured from insurers for unjustified refusal to pay under a policy (including a late payment of a claim)?

## United Kingdom

Clause 13A provides that it is an implied term of every insurance contract that an insurer must pay any sums due in respect of a claim "within a reasonable time". This will include a reasonable time to investigate and assess the claim. Reasonableness will depend on a number of factors such as the size and complexity of the claim and the type of insurance and factors outside the insurer's control.

## France

In theory, damages could be recoverable by an insured from insurers for unjustified refusal to pay under a policy. In practice, that is very rarely the case and it only happens in very specific cases in which the insurer's behaviour is obviously unjustified and in bad faith and the resulting damage is significant.

## South Africa

Damages may not currently be recovered but the South African courts will be guided by the approach adopted by the UK courts. To the extent that the action for the payment of indemnity is successfully instituted, interest and costs will be recovered. Interest, until recently, ran at 15.5% per annum but now runs at 9%.

## Australia

At common law in Australia, the court can award damages to compensate for loss of use of money that a party has paid out as a result of the other party's breach (*Hunderford v Walker* (1989) 171 CLR 125). The rule is not confined to insurance but applies to contracts generally. The principle has however been held to apply to contracts of insurance.

In addition, the ICA provides that interest will run from the date at which it was 'unreasonable for the insurer to have withheld payment of the amount' to the day on which payment is made. That date may be before the date at which the insurer formally denies the claim.

## Canada

In exceptional cases, bad faith awards are available under Canadian Common Law if the insurer has acted contrary to its obligations of good faith and fair dealing in handling or settling a claim. The vast majority of such cases are in "consumer" insurance cases, but the principles can be applied in commercial insurance, although this is rare.

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### **United States**

Yes. In many states, insureds may recover damages in limited circumstances for an unjustified refusal to pay under a policy, including punitive and consequential damages, and/or costs for common law or statutory bad faith.

### **Hong Kong**

The general principle is that damages cannot be recovered for unjustified refusal to pay under a policy. The remedy under the current insurance law regime is an award of interest. In Hong Kong, there is no provision similar to section 13A of the UK Insurance Act. The Amendment Ordinance also does not have a similar provision. It is not expected that similar requirement will be introduced in Hong Kong in the near future.

### **Singapore**

Damages are recoverable for non-payment of a valid claim under a policy. However, this may not extend to damages for consequential losses if the English common law approach is followed. There are no provisions similar to s13A of the Insurance Act 2015 in Singapore, and there is currently no proposal to introduce such a provision by legislation. The issue is therefore dealt with by common law.

### **Middle East**

No such damages are recoverable. However, pursuant to both the Civil Code and the Insurance Authority Code of Conduct, an insurer owes a general duty of good faith when dealing with their insured. Theoretically, it may be possible for an insured to: (a) claim damages for breach of this duty of good faith when adjusting and settling claims; and (b) claim damages for consequential losses flowing from the insurer's breach. That said, we have not seen and are not aware of any cases in the UAE, which have considered these issues. Interest is payable on claims, often at punitive rates of 9 to 12%.

# Is there a perception that the current laws in the jurisdiction work effectively, and are there any specific proposals for amendment?

## United Kingdom

There is concern that some of the new provisions contained in the Act are unclear and there is speculation about how they might be interpreted by the courts. There is also potential further future reform in respect of insurable interest.

## France

There is no immediate plan for reform of the general provisions of the Insurance Code.

## South Africa

The Financial Services Board has committed the industry to an outcomes based regulatory and supervisory policy known as “Treating Customers Fairly” which requires insurers to demonstrate a commitment to a number of outcomes at each phase of the insurance product life cycle.

The perception generally is that the present laws work reasonably effectively.

Change is certainly afoot but this relates more to prudential industry regulation than substantive insurance law reform.

On the 17th of April 2015, the National Treasury and the Financial Services Board issued a request for public comment in relation to the Draft Insurance Bill of 2015 (“the Bill”), which aims to achieve a “seamless transition” into the Twin Peaks model of governance envisaged in the over-arching Financial Sector Regulation Bill.

It is important to note that the Bill constitutes framework legislation, meaning that it is designed to be an “empowering” or “enabling” statute that sets out the minimum provisions and powers necessary to regulate insurers, whilst delegating the power to make secondary legislation as well as the authority to implement and enforce the Bill to the Financial Services Board. It is therefore difficult to speculate the precise effect which it is likely to have but it seems the intention of government is to align provisions regarding corporate governance and solvency with the IMF’s “Basel III” standards.

## Australia

The ICA has been in place since 1984. There is a general perception that the legislation is effective (although that is not to say that it is immune from criticism).

There is now a significant body of case law which assists in interpreting the provisions, and therefore provides further certainty. In other words, it is now a fairly mature and well understood regime.

There are no amendments on the horizon, although some amendments which were made in 2013 will come into force in December 2015.

## Canada

The law is generally perceived as effective and predictable. Certain provinces have carried out reforms in the last ten years (British Columbia and Alberta). Further reforms will no doubt occur but no whole scale changes are anticipated.

## United States

Generally, yes, but this will depend on the applicable state law.

## Hong Kong

The current law regime is generally perceived as effective, and flexible for both insurer and insured.

In July 2015, the Legislative Council has passed the proposed amendments to the current Insurance Companies Ordinance (Cap 41) (the ICO), which will be renamed as the Insurance Ordinance (the Amendment Ordinance). The objective of the Amendment Ordinance is largely not to alter the balance between insurer and insured, but to introduce a new regulator and a statutory licensing system for insurance intermediaries in order to bring the regulatory regime in line with international standards. The Amendment Ordinance has not come into effect, and will be implemented in three stages. It is expected to be fully implemented within two to three years.

One of the changes in the Amendment Ordinance is to impose the requirement for insurance intermediaries (including the insurance agents and brokers) to act honestly, fairly and in the best interests of the insured. It remains uncertain as to how this requirement will operate in practice, although radical change from the current position is not expected. The new regulator will issue a Code of Conduct to provide clarification and elaboration.

## Singapore

Generally, the perception is that the current laws work effectively, at least from the perspective of the insurer. There are currently no specific proposals for amendment which would tilt the balance towards the insured.

## Middle East

The laws are under-developed and often ineffective and do not allow for commercial certainty in many cases. However, there is no immediate plan for reform of the general provisions of the Insurance laws.

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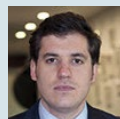
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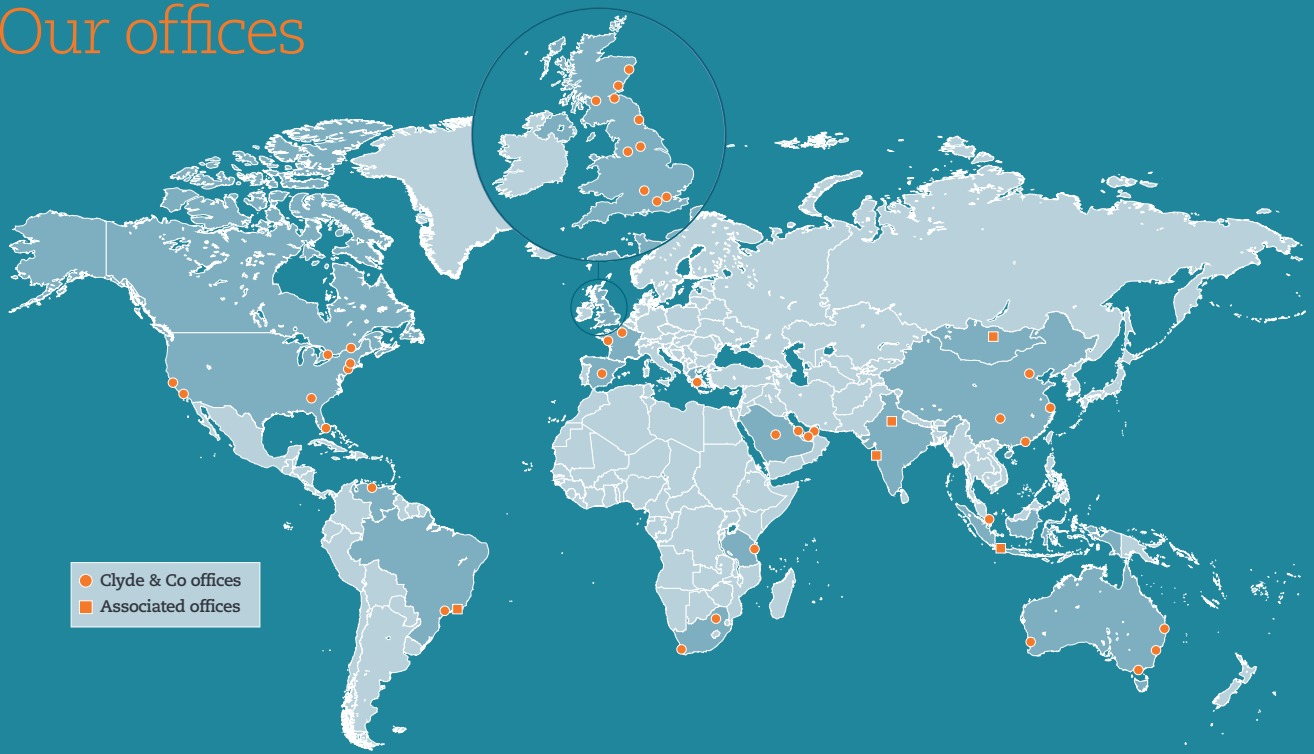


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