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Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; and Late Payment



The Law Commission and The Scottish Law Commission

(LAW COM No 353)

(SCOT LAW COM No 238)

INSURANCE CONTRACT LAW: BUSINESS DISCLOSURE; WARRANTIES; INSURERS' REMEDIES FOR FRAUDULENT CLAIMS; AND LATE PAYMENT

*Presented to the Parliament of the United Kingdom by the Lord Chancellor
and Secretary of State for Justice
by Command of Her Majesty*

Laid before the Scottish Parliament by the Scottish Ministers

July 2014

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The terms of this report were agreed on 3 July 2014.

The text of this report is available on the Internet at:

<http://lawcommission.justice.gov.uk/areas/insurance-contract-law.htm>

<http://www.scotlawcom.gov.uk/publications/>

**THE LAW COMMISSION
THE SCOTTISH LAW COMMISSION**

**INSURANCE CONTRACT LAW: BUSINESS
DISCLOSURE; WARRANTIES; INSURERS' REMEDIES
FOR FRAUDULENT CLAIMS; AND LATE PAYMENT**

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TABLE OF ABBREVIATIONS

The 1906 Act	Marine Insurance Act 1906
ABI	Association of British Insurers
Airmic	The risk managers' association
BIBA	British Insurance Brokers' Association
BILA	British Insurance Law Association
CIDRA	Consumer Insurance (Disclosure and Representations) Act 2012
FOS	Financial Ombudsman Service
FCA	Financial Conduct Authority
FSMA	Financial Services and Markets Act 2000
ICOBS	Insurance Conduct of Business Sourcebook
IUA	International Underwriting Association
LMA	Lloyd's Market Association
NZLRC	New Zealand Law Reform Commission
PEICL	Principles of European Insurance Contract Law
PRA	Prudential Regulation Authority
UTCCR	Unfair Terms in Consumer Contracts Regulations 1999

GLOSSARY OF TERMS

Assured/insured	Another name for a policyholder. The “insured” is now defined in clause 1 of the draft Bill.
Broker	An individual or firm who arranges the sale or purchase of insurance.
Cover	Insurance or reinsurance of one or more risks.
Data dumping	Where a proposer gives an insurer a large amount of undigested information for the insurer to sort through and decide what’s relevant.
Enquiry/inquiry	These are used interchangeably to denote the concept of asking questions, rather than establishing a full scale investigation. We understand the latter is generally referred to as an “inquiry”.
Hard market	Where the demand for insurance outstrips the supply. This can result in higher premiums or less extensive cover being offered.
Insurance intermediary	Someone through whom insurance is bought or sold, usually a broker.
Insurer/underwriter	These terms can be used interchangeably; we tend to use the former to mean the insuring firm or company, and the latter to mean the individual(s) making the underwriting decision.
Personal lines	Insurance cover for individual consumers, such as buildings and contents insurance, personal injury insurance or motor insurance.
Placing broker	A broker who places insurance cover on behalf of its client with an underwriter.
Policyholder	The person insured under an insurance contract.
Premium	The price charged by the insurer in return for providing insurance cover.
Producing broker	A broker who introduces a proposal for insurance or reinsurance to its own broking firm or another broking firm.
Proposal form	A standard form usually produced by the insurer which asks for information about the proposer. The insurer bases its decision of whether and on what terms to offer cover on the information provided.
Proposer	The party seeking insurance.

Reinsurance	Insurance purchased by one insurer from another insurer to cover losses it might incur in relation to claims made by its policyholders.
Retrocession	The reinsurance of a reinsurer by another reinsurer.
Soft market	Where the availability of insurance outstrips the demand. This can result in lower premiums or an offer of more extensive cover.
Underwriting	The process by which an underwriter evaluates and assesses the risk for which cover is sought and decides whether to offer cover, on what terms and at what price.

MAIN PROJECT PUBLICATIONS

- CP1 Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (June 2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134.
- http://lawcommission.justice.gov.uk/docs/cp182_ICL_Misrep_Non-disclosure_Breach_of_Warranty.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/123/107/
- CP2 Insurance Contract Law: Post Contract Duties and other Issues (December 2011) Law Commission Consultation Paper No 201; Scottish Law Commission Discussion Paper No 152.
- http://lawcommission.justice.gov.uk/docs/cp201_ICL_post_contract_duties.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/947/107/
- CP3 The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155.
- http://lawcommission.justice.gov.uk/docs/cp204_ICL_business-disclosure.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/1020/107/
- Consumer Report Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (December 2009) Law Com No 319; Scot Law Com No 219.
- http://lawcommission.justice.gov.uk/docs/lc319_Consumer_Insurance_Law.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/268/107/
- IP1 Issues Paper 1 - Misrepresentation and Non-Disclosure (September 2006)
- http://lawcommission.justice.gov.uk/docs/ICL1_Misrepresentation_and_Non-disclosure.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/214/107/
- IP2 Issues Paper 2 - Warranties (November 2006)
- <http://lawcommission.justice.gov.uk/consultations/warranties.htm> and
http://www.scotlawcom.gov.uk/index.php/download_file/view/215/107/
- IP3 Issues Paper 3 - Intermediaries and Pre-contract Information (March 2007)
- http://lawcommission.justice.gov.uk/docs/ICL3_Intermediaries_and_Pre-contract_Information.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/216/107/

- IP4 Issues Paper 4 - Insurable Interest (January 2008)
[http://lawcommission.justice.gov.uk/docs/ICL3 Intermediaries and Pre-contract Information.pdf](http://lawcommission.justice.gov.uk/docs/ICL3_Intermediaries_and_Pre-contract_Information.pdf) and
http://www.scotlawcom.gov.uk/index.php/download_file/view/203/107/
- IP5 Issues Paper 5 - Micro-Businesses (April 2009)
[http://lawcommission.justice.gov.uk/docs/ICL5 Micro-businesses.pdf](http://lawcommission.justice.gov.uk/docs/ICL5_Micro-businesses.pdf)
and
http://www.scotlawcom.gov.uk/index.php/download_file/view/201/107/
- IP6 Issues Paper 6 - Damages for Late Payment and the Insurer's Duty of Good Faith (March 2010)
[http://lawcommission.justice.gov.uk/docs/ICL6 Damages for Late Payment.pdf](http://lawcommission.justice.gov.uk/docs/ICL6_Damages_for_Late_Payment.pdf) and
http://www.scotlawcom.gov.uk/index.php/download_file/view/192/107/
- IP7 Issues Paper 7 - The Insured's Post-Contract Duty of Good Faith (July 2010)
[http://lawcommission.justice.gov.uk/docs/ICL6 Damages for Late Payment.pdf](http://lawcommission.justice.gov.uk/docs/ICL6_Damages_for_Late_Payment.pdf) and
http://www.scotlawcom.gov.uk/index.php/download_file/view/208/107/
- IP8 Issues Paper 8 - The Broker's Liability for Premiums: Should Section 53 be Reformed? (July 2010)
[http://lawcommission.justice.gov.uk/docs/ICL8 Brokers Liability for Premiums.pdf](http://lawcommission.justice.gov.uk/docs/ICL8_Brokers_Liability_for_Premiums.pdf) and
http://www.scotlawcom.gov.uk/index.php/download_file/view/205/107/
- IP9 Issues Paper 9 - The Requirement for a Formal Marine Policy: Should Section 22 Be Repealed? (October 2010)
[http://lawcommission.justice.gov.uk/docs/ICL9 Requirement for Formal Marine Policy.pdf](http://lawcommission.justice.gov.uk/docs/ICL9_Requirement_for_Forma_l_Marine_Policy.pdf) and
http://www.scotlawcom.gov.uk/index.php/download_file/view/580/107/

Summaries of responses to each of the consultations and issues papers are available at: <http://lawcommission.justice.gov.uk/areas/insurance-contract-law.htm> and <http://www.scotlawcom.gov.uk/law-reform-projects/joint-projects/insurance-law>.

MAIN TEXTS

Arnould	Arnould's Law of Marine Insurance and Average (17th ed 2008)
J Birds	Birds' Modern Insurance Law (9th ed 2013)
M A Clarke	The Law of Insurance Contracts (5th ed 2006)
Chitty	Chitty on Contracts (31st ed 2012)
Colinvaux	Colinvaux's Law of Insurance (9th ed 2010),
Colinvaux & Merkin	Colinvaux & Merkin's Insurance Contract Law
MacGillivray	J Birds, S Miles, B Lynch, MacGillivray on Insurance (12th ed 2012)
L Macgregor	The Law of Agency in Scotland (2013)
W W McBryde	The Law of Contract in Scotland (3rd ed 2007)
E C Reid & J G W Blackie	Personal Bar (2006)
B Soyer	Warranties in Marine Insurance (2nd ed 2006)
B Soyer (ed)	Reforming Marine and Commercial Insurance Law (2008)

All websites referenced in this document were valid as of 30 June 2014.

PART 1

INTRODUCTION

THE LAW COMMISSION AND THE SCOTTISH LAW COMMISSION

INSURANCE CONTRACT LAW: BUSINESS DISCLOSURE; WARRANTIES; INSURERS' REMEDIES FOR FRAUDULENT CLAIMS; AND LATE PAYMENT

To the Right Honourable Chris Grayling, MP, Lord Chancellor and Secretary of State for Justice, and the Scottish Ministers

CHAPTER 1 INTRODUCTION

- 1.1 Insurance underpins a healthy and prosperous society, enabling businesses and individuals to protect themselves against risk. The UK insurance industry is the third largest in the world,¹ the largest in Europe and a vital part of the UK economy.² The Government's UK insurance growth action plan recognises the fundamental role played by insurance, "whether strengthening the resilience of local communities, sustaining regional growth or underpinning global trade."³ It states:

The Government wants to see an insurance sector that helps customers manage risk, puts its customers first, by harnessing the power of new technology and creating products that meet their needs, and has their trust and confidence.⁴

- 1.2 Insurance is not only important for the individual consumer or business customer. It also has ramifications for the whole economy, restoring businesses to health after natural disasters such as floods. Further, insurance products and services are also a crucial UK export.

¹ Behind the USA and Japan.

² The UK insurance market manages investments amounting to 25% of the UK's total net worth and contributing over £10 billion in taxes to the Government: Association of British Insurers, *UK Insurance Key Facts 2013*, pp 1 and 2. <https://www.abi.org.uk/~media/Files/Documents/Publications/Public/2013/industry%20data/UK%20Insurance%20Key%20Facts%202013.ashx>.

³ HM Treasury, *The UK insurance growth action plan* (December 2013), Foreword, p 3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263148/the_UK_insurance_growth_action_plan.pdf.

⁴ Above, para 5.3.

- 1.3 Since 2006 the Law Commission of England and Wales and the Scottish Law Commission have been engaged in a joint project examining UK insurance contract law. In many ways the current law is outdated and out of step with the realities of 21st century commercial practices. This increases the likelihood that insurance may fail to respond as expected, or at all. It leads to disputes between insurers and policyholders, causing delay, expense and uncertainty. Furthermore, it risks undermining trust in UK insurance in the international marketplace.
- 1.4 The two Law Commissions have concluded that there is a need to reform aspects of insurance law to help maintain an effective and competitive insurance market, in line with the Government's action plan.

A NEW INSURANCE CONTRACTS ACT

- 1.5 In this Report we publish and explain a draft Bill to reform insurance contract law in four targeted areas:
- (1) disclosure and misrepresentation in business and other non-consumer insurance contracts;
 - (2) insurance warranties;
 - (3) the insurer's remedies for fraudulent claims; and
 - (4) damages for late payment of claims.
- 1.6 Our reforms are aimed at ensuring a better balance of interests between policyholders and insurers. We hope that a Bill can be introduced into Parliament soon, to increase confidence and investment in the UK insurance market. At the time of writing, HM Treasury is consulting on whether the draft Bill will be suitable for the special procedure for uncontroversial Law Commission Bills in the 2014-15 Parliamentary session.

PREVIOUS REPORTS

- 1.7 There have been several previous reports calling for the reform of insurance contract law. The Law Reform Committee recommended reform in 1957.⁵ The Law Commission undertook a review in 1980,⁶ concluding that the law was "undoubtedly in need of reform", and that such reform had been "too long delayed".⁷

⁵ Fifth Report of the Law Reform Committee (1957) Cmnd 62.

⁶ Insurance law: Non-disclosure and Breach of Warranty (1980) Law Com No 104.

⁷ Above at para 1.21.

- 1.8 A major factor in our decision to return to this area was a report by the British Insurance Law Association (BILA) in 2002. The report was prepared by a sub-committee with an impressive breadth of membership – academics, insurers, lawyers and loss adjusters. BILA declared itself “satisfied that there is a need for reform” and expressly supported previous work by the Law Commission in this field.⁸

A HISTORY OF THE PROJECT

- 1.9 We started our joint review of insurance contract law in 2006 in response to BILA’s report. As we set out below, the project has now involved over seven years of research and consultation – and one Act of Parliament. We have had the benefit of a great deal of help and support from a wide cross section of the insurance market, together with legal practitioners and judges. Our views and proposals have developed as a result.
- 1.10 There is now widespread acceptance, including within the insurance industry, that legislative reform is needed. There is also agreement on the general substance of the proposed reforms.

Issues papers

- 1.11 Our initial views were set out in a series of nine issues papers, listed at the beginning of this Report. Responses to these papers helped to refine our ideas to the point that they were sufficiently well-developed for inclusion in a series of three consultation papers.

Consultation papers and responses

- 1.12 In July 2007, we published our first consultation paper, setting out detailed proposals for reform of the rules on disclosure and warranties.⁹ We received 105 written responses and attended over 50 meetings with insurers, policyholders, brokers, lawyers and representative groups. We produced summaries of responses on the consumer proposals in May 2008 and on the non-consumer proposals in October 2008.

⁸ BILA, *Insurance Contract Law Reform – Recommendations to the Law Commissions* (2002) at para 4.

⁹ Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (July 2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134.
<http://lawcommission.justice.gov.uk/consultations/misrep-breach-warranty.hm> and
http://www.scotlawcom.gov.uk/index.php/download_file/view/123/107/.

- 1.13 We decided to focus initially on the consumer's duty to disclose information to the insurer and in December 2009 we published our final report and draft Bill on this topic.¹⁰ The Bill was passed by Parliament using the special procedure for non-controversial Law Commission Bills,¹¹ and became the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA replaces the consumer's duty to volunteer information with a duty to answer the insurer's questions honestly and reasonably.
- 1.14 We then returned to working on general issues of insurance contract law. In December 2011 we published our second consultation paper, covering damages for late payment of claims, remedies for fraudulent claims, insurable interest and policies and premiums in marine insurance (CP2).¹² We followed this in June 2012 with our third consultation paper on the duty of disclosure in business insurance, and on insurance warranties in all types of contract (CP3).¹³ We received 53 written responses to CP2, and published summaries of these in December 2012. A total of 50 responses were received to CP3, and we published our summary of these in March 2013. We also conducted consultation exercises on draft clauses from the Bill, published in January and February 2014.

Future work

- 1.15 Three areas which we have considered during this project are not covered by this report. These areas are: insurable interest; the broker's liability for premiums; and the requirement for a formal marine policy. We intend to publish a third, and final, report by the end of 2014.

¹⁰ Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (December 2009) Cm 7758, Law Commission No 319; Scottish Law Commission No 219. <http://lawcommission.justice.gov.uk/areas/consumer-insurance.htm> and http://www.scotlawcom.gov.uk/index.php/download_file/view/268/107/.

¹¹ Described at <http://www.publications.parliament.uk/pa/ld200708/ldselect/ldprohse/63/6303.htm>.

¹² Insurance Contract Law: Post Contract Duties and Other Issues (December 2011) Law Commission Consultation Paper No 201; Scottish Law Commission Discussion Paper No 152. http://lawcommission.justice.gov.uk/consultations/post_contract_duties.htm and http://www.scotlawcom.gov.uk/index.php/download_file/view/947/107/.

¹³ Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155. http://lawcommission.justice.gov.uk/consultations/business_disclosure.htm and http://www.scotlawcom.gov.uk/index.php/download_file/view/1020/107/.

THE CASE FOR REFORM

The changing face of the insurance market

- 1.16 The current law in the UK is based on principles developed in the eighteenth and nineteenth centuries and codified in the Marine Insurance Act 1906 (the 1906 Act). Although the 1906 Act appears to apply only to marine insurance, most of its principles have been applied to non-marine insurance on the basis that the 1906 Act embodies the common law (which itself is mostly based on principles developed in marine cases). The Act is written in clear, forthright terms which can constrain the court's ability to develop the law.
- 1.17 When Lord Mansfield first developed the principle of good faith, the insurance market was a small group of individuals based in London. In 1771, 79 underwriters joined together to form the Society of Lloyd's.¹⁴ Since then, the insurance market has grown substantially and changed beyond all recognition. By 1988 Lloyd's had 32,433 individual members, known as Names.¹⁵ This was the high-water mark for individual membership. By 2010, corporate vehicles provided 95% of the capital needed to underwrite business at Lloyd's. Similarly, the International Underwriting Association, representing London market insurers who do not participate in the Lloyd's market, currently has 66 member companies.¹⁶ The vast majority of insurance is now written by corporate insurers, many of whose parent companies are based abroad.
- 1.18 These changes have meant that a market which was initially based on face-to-face contact and social bonds has developed into one based on systems, procedures and sophisticated data analysis. Furthermore, the types of risks insured have widened and the volume of information available to market participants has grown exponentially. 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.

¹⁴ Described in P L Bernstein, *Against the Gods: The Remarkable Story of Risk* (1996) at p 91. The late eighteenth and early nineteenth century Court of Session cases reported in Morison's Dictionary under the heading "Insurance" give the impression that Scottish merchants usually effected their marine insurance through fellow merchants in their home port, although underwriting by merchants from other ports, including some in England, was not unknown.

¹⁵ P T O'Neill and J W Woloniecki, *The Law of Reinsurance* (3rd ed 2010) at paras 2-012 and 2-014.

¹⁶ See http://www.iaa.co.uk/IIA_Test/About/Members/IIA_Test/About_the_IIA/Members.aspx?key=726cc99e-fcbb-4b02-9d74-d53c80a163df.

- 1.19 The 1906 Act is generally accepted to have provided the insurance market and legal profession with “an accessible and comprehensive legal framework.”¹⁷ It became a model for codification, particularly in common law jurisdictions, forming the basis of marine insurance legislation in New Zealand, Australia, Malaysia, India, Hong Kong, Canada and Singapore and influencing the laws of the United States and Japan. However, many of these countries have since reformed their laws, leaving the UK out of line with an international marketplace.¹⁸

The problems with codification

- 1.20 Codification has made it difficult for the courts to develop the law to keep pace with commercial changes. Although recent cases have glossed the 1906 Act to accommodate contemporary conditions, the clear words of the 1906 Act continue to exert a strong gravitational pull. The law looks certain on paper, but in practice it is far from it.
- 1.21 In seeking to do justice the courts are forced to reinterpret either the law or the facts, leading to major uncertainties. This encourages parties to seek alternative forums in which to resolve disputes, such as the Financial Ombudsman Service (FOS) for consumer matters and confidential arbitration in commercial disputes. This further inhibits the development of the law in any modern and consistent fashion.
- 1.22 Codification is a one-way street. Once the law has been codified, there is no practical way of de-codifying it.¹⁹ Any revision to the 1906 Act requires further primary legislation, which is why this report focuses on statutory reform.
- 1.23 The author of the 1906 Act, Sir Mackenzie Chalmers, was aware that codification had both advantages and disadvantages. In 1901, during the twelve years it took for his Bill to become law, he said that while men of business would probably prefer a code, lawyers would feel constrained by it, given that no code can provide for every case. Nevertheless, he concluded:

It is cheaper to legislate than to litigate; moreover, while a moot point is being litigated and appealed, pending business is embarrassed.²⁰

- 1.24 We do not think that Chalmers intended his Act to continue in force for more than a hundred years without amendment. He would have assumed that future generations would maintain the law in the same way as they would maintain buildings and infrastructure. We hope that Parliament will be able to carry out this necessary maintenance soon.

¹⁷ B Soyer in B Soyer, ed, *Reforming Marine and Commercial Insurance Law* (2008) Preface, vii.

¹⁸ In CP2 we refer in particular to the changes in New Zealand, Australia, Canada, Ireland and the USA.

¹⁹ Other than repealing it entirely and reverting to the common law, which would produce immense uncertainty.

²⁰ M D Chalmers CSI and D Owen, *A Digest of the Law of Marine Insurance* (1901), at viii, quoted by Lord Justice Longmore in the Pat Saxton Memorial Lecture, *An Insurance Contracts Act for a New Century*, 5 March 2001, at para 29.

The law allows unmeritorious refusals

- 1.25 The 1906 Act is insurer-friendly. The principles were developed at a time when the insured knew their business while the insurer did not, and were designed to protect the fledgling insurance industry against exploitation by the insured. Where a policyholder is in breach of an obligation, the law gives wide-ranging opportunities for the insurer to avoid the contract and refuse all claims, or to treat its liability as discharged, even where the remedy seems out of proportion to the wrong done by the policyholder.
- 1.26 In this Report we discuss three areas where the law currently allows an insurer to refuse a claim irrespective of the merits of the case. It would be rare for an insurer to deliberately exploit these defects in the law and refuse claims without a good commercial reason, but we think that these defects exacerbate disputes. Furthermore, they have the potential to bring UK insurance law into disrepute. If UK law were to lose its international reputation, it could take many years to rebuild. The three areas are outlined below.

The duty of disclosure

- 1.27 The duty of disclosure requires the policyholder to disclose to the insurer every material circumstance which they know or ought to know before entering into a contract of insurance. This duty is so wide and undefined that the policyholder can rarely be certain that they have complied with it. Once a claim is made, an insurer may find another circumstance which was not mentioned. This problem is exacerbated by the single, draconian remedy of “avoidance”, which allows the insurer to refuse all claims. Although complete refusals are rare, avoidance is a powerful negotiating tool, which can be used to reduce the scale of payments.

Breach of warranty

- 1.28 Typically, an insurance warranty is a promise by the policyholder to do something to mitigate the risk, for example to maintain an alarm or sprinkler system. It is fair that if the policyholder fails to mitigate a risk as agreed, the insurer should not be liable to pay for it. However, any breach of warranty discharges the insurer from liability, even if the breach is remedied. For example, if the alarm fails and is then repaired, the insurer can refuse a claim which occurs after the alarm has been restored to full working order. Furthermore, the insurer can refuse any claim, no matter how unrelated it is to the breach. For example, a flood claim can be refused because the burglar alarm is not working. Again, it is very rare for a claim to be refused entirely on this sort of ground, but arguments of this type may be made as part of a dispute, adding cost, complexity and delay to the settlement process.

“Basis of the contract” clauses

- 1.29 The problems with the law of insurance warranties are compounded by the fact that statements on a proposal form may be converted into a warranty using obscure words that few policyholders understand. For example, if a policyholder signs a clause stating that the proposal forms the “basis of the contract”, this converts every statement on that form into a warranty. This can have draconian consequences. It allows the insurer to avoid paying a claim if any statement on the form is inaccurate, even if the statement is minor and immaterial. Thus a mistake in an address which has no bearing on the risk may in theory be used to refuse a claim.²¹
- 1.30 Judges have criticised “basis of the contract” clauses for over a century. In 1908, Lord Justice Fletcher Moulton said he wished he could “adequately warn the public against such practices”.²² However, as recently as 2013, the Court of Appeal confirmed that “basis of the contract” clauses remain valid.²³

The problem of fraud

- 1.31 The harsh rules on disclosure and warranties are sometimes used when the insurer suspects, but cannot prove, fraud. While we have every sympathy with an insurer who suffers fraud, it is dangerous to allow an insurer to refuse claims on a technicality where the policyholder has not committed a fraud, but is wrongly suspected of doing so. This brings the industry into disrepute and reduces the necessary trust. We accept that insurers are particularly vulnerable to fraud by policyholders and that the law needs to provide well-known, robust sanctions. Unfortunately, the law in this area is confused. The draft Bill therefore sets out clear remedies.

No damages for late payment in English law

- 1.32 Another problem is that the English courts have held that an insurer is not liable to pay damages for loss caused by their failure to pay valid claims within a reasonable time. For example, if an insurer unreasonably delays payment for three years, and as a result a business fails, the insurer is not liable for the losses caused by the failure to pay, however foreseeable. This is out of line with normal contract law principles, with the law in Scotland and with the other jurisdictions we have looked at.

PROBLEMS IN PRACTICE

- 1.33 We have received evidence from UK businesses that the current law is adding to insurance disputes.

²¹ See, for example, *Dawsons Ltd v Bonnin* [1922] 2 AC 413, 1922 SC (HL) 156.

²² *Joel v Law Union and Crown Insurance Co* [1908] 2 KB 863 at 885.

²³ *Genesis Housing Association Ltd v Liberty Syndicate Management Ltd for and on behalf of Liberty Syndicate 4472 at Lloyd’s* [2013] EWCA Civ 1173, [2013] WLR (D) 368.

- 1.34 Mactavish is a research and advisory service specialising in insurance and risk. In 2012 and 2013 it interviewed around 400 UK businesses in both the public and private sectors, each with an annual turnover of £50m or more. Insurance claims were common: around 40% reported making a significant insurance claim within the previous three or four years. However, only a quarter of those claims were said to have been (or were about to be) resolved to the insured's general satisfaction. Disputes had arisen in 45% of claims, and these disputes had taken an average of just under 3 years to resolve. The four main grounds for dispute were (in order): policy coverage, quantification of loss, breach of warranty or condition, and non-disclosure.²⁴
- 1.35 The risk managers' association, Airmic, represents insurance buyers and claims handlers for about 75% of FTSE 100 companies and a substantial number from FTSE 250 and smaller firms. In 2010, Airmic surveyed its members' experience of problems with the duty of disclosure. That survey also revealed a high rate of disputes: 31% of participants were found to have had issues of non-disclosure raised against them in the last five years, and 5% had been involved in litigation on the issue. In 2013 Airmic found that non-disclosure continued to be a major concern. When asked to identify "the five aspects of the insurance market which are of most concern to you", just over half (53%) mentioned "innocent non-disclosure of material information". This put it at the top of the list. Meanwhile, two-fifths (42%) mentioned "delayed insurance claim payments" and a third mentioned "warranties and basis of the contract clauses".
- 1.36 Recent research by the British Insurance Brokers' Association (BIBA), found that 89% of respondents thought that insurers were becoming stricter in their approach to claims payment, with 77% of them attributing this to the general economic climate.²⁵
- 1.37 These figures show a high (and worrying) rate of dispute. Clearly, not all are due to difficulties with the law, but some are. We think that defects with the law exacerbate these disputes, leading to cost and delays. In the current economic climate it may be difficult for a business to borrow money while waiting for its insurance claim to be paid, meaning that the business is extremely vulnerable to delay by an insurer. This puts pressure on companies to accept lower settlements.
- 1.38 In their response to CP3, Mactavish summed up the position as follows:

The current corporate insurance market is characterised by too much coverage uncertainty, too many disputes, too much leverage of dispute potential in negotiation and too little work to narrow the scope for dispute at the placement stage.

²⁴ Mactavish summary of recent evidence provided to the Law Commission in January 2014.

²⁵ BIBA member research, "Insurance brokers adding value in the claims process" (January 2013). <http://www.biba.org.uk/UploadedFiles/752claimsresearch2013.pdf>.

THE EFFECT OF “QUALITY UNCERTAINTY”

- 1.39 One problem is that insurance buyers find it difficult to assess the quality of insurance when entering into a contract. They cannot tell whether claims will be paid without difficulty, or whether the insurer will exploit loopholes in the law to delay payment and reduce the size of settlements.

“The market for lemons”

- 1.40 Economists have studied the effect of “quality uncertainty” on markets generally. The problem was first identified in 1970 by Professor Akerlof in his groundbreaking essay on “the market for lemons”.²⁶ In the USA, a “lemon” is a second hand car which looks adequate but proves defective. Akerlof used this as an example of what happens when sellers can assess the quality of the product but buyers cannot. The effect is a race to the bottom, where poor quality products drive out the good ones.
- 1.41 In Professor Akerlof’s example, half the cars are “lemons” and half are good (“plums”). The owners of lemons are prepared to sell for \$1000; the owners of plums for \$2000. The buyers would be happy to pay more: \$1200 for a lemon and \$2400 for a plum. At first sight, this looks like a successful market, but unfortunately the buyers do not know which car is which. All they know is that half the cars are lemons. So they will discount the amount they are willing to pay to \$1800, to allow for the fact they may get a lemon. But the owners of plums are not prepared to sell for this sum, so they withdraw their cars from the market. As the better cars are withdrawn, the average quality falls. This leads to further reductions in price, leading more and more owners to withdraw. Hence the race to the bottom.
- 1.42 In other words, if buyers cannot tell good quality products from poor ones, the mere presence of poor quality goods or services can destroy the market for good quality ones. People who want to buy good products can no longer do so, even though they are happy to pay a fair price.

The relevance to the insurance market

- 1.43 We think that the insurance market has some features of a “market for lemons”. Unable to assess quality, policyholders tend to buy on price. The emphasis on price then puts greater pressure on insurers to reduce quality.²⁷
- 1.44 Some aspects of insurance contract law establish a default regime which permits insurers to escape payment for a commercially unmeritorious reason. Many insurers have told us that they do not use the excuses the law offers. However, insurers offering a good quality product remain vulnerable to competitive pressure from others, as long as policyholders do not know how any particular insurer will act in a particular situation.

²⁶ G Akerlof, “The Market for ‘Lemons’: Quality Uncertainty and the Market Mechanism”, *The Quarterly Journal of Economics*, Vol 84 No 3 (Aug 1970) pp 488-500.

²⁷ The rise of price comparison websites provides some evidence of this phenomenon.

- 1.45 Policyholders may want to buy “plums”, and may be happy to pay for “plums”, but may be unable to do so. We are told that policyholders often ask for better terms, but find it too difficult and resource-intensive to negotiate.²⁸ Furthermore, when a policyholder asks for better terms, the insurer may suspect that the policyholder is contemplating a dubious claim, leading to an outright refusal.
- 1.46 Our reforms are designed to change the default regime so that it meets a basic standard. Outside the consumer market, businesses should still be able to negotiate for “lemons” if they wish to do so, but we think that “lemon terms” should be brought to their attention. In Part 6 of this Report we recommend that in non-consumer insurance, the parties should be entitled to contract out of the default regime, but only if the term is written in clear, unambiguous language and is brought to the policyholder’s attention.
- 1.47 Some consultees have worried that our recommendations will lead to increases in premiums. We think these worries are over-stated, for two reasons. The first is that many insurers have said that the recommendations reflect their current behaviour. To the extent that this is true, they should not expect to have a significant increase in pay-outs and therefore should not have to make any significant price increases.
- 1.48 Secondly, policyholders have said that they would be willing to pay for more effective insurance. Our reforms are aimed at improving the market so that commercial parties can negotiate for the price and quality which meets their needs. Where price is the key determining factor for a policyholder they may agree to exclusions or limitations to reduce the up-front cost, with the associated (and accepted) risk that the insurance may not respond in as many circumstances.

²⁸ Mactavish summary of recent evidence provided to the Law Commission in January 2014.

THE APPROACH OF THE DRAFT BILL

- 1.49 This Report and draft Bill set out our recommendations in four main areas.
- (1) We recommend bringing together the law of non-disclosure and misrepresentation into a single “duty of fair presentation”. Part 2 of the draft Bill retains the duty on business policyholders to volunteer information, but clarifies its boundaries, defining what an insured knows or ought to know. The Bill also requires insurers to play a more active role, asking questions in some circumstances. Importantly, we also recommend a new system of proportionate remedies to apply where the draconian threat of avoidance is inappropriate.
 - (2) On warranties, Part 3 of the draft Bill implements three main recommendations. It abolishes “basis of the contract” clauses. It requires the insurer to pay a claim which arises after a breach of warranty has been remedied. It also states that where a term is designed to prevent loss of a particular type (or at a particular place or time) it should not remove the insurer’s liability to pay for a different type of loss (or loss at a different place or time).
 - (3) The first part of Part 4 of the draft Bill provides the insurer with clear, robust remedies for fraud. The main remedy in the draft Bill is the one already established by the courts: if a claim is tainted by fraud, the policyholder forfeits the whole claim. The draft Bill also clarifies an area of uncertainty: the insurer may refuse any claim arising after the fraudulent act. However, previous valid claims are unaffected.
 - (4) The second part of Part 4 requires insurers to pay any sums due in respect of the claim within a reasonable time. If they do not, insurers may be liable for losses caused by their breach, on normal contractual principles.
- 1.50 Part 5 of the draft Bill makes changes to the duty of good faith in section 17 of the 1906 Act and sets out the rules on contracting out of the recommended default regime. Part 6 makes consequential amendments. These include amendments to the Road Traffic Act 1988, necessitated by the changes to the duty of fair presentation.
- 1.51 The draft Bill is intended to develop the law rather than replace it. Many of our recommendations are based on existing judicial interpretation. Key terms (such as “insurance” and “fraudulent claim”) are intended to bear their existing common law meanings, so are deliberately left undefined in the draft Bill. Instead, these terms are defined by case law, which will continue to be developed by judges. We do not wish such definitions to be preserved in aspic and become inappropriate in the future. In other cases we have retained the existing statutory language (as in “material circumstance”), signalling that the existing case law will continue to apply. We do not wish to make changes unless strictly necessary and the draft Bill is intended to operate with the structure of the existing law. It is therefore short and principles-based.

LEGISLATIVE COMPETENCE AND COMPATIBILITY WITH THE EUROPEAN CONVENTION ON HUMAN RIGHTS AND EU LAW

- 1.52 In anticipation of the implementation of our recommendations, we note that the law of insurance is specifically reserved to the competence of the Westminster Parliament.²⁹ We are also of the view that the proposed legislation is fully compatible with the European Convention on Human Rights and that it raises no issues under European Union law.

SUPPORT FOR REFORM

- 1.53 Support for our proposals comes from across the insurance market including from insurers, brokers, lawyers, regulators, trade associations, judges and individual policyholders.

- (1) 80% of consultees (36 of 45) agreed with the need to reform the law relating to the business policyholder's obligation to provide information when buying insurance and the insurer's remedies if the policyholder fails to provide accurate information.
- (2) 88% of consultees (36 of 41) agreed that the law of insurance warranties required amendment.
- (3) 87% of consultees (34 of 39) agreed that insurers should have a contractual obligation to pay valid insurance claims within a reasonable time.
- (4) 92%, 75% and 94% of consultees (out of 38) agreed with the Commissions' core proposals relating to insurance fraud.

- 1.54 The remaining balance of consultees did not necessarily disagree with our proposals. They sometimes proposed alternative solutions or sought clarification. Consultees' views on individual detailed recommendations varied. However, we do not recommend any changes to the existing law without a substantial majority in favour.

- 1.55 The Association of British Insurers (ABI) summarised its position as follows:

The ABI has been supportive of the Law Commissions' work to date on reforming insurance contract law. We appreciate the care taken by the Law Commissions to ascertain the views of as many stakeholders as possible in order to ensure that the reforms are as effective as possible. The ABI's members are largely supportive of the Law Commissions' proposals as set out in the Draft Insurance Contracts Bill.

²⁹ In terms of section A3 (Financial Services) of Part II of Schedule 5 to the Scotland Act 1998.

1.56 Airmic, in response to our consultation on the draft Bill clauses, said:

The draft clauses represent a significant advance on those provisions of the Marine Insurance Act 1906 (MIA) covered by the consultation. These draft clauses should be urgently enacted, given the length and extent of the consultation activities that underpin the proposals.

The Law Commission has succeeded in producing a set of draft clauses that describe a default scheme that will create a significantly more fair and equitable contractual relationship between the insured and the insurer. The draft clauses provide greater clarity than the existing MIA provisions in relation to the disclosure duties of the insured ... Also, the suggested range of remedies available to the insurer in the event of breach by the insured of the duty to provide a fair presentation of the risk is balanced and well-structured.

1.57 The International Underwriting Association commented in response to the same consultation:

We recognise that there have been competing interests on a broad range of insurance contract law items and appreciate that the Law Commission has, by and large, come to a balanced and proportionate review of insurance contract law, maintaining suitable flexibility for business parties to come to their own arrangements as required. This approach is crucial in recognising the bargaining power and expertise utilised by wholesale (re)insurers and their advisors and ultimately supports the efficiency of the London market as a renowned global insurance centre.

THE STRUCTURE OF THIS REPORT

1.58 The next Chapter explains the application of our recommendations to consumer and non-consumer insurance, and considers some key definitions. This Report is then divided into further Parts:

- (1) Part 2 describes the current law on pre-contractual disclosure and representations. It also explains our recommendation to replace the existing duties with a duty to make a fair presentation of the risk.
- (2) Part 3 deals with insurance warranties.
- (3) Part 4 looks at remedies for fraudulent claims.
- (4) Part 5 considers damages for late payment of claims.

1.59 Part 6 is divided into four Chapters and deals with matters of general application:

- (1) The first Chapter of Part 6 sets out our recommended rules for contracting out of the reforms set out in the previous Parts.
- (2) The following Chapter reaffirms the insurance contract as one of utmost good faith. It then sets out our reasons for recommending the removal of avoidance as a remedy for breach of good faith from section 17 of the 1906 Act.

(3) The penultimate Chapter considers the effects of our recommended reforms on compulsory insurances, with a particular focus on motor and employers' liability arrangements.

(4) The final Chapter contains a list of our recommendations.

1.60 The Report has three appendices:

(1) Appendix A contains the draft Bill and Explanatory Notes.

(2) Appendix B discusses remedies for breach of the duty of fair presentation in the context of variations.

(3) Appendix C lists those who responded to our second and third consultation papers and to our limited consultation on the draft Bill.

1.61 An impact assessment for our proposals will be published on our websites.³⁰

THANKS

1.62 We would like to thank all those who responded to issues papers, consultations and requests for information. We are extremely grateful for all contributions to this lengthy project. With the help of our consultees, we hope we have been able to set out recommendations for a modern law of insurance contracts that both commands widespread support and protects the competitive position of the UK insurance market in the long term.

³⁰ <http://lawcommission.justice.gov.uk/areas/insurance-contract-law.htm> and <http://www.scotlawcom.gov.uk/law-reform-projects/joint-projects/insurance-law>.

CHAPTER 2

THE SCOPE OF THE RECOMMENDATIONS AND KEY DEFINITIONS

INTRODUCTION

- 2.1 In this Chapter we consider overarching matters which inform the scope of our recommendations as a whole.
- 2.2 We consider the definitions of “insurance”, and “consumer” and “non-consumer” insurance. Our approach in the draft Bill is necessarily influenced by the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) which came into force in April 2013.
- 2.3 In this Chapter we also explain our reasons for recommending a single regime for all “non-consumer” insureds, whether they are a sole trader or multinational company. Finally, we discuss the definition of “insured”, and the fact that our recommendations are principally concerned with contractual insurance relationships rather than the rights of potential third party beneficiaries.
- 2.4 Finally, we briefly consider matters of commencement, application and extent.

THE DEFINITION OF INSURANCE

- 2.5 The draft Bill does not define insurance. In 1980, the Law Commission noted that there was no statutory definition of “a contract of insurance”. However, the courts are experienced in determining these matters.¹ The Commission thought that a statutory definition would be “unnecessary and undesirable”.²
- 2.6 The Marine Insurance Act 1906 (the 1906 Act) does not have a definition of insurance, relying instead on common law principles.³ Many of our recommendations are designed to replace some of the provisions of the 1906 Act, and therefore the scope of their application must be the same.
- 2.7 We have reached the same conclusion as the Law Commission did in 1980. The matter should be left to the courts, applying common law principles. This is the same approach as that adopted in CIDRA.

¹ See, generally, *Chitty on Contracts* (31st ed 2012) para 41-001 and following.

² Insurance Law: Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 2.7.

³ Although section 1 of the 1906 Act does provide a definition of a contract of marine insurance.

- 2.8 The regulatory regime is constrained by the Financial Services and Markets Act 2000 (Regulated Activities) Order 2001,⁴ which largely adopts the common law approach to defining insurance, subject to some specific inclusions and exclusions. In practice, we think that whether a contract is offered by an authorised insurance company will influence a court’s categorisation of the contract.⁵ However, the courts will not be bound by any specific inclusions or exclusions within the Regulated Activities Order in force at the time.
- 2.9 Contracts of reinsurance and retrocession are treated as contracts of insurance at common law and this will continue.⁶

A CONTRACTUAL RELATIONSHIP: THE INSURED AND THE INSURER

- 2.10 Clause 1 of the draft Bill includes definitions of “insurer” and “insured”. Importantly, each is described as a “party to the contract of insurance”.⁷
- 2.11 Our review has been limited to insurance contract law. In the vast majority of cases therefore, it concerns the rights and obligations of the parties to the insurance contract. Our reforms do not directly concern, for example, the position of third party beneficiaries under liability policies.

A note on terminology

- 2.12 In this Report we describe the parties to an insurance contract as “insurer” and “insured”, or as “insurer” and “policyholder”. Insured and policyholder are used synonymously. Although the draft Bill refers to the “insured”, in non-legislative prose we think that “policyholder” is often less likely to cause confusion than the insured/insurer combination.

CONSUMER AND NON-CONSUMER INSURANCE

- 2.13 Most of our recommendations apply to both consumer and non-consumer insurance. However, the distinction is important for two reasons. First, Part 2 of the draft Bill (dealing with the duty of fair presentation) only covers non-consumer insurance. The equivalent provisions for consumers are already found in CIDRA. Secondly, the reforms are intended to be mandatory for consumer contracts, but a default regime for non-consumer contracts. The distinction is therefore crucial in understanding the provisions on contracting out.
- 2.14 “Consumer” and “consumer insurance contract” are already defined in CIDRA. “Non-consumer insurance” must therefore capture all insurance contracts which are not entered into by a “consumer”, as defined in CIDRA.

⁴ SI 2001/544.

⁵ As the Law Commission said in 1980, in cases of uncertainty the courts will have regard “to whether one of the parties is an authorised insurance company” (para 2.7).

⁶ *Delver, Assignee of Bunn v Barnes* (1807) 1 Taunt 48, by Lord Mansfield.

⁷ The “insured” also includes a potential insured in the context of the recommended duty of fair presentation, which arises pre-contract. This is discussed in Chapter 7.

Consumer insurance

2.15 Section 1 of CIDRA defines a “consumer insurance contract” as an insurance contract between an insurer⁸ and:

an individual who enters into the contract wholly or mainly for purposes unrelated to the individual's trade, business or profession.

2.16 In other words, to be a consumer the insured must meet two tests. First, they must be an individual – that is a natural rather than a non-natural person. Secondly, they must enter into a contract “wholly or mainly” for purposes unrelated to their trade, business or profession.

2.17 This means that in “mixed use” policies, where the insurance covers some private and some business use, one needs to look at the main purpose of the insurance. For example, insurance on a car used mainly as a taxi with only the occasional private trip would be considered commercial insurance. However, an individual who insured their home contents for £30,000 including £3,000 of business equipment would be considered a consumer.

2.18 Clause 1 of the draft Bill imports CIDRA’s definition of “consumer insurance contract”. It provides that a “non-consumer insurance contract” means an insurance contract that is not a consumer insurance contract.

Non-consumer insurance

2.19 The effect of this definition is that an insurance contract may be “non-consumer” for two reasons: either the policyholder is not an individual, or they have entered into the contract mainly for trade, business or professional reasons.

2.20 In many cases, both reasons will apply: the policyholder will be a company or other corporate entity taking out insurance for commercial reasons. However, either reason is enough in itself. For example, an individual person acting as a sole trader and buying insurance mainly related to their business would be a non-consumer. Equally, any company taking out insurance will be a non-consumer, even if the company is not engaged in business or trade. An example would be a company set up by a wealthy individual to own a yacht. If the company were to insure the yacht, it would not be a consumer insurance contract, even if the yacht were used only for leisure purposes.

2.21 In CP3 we described non-consumer insurance as “business insurance”. This is a useful shorthand, but in the draft Bill we use the term “non-consumer insurance” to clarify that the duty covers all contracts which do not fall within CIDRA, including those made with charities and not-for-profit organisations.

⁸ Defined by section 1 of CIDRA as “a person who carries on the business of insurance and who becomes a party to the contract by way of that business (whether or not in accordance with permission for the purposes of the Financial Services and Markets Act 2000)”.

ONE REGIME FOR ALL BUSINESS INSURANCE

- 2.22 The distinction between consumers and non-consumers is the only distinction we make between different types of policyholder. Our recommendations for non-consumers therefore apply to all business and other non-consumer insurance. This includes insurance for micro-businesses and small or medium-sized enterprises, as well as large risks, marine insurance and reinsurance.

A separate regime for micro-businesses?

- 2.23 In response to our 2007 Consultation Paper,⁹ some respondents suggested that additional protections should be provided to the smallest businesses, that is, those with fewer than 10 employees.¹⁰ We consulted on this point in Issues Paper 5, where we considered whether micro-businesses should be treated like consumers for the purposes of pre-contractual information, unfair terms and warranties.¹¹ In CP3, we explained in detail why we were not proceeding with this proposal.¹²
- 2.24 The first problem was the difficulty of definition. The Financial Ombudsman Service (FOS) definition of a micro-business is extremely complicated. It has three limbs, looking at numbers of staff, annual turnover and balance sheet. The test also includes special provision for changes in turnover; for new enterprises; and for linked enterprises. As it is a European test, figures are given in euros and need to be converted into sterling.¹³
- 2.25 The FOS is able to apply this test at the time of the dispute, but we concluded that it was too complex to apply when the insurance was bought. There was too much risk that a business would think of itself as a small business, and fail to give a full presentation of the risk, but would then find to its surprise that it was not treated as a small business. There was also a risk that some extremely complex “special purpose vehicles” engaged in sophisticated financial transactions would be classified inappropriately as small businesses because they did not employ staff.
- 2.26 Secondly, insurers expressed concern about the costs of complying with three separate insurance law regimes. Before every contract, insurers would need to enquire about the status of the insured (leading to difficult questions about the effect of a mistake in replying to these questions). Insurers also mentioned problems with documentation, IT and training costs.

⁹ Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (June 2007).

¹⁰ Of 57 consultees who gave their views, 15 thought there was a need to provide further protection.

¹¹ Issues Paper 5: Micro-Businesses. Should micro-businesses be treated like consumers for the purposes of pre-contractual information and unfair terms? (April 2009).

¹² See CP3, Appendix A.

¹³ See CP3, Appendix A. In particular, see A.33 and A.41 and following.

2.27 Thirdly, we did not find evidence that in practice micro-businesses are particularly disadvantaged by insurance law. In this market, insurers usually ask questions and do not rely on the insured to present the risk. The evidence suggested that the main problems occurred in large claims, which tended to come from large businesses.

2.28 We concluded that while there might appear to be a logical case to distinguish small businesses, there was insufficient evidence of a systemic problem in practice to justify the costs of imposing a third regime. Nor are micro-businesses without protection. As we discuss below, they are entitled to complain to the FOS, which is not bound by the letter of the law. The FOS can apply consumer-type protection if it thinks it fair and reasonable to do so.

A default regime with flexible protection for small businesses

2.29 For non-consumer insurance we recommend a default regime, which parties can contract out of where appropriate. However, we recognise that smaller insureds are likely to be less aware of insurance law and less able to secure favourable contractual terms than a large sophisticated insured with a strong negotiating position.

2.30 As we discuss in Chapter 29, we recommend two procedural requirements if a contract term puts the insured in a worse position than they would be in under the draft Bill. These procedural requirements are intended to operate flexibly, depending on the circumstances of the insured: insurers will need to do more to bring a term to the attention of a small business, particularly if the business is buying online without a broker.

THE ROLE OF THE FINANCIAL OMBUDSMAN SERVICE

2.31 The Financial Ombudsman Service (FOS) was established by the Financial Services and Markets Act 2000. Under section 228, ombudsmen are directed to determine complaints “by reference to what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case”. Ombudsmen may therefore depart from the law where they consider the law to be operating unjustly.

- 2.32 The FOS has jurisdiction to hear complaints from consumers and micro-businesses.¹⁴ For most consumer and micro-business policyholders with disputes about insurance, the FOS offers the only realistic method of redress. There are many reasons why a policyholder may prefer to use the FOS rather than the courts, including the fact that the FOS is free to use.¹⁵ Moreover, for some types of dispute, the FOS offers policyholders the only opportunity of obtaining a result outside the constraints of the strict legal framework, which includes the 1906 Act. If the policyholder went to court, the court would be forced to apply the full rigour of the law.
- 2.33 Currently the FOS is in a difficult position. It may decide that it would not be “fair and reasonable” to apply the rules of the 1906 Act to a micro-business. However CIDRA also may be inappropriate because it is designed for consumers. The vast majority of businesses in the UK are small¹⁶ and this uncertainty is not good for them or for their insurers.
- 2.34 Several consultees have asked how our recommendations would affect the decisions which the FOS makes. We have consulted regularly with the FOS about our proposals for reform of insurance contract law. Given that our recommendations are intended to redress the balance of the law to make it more neutral, we hope that the FOS would more often feel able to apply a new Act. However, the responsibility of the ombudsmen is to decide what is “fair and reasonable in all the circumstances”. There may always be cases in which the FOS considers that strict application of the law is not the answer. The FOS therefore provides some further protection to micro-businesses where the strict application of the principles in the draft Bill would not be appropriate.

LEAD-IN TIME

- 2.35 In many instances we have been told that our recommendations represent what is already best practice in the market, so that this legislation may not involve many significant changes in practice. Further, we understand that most insurers regularly review their application forms, processes and policy wording. We hope that our recommendations will be one factor to be borne in mind during these reviews, with firms ensuring that their practices and contracts accommodate the recommendations or make it clear where they are providing an alternative regime. We do not think that insurers need to wait for the legislation to be enacted before doing this.

¹⁴ A “micro-business” is defined as a business which employs fewer than 10 staff and has an annual turnover of less than €2 million. The current rules came into effect on 1 November 2009 as a result of the implementation of the Payment Services Directive (PSD). The PSD adopts the general European definition of a micro-enterprise, as set out in the European Commission’s Recommendation 2003/361/EC.

¹⁵ In our 2007 Consultation Paper, para 3.56, we listed ten reasons. The FOS is also quicker, more accessible and more inquisitorial, and can be used without legal representation.

¹⁶ In 2011, the Office for National Statistics found that 88.8% of businesses had fewer than 10 employees, Office for National Statistics, “UK Business: Activity, Size and location 2011” (October 2011).

- 2.36 However, the draft Bill also provides a one year lead-in time, between being passed and coming into effect.¹⁷ This is to ensure that insurers have time to carry out a final review of their processes in light of the legislation.

APPLICATION

- 2.37 If the draft Bill were to be enacted, the recommendations would apply to contracts of insurance entered into after the legislation came into force.¹⁸ In addition, because Part 2 of the draft Bill makes specific provision for variations to insurance contracts in the context of our fair presentation recommendations, those provisions would also apply to variations agreed after the legislation came into force but which affect pre-existing contracts.¹⁹

EXTENT

- 2.38 The draft Bill extends to England and Wales and to Scotland.²⁰ Neither the Law Commission nor the Scottish Law Commission has the requisite mandate to make recommendations or draft legislation to cover Northern Ireland, the Channel Islands or any other jurisdiction.

¹⁷ See draft Bill, clause 20(2).

¹⁸ See draft Bill, clauses 20(3)(a) and 20(4).

¹⁹ See draft Bill, clause 20(3)(b).

²⁰ See draft Bill, clause 20(5).

PART 2

FAIR PRESENTATION

CHAPTER 3

FAIR PRESENTATION: INTRODUCTION

- 3.1 An insured often knows more than the insurer about the risk to be insured. It is therefore important to encourage a full and frank exchange of information before the insurance contract is made. Under the current law, the onus is on the prospective policyholder to disclose information to the insurer. This obligation to “present the risk” enables the UK insurance market to provide insurance for a wide variety of large and specialist risks, efficiently and cost-effectively.
- 3.2 We think that this fundamental pre-contract duty is important to the successful operation of the UK insurance market. However, the law which governs the duty is more than 100 years old. It no longer works as well as it should. The law pre-dates the information revolution, before which the volume of data that firms stored, analysed and accessed was much smaller. The law is unclear and difficult to comply with, and the consequences of breaching the duty are harsh.
- 3.3 Good disclosure requires co-operation between both parties: the policyholder knows how the business is run; the insurer knows which facts are relevant to assessing the risk. We think that the law should do more to encourage both sides to work together to exchange information.

REFORMING THE DUTY FOR NON-CONSUMER POLICYHOLDERS

- 3.4 For consumer insurance, the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) removed the duty on policyholders to volunteer information to the insurer. Instead consumers need only answer the insurer’s questions carefully and honestly.
- 3.5 In this Part of the Report, we recommend reforms for all other forms of insurance, including insurance taken out by large and small businesses and by charities. For non-consumer insurance, we recommend preserving the duty on the policyholder to present the risk, subject to some reforms. These are designed to provide policyholders with more guidance on what to include; to require insurers to play an active role in the process, by asking questions as appropriate; and to introduce fairer, more proportionate remedies when the duty is breached.
- 3.6 Our reforms are designed as a default regime. We wish to preserve freedom of contract, so the parties to a contract would be free to agree other arrangements. However, as we explain in Chapter 29, where the insurer proposes a disadvantageous term, it must be clear and unambiguous in its effect, and the insurer must take sufficient steps to bring it to the policyholder’s attention before the contract is signed.

THE CURRENT DUTY OF DISCLOSURE

- 3.7 The current law is set out in the Marine Insurance Act 1906 (the 1906 Act). The central element is section 18, which places an onerous duty on the assured (the policyholder) to disclose to the insurer “every material circumstance” which the policyholder “knows or ought to know” before concluding a contract. Under section 18(2), a material circumstance is defined as “every circumstance which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk”.
- 3.8 This effectively requires the policyholder to look into the mind of a hypothetical prudent insurer and to work out what would influence it, with little additional guidance. The words of section 18 suggest that the insurer may play a passive role, without asking questions or indicating what it wishes to know. As a result, anxious policyholders may burden insurers with huge amounts of unsorted information in an attempt to ensure that nothing is omitted. These “data dumps” are often unhelpful.
- 3.9 However, the duty of disclosure may not be quite as strict as first appears. The courts have developed the concept of “a fair presentation of the risk”. Case law requires insurers to ask questions where the disclosure they have received to date suggests that there is more they need to know. Insurers are said to “waive” their right to that further information if they do not ask those questions. However, there is a tension between this case law and the words of section 18.
- 3.10 If the policyholder fails to comply with the duty of disclosure, the law provides the insurer with only one remedy: avoidance of the contract. In other words, the contract can be treated as if it has never been made, and all claims made under it refused. This harsh remedy may over-protect insurers against minor failures.

PROBLEMS

- 3.11 The duty of disclosure has been subject to major criticisms over many years, including reports from the Law Reform Committee in 1957,¹ from the Law Commission in 1980² and from the British Insurance Law Association in 2002.³ There is continuing evidence that the duty does not work well. In particular:
- (1) The duty is poorly understood – and often appears so onerous that policyholders do not know how to go about complying with it.

¹ Law Reform Committee, Fifth Report (1957) Cmnd 62.

² Law Commission, Insurance Law: Non-disclosure and Breach of Warranty (1980) Law Com No 104.

³ BILA, *Insurance Contract Law Reform – Recommendations to the Law Commissions* (2002).

- (2) Medium to large companies in particular do not know how to judge what the company “knows or ought to know”. They do not know how to go about gathering information for disclosure.
- (3) Although there are exceptions in section 18(3), these are written in archaic language and not well known.
- (4) The statute appears to allow insurers to play a passive role, without asking questions about relevant issues. This encourages “underwriting at claims stage”, where insurers ask questions only when a claim arises, and then use that information to threaten refusal of the claim.
- (5) Avoidance is an “all or nothing” remedy, which leads to adversarial disputes. It can be overly harsh, allowing insurers to refuse the whole claim even if, had they known the full information, they would still have accepted the risk but at a slightly higher premium.

CONSULTATION ON THE DUTY OF FAIR PRESENTATION

- 3.12 As discussed in Chapter 1, our present recommendations and draft Bill clauses on disclosure and misrepresentation follow substantial consultation with the insurance industry and other interested stakeholders over several years.

A history of the consultation process

Issues papers

- 3.13 Our initial views on the matters covered in this Part were set out in two separate issues papers.
- (1) Issues Paper 1 (IP1), in September 2006, which considered the law of misrepresentation and non-disclosure in both a consumer and a business context.⁴

⁴ Issues Paper 1: Misrepresentation and Non-Disclosure (September 2006). http://lawcommission.justice.gov.uk/docs/ICL1_Misrepresentation_and_Non-disclosure.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/214/107/.

- (2) Issues Paper 3 (IP3), in March 2007, on intermediaries and pre-contractual information, which looked at when the policyholder is responsible for mistakes by an intermediary in communicating information to the insurer.⁵

Our 2007 consultation paper and reforms to consumer insurance

- 3.14 In July 2007, we published our first consultation paper (CP1),⁶ setting out detailed proposals for reform. This paper considered issues of disclosure and misrepresentation in both the consumer and non-consumer context.
- 3.15 There was strong support for reforming consumer law in this area,⁷ and we decided to give this priority. In 2009 we published a report recommending reform of the law of disclosure and misrepresentation in consumer insurance.⁸ This led to CIDRA, which came into force in April 2013.
- 3.16 For non-consumer insurance, we proposed a test based on what a reasonable insured would think was relevant to an insurer. We received substantial feedback on this test, which led us to modify our views. We published a summary of the responses which is available on our websites.⁹

⁵ Issues Paper 3: Intermediaries and Pre-contract Information (March 2007).
http://lawcommission.justice.gov.uk/docs/ICL3_Intermediaries_and_Pre-contract_Information.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/216/107/.

⁶ See Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (June 2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134.

⁷ Reforming Insurance Contract Law: a summary of responses to consultation on consumer issues (May 2008).
http://lawcommission.justice.gov.uk/docs/ICL_summary_of_responses_consumer.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/217/107/

⁸ Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (December 2009) Law Com No 319; Scot Law Com No 219.
http://lawcommission.justice.gov.uk/docs/lc319_Consumer_Insurance_Law.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/268/107/.

⁹ Reforming Insurance Contract Law: a summary of responses to consultation on business issues (October 2008).
http://lawcommission.justice.gov.uk/docs/cp182_ICL_summary_of_responses_business.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/218/107/.

Our 2012 consultation paper on non-consumer insurance

- 3.17 We published updated proposals for non-consumer insurance in our June 2012 Consultation Paper (CP3).¹⁰ We received 50 responses to our proposals on disclosure and misrepresentations, and attended meetings with insurers, policyholders, brokers, lawyers and representative groups.
- 3.18 In March 2013 we published a summary of responses to our non-consumer proposals.¹¹ Our updated proposals received considerably more support and indicated that we had managed to balance the range of interests at stake.
- 3.19 The recommendations set out in this report are intended to implement those 2012 proposals.

SUPPORT FOR REFORM

- 3.20 The great majority of consultees (80%) agreed that there was a need to reform sections 18 to 20 of the 1906 Act. This included many insurers and insurance groups, including Direct Line Group, RSA, AXA Corporate Solutions Assurance (AXA), Chartis, NFU Mutual Insurance Society (NFU Mutual), GRiD and the Investment & Life Assurance Group (ILAG). The Association of British Insurers (ABI) told us:

The proposals appear to offer greater clarity for insureds in respect of their duty to disclose and the impact of not disclosing material information. It is in the interests of both insurers and insureds that the duty of disclosure has been complied with, leading to greater certainty that risks are correctly assessed and priced and coverage will be assured.

¹⁰ Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155.
http://lawcommission.justice.gov.uk/docs/cp204_ICL_business-disclosure.pdf and
<http://www.scotlawcom.gov.uk/law-reform-projects/joint-projects/insurance-law>.

¹¹ Summary of responses to third consultation paper, Chapter 1: The business insured's duty of disclosure (March 2013). http://lawcommission.justice.gov.uk/docs/duty-of-disclosure_responses_duty.pdf and <http://www.scotlawcom.gov.uk/law-reform-projects/joint-projects/insurance-law>.

- 3.21 The risk managers' association Airmic¹² reported that their members were "overwhelmingly in favour of reform". Airmic's 2013 member survey revealed that the possible failure of claims due to innocent non-disclosure of information was the number one concern of commercial insurance buyers.¹³
- 3.22 Professor John Birds agreed with the call for reform, saying that "given the developments since the 1906 Act... this would be eminently sensible".

THE STRUCTURE OF THIS PART

- 3.23 This Part is divided into 8 further chapters:
- (1) In the next chapter, we briefly summarise the current law of disclosure and misrepresentation.
 - (2) Chapter 5 sets out the case for reform.
 - (3) Chapter 6 provides an overview of our recommendations.
- 3.24 The details of the recommendations are set out in the following chapters:
- (1) In Chapter 7, we discuss our recommendations for a new duty on the insured to make a fair presentation of the risk, encompassing updated duties in relation to disclosure as well as the duty not to make misrepresentations.
 - (2) In Chapter 8, we focus on the insured's knowledge. We set out our recommendations to define what an insured knows or ought to know for the purposes of disclosure.
 - (3) In Chapter 9, we look at the agent's knowledge, explaining why we think that section 19 of the 1906 Act should be incorporated into the insured's overarching duty of fair presentation.
 - (4) In Chapter 10, we discuss the existing exceptions to the insured's pre-contractual duties, including exceptions based on the insurer's actual, attributed and constructive knowledge. We make certain recommendations for change.

¹² Airmic represents the insurance buyers and claims handlers for about 75% of FTSE 100 companies and a substantial number from FTSE 250 and smaller firms.

¹³ Airmic, Pre Conference Survey 2013.

- (5) In Chapter 11, we discuss the difficulties with the single remedy of avoidance provided by the current law. We set out a recommended scheme of proportionate remedies, and a statutory requirement for the insurer to show inducement before a remedy is available.

CHAPTER 4

THE CURRENT LAW

- 4.1 Here we provide a brief summary of the current duties on policyholders to provide information to the insurer about the risk. For further detail, readers are referred to Consultation Paper 3 (CP3).¹

THE MARINE INSURANCE ACT 1906

- 4.2 The law governing disclosure and representations in the non-consumer context is contained in sections 17 to 20 of the Marine Insurance Act 1906.² The 1906 Act codifies principles developed in the eighteenth and nineteenth centuries. Although the 1906 Act only appears to relate to marine insurance, most of its principles (including sections 17 to 20) have been taken to apply to all insurance on the basis that it embodies the common law.³

SECTION 17: A CONTRACT OF THE UTMOST GOOD FAITH

- 4.3 Section 17 of the 1906 Act states:

A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.

- 4.4 Insurance contracts are therefore one of a small number of types of contract that are of the “utmost good faith”.
- 4.5 The requirement on the policyholder to disclose relevant information before entering into the contract is one example of the duty of good faith. It contrasts with the law which applies to other (non-insurance) commercial contracts, where a party must not misrepresent facts but is under no obligation to disclose facts about which it is not asked.

¹ Insurance Contract Law: The Business Insured’s Duty of Disclosure and the Law of Warranties (June 2012). See also Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (June 2007) (CP1); Issues Paper 1: Misrepresentation and Non-Disclosure (September 2006) and Issues Paper 3: Intermediaries and Pre-contract Information (March 2007).

² Sections 18 to 20 do not apply to consumer insurance, by virtue of the Consumer Insurance (Disclosure and Representations) Act 2012.

³ See, for example, Lord Mustill’s comment in *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501 at 518.

- 4.6 The principle of good faith is wider than the policyholder's duties to provide the insurer with pre-contract information. We consider good faith in its own right in Chapter 30.

SECTION 18: THE DUTY OF DISCLOSURE AND EXCEPTIONS TO THE DUTY

- 4.7 Section 18 of the 1906 Act places a duty on the policyholder to disclose information to the insurer.

Section 18(1)

- 4.8 The essential duty is set out in section 18(1), which states:

Subject to the provisions of this section, the assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured, and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him. If the assured fails to make such disclosure, the insurer may avoid the contract.

Below we look at these words in more detail.

“Before the contract is concluded”

- 4.9 The duty to disclose arises only before the contract is formed or varied. Unlike in some civil law systems, there is no general duty to inform the insurer of changes to the risk while the contract subsists.
- 4.10 In the UK, most insurance policies are for a fixed term, typically a year. At the end of the year, most policies fall due for renewal. The legal position is clear: a renewal is a new contract, and the duty to disclose arises again.
- 4.11 When negotiating a variation to the contract, policyholders must disclose facts “material to the *additional* risk being accepted by the variation” as a matter of good faith.⁴ There is no requirement to disclose information relating to the rest of the original policy.⁵

⁴ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 by Lord Hobhouse at [54] (emphasis in original). Variations are not mentioned in section 18. Instead, the duty to disclose on variation is seen as part of the more general duty of good faith.

⁵ *Lishman v Northern Maritime* (1875) LR 10 CP 179.

“Known to the assured”

- 4.12 Policyholders must disclose information which they “know”, or which they ought to know “in the ordinary course of business”. This is a complex test involving the law of agency and attribution of knowledge. It raises difficult questions about whose knowledge is relevant and how far an organisation should go to gather information not already known by its senior management and people arranging the insurance.
- 4.13 The issue has considerable practical relevance as, before presenting a risk, each policyholder must search for relevant information. We have been told that there is a need for greater clarity about how policyholders should go about this task. We look at this more fully in Chapter 8.

“Every material circumstance”

- 4.14 Material circumstances are defined in section 18(2) of the 1906 Act:
- Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk.
- 4.15 The issue is therefore looked at from the point of view of a hypothetical “prudent insurer”. The policyholder is required to understand what information would influence the judgment of a prudent underwriter.
- 4.16 In *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*,⁶ the House of Lords confirmed that a material circumstance is one that would have an effect on the mind of the prudent insurer in assessing the risk. It is not necessary that it would have a decisive effect on the insurer's acceptance of the risk or on the amount of premium charged.
- 4.17 In Scots law, the *Pan Atlantic* test of materiality does not apply to life insurance, but it has been applied to other forms of insurance.⁷

⁶ [1995] 1 AC 501. The case mainly concerns non-disclosure, but the matters discussed in this context apply equally to misrepresentation.

⁷ The test in *Life Association of Scotland v Foster* (1873) 11 M 351 (materiality to the reasonable person in the position of the insured) has been held to apply to life and health insurance cases in Scotland; see *Hooper v Royal London General Insurance Co Ltd* 1993 SLT 679 and *Cuthbertson v Friends' Provident Life Office* 2006 SLT 567. In all other types of insurance, however, the relevant test is that in *Pan Atlantic*; see for example *Gaelic Assignments Ltd v Sharp* 2001 SLT 914 and *Mitchell v Hiscox Underwriting Ltd* [2010] CSIH 18, 2010 GWD 13-244.

“The insurer may avoid the contract”

- 4.18 Section 18(1) provides the only remedy for non-disclosure: avoidance of the contract. The contract is treated as if it never existed, and the insurer may refuse all claims made under it.

Exceptions to the duty to disclose

- 4.19 Section 18(3) of the 1906 Act sets out four exceptions to the general duty of disclosure. Unless the insurer makes an enquiry, an insured need not disclose:
- (a) any circumstance which diminishes the risk;
 - (b) any circumstance which is known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know;
 - (c) any circumstance as to which information is waived by the insurer;
 - (d) any circumstance which it is superfluous to disclose by reason of any express or implied warranty.

Waiver and a “fair presentation of the risk”

- 4.20 Section 18(3)(c) of the 1906 Act grants an exception from the duty of disclosure where information is “waived by the insurer”. Several court judgments have used this provision to protect policyholders from the full harshness of section 18(1). They have done this by giving “waiver” a much broader meaning than it has in other areas of law.
- 4.21 In most legal contexts, waiver is a relatively narrow doctrine. It applies where a party makes an unequivocal representation in full knowledge of the facts.⁸ In the insurance context, an insurer may waive by omission. The courts have held that if a policyholder makes a fair presentation of the risk which would prompt a reasonably careful insurer to make further enquiries, the insurer who fails to make such enquiries has waived the information which further enquiries would have revealed.⁹ The waiver exception has therefore been used to encourage insurers to take a more active role in assessing the risk.

⁸ See *Chitty on Contracts* (31st ed 2012), in particular para 24-007 and following. For Scots law, see E C Reid and J G W Blackie, *Personal Bar* (2006), Ch 3 (IV) and (V).

⁹ The Scots law position on waiver is similar; see E C Reid and J G W Blackie, *Personal Bar* (2006), pp 238 to 242.

- 4.22 The following key passage in a leading textbook, *MacGillivray*, was affirmed by the Court of Appeal in *WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA*.¹⁰

[T]he assured must perform his duty of disclosure properly by making a fair presentation of the risk proposed for insurance. If the insurers thereby receive information from the assured or his agent which, taken on its own or in conjunction with other acts known to them or which they are presumed to know, would naturally prompt a reasonably careful insurer to make further inquiries, then, if they omit to make the appropriate check or inquiry, assuming it can be made reasonably, they will be held to have waived disclosure of the material fact which that inquiry would have necessarily revealed.¹¹

- 4.23 Lord Justice Rix elaborated on the principle as follows:

Ultimately, it seems, the question is: Has the insurer been put fairly on inquiry about the existence of other material facts, which such inquiry would necessarily have revealed?¹²

- 4.24 This test is an objective one, the relevant standard being that of a reasonably careful insurer. Lord Justice Rix described this hypothetical insurer as being “neither a detective on one hand nor lacking in common sense on the other”, noting that “mere possibilities will not put him on inquiry”.¹³

How far must the insurer ask questions?

- 4.25 There is discussion within the case law about how often the insurer is obliged to ask questions. In some formulations, it has been suggested that issues of waiver arise rarely, and only after the policyholder has shown that it made a fair presentation of the risk. This was the view taken by Mr Justice Hobhouse in *Iron Trades Mutual v Companhia de Seguros Imperio*:

¹⁰ [2004] EWCA Civ 962, [2004] 2 All ER (Comm) 613 at [63].

¹¹ *MacGillivray on Insurance Law* (10th ed 2003) para 17-83. A very similar statement appears in *MacGillivray on Insurance Law* (12th ed 2012) at para 17-088.

¹² *WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA* [2004] EWCA Civ 962, [2004] 2 All ER (Comm) 613 by Rix LJ at [64].

¹³ [2004] EWCA Civ 962, [2004] 2 All ER 613 at [64].

If a proposer has made a fair presentation of the risk, he has discharged his duty; if he has not, then a failure by an insurer to inquire will not relieve the proposer of his duty to make proper disclosure.¹⁴

- 4.26 By contrast, in *WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA*, Lord Justice Rix suggested that there is a more extensive doctrine, “founded on the concept of fairness”:

It would not in my judgment be fair to castigate a presentation as unfair and thus put an assured in peril of the draconian remedy of avoidance where an insurer had waived the relevant information.¹⁵

- 4.27 Thus the requirement to ask questions arises not simply from the doctrine of waiver, as set out in section 18(3), but also from the mutual duty of good faith.

Limited questions

- 4.28 The doctrine of waiver can be used to curtail the duty of disclosure in several other ways. In particular, an insurer who asks an expressly limited question may be taken to indicate that it has no interest in information which falls outside the scope of that question. If so, it will be deemed to have waived such information.¹⁶

- 4.29 An example would be a form which asks about claims in the last five years. An insurer who asks such a question would normally be taken to have waived information about claims made more than five years ago. We discussed some relevant cases in CP3.¹⁷

¹⁴ [1991] Re LR 213 at 224.

¹⁵ [2004] EWCA Civ 962 at [46].

¹⁶ See Lord Justice Longmore in *Doheny v New India Assurance Ltd* [2004] EWCA Civ 1705, [2005] Lloyd's Rep IR 251 at [19].

¹⁷ CP3, paras 5.58 and 5.59. See, for example, *Roberts v Plaisted* [1989] 2 Lloyd's Rep 341; *Cape Plc v Iron Trades Employers Insurance Association Ltd* [2004] Lloyd's Rep IR 75; and *O'Kane v Jones* [2005] Lloyd's Rep IR 174.

- 4.30 It is important to note, however, that these cases all involved specific and limited information. The courts have not been willing to accept waiver arguments in cases in which the category of information supposedly waived has been too wide or difficult to define.¹⁸

The disclosed information must not be misleading

- 4.31 This can be illustrated by the case of *CTI v Oceanus*.¹⁹ The policyholders insured damage to their containers, and the brokers presented the risk to the insurer by relying on summaries which they had prepared of claims rates under earlier policies. These rates turned out to be highly inaccurate. The brokers also gave the insurers a full file of information, including lengthy policy documents from which the actual rates could have been ascertained.
- 4.32 The court found that there was nothing in the brokers' presentation which would have prompted a reasonable insurer to make further enquiries. The insurer was entitled to take the summaries at face value, and no waiver arose. As Lord Justice Parker put it:

So long as [the] summary is fair, the insurer cannot complain that the full details of the experience were not disclosed. He must however be entitled to assume that the summary is fair. From this follows that, if he then proceeds to negotiate on the basis of the summary without enquiry as to its accuracy, he waives nothing. He can assume both that it is accurate as far as it goes and that, if it covers only part of the past experience, there is nothing in the part omitted which would vitiate the summary.²⁰

¹⁸ See, for example, *Synergy Health (UK) Ltd v CGU Insurance Plc* [2010] EWHC 2583 (Comm), [2011] Lloyd's Rep IR 500: a request to fill out a Declaration of Material Facts covering moral hazard (such as convictions and bankruptcies) was found not to obviate the obligation to disclose the unrelated fact that an intruder alarm had not been installed on the premises.

¹⁹ [1984] 1 Lloyd's Rep 476.

²⁰ [1984] 1 Lloyd's Rep 476 at 511 to 512.

- 4.33 On the other hand, the insurer “cannot shut his eyes to obvious incompleteness and then complain of his bargain made in ignorance of the whole story”. The insurer will be taken to have waived information if “through negligence or stupidity or inexperience or pigheadedness” he does not “pursue enquiries which a prudent underwriter would have pursued”.²¹

SECTION 19: DISCLOSURE BY THE BROKER

- 4.34 Section 19 of the 1906 Act extends the insured’s duty of disclosure where insurance is placed through a broker or other agent, requiring information known to the agent to be disclosed. The only remedy for breach of the section is that the insurer may avoid its contract with the policyholder. The effect of section 19, therefore, is to extend the policyholder’s duty to the insurer, not only to disclose information which the policyholder knows or ought to know, but also to disclose some additional circumstances which are known only to the broker.
- 4.35 The law on section 19 is confused, with several contradictory judicial statements about what it covers.²² We discuss this in Chapter 9.

SECTION 20: MISREPRESENTATIONS

- 4.36 Section 20(1) of the Marine Insurance Act 1906 Act provides:

Every material representation made by the assured or his agent to the insurer during the negotiations for the contract, and before the contract is concluded, must be true. If it be untrue the insurer may avoid the contract.

- 4.37 The definition of a material representation in section 20(2) repeats the test for “material circumstances” in section 18(2): it must influence the judgment of a prudent insurer in fixing the premium or deciding whether to take the risk.

- 4.38 Section 20(3) of the 1906 Act provides:

A representation may be either a representation as to a matter of fact, or as to a matter of expectation or belief.

²¹ Above, by Stephenson LJ at 529 for those non-disclosures or misrepresentations which are not dishonest.

²² For more detail see CP3, Part 7.

4.39 Section 20(4) applies to factual representations:

A representation as to a matter of fact is true, if it be substantially correct, that is to say, if the difference between what is represented and what is actually correct would not be considered material by a prudent insurer.

4.40 By contrast, section 20(5) applies to representations of expectation or belief:

A representation as to a matter of expectation or belief is true if it be made in good faith.

4.41 The courts have confirmed that, where a statement by an insured is a matter of opinion rather than fact, it is sufficient that the opinion is given in good faith. It is not necessary that it should be based on reasonable grounds.²³ However, as Lord Justice Peter Gibson said:

Of course the absence of reasonable grounds for that belief might point to the absence of good faith for that belief. But in a case such as the present where the bad faith of the plaintiff is not alleged, I can see no basis for implication of a representation of reasonable grounds for belief.²⁴

4.42 In practice, misrepresentation and non-disclosure are often pleaded together, in respect of the same set of facts. In commercial litigation, the law of non-disclosure has tended to dominate, with relatively little attention being given to misrepresentation in an insurance context. As one textbook writer explains:

Historically, misrepresentation in the strict sense has not been of particular importance in the insurance context. This is partly because the extreme width of the duty to disclose material facts ... has meant that often non-disclosure has subsumed questions of misrepresentation. Cases have frequently failed to distinguish between the two defences taken by an insurer and indeed it appears to be standard practice for an insurer, where possible, to plead both defences.²⁵

²³ *Economides v Commercial Union Assurance Co Plc* [1998] QB 587.

²⁴ *Economides v Commercial Union Assurance Co Plc* [1998] QB 587 at 606.

²⁵ J Birds, *Birds' Modern Insurance Law* (9th ed 2013) pp 114 and 115.

- 4.43 In Chapter 7 we recommend drawing the duty not to make misrepresentations into the “duty of fair presentation”.

THE INSURER’S REMEDIES FOR BREACH

The inducement test

- 4.44 For many years, the courts have said that the insurer should only have a remedy for an insured’s non-disclosure or misrepresentation under the 1906 Act if it can satisfy the “inducement test”.²⁶ This requires the insurer to show that, without the non-disclosure or misrepresentation, it would have acted differently in its assessment of the risk: that is, it would not have entered into the contract at all, or would have entered it only on different terms.
- 4.45 Although the inducement test is an important part of the case law, it does not appear on the face of the statute. In Chapter 11, we recommend including this requirement within the legislation.

Avoidance

- 4.46 At present, the law provides only one remedy for non-disclosure or misrepresentation: avoidance of the contract. In other words, the contract is treated as if it has never been made, and all claims made under it are refused. In Chapter 11, we argue that avoidance is often unfair to the insured and can over-protect the insurer. We recommend an alternative scheme of more proportionate remedies.

Return of premiums

- 4.47 Avoidance normally requires restitution: the parties must be restored to the positions they were in prior to the contract being made, except where one is guilty of fraud. For marine insurance, section 84(3)(a) of the 1906 Act provides:

Where the policy is void, or is avoided by the insurer as from the commencement of the risk, the premium is returnable, provided that there has been no fraud or illegality on the part of the assured ...

²⁶ *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501.

- 4.48 In Chapter 11, we recommend confirming in statute that unless a non-disclosure or misrepresentation is deliberate or reckless, premiums should be returned.

CONCLUSION

- 4.49 The existing duty of disclosure appears unduly wide. The policyholder also has to disclose “every material circumstance” which might be relevant to an insurer, while the insurer may apparently play an entirely passive role. Section 19 complicates matters by appearing to place a stand-alone duty of disclosure on the policyholder’s broker or other agent, although the insurer’s remedy for breach is against the policyholder. These problems are compounded by the fact that the only remedy for non-disclosure is avoidance of the contract.
- 4.50 We have seen that case law has gone some way towards lessening the disclosure burden on insureds.²⁷ Many recent statements of the law put the policyholder’s duty to disclose in more limited terms than the bare statutory wording. Nevertheless, there are still difficulties with the duty even as developed in case law. In the next chapter, we look at the case for statutory reform.

²⁷ Above at para 4.20 and following.

CHAPTER 5

THE CASE FOR REFORM

- 5.1 The duty of disclosure supports a strong UK commercial insurance market. The requirement on policyholders to present the risk is efficient: it means that insurers can cover a huge variety of general and specialist risks, many of which are international. But the duties set out in the Marine Insurance Act 1906 give rise to a variety of problems which are sometimes mitigated, but not solved, by judicial creativity.
- 5.2 The 1906 Act codifies principles developed in the eighteenth and nineteenth centuries, when communications were slow and access to information was difficult. It was drafted on the principle that the proposer knows everything about the risk and the underwriter knows nothing. It therefore sought to protect insurers. Furthermore, businesses were smaller and their records were hand-written and hand copied; they simply held less information. The category of “every material circumstance which the insured knows or ought to know” appeared finite, so that it seemed possible to comply with the obligation to disclose it to the insurer.
- 5.3 Electronic communication and data storage have radically altered the scale of commercial enterprises and the way in which information can be transmitted, stored, accessed and processed. With so much information available, there is now a need both to define the limits of the duty and to prevent policyholders from “dumping” huge quantities of undigested information on the insurer. Similarly, as insurers become more skilled and have access to sophisticated risk models, there is a need to reconsider what insurers should be taken to know, and how far they should use this knowledge to probe the policyholder’s presentation.
- 5.4 These concerns are not purely of interest to lawyers and legal academics. They have a real impact on corporate Britain. Most companies depend on insurance to cope with unforeseen events. Few could simply absorb a significant loss by accessing existing capital or borrowing money. And, following the financial crisis, it has become more difficult for many businesses to borrow, increasing their dependence on insurance to make good a loss.
- 5.5 In this chapter we discuss these problems in light of the available evidence and consultees’ comments. We also identify the key arguments made by the few opponents of our recommendations. We conclude that there is a strong case for reform which draws on the best principles set out in the existing case law.

FIVE PROBLEMS WITH THE CURRENT LAW

5.6 In Consultation Paper 3 (CP3),¹ we identified several problems with the way the duty of disclosure operates. We found that:

- (1) the duty is poorly understood;
- (2) the duty is too onerous, particularly on medium and large companies;
- (3) the requirement to disclose every material fact encourages data dumping - that is, the presentation of huge volumes of material without distinction between the material and trivial;
- (4) the 1906 Act gives rise to too many disputes and, in particular, encourages “underwriting at claims stage”; and
- (5) the single remedy of avoidance in all cases is too harsh.

5.7 We discuss each of these in turn below.

The duty is poorly understood

5.8 The words of the statute are not particularly complex. Rather, the problem is that the conceptual basis is counter-intuitive. Despite continual warnings, few policyholders believe that they must predict what the insurer wants to know while the insurer need not ask any questions or give any guidance. Even if insurance buyers understand the duty in theory, they may have little idea how to satisfy it. Companies are much more complex than they were in 1906, with knowledge spread through hundreds, if not thousands, of employees. It is unclear which knowledge is relevant to the insurer, or what a company “ought to know”.

¹ CP3, Part 4.

- 5.9 Research shows that even professional risk managers may fail to understand the duty. A survey by the Mactavish Group found that 87% of buyers were unaware of how onerous the duty was. Furthermore, 65% demonstrated this ignorance by failing to review the information used to place their risks with insurers.² This problem also emerged from the responses to our 2007 and 2012 Consultation Papers. As the Construction Industry Council put it, “there is little doubt that the current arrangements for insurance law are often little understood, even by relatively informed buyers of insurance”. Royal & Sun Alliance (RSA) agreed:

In our experience many in the commercial insurance market (be they insureds, brokers and, indeed, insurers themselves) do not properly understand the operation of these sections of the Act and the disclosure-related legal duties and rights that flow from them.

- 5.10 This leads to widespread failure to provide material information. Mactavish found many examples of material omissions. These included cursory discussions of the end use to which products are put, inadequate information about the firm’s dependency on particular sources, and failures to mention non-core activities. For example, a manufacturing company failed to mention that it undertook sensitive contract testing work for third parties.

The role of brokers

- 5.11 Most non-consumer insurance transactions involve a broker, who has a duty to assist with the presentation of the risk to insurers. Some insurers have argued that reform of the law is unnecessary because brokers, as insurance experts with an understanding of the law and of insurers’ expectations, should guide the policyholder towards fulfilment of the disclosure duty.

² Corporate Risk & Insurance - The Case for Placement Reform. The Mactavish Protocols (2011). Mactavish is a research and advisory business specialising in the analysis of commercial risk, insurance policy reliability and insurance governance. The Report is the second part of a programme of research by Mactavish and draws on over 100 consultations with senior personnel in insurers, brokers and relevant service providers, 624 customer consultations and direct analysis of placement information.

- 5.12 However, other consultees have pointed to the increasing pressure on brokers to keep their costs low.³ This means that they now have less time to investigate companies' activities and prepare presentations. Consultees identified a corresponding "widespread de-skilling" across the industry, with fewer site visits and surveys.
- 5.13 It cannot be guaranteed that the policyholder will fulfil the duty, even with good advice. Without detailed knowledge of every aspect of a client's business, an expert can only advise on matters that a typical insurer would consider material for a typical policyholder of that type buying that type of insurance. As organisations are increasingly multinational and multifaceted, relevant information may still be missed in the first instance.

The duty is too onerous

- 5.14 Even in a relatively small organisation, "every material circumstance" may constitute a significant volume of information. For medium and large companies, the duty of disclosure may appear almost insurmountable.
- 5.15 Non-consumer insureds are expected to make a full presentation of the risk to the insurer, but will often struggle to be sure that they have collated all material information. It is difficult to know whose knowledge within the insured's organisation is relevant, and to know how far the people arranging the insurance must go to collate information which does not already reside with them or the senior management.
- 5.16 In 2010, Airmic, the risk managers' association, conducted a survey of its members which showed that presenting a risk is a major task.⁴ Three quarters of members who responded had spent between two and six months preparing information to submit to insurers. Members said that 38% of submissions for property risks exceeded 50 pages; 36% did so for casualty insurance; and 26% for directors' and officers' liability insurance.⁵

³ For example, the Mactavish Group estimated that in 2010 fees in the mid to large corporate sector were 25-30% lower than in 2007. Corporate Risk & Insurance - The Case for Placement Reform. The Mactavish Protocols (2011).

⁴ Airmic has a membership of over 1,100 and represents the insurance buyers and claims handlers for about 75% of the FTSE 100 companies.

⁵ Airmic, Non-disclosure of material information – Member Survey (2010). The survey is based on 111 responses.

- 5.17 Despite the quantity of information provided, Airmic points out that many businesses are now so complex that few can be sure they have assembled all the requisite information and told insurers everything they would want to know. Their Chief Executive, John Hurrell, observed:

The current law was drafted before the existence of large, complex multinational organisations and it fails to make clear what the risk manager has to do. In a large company it is simply not possible for the risk manager to anticipate every piece of information that an underwriter might deem material.⁶

Onerous on larger businesses

- 5.18 Originally, we had assumed that the burden of disclosure would fall disproportionately on small businesses. In response to our 2007 Consultation Paper, some respondents suggested that additional protections should be provided to the smallest businesses, and that micro-businesses (those with fewer than 10 employees) should be treated like consumers, with the same level of protection.
- 5.19 In fact we have received evidence that it is larger businesses which experience the greater problems with disclosure. The Mactavish Report suggests that the greatest problems are experienced by businesses with a turnover of between £50 million and £5 billion.⁷
- 5.20 Small businesses buying “off the peg” insurance are usually asked specific questions, which makes the disclosure process less onerous. In CP3 we concluded that there was insufficient evidence to suggest that they required a separate regime.⁸ By contrast, large businesses are expected to present the risk, without insurers asking questions or indicating what they wish to know. This is particularly difficult for large multinational businesses.⁹

⁶ In an article by Jonathan Swift, entitled “Comment – insurance law reform: Reform can’t wait”, *Post Magazine* (14 April 2010).

⁷ Corporate Risk & Insurance - The Case for Placement Reform. The Mactavish Protocols (2011).

⁸ CP3, paras 1.10 to 1.15.

⁹ See Airmic, *Disclosure of material facts and information in business insurance* (2011).

5.21 A different type of co-operation between insured and insurer is required in order to ensure good disclosure in the context of larger companies. The insured understands its organisation and has the means to collate the desired information; the insurer knows what type of information is relevant to assessing the risk. Although the insurer may not be in a position to ask standard questions at the outset, once it has received an initial presentation it may well be able to give guidance as to matters on which it would like more detail. We see disclosure as a reciprocal process.

Onerous by international standards

5.22 In CP3 we examined the comparable law in five other jurisdictions: Australia, New York, Ireland, Germany and France. We also considered the approach to disclosure taken by the Principles of European Insurance Contract Law (PEICL).¹⁰ We identified that, by international standards, UK insurance law appears to be particularly favourable to the insurer.

5.23 In the civil law countries we considered, and under the PEICL, the onus is on the insurer to ask questions. Furthermore, avoidance is restricted to intentional or fraudulent misrepresentations: in the absence of bad faith, proportionate remedies are applied.

5.24 Australia, New York and Ireland originally had duties based on, or similar to, the disclosure duty in the 1906 Act. Each of them has retained the duty to volunteer information, but the requirement is more limited than in the UK. The three jurisdictions have taken different approaches to limiting the duty.

5.25 In Australia, the issue is whether “a reasonable person in the circumstances” could be expected to know that the matter was relevant to the insurer. In New York, the test is whether the insured “wilfully concealed” the matter. In Ireland, the 1906 Act is still part of the law but the courts have used the exceptions liberally, to the extent that:

The insured’s duty is balanced by a reciprocal duty on the insurer to make its own reasonable inquiries, to carry out all prudent investigations and to act at all times in a professional manner.¹¹

¹⁰ CP3, Part 3.

¹¹ *Manor Park Homebuilders Ltd v AIG Europe (Ireland) Ltd* [2008] IEHC 174, [2009] 1 ILRM 190.

5.26 The UK insurance market is international. It is the third largest in the world and accounts for 7% of global premiums.¹² The Lloyd's Market Association (LMA) emphasised the “high volume and value of overseas business placed in the Lloyd's market”. They pointed out that international business accounts for “some 80% of the £20 billion plus of premium income placed in the market”. UK law and the UK insurance market are therefore competing in an international market. Many competing jurisdictions have reviewed or are in the process of reviewing their insurance legislation and regulation. Failing to update to a workable legal framework threatens to discredit the UK market.

5.27 The British Insurance Brokers' Association (BIBA) said:

BIBA strongly agrees that the changes are necessary to maintain London's pre-eminence in the insurance world.

The current law leads to “data dumping” and other poor presentations

5.28 The 1906 Act makes no provision about the manner in which disclosure must be made. This, when combined with confusion over what needs to be disclosed, sometimes leads to prospective policyholders giving large amounts of undigested information for the insurer to sort through and decide what is relevant. A lack of structuring and indexing combined with an overwhelming amount of information is known in extreme cases as a “data dump”.

5.29 For a busy underwriter, each presentation is one of many in need of assessment. Leaving insurers to navigate their own way through copious amounts of unfamiliar data with little or no signposting undermines the underwriting process. However, on a strict view of the 1906 Act, data dumping and other poor or convoluted presentations are unobjectionable. In some cases, the practice might even be employed to bury important information and yet it still arguably complies with the duty of disclosure.

5.30 In Chapter 7, we recommend that information should be disclosed in a manner which would be reasonably clear and accessible to a prudent insurer. That would apply both to attempts to over supply information and to attempts to “drip feed” information to the insurer.

¹² In 2012, global premiums were valued at €3.2 trillion. See Munich Re, *Insurance Market Outlook* (May 2013).

Too many disputes

- 5.31 As we discussed in Chapter 1, the duty of disclosure generates a high volume of disputes and litigation. According to an Airmic survey in 2010,¹³ a third of their members had experienced a dispute over non-disclosure issues in the last five years, and one in twenty had been involved in litigation on the issue. The risk of innocent non-disclosure topped the list of risk managers' concerns about insurance in the 2013 Airmic Pre-Conference Survey. Recent research by BIBA found that 89% of brokers thought that insurers were becoming stricter in their approach to claims payment.¹⁴
- 5.32 Although most cases settle, many proceed to dispute resolution. Having said that, this does not mean that the courts have frequent opportunities to develop the law or provide precedent for good practice. Research by Mactavish suggests that over 50% of all commercial insurance policies (closer to 100% for some classes of insurance such as property and casualty) contain binding arbitration clauses, so that disputes are not brought before a court.
- 5.33 As many insurance disputes involve questions of fact we do not suggest that our reforms would prevent litigation. However we do not consider our proposals will increase the volume of disputes. By encouraging greater contract clarity our reforms may well reduce the scope for argument.

Disputes when “soft markets” turn “hard”

- 5.34 The insurance market is cyclical. Markets are said to be “soft” when there are many insurers in the market. Insurance is relatively cheap and insurers are keen to write business. As prices become too low, insurers start to make a loss and many exit the market, creating a “hard” market. Capacity reduces and prices increase.
- 5.35 A soft market can result in superficial presentations by buyers, cost cutting by brokers and over-exuberant underwriting by insurers who are under intense pressure to secure new business and so may fail to ask many questions. On the other hand, in soft markets, insurers may also pay claims as a matter of goodwill, as they are keen to retain business. A theme of the Mactavish Report is that many claims are paid on this basis.

¹³ Airmic, Non-disclosure of material information – Member Survey (2010).

¹⁴ BIBA member research, Insurance brokers adding value in the claims process (January 2013).

- 5.36 The problems come when soft markets start to turn hard. If insurers discover that they have underpriced the risk they have taken on, they may be more inclined to raise issues of non-disclosure when a claim is made.

Underwriting at claims stage

- 5.37 A general pressure to write more business and keep prices low combined with insurers' apparent right to play a passive role can at its worst give rise to "underwriting at claims stage". In other words, an insurer may accept a poor presentation and ask questions only once a claim arises. If the insurer discovers that the policyholder has failed to disclose a material circumstance, the remedy of avoidance puts the insurer into a strong position. The courts have used the doctrine of "waiver" to protect some policyholders in particular circumstances, but this is not a satisfactory solution.
- 5.38 The current law can also support a "race to the bottom" for risk presentations. We have been provided with examples of the same risk being shown to insurers by different brokers. The quality of information given varied greatly and the worst presentation produced the lowest indicative quote. Well-established insurers have complained to us that the current law supports those who seek to undercut on price when the risk is presented, in the hope perhaps that nothing happens, but then underwrite the risk properly if a claim arises. Such an approach undermines the overall credibility and reputation of the market.
- 5.39 The Mactavish Report observed that this could have serious consequences for businesses in current market conditions:

If, for whatever reason, a major insurance policy fails to pay out, most firms would either struggle to raise debt to pay for the loss, or would be charged prohibitively expensive amounts to do so.¹⁵

¹⁵ Corporate Risk & Insurance - The Case for Placement Reform. The Mactavish Protocols (2011). Mactavish's research has also shown that far more UK companies are materially dependent on insurance now than pre-financial crisis; that is, they could not now absorb a major loss of half or two-thirds of the insurance policy limit on a major class without severe financial and strategic consequences. In the current economic climate, it will also be more difficult for firms to obtain bridging finance. Also, the Mactavish summary of recent evidence provided to the Law Commission in January 2014.

5.40 Although:

It is worth pointing out that disputes do not necessarily mean outright refusal of claims; rather, they more often mean delays in settlement or protracted negotiations about the size of claim payments.

The single remedy of avoidance is too harsh

5.41 Avoidance is an “all or nothing” remedy. This encourages an adversarial approach and fails to reflect the commercial realities of the situation.

5.42 An insured who fails to mention a minor issue loses all benefit from the policy, even if the insurer would only have added a small amount to the premium had it known the true facts. This over-protects the insurer against the loss it might have suffered had the claim been paid, and provides no incentive for insurers to ask appropriate questions. Even where avoidance is not actually invoked, the threat of it puts the insurer in a very strong position to negotiate a low settlement.

5.43 As a reaction against this harsh penalty, the courts sometimes strain their interpretation of the law to say that there has been no non-disclosure. The policyholder may be paid their full claim, even though they failed to disclose a matter which would have led to an increase in premium.

AN EVOLUTIONARY APPROACH TO REFORM

Retaining a duty of disclosure

5.44 Although we have identified problems with the duty of disclosure in its current form, we do not recommend removing the duty on policyholders to volunteer information, as we did for consumer insurance. The duty on policyholders to present the risk saves time and effort, and makes it easier to insure non-standard risks. In particular, it requires policyholders to tell insurers about surprising and unusual circumstances, which may not be covered by standard questions.

The 2007 proposals: a “reasonable insured” test

- 5.45 In 2007, we considered a bigger departure from the existing duty. We proposed to replace the definition of “material circumstance” in section 18(2) of the 1906 Act. Instead of a test based on what would influence a prudent insurer, we proposed a test based on what a “reasonable insured” would think was relevant to the insurer.¹⁶ The proposal received a mixed response. Although half of respondents supported the new test, this was sometimes qualified and many criticised it for being uncertain.
- 5.46 NFU Mutual pointed out that the characteristics of the reasonable insured would:
- ... change from one business to the next, according to in particular: (1) the nature and size of the business; and (2) whether or not a broker was used in the transaction. There is no single test, obtaining expert evidence will be almost impossible and the net result will be to give the trial judge a very wide discretion in each case.
- 5.47 Other consultees agreed and said that moving to a “reasonable insured” test may not be a significant help to the insured, because the onus would still be on them to give disclosure of material facts and the disclosure exercise would not be significantly changed. This reduced the justification for introducing such a fundamental reform.
- 5.48 We accepted that a “reasonable insured” test would introduce an unknown and untested concept into the law. In Australia, where a similar reform was introduced in 1984, subsequent legislation has been required in order to clarify how it should be applied.¹⁷ It would take time for judges to develop a consistent approach, and during this time it would be even more difficult to advise businesses about what they were expected to disclose.

Our 2012 proposals and final recommendations: capturing best practice

- 5.49 In CP3 and in this Report our approach is more evolutionary. It retains the essential features of the current law: the duty to disclose that which a prudent insurer would want to know. It also uses principles taken from case law which interpret the 1906 Act.

¹⁶ Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (June 2007) at paras 5.83 and 12.31.

¹⁷ CP3, paras 3.2 to 3.8.

- 5.50 There is an important body of case law on section 18 of the 1906 Act. In some cases, the courts have restricted the ambit of the duty of disclosure. For example, the courts have stressed that the policyholder should make a fair presentation of the risk.¹⁸ If this would prompt a reasonable insurer to make further enquiries these should be made. Where the insurer fails to make those enquiries, then the insurer cannot avoid the policy for a failure on the policyholder's part to provide information which those enquiries would have revealed.¹⁹ A search of reported judgments shows that the phrase "fair presentation of the risk" has been used in at least 15 cases in the past ten years. This shows it is now a common part of the case law.
- 5.51 Although many cases set out helpful "glosses" on the nature of section 18, most have been decided on specific facts after the event and with the aim of doing justice in that particular case. We do not, therefore, think that it is satisfactory to force parties to dispute a disclosure point in court in the hope of obtaining the benefit of those "glosses".
- 5.52 In Chapter 7, we recommend drawing on this case law to provide clearer duties on the insured and insurer.
- 5.53 Insurers too recognise that there are difficulties with the current law, and that it does not represent best practice. In their response to CP3, Direct Line Group stated that "The gap between the law and its practical application has been growing for some time...". RSA made the same point, finding the law to be "...out of step with modern commercial insurance practice".
- 5.54 Most consultees accept that our recommendations represent a balance of competing interests. Although the International Underwriting Association (IUA) opposed radical change to the rules on disclosure, in their response to CP3 they said they could:

appreciate and support the approach taken by the Law Commission to improve the risk presentation process and dialogue between the contractual parties (including brokers). Increased clarity and transparency in the presentation process and a reduction in disputes benefits all parties and allows insurers to more accurately assess and price risks to the ultimate benefit of policyholders.

¹⁸ See for example, *WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA* [2004] EWCA Civ 962, [2004] 2 All ER 613 at [63]. See also Consultation Paper 3 (CP3), Part 5 for a detailed discussion of the case law.

¹⁹ See above; and see the discussion at CP3, para 5.38 and following.

THE CONTRARY ARGUMENTS

- 5.55 Not everyone agreed with our proposals in CP3. Some consultees did not believe that we had made out a sufficiently strong case for reform, and others felt that our proposals would create more rather than less uncertainty. Below we discuss the main opposing arguments.

Reform unnecessary

- 5.56 In total, seven respondents disagreed with the need for reform, while two were unsure. Many of those who doubted the need for reform are participants in specialist insurance markets, such as Lloyd's, in which large and complex risks are insured or reinsured.
- 5.57 The reasons put forward by those opposed to change were that the law is well understood and causes few disputes; that the UK insurance market is internationally competitive; and that business policyholders are sophisticated and are professionally advised by brokers. It may be that the need for reform is less evident in specialist markets, where all participants are better informed of their obligations. This is why we recommend a default regime which allows contracting out of our reforms where both parties agree to that.
- 5.58 In general, however, these arguments contrast with the evidence we have been given by Airmic and others that even large businesses find the disclosure duty difficult to comply with and that the issue is a common source of dispute.

The parties can already negotiate better terms

- 5.59 Policyholders can of course already seek to negotiate better terms than the 1906 Act provides and many do, particularly in professional indemnity insurance.²⁰ It has been suggested that this removes the need for reform, as businesses can already find insurance on the terms which meet their needs. Many businesses are represented by large brokers with strong negotiating power so, on occasion, the insurer may be the weaker party.

²⁰ For example, insurers wishing to offer qualifying solicitors' liability insurance in England and Wales must enter into an agreement with the Law Society, by which they make their policies subject to certain minimum terms of cover (Solicitors Regulation Authority, *Qualifying Insurers' Agreement*, clause 2.9). These minimum terms prohibit the insurer from avoiding policies "on any grounds whatsoever including, without limitation, non-disclosure or misrepresentation, whether fraudulent or not" (Solicitors Regulation Authority, *Minimum Terms and Conditions of Professional Indemnity Insurance*, clause 4.1).

- 5.60 The problem is that negotiating better terms takes expertise, time and bargaining power. We have been told of medium to large businesses which have attempted to negotiate better terms without success.²¹
- 5.61 One problem is that insurance is often bought quickly and cheaply. For example, unlike other large commercial contracts, insurance contracts are almost never negotiated by lawyers. This is a significant advantage, but it does mean that the parties may be unaware of the intricacies of the 1906 Act. Furthermore, negotiations may increase transaction costs. Insurance represents a very cost effective way to access large sums of contingent capital and we would not want to see that undermined.
- 5.62 The second problem is that any insured who raises questions about the effect of a non-disclosure may raise the insurer's suspicion that they are contemplating a failure to disclose. This alone may be enough to cause the insurer to reject the new term, if not the entire policy.
- 5.63 We aim to produce a balanced regime which would be suitable for the great majority of insurance contracts without the need for further negotiation on these points. Where sophisticated parties do wish to depart from it, they will be able to do so, subject to straightforward "transparency" requirements.

Concerns about a drop in standards of presentation

- 5.64 A small number of consultees were concerned that our recommendations would lead to a drop in standards of presentation. They noted that, failing disclosure of "every material circumstance" known to the insured, the insured might still comply with its duty if it gives "sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances".²²
- 5.65 The Lloyd's Market Association (LMA) expressed concerns that this alternative:

may mean that several rounds of broker presentations are required, to establish the information which now would be expected at first presentation. This would hinder market efficiency ...

[It] may shift market practice, so that an insurer would as a matter of course carry out due diligence enquiries into an insured's business, if the insurer comes to expect only "sufficient information" will be presented. This would impact market efficiency and increase costs of concluding contracts – and may meet resistance from buyers.

²¹ Mactavish summary of recent evidence provided to the Law Commission in January 2014.

²² This recommendation is discussed in more detail in the following chapter.

- 5.66 We agree with the LMA that the primary duty of disclosure should be the first limb of the duty of fair presentation and the Bill is drafted on that basis. However, we think that it is unlikely that a policyholder would deliberately take advantage of the second limb to disclose only the bare minimum.
- 5.67 For an insured or broker to try to disclose the bare minimum would be a risky strategy, particularly in the first few years as the courts developed precedent on the new provisions. Given the overarching duty of good faith, we do not think that courts would look sympathetically on a party who sought to abuse the “sufficient information” standard. The court might find that the information was too sparse to put a prudent insurer on notice, or that a cryptic presentation was not “clear and accessible” to a prudent insurer.
- 5.68 Indeed, we think our recommendations could help to improve the standard of presentation. Mactavish found that, under the current law, poor presentations are widespread. They said:

The same weaknesses and limitations seem to crop up in almost all cases. The senior insurance personnel consulted as part of this work concurred that the weaknesses are endemic and market-wide. Of course, there is some variation in the standards of disclosure – and specific areas of error or omission – but the overall picture is consistent enough to confirm that current market standards are inadequate.²³

- 5.69 There are a number of reasons for this, but lack of understanding (or even awareness) of the duty, combined with difficulties with predicting what should be disclosed, are key issues. Although law reform could not solve practical matters connected with the placement process, it could encourage insureds, brokers and insurers alike to re-examine their processes.

The need for presentations about unusual risks

- 5.70 One advantage the UK enjoys is that some unusual risks, considered uninsurable in other jurisdictions, are insured in the London market using English law. Clearly, in these cases, it is not possible for the insurer simply to ask standard questions. Nor would the relevant information be generally available. We have been told that the duty of disclosure is particularly valuable for these risks, as it ensures that policyholders present the full extent of risk.

²³ Corporate Risk & Insurance - The Case for Placement Reform. The Mactavish Protocols (2011), p 17.

- 5.71 It has been suggested that the reforms may damage this market. In response, we would stress that the parties will be able to contract out of our default regime and make bespoke contractual arrangements. In particular, the parties may agree that any failure of disclosure would result in avoidance of the contract. We do not wish to stop these contractual arrangements – only to ensure that the parties are fully aware of the implication of the terms.

Concerns about loss of precedent

- 5.72 Two consultees expressed concern that any legislation enacted would have the result of displacing important judicial interpretation of, and comment on, the cases on which we have based our recommendations. Catlin said:

We are deeply concerned that as currently drafted the bill will jettison some 250 years of case law as courts struggle to interpret brand new language. We accept that it is impossible for any legislation to replicate all of the existing case law, but we think that it would be a very retrograde step if the case law were to be lost.

- 5.73 We agree with the second sentence. It is not our intention that past case law is superseded. Indeed, we have intentionally built on existing case law and incorporated much of the 1906 Act terminology in order to retain the benefit of it.²⁴ Our changes are designed to reflect the fact that the world is no longer as it was 250 years ago.

CONCLUSION ON THE NEED FOR REFORM

- 5.74 We concluded in CP3 that the duty of disclosure causes problems in non-consumer insurance. The duty is poorly understood and difficult to comply with. It is also too one-sided, giving the impression that insurers can play a passive role and then rely on poor disclosure and the threat of avoidance as a strong negotiation tool at claims stage.
- 5.75 For general insurance the case for reform is convincing. It may be that in some specialist and sophisticated markets, the parties would prefer to contract on the basis of a more onerous disclosure duty, and under our reforms they will be free to do so.

²⁴ For example, as discussed in the following chapters, we recommend the use of “material circumstance”, “prudent insurer”, “substantially correct” and, indeed “disclosure”.

5.76 The law on disclosure and misrepresentation was codified in the 1906 Act. Although the development of case law has in some instances signalled a departure from application of the statutory provisions in their most extreme form, the developments are not always applied consistently. This can add uncertainty and lead to unnecessary disputes. We think that over a hundred years after the original codification, the law needs to be updated.

CHAPTER 6

OVERVIEW OF RECOMMENDATIONS

- 6.1 We recommend a new duty of fair presentation to apply to all policyholders who are not consumers. This will encompass the current duties of disclosure and representation set out in the Marine Insurance Act 1906.
- 6.2 In many ways the duty of fair presentation in the draft Bill reflects the existing law, but changes have been introduced in six areas. In the next chapters we recommend reforms designed to:
- (1) encourage active engagement by the insurer rather than passive underwriting, asking questions of the insured if the desired information is not provided in the first instance;
 - (2) encourage policyholders to structure and signpost their presentations in a clear and accessible way, and prevent data dumps;
 - (3) give guidance as to how the insured should prepare a fair presentation, by undertaking a reasonable search of available information and giving examples of what circumstances might be material;
 - (4) clarify whose knowledge in the insured's organisation is attributed to the insured for the purposes of disclosure;
 - (5) clarify the exceptions to the duty of disclosure, including circumstances "which are known or presumed to be known to the insurer"; and
 - (6) replace the remedy of avoidance in all circumstances with more proportionate remedies.
- 6.3 This is a default regime, which may be altered by agreement between the parties.

A DUTY OF FAIR PRESENTATION FOR ALL NON-CONSUMER INSURANCE

- 6.4 The recommendations we make in this Part are aimed at all business and other non-consumer insurance. This includes insurance for micro-businesses and small or medium enterprises, as well as large risks, marine insurance and reinsurance.¹

¹ In the previous chapter, we explained that large businesses experience greater difficulties with the existing duty of disclosure than smaller businesses. See para 5.18 and following.

BUILDING ON THE CURRENT LAW

- 6.5 Our recommendations build on the current law as set out in the 1906 Act and as interpreted in case law. Many aspects of our recommended “duty of fair presentation” are already part of the law. We are not proposing changes to whom the duty applies to, or when it arises. The duty will continue to include positive elements to disclose material circumstances and negative elements not to misrepresent them. Furthermore, what is “material” will continue to be defined by reference to circumstances which would influence the judgment of a prudent insurer.

THE RECOMMENDED REFORMS

A more active role for insurers

- 6.6 The current words of section 18 suggest that an insurer may simply sit back and wait for the policyholder to disclose every material circumstance. The courts have suggested that this should be read subject to the doctrine of “waiver”. Where a policyholder gives the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries, the insurer should ask appropriate questions. If the insurer fails to do so, it may not seek a remedy against the policyholder for failing to disclose material circumstances which those enquires would have revealed.²
- 6.7 We think this should be seen as central to the duty of disclosure. Good disclosure requires co-operation from both sides. The policyholder knows the facts; the insurer knows which facts are relevant. To provide an effective and efficient process, we think that insurers should see their role as assessing what they are told and asking further questions as appropriate.
- 6.8 We therefore recommend that the disclosure duty should have two limbs. We think that the insured should either:
- (1) disclose every material circumstance which the insured knows or ought to know; or
 - (2) failing that, disclose sufficient information to put a prudent insurer on notice that it needs to make further inquiries for the purpose of revealing those circumstances.

² See for example, *WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA* [2004] EWCA Civ 962, [2004] 2 All ER 613 at [63]. See also Consultation Paper 3 (CP3), Part 5 for a detailed discussion of the case law.

An end to data dumping and oblique presentations

- 6.9 At present, a policyholder may be able to fulfil its duty of disclosure by sending large quantities of unsorted information on to the insurer, without a summary or signposting. We recommend that this should not constitute a fair presentation of the risk. Instead, policyholders should disclose information in a manner which would be reasonably clear and accessible to a prudent insurer.

Clarifying what an insured “knows or ought to know”

- 6.10 Under section 18, an insured must disclose every material circumstance which it knows or ought to know “in the ordinary course of business”. However, neither the statute nor the case law provides much guidance on whose knowledge within the organisation is relevant for these purposes, or what enquiries the insured should carry out before applying for insurance.
- 6.11 Risk managers told us that this issue was of great practical importance, as they need to know how to go about gathering information. As an Airmic guide makes clear, this can be an onerous task, which may involve multiple sources of information and many months’ work.³
- 6.12 We wish to give policyholders greater guidance on how to comply with their duties. The draft Bill therefore defines what a policyholder “knows or ought to know” for the purposes of a fair presentation. In broad terms, we recommend that a policyholder should be taken to know what is known to its senior management or to the individuals who participate in the procurement of the insurance. In addition, the insured should carry out a reasonable search of available information, including making enquiries of its staff and agents.

Examples of material circumstances

- 6.13 To provide policyholders with greater guidance on the type of information which should be disclosed, we recommend an indicative and non-exhaustive list of circumstances which may be material, taken from the case law. The draft Bill lists three examples of circumstances which may be material:
- (1) special or unusual facts relating to the risk;
 - (2) any particular concerns which led the insured to seek insurance; and

³ Airmic, *Disclosure of Material Facts and Information in Business Insurance* (2011). Discussed in CP3, from para 6.68.

- (3) anything which those concerned with the class of insurance and field of activity would generally understand as something that should be dealt with in a fair presentation of risks of the type in question.
- 6.14 The most significant example is the third: circumstances which those in the market would generally understand should be covered. We hope that insurers, brokers and policyholders will work together to develop guidance and protocols about what should be disclosed, to put flesh on the bones of this structure.

Clarifying the exceptions

- 6.15 Some exceptions to the duty of disclosure are set out in section 18(3) of the 1906 Act, but these are not well-known or understood. In particular, section 18(3)(b) refers to circumstances “which are known or presumed to be known to the insurer”, adding that an insurer is presumed to know matters of “common notoriety or knowledge” and matters which it ought to know “in the ordinary course of business”.
- 6.16 Policyholders may now be very large organisations in which knowledge is spread through multiple people and sites – and the same is true for insurers. Information held in an old claims file on a legacy system may not be available to the underwriter making the decision.
- 6.17 We recommend clarification of what an insurer should be taken to know. The test should concentrate on information which is known or available to the underwriter. Information held elsewhere in the organisation should only be exempt from disclosure if it should have been communicated to the underwriter or was readily available to the underwriter. At the same time, insurers should be reasonably competent. They should be expected to know matters of common knowledge or circumstances which that type of insurer would reasonably be expected to know.
- 6.18 We see the exception currently set out in section 18(3)(c) as composed of three categories: what an insurer knows, ought to know and is presumed to know. We recommend that:
- (1) an insurer only knows something if it is known to the people participating in the underwriting decision;
 - (2) an insurer ought to know something:
 - (a) if it is known to the insurer’s employee or agent and ought reasonably to have been passed to the underwriter; or
 - (b) it is held by the insurer and was readily available to the underwriter;
 - (3) an insurer is presumed to know something if it is common knowledge, or it is something which an insurer offering that type of insurance ought to know in the ordinary course of business.

A new system of remedies

- 6.19 The most significant change we recommend is to the remedies. Where the insured's breach of the duty of fair presentation is deliberate or reckless, we think that the insurer should continue to be entitled to avoid the contract and refuse all claims. It need not return any premium paid.
- 6.20 In other cases, however, the insurer should have a more proportionate remedy based on what it would have done had the presentation been fair. For example:
- (1) if the insurer would have accepted the risk but charged a higher premium, it may reduce any claim proportionately;
 - (2) if the insurer would have entered into the contract on different terms (other than premium), it may treat the contract as if it contained those terms;
 - (3) if the insurer would not have entered into the contract at all, it may avoid the contract and refuse all claims, but must return the premium.
- 6.21 These remedies have already been introduced for consumer insurance and are familiar to the insurance industry.⁴

A DEFAULT REGIME

- 6.22 These recommendations are intended to be a default regime. We are seeking a workable system which balances the interests of the parties, and is suitable for most cases. We 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.
- 6.23 However, given the range of risks which may be covered by non-consumer insurance, parties may need freedom to agree bespoke arrangements in their contracts. In sophisticated markets including the marine insurance market we would expect contracting out to be more widespread.

⁴ Consumer Insurance (Disclosure and Representations) Act 2012.

- 6.24 We do not propose to place any general restrictions on the *extent* to which the regime can be altered by contract. Parties may agree specific provisions about the extent of the duty of fair presentation which we recommend, potentially making it more onerous on the insured. They may agree bespoke provisions determining how far the insured has to go to collect information about its organisation, or increasing the number of people whose knowledge is directly attributed to the insured. The insurer may also wish to provide that any breach of the duty of fair presentation allows it to avoid the contract entirely, rather than giving rise to the recommended regime of proportionate remedies.
- 6.25 On the other hand, we recommend that, wherever an insurer wishes to include a contractual term which puts the insured in a worse position than it would be in under our recommended regime, the insurer should have to satisfy two procedural requirements:
- (1) the insurer must take sufficient steps to draw the term to the insured's attention before the contract is entered into; and
 - (2) the term must be clear and unambiguous as to its effect.
- 6.26 These are referred to in the draft Bill as the "transparency requirements". The operation of the transparency requirements and the policy behind our contracting out recommendations are discussed in more detail in Chapter 29.

DIFFERENCES BETWEEN CONSUMER AND NON-CONSUMER INSURANCE

- 6.27 Some of our recommendations for the consumer market, implemented by the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA), were designed to "protect" consumers. This is not the aim of the recommendations in this Part. Instead, we are seeking a "neutral" law that strikes a balance between the parties and which will impose reciprocal obligations.
- 6.28 Commercial insurance involves a much greater variety of unusual or specialist risks than consumer insurance. There will not necessarily be a standard proposal form, nor can the underwriting process be composed entirely of scripted questions. Insurers cannot take charge of the disclosure process as completely as they do for consumer policies given the sheer variety of risks they are asked to consider in the non-consumer context.
- 6.29 The remedies we recommend in this Report are similar to the remedies we recommended for consumer insurance and which are now enacted in CIDRA.

6.30 In other respects, there are significant differences between the duty of fair presentation and the duty to take reasonable care not to make a misrepresentation under section 2(2) of CIDRA. First, a commercial policyholder is still required to volunteer information. Secondly, the duty is not to misrepresent, rather than confined to taking reasonable care not to misrepresent. Thirdly, under CIDRA the rules are mandatory. An insurer may not use a contract term to put the consumer in a worse position than it would be in under the provisions of CIDRA.⁵ By contrast, in non-consumer insurance, the parties may extend as well as reduce the duty of fair presentation.

⁵ CIDRA, s 10.

CHAPTER 7

DETAILED RECOMMENDATIONS: THE DUTY OF FAIR PRESENTATION

7.1 We recommend that before taking out insurance, policyholders who are not consumers should be under a new statutory duty to give a fair presentation of the risk. We see this duty as a broad concept which covers three areas:

- (1) what must be disclosed;
- (2) how that information is presented; and
- (3) a duty not to make misrepresentations.

7.2 The duty of disclosure applies to information which the insured “knows or ought to know”. This is a defined term, which is discussed in detail in the following chapter.

7.3 Here we explain the various elements of the duty of fair presentation.

APPLICATION: NON-CONSUMER INSURANCE CONTRACTS

7.4 Clause 2 of the draft Bill states that the duty of fair presentation “applies to non-consumer insurance contracts only”.

7.5 The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) addressed the duty of disclosure, and related duties, for all consumer insurance contracts.¹ The definitions of consumer and non-consumer insurance are discussed in Chapter 2.²

THE DUTY OF FAIR PRESENTATION

7.6 The draft Bill imposes a duty to make a fair presentation of the risk. This duty replaces the existing duties under sections 18, 19 and 20 of the Marine Insurance Act 1906 (the 1906 Act).³

7.7 Clause 3(1) introduces the new duty. It provides that:

Before a contract of insurance is entered into, the insured must make to the insurer a fair presentation of the risk.

¹ See para 6.27 above.

² From para 2.13.

7.8 There are three elements to this clause, which we discuss below.

- (1) The duty attaches “before the contract of insurance is entered into”.
- (2) The duty falls on “the insured”.
- (3) The insured must make a “fair presentation of the risk”.

Before the contract is entered into

7.9 This wording is an updated version of the section 18(1) words, “before the contract is concluded”. No change is intended to the law in terms of the timing of the duty.⁴

7.10 In the UK, most insurance policies are for a fixed term, typically a year. At the end of the year, most policies fall due for renewal. The legal position is clear: renewal is a new contract, and the duty to make a fair presentation would arise again.

Variations

7.11 Under the current law, when a policyholder seeks to vary a contract of insurance, only information relating to the variation itself must be disclosed. There is no requirement to disclose information relating to the rest of the original policy.⁵ Although variations are not mentioned in section 18 of the 1906 Act, this is seen as an element of the general duty of good faith, as set out in section 17.

7.12 Clause 2(2) of the draft Bill provides that the duty of fair presentation also applies to variations. Clause 2(2)(a) follows the current law by providing that the duty to make a fair presentation of the “risk” relates only to the risk “relevant to the proposed variation”.

The insured

7.13 The duty of fair presentation falls on “the insured”. Clause 1 defines the insured as:

The party to a contract of insurance who is the insured under the contract, or would be if the contract were entered into.

³ Sections 18, 19 and 20 of the 1906 Act are repealed by clause 19(2) of the draft Bill.

⁴ The current law is discussed at Chapter 4.

⁵ See para 4.11, and para 11.97 and following.

- 7.14 The insured is therefore the party, or parties, to the contract with the insurer. The second limb of this definition addresses the fact that the duty of fair presentation attaches before the contract is entered into and therefore before “the insured” has actually become a party to the contract.

Co-insurance

- 7.15 In some situations, one party may enter into a contract on behalf of others. In such cases, who “the insured” is, and will continue to be, is a question of construction of the particular contract. There are three possible outcomes.

- (1) The parties are joint insureds under a joint policy. This means that they must all make a fair presentation of the risk. A failure by one will affect the contract for all others.⁶
- (2) The parties are composite insureds, so that each is a separate insured under a bundle of insurance contracts. Each insured must present its own risk fairly (either personally or through the main insured who acts as their agent). However, a failure by one will affect only that party’s insurance. The other parties will be unaffected.⁷
- (3) The beneficiaries of the policy are third parties who are not parties to the contract at all. They are not “the insured” and have no separate duties to present information.

- 7.16 Where a holding or parent company arranges insurance on behalf of all group or subsidiary companies, the courts have so far tended to regard the interests of the companies as composite rather than joint, and have treated the single policy as a bundle of insurance contracts. In *New Hampshire Insurance Co Ltd v MGN Ltd*, the court referred to:

the companies rather than the group as parties to the insurance contract (as they must have been), and also as the owners of separate interests which were covered by insurance separately.⁸

- 7.17 In such a situation, each insured would be subject to the duty of fair presentation. However, it may be that the holding or parent company makes the presentation as agent on behalf of all the “insureds”.

⁶ A policy is joint where the interests of the parties covered by the policy are the same; that is “they are exposed to the same risks and will suffer a joint loss by the occurrence of an insured peril”. See *MacGillivray on Insurance Law* (12th ed 2012) para 1-202.

⁷ See *Arab Bank Plc v Zurich Insurance Co* [1999] 1 Lloyd’s Rep 262.

⁸ *New Hampshire Insurance Co Ltd v MGN Ltd* [1996] CLC 1692 at 1737.

7.18 We are not recommending any change to the law in this area, and the courts will continue to construe contracts as they do now.

A three limbed test

7.19 A fair presentation has three elements. These are set out in clause 3(3), which defines a “fair presentation of the risk” as one:

- (a) which makes the disclosure required by subsection 3(4);
- (b) which makes that disclosure in a manner which would be reasonably clear and accessible to a prudent insurer; and
- (c) in which every material representation as to a matter of fact is substantially correct, and if as to a matter of expectation or belief, is made in good faith.

7.20 Below, we look at each of these in detail.

DISCLOSURE

7.21 Clause 3(4) defines a new duty of disclosure, which reflects the existing duty in section 18(1) of the 1906 Act with some important changes taken from the case law.⁹ Under the draft Bill, the insured must:

- (a) disclose every material circumstance which the insured knows or ought to know; or
- (b) failing that, disclose sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those circumstances.

7.22 There are therefore two ways to satisfy the duty of disclosure. Clause 3(4)(a) effectively repeats the existing disclosure duty from section 18(1) of the 1906 Act. Its key features are that the insured must disclose “every material circumstance” which the insured “knows or ought to know”.¹⁰ The second way to satisfy the duty, in clause 3(4)(b), is intended to operate where the insured has failed to satisfy the absolute duty in clause 3(4)(a) but has nevertheless disclosed enough information. The main elements of these clauses are discussed below.

⁹ See, for example, *WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA* [2004] EWCA Civ 962, [2004] 2 All ER 613 at [63]; *Garnat Trading & Shipping (Singapore) Pte Ltd v Baominh Insurance Corporation* [2010] EWHC 2578 (Comm), [2011] 1 Lloyd’s Rep 589, by Clarke J. See also CP3, Part 5 for a detailed discussion of the case law.

¹⁰ What the insured “knows or ought to know” is discussed in the following chapter.

Material circumstances and the prudent insurer

- 7.23 As under the current law, the new disclosure duty is based upon a requirement to disclose “every material circumstance”.
- 7.24 Material circumstance is defined in clause 7(3), using similar words to section 18(2) of the 1906 Act. A circumstance is material if it would influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms.
- 7.25 The concepts of “material circumstance” and “prudent insurer” are intentionally taken from the existing statute. We would expect existing case law to continue to be used to interpret them.¹¹

Examples of things which may be material circumstances

- 7.26 In CP3¹² we considered the relevant case law and identified a number of matters which were generally accepted to be “material circumstances” which should be disclosed as part of a fair presentation of the risk.
- 7.27 In CP3 we also discussed the possibility of including some of these matters as guidance on the face of the Bill.¹³ We have drafted this in clause 7(4) which gives the following examples of things which may be material circumstances:
- (a) special or unusual facts relating to the risk;
 - (b) any particular concerns which led the insured to seek insurance cover for the risk;
 - (c) anything which those concerned with the class of insurance and field of activity in question would generally understand as being something that should be dealt with in a fair presentation of risks of the type in question.
- 7.28 This non-exhaustive list emerged from our review of relevant case law and consultees told us it was helpful to include it on the face of the legislation.¹⁴

¹¹ In Chapter 5, we discuss our proposal in 2007 to replace the “prudent insurer” test with one based on the “reasonable insured”. We also summarise our reasons for moving on from that proposal. See para 5.45 and following.

¹² CP3, paras 5.14 to 5.37.

¹³ CP3, para 5.79.

¹⁴ We asked a specific question about this in our January 2014 consultation on the draft clauses, and most consultees who responded to this question advised that it was helpful to include the list in the draft Bill.

- 7.29 Of these three categories, we think (c) has the most potential for development by the market. It is intended to recognise that the type of information which should be disclosed may vary significantly depending on the “class” of insurance being purchased (for example, professional indemnity, employer’s liability, property) and the “field of activity” in which the insured operates (for example, heavy industries, shipping, financial auditing).
- 7.30 We think it would be helpful for insurers, brokers and policyholder bodies to work together to develop guidance and protocols setting out what a standard presentation of the risk should include in particular circumstances.
- 7.31 We think that a test based on established market understanding would encourage initiatives of this type. Where an insurer could show that it had not been told information which the protocol that the insured was following specifically stated should be included, this would suggest that the risk had not been fairly presented.

What the insured “knows or ought to know”

- 7.32 As we have discussed, section 18(1) of the 1906 Act states that the assured must disclose every material circumstance “which is known to the assured”, and “the assured is deemed to know every circumstance which, in the ordinary course of business ought to be known by him”. In other words, under the 1906 Act, the duty of disclosure applies to information which the insured knows or ought to know.
- 7.33 The draft clauses take the same approach, by referring to “every material circumstance which the insured knows or ought to know”.¹⁵ What the insured “knows” and what the insured “ought to know” are defined in clause 4, and discussed in detail in Chapter 8.

Sufficient information to put a prudent insurer on notice

- 7.34 Clause 3(4)(b) represents the key change we recommend to the duty of disclosure. It reflects the trend in case law of accepting that it may not be possible or necessary for every material circumstance to be disclosed.
- 7.35 As a recent case put it:

¹⁵ See draft Bill, clause 3(4)(a).

A minute disclosure of every material circumstance is not required. The assured complies with the duty if he discloses sufficient to call the attention of the underwriter to the relevant facts and matters in such a way that, if the latter desires further information, he can ask for it. A fair and accurate presentation of a summary of the material facts is sufficient if it would enable a prudent underwriter to form a proper judgment, either on the presentation alone, or by asking questions if he was sufficiently put upon enquiry and wanted to know further details, whether to accept the proposal and, if so, on what terms.¹⁶

- 7.36 This suggests that, even under the current law, an insured complies with the duty of disclosure if it discloses enough information either to allow the insurer to make an assessment of the risk or to put the insurer on notice that it needs to ask for more information. We recommend that this formulation of the duty of disclosure should be confirmed in statute.
- 7.37 Clause 3(4)(b) provides that, even where a material circumstance is not itself disclosed, the insured may still have done enough to satisfy the disclosure duty. The question is whether it has given the insurer sufficient “signposts” which would lead a prudent insurer to make further enquiries which, when answered, would reveal material circumstances.
- 7.38 This recommendation is intended to ensure that insurers are engaged in the disclosure and fair presentation process. Insurers should not “underwrite at claims stage”, allowing questions to go unasked until a claim is received. If a prudent insurer, reviewing the disclosed information, would be prompted to ask further questions or to seek further information, a failure on the part of the actual insurer to do so should not prejudice the insured at a later stage.

Example: putting a prudent insurer on notice

X Co takes out product liability insurance, describing itself on the proposal form as a maker of “valves”. The insurer does not ask further questions.

In fact the valves are used in the petrochemical industry. A valve fails, leading to a massive explosion at a petrochemical plant and subsequently a large claim.

¹⁶ *Garnat Trading & Shipping (Singapore) Pte Ltd and Another v Baominh Insurance Corporation* [2010] EWHC 2578 (Comm), [2011] 1 Lloyd's Rep 589 by Clarke J at [135]. The case proceeded to the Court of Appeal, and this formulation was not questioned.

The failure by X Co to state that its valves were used in the safety mechanisms of petrol storage facilities or other high-risk industry is likely to be a non-disclosure under the existing law. The high likelihood of serious damage would make this a material circumstance.

It would also be a material circumstance under our recommended regime, and ideally it should be disclosed. However, there is a further question to be asked: has the proposer said enough to put a prudent insurer on notice that it should make further enquiries?

We think that the mere mention of “valves” is not sufficient. It is too vague to attract any attention or put the insurer “on notice”. If X Co had described itself as making “specialist” valves, the position might be less clear. There is certainly an argument that the mention of “specialist” valves would lead a prudent underwriter to question the meaning of this term.

Certainly, if X Co had listed its three principal clients (all in the petrochemical industry), we think it would have met the fair presentation standard. A prudent insurer would be aware of the need for further enquiries about the possible risks should a valve fail.

- 7.39 As we have already mentioned, we think the primary duty of disclosure should be that in clause 3(4)(a).¹⁷ We include clause 3(4)(b) because we recognise that there may be circumstances in which satisfying the duty without guidance from the insurer will be almost impossible for an insured, and where an insurer could and should have assisted by making further enquiries. Recognising that disclosure will often require participation by the insurer is a central theme of our recommendations. However, we think that the courts would treat clause 3(4)(b) as an alternative only where the insured has tried but failed to comply with clause 3(4)(a) and shows that it has given the insurer a good base on which to make its enquiries. Considering similar matters, Lord Justice Rix said in *WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA*:

Mere possibilities will not put [the reasonably careful underwriter] on inquiry, and little if anything can make up for non-disclosure of the unusual or special. Overriding all ... is the notion of fairness, and that applies mutually to both parties, even if the presentation starts with the would-be assured.¹⁸

¹⁷ See para 5.66 and following.

¹⁸ [2004] EWCA Civ 962, [2004] 2 All ER 613 at [64].

7.40 Given the overarching duty of good faith,¹⁹ we do not think the courts would employ clause 3(4)(b) to aid an insured who intentionally disclosed a limited amount of information, hoping that the insurer would fail to make further enquiries to reveal the full picture. This is particularly so in light of the clause 3(3)(b) requirement that a presentation must be “clear and accessible”. This requirement is discussed in more detail below.

“A REASONABLY CLEAR AND ACCESSIBLE MANNER”

7.41 This is the second element of the duty of fair presentation. Clause 3(3)(b) of the draft Bill requires that disclosure is made in a manner which would be reasonably clear and accessible to a prudent insurer. Failure to satisfy this requirement will amount to a breach of the duty of fair presentation, in the same way as a disclosure failure.

7.42 This requirement relates to the *form* of presentation, rather than the substance. It is designed to encourage a better quality of presentation. The current law permits policyholders to overwhelm the insurer with a large amount of undigested information. This is neither efficient nor effective. We recommend therefore that the duty of fair presentation should also require the insured to present the information in a reasonably clear and accessible way.

7.43 We anticipate that whether this requirement has been breached will be highly fact specific: an underwriter’s “data dump” may be an insured’s “detailed risk information”. We do not see this duty as relating to the amount of information. Instead it is about the need to structure, index and signpost the information which is given.

7.44 A large volume of data would not be objectionable if it were organised appropriately and presented to the underwriter in a form which would allow it to navigate to what is important. Equally, it would be acceptable if it were accompanied by an overview highlighting material points, provided that the summary is “fair and accurate”.²⁰ As was confirmed in *CTI v Oceanus*, the underwriter:

¹⁹ Discussed in more detail in Chapter 30.

²⁰ *Garnat Trading & Shipping (Singapore) Pte Ltd and Another v Baominh Insurance Corporation* [2010] EWHC 2578 (Comm), [2011] 1 Lloyd’s Rep 589 by Clarke J at [135].

can expect to be given a fair summary and can assume that placing files which he has an opportunity of examining contain nothing exceptional or unusual; for a summary which excludes such matters is not a fair summary.²¹

- 7.45 The test is an objective one. It requires that the presentation would be reasonably clear and accessible to “a prudent insurer”, that is an insurer who is acting prudently to understand and evaluate risks. The presentation does not necessarily have to be accessible to the particular underwriter in question, who may be less than “prudent”.
- 7.46 As well as combating data dumps, we think the requirement to make a presentation in a “clear and accessible” manner might also be breached where an insured seeks to abuse the “sufficient information” limb of the disclosure test. For example, if the insured makes its disclosure in a piecemeal fashion or the presentation contains only oblique references to material circumstances, made in the hope that the insurer will fail to make further enquiries, we think that this would not be “clear and accessible”.

A DUTY NOT TO MAKE MISREPRESENTATIONS

- 7.47 This third element of the duty of fair presentation is based on section 20 of the 1906 Act. We have brought material representations within the duty of fair presentation alongside disclosure because there is often little practical difference between a non-disclosure and a misrepresentation: breaches often concern the same information, and the same inducement test and remedies for breach apply.²²
- 7.48 Section 20 of the 1906 Act recognises a difference between matters of fact and matters of expectation or belief. Facts must be substantially correct, whereas expectations or beliefs must be represented in good faith under section 20(5). The distinction between a representation of fact and one of belief is a matter of construction.

²¹ *Container Transport International Inc and Reliance Group Inc v Oceanus Mutual Underwriting Association (Bermuda) Ltd* [1984] 1 Lloyd’s Rep 476 by Stephenson LJ at 529.

²² See above, para 4.44 and Chapter 4 generally. Lord Mustill in *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501 at 549 noted that in practice the difference between the two is “often imperceptible”.

- 7.49 In practice, the courts are heavily influenced by whether the matter is one which the policyholder knew about or should have known about. If so, the court is likely to hold that the statement must be true or substantially correct. If it is outside the matters which the policyholder could be expected to know about, it is probably a matter of expectation or belief and must be made in good faith.
- 7.50 For example, in two nineteenth century cases regarding the position of ships, it was held that the broker could not have known where the ships were. This must be a matter of expectation or belief.²³ By contrast, a statement about the presence of fire hydrants was held to be a statement of fact, even though it was preceded by “we have been informed”.²⁴ The insured should have known whether the hydrants existed.
- 7.51 In CP3 we considered recommending statutory language along these lines, so that there would be an explicit distinction in the context of misrepresentation between matters which the insured knew or ought to have known, and other matters. On further consultation we decided that such a change was not necessary; the wording of the 1906 Act has not caused problems in practice as the courts are already taking this approach. We therefore recommend using language similar to the existing section 20. However, we recommend that the duty not to make misrepresentations should be included as part of the duty of fair presentation rather than completely separate from the duty of disclosure.
- 7.52 Clause 3(3)(c) provides that every “material representation” made by the insured must be:
- (1) “substantially correct”, if as to a matter of fact; or
 - (2) made in “good faith”, if as to a matter of expectation or belief.

²³ *Hubbard v Glover* (1812) 3 Camp 313; *Brine v Featherstone* (1813) Taunt 869.

²⁴ *Sirius International Insurance Corp v Oriental Assurance Corp* [1999] Lloyd’s Rep IR 343.

7.53 We think that the courts should, and will, continue to distinguish between matters of “fact” and other matters in the way we have discussed above.²⁵ For example, suppose the insurer asks whether any of the insured’s employees have criminal convictions, and the insured answers no. In fact, this is not correct: one member of staff has a conviction for theft. If the senior manager or insurance buyer knew about this conviction, there would clearly be a breach of the duty of fair presentation. Similarly, there would also be a breach if the insured should have known about the conviction by carrying out a reasonable search. The position may be different if the conviction was not something which could be discovered by a reasonable search – for example, if the conviction was in another country and the employee had lied about it. In these circumstances it may be enough that the representation is made in good faith.

Material representation

7.54 Section 20 of the 1906 Act is concerned with “material representations”. We do not recommend any changes to this. Given the requirement for the insurer to show inducement before it has a remedy for misrepresentation, even without the reference to “material” representations it is highly unlikely that an insurer could have claimed a remedy as a result of an immaterial or minor misrepresentation.

7.55 Clause 7(3) provides that a material representation is one which would influence the judgment of a prudent insurer in determining whether to take the risk and if so, on what terms. This echoes section 20(2) of the 1906 Act.

Substantially correct

7.56 The concept of a material representation being “substantially correct” is taken from section 20 of the 1906 Act. Like section 20(4) of the 1906 Act, clause 7(5) of the draft Bill provides that a material representation is substantially correct if:

a prudent insurer would not consider the difference between what is represented and what is actually correct to be material.

In good faith

7.57 As we have discussed above, the courts have confirmed that good faith in this context means just that. It is not sufficient that a representation is based on reasonable grounds, although of course “the absence of reasonable grounds for that belief might point to the absence of good faith for that belief”.²⁶

²⁵ See also *Economides v Commercial Union Assurance Co Plc* [1998] QB 587.

²⁶ *Economides v Commercial Union Assurance Co Plc* [1998] QB 587 by Gibson LJ at 606.

Withdrawing a misrepresentation

- 7.58 Clause 7(6) provides that a representation may be withdrawn or corrected before the contract is entered into. This reflects the current law, as set out in section 20(6) of the 1906 Act.

RECOMMENDATIONS

Recommendation 1: For non-consumer insurance, the current law set out in sections 18 to 20 of the Marine Insurance Act 1906 should be replaced with a new statutory duty of fair presentation.

The new duty should reflect the current law subject to the following changes:

Recommendation 2: The disclosure duty should have two limbs. The insured should either:

- (a) disclose every material circumstance which the insured knows or ought to know; or
- (b) failing that, disclose sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those circumstances.

Recommendation 3: The statute should include an indicative and non-exhaustive list of circumstances which may be material, taken from the case law, namely:

- (a) special or unusual facts relating to the risk;
- (b) any particular concerns which led the insured to seek insurance; and
- (c) anything which those concerned with the class of insurance and field of activity would generally understand as something that should be dealt with in a fair presentation of risks of the type in question.

Recommendation 4: The insured should disclose information in a manner which would be reasonably clear and accessible to a prudent insurer.

Recommendation 5: The duty of fair presentation should also include the existing duty not to make misrepresentations.

These recommendations are intended to be a default scheme for non-consumer insurance and are subject to our contracting out recommendations in Chapter 29.

- 7.59 As we discuss in Chapter 8, we recommend statutory definitions of what an insured knows or ought to know. We also think that the duty of fair presentation should be subject to the exceptions discussed in Chapter 10.

CHAPTER 8

DETAILED RECOMMENDATIONS: THE INSURED'S KNOWLEDGE

- 8.1 Section 18(1) of the Marine Insurance Act 1906 (the 1906 Act) requires a non-consumer insured to disclose to the insurer:

every material circumstance ... which is known to the assured, and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him.

- 8.2 In other words, before entering an insurance contract a prospective insured must disclose material information which it knows or which it ought to know in the ordinary course of business. This leads to difficult questions.

- (1) Whose knowledge is relevant to determining what the insured “knows” (the attribution question)?
- (2) What more “ought” the insured to know, and what must it do to discover it (the constructive knowledge question)?

- 8.3 The issue is particularly difficult where the policyholder is not an individual (or natural person) but some other entity (which may or may not have a separate legal personality).¹ While deciding what an individual knows is simply a matter of fact and evidence, deciding what an organisation “knows” first involves an analysis of whose knowledge counts towards the organisation’s “knowledge” from a legal perspective.

- 8.4 In this chapter, we outline the uncertainties in the current law, both concerning attribution of knowledge generally and under section 18 specifically. We discuss the difficulties this creates.

¹ The status of partnerships is complex. Partnerships are recognised as having legal personality in Scotland, but not in England and Wales (though for some practical purposes they are treated as if they do have legal personality). For further details, see Partnership Law (November 2003) Law Com No 283; Scot Law Com No 192. http://lawcommission.justice.gov.uk/docs/lc283_Partnership_Law.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/266.

- 8.5 We recommend that the duty of fair presentation should continue to be based on what the insured “knows or ought to know”, but that these words should be more closely defined. We identify the types of people whose knowledge should be directly attributed to the insured, so that the knowledge of those individuals is “known” by the insured. We also recommend that the insured “ought to know” that which would have been revealed by a reasonable search of information available to it.
- 8.6 A more thorough discussion of the current law can be found in Chapter 6 of Consultation Paper 3 (CP3).²

THE CURRENT LAW

- 8.7 Where a natural person seeks insurance, the issue of knowledge is relatively straightforward: as one case put it, “the actual knowledge of a natural person means what it says – he knows what he knows”.³
- 8.8 Where a corporation seeks insurance, however, the position is more complex. The issue is not unique to insurance law: it arises frequently within the general law, and section 18 of the 1906 Act must be interpreted against that background.

Attributing knowledge: general legal principles

- 8.9 The traditional approach to attributing knowledge within a corporation is to identify its “directing mind and will”. In *HL Bolton (Engineering) Co Ltd v TJ Graham & Sons Ltd*, Lord Denning distinguished between a company’s directors and managers and other employees:

Some of the people in the company are mere servants and agents who are nothing more than hands to do the work and cannot be said to represent the mind or will. Others are directors and managers who represent the directing mind and will of the company and control what it does. The state of mind of those managers is the state of mind of the company and is treated by the law as such.⁴

² Insurance Contract Law: The Business Insured’s Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155.

³ *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136 by Lord Justice Staughton at 1141.

⁴ [1957] 1 QB 159 at 172.

8.10 In some cases, however, “the directing mind and will” test is too narrow. For example, when a supermarket sells a video classified as “18” to a 14 year old, it is clearly the knowledge of the sales clerk rather than the board which is relevant. The courts have therefore developed a broader test, based on the purpose of the relevant statute or regulation.⁵

8.11 In *Meridian Global Funds Management Asia Ltd v Securities Commission*, Lord Hoffmann held that the court should not look solely at the corporate hierarchy but should also consider the purpose of the provision in question:

Whose act (or knowledge, or state of mind) was *for this purpose* intended to count as the act etc of the company? One finds the answer to the question by applying the usual canons of interpretation, taking into account the language of the rule (if it is a statute) and its content and policy.⁶

8.12 This broader test recognises that it is sometimes necessary to attribute the acts or thoughts of individuals who were not part of “the directing mind and will” of the corporation. Otherwise directors could insulate the corporation by delegating their functions and claiming to have no knowledge of what was done.

8.13 The courts have stressed, however, that the broader test does not necessarily extend to all employees – it depends on the facts of the case.⁷ For example, in the context of the Health and Safety at Work etc. Act 1974, the court applied a directing mind test and found it included store management level responsibilities.⁸ In *Real Estate Opportunities v Aberdeen Asset Managers*, the judge said that, for the purposes of section 348 of the Financial Services and Markets Act 2000, the company could be taken to know generally what was known by its employees in the course of their employment.⁹

8.14 The broader test preserves flexibility but at the cost of considerable uncertainty.

⁵ For further general discussion, see Law Commission, *Criminal Liability in Regulatory Contexts* (August 2010), Law Commission Consultation Paper No 195. http://lawcommission.justice.gov.uk/docs/cp195_Criminal_Liability_consultation.pdf.

⁶ [1995] 2 AC 500 at 507.

⁷ *Re Supply of Ready Mixed Concrete (No 2), Director General of Fair Trading v Pioneer Concrete (UK) Ltd* [1995] 1 AC 456 at 511.

⁸ *R v Gateway Foodmarkets Ltd* [1997] 3 All ER 78, (1997) 94(3) LS Gazette 28.

⁹ [2007] EWCA Civ 197, [2007] Bus LR 971 at [57].

Attributing knowledge for the purposes of section 18

- 8.15 The next consideration is how knowledge is attributed to further the purpose of section 18 of the 1906 Act. In *PCW Syndicates*, Lord Justice Staughton applied the broader test:

I can see no reason to restrict the knowledge of a company under s18 to what is known at a high level, by the directing mind and will. I would have thought that knowledge held by employees whose business it was to arrange insurance for the company would be relevant, and perhaps also the knowledge of some other employees.¹⁰

- 8.16 We think that this is broadly correct and applies to all corporate policyholders. Section 18 must clearly apply to anything known to the directing will and mind of the company. In the case of a large, publicly quoted company, this would normally be members of the board. If the board know (or any member of the board knows) material circumstances, these should be disclosed. It should be no excuse that the board concealed information from their risk manager.
- 8.17 It is also appropriate that knowledge should be attributed to the employees and agents who arrange insurance.
- 8.18 We think, however, that it is unhelpful to talk about “perhaps” including the knowledge of some other employees. This is an issue on which businesses and insurers need more certainty. We think that the more helpful way of including information known by other employees is to place the persons arranging insurance under a duty to make reasonable enquiries (including questioning other employees). Below we consider the extent to which insurance managers should investigate.

What ought the insured to know?

- 8.19 The next question is what a policyholder ought to know in the ordinary course of business. There are several difficult issues with this test. The first is whether it is limited only to “blind eye” knowledge – things which the policyholder would have known had it not deliberately avoided acquiring the information. Alternatively, does it extend to a positive duty to make enquiries?
- 8.20 There is also a debate over whether the test is objective or subjective. Does it extend to information which a risk manager would have discovered in a reasonably well-run company, or only to information which a risk manager would have discovered through reasonable inquiries in the fallible, and sometimes negligent, company which actually sought insurance?

- 8.21 The current law on these issues is malleable and driven by the facts of individual cases. The various issues are often considered together, which obfuscates the true meaning of section 18(1) of the 1906 Act.

Blind eye knowledge

- 8.22 It is well accepted that knowledge includes circumstances to which a prospective policyholder has “turned a blind eye”. The courts have consistently interpreted knowledge to include cases where someone has deliberately failed to make an enquiry in case it results in the receipt of unwelcome information. In *The Star Sea*, Lord Scott described the concept in the following terms:

“Blind-eye” knowledge approximates to knowledge. Nelson at the battle of Copenhagen made a deliberate decision to place the telescope to his blind eye in order to avoid seeing what he knew he would see if he placed it to his good eye. It is, I think, common ground – and if it is not, it should be – that an imputation of blind-eye knowledge requires an amalgam of suspicion that certain facts may exist and a decision to refrain from taking any step to confirm their existence.¹¹

- 8.23 In *The Eurysthenes* Lord Denning MR explained that:

This “turning a blind eye” is far more blameworthy than mere negligence. Negligence in not knowing the truth is not equivalent to knowledge of it.¹²

- 8.24 It is clearly right that one should look not only at what the relevant people knew but also at information they had deliberately avoided acquiring for fear it might confirm their suspicions. Below we recommend that knowledge should include not only actual knowledge but also “blind eye” knowledge.

¹⁰ [1996] 1 WLR 1136 at 1142.

¹¹ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [112]. See similarly Lord Denning in *Compania Maritima San Basilio SA v Oceanus Mutual Underwriting Association (Bermuda) Ltd (The Eurysthenes)* [1977] QB 49 at 68.

¹² *Compania Maritima San Basilio SA v Oceanus Mutual Underwriting Association (Bermuda) Ltd (The Eurysthenes)* [1977] QB 49 at 68.

A duty to enquire?

- 8.25 The difficult question is whether the test goes beyond “blind eye” knowledge to a positive duty on the policyholder to make enquiries. Some cases suggest that it does, as we discussed in CP3.¹³
- 8.26 If the policyholder has an obligation to make reasonable enquiries under the current law, how is that to be judged? There has been debate over whether the test is subjective, by reference to the way the policyholder actually runs its business, or objective, by reference to the way a reasonable policyholder would run its business.
- 8.27 In CP3 we set out the differences of opinion on this subject in the major textbooks.¹⁴ In the 16th edition, the editors of *Arnould* said that the standard must be subjective:

To hold otherwise would be tantamount to saying that underwriters only insure those who conduct their business prudently, whereas it is a commonplace that one of the purposes of insurance is to obtain cover against the consequences of negligence in the management of the assured’s affairs.¹⁵

- 8.28 However, in the 17th edition, the editors noted a move towards a more objective standard:

There is a subjective element, that the insured is a member of a class (such as in the *PCW* case a Lloyd’s syndicate) but beyond that the question should be judged objectively, by reference to a reasonable, prudent insured in that class.¹⁶

¹³ CP3, from para 6.33.

¹⁴ CP3, from para 6.36.

¹⁵ *Arnould’s Law of Marine Insurance and Average* (16th ed 1997) para 640, quoted in *Arnould’s* (17th ed 2008) at para 16-36. See also CP3, para 6.37.

¹⁶ *Arnould’s Law of Marine Insurance and Average* (17th ed 2008) at para 16-46, citing *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136.

- 8.29 *Australia & New Zealand Bank Ltd v Colonial & Eagle Wharves Ltd* is used to justify a subjective standard.¹⁷ In that case the judge also found on the facts that any reasonable enquiries the board could have been expected to make would not have revealed the information the underwriter claimed was material, because it would have required an employee to admit his own negligence. We think that this is a key issue in considering the limits of what a reasonable search would reveal.¹⁸
- 8.30 It also demonstrates the importance of separating the attribution question from the question of constructive knowledge. If a person's knowledge is attributed to an entity, then the entity is deemed to know any information which that person may fraudulently or negligently withhold. If, however, the entity is only required to make enquiries of that person, the entity does not have constructive knowledge of information which it would not have uncovered even if it had made those enquiries.

THE CASE FOR REFORM

- 8.31 There is considerable case law concerning questions of attributed and constructive knowledge, providing flexible answers, based on the circumstances of each case. For most purposes, both in the context of insurance law and beyond, we think that the flexibility of the common law is helpful and appropriate.
- 8.32 This is particularly true in the context of fraudulent claims, discussed in Part 4. Most insurance contracts are not affected by fraudulent claims. Where fraud does arise, it may be appropriate for a wide category of persons to be caught within the attribution test, and for the matter to be judged flexibly and retrospectively. The courts can rely on a wealth of authorities concerning the attribution of fraudulent behaviour outside the insurance context.¹⁹ Therefore we do not make any recommendations for reform of attribution of knowledge in the context of fraudulent claims.

¹⁷ [1960] 2 Lloyd's Rep 241; see *Arnould's Law of Marine Insurance and Average* (17th ed 2008), para 16-38; Birds, Lynch and Milnes, *MacGillivray on Insurance Law* (12th ed 2012), para 17-014.

¹⁸ See from para 8.80 below, and particularly from para 8.83.

¹⁹ See for example *Morris v Bank of India* [2005] EWCA Civ 693, [2005] BCC 739, which highlights the fact specific nature of these decisions and the need for more flexibility.

- 8.33 By contrast, all contracts of insurance are affected by, and rely on compliance with, the duty of fair presentation. An insured needs to be able to predict in advance and with some clarity what information must be included in its presentation. That depends on whose knowledge will be attributed to the insured, and how much more the insured must do in order to gather information. There may be a large number of people, both within the insured's organisation and elsewhere, who know or have access to relevant information.
- 8.34 There is a need for clear rules which can be followed on a day to day basis. Common law rules cannot provide this certainty, although there are helpful principles which can be drawn from them.
- 8.35 Further, an insured party cannot exercise control over all of its employees and agents. From a policy perspective, protecting itself against the fraud and negligence of employees may be one of an insured's reasons for purchasing insurance.²⁰ We think that a limited number of people should have their knowledge attributed to an insured in a disclosure context. Instead, insureds should be under a clear duty to carry out a reasonable search.
- 8.36 These points were made by a number of consultees to our 2007 consultation, in which we did not make any specific proposals about defining what the insured "knows or ought to know".
- 8.37 Our CP3 proposals to clarify these matters in statute received strong support. Of the 41 respondents to this question, 34 (83%) agreed. The Chartered Insurance Institute noted that the current wording of section 18(1) "does not reflect the complexities of corporate entities". Allen & Overy added that it "can lead to confusion and unnecessary litigation". K&L Gates welcomed reform and reported that "issues on knowledge frequently lead to disputes with insurers under the current law". The Association of British Insurers (ABI) supported our proposals for clarification, saying that they would "provide more certainty and thereby reduce disputes".

Negotiated solutions

- 8.38 The issue of what a policyholder knows and ought to know is a major concern to larger companies. Some have already begun to explore solutions with insurers, including contractual terms to define whose knowledge is relevant or to determine the extent of any search of information the insured should undertake. Airmic told us that one member agreed a restriction to:

²⁰ The *Hampshire Land* principle adds another complication (fraud by an agent is not attributed to the principal where the fraud is perpetrated against the principal.) This is discussed from para 8.67 below.

“knowledge residing in the insurance department”, not in the heads of every employee throughout the company worldwide.

8.39 Airmic also published a guide, *Disclosure of Material Facts and Information in Business Insurance*, seeking to give guidance to buyers about what information should be disclosed and what procedures they should go through before preparing their presentation.²¹

8.40 In an article published in *Post Magazine*, Airmic said, “helpful though these initiatives might be, they simply paper over the cracks in our outdated insurance law”.²²

Conclusion on the case for reform

8.41 For large companies and other entities, the issue of what the insured knows or ought to know has major practical implications. It is in all parties’ interests that the insured takes appropriate steps to identify and gather relevant information for its presentation.

8.42 There needs to be greater clarity on this issue. We think that a statutory definition, combined with detailed protocols agreed by market participants, would give insureds the best chance of making a fair presentation of the risk.

8.43 We therefore recommend that the legislation should define what an insured “knows” or “ought to know” for the purposes of a fair presentation. Clause 4 of the draft Bill does this in two ways.

- (1) To define what an insured “knows”, it specifically identifies the individuals whose knowledge should be directly attributed to the insured.
- (2) It introduces a duty to search. Clause 4(4) provides that an insured “ought to know” matters which should reasonably have been revealed by a reasonable search of available information.

8.44 Below we look at each element in turn.

²¹ See further discussion in CP3, paras 6.68 to 6.72.

²² Quoted in Jonathan Swift, “Comment – insurance law reform: Reform can’t wait”, *Post Magazine* (14 April 2010).

RECOMMENDATION: DEFINING WHAT AN INSURED “KNOWS”

- 8.45 We recommend that the new legislation should identify the individuals whose knowledge should be directly attributed to the insured. In particular, where an insured is an organisation, we recommend the insured should be taken to know not only what is known by its “directing mind and will”, but also what is known by the people who arrange its insurance. This follows Lord Justice Staughton’s statement in *PCW Syndicates*.²³
- 8.46 We recommend that an insured should be taken to know both what these individuals actually know and what they have deliberately refrained from knowing (blind eye knowledge).²⁴ This is provided for in clause 6(2) which states that:
- references to an individual’s knowledge include not only actual knowledge, but also matters which the individual suspected, and of which the individual would have had knowledge but for deliberately refraining from confirming them or enquiring about them.
- 8.47 Below, we explain that these provisions effectively displace the common law of attribution in the context of the duty of fair presentation. However, we make specific provision to preserve any common law rule by which the knowledge of a fraudster is not attributed to the party on whom the fraud is practised.²⁵

Where the insured is an individual

- 8.48 As we have said, where an insured is an individual (such as in the case of a sole trader or practitioner), it is clear that their own knowledge must be attributed to them. Under our recommendations, this includes not only actual knowledge but also blind eye knowledge.²⁶
- 8.49 However, there may well be other people connected with that individual who know, or have access to, information which should form part of the insured’s fair presentation. We think that an individual insured should also be taken to “know” anything which is known by the person or people who are responsible for their insurance.
- 8.50 This is included in clause 4(2). Who is “responsible for the insured’s insurance” is discussed further below, but may include employees or external agents. Again, what these individuals know should include both actual knowledge and blind eye knowledge.

²³ [1996] 1 WLR 1136 at 1142.

²⁴ See para 8.22 above.

²⁵ See draft Bill, clause 6(4).

²⁶ See draft Bill, clause 6(2).

Where the insured is not an individual

8.51 Where the insured is a corporate entity, we recommend that the insured should be taken to “know” what is known by individuals who are:

- (1) part of the insured’s senior management; or
- (2) responsible for the insured’s insurance.

8.52 This is provided in clause 4(3), which would apply to all non-consumer insureds other than individuals (including companies, limited liability partnerships and public bodies). Again, this includes actual and blind eye knowledge.²⁷

8.53 We consider each of these tests below.

The insured’s senior management

8.54 Who is “part of the insured’s senior management” is defined in clause 4(5)(b) as:

those individuals who play significant roles in the making of decisions about how the insured’s activities are to be managed or organised.

8.55 The definition would include (and be more or less limited to) board members or their equivalent in a non-corporate organisation. It is not generally intended to capture, for example, regional or middle managers.²⁸ It replicates the common law “directing mind and will” test, but without its broader extensions.

8.56 The definition of “senior management” in the draft Bill can be usefully compared with (and distinguished from) the definition of the same term in the Corporate Manslaughter and Corporate Homicide Act 2007. Section 1(4)(c) of that Act reads:

“senior management”, in relation to an organisation, means the persons who play significant roles in—

- (i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised; or
- (ii) the actual managing or organising of the whole or a substantial part of those activities.

8.57 The explanatory notes to this definition state:

²⁷ See draft Bill, clause 6(2) and above at para 8.46.

²⁸ The knowledge of these individuals should generally be caught by the requirement for a reasonable search, discussed below from para 8.77.

This covers both those in the direct chain of management as well as those in, for example, strategic or regulatory compliance roles.

- 8.58 When we formulated the definition of senior management for the purposes of the draft Bill, we began by looking at the 2007 Act. We thought that the definition there was wider than it should be in the fair presentation context. Unlike the 2007 Act, we intend to catch high-level senior management but not regional or middle-managers involved in only part of the organisation. We wish to follow *Gibson v Barton* by including only those people with:

the management of the whole affairs of the company; not an agent who is to do one thing, or a servant who is to obey orders and do another, but a manager who is entrusted with the power to manage the whole of the affairs.²⁹

- 8.59 We appreciate that legal persons includes a diverse range of entities beyond registered companies. This has implications for the approach to identifying the highest level of management of the entity. It might be helpful to consider who we think would be the “senior management” in different situations.

- (1) Limited liability partnership (LLP) – normally, an LLP would have a board. We expect that the board would constitute the “senior management”.
- (2) National company – the board would constitute the senior management.
- (3) Multinational or global corporation with subsidiaries – this will depend on how the particular insurance policy is structured. As we have discussed, we think that this type of policy would usually be construed as a number of separate composite contracts of insurance.³⁰ On this basis, each entity would be an “insured” with fair presentation obligations and the knowledge of the board of the relevant insured would be attributed to it.
- (4) Local authority – the Executive (or equivalent) would constitute the senior management.
- (5) Charitable Incorporated Organisation (CIO) or Scottish Charitable Incorporated Organisation (SCIO) – the charity trustees would constitute the senior management.

²⁹ By Blackburn J, *Gibson v Barton* (1874-75) LR 10 QB 329.

³⁰ See discussion above from para 7.15.

- 8.60 While there may be other people (including employees and agents of all levels) who have highly relevant information (for example, strategic or regulatory compliance officers, or regional managers of significant parts of an entity), their knowledge should generally be caught by the “reasonable search” requirement which we recommend below.

Individuals responsible for the insured’s insurance

- 8.61 As discussed above, we have based this aspect of our recommendations on Lord Justice Staughton’s comments in *PCW Syndicates*.³¹ They were made in the context of a corporate insured, but we think they can be properly extended to an insured who is an individual but who arranges their insurance through, or with the assistance of, others.

- 8.62 Under clause 4(5)(a) of the draft Bill, a person is “responsible for the insured’s insurance” if that individual:

participates on behalf of the insured in the process of procuring the insured’s insurance (whether the individual does so as the insured’s employee or agent, or as an employee of the insured’s agent, or in any other capacity).

- 8.63 This definition is intended to catch all those individuals who participate in the insurance buying process, perhaps by collating information about the risk for the purposes of the disclosure obligation, negotiating with insurers or brokers, giving instructions to brokers on behalf of the insured or approving tenders.

- 8.64 Such people may be risk managers or a more general procurement officer or team, for example. They may also be external contractors. The individuals concerned may well be quite junior (particularly in some small and medium sized companies). If the final purchasing decision is escalated, we think the knowledge of both the people who compiled the information and the people making the final purchase decision should be attributed to the insured.

The insured’s agent

- 8.65 The definition of individuals responsible for the insured’s insurance also explicitly captures agents of the insured. This will include brokers and other intermediaries. Importantly, it captures only the individual agent (or employee of the agent), rather than, for example, the collective knowledge of a large broking firm.

³¹ *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136 by Lord Justice Staughton at 1147.

- 8.66 The current law concerning the agent's knowledge, and our recommendations in respect of it, are discussed separately in Chapter 9.

Concealing fraud: the *Hampshire Land* principle

- 8.67 Our recommendations effectively displace the common law of attribution from the duty of fair presentation. We have therefore considered carefully whether there are other principles within the current law which we need to preserve for these purposes.
- 8.68 The common law includes an exception to the general rules of attribution in cases of fraud. This is known as the *Hampshire Land* principle, and broadly means that a company or other principal is not fixed with knowledge of a fraud practised against it by an agent or officer.³² However, the exact scope of the principle is far from clear. A recent House of Lords decision demonstrated the variety of judicial opinion on this subject.³³

A narrow interpretation

- 8.69 The main question is whether the *Hampshire Land* principle applies where the principal is a secondary victim of a fraud directed at another (because of consequential liabilities/losses suffered by the principal as a result of the fraud) or whether such an application is stretching the principle too far.³⁴ The narrower view is that the principal has to be the primary victim – that is, that the fraud must be perpetrated directly against the principal.
- 8.70 To some extent, our knowledge proposals are intentionally designed so that the fraud of certain individuals is attributed to their principal. For example, where senior managers of a company fraudulently misrepresent the extent of the risks in their business practices to obtain cheaper insurance, we think that this should be attributed to the company so that the insurer is entitled to avoid the policy. Therefore, we do not think that the wider interpretation of the *Hampshire Land* principle should be applied to limit our knowledge provisions.

³² From *Re Hampshire Land Company* [1896] 2 Ch 743. For Scotland, see L Macgregor, *The Law of Agency in Scotland* (2013), para 13-24.

³³ *Moore Stephens v Stone & Rolls Ltd* [2009] UKHL 39, [2009] 1 AC 1391. The issue concerned attribution in a one man company where the director had used the company as a vehicle for fraud. Lord Phillips found in these circumstances “there is no difficulty” in attributing the knowledge of that person to the company (at [51]). Lord Brown and Lord Walker agreed on this point. By contrast, Lord Scott said that the company had a separate legal personality and was the “victim” of the fraud (at [110] and [117] to [118]). Lord Mance concluded that, because the company was insolvent, the director was in breach of his duty by failing to have regard to the interests of the creditors – there was someone else to defraud and his knowledge could not be attributed to the company (at [229]).

8.71 However, we see a policy argument in favour of the *Hampshire Land* principle in its more restricted sense, where the insured company is the direct victim of the fraud perpetrated by an individual or individuals who should be representing its interests. The rationale is that it is contrary to common sense and justice to attribute to a principal knowledge of something that their agent would be anxious to conceal from them.³⁵

8.72 The application of this rule in an insurance disclosure context can be seen in *Group Josi Re*.³⁶ Group Josi, a Belgian reinsurance company, alleged non-disclosure against the defendant insurance companies and their agent. Group Josi claimed that the defendants had failed to disclose fraudulent conduct by the chairman, deputy chairman and managing director of the agent who were taking an overriding commission from the reinsurers for their own benefit instead of crediting it to the insurers.

8.73 Lord Justice Saville held that section 18 of the 1906 Act does not require disclosure of information that an agent fraudulently withholds from its principal:

The section itself distinguishes between the knowledge of the assured and knowledge which the assured is deemed to have. The latter type of knowledge is limited to circumstances which, in the ordinary course of business, ought to be known by the assured. To my mind, the proposition that in the present case the reinsured companies ought in the ordinary course of business to have known that they were being defrauded simply offends common sense. In the ordinary course of business those being defrauded do not know of that fact. If they did, they would not be defrauded.³⁷

8.74 The court was highly critical of any attempt to attach the insured with the agent's fraudulent knowledge:

³⁴ See, for example, *Arab Bank plc v Zurich Insurance Co* [1999] 1 Lloyd's Rep 262 for a wide application of the principle in an insurance context.

³⁵ *Moore Stephens v Stone Rolls Limited* [2009] UKHL 39, [2009] 1 AC 1391 at [43].

³⁶ *Group Josi Re v Walbrook Insurance Co Ltd* [1996] 1 WLR 1152. See also the related case of *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136.

³⁷ [1996] 1 WLR 1152 at 1168.

It would be wholly unreasonable for an insurer to contract on the basis that information of this kind [ie that the agent was defrauding his principal] had been provided to the assured.³⁸

Recommendation

- 8.75 We wish to preserve the rule that the knowledge of a fraudster is not attributed to the party on whom the fraud is practised. However, there are still uncertainties about the application of the principle and we would not want to exclude debate by legislating too prescriptively. We therefore think that we need to preserve the common law flexibility rather than recommending a defined rule.
- 8.76 Clause 6(4) therefore preserves “any rule of law” according to which the knowledge of a fraudster is not attributed to the party on whom the fraud is practised.

RECOMMENDATION: DEFINING WHAT AN INSURED “OUGHT TO KNOW”

A duty to search

- 8.77 We have discussed what an insured should be taken to “know”. The next question is what an insured “ought to know”. We think this should be based on matters which would be revealed by a reasonable search of available information.
- 8.78 Conducting a reasonable search of information available to the insured is part of a good insurance placement process. The insurer is entitled to expect that the insured knows more about its operations than that which the directing mind and will or senior management happen to know, particularly in large, potentially multinational companies where the board members or equivalent could not generally be expected to have more than a high level, strategic overview.
- 8.79 The “reasonable search” requirement is a key element of our knowledge proposals and has support from a wide range of consultees. Airmic already acknowledges that members may need to conduct a search of information as part of the disclosure process.³⁹
- 8.80 We therefore recommend the introduction of a statutory duty to take positive steps to collate relevant information for the purposes of making a fair presentation. Clause 4(4) defines what an insured “ought to know” as that which:

³⁸ [1996] 1 WLR 1152 at 1168.

³⁹ Airmic, *Disclosure of Material Facts and Information in Business Insurance* (2011).

should reasonably have been revealed by a reasonable search of information available to the insured (whether within its own organisation or held by others, for example its agent, and whether the search is conducted by making enquiries or by any other means).

- 8.81 This provision therefore expressly states what has been suggested by some of the cases: that is, insurance buyers have a positive duty to seek out information about their organisation.⁴⁰ There are several elements to this requirement, which we discuss below.

Which insureds have to undertake a reasonable search?

- 8.82 The obligation to conduct a reasonable search under clause 4(4) applies to all insureds, natural and non-natural.

What constitutes a “reasonable search”?

- 8.83 We think much of this must be down to the application of “reasonable” to a particular set of facts. We expect that what is “reasonable” will depend on the size, nature and complexity of the business. We refer again to the comment in *Arnould* that the question “should be judged objectively, by reference to a reasonable, prudent insured in that class”.⁴¹
- 8.84 The degree of thoroughness of a reasonable search for potentially material information will vary according to whether the insured is a small business with five employees or a multinational entity with five thousand. Where the insured is an individual, there may be no employees to ask but there may be records to interrogate and/or outside advisors to consult.
- 8.85 For large insurance contracts, we hope that the parties will discuss and reach agreement on the nature of the search to be undertaken. This process would be made much easier by the development of industry-produced protocols on the types of search which are expected.

⁴⁰ See, for example, *Inversiones Manria SA v Sphere Drake Insurance Co Plc* [1989] 1 Lloyd's Rep 69; *Aiken v Stewart Wrightson Members Agency Ltd* [1995] 3 All ER 449, [1995] 2 Lloyd's Rep 618; *London General Insurance Co Ltd v General Marine Underwriters' Association Ltd* [1920] 3 KB 23. See also CP3, from para 6.33.

⁴¹ *Arnould's Law of Marine Insurance and Average* (2008 17th ed), para 16-46.

Matters which “should reasonably have been revealed”

- 8.86 We recommend that the insured ought to know only what should reasonably have been revealed by the reasonable search. The insured should not be taken to have constructive knowledge of information which could not reasonably have been discovered, such as information which would have been withheld through negligence or fraud.
- 8.87 We think that this reflects the current law. *Australia & New Zealand Bank Ltd v Colonial & Eagle Wharves Ltd*, confirmed that the results of any search could not be expected to include an admission by a servant of his own negligence.⁴² In contrast, the knowledge of an “agent to know”, who could be expected to keep their employer or principal informed of relevant information, may well be included as what the insured “ought to know”.⁴³

What is “available to the insured”?

- 8.88 Again, we think what is “available to the insured” is necessarily a matter of fact in the circumstances of a particular case.
- 8.89 We would generally expect it to include information held within the insured’s organisation, including in computer records and known to employees (within reason). We think that how far an insured must go to question individual employees will vary widely depending on how many there are. It might be, for example, that all managers of a certain level should be consulted.
- 8.90 In some circumstances, the insured should also make enquiries of outside advisors such as brokers/agents, lawyers, technical advisors and suppliers who may know about matters which are relevant to the insurer. Clause 4(4) explicitly provides that a reasonable search should encompass a search of information available to the insured but held by its agent. The current law concerning the agent’s knowledge, and our recommendations in respect of it (including in respect of the reasonable search requirement) are discussed separately in the next chapter.

⁴² [1960] 2 Lloyd’s Rep 241.

⁴³ See, for example, *Montefiore v Proudfoot* (1866 - 67) LR 2 QB 511.

- 8.91 Where a parent or holding company places insurance on behalf of a number of subsidiary or group companies we expect that the placing company should make reasonable enquiries of those companies. In addition, where the insurance cover is composite insurance so that each company is an “insured” under a separate policy, the knowledge of the board of each company would be directly attributed to that company.⁴⁴

CONTRACTING OUT

- 8.92 As in other areas of our recommendations, the parties will be able to agree alternative contractual arrangements to deal with questions of the insured’s knowledge. So long as there is compliance with the transparency requirements, an insurance contract may, for example, expand the categories of people whose knowledge is attributed to the insured.
- 8.93 This may be particularly appropriate if there is an employee or other agent of the insured whose knowledge will be particularly relevant to the insured risk. This might include, for example, the captain of a ship or a particular agent. The parties might also agree particular provisions to determine the scope of the search the insured must conduct.
- 8.94 In other situations, it might be particularly important to the insured to ensure that certain knowledge is *not* attributed to it. For example, where a professional indemnity policy is purchased for the benefit of all of the directors of a company, it would defeat the purpose of that policy if the knowledge of a fraudulent director was attributed to the innocent co-insureds. In such situations the insurance is likely to be composite rather than joint insurance,⁴⁵ but it is an issue worth considering.

RECOMMENDATIONS

Recommendation 6: The legislation should provide greater certainty by defining both what an insured “knows” and what an insured “ought to know” for the purposes of the duty of fair presentation.

Recommendation 7: An insured should be taken to know what is known to the following specified individuals:

- (1) Where the insured is a natural person, the specified individuals should be the insured, and those responsible for the insured’s insurance.

⁴⁴ See brief discussion from para 7.15 above.

⁴⁵ See, for example, *Arab Bank plc v Zurich Insurance Co* [1999] 1 Lloyd’s Rep IR 262.

- (2) Where the insured is not a natural person, the specified individuals should be the insured's senior management and those responsible for the insured's insurance.

Recommendation 8: "Senior management" for these purposes should mean those who play significant roles in making decisions about how the insured's activities are to be managed or organised.

Recommendation 9: "Those responsible for the insured's insurance" for these purposes should mean those who participate on behalf of the insured in the process of procuring the insured's insurance (whether the individual does so as the insured's employee or agent, or as an employee of the insured's agent, or in any other capacity).

Recommendation 10: For these purposes, an insured "ought to know" that which should reasonably have been revealed by a reasonable search of information available to the insured (whether within its own organisation or held by others, for example its agent), including by making reasonable enquiries.

These recommendations are intended to be a default scheme for non-consumer insurance and are subject to our contracting out recommendations in Chapter 29.

- 8.95 As discussed above, the draft Bill also sets out some general principles relating to the attribution of knowledge, concerning fraud and blind eye knowledge. As these exceptions apply to the insured, agents and the insurer, we list them at the end of Chapter 10.

CHAPTER 9

DETAILED RECOMMENDATIONS: THE BROKER'S KNOWLEDGE

- 9.1 Section 19 of the Marine Insurance Act 1906 addresses the role of the insured's broker in making pre-contract disclosure to the insurer. It is a confusing provision. At first sight it appears to place a duty on the broker to disclose information, but we think this is misleading. The effect of a breach of section 19 falls on the insured, not the broker. Effectively, section 19 extends the insured's duty to disclose information beyond that which it knows or ought to know, to include information which the broker knows or ought to know.
- 9.2 Under our recommended reforms, this point is made explicit. The draft Bill does not include a direct equivalent to section 19. Instead, the definition of what an insured "knows" includes information known by an individual broker or other agent who participates in the process of procuring the insured's insurance. Similarly, the definition of what an insured "ought to know" includes information which would have been revealed by a reasonable search of available information held by others, such as the broker.
- 9.3 This is a conceptual change which we think is worth explaining in a separate chapter. Here we look first at the current law, then at the case for reform and finally at our recommendations. We explain how the provisions in clause 4 of the draft Bill capture relevant information held by the broker.
- 9.4 We recognise that brokers often play a central role in the presentation process, and it is crucial that brokers should disclose what they know about the insured's business. Brokers may have acted for clients for many years, and acquired considerable knowledge of the insured's business. It is therefore right that an insured's duty of fair presentation should encompass information known to its agent. However, brokers may act for many other clients and hold information about them on a confidential basis. It is important that the obligation to disclose information on behalf of the insured does not extend too far, to cover confidential information which the broker holds about other clients.

THE CURRENT LAW

- 9.5 Section 19 of the 1906 Act applies where the insured uses a broker to effect insurance. It reads:

Subject to the provisions of the preceding section as to circumstances which need not be disclosed, where an insurance is effected for the assured by an agent, the agent must disclose to the insurer—

- (a) Every material circumstance which is known to himself, and an agent to insure is deemed to know every circumstance which in the ordinary course of business ought to be known by, or to have been communicated to, him; and

- (b) Every material circumstance which the assured is bound to disclose, unless it comes to his knowledge too late to communicate it to the agent.

9.6 It has been taken to apply to non-marine as well as marine insurance.¹ The law on section 19 is confused, with several contrary judicial statements about what it covers.²

The nature of the duty

9.7 Although section 19 of the 1906 Act appears to place a duty on the agent, this is misleading. The section does not impose any penalty on the agent. In *HIH Casualty and General Insurance Ltd v Chase Manhattan Bank*, the court found that breach of section 19 did not give the insurer the right to claim damages against the agent.³

9.8 Instead, a breach of section 19 gives the insurer the right to avoid the contract against the policyholder.⁴ It is therefore the policyholder who has the interest in making sure that the insurer receives full disclosure, as it is the policyholder who stands to lose should the section be breached.

9.9 Since the insurer's only remedies for breach of section 19 are against the insured, it is best seen as an extension of the insured's duty to disclose. The insured must not only disclose the information which it knows or ought to know, but must also ensure the disclosure of any information which the agent knows or ought to know. If not, the insured may suffer harsh consequences.

Section 19(b)

9.10 This section requires the agent to disclose every fact that the applicant for insurance is bound to disclose. At first sight, this seems reasonable. However, where a policyholder has failed to disclose something it should have disclosed, the insurer already has a right to avoid on that basis. Section 19(b) appears to add little to an insurer's existing remedies for non-disclosure under section 18, given that it does not provide a remedy against the agent.

¹ See *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136.

² Section 19, and any equivalent rule of (common) law, no longer apply to consumer insurance contracts. See Consumer Insurance (Disclosure and Representations) Act 2012, ss 11(1)(b) and 11(2)(b).

³ [2003] UKHL 6, [2003] 2 Lloyd's Rep 61. The agent would be liable too but only where the agent's conduct amounted to a negligent or fraudulent misrepresentation, assuming that the necessary common law requirements for such an action could be established. See also CP3 at para 7.13 and following.

⁴ *Colinvaux's Law of Insurance* (9th ed 2010), para 6-044.

Section 19(a)

- 9.11 Section 19(a) of the 1906 Act is more problematic, because it appears to extend the limits of disclosure beyond section 18. Under section 18(1), the policyholder need only disclose information which it knew or ought to have known. Under section 19(a), the policy may also be avoided if there was a failure to disclose circumstances which the agent knew or ought to have known, even if there was no reason for the policyholder to be aware of them. This leads to difficult questions. First, to which agents does the duty extend, and, secondly, what information is included?
- 9.12 If taken at face value, section 19(a) could extend widely, to any information received by an agent in any capacity. As the broker market consolidates, brokers may act for hundreds if not thousands of clients, receiving sensitive market information over vast numbers of claims throughout the industry. Is a broker expected to disclose confidential claims information relating to other clients? The general view appears to be that it is not, as discussed below. The courts have restricted the application of section 19(a) to cases in which the broker received or held the information in its capacity as agent of the policyholder.

To which agents does the section 19 duty extend?

- 9.13 Section 19 is titled “Disclosure by agent effecting insurance”. Section 19(a) then refers to “an agent to insure”. As discussed in CP3, it has sometimes been held that only the final placing broker falls within section 19.⁵ However, the better view seems to be that it also applies to intermediate agents.⁶
- 9.14 We said in CP3 that this debate makes little practical difference in most cases. Section 19 states that the final placing agent must not only disclose every material circumstance “known to himself”, but also every material circumstance which ought “to have been communicated to him”. This means that the insurance may be avoided not only if the placing agent fails to disclose information which it knows, but also if an intermediate agent has failed to pass information up the chain.

⁵ *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136. See CP3, from para 7.21.

⁶ See CP3, paras 7.21 to 7.26. See also *Blackburn Low & Co v Haslam* (1888) LR 21 QBD 144; *Baker v Lombard Continental Insurance plc* (unreported) 24 January 1997; and *GMA v Unistorebrand International Insurance* [1995] LRLR 333.

9.15 In some circumstances, however, the issue of what should be communicated may depend on the arrangements between different agents in the chain. Some intermediate agents may not be in the UK, and may be subject to different regulatory regimes about what information should be communicated to whom. Some agents may have made express agreements about what should be communicated. We said that these factors add an unwarranted level of complexity to the law.⁷

What information held by the agent is caught?

9.16 At first sight, section 19(a) suggests that an agent should tell the insurer about information it has received in any capacity, if that information would influence a prudent insurer in fixing the premium or deciding whether to take the risk.

9.17 There are various observations in the case law which suggest that the section does indeed require an agent to disclose information, regardless of the capacity in which it was received.⁸ However, as we discuss in CP3, the best reading of the current law appears to be that section 19 of the 1906 Act has a limited application.⁹ It only applies to information which is received or held by agents in their capacity as agents for the policyholder.¹⁰ The courts appear reluctant to allow an insurer to avoid an insurance contract against an innocent policyholder for something which the policyholder did not know, and had no reason to know, but which the broker knew in an entirely different capacity.

9.18 Another limit on the scope of section 19 was confirmed in *Group Josi Re v Walbrook Insurance Co Ltd*.¹¹ In this case, the Court of Appeal found that section 19 did not require the agent to disclose, on behalf of its client, that it was defrauding that client. This is an example of the *Hampshire Land* principle discussed in Chapter 8.¹²

⁷ See generally CP3 Part 7, especially paras 7.24 and 7.25.

⁸ See Lord Justice Hoffmann in *El Ajou v Dollar Land Holdings Plc and another (No 1)* [1994] 2 All ER 685 at 702 and in *Société Anonyme d'Intermediaries Luxembourgeois (SAIL) v Farex Gie* [1994] CLC 1094 at 1111.

⁹ CP3, from para 7.27.

¹⁰ *PCW Syndicates v PCW Reinsurers* [1996] 1 WLR 1136 by Lord Justice Staughton at 1147.

¹¹ [1996] 1 All ER 791.

¹² From para 8.67.

THE CASE FOR REFORM

- 9.19 Section 19 as currently enacted is confusing and its scope is unclear. Although it is expressed as an obligation on the agent, the insurer's remedy is against the policyholder. There are doubts as to which agents it catches, and there is no acknowledgement that agents hold confidential information on behalf of other clients.
- 9.20 Section 19 and any equivalent common law rule no longer apply in relation to consumer insurance and there are no specific provisions concerning the agent's knowledge as attributed to consumers.¹³ In contrast, for non-consumer insurance we think that the principle underlying section 19 is important and should be retained. Brokers are frequently involved in enabling business insureds to fulfil their pre-contract requirements and may know more about the organisation and the risk than the employee involved in organising the insurance. It is therefore right that, in non-consumer insurance, the agent's knowledge should be given specific consideration.
- 9.21 In 2007 we proposed to re-characterise section 19 as a duty on brokers and other agents to insurers, with breach by the agent giving the insurer a right to damages.¹⁴ There was substantial opposition to this, as we discussed in CP3, and we did not proceed with it at that stage.¹⁵
- 9.22 Most respondents to CP3 agreed that there was a need to clarify the scope and nature of section 19(a), and that section 19(b) should be repealed. The International Underwriting Association (IUA) said:
- Though the legislation is uncomplicated, the differing interpretations of Section 19(a) by the judiciary, particularly the Court of Appeal decision in *PCW Syndicates* (which we would disagree with) provides for a stronger argument for reform.
- 9.23 Brokers were particularly concerned about disclosure requirements which would lead to conflicts of interest between clients and breaches of their confidentiality duties.

¹³ Consumer Insurance (Disclosure and Representations) Act 2012, ss11(1)(b) and 11(2)(b). See also s 19(2) of the 1906 Act.

¹⁴ Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) LCCP 182/SLCDP 134, para 10.73.

¹⁵ See CP3, from para 7.40.

- 9.24 Consultees agreed that the knowledge of producing, placing and intermediate brokers should be included within the disclosure duty, but that confidential information held by the agent in another capacity should not have to be disclosed.

THE AGENT'S KNOWLEDGE: OUR RECOMMENDATIONS

- 9.25 In line with our proposals in CP3, we do not recommend that there should be a disclosure duty on the broker which is actionable in the event of breach. Rather, we think that what the agent knows should be seen as a subset of what the insured is taken to know.
- 9.26 Our recommendations address how far a non-consumer insured must disclose information known to its agent when applying for insurance. They do so in two ways:
- (1) an individual agent (or employee of an agent) is one of those individuals who are "responsible for arranging the insured's insurance", so that what is known to the individual broker, managing agent or other agent is attributed to the insured and must be disclosed; and
 - (2) the insured's duty to make a reasonable search includes information held by the broker or other agent, but only insofar as it is "available to the insured".
- 9.27 Both provisions are subject to important exceptions. In particular, we recommend an exception for confidential information received from another client, which we discuss below. An attribution of knowledge is also subject to the common law rule that knowledge of a fraudster is not attributed to the party on whom the fraud is practised, discussed in Chapter 8. For example, an insured is not taken to know that its broker is defrauding it, where the broker conceals this information.

KNOWLEDGE OF AN AGENT "RESPONSIBLE FOR ARRANGING THE INSURED'S INSURANCE"

- 9.28 As discussed in Chapter 8, the definition of individuals responsible for arranging the insured's insurance is relatively wide. Clause 4(5)(a) states that an individual is responsible for the insured's insurance:
- if the individual participates on behalf of the insured in the process of procuring the insured's insurance (whether the individual does so as the insured's employee or agent, or as an employee of the insured's agent, or in any other capacity).

- 9.29 This test is designed to include more than just the broker who acts as the placing agent. It includes any agent who plays a role in arranging the insurance, including intermediaries. Therefore, where there is a chain of agents, each of them will fall within this category.
- 9.30 The managing agents of a Lloyd's syndicate are responsible for arranging reinsurance,¹⁶ but may use external brokers to actually place their reinsurance. The definition of people responsible for the insured's insurance would include managing agents.
- 9.31 In some circumstances, one party enters into an insurance contract on behalf of a number of other parties. This may occur where a parent company takes out insurance for all of its subsidiaries, or a main contractor arranges insurance for itself and all its sub-contractors on site. Such arrangements are often treated as a bundle of insurance contracts between the insurer and each of the parties. In these situations, we think that the relevant *individuals* acting for the parent company or main contractor would be "agents responsible for arranging the insured's insurance" on behalf of the subsidiary or sub-contractor.
- 9.32 However, only the knowledge of agents involved in the process of procuring the insured's insurance would be attributed to the insured under this test. The knowledge of other agents, such as technical advisors and lawyers, would not be caught by the provision unless they take an active role in the insurance-buying process (perhaps, for example, if a surveyor is asked to report on a building for the purposes of obtaining insurance for it). Instead, information held by other agents may be captured by the obligation to make a reasonable search, discussed below.

Actual and blind eye knowledge

- 9.33 What the individual agent knows is a matter of fact. As we discuss in Chapter 8, however, individual agents' knowledge will include not only their actual knowledge but also their "blind eye" knowledge.¹⁷

Limits on the test

- 9.34 There are some important limits on the attribution rules we recommend. First, the persons responsible for arranging the insured's insurance are defined as "individuals". Therefore only the knowledge of the actual person or people acting as the insured's agent will be caught, and not the corporate knowledge of, for example, a large broking firm.

¹⁶ See *Arnould's Law of Marine Insurance and Average* (17th ed 2008) at 636.

¹⁷ See draft Bill, clause 6(2).

- 9.35 Secondly, as we discuss below, there is no obligation to disclose confidential information held by the broker on behalf of other clients.
- 9.36 Finally, the knowledge attributed to the insured may also be limited if the agent withholds information as a result of its perpetrating a fraud against the insured.¹⁸ This reflects the decision in *Group Josi Re v Walbrook Insurance Co Ltd*,¹⁹ and is discussed in Chapter 8. Our policy is reflected in clause 6(4) of the draft Bill, which applies to all attributions of knowledge for the purposes of the duty of fair presentation.

A REASONABLE SEARCH OF INFORMATION HELD BY THE INSURED'S AGENT(S)

- 9.37 Clause 4(4) provides that, whether an individual or not, an insured "ought to know":

what should reasonably have been revealed by a reasonable search of information available to the insured (whether within its own organisation or held by others, for example its agent, and whether the search is conducted by making enquiries or by any other means).

- 9.38 In this case, the category of agents caught is wider. It potentially encompasses all agents who hold information about the insured, whether or not they are involved in procuring the insured's insurance. Policyholders may therefore have to make enquiries of agents such as lawyers and technical advisors who may hold information relevant to the risk. Which agents should be included in the search will vary depending on the circumstances and the type of insurance. An insured's solicitor may have information relevant to a professional indemnity policy but not a building and contents policy.
- 9.39 Furthermore, information caught by the reasonable search requirement will potentially cover all information held by the agent's organisation, rather than just information known to the individual agent acting for the insured. However, the information which will be caught is limited by the fact that the information must be *available to the insured*. The insured cannot be regarded as having unlimited access to its agents' records. In particular, it will not have access to confidential information held by its agents on behalf of other clients.

¹⁸ This is the *Hampshire Land* principle. See clause 6(4) of the draft Bill and the discussion at from para 8.67 above.

¹⁹ [1996] 1 All ER 791.

- 9.40 We do not recommend placing a separate obligation on the agent to undertake a reasonable search. The duty to search remains with the insured. However, where a broker or other agent arranges the insurance on behalf of the insured, it may well be that agent who arranges or carries out the search. In this case, any failure by the agent in conducting the reasonable search would be counted as a failure by the insured.

CONFIDENTIAL INFORMATION

- 9.41 An agent may receive information relevant to the risk from other clients. The large brokers, for example, receive advance notice of claims from many thousands of customers, and this may alert them to risks within whole industries.

- 9.42 In CP3, we suggested that the duty of disclosure should only apply to information received or held by that agent in its capacity as agent for the policyholder. This was controversial. As the International Underwriting Association (IUA) noted:

Many brokers develop and provide risk management services and statistics. Whilst not drafted with individual risks in mind, these may nevertheless contain placement information that could materially impact specific risks and there is an argument to suggest such information should be disclosed, or at least should be admissible so that cases can be judged on their own specific facts as to whether such non-specific information should have been disclosed.

- 9.43 We have developed our thinking in the light of the consultation. The key issue is not the capacity in which the information was acquired but whether it is confidential to other clients. In particular, the British Insurance Brokers' Association (BIBA) was concerned to ensure that our recommendations:

should avoid the agent facing a potential conflict of interest, or the client being deemed to know information it would have never been able to access.

- 9.44 We now recommend that the exception should apply only to confidential information, not to all the information which a broker received in another capacity. This means that generic risk information held by the broker may be something which the insured should disclose, either because it is known to the individual broker participating in the procurement, or because it is something which would have been revealed by reasonable searches. For example, an analysis of a particular type of risk is unlikely to be confidential and may be something which should be disclosed.

9.45 However, when brokers receive information about risks or possible claims facing particular clients, matters become less easy when that information could potentially be relevant to the risks which other clients are seeking to insure. Take a case where a broker acts for E, which manufactures medical implants. If the broker is told of risks associated with the implants this information may be relevant not only to E's insurer but also to an insurer providing liability cover to a clinic using the implant, for whom the broker also acts. Again, if the broker acts for a motor manufacturer, F, and receives information suggesting problems with the brakes on its trucks, this may influence the insurer of a haulier using those trucks. However, we do not think that the knowledge of the broker should be attributed to the clinic, or the haulier, for the purposes of the duty of fair presentation if the broker has a duty of confidentiality not to reveal that information.

9.46 This recommendation is given effect in Clause 6(3) of the draft Bill. Clause 6(3) provides that references to an individual's knowledge:

do not include confidential information acquired by ... the insured's agent, through a business relationship with someone other than the insured.

WHO DOES THE AGENT ACT FOR?

9.47 In Schedule 2 to the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) we included provisions to determine whether an agent acts for the insurer or the insured. We do not think there is a need to replicate these provisions for non-consumer insurance. That is because the problems raised by tied and multi-tied agents are almost entirely confined to the consumer sphere. For most non-consumer contracts, it is settled law that the broker acts for the insured,²⁰ and we do not wish to disturb this.

THE AGENT'S LIABILITY TO THE INSURED

9.48 In CP3, we discussed whether a breach by the broker of section 19 of the 1906 Act would or should give the insured the right to claim damages against the broker.²¹

²⁰ See, for example, *Rozanes v Bowen* (1928) 32 Lloyd's Law Reports 98; *Anglos-African Merchants v Bayley* [1970] 1 QB 311. See more generally our June 2007 Consultation Paper - Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134, para 9.23 and following.

²¹ CP3, from 7.47.

- 9.49 We noted that, under the current law, an agent owes his principal a duty to exercise reasonable care and skill in fulfilling his duties.²² This obligation arises in contract, tort/delict, or both. Brokers also owe fiduciary duties to the policyholder as well as a particular duty to protect the policyholder from litigation.²³ Breach of the existing section 19 duty may be a breach of these various obligations and if the policyholder succeeds against the broker, then the broker must put it in the position in which it would have been had the policy not been avoided.²⁴
- 9.50 Not every breach of section 19 of the 1906 Act will give the policyholder a right to damages. There must have been a breach of, or failure in, reasonable skill and ordinary diligence for which the broker is responsible. Furthermore, in some cases, the broker may not be the one at fault, such as where the policyholder has instructed the broker not to disclose information.
- 9.51 We would expect the position to be similar following our recommended reforms.
- 9.52 We do not recommend any reforms in respect of the broker or other agent's liability to the insured where the agent's act or omission caused the insured to be in breach of the new duty of fair presentation. That would be outside the ambit of our project, which concerns the relationship under the insurance contract and not associated professional appointments. Where an insurer has a remedy against the insured as a result of the broker's fault and the insured is innocent of wrongdoing, the insured would appear to have an action against the broker. That action, however, arises under general law. It does not depend on our recommendations or draft Bill.

RECOMMENDATIONS

Recommendation 11: In non-consumer insurance, there should be no specific provisions requiring an agent to disclose information to the insurer. Instead, before entering into an insurance contract, the insured should be obliged to disclose two types of information known to its agents:

- (1) information known to those individuals who participate in the process of procuring its insurance;

²² *HIH Casualty and General Insurance Co Ltd v Chase Manhattan Bank* [2003] UKHL 6; [2003] Lloyd's Rep IR 230. For Scots law, see L Macgregor, *The Law of Agency in Scotland* (2013), paras 7.04 to 7.14. This topic is explored in greater depth in *Colinvaux & Merkin's Insurance Contract Law* from 10774/3.

²³ See *Arnould's Law of Marine Insurance and Average* (17th ed 2008), para 7-10, and L Macgregor, *The Law of Agency in Scotland* (2013), Ch 6.

²⁴ Birds, Lynch and Milnes, *MacGillivray on Insurance Law* (12th ed 2012), para 37-37.

- (2) information which should reasonably have been revealed by a reasonable search of information available to the insured.

These recommendations are intended to be a default scheme for non-consumer insurance and are subject to our contracting out recommendations in Chapter 29.

- 9.53 As discussed above, the draft Bill also sets out some general principles relating to the attribution of knowledge, concerning fraud, confidential information and blind eye knowledge. As these exceptions apply to the insured, agents and the insurer, we list them at the end of Chapter 10.

CHAPTER 10

DETAILED RECOMMENDATIONS: THE INSURER'S KNOWLEDGE AND OTHER EXCEPTIONS

- 10.1 Section 18(3) of the Marine Insurance Act 1906 sets out four exceptions to the general duty of disclosure. Unless the insurer specifically asks a relevant question, a policyholder need not disclose:
- (a) any circumstance which diminishes the risk;
 - (b) any circumstance which is known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know;
 - (c) any circumstance as to which information is waived by the insurer;
 - (d) any circumstance which it is superfluous to disclose by reason of any express or implied warranty.
- 10.2 Of this list, the most important is (b), which provides that the insured need not disclose anything which the insurer already knows or is presumed to know. The legislation and subsequent case law give some guidance about this test.
- 10.3 In Consultation Paper 3 (CP3),¹ we agreed with the principles behind each of the exceptions, but thought that section 18(3)(b) in particular could be better expressed and understood.
- 10.4 In this chapter, we briefly discuss section 18(3)(b) and set out recommendations for reform. In line with our recommendations for the insured's knowledge discussed in Chapter 8, we recommend clarifying whose knowledge should be attributed to the insurer. We also define in more detail what the insurer ought, or is presumed, to know.

¹ Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155.

10.5 We recommend that the exceptions concerning waiver and circumstances which diminish the risk are replicated for the new duty of fair presentation. As a result of our recommendations in respect of warranties,² we do not recommend retaining the warranty exception. These matters are discussed at the end of this chapter.

SECTION 18(3)(b): THE CURRENT LAW

10.6 The effect of section 18(3)(b) is that a policyholder need not disclose:

- (1) matters which the insurer knows;
- (2) matters of “common notoriety or knowledge”; or
- (3) matters which an insurer ought to know in the ordinary course of business.

10.7 The onus is on the policyholder to prove that section 18(3)(b) applies.

10.8 It is important to note that the subsection does not apply to misrepresentations under section 20 of the 1906 Act. If an insurer asks a question about these matters, the policyholder must give a truthful answer. Thus the policyholder is only excused from disclosure “in the absence of enquiry”.³

10.9 Section 18(3)(b) has proved complex and its meaning is not entirely clear. In CP3 we distinguished between:

- (1) general public knowledge;
- (2) industry knowledge which an insurer ought to know about; and
- (3) other matters, such as the policyholder’s individual circumstances.

10.10 Below we look at each of these in turn.

General public knowledge

10.11 Under section 18(3)(b) of the 1906 Act, a prospective insurer is presumed to know “matters of common notoriety or knowledge”.

² Discussed in Part 3 of this Report.

³ See *Brotherton v Aseguradora Colseguros SA (No 3)* [2003] EWHC 1741 (Comm), [2003] Lloyd’s Rep IR 762.

- 10.12 The standard appears to be an objective one. A major textbook, *MacGillivray*, explains that insurers are credited “with knowledge of matters of public knowledge or notoriety which a generally well-informed person might fairly be expected to know”.⁴

Industry knowledge

- 10.13 An insurer is also presumed to know specialist matters which an insurer in the ordinary course of his business ought to know, including the normal practices and risks present in any trade which it underwrites. In *Noble v Kennaway* Lord Mansfield explained this requirement as follows:

Every underwriter is presumed to be acquainted with the practice of the trade he insures, and whether it is established or not if he does not know it, he ought to inform himself.⁵

- 10.14 Insurers are expected to take positive steps to acquire knowledge of the trade they are insuring,⁶ restricting the prospective policyholder’s duty of disclosure.⁷
- 10.15 Again, we think that the standard is appropriate but that it could be expressed more clearly in the legislation.

Other knowledge

- 10.16 Section 18(3)(b) also applies to other knowledge, such as information about the policyholder’s individual circumstances. Typically, the issue arises when the policyholder has told the insurer information in connection with another policy, or another claim, but that information has not been passed to the underwriter who makes the decision. This raises questions of attribution: whose knowledge is relevant for the purposes of section 18(3)(b), and what procedures should they carry out?

⁴ Birds, Lynch and Milnes, *MacGillivray on Insurance Law* (12th ed 2012) at 17-079.

⁵ (1780) 2 Doug KB 511 at 512.

⁶ See *Colinvaux & Merkin’s Insurance Contract Law*, para A-0895 and the cases cited there.

⁷ For example, in *Société Anonyme d’Intermediaries Luxembourgeois (SAIL) v Farex Gie* [1995] LRLR 116, Saville LJ treated the relevant test as being simply an objective test of what an insurer ought to know (at 156).

Whose knowledge is attributed to the insurer?

- 10.17 In Chapter 8 we briefly consider the general law on attribution of knowledge within corporate organisations.⁸ Traditional thinking would impute only the knowledge of individuals who were the organisation's "directing mind and will" (generally directors). More recently however, the courts have considered the purpose of each statutory provision, and decided the issue with a view to furthering that purpose.⁹
- 10.18 For the purposes of section 18(3)(b) of the 1906 Act, the most important person is the person who makes the underwriting decision to fix the premium or determine whether to take the risk. In *Evans v Employers Mutual Insurance Association Ltd*, the relevant decision was delegated to a clerk, and the clerk's knowledge was imputed to the insurers.¹⁰ We think this is a sensible result.
- 10.19 Information will also be known to the insurer if it was received by an agent of the insurer who is under an obligation to channel the information to the underwriter in question.¹¹ In *Joel v Law Union & Crown Insurance Company*,¹² a doctor commissioned by an insurer to examine a prospective policyholder was considered to be the agent of the insurer for the purpose of channelling information. Information which the doctor acquired by his examination was attributed to the insurer. We think it must be correct that the insurer is taken to know this type of information, particularly when it has been prepared specifically for the purpose of assisting the underwriter in the assessment of the risk.

Information acquired in a different context

- 10.20 An insurer may receive information relevant to a future proposal before it ever contemplates issuing a policy. Generally an insurer is not treated as having actual knowledge of a fact if it has no reason to draw a connection between the policyholder's proposal and information acquired previously.¹³

⁸ From para 8.9. A more detailed discussion is contained in Part 6 of CP3.

⁹ Following *Meridian Global Funds Management Asia Ltd v Securities Commission* [1995] 2 AC 500.

¹⁰ [1936] 1 KB 505.

¹¹ M A Clarke, *The Law of Insurance Contracts* (Issue 23, 1 June 2011) 23-9A2, pp 23 to 41.

¹² [1908] 2 KB 863.

¹³ For example, see *Bates v Hewitt* (1866-67) LR 2 QB 595 and Birds, Lynch and Milnes, *MacGillivray on Insurance Law* (12th ed 2012) at 17-080.

10.21 In *The Grecia Express*,¹⁴ Mr Justice Colman concluded that a policyholder is not entitled to presume that an underwriter will retain knowledge of previous casualties and relate the information to the new policy. This proposition, together with an 18 month delay between the previous casualty and the new risk, led the court to find that the insurer did not know information for the purposes of section 18(3)(b), despite knowing of the casualty at the time it occurred.

An obligation to search records?

10.22 In CP3 we considered whether an insurer is deemed to know information recorded in its files about its previous dealings with a prospective policyholder.

10.23 The issue has arisen in the context of waiver. In *Mahli v Abbey Life Assurance Co Ltd*,¹⁵ the insurer disclaimed liability on a 1984 life insurance policy on the ground of non-disclosure of the deceased policyholder's alcoholism and malaria. The policyholder's wife claimed that the insurer had waived its right to avoid the policy when it accepted premiums after it had been informed of these circumstances.

10.24 In 1986 the insurers were told about Mr Mahli's medical problems in the context of an application for a second policy, but they failed to relate them to his 1984 application. The underwriter checked the computer system, which noted that Mr Mahli had a previous policy, but failed to find the relevant documents. The court heard expert evidence that it was not the practice of underwriters to check earlier policies: "the pressure of work in the offices is such that this would be quite impracticable". On this basis the majority of the Court of Appeal upheld the trial judge's finding that the insurer did not have constructive knowledge of the non-disclosure when it continued to accept premiums.

10.25 However, Lord Justice McCowan dissented on the grounds that the insurer had all the relevant information in its systems. He accepted that individuals are not expected to personally remember information received, but thought that the insurer should be taken to be aware of information held in its computer system or in hard copy files. Lord Justice McCowan said:

¹⁴ *Strive Shipping Corp v Hellenic Mutual War Risks Association (Bermuda) Ltd (The Grecia Express)* [2002] EWHC 203 (Comm), [2002] 2 Lloyd's Rep 88.

¹⁵ [1996] LRLR 237.

I fail to see why the information in it was not in the knowledge of the company in September 1986 every bit as much as in May 1988 when that company used that knowledge to repudiate the policy. There is no question at either date of the information having been forgotten or lost.¹⁶

- 10.26 The decision is fact specific, and it is difficult to draw hard and fast principles. It is clear, however, that the courts are reluctant to find that an insurer has constructive knowledge of the policyholder's circumstances. We said in CP3 that we thought an insurer would be expected to check its computer systems, but would not be expected to carry out elaborate or impractical enquiries, or to match information across the organisation.
- 10.27 Below, we recommend that an underwriter should be considered to know information held in the insurer's records, but only if it is readily available to the underwriter.

THE CASE FOR REFORM

- 10.28 Since *Carter v Boehm* in 1766,¹⁷ insurers have been expected to inform themselves about matters relevant to the risks they underwrite. They are not entitled to expect the policyholder to disclose matters which they should know already. This principle was included in the 1906 Act and forms an important counterweight to the duty of disclosure.
- 10.29 The principle has become increasingly important as more information becomes available to insurers. As one consultee said:

The insurance (and reinsurance) market has evolved significantly since the 1906 Act and the cases that preceded it. Modern communication, particularly the internet, has led to a modern professional insurer being able actively to inform himself about a risk in a way that his predecessors, with access to far less information in times when communications were far slower, could not.

- 10.30 Similarly, with the advent of computerised records systems, underwriters are better able to acquaint themselves with the information they already hold on file about a specific insured.

¹⁶ [1996] LRLR 237 at 245 by Lord Justice McCowan.

¹⁷ (1766) 3 Burr 1905.

- 10.31 We think that the current law is broadly right but it needs to be made clearer. In Chapter 8, we recommended clarification of what an insured “knows” or “ought to know” because it is important that an insured can predict with some certainty what it has to disclose. It is also important that insurers can predict what they will be expected to know, because that will be excluded from the insured’s duty.
- 10.32 Some elements of section 18(3) are not as clear as they should be. The 1906 Act makes three references to circumstances which “in the ordinary course of business ought to be known” and we have argued that the phrase is far from clear. Interpretation of section 18(3) is also difficult because of the antiquated language used; particularly “common notoriety”, which means very little in the language of today.
- 10.33 Although we do not recommend any significant change to the substance of the insurer’s knowledge, we think there are various elements which would benefit from modernisation. The draft Bill therefore defines what an insurer knows, ought to know or is presumed to know.

THE INSURER’S KNOWLEDGE: OUR RECOMMENDATIONS

- 10.34 We recommend that, in the absence of enquiry by the insurer, the insured does not have to disclose information which the insurer:
- (1) knows;
 - (2) ought to know; or
 - (3) is presumed to know.
- 10.35 These exceptions are contained in clauses 3(5)(b), (c) and (d) and defined in clause 5.

What the insurer “knows”

- 10.36 In clause 5(1), we provide for what the insurer “knows”. An insurer knows something only if it is known to:
- one or more of the individuals who participate on behalf of the insurer in the decision whether to take the risk and, if so, on what terms (whether the individual does so as the insurer’s employee or agent, or as an employee of the insurer’s agent, or in any other capacity).

- 10.37 This provision is intended to capture the person who is or people who are involved in making the particular underwriting decision, and therefore echoes cases such as *Evans v Employers Mutual Insurance Association Ltd.*¹⁸ However, under our recommendations, *only* the knowledge of the underwriter(s) involved in decisions about the policy in question should be directly attributed to the insurer. This is therefore a more limited attribution test than that which might be used under common law.
- 10.38 Common law will usually attribute to an entity the knowledge of its “directing mind and will”. This would probably include the insurer’s board (or equivalent). However, unlike our recommendations on the insured’s knowledge,¹⁹ we do not recommend that the knowledge of the insurer’s senior management or board should be attributed to the insurer. The insurer’s board would not normally be involved in individual underwriting decisions and is unlikely to have any relevant information about the specific insured or risk. In practice, underwriters make the decision whether to take the risk. Decisions may be escalated to the board for very large risks, but this is extremely unusual. In that case, the board would be caught by clause 5(1) as included in the group of persons making the underwriting decision.
- 10.39 We think this clarification of the attribution rules benefits both the insurer and the insured. The insurer will not be fixed with the knowledge of its senior management who are unlikely to communicate directly with the individual underwriter about any specific case. The insured is benefitted because it knows that the knowledge of the underwriter(s) dealing with its proposal will be taken into account.

Person(s) making the underwriting decision

- 10.40 The definition is intended to catch any persons who play a meaningful role in the underwriting decision. If a team has been working on a big contract then we think the knowledge residing in that team and each individual member should be caught. If a risk is escalated to the underwriter’s manager to be signed off, the manager is the person who makes the final underwriting decision but the original underwriter’s knowledge is also attributed to the insurer. If the decision is made by a junior underwriter with a manager having ultimate responsibility for that decision, they would both be covered.

¹⁸ [1936] 1 KB 505.

¹⁹ Discussed above from para 8.51.

10.41 We have considered how this test applies where policyholders buy insurance online, inputting data into a computer program, which then makes the decision electronically. Even in this apparently impersonal process, there will still be an individual or group of individuals who signed off on the pricing structure and the risk weightings on which the program is based. They have therefore “made” the underwriting decision for all the policies written using that program. We think it would be difficult to say that these individuals “know” anything about the particular insured, but they may know a great deal about the generic risks. Our recommendations also address what the insurer “ought to know” and “is presumed to know” in those circumstances.

General provisions on attributing knowledge to the insurer

10.42 Clause 5(1) should be read subject to the general provisions on knowledge set out in clause 6 of the draft Bill and discussed in Chapters 8 and 9. These provide that:

- (1) an individual's knowledge includes not only their actual knowledge but also their blind eye knowledge;²⁰
- (2) references to an individual's knowledge do not include confidential information which the insurer's agent has acquired through a business relationship with someone other than the insurer;²¹ and
- (3) the insurer should not be taken to know that its employee or agent has perpetrated a fraud on the insurer, possibly in conjunction with the insured.²²

What the insurer “ought to know”

10.43 We recommend that an insurer “ought to know” something only if:

- (a) an employee or agent of the insurer knows it, and ought reasonably to have passed it on to the particular underwriter(s);
or
- (b) the relevant information is held by the insurer and is readily available to the particular underwriter(s).

10.44 This definition is at clause 5(2).

²⁰ See clause 6(2) of the draft Bill, discussed at para 8.46. See also from para 8.22.

²¹ See clause 6(3) of the draft Bill, discussed from para 9.41.

²² See clause 6(4) of the draft Bill, discussed at from para 8.67.

An employee or agent knows it and ought reasonably to have passed it on

- 10.45 This provision is contained in clause 5(2)(a).
- 10.46 As discussed above, we think it must be correct that the insurer is taken to have constructive knowledge of information known or held by another employee or agent of the insurer and who ought reasonably to have passed it on.
- 10.47 This is particularly so where the information has been prepared specifically for the purpose of assisting the underwriter in his assessment of the risk. Above, we gave the example of a doctor commissioned by an insurer to examine a prospective policyholder.²³ Another example would be a surveyor who is asked to make a report of a prospective insured site. Such agents ought to communicate their knowledge to the underwriter.
- 10.48 A more difficult question arises where the information has been gathered in relation to a claim on a different policy. During our limited consultation on the draft clauses, DAC Beachcroft gave an example of the insurer's loss adjuster making a site visit in connection with such a claim. If the loss adjuster notices something unusual about the insured property (such as a thatched roof), ought it reasonably to have passed this back to the underwriter? We think that a loss adjuster is unlikely to have any relationship with the underwriter and would not be expected to pass information to them. Unlike a surveyor instructed by the underwriter to assess a risk, the loss adjuster's relationship is with the claims department and concerns a historic loss. However, if the loss adjuster includes information in a report to the claims department, this may be available to the underwriter under limb (b), which we now discuss.

It is held by the insurer and readily available to the underwriter

- 10.49 This provision is contained in clause 5(2)(b) of the draft Bill.
- 10.50 In CP3 and above from paragraph 10.21 we referred to two cases, *Mahli v Abbey Life Assurance Co Ltd*²⁴ and *The Grecia Express*,²⁵ which imply that insurers may not need to consult their records, even for short periods of time. This encourages passivity among underwriters, and fails to reflect adequately the availability of information in electronic systems.

²³ *Joel v Law Union & Crown Insurance Company* [1908] 2 KB 863.

²⁴ [1996] LRLR 237.

²⁵ *Strive Shipping Corp v Hellenic Mutual War Risks Association (Bermuda) Ltd (The Grecia Express)* [2002] EWHC 203 (Comm), [2002] 2 Lloyd's Rep 88.

- 10.51 We think it is reasonable that an insured who has been with an insurer for several years will expect the insurer to know certain information about it and its claims history. However, insurers have been wary of accepting any positive obligation to search their records, particularly because claims information may not be available to the underwriting department. Further, insurers may hold information on a variety of outdated “legacy” systems which cannot be searched by all staff.
- 10.52 In clause 5(2)(b) we have sought to balance the competing interests of insured and insurer. The provision is intended to catch information “held by the insurer” and which is “readily available” to the person making the underwriting decision (as defined in clause 5(1)). Whether something falls within this category or not will be a question of fact. Where the underwriter genuinely does not have electronic access to the claims department’s records, the information contained there may not be “readily available” to the underwriter.
- 10.53 As IT systems improve, historic data about policyholders will become an increasingly important source of data. Indeed, an insurer may find it easier to assess information already processed and analysed by its own organisation than the same information presented by the insured as a “material circumstance” in an unfamiliar format or from a different perspective.
- 10.54 Under clause 5(2)(b) the information must be “held by the insurer”. This caveat was not included in the draft clauses on which we consulted in January 2014 and several insurers expressed concern that all the information on the internet could be said to be “readily available” to the underwriter. On reflection, we agree that the provision should not have been drafted so widely. We have since limited the provision so that the insurer “ought to know” information only if it is readily available to them within the insurer’s organisation. As we discuss below, insurers are also expected to know common knowledge and industry knowledge, but this is a more constrained test than being expected to know everything available on the internet.

What the insurer is “presumed to know”

- 10.55 As defined in clause 5(3) of the draft Bill, the insurer is presumed to know:
- (1) things which are common knowledge; and
 - (2) 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.
- 10.56 This clause is intended to be a restatement and modernisation of section 18(3)(b) of the 1906 Act, which we set out at the beginning of this chapter.

Common knowledge

- 10.57 We think the current law is correct to presume that an insurer is aware of common knowledge. In replicating this provision, we have removed the reference to “common notoriety” because its meaning has changed since 1906. At the time the 1906 Act was drafted, “notoriety” appeared to mean the state of being “well-known”, whereas now it suggests an element of infamy.²⁶
- 10.58 We do not intend any change in what is to be regarded as common knowledge and think it could be interpreted widely. The issue of what constitutes common knowledge has become particularly current since the advent of social media, and we think it may be helpful to give an example of how we think the phrase would be interpreted.
- 10.59 X, a well-known entertainer, is regularly rumoured in the mainstream media to have a drug problem and has not commenced libel proceedings against those making the allegations. When cancellation of event cover is sought for X’s next tour, we think these rumours would be found to be matters of common knowledge that need not be disclosed to the underwriter.

Circumstances an insurer would reasonably be expected to know in the ordinary course of business

- 10.60 Under the current law, an insurer is expected to know the risks inherent in the types of business for which it routinely provides cover. Section 18(3)(b) of the 1906 Act refers to “matters which an insurer in the ordinary course of his business, as such, ought to know”. We think the principle behind this provision is right but we recommend that it should be more clearly expressed in legislation.

“NAÏVE CAPACITY”

- 10.61 Part of the motivation for this change is the problem that inexperienced insurers may enter a new market, under-price the risk due to their lack of understanding and then attempt to escape liability on the basis of non-disclosure. This is referred to in the market as “naïve capacity”. A public liability insurer providing cover to retailers should not be able to expand into construction sites or energy plants without informing themselves of the particular risks of those industries. As Lord Mansfield said in *Noble v Kennaway*.²⁷

²⁶ *Strive Shipping Corp v Hellenic Mutual War Risks Association (Bermuda) Ltd (The Grecia Express)* [2002] EWHC 203 (Comm), [2002] 2 Lloyd’s Rep 88 interprets presumed knowledge but does not distinguish between common notoriety and common knowledge. The terms are also used interchangeably in *Nordic Holdings Ltd v Mott Macdonald Ltd* [2001] All ER (D) 401 (Jul); 77 Con LR 88.

²⁷ (1780) 2 Doug KB 511.

Every underwriter is presumed to be acquainted with the practice of the trade he insures, and whether it is established or not if he does not know it, he ought to inform himself.

CLASS OF INSURANCE AND FIELD OF ACTIVITY

- 10.62 Clause 5(3)(b) of the draft Bill refers to a “class of insurance” and a “field of activity”. Some underwriters operate by “field of activity”, for example, onshore energy or marine insurance. Others operate by class of insurance (for example, employers’ liability, professional indemnity). Some may specialise in a few classes of insurance to a particular industry, such as Protection and Indemnity (P&I) clubs in marine insurance.
- 10.63 Those operating by class may know less about how the businesses they insure actually operate, but we think that all insurers should be expected to understand a broad outline of the risks. For example, we think that a reasonably well-informed underwriter writing employers’ liability insurance for a plastics company should know that rates of injury in plastics manufacture are higher than in other industries. On the other hand, they may not be expected to know about the particular risks of exposure to styrene in contact moulding of fibre-reinforced plastic.

OTHER EXCEPTIONS TO THE DUTY OF FAIR PRESENTATION

- 10.64 Section 18(3) of the 1906 Act lists three other exceptions to the duty of disclosure. These cover circumstances which diminish the risk; which are waived by the insurer; or which are covered by warranties. We think the first two exceptions remain appropriate and applicable to the disclosure duty as expressed in the draft Bill.²⁸
- 10.65 Clause 3(5) therefore provides that, in the absence of inquiry, the duty of disclosure²⁹ does not require the insured to disclose a circumstance if:
- (a) it diminishes the risk, or
 - (b) it is something as to which the insurer waives information.
- 10.66 These exceptions replicate the relevant provisions in the 1906 Act and we do not intend any change in their application.

²⁸ We discuss the warranty exception below at para 10.73.

²⁹ The duty of disclosure is contained in clause 3(3)(a) of the draft Bill and further defined in clause 3(4)).

Circumstances which diminish the risk

- 10.67 This exception appears in the 1906 Act at section 18(3)(a). It is said³⁰ to originate in Lord Mansfield's judgment in *Carter v Boehm*, where he commented:

The underwriter need not be told what lessens the risque agreed and understood to be run by the express terms of the policy ... If he insures for three years, then he need not be told of any circumstance to show that it may be over in two; or if he insures a voyage with liberty of deviation, he need not be told what tends to show there will be no deviation.³¹

- 10.68 It is replicated in the draft Bill at clause 3(5)(a).

Something as to which the insurer waives information

- 10.69 As we have discussed in Chapter 4, the courts have developed the waiver exception in section 18(3)(c) to reduce the harshness of the disclosure obligation. The courts have held that if a policyholder makes a fair presentation of the risk which would prompt a reasonably careful insurer to make further enquiries, the insurer who fails to make such enquiries has waived the right to the information which further enquiries would have revealed.³²
- 10.70 We have recommended an updated duty of disclosure which may be satisfied if the insured has disclosed sufficient information to put a prudent insurer on notice that it should ask more questions in order to reveal material circumstances. Waiver therefore has a less important role to play under our recommended reforms.
- 10.71 However, the waiver exception may be relied upon in other contexts. For example, an insurer who asks limited questions on a proposal form may waive information which falls outside the scope of those questions. Parties may even make express agreements to waive disclosure or aspects of it.³³ We think these rules are well understood and can be left to the courts to develop. We therefore replicate the waiver exception at clause 3(5)(e).

³⁰ *Colinvaux's Law of Insurance* (9th ed 2010), para 6-63.

³¹ (1766) 3 Burr 1905 at 1910. The word "risque" is an archaic spelling of "risk".

³² The Scots law position on waiver is similar; see E C Reid & J G W Blackie, *Personal Bar* (2006), pp 238 to 242.

³³ *Colinvaux's Law of Insurance* (9th ed 2010), para 6-69.

“In the absence of enquiry” and misrepresentations

- 10.72 Fundamentally, if the insurer does not enquire about an alleged undisclosed matter which is the subject of an exception, the insured has made a fair presentation. However, if the insurer does ask, the insured must comply with the obligation in clause 3(3)(c) not to make material misrepresentations. The exceptions are therefore exceptions to what must be *disclosed* as part of a fair presentation rather than exceptions to the entire duty of fair presentation.

Removal of the exception for circumstances covered by a warranty

- 10.73 Under the current law, breach by the insured of a warranty in an insurance contract discharges the insurer’s liability under the contract from the date of the breach.³⁴ The remedies of discharge (for breach of warranty) and avoidance (for non-disclosure) are relatively similar. The exception at section 18(3)(d) of the 1906 Act therefore presumes that disclosure of warranted matter would be “superfluous”.
- 10.74 Under our warranties recommendations, the remedy for breach of warranty is less absolute: liability is suspended (either in total or for a particular type of loss) until the breach has been remedied, rather than discharged altogether.³⁵ Similarly, we recommend the introduction of proportionate remedies to replace the single remedy of avoidance for non-disclosure. As a result, the remedies for breach of warranty and breach of the duty of disclosure may now produce very different results depending on the facts of the case. This being the case, warranting a matter can no longer be said to make disclosure of the same matter “superfluous”. We do not therefore recommend replicating the exception.

RECOMMENDATIONS

Recommendation 12: In the absence of enquiry by the insurer, the insured should not have to disclose information which:

- (1) the insurer knows;
- (2) the insurer ought to know;
- (3) the insurer is presumed to know;
- (4) diminishes the risk; or
- (5) is something as to which the insurer has waived disclosure.

³⁴ 1906 Act, s 33(3).

³⁵ See clauses 10 and 11 of the draft Bill, discussed in Part 3 of this Report.

Recommendation 13: An insurer should be taken to know something only if it is known to one or more of the individuals who participate in the underwriting decision (whether as the insurer's employee or agent, or as an employee of the insurer's agent, or in any other capacity).

Recommendation 14: The insurer "ought to know" something only if:

- (a) an employee or agent of the insurer knows it, and ought reasonably to have passed it on to the particular underwriter(s);
or
- (b) the relevant information is held by the insurer and is readily available to the particular underwriter(s).

Recommendation 15: The insurer should be presumed to know:

- (1) things which are common knowledge; and
- (2) things which an insurer offering insurance of the class in question to proposers in the field of activity in question would reasonably be expected to know in the ordinary course of business.

Recommendation 16: The recommendations concerning the knowledge of the insured, the agent and the insurer should be subject to the following general rules:

- (1) An individual's knowledge should include not only their actual knowledge but also their blind eye knowledge.
- (2) References to an individual's knowledge should not include confidential information acquired by an agent through a business relationship with someone other than the insured or insurer, as relevant.
- (3) The principal (whether insured or insurer) should not be taken to know that its employee or agent has perpetrated a fraud on it.

These recommendations are intended to be a default scheme for non-consumer insurance and are subject to our contracting out recommendations in Chapter 29.

CHAPTER 11

DETAILED RECOMMENDATIONS: REMEDIES

- 11.1 Under the current law, an insurer's only remedy for non-disclosure or misrepresentation is avoidance. In other words, the insurer may treat the contract as if it never existed, and refuse all claims. Where the policyholder does not act deliberately or recklessly, this may be overly harsh. Here we recommend an alternative scheme of more proportionate remedies.
- 11.2 We start by looking at the inducement test, developed by the courts. This is an important part of the law and we think that it should be included in statute. We then explain why we think the remedy of automatic avoidance should be reformed.
- 11.3 The next sections set out our detailed recommendations. We define what we mean by a "deliberate or reckless breach", and explain why in these cases it is right that the insurer's remedy should impose a form of penalty on the insured. For other breaches, we recommend that the insurer should be entitled to a proportionate remedy, based on what it would have done if the insured had made a fair presentation.
- 11.4 These remedies are intended to be a default regime. Parties would be free to agree alternative remedies in their contracts, provided these terms meet the transparency requirements discussed in Chapter 29.
- 11.5 The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) introduced a scheme of proportionate remedies for consumer insurance.¹ Although the fundamental duties on consumer and non-consumer insurance buyers differ, the remedies available under CIDRA align with those which we recommend for non-consumer insurance. As in CIDRA, the remedies are provided in the Schedule to the draft Bill.

THE INDUCEMENT TEST

- 11.6 In *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*,² the House of Lords held that the insurer should only have a remedy for non-disclosure or misrepresentation if it can show that, without the breach, it would have acted differently: that is, but for the breach, the insurer would not have entered into the insurance contract at all, or would have done so only on different terms.

¹ See Schedule 1 to CIDRA.

² [1995] 1 AC 501.

- 11.7 This is known as the “inducement test”. It looks not at the hypothetical prudent insurer but at the actual insurer. If the insurer had known the full story, what would it have done? If the breach would have made no difference to the decision, the insurer has no remedy.
- 11.8 Since *Pan Atlantic*, the courts have developed and clarified this test. At one stage, there was some debate about whether inducement could be presumed.³ As we discussed in Consultation Paper 3 (CP3),⁴ recent case law has confirmed that it cannot be presumed.⁵ The insurer must prove inducement on the balance of probabilities – though it may sometimes be possible to infer inducement from the facts in the absence of direct evidence.

Our recommendation: the inducement test in statute

- 11.9 In CP3, we proposed to retain this test and include it in statute. This was uncontroversial. Of the 39 consultees who responded to the proposal, 36 (92%) agreed. We now recommend that the inducement test be given statutory backing. The inducement test is already included in section 4(1)(b) of CIDRA and the draft Bill defines inducement in similar terms.
- 11.10 Clause 8(1) of the draft Bill reads:
- The insurer has a remedy against the insured for a breach of the duty of fair presentation only if the insurer shows that, but for the breach, the insurer –
- (a) would not have entered into the contract at all, or
- (b) would have done so only on different terms.
- 11.11 This preserves the current law, and we would expect the courts to interpret the provision in the light of existing case law.
- 11.12 A breach for which the insurer has a remedy (that is, a breach that satisfies the inducement test) is identified in clause 8(3) as a “qualifying breach”.

³ See, for example, *Pan Atlantic* (above), by Lord Mustill at 551 and *St Paul Fire and Marine Insurance Co Ltd v McConnell Dowell Constructors Ltd* [1995] 2 Lloyd’s Rep 116.

⁴ Insurance Contract Law: The Business Insured’s Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155.

⁵ CP3, from para 5.61. See also *Assicurazioni Generali SpA v Arab Insurance Group (BSC)* [2003] Lloyd’s Rep IR 131, [2002] EWCA Civ 1642.

AVOIDANCE AS THE SOLE REMEDY: THE CASE FOR REFORM

11.13 Avoidance is the sole remedy under the 1906 Act for both non-disclosure⁶ and misrepresentation.⁷ This means that, if the insurer chooses, the contract is treated as if it never existed and the insurer has no liability to pay any claims. Usually, the insurer must return the premium to the insured, although there is a general exception in the case of fraud. In CP3 we identified several problems with the single remedy of avoidance.

An overly harsh remedy

11.14 Providing a single remedy for non-disclosure and misrepresentation fails to reflect the full array of circumstances in which such breaches of duty can arise.

11.15 Although non-disclosure is widespread, most is not deliberate or dishonest.⁸ Insureds are often unaware of the full extent of their duty to volunteer information, and many do not understand what would influence a prudent insurer. In addition, it may simply be impossible for a large multinational company to be certain that all the relevant information has been disclosed. The single remedy gives no scope for differentiating between insureds who make an accidental omission and those who deliberately conceal or misrepresent information in order to obtain a better insurance deal.

11.16 Similarly, avoidance does not take into account the impact of the non-disclosure or misrepresentation on the insurer's assessment of the risk. In many cases, the insurer would still have insured the risk if it had known the full facts. It might simply have charged a higher premium, or offered different policy terms such as a higher excess. Allowing the insurer to refuse all claims appears inequitable in these circumstances. The insurer is absolved of all liability and the insured is left with, at best, its premium returned. This rarely compensates the insured for loss of the benefit of a valid insurance policy.

11.17 Ensuring a fair presentation of the risk requires co-operation from both sides: policyholders need to collect better information and insurers need to do more, individually and collectively, to explain what they need to be told. Avoidance as a fall-back option may not do enough to incentivise insurers to encourage better presentations.

11.18 However, we agree that avoidance is appropriate for deliberate or reckless conduct, or where an insurer would not have taken the risk at all.

⁶ 1906 Act, s 18(1).

⁷ 1906 Act, s 20(1).

⁸ CP3, para 9.28. See also CP3, Part 4.

An “all or nothing” remedy

- 11.19 We think that avoidance may encourage an unduly adversarial approach, with parties arguing for “all” or “nothing”. Even where, as is common, avoidance is only used as a threat, it is a strong negotiating tool. Threatened with the exercise of the insurer’s statutory right to avoid, insureds may accept unduly low settlements in the alternative.
- 11.20 Avoidance may also have the opposite effect. In some cases, where the courts are faced with an “all or nothing” solution, they may be reluctant to allow insurers to use the “nuclear” option. Faced with a clearly unfair result, the court may find that there has been no inducement, or that the insurer has waived its right to the information, and allow the insured to recover its full claim. In this opposite situation, the insurer is *under*-compensated.
- 11.21 Finally, the all or nothing approach may lead the disputing parties to take entrenched positions, which discourages settlement.

The alternative: proportionate remedies

- 11.22 Under normal principles of contract law, compensation for breach of a duty by one party should aim to put the injured party into the position it would have been in had the other party fulfilled its duties. Proportionate remedies apply this principle to insurance law. They seek to compensate the insured by putting it, as far as practicable, into the situation it would have been in had it received a fair presentation of the risk.
- 11.23 Proportionate remedies are used in most civil law jurisdictions.⁹ They have been applied by the Financial Ombudsman Service (FOS) since the 1990s,¹⁰ and are now part of consumer insurance law.

Consultees’ views

- 11.24 In CP3 we asked if automatic avoidance should be replaced with a default regime of proportionate remedies.¹¹ Consultees strongly supported this proposal. Of 44 respondents to this question, 32 (73%) agreed.

⁹ In *Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (June 2007) (CP1) we considered proportionate remedies in France, Germany, Norway and Sweden (see paras 4.101 and 4.154. Proportionate remedies are also used in the Principles of European Insurance Contract Law (PEICL) at Art 2:102(5).

¹⁰ In 1997, the National Consumer Council commented that “the ombudsman regularly uses the proportionality principle to settle the amount of the claim to be paid in non-disclosure cases”: *Insurance Law Reform* (1997) pp 26 and 55. However, our survey of FOS decisions from 2003 to 2005 found that proportionate remedies were used relatively rarely. See CP1, Appendix C, para C.80.

Agreement

- 11.25 Avoidance was called “an unfair bludgeon” (Bar Council), “draconian” (British Insurance Law Association), and an “all or nothing approach” (Allen & Overy and the Judges of the Court of Session). Royal & Sun Alliance Insurance (RSA) reflected the general mood of consultation responses in their view that avoidance “does not reflect what RSA considers to be reasonable business practice in the modern age”.
- 11.26 This reflects the results of our 2007 consultation where the Commercial Court Users Working Party commented:
- It is accepted that the “all or nothing” nature of the avoidance remedy may lead to a disproportionate result. Insurers can find themselves in the situation of having to avoid a policy, in circumstances where they do not wish to do so, because no other remedy is available.
- 11.27 In 2007, several insurers said that they already operated an informal system of proportionate remedies. They thought that proportionate remedies reflected commercial reality. Bright Grey, Aviva plc and Allianz Insurance plc, for example, all wrote in favour of applying a compensatory remedy to cases of non-culpable behaviour.
- 11.28 In response to CP3, most consultees thought that proportionate remedies were a fairer and more commercially sound approach. The Faculty of Advocates noted our proposal “would reflect the reality of what would have happened, had there been proper disclosure”. The London & International Insurance Brokers’ Association (LIIBA) reported that there was “broad support” for our reform and Airmic said that their members were “on balance in favour of this suggestion”.
- 11.29 Several consultees cited the use of proportionate remedies by the FOS and European civil law systems. Philippe Chennaux, a risk and insurance consultant based in Belgium, reported that they had “created few problems in the last 40 years or so”.

¹¹ CP3, para 9.39.

Opposing arguments

11.30 Only four (of 44) consultees disagreed with the principle of proportionate remedies. As we identified in our summary of responses,¹² four themes emerged from their comments.

- (1) First, it was felt that limiting insurers' automatic entitlement to avoidance of the contract to dishonest conduct was overly restrictive as dishonesty is too hard to prove. We explain our approach to these concerns, in the form of the "deliberate or reckless" formulation, below.¹³
- (2) Secondly, it was said that proportionate remedies would increase uncertainty and litigation, or at the least would merely shift litigation to focus on the insurer's hypothetical response to a hypothetical fair presentation. We discuss the question of proving what the insurer would have done below from paragraph 11.74.
- (3) Thirdly, these consultees thought that proportionate remedies would undermine a policyholder's incentive to make proper disclosure. However, the proportionate remedies scheme is still designed to compensate the insurer adequately, so it is very much in the insured's interests to make a fair presentation.
- (4) Finally, some argued that in practice insurers already negotiate fair settlements regardless of the law and as such there is no need for reform. While we accept this is the case, equitable remedies should not rely on gestures of goodwill by insurers. The law should not be out of line with commercial practice.

Conclusion on the need for reform

11.31 Avoidance is an inflexible remedy which can over-compensate the insurer. It fails to reflect normal compensatory principles and commercial reality. Very few consultees defended it.

11.32 We think automatic avoidance should be reserved for cases in which the policyholder is culpable in some way. In other cases, the law should seek to compensate the insurer by putting it, as far as possible, into the situation it would have been in had it received a fair presentation of the risk.

¹² Summary of responses to CP3, Chapter 1: The business insured's duty of disclosure (March 2013), pp 26 and 27.

¹³ From para 11.35.

- 11.33 Proportionate remedies work well in other jurisdictions and are used in consumer insurance. We think they should be the default regime for non-consumer insurance. We accept that proportionate remedies might not be appropriate for all insurance contracts, but the parties would be free to reach other arrangements if that would be more suitable.
- 11.34 Below we set out our recommendations in more detail, starting with cases where the policyholder has acted deliberately or recklessly.

REMEDIES FOR DELIBERATE OR RECKLESS BREACHES

- 11.35 The first distinction we make is between dishonest, or “deliberate or reckless” breaches of the duty of fair presentation, and all other breaches.¹⁴ We recommend that where a breach of the duty of fair presentation is deliberate or reckless, the insurer should be entitled to avoid the contract and refuse all claims. The insurer should also be entitled to keep the premiums.
- 11.36 Dishonesty strikes at the heart of the good faith concept which underlies insurance contracts. Ever since our first Issues Paper (IP1),¹⁵ we have said that a deliberate and dishonest non-disclosure or misrepresentation should continue to give rise to the remedy of avoidance. This approach has been consistently supported.
- 11.37 In IP1 we described dishonest disclosures and misrepresentations as “fraudulent”. However, many insurers associated that term with criminal standards of proof, and thought that they would only very rarely be in a position to prove that an insured had acted fraudulently in preparing its presentation. It is not our intention that the insurer’s task of proving that a breach of the duty of fair presentation was made deliberately or recklessly should be unduly onerous, or require an exceptionally high standard of proof.
- 11.38 In CP3 we proposed that dishonest breaches should be referred to as “deliberate or reckless”. This reflects our approach in CIDRA.¹⁶

Defining deliberate or reckless breach in consumer insurance

- 11.39 Section 5(2) of CIDRA states that a qualifying misrepresentation is deliberate or reckless if the consumer:
- (a) knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and

¹⁴ Clause 8(4) of the draft Bill.

¹⁵ Issues Paper 1: Misrepresentation and Non-disclosure (September 2006).

¹⁶ CIDRA, section 5(2) and Schedule 1, para 2.

- (b) 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.

11.40 This reflects guidance issued by the Association of British Insurers (ABI) in 2008.¹⁷

Defining deliberate or reckless breach in non-consumer insurance

11.41 We have based the definition on the concepts of knowing or not caring used in CIDRA. This approach was supported by several consultees including Direct Line Group and RSA, who saw no reason to differentiate between consumers and businesses in this context. However, as the pre-contractual duty we recommend for non-consumers is different from that in CIDRA, the definition requires some adjustment.

11.42 Clause 8(5) of the draft Bill provides that a qualifying breach is deliberate or reckless if the insured:

- (a) knew that it was in breach of the duty of fair presentation, or
- (b) did not care whether or not it was in breach of that duty.

Deliberate

11.43 We think a deliberate breach of the duty of fair presentation could involve *intentionally*:

- (1) refraining from disclosing a circumstance which the insured knows to be material;
- (2) making a data dump or otherwise presenting risk in a particular way in order to conceal certain information (as in the case where a summary is very misleading); or
- (3) intentionally lying about a material representation, either in the initial presentation or by knowingly giving a false response to an insurer enquiry.

¹⁷ Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (December 2009) Law Com No 319 / Scot Law Com No 219 (Consumer Report), para 6.27. Also see ABI Guidance, "Non-Disclosure and Treating Customers Fairly in Claims for Long-Term Protection Insurance Products" (January 2008), para 2.1.

Reckless

- 11.44 Recklessness is a difficult concept. In the case law it is described as making a statement without caring whether it is true or false.¹⁸ In this context, “not caring” is different from acting “carelessly”, by not taking sufficient care. It requires a lack of interest in making a fair presentation; perhaps an almost complete disregard for the quality of the presentation.
- 11.45 In the consumer context, we explored whether there were ways in which we could explain the concept more precisely, but concluded that it was best left to the courts. We think that the same must be true here. There are too many ways in which an insured might behave recklessly.
- 11.46 We think that recklessness might be particularly salient in the data dump context, where an insured does not care whether the insurer will be able to make sense of the information provided, with the result that obviously important information may well be missed. It may also be shown by answering a question with no attempt to check the facts.

The burden of proof

- 11.47 We think it has to be for the insurer to show that the insured acted deliberately or recklessly. It follows normal legal principles that the party alleging wrongdoing must substantiate it. The alternative – a presumption that the insured acted deliberately or recklessly, which the insured would have to rebut – would be untenable.
- 11.48 However, it is not our intention that proving deliberate or reckless behaviour should be unduly onerous. This is why we did not use the common law notion of fraud.
- 11.49 The burden of proof is addressed in clause 8(6) of the draft Bill.

Principal remedy for deliberate or reckless breach: avoidance

- 11.50 Where the insured has acted deliberately or recklessly in breaching the duty of fair presentation, the insurer should be entitled to avoid the contract and refuse all claims under it. This is provided in paragraph 2(a) of the Schedule to the draft Bill.

¹⁸ *Derry v Peek* (1889) LR 14 App Cas 337.

Retention of premium

- 11.51 Avoidance normally requires restitution: the parties must be restored to the positions they were in prior to the contract being made. In most cases, the policyholder is entitled to the return of any premium paid. However, there is a general exception in the case of fraud.
- 11.52 As we have said, section 84(3)(a) of the 1906 Act governs the return of premiums in marine insurance. It states:
- Where the policy is void, or is avoided by the insurer as from the commencement of the risk, the premium is returnable, *provided that there has been no fraud or illegality* on the part of the assured ...
(emphasis added)
- 11.53 Whether section 84(3)(a) applies to non-marine insurance is unclear.¹⁹ In any case, section 84 refers to “fraud or illegality”. This is not necessarily synonymous with “deliberate or reckless conduct”.
- 11.54 We recommend that the statute should clarify that in the event of a deliberate or reckless breach, the insurer is not required to return any premiums paid. This is addressed in paragraph 2(b) of the Schedule to the draft Bill.
- 11.55 Paragraph 12 of the Schedule provides that section 84 of the 1906 Act is to be read subject to the provisions of the Schedule. This is because deliberate or reckless conduct under our definition is not necessarily equivalent to fraud: it is intended to include, and extend beyond, fraud.
- 11.56 CIDRA provides that in the event of deliberate or reckless behaviour by the consumer, the insurer need not return any of the premiums paid, “except to the extent (if any) that it would be unfair to the consumer to retain them”.²⁰ We do not think there is any need for a similar caveat in non-consumer insurance. We had two particular concerns in consumer insurance: investment-type life insurance and joint lives policies.²¹ Long-term contracts of an investment nature are not common in non-consumer insurance, and joint lives policies are virtually unheard of. We do not think that retention of the premium by the insurer will be overly harsh to dishonest non-consumer insureds in the way that it might threaten a consumer with a significant loss of their savings.

¹⁹ *MacGillivray on Insurance Law* (12th ed 2012) at 8-030 and n 94. Section 84 was held to apply to non-marine insurance in *Swiss Reinsurance Co v United India Insurance Co Ltd* [2005] Lloyd’s Rep IR 341, but this was not in the context of fraud.

²⁰ CIDRA, Schedule 1, para 2(b).

²¹ Consumer Report, paras 6.44 to 6.53.

REMEDIES FOR OTHER BREACHES

- 11.57 Under normal principles of contract law, any remedy should aim to put the injured party into the position it would have been in had the other party fulfilled its duties.
- 11.58 The principle behind our recommended scheme of proportionate remedies is that the insurer should be put into a position that, as far as practicable, reflects the position it would have been in had the insured fulfilled its duty to make a fair presentation.²² This provides the insurer with a remedy appropriate to the detriment suffered because of the insured's breach, rather than the blanket "all or nothing" remedy of avoidance under the current law.
- 11.59 These remedies would apply to all breaches which are not deliberate or reckless. Unlike CIDRA, our recommendations do not distinguish between "negligent" and "innocent" breaches.²³ If the insurer demonstrates a breach, and shows that the inducement test is satisfied, then there has been a "qualifying breach" and the insurer has a remedy.
- 11.60 We recommend that:
- (1) if the insurer would not have entered into the insurance contract at all, it may avoid the contract;
 - (2) if the insurer would have entered into the contract on different terms (other than the premium), the contract is to be treated as if it included those terms;
 - (3) if the insurer would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim (which may be additional to the inclusion of other terms).
- 11.61 These remedies were supported by consultees: in response to CP3, 92% of consultees supported (1); 85% supported (2); and 69% supported (3).²⁴ Below we explain these remedies in more detail.

Where the insurer would not have contracted on any terms

- 11.62 If the insurer shows that, if it had received a fair presentation of the risk, it would not have entered into the contract on any terms, we recommend that the insurer should be entitled to avoid the contract.

²² As we discuss from para 11.80, the remedies are necessarily aimed at compensating the insurer and putting the insurer in the position it should have been in.

²³ As discussed in CP3, from para 9.8, we considered such a distinction in CP1, our 2007 paper, but had moved away from that by CP3.

²⁴ Respectively 36, 33 and 27 of 39 respondents to these questions.

11.63 The insurer should be entitled to refuse all claims. However, because the insured has not acted fraudulently, deliberately or recklessly, the insurer should return any premiums paid in accordance with existing legal principles.²⁵

11.64 This remedy is provided in paragraph 4 of the Schedule to the draft Bill.

Where the insurer would have included additional terms

11.65 If the insurer shows that it would have entered into the contract on different terms from the actual contract, other than terms about the premium, the insurer should be able to treat the contract as if it includes those terms. These different or additional terms would be treated as applying from the outset of the contract.

11.66 This remedy is provided in paragraph 5 of the Schedule.

11.67 The effect on claims will depend on the term imposed. We anticipate that the principal types of terms that insurers will seek to include are as follows.

- (1) Exclusions: if a fair presentation had been made, the insurer might have excluded liability for certain types of loss. If so, the validity of a claim will depend upon whether it falls within the terms of the exclusion.
- (2) Warranties and other terms designed to reduce particular risks: knowing the full facts, an insurer might have required the insured to warrant that it would act in a certain way. If the insured's actions have put it in breach of that warranty, the insurer's liability will be suspended either entirely or in respect of the particular type of loss to which the warranty is relevant.²⁶
- (3) Excesses: the insurer might have imposed an excess. The excess may cover the whole policy or particular types of loss. If the claim falls within the terms of the excess it will be reduced by the amount of the excess.

Where the insurer would have charged a higher premium

11.68 If the insurer would have charged a higher premium for entering into the contract, the insurer should be entitled to reduce proportionately the amount to be paid on each claim.

11.69 This remedy is given in paragraphs 6(1) and (2) of the Schedule to the draft Bill.

²⁵ *Cornhill Insurance Co v L&B Assenheim* (1937) 58 Ll L Rep 27 by Mackinnon J at 37: "Avoidance of the policy, of course, results in it being set aside *ab initio*, the repayment of any losses, and the return of any premiums paid under it...". See also section 84(3)(a) of the Marine Insurance Act 1906.

²⁶ See our recommendations in respect of warranties, contained in Part 3 of this Report. See also clauses 10 and 11 of the draft Bill.

- 11.70 Paragraph 6(2) defines “reduce proportionately”. It means that the insurer need only pay X% of what it would otherwise have been under an obligation to pay, where:

$$X = \frac{\text{Premium actually charged}}{\text{Higher premium}} \times 100$$

- 11.71 To take a simple illustration, if the insurer should have charged £2,000 but only charged £1,000, then the policyholder has paid only 50% of the correct charge (the premium) and the claim will be reduced by half.
- 11.72 Insureds are not given a right to pay the extra premium that the insurer would have charged in order to retain cover. This would under-compensate the insurer, who would thereby be forced to cover the risk after it had materialised, despite not having been given sufficient information to gauge accurately the degree of likelihood of it materialising or its extent. It would be open to insurers to decide to accept the higher premium as part of a commercial settlement.

Combination of terms and premium

- 11.73 Where the insurer would have entered into the contract on different terms and at a higher premium, the insurer should be entitled to apply both remedies. The contract may be treated as if it included the additional terms from the outset, and any claims may be reduced in proportion to the increase in premium.

Proving how the insurer would have acted

- 11.74 In the case of standardised risks, showing how the insurer would have acted in particular circumstances may be relatively straightforward. In relation to more bespoke risks for which there are no pricing tariffs or a range of comparable policies to point to, we accept that this will be an issue for dispute.
- 11.75 The Chartered Insurance Institute understood that this is an inevitable result of removing the disproportionate “one size” remedy of avoidance:

We accept that remedies can be complex in situations where the insurance is bespoke or the risk characteristics are unique, and assessing what the insurer would have done had they been in possession of the information might be difficult. Nevertheless, proposing a range of remedies short of avoidance is the right approach

- 11.76 Evidence of how the insurer would have acted may be derived from a number of sources, including pricing manuals and models, contemporaneous policies and oral evidence from the individual underwriter or expert witnesses. There may also be commercial reasons for similar risks being written on different terms for different policyholders. This would also be a matter of evidence in the circumstances.

- 11.77 It may be the case that the insurer would have been willing to contract on a number of bases. For instance, the insurer might have been willing to accept the risk for a high premium, or at a lower premium level with an exclusion or warranty. The court will need to decide which offer the insurer would most likely have put to the insured.
- 11.78 We believe that the courts are best placed to decide what evidence is admissible and sufficient to show how the insurer would have acted. The courts make similar decisions at present when deciding issues of materiality and, in particular, inducement.²⁷

The limits on considering what would have happened

- 11.79 We have explained that proportionate remedies seek to put the insurer, as far as practicable, into the situation it would have been in had it received a fair presentation of the risk. Note the phrase “as far as practicable”. Here we look at the limits of what is practicable in considering what the world might have been like in hypothetical circumstances.
- 11.80 The parties have already been brought together under the influence of the insured’s breach of the fair presentation duty and are (subject to avoidance) stuck with each other. We do not think that it is right or realistic to encourage speculations about what would have happened if the parties had negotiated on a different basis.
- 11.81 For example, if the insurer would have charged a higher premium, we do not think it should be open to the insured to say that it could have obtained the insurance at a lower premium elsewhere. Nor where the insurer would have contracted on different terms should it be open to the insured to say that it could have obtained the insurance elsewhere on more favourable terms.

²⁷ See, for example, *Drake Insurance plc v Provident Insurance plc* [2003] EWCA Civ 1834, [2004] QB 601 paras 62 to 64, in which the Court of Appeal examined not only what the insurer would have done had a speeding conviction been disclosed, but also whether this would have led to discussion of an earlier accident, resulting in its reclassification in the insurer’s records as being “no fault”.

- 11.82 Similarly, it should not be open to an insured to say that it would have complied with any term which the insurer would have imposed (for example, an exclusion or warranty) and so the loss should be covered. During consultation, the example was put to us of a business which keeps its vehicles in an area which has suffered a series of thefts of commercial vehicles. The business fails to disclose this and a vehicle is stolen. The insurer responds that had this information been properly disclosed it would have required the vehicles to be parked in a secure location, which the business says it would have done if this term had been imposed. Consultees were rightly concerned about the circularity of such arguments.
- 11.83 Similar arguments apply to insurers. We do not think that the enquiry should extend to whether the insurer would have reinsured the risk or acted differently in accepting subsequent risks (for example, in relation to capacity limits in group life cover). This is necessary to prevent complicated evidential arguments arising about how the insurer would have conducted itself and the terms on which it could have obtained reinsurance cover.
- 11.84 If parties consider the default remedies inappropriate for their particular arrangements (as may be the case for some specialist and sophisticated markets), they can negotiate and provide for more suitable outcomes in their contracts.

THE EFFECT OF A BREACH OF FAIR PRESENTATION ON FUTURE COVER

- 11.85 Most disputes about breaches of the duty of fair presentation will be in the context of a claim. Nevertheless, where an insurer has the right to apply a proportionate remedy, the question arises whether it should also have the right to cancel the contract for the future. Equally, where a proportionate remedy would be applied to every future claim, the insured may feel that the policy no longer meets their needs.
- 11.86 In principle, we think that either party should be able to cancel. In CP3 we asked whether insureds and insurers should be given statutory rights to cancel insurance contracts to which a proportionate remedy has been applied.
- 11.87 Although most consultees agreed that there should be a right to cancel, many thought that the issue was best dealt with by the terms of the contract. As the Investment & Life Assurance Group (ILAG) said:
- In practice we question whether a statute is necessary to deal with this as there are existing industry practices and contract terms.
- 11.88 Similarly, Airmic replied that “cancellation rights already exist and do not need to be further explained or qualified as part of these proposed reforms”. Swiss Re said that cancellation rights should be agreed by the parties at the outset of the contract as it will “depend upon the circumstances if cancellation is appropriate”. Even some respondents who agreed with statutory cancellation rights commented that the issue would usually be dealt with by the contract. After expressing agreement with a statutory right, Direct Line Group said that “in any event, policies usually contain provision for cancellation”.

- 11.89 We have been persuaded that the issue should be left to the terms of the contract. Insurers should be entitled to include general or specific cancellation rights, as they think appropriate. However, we do not recommend statutory cancellation rights, which could cause unforeseen problems.
- 11.90 This approach contrasts with CIDRA, which includes statutory termination rights for both insurers and consumers in these circumstances.²⁸ Some consumer insurance contracts, particularly life and health insurance, may run for long terms. A consumer may be severely disadvantaged if they are obligated to continue to pay premiums for insurance which, because of the application of a proportionate remedy, no longer meets their needs.
- 11.91 These considerations do not apply to non-consumer insurance, where policies will typically be short-term in nature and are more frequently bespoke. Many contracts will already include cancellation rights.
- 11.92 Furthermore, we expect that in many cases the parties will be able to negotiate a satisfactory position for the future, in lieu of the ongoing application of proportionate remedies to any claim which arises. For example, the parties may agree that the insured will pay a higher premium, or that certain additional requirements will be included in the policy. A few consultees expressed concern that the balance of power is frequently such that the insured will not be in a position to persuade the insurer to agree. However, it would not be appropriate in primary legislation to include an obligation on parties to enter into negotiations, nor would it be possible to stipulate a particular outcome.

PROPORTIONATE REMEDIES IN REINSURANCE AND RETROCESSION CONTRACTS

- 11.93 We do not recommend any special rules for the operation of proportionate remedies in contracts of reinsurance and retrocession. We believe that proportionate remedies will operate without difficulty for many reinsurance arrangements. Two types of breach of the fair presentation duty may be distinguished:
- (1) those by the underlying policyholders about the individual risks insured; and
 - (2) those by the insurer when obtaining reinsurance (or the reinsurer when obtaining retrocession) about the composition or quality of the insurance portfolio.

²⁸ CIDRA, Schedule 1, paragraph 9.

- 11.94 Most consultees agreed that it would be easy to apply proportionate remedies relating to the first category of failures along the reinsurance chain, at least where the reinsurance is written on “back-to-back” terms as is most common. The liability of the reinsurer would reflect the liability of the insurer once a proportionate remedy has been applied. For example, an insurer presented with a £10,000 claim to which it is entitled to apply a proportionate reduction of 25% must pay the policyholder £7,500. If the insurer has reinsured 80% of the risk, it may recover £6,000 from the reinsurer.
- 11.95 Applying proportionate remedies may be more difficult where the reinsurance is not written back-to-back or if the fair presentation failure is between the insurer and reinsurer (or reinsurer and retrocessionaire). These issues are less common, and difficulties already exist in applying remedies under the current law. We have been told that these contracts already provide for specific remedies to cover the issues of non-disclosure and misrepresentation and agree that contractual arrangements are best placed to provide for the parties’ needs.
- 11.96 Proportionate remedies only represent the default regime and parties are free to agree alternatives in their contracts.²⁹

VARIATIONS

The current law

- 11.97 Businesses often wish to vary their insurance cover during the contract term, particularly to expand the scope of coverage to new risks. When negotiating the variation, insureds must disclose facts “material to the *additional* risk being accepted by the variation” as a matter of good faith,³⁰ but do not need to represent the original risk.
- 11.98 The insurer’s remedy for non-disclosure or misrepresentation in relation to a variation to the policy is also based on good faith. Section 17 of the 1906 Act gives the insurer a remedy to avoid the contract if good faith is not observed by the insured. The courts have interpreted this as an entitlement to avoid the variation itself. That is, the insurer is entitled “to avoid the agreement by which the policy was amended, not the entire contract”.³¹ Effectively this means that the insurance contract is treated as if the *variation* had never been made.

²⁹ See Chapter 29.

³⁰ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 by Lord Hobhouse at [54].

³¹ See *MacGillivray on Insurance Law* (12th ed 2012) para 17-027.

11.99 While the courts have strained section 17 in this way to prevent a breach of good faith on variation affecting the whole contract, there is still the potential for harsh results. An insurer can avoid the variation even if it would still have agreed to cover the new peril, for example, had it received a fair presentation of the additional risk, albeit on different terms/premium.

Our recommendations

11.100 In Chapter 7, we recommend that the duty of fair presentation should apply to variations. Clause 2(2) requires the insured to make a fair presentation of the changes in the risk “relevant to the proposed variation”.

11.101 In terms of remedies, we have said that even the current solution of avoiding the variation can have harsh results on the insured. We therefore recommend that proportionate remedies should also be applied to breaches of the fair presentation duty in the context of variations. This is the approach taken by CIDRA.³² The remedy should be based on what the insurer would have done had the insured made a fair presentation of the additional or changed risk on variation.

11.102 Broadly, we recommend the following remedies for a qualifying breach of the duty of fair presentation in relation to a variation.

- (1) Where the breach was deliberate or reckless, the insurer may by notice treat the contract as having terminated with effect from the time the variation was made, and need not return any additional premium paid in respect of the variation.
- (2) If the insurer would not have agreed to the variation on any terms, the insurer may treat the contract as if the variation was never made. The original contract should subsist. The insurer should return any additional premium paid for the variation.
- (3) If the insurer would have included additional terms relating to the variation (for example a warranty relating to the new risk), the insurer may treat the variation as if it contained those terms.
- (4) If the insurer would have charged a higher premium for the variation or would not have reduced the premium as a result of the variation, any claims arising after the variation may be reduced in proportion to the premium that the insurer would have charged.

11.103 These are set out in Part 2 of the Schedule to the draft Bill.

³² CIDRA, Schedule 1, Part 2.

11.104 This issue is discussed in more detail in Appendix B.

CONTRACTING OUT

11.105 As with other areas of reform covered by the draft Bill, and other aspects of our fair presentation recommendations, we think that the scheme of remedies should be a default regime for non-consumer insurance contracts.

11.106 Insurers should be entitled to negotiate alternative arrangements with a particular insured, even reinstating the single remedy of avoidance in the event of any breach of the fair presentation duty.

11.107 Any such term, which would have the result of putting the insured in a worse position than it would be in if the default remedies had applied, will be subject to clauses 17 and 18 of the draft Bill and, in particular, the transparency requirements. These clauses and requirements are discussed in more detail in Chapter 29.

RECOMMENDATIONS

Recommendation 17: The inducement test developed by the courts should be set out in statute. The statute should provide that the insurer has a remedy against the insured for a breach of the duty of fair presentation only if the insurer shows that, but for the breach, the insurer:

- (1) would not have entered into the contract at all; or
- (2) would have done so only on different terms.

Recommendation 18: Where a breach of the duty of fair presentation is deliberate or reckless, the insurer should be entitled to avoid the contract and refuse all claims. The insurer should also be entitled to keep the premiums.

Recommendation 19: A breach should be considered deliberate or reckless if the insured:

- (1) knew that it was in breach of the duty of fair presentation; or
- (2) did not care whether or not it was in breach of that duty.

Recommendation 20: In other cases, we recommend a scheme of proportionate remedies which aim, as far as practicable, to put the insurer in the position it would have been in had the insured fulfilled its duty to make a fair presentation. In particular:

- (1) if the insurer would not have entered into the insurance contract at all, it may avoid the contract;
- (2) if the insurer would have entered into the contract on different terms (other than the premium), the contract is to be treated as if it included those terms.

- (3) if the insurer would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim (which may be additional to the inclusion of other terms).

Recommendation 21: Proportionate remedies should also apply in the event of a breach of the duty of fair presentation in the context of a variation.

These recommendations are intended to be a default scheme for non-consumer insurance and are subject to our contracting out recommendations in Chapter 29.

PART 3

WARRANTIES

CHAPTER 12

WARRANTIES: INTRODUCTION

- 12.1 In general contract law, “warranties” are relatively minor contractual terms, breach of which gives rise to damages. By contrast, compliance with an insurance warranty is of paramount importance. It is essentially a promise made by the policyholder to the insurer which, if broken, will have harsh consequences for the policyholder.
- 12.2 The general principles of insurance warranty law are founded on the rulings of Lord Mansfield, made in the late eighteenth century. The classic case is *De Hahn v Hartley*.¹ There, an insurance policy contained a term to the effect that a ship would leave Liverpool (for the West Indies) with “50 hands or upwards”. The term was designed to guard against the substantial risk of piracy or other violent misfortune encountered on such voyages. The ship left Liverpool with a crew of only 46. Before it left the relatively safe waters around Britain, it picked up another six crew-members in Anglesey, just a few hours into the voyage and before any loss was suffered. The ship was eventually captured and lost off the coast of Africa. The insurer refused to pay the claim on the basis that the term had not been strictly complied with. The court agreed: warranties had to be complied with exactly, and the insurer would be discharged from liability where they were not. It was immaterial that the breach of warranty had been remedied within a few hours and before any loss occurred.
- 12.3 These principles were codified in the Marine Insurance Act 1906 (the 1906 Act). Section 33(3) states that a warranty “must be exactly complied with, whether material to the risk or not”. If not, then “the insurer is discharged from liability from the date of the breach of warranty”. Section 34(2) confirms that once a warranty is breached, the policyholder “cannot avail himself of the defence that the breach has been remedied, and the warranty complied with, before loss”. The 1906 Act applies only to marine insurance, but the common law has evolved in parallel and the same rules are said to apply to all insurance contracts.² In particular, the provisions which prescribe the consequences of breach of warranty apply to all insurance.³

PROBLEMS WITH THE CURRENT LAW

- 12.4 The law of insurance warranties has been subject to major criticisms over many years. In Consultation Paper 3 (CP3) we identified four problems with it:
- (1) An insurer may refuse a claim for a trivial mistake which has no bearing on the risk.
 - (2) The insured cannot use the defence that the breach has been remedied.

¹ (1786) 1 TR 343.

² See generally *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501.

³ J Birds, *Birds' Modern Insurance Law* (9th ed 2013) at p 167, citing *Hussain v Brown* [1996] 1 Lloyd's Rep 627.

- (3) The breach of warranty discharges the insurer from all liability, not just liability for the type of loss in question. For example, a failure to install the right sort of burglar alarm would discharge the insurer from liability for a flood claim.
 - (4) A statement may be converted into a warranty using obscure words that few policyholders understand. For example, if a policyholder signs a statement on a proposal form that their answers form the “basis of the contract”, this can have draconian consequences.
- 12.5 For many years, the courts have attempted to moderate the harshness of the law with creative reasoning. This approach has allowed the courts to do justice in some individual cases and it discourages insurers from taking purely technical points. While this has its advantages, it also introduces complexity and uncertainty into the law.

OUR RECOMMENDATIONS

- 12.6 We make three key recommendations:
- (1) To abolish basis of the contract clauses.
 - (2) To provide that breach of warranty suspends rather than discharges the insurer’s liability, which may be revived if and when the breach is remedied.
 - (3) Where terms are designed to reduce the risk of loss of a particular type (or at a particular time or place) they should not affect losses of a different kind (or at a different time or place).
- 12.7 For consumer insurance, we propose a compulsory regime, so that an insurer could not use a contract term to put the consumer in a worse position than they would be in under the draft Bill. In non-consumer insurance, the parties would generally be free to make alternative arrangements in their contracts, provided that the consequences of the contract terms are clear and that the insurer takes sufficient steps to bring it to the insured’s attention.

A HISTORY OF THE CONSULTATION PROCESS

Issues Paper 2 and our 2007 consultation paper

- 12.8 In 2006 we published an Issues Paper on insurance warranties (IP2) in which we tentatively proposed that a policyholder should be entitled to be paid a claim if the breach of warranty did not contribute to the loss.⁴
- 12.9 We developed this proposal in our first consultation paper (CP1), published in 2007.⁵ In that paper, we also distinguished between warranties of past or present fact and warranties of future conduct.

⁴ Issues Paper 2: Warranties (November 2006), para 7.76.
<http://lawcommission.justice.gov.uk/consultations/warranties.htm> and
http://www.scotlawcom.gov.uk/index.php/download_file/view/215/107/.

- 12.10 There was considerable support for reform in this area. Many respondents agreed that the current law is archaic and unfair. There was also majority support for the idea that the insurer should only refuse a claim if it has some causal connection with the breach of warranty.
- 12.11 On the other hand, several criticisms were made of the proposals. Many thought that our proposals were too complicated, particularly in the distinction between current fact warranties and future conduct warranties. Concerns were also expressed that a causal connection test was inappropriate for many terms.

Reforms to consumer insurance

- 12.12 In December 2009, we published a Report and draft Bill, *Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation*.⁶ We recommended that basis of the contract clauses should be abolished in the context of consumer insurance contracts. This resulted in section 6 of the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA).

Our 2012 Consultation Paper

- 12.13 In light of the responses we received to our 2007 Consultation Paper, we reconsidered our approach to warranties. In June 2012, we published our third Consultation Paper: *Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties* (CP3).⁷ This report and the clauses in the draft Bill are intended to implement our 2012 proposals.

Limited consultation on the draft clauses

- 12.14 In March 2014, we launched a brief consultation on the draft Bill clauses on warranties and related issues. We received 20 responses to this element of the consultation. Consultees generally welcomed our proposed reforms and were broadly supportive of the draft provisions of the Bill.

SUPPORT FOR REFORM

- 12.15 The vast majority of consultees from all sides of the market support reform in this area. In response to CP3, 36 out of 42 respondents (88%) agreed that there was a need to reform the law of warranties as set out in sections 33 and 34 of the 1906 Act. The comments of one consultee (who did not wish to be named) reflected widely held opinions:

⁵ Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (June 2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134. http://lawcommission.justice.gov.uk/docs/cp182_ICL_Misrep_Non-disclosure_Breach_of_Warranty.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/123/107/.

⁶ Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (December 2009) Law Com No 319; Scot Law Com No 219. http://lawcommission.justice.gov.uk/docs/lc319_Consumer_Insurance_Law.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/268/107/.

⁷ The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155. http://lawcommission.justice.gov.uk/docs/cp204_ICL_business-disclosure.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/1020/107/.

The current law in relation to warranties brings English law into disrepute and puts the English market at a competitive disadvantage against other jurisdictions in which a more balanced approach to the effect of such terms has been adopted. The draconian nature of a warranty under English law leaves insureds too often at the mercy of the goodwill of insurers in the event of breach.

THE STRUCTURE OF THIS PART

12.16 This Part is divided into 6 further chapters:

- (1) In the next chapter, we provide a brief overview of the current law. Fuller accounts of the law are provided in IP2 and CP3.
- (2) Chapter 14 sets out the case for reform.
- (3) Chapter 15 provides an overview of our recommendations. We also explain those areas which we do not intend to reform.

12.17 The details of the recommendations are then set out in the following 3 chapters.

- (1) In Chapter 16 we focus on basis of the contract clauses. We argue that they should be of no effect. Where an insurer seeks a warranty in respect of information given at the pre-contract stage, this should be specifically included in the policy.
- (2) In Chapter 17 we recommend a new remedy regime for breach of warranty.
- (3) In Chapter 18 we look at warranties and other terms which relate to the risk of particular types of loss, or loss at a particular time or place. We recommend that the insurer should remain liable for different types of loss (or loss at a different time or place).

CHAPTER 13

THE CURRENT LAW

- 13.1 The effect of a warranty in an insurance contract is prescribed by the Marine Insurance Act 1906 Act. The relevant provisions have been held to apply to all types of insurance, not just marine insurance.¹ Their combined effect is that if a policyholder breaches a warranty, the insurer may refuse claims for any subsequent losses. This is true even if the breach was minor, had no relevance to the loss, or had already been remedied before the loss took place.

IDENTIFYING A WARRANTY

- 13.2 In insurance law, a warranty is a particularly important contractual term which, if breached, results in the automatic discharge of the insurer's liability for loss.
- 13.3 A partial definition is provided by section 33(1) of the 1906 Act:

A warranty ... means a promissory warranty, that is to say, a warranty by which the assured undertakes that some particular thing shall or shall not be done, or that some condition shall be fulfilled, or whereby he affirms or negatives the existence of a particular state of facts.

- 13.4 Identifying a warranty in an insurance contract has caused considerable confusion. Warranties may be express or implied into the contract.² Section 35(1) of the 1906 Act states that "an express warranty may be in any form of words from which the intention to warrant is to be inferred".³ As such, there is no particular form of words which confers warranty status on a term. Merely calling something a "warranty" may not be enough as the term is "always used with the greatest ambiguity in a policy".⁴ In *HIH Casualty & General Insurance Ltd v New Hampshire Insurance Co*, Lord Justice Rix provided this guidance:

It is a question of construction, and the presence or absence of the word "warranty" or "warranted" is not conclusive. One test is whether it is a term which goes to the root of the transaction; a second, whether it is descriptive or bears materially on the risk of loss; a third, whether damages would be an unsatisfactory or inadequate remedy.⁵

- 13.5 Identifying warranties in insurance policies is therefore not a precise science. The interpretative approach to classification of terms in this context tends to be highly fact-specific and often motivated by judges' wish to avoid the harsh consequences of designating a term a warranty.

¹ See generally *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501 at 518. See also J Birds, *Birds' Modern Insurance Law* (9th ed 2013) at p 167, which cites *Hussain v Brown* [1996] 1 Lloyd's Rep 627.

² 1906 Act, s 33(2).

³ 1906 Act, s 35(1).

⁴ *Roberts v Anglo-Saxon Insurance Association Ltd* (1927) 27 Lloyd's Rep 313.

⁵ [2001] 2 Lloyd's Rep 161, [2001] EWCA Civ 735 at [101].

“BASIS OF THE CONTRACT” CLAUSES

- 13.6 Warranties can also be created through “basis of the contract clauses”. If a prospective policyholder signs a statement on a proposal form stating that the answers given form the “basis of the contract”, this has the effect of converting all the answers into warranties.
- 13.7 This means that where a policyholder makes a minor mistake on an application form, they are in breach of a warranty and the insurer is discharged from liability for all claims. As discussed in Part 2, under section 20 of the 1906 Act, the insurer may only avoid the contract if a misrepresentation made before the insurance contract is entered into is “material”. A basis of the contract clause goes beyond section 20, and allows the insurer to avoid liability for any inaccuracy, however immaterial.
- 13.8 The leading case on the issue is *Dawsons Ltd v Bonnin*.⁶ A furniture removal firm took out insurance on a lorry. The firm filled out a proposal form, giving its business address in central Glasgow. When asked where the lorry was usually parked, it inadvertently wrote “above address”. In fact, the lorry was usually parked in the outskirts of Glasgow. The firm argued that this fact was not material: it did not increase the risk and probably reduced it. However, the form contained a declaration that the proposal “shall be the basis of the contract”. The House of Lords held that this had the effect of converting the statements into warranties. Thus it did not matter whether the mistake was material. The insurer could use any mistake on the form to refuse all claims under the policy.
- 13.9 Basis of the contract clauses have been described as “traps”, as they allow the insurer to refuse claims on the basis of minor and irrelevant mistakes.⁷
- 13.10 Section 6 of the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) made basis of the contract clauses void in consumer insurance contracts. However, such clauses are still routinely used in non-consumer insurance contracts. In the recent case of *Genesis Housing Association Ltd v Liberty Syndicate Management Ltd*,⁸ the Court of Appeal confirmed that, where a basis of the contract clause is in place, an insurer may refuse a claim for any inaccuracy on a proposal form and such inaccuracy could not be dismissed as “immaterial”.

THE EFFECT OF A WARRANTY

Automatic discharge of the insurer’s liability

- 13.11 The 1906 Act provides that if a warranty is not complied with, the insurer is discharged from liability from the time of the breach and is not liable for any loss arising after that event. Section 33(3) of the 1906 Act states that a warranty:

⁶ [1922] 2 AC 413, 1922 SC (HL) 156.

⁷ *Zurich General Accident & Liability Insurance Co v Morrison* [1942] 2 KB 53 by Lord Greene MR at 58. Basis of the contract clauses have been the subject of criticism by commentators and judges which we examined more fully in CP1, para 4.219 and following and 5.112 and following.

⁸ *Genesis Housing Association Ltd v Liberty Syndicate Management Ltd for and on behalf of Liberty Syndicate 4472 at Lloyd’s* [2013] EWCA Civ 1173, [2013] WLR (D) 368. See also *Unipac (Scotland) Ltd v Aegon Insurance Co (UK) Ltd* 1996 SLT 1197.

must be exactly complied with, whether it be material to the risk or not. If it be not so complied with, then, subject to any express provision in the policy, *the insurer is discharged from liability as from the date of the breach of warranty*, but without prejudice to any liability incurred by him before that date. (emphasis added)

- 13.12 This means that following a breach the insurer is no longer liable to pay any claim. In *The Good Luck*,⁹ Lord Goff explained the effect of a breach of warranty as follows:

What [breach of warranty] does (as section 33(3) makes plain) is to discharge the insurer from liability as from the date of the breach. Certainly, it does not have the effect of avoiding the contract *ab initio*. Nor, strictly speaking, does it have the effect of bringing the contract to an end. It is possible that there may be obligations of the assured under the contract which will survive the discharge of the insurer from liability, as for example a continuing liability to pay a premium. Even if in the result no further obligations rest on either party, it is not correct to speak of the contract being avoided; and it is, strictly speaking, more accurate to keep to the carefully chosen words in section 33(3) of the Act, rather than to speak of the contract being brought to an end, though that may be the practical effect.¹⁰

- 13.13 This emphasises that although the insurer's liability is discharged, the contract remains in force for other purposes. In particular, the insured remains liable to pay the premium.

Breach not material to risk or loss

- 13.14 Breach of a single warranty discharges liability for all risks covered by the policy. So, for example, breach of a warranty which is associated with one risk, such as fire, will also discharge the insurer from liability for losses of some other kind, such as flooding.¹¹
- 13.15 The court in *Printpak v AGF Insurance Ltd*¹² took a different approach, but it was highly fact specific. There, insurers were held liable for a fire loss even though the policyholder was in breach of a burglar alarm warranty. This result was reached because the policy comprised separate sections, each of which afforded a different kind of insurance cover and specified a different insured value. Section A of the policy covered fire damage (among other risks). Section B covered theft, and included the burglar alarm warranty. Analysing the contract structure, the court found that the burglar alarm warranty did not apply to fire damage. However, if the policy had been structured slightly differently, the court would have been forced to reach the opposite result.

⁹ *Bank of Nova Scotia v Hellenic Mutual War Risks Association (Bermuda) Ltd (The Good Luck)* [1992] 1 AC 233, [1991] 3 All ER 1.

¹⁰ *The Good Luck* [1992] 1 AC 233 at 263.

¹¹ This is the effect of the 1906 Act, s 33(3).

¹² [1999] Lloyd's Rep IR 542, [1999] 1 All ER (Comm) 466 CA.

- 13.16 It is far more usual for warranties to be construed as applying to the entirety of a policy regardless of the relationship between the term and any loss which may have occurred, and not to individual types of loss or areas of the policy.

Later remedy irrelevant

- 13.17 A breach of warranty by the policyholder is fatal to the insurer's liability under the policy, even where the breach is remedied before any loss occurs. Under section 34(2), once a warranty is broken, the policyholder:

...cannot avail himself of the defence that the breach has been remedied, and the warranty complied with, before loss.

- 13.18 The starkness of this is well demonstrated by the example of a premium payment warranty. If the insurance contract contains a warranty that the policyholder will pay the premium, or an instalment of the premium, by a certain time, a payment delayed by just one or two days will discharge the insurer's future liability. Although the policyholder may pay the outstanding instalment and so remedy the breach, they are still left without cover. In addition, they remain liable to pay each future instalment as it falls due.¹³

"Subject to any express provision"

- 13.19 The principle of automatic discharge of liability is subject to any express terms of the contract.¹⁴ It therefore represents the default position. Where there is an express provision, the effect can be that it "waters down" section 33 by restricting the circumstances in which a warranty will bite.¹⁵

EXCUSED NON-COMPLIANCE AND WAIVER

- 13.20 The 1906 Act provides two instances where the breach of a warranty does not end the insurer's liability for loss. First, section 34(1) provides that non-compliance is excused where, by change of circumstances, the warranty ceases to be applicable or when compliance is rendered unlawful by subsequent law.

- 13.21 Secondly, section 34(3) gives the insurer the power to waive a breach of warranty. This is regardless of the automatic discharge of the insurer's liability under section 33(3). There is academic debate about how liability which has ceased to exist can be resurrected by waiver. Professor Clarke explained the contradiction thus:

The contract is dead but the insurer can still waive it back to life.¹⁶

¹³ *JA Chapman & Co Ltd v Kadirga Denizcilik ve Ticaret AS & Ors* [1998] Lloyd's Rep IR 377.

¹⁴ 1906 Act, s 33(3).

¹⁵ But see *Printpak v AGF Insurance Ltd* [1999] Lloyd's Rep IR 542 by Lord Justice Hirst at 546.

¹⁶ M A Clarke, *Insurance Warranties: The absolute end?* (2007) *Lloyd's Maritime and Commercial Law Quarterly* 474.

- 13.22 As we explained in CP3, in English law, waiver of a warranty would probably need to be “by estoppel” rather than “by election”.¹⁷ “Waiver by estoppel” requires the insurer to make an unequivocal representation, in words or conduct, which the policyholder has relied upon in circumstances “where it would be inequitable for the promise to be withdrawn”.¹⁸
- 13.23 Scots law does not draw a distinction between waiver by election and waiver by estoppel.¹⁹ A party relying on the other party’s abandonment of a right must demonstrate that it has conducted its affairs on the basis of the waiver, but need not show that it has actually suffered prejudice as a consequence of relying upon it.²⁰

MODERATING HARSH LAW THROUGH STRICT INTERPRETATION

- 13.24 For many years, the courts have attempted to moderate the harshness of the law through creative interpretation. This has allowed them to do justice in individual cases. It is well established that warranties should be construed strictly, against the interest of the party who has put them forward. Terms which appear to be warranties may also be construed as being suspensory provisions, with the effect of suspending the policy for any period during which the circumstances specified in the clause are not satisfied.²¹
- 13.25 In IP2²² and CP3,²³ we set out the various principles of interpretation that the courts have developed to mitigate the harsh effects of a warranty where appropriate. We also noted that the case law was inconsistent. This can be illustrated by contrasting the following two cases.

Kler Knitwear

- 13.26 A striking example where an apparent warranty was found not to be a warranty is *Kler Knitwear Ltd v Lombard General Insurance Co Ltd*.²⁴ The cover was subject to a term that the policyholder’s sprinkler system would be inspected 30 days after renewal. The contract stated that the term was a warranty and specified that noncompliance would bar any claim “whether it increases the risk or not”. In fact, the inspection was about 60 days late and showed that the system was working. The factory later suffered storm damage (which was wholly unconnected with the sprinklers).

¹⁷ See CP3, paras 12.36 to 12.43. See also *Kosmar Villa Holidays Plc v Trustees of Syndicate 1243* [2008] EWCA Civ 147 at [68] and [70].

¹⁸ See also *Kosmar Villa Holidays Plc v Trustees of Syndicate 1243* [2008] EWCA Civ 147 at [38].

¹⁹ See E C Reid & J G W Blackie, *Personal Bar* (2006), paras 3-12 to 3-16 and 3-40 to 3-41.

²⁰ *Armia Ltd v Daejan Developments Ltd* 1979 SC (HL) 56 by Lord Fraser of Tullybelton at 68 and by Lord Keith of Kinkel at 71. See also *Moodiesburn House Hotel Ltd v Norwich Union Insurance Co Ltd* 2002 SLT 1069.

²¹ B Soyler, *Warranties in Marine Insurance* (2nd ed 2006), para 2.79.

²² Issues Paper 2: Warranties (November 2006), Part 4 at para 4.4 and following.

²³ CP3, para 12.46.

²⁴ [2000] Lloyd’s Rep IR 47.

13.27 Mr Justice Morland accepted in principle that if on a proper construction of the clause the parties intended it to be a warranty, then the court “must uphold that intention”, however harsh and unfair the consequences. However, he found that this particular clause was merely “a suspensive condition”, which applied only during the 60 days when the policyholder had failed to inspect the sprinkler system.²⁵

13.28 The case is difficult because on its facts it appears that the parties did intend the term to be a warranty. One commentator noted that:

It is difficult to see how the insurer could have stipulated this in any clearer terms. The term itself was called a warranty and was drafted in clear and intelligible language and the consequences of noncompliance were spelled out.²⁶

Sugar Hut

13.29 In *Sugar Hut Group Ltd v Great Lakes Reinsurance (UK) plc*, the court took a different approach.²⁷ The claimants insured four nightclubs. When the Brentwood club suffered fire damage, the insurers refused the claims on various grounds. The judge found that the insurers were entitled to refuse cover for multiple reasons, including several non-disclosures and breaches of warranty. The judge considered the decision in *Kler Knitwear* but held that in this case several terms were in fact “true warranties” rather than suspensory provisions.

13.30 In particular, one term obliged the policyholders to install a burglar alarm that rang through to a central monitoring station. The court found that the alarm was inadequate as it only contacted a Sugar Hut employee. Mr Justice Burton held that this alone would be sufficient to absolve the insurers from liability under the contract. The term:

was significantly material to the risk of loss; and it does not influence such conclusion ... that in the event the absence of such burglar alarm was not in any way causative of the loss suffered by the fire.²⁸

13.31 The judge heard evidence that the insurers had extended the deadline for upgrading the alarm, which suggested that the term was treated as a suspensory provision. The judge found, however, that this made no difference. In *Kler Knitwear*, the sprinkler requirement was complied with before the storm damage. Here the upgrade work was never carried out. As the defendants remained in breach, liability for all risks was suspended at the time of the fire.

²⁵ A “suspensive condition” in this sense applies in certain circumstances to suspend the policy. In other contexts, however, a suspensive condition, like a condition precedent, suspends purification of the contract so that it only comes into effect and is enforceable if the conditions of the term are met. See *Chitty on Contracts* (31st ed 2012), Chapter 2, footnote 748, and W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007), paras 5-35 to 5-40.

²⁶ J Birds, *Birds’ Modern Insurance Law* (9th ed 2013), para 9.8.

²⁷ [2010] EWHC 2636 (Comm), [2011] Lloyd’s Rep IR 198.

²⁸ Above at [49].

WARRANTIES IN CONSUMER INSURANCE: OTHER PROTECTION

- 13.32 For consumers, there are other statutory and regulatory safeguards in relation to warranties. In CP3, we discussed the Financial Conduct Authority (FCA) rules,²⁹ Financial Ombudsman Service (FOS) decisions and the Unfair Terms in Consumer Contracts Regulations 1999 (UTCCRs).³⁰

FCA rules

- 13.33 The most important provision in relation to warranties is now to be found in the Financial Conduct Authority Handbook. Insurance: Conduct of Business sourcebook (ICOBS) 8.1.2 states:

A rejection of a consumer policyholder's claim is unreasonable, except where there is evidence of fraud, if it is:

[...]

(3) for breach of warranty or condition unless the circumstances of the claim are connected to the breach...³¹

- 13.34 However, this rule cannot be applied in court. Courts continue to be bound by the 1906 Act. In practice, the rules only apply in a regulatory context. In theory, it is possible for a consumer to bring an action for breach of statutory duty,³² although this is neither simple nor straightforward. In practice, we are not aware that any action has ever been brought as a result of a breach of the FCA rules on warranties. Its main effect is that it is used to guide FOS decisions.

FOS decisions

- 13.35 The FOS has jurisdiction to hear complaints from consumers and micro-businesses,³³ and has a general discretion to decide cases according to what is fair and reasonable. In 2006, the Law Commissions carried out a study to gain a better understanding of the FOS approach to warranties. We read 50 final ombudsman decisions concerning consumer policy terms, and a further 18 cases concerning terms in small business cases.³⁴

²⁹ In CP3, we discussed the "FSA rules". The Financial Services Authority (FSA) has since been split into the Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA). The rules to which we referred are now known as the FCA rules.

³⁰ See CP3, from para 12.60. The UTCCRs are due to be revoked and replaced by the provisions of the Consumer Rights Bill.

³¹ Rule 8.1.2 (3)(b) also adds "and unless... the warranty is material to the risk and was drawn to the customer's attention before the conclusion of the contract." Rule 8.1.2 provides an exception in insurance on the life of another: here warranties may be used to give representations by the life insured the same status as representations by the policyholder. The use of warranties in these circumstances has been superseded by s 7 of CIDRA, which provides for the same effect.

³² See s 138D of the Financial Services and Markets Act 2000 (as amended).

³³ A "micro-business" is defined as a business which employs fewer than 10 staff and has an annual turnover of less than €2 million.

³⁴ See Issues Paper 2: Warranties (November 2006), IP2, Appendix B.

- 13.36 We found that it was rare for insurers to insist on the strict application of the law on warranties in consumer cases. Although a few exclusions appeared to be written in wide terms, no insurer argued that they should be discharged from liability by an immaterial breach, or where the breach had already been remedied. However, issues of causal connection can arise in relation to exclusion terms as well as in relation to warranties. In some cases, the FOS overturned an insurer's decision to reject a claim where the breach the insurer relied on did not cause the loss in question.
- 13.37 Warranties were more common in small business contracts. Examples included a Chinese restaurant subject to a warranty that the wok should never be left unattended; and a pub subject to warranties over how the deep fat frying range should be cleaned. We did not find any cases in which an insurer had attempted to refuse a claim solely because of a breach of warranty that had no connection with the claim. However, insurers did raise secondary issues about such breaches. Generally, the FOS gave short shrift to technical defences which had no connection to the claim.
- 13.38 In consumer insurance, insurers appear to accept that a breach of warranty should not discharge an insurer from liability for claims unconnected to the breach. However, this leads to a disjuncture between the law as set out in statute and the law as it is applied in practice.

CONCLUSION

- 13.39 The strict law of warranties, as set out in the 1906 Act, is extremely harsh. A breach of warranty automatically discharges an insurer from all liability from the time of the breach, even if the warranty has no bearing on the risk. Once a warranty has been breached, the insurer may reject all claims, even for losses which occur after the breach has been remedied. In the next chapter, we set out the case for reform.

CHAPTER 14

THE CASE FOR REFORM

- 14.1 The law of insurance warranties has attracted criticisms for many years.¹ In 1980, the Law Commission commented that “it seems quite wrong that an insurer should be entitled to demand strict compliance with a warranty which is not material to the risk”.² Similarly, it seems unjust that an insurer should be entitled to reject a claim for any breach, “no matter how irrelevant the breach may be to the loss”.³

THE LAW IS ANOMALOUS AND UNEXPECTED

- 14.2 The current law is particularly difficult to defend because it is out of line with general contract law, where a breach of warranty only gives rise to damages.⁴ While it may be appropriate in some situations that an insurer is entitled to terminate all liability because a policyholder acts in contravention of the terms of the insurance contract, we do not consider that this result should be reached by the mere reference to “warranty” or “basis of the contract”.
- 14.3 Policyholders – from consumers to sophisticated businesses – routinely agree to contractual terms without a proper understanding of their significance, with the result that their insurance fails to respond as expected. Insurers tell us that they do not as a matter of routine rely on technical warranty arguments to escape liability where a breach of warranty is irrelevant to the loss claimed. However, with the law as it currently stands, policyholders are at the mercy of their insurer as to which approach is taken, and insurers are increasingly accepting that this situation is unfair.
- 14.4 Direct Line Group recognised that reform is “necessary to bring clarity and consistency between the law and common practice”, emphasising the need to ensure that “any reform is balanced and protects the interests of both parties”. RSA also thought that the current law did not reflect “prudent commercial practice” or what “commercial customers expect from RSA when they insure with us”.

¹ See for example, B Soyer “Reforming Insurance Warranties – are we finally moving forward?” in B Soyer (ed) *Reforming Marine & Commercial Insurance Law* (2008), p 127; A Longmore, “Good Faith and Breach of Warranty: Are We Moving Forwards or Backwards?” (2004) *Lloyd's Maritime and Commercial Law Quarterly* p 158. See also the National Consumer Council, *Insurance Law Reform: the consumer case for review of insurance law* (May 1997). And see K G C Reid and R Zimmermann (eds), *A History of Private Law in Scotland* (2000), vol 2, pp 360 to 361 contributed by A D M Forte.

² Insurance Law: Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 6.9(a).

³ Insurance Law: Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 6.9(b).

⁴ It should be noted that the general Scots law of contract does not distinguish contract terms into “conditions” and “warranties”, with termination available only for breach of the former. In Scots law breach of a warranty may justify termination if sufficiently material.

PROBLEMS IN PRACTICE

- 14.5 Although warranties do not cause as many problems as the duty of disclosure, they are still a common cause of dispute. Mactavish⁵ found that insurance warranties are the third most common ground for claims disputes.⁶ This follows their 2011 report which found that insurance buyers in mid-sized firms, turning over between £50 million and £5 billion, often failed to understand “key legal terms such as warranties and their implications when it comes to policy coverage”.⁷
- 14.6 In May 2013, Airmic, the risk managers association, carried out a survey in which 129 members took part. A third mentioned warranties and basis of the contract clauses as matters which caused concern for corporate insurance buyers.⁸

THE INTERNATIONAL CONTEXT

- 14.7 In CP3, we said that from an international perspective the UK law on warranties seems unbalanced, tending to favour the insurer over the policyholder.⁹ In the common law world, most jurisdictions have moved away from the UK approach. Although both Australia and New Zealand originally adopted statutory law equivalents to the Marine Insurance Act 1906 (the 1906 Act), both have now enacted reforms. In Canada, the Supreme Court has limited the effect of a breach of warranty to situations where the breach is material to the particular type of loss.¹⁰ In the USA, insurance law is left to individual states and many have introduced statutory reform. We looked particularly at New York law, under which a breach of warranty will only avoid an insurance contract if it would materially increase the risk of loss.

⁵ Mactavish is a research and advisory group specialising in insurance.

⁶ Summary of recent Mactavish evidence, presented by Mactavish to the Law Commission during the consultation process in January 2014.

⁷ Corporate Risk & Insurance – The Case for Placement Reform. The Mactavish Protocols (2011) at p 12.

⁸ Airmic News, “Losing claims through innocent non-disclosure is the top concern for corporate insurance buyers”, 1 July 2013.

⁹ See Part 13 of CP3 for a fuller discussion of comparative law.

¹⁰ See *Century Insurance Company of Canada v Case Existological Laboratories Ltd (The Bamcell II)* [1984] 1 Western Weekly Reports 97.

- 14.8 From a civil law perspective, the idea that an insurer is discharged from liability for all risks where there has been an unconnected breach of warranty seems particularly strange. Trine-Lise Wilhelmsen, a Professor at the Scandinavian Institute of Maritime Law, commented that in the civil law world, the common law concept of a warranty in an insurance contract is “hard to understand and even harder to explain”. Although the words may seem “deceptively simple”, the consequences lack “logical reason” and cannot be explained in terms of either legal fairness or economic efficiency.¹¹ John Hare, Professor of Shipping Law at the University of Cape Town, described the Anglo-American marine insurance warranty as “a prodigal aberration from the European *ius communis* of marine insurance”.¹²

BASIS OF THE CONTRACT CLAUSES

- 14.9 Judges have been particularly critical of basis of the contract clauses. The 1980 Law Commission Report quoted judicial criticisms of such clauses dating from 1853.¹³ In 1908, Lord Justice Fletcher Moulton said he wished he could “adequately warn the public against such practices”.¹⁴ In 1927, Lord Wrenbury said:

Here, upon purely technical grounds, [the insurers], having in point of fact not been deceived in any material particular, avail themselves of what seems to me the contemptible defence that although they have taken the premiums, they are protected from paying.¹⁵

- 14.10 Although consumers are now protected against basis of the contract clauses as a result of the Consumer Insurance (Disclosure and Representations) Act 2012, such clauses remain a problem for non-consumer policyholders. As we have seen, in 2013, the Court of Appeal upheld a basis of the contract clause and confirmed that insurers were discharged from liability for any error, material or immaterial.¹⁶

SUPPORT FOR REFORM

- 14.11 In CP3 we asked whether consultees agreed that there is a need to reform the law of warranties as set out in sections 33 to 34 of the 1906 Act. Overall there was strong support for reform. Of 41 respondents to this question, 36 (88%) agreed. Two consultees (5%) disagreed and three (7%) marked “other”.

¹¹ Duty of Disclosure, Duty of Good Faith, Alternation of Risk and Warranties: An Analysis of the Replies to the CMI Questionnaire, CMI Yearbook 2000, p 392 and 409.

¹² J Hare, *The Omnipotent Warranty: England v The World*, paper presented at International Marine Insurance Conference, November 1999, available at: <http://web.uct.ac.za/depts/shiplaw/imic99.htm>.

¹³ Insurance Law: Non-Disclosure and Breach of Warranty (1980) Law Com No 104, para 7.2, referring to *Anderson v Fitzgerald* (1853) 4 HL Cases 484, 10 ER 551.

¹⁴ *Joel v Law Union and Crown Insurance Co* [1908] 2 KB 863, at 885.

¹⁵ *Glicksman v Lancashire and General Assurance Co Ltd* [1927] AC 139. See also *Mackay v London General Insurance Co Ltd* [1935] 51 Lloyd's Law Report 201 and *Provincial Insurance Co Ltd v Morgan* [1933] AC 240 at 250.

¹⁶ *Genesis Housing Association Ltd v Liberty Syndicate Management Ltd for and on behalf of Liberty Syndicate* 4472 at Lloyd's [2013] EWCA Civ 1173, [2013] WLR (D) 368.

- 14.12 K&L Gates LLP “fully agreed with the Law Commission regarding the need to reform this archaic and imbalanced area of law”. The Judges of the Court of Session thought that the “law is currently biased too far in favour of the interests of insurers. There is a clear need for reform”. In a similar vein, the Financial Ombudsman Service (FOS) said that “the proposals put forward by the consultation would bring the law more in line with our own approach”.
- 14.13 The Association of British Insurers (ABI) thought that reform relating to the consequences of a breach of warranty was necessary, but maintained that “in business insurance the guiding principle should be freedom of contract”. They argued that provided an insured was properly informed, the circumstances in which an insurer would not have to pay a claim could be extended or limited by contract.
- 14.14 Airmic members have been “overwhelmingly in favour” of reform in this area, and indeed are already looking to make changes in industry practice. In November 2013, Airmic published a practical guide to warranties for its members entitled “*Warranties in Insurance Policies*”.¹⁷ In this guide, Airmic has suggested that its members seek to address the inclusion of warranties in their policies immediately. The guide states:
- Airmic believes that the proposal to amend warranties to become suspensive conditions is one that should be put into practice immediately and in advance of any change in the law.¹⁸
- 14.15 Airmic advised its members to review their existing insurance policies and discuss options with their insurance broker and negotiate with their underwriter. Airmic also included sample endorsements regarding (1) the removal of all warranties (2) rendering warranties suspensory and (3) disapplying basis of the contract clauses. A number of insurers, including AXA and ACE, have already pledged to remove basis of the contract clauses from their policies.¹⁹
- 14.16 The success of this market-led protocol remains to be seen. It is certainly a positive start, but without the support of the law it still relies on insurers’ goodwill or the relative bargaining power of the parties in a particular situation.

THE OPPOSING ARGUMENTS

- 14.17 A small number of consultees argued that warranties, with automatic discharge of liability upon breach, were a necessary feature of insurance contracts.

¹⁷ Airmic, “Warranties in Insurance Policies” (2013).

¹⁸ Above, p 7.

¹⁹ Commercial Risk Europe, “Second leading insurer removes basis clauses from UK contracts”, 4 July 2013.

14.18 One argument for the current law is that an insurer must be able to understand the exact risk it has agreed to cover, and should not have to continue to provide cover if there is an inaccuracy. When an insured is in breach of a warranty, the consequences of that breach follow naturally since the insurer had never agreed to accept a risk other than that defined (in part) by the warranties.²⁰ We would reply, however, that this view is not accepted in most other jurisdictions.

14.19 Several consultees argued that insurers should not be required to provide cover for the sort of policyholder who breached warranties. The Forum of Insurance Lawyers (FOIL) put this very clearly:

A company which accepts a warranty in its insurance policy to inspect its sprinkler system is accepting a responsibility it is under a contractual obligation to meet. If it fails to meet that obligation it gives an indication that this is not a well-run organisation mindful of the need to reduce risk. What other basic precautions are being ignored?

14.20 We think this argument is rather aspirational. The reality is that people and organisations are fallible, and that insurance is often purchased to protect against human error. If only perfect businesses were able to buy insurance, the market for insurance would be a small one.

14.21 The automatic discharge of an insurer's liability upon breach of warranty gives insurers far greater rights than parties to other commercial contracts, and in many situations the extent of the remedy will over-compensate the insurer. However, the main issue is that these consequences flow automatically from the fact that a term is an "insurance warranty". Use of the word "warranty" in insurance contracts is prolific, and yet poorly understood by parties on all sides of the market. Even parties who read the terms of the policy thoroughly may not realise the gravity of a breach of warranty.

14.22 We are not preventing insurers from including conditions which are so fundamental that breach by the insured should discharge the insurer from all liability. However, where this is the case, the insurer should ensure that the consequences of breach are set out fully in the contract, and should take sufficient steps to draw the insured's attention to it.

REASONS FOR REJECTING A CAUSAL CONNECTION TEST

14.23 There have been many previous proposals for reform. In 1980, the Law Commission proposed that the insurer should be required to pay the claim if the policyholder could show that "the breach would not have increased the risk that the loss would occur in the way in which it did". In 2007, we formulated a similar test: that the policyholder should be entitled to have their claim paid if they could prove on a balance of probability that the event or circumstances constituting the breach of warranty did not contribute to the loss.

²⁰ For a helpful exposition of this analysis, see H Bennett, "Reflections on Values: The Law Commissions' proposals with respect to remedies for breach of promissory warranty and pre-formation non-disclosure and misrepresentation in commercial insurance", in B Soyer (ed) *Reforming Marine and Commercial Insurance Law* (2008).

- 14.24 This proposal was criticised on the basis of increased investigation costs, complex litigation, uncertain outcomes and difficulties of proof. It was also pointed out that a causation test would not be appropriate for all warranties, since some may be relevant to the loss without having a causal connection with it. For example, a past claim does not cause (or even contribute to) a future claim, but it may be highly relevant to the insurer's assessment of the likelihood of future claims. Similarly, the fact that an employee has past criminal convictions does not "cause" future misdemeanours, but it is a highly relevant consideration.
- 14.25 Another example would be where the policyholder warrants that "all drivers will be over 21". Again, it may be possible to show for a particular accident that the age of the driver was not a contributory cause, but we do not think that insurers should remain liable for claims arising when the vehicle is driven by a person under 21.
- 14.26 In CP3 we looked at the experience in New Zealand, where a causal connection test was introduced by section 11 of the Insurance Law Reform Act 1977.²¹ The New Zealand Law Reform Commission looked at difficulties with this provision. It recommended that the causation test should not apply to a list of terms, including terms which define the age, identity or experience of a driver or the geographical area in which a loss must be incurred.
- 14.27 On the basis of these criticisms, we are no longer proposing a causation based approach. CP3 proposed an alternative policy which we now intend to pursue. We provide an overview of our recommendations in the next chapter.

CONCLUSION: THE NEED FOR STATUTORY REFORM

- 14.28 We think that there is a strong argument to reform the law of insurance warranties, so as to create a default regime which meets the expectations of an international market place. As the law of insurance warranties is codified in the 1906 Act, primary legislation is required to change it.
- 14.29 The courts can and do use interpretative principles to evade the harshness of the law and to do justice in individual cases. We have been told that this discourages insurers from taking purely technical points or attempting to use warranties in a wholly unreasonable way. The problem is that where the outcome of a case is dependent on the courts' interpretation or an insurer's discretion, inconsistencies creep in. The very fact that the courts do not appear to want to apply the law in a consistent and technical manner suggests that there is a problem with the law as it stands

²¹ CP3, paras 13.3 to 13.9.

CHAPTER 15

OVERVIEW OF RECOMMENDATIONS

- 15.1 In this chapter we give an overview of our key recommendations, discussed in more detail in the following chapters. We also note matters which our recommendations do not cover.

AN OUTLINE OF THE KEY RECOMMENDATIONS

“Basis of the contract” clauses to be of no effect

- 15.2 These clauses convert even minor representations that an insured has made at placement into warranties and allow the insurer to avoid paying out if it turns out any of them are or have become untrue. We recommend that basis of the contract clauses should be of no effect.
- 15.3 Instead, insurers will be protected in two ways. Where a policyholder makes a material misrepresentation before entering into a contract of insurance, this will be a breach of the duty of fair presentation, as set out in Part 2 of this Report. If insurers wish to have greater rights to refuse claims, they may still use warranties of past or present fact, but they should be included specifically in the contract.
- 15.4 Our recommendation applies to non-consumer insurance policies. Basis of the contract clauses in consumer insurance contracts were abolished by the Consumer Insurance (Disclosure and Representations) Act 2012.

Breaches of warranty may be remedied

- 15.5 Breach of warranty currently leads to an automatic discharge of the insurer’s liability from that point. We recommend that, instead, the insurer’s liability should be suspended rather than discharged in the event of breach, and that liability could be restored if the breach of warranty is remedied. Where the breach is remedied before a loss, the insurer should pay the claim. Where loss occurs, or is attributable to something happening, after a breach but before remedy, the insurer should not be liable for that loss. There was strong support for this proposal: of 42 consultees who responded to the question, 33 (79%) agreed with our proposals.
- 15.6 Several consultees pointed out that some breaches of warranty could not be remedied. We agree. In these cases, liability should remain suspended, as occurs where a breach could be remedied but has not been.
- 15.7 We discuss how and when a breach of warranty may be remedied in Chapter 17.

Terms relevant to particular losses affect only that type of loss

- 15.8 This recommendation focuses on warranties and other terms which are designed to reduce the risk of a particular type of loss, or the risk of loss at a particular time or in a particular place.

- 15.9 We recommend that the insurer's remedy for breach of such a term should be that it is not liable to pay claims in respect of losses caused by that category of risk. Thus the breach of a warranty to install a burglar alarm would suspend liability for loss caused by an intruder but not for flood loss. Similarly, a failure to employ a night watchman would suspend the insurer's liability for losses at night but not for losses during the day. This proposal is not confined to traditional warranties, and would apply to any contract term designed to reduce particular risks.

Contracting out

- 15.10 For consumer insurance, we propose a compulsory regime, so that an insurer could not use a contract term to put the consumer in a worse position than they would be in under the draft Bill.
- 15.11 In non-consumer insurance, however, the parties would generally be free to make alternative arrangements in their contracts. We are not preventing insurers from including conditions which are so fundamental that breach by the insured should discharge the insurer from all liability. However, where this is the case, the insurer should ensure that the consequences of breach are set out fully in the term, and should draw the insured's attention to it.
- 15.12 Parties should not be able to contract out of the prohibition on basis of the contract clauses. By this, we mean that the parties should not be able to agree to convert statements into warranties by use of a basis of the contract clause (or any other form of generic wording). On the other hand, the parties *may* agree to include specific warranties relating to the same issues as the statements on the proposal form, provided that they are explicitly set out in the contract.

ISSUES NOT COVERED

Definition of warranty

- 15.13 There is currently a statutory definition of a warranty in the Marine Insurance Act 1906 (the 1906 Act) and a parallel common law definition for non-marine insurance. However, as discussed in Chapter 13, the courts have reached some surprising and contradictory results in applying these definitions, in order to avoid the harsh consequences of the law of warranties. Previous attempts at reforming the law of warranties have run into difficulties because of the problems in identifying and defining "warranty".¹
- 15.14 For the purposes of this reform, we do not propose to formulate a definition of "warranty" beyond that which already exists. Our intention is that the new remedy for breach of warranty will apply to any term which is currently a warranty under the existing law. Following our reforms, the distinction between a warranty and a suspensory provision will not be significant as both types of term will be treated in the same way.

¹ Insurance Law: Non-Disclosure and Breach of Warranty (1980) Law Com No 104.

15.15 Nor would a definition of warranty affect our recommendation relating to terms designed to reduce the risk of a particular type of loss. This recommendation would apply to some (but not all) warranties, and may also apply to other terms, such as conditions precedent.

Requirement for writing

15.16 In marine insurance, there must be a written policy. Section 22 of the 1906 Act provides that “a contract of marine insurance is inadmissible in evidence unless it is embodied in a marine policy”.

15.17 Section 35 of the 1906 Act then states at subsection (2):

An express warranty must be included in, or written upon, the policy, or must be contained in some document incorporated by reference into the policy.

15.18 These provisions apply only to marine insurance and not other forms of insurance.

15.19 In Consultation Paper 2 (CP2), we proposed that section 22 of the 1906 Act should be repealed because the basis for its existence (to prevent stamp duty evasion by requiring a physical policy to be stamped) has been abolished.² We said that there should be no statutory requirement for marine insurance to be in any particular form and, although it is desirable to put contract terms in writing, this should be a matter for the industry.

15.20 In Consultation Paper 3 (CP3), we said that our position was the same in relation to warranties. Although it is clearly desirable that particularly important or draconian terms should be in writing, we said there was no longer any reason for singling out warranties in statute as particularly draconian. In consumer insurance, insurers must comply with the Financial Conduct Authority (FCA) rules on key facts documents. We noted that, in non-consumer insurance, insurers already put warranties in writing and we expect this to continue.

15.21 Under our proposals, the difference between warranties and other types of clause restricting the insurer’s liability would be narrowed. On that basis, we suggested that there was no reason to have a requirement that warranties be in writing if we do not have this requirement for other terms. We asked whether consultees agreed that there was no need for an express requirement that, in order to take effect, a warranty must be in writing.

15.22 Responses were divided. It was clear that respondents thought that warranties should be in writing, but less clear whether they thought a statutory provision was required. We think that, in reality, parties will always put onerous provisions like warranties in writing. We do not recommend repealing section 35(2) for marine insurance, but we do not think that it should be extended to other types of insurance.

² CP2, Part 17.

No need for a statutory right to cancel

- 15.23 In 2007 we proposed that where the policyholder has breached a warranty, the insurer should have a statutory right to cancel the contract by giving reasonable notice, and returning premiums on a pro-rata basis. Respondents to that consultation felt that such a right was of limited use. It was pointed out that policies often include a contractual right to cancel. A statutory right to cancel may be overly complex, especially if it included provision for reasonable notice and pro-rata repayment, as we provisionally concluded that it should.
- 15.24 In CP3, we therefore suggested that the insurer's right to cancel the contract following a breach of warranty by a policyholder should be contractual rather than statutory. All consultees agreed that the insurer's rights to cancel should be governed by the terms of the contract and we do not recommend a statutory right to cancel.

REINSURANCE

- 15.25 In CP3, we proposed that our reforms should apply to reinsurance in exactly the same way as to primary insurance contracts. We anticipated that many reinsurers would want to negotiate bespoke remedies for breaches of warranty, but where they did not do so we thought our regime should apply by default. 97% agreed. RSA said that:

In order to maintain the alignment between direct insurance and reinsurance we believe that it is correct that the proposed default regime in respect of a breach of warranty should apply equally to both.

- 15.26 We do not believe there is any need to make specific allowances for reinsurance contracts which will fall within the general rules for non-consumer insurance contracts.

CHAPTER 16

DETAILED RECOMMENDATIONS: BASIS OF THE CONTRACT CLAUSES

- 16.1 At present, in non-consumer insurance, it is common for proposal forms to include declarations that the answers given “form the basis of the contract”. This has the effect of converting all the answers given into warranties. If even a minor point turns out to be, or becomes, untrue, the insurer is discharged from all liability under the insurance contract. Unlike a failure to disclose information or a misrepresentation, the insurer is not required to show that warranted matters are material or induced it to enter into the contract. In this chapter we recommend that basis of the contract clauses should be of no effect, so that more explicit wording must be used before a warranty is created.

AN ONGOING PROBLEM

- 16.2 The problems with such clauses are obvious. Few policyholders – from small companies to sophisticated insurance buyers advised by expert brokers – understand the significance of signing a statement that their answers were “warranted” or that they formed “the basis of the contract”. Nor is it clear why insurers should be permitted to refuse claims because of trivial or immaterial mistakes on application forms.
- 16.3 The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) gave effect to the Law Commissions’ recommendations that basis of the contract clauses should be of no effect in consumer insurance contracts.¹
- 16.4 As we have discussed, judges are highly critical of these clauses, and a number of insurers have pledged to remove them from their standard form contracts.² However, such clauses remain a problem for non-consumer policyholders. Anecdotal evidence from Mactavish suggests that they remain prevalent in all forms of non-consumer insurance contracts. In 1996, the Court of Session upheld such a clause against a small business.³ In a recent case, *Genesis Housing Association Ltd v Liberty Syndicate Management Ltd*,⁴ the Court of Appeal confirmed that in business insurance, where a basis of the contract clause was in place, an insurer may refuse a claim for any inaccuracy on a proposal form and such inaccuracy could not be dismissed as “immaterial”.

¹ Report on Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (December 2009) Law Com No 319; Scot Law Com No 219 and s 6 of CIDRA.

² From para 14.9 above.

³ *Unipac (Scotland) Ltd v Aegon Insurance Co (UK) Ltd* 1996 SLT 1197.

⁴ *Genesis Housing Association Ltd v Liberty Syndicate Management Ltd for and on behalf of Liberty Syndicate* 4472 at Lloyd’s [2013] EWCA Civ 1173, [2013] WLR (D) 368.

16.5 In CP3, we argued that basis of the contract clauses should be abolished for business insurance, as they had been abolished for consumer insurance. We proposed that a term in a proposal form, contract or accompanying document which states that the policyholder warrants the accuracy of the answers given or that the answers form the basis of the contract should be of no effect. We thought that if the insurer wished to include specific warranties about matters covered in the proposal form, those matters should be spelled out in the policy.

16.6 Abolishing basis of the contract clauses was a popular proposal. Most consultees agreed that it should not be possible for an insurer to use a contract term to convert the answers in a proposal form into warranties. The Law Society of Scotland said:

It is clauses such as these that give rise to the impression that insurers can avoid liability for an insured risk at their discretion.

16.7 The Lloyd's Market Association (LMA) also gave their support:

Blanket "basis of the contract clauses" in commercial contracts, i.e. that all representations in the disclosure material be converted to warranties and incorporated into the contract of insurance, should be of no effect.

16.8 Clause 9 in the draft Bill addresses this recommendation. It mirrors section 6 of CIDRA, which prevents insurers from using basis of the contract clauses in the consumer context.

16.9 Clause 9 states:

Warranties and representations

- (1) This section applies to representations made by the insured in connection with –
 - (a) a proposed non-consumer insurance contract, or
 - (b) a proposed variation to a non-consumer insurance contract.
- (2) Such a representation is not capable of being converted into a warranty by means of any provision of the non-consumer insurance contract (or of the terms of the variation), or of any other contract (and whether by declaring the representation to form the basis of the contract or otherwise).

16.10 The "representations" made by the insured may include specific answers given on a proposal form, and any information compiled by the insured or their broker in support of their proposal as part of their pre-contractual obligations. The clause prevents the insurer using a contract term or other device, either on the proposal form or in the policy document, to convert those representations into warranties.

16.11 It remains possible for insurers to include specific warranties within their policies. These warranties may deal with issues that are also covered by questions on the proposal form, or other disclosed information.

Contracting out

- 16.12 Clauses 17(1) and 17(2)(a) of the draft Bill provide that an insurer may not use a contract term to put the non-consumer policyholder in a worse position than they would be in under clause 9. That is, the insurer cannot reinstate the effect of a basis of the contract clause.
- 16.13 This would not prevent insurers from including a warranty which mirrors the content of an answer on the proposal form. For example, if the policyholder states that a property is built of brick and slate, nothing would prevent the policy including the term “warranted: property built of brick and slate”.

RECOMMENDATIONS

Recommendation 22: Basis of the contract clauses in non-consumer insurance contracts should be of no effect. Representations should not be capable of being converted into warranties by means of a policy term or statement on the proposal form.⁵

Recommendation 23: This proposed reform should not be capable of being avoided by the use of a contract term.

⁵ See draft Bill, clause 9.

CHAPTER 17

DETAILED RECOMMENDATIONS: WHERE THE BREACH OF WARRANTY IS REMEDIED

- 17.1 As discussed in Chapter 13, the current law provides that the insurer is discharged from all liability when a warranty is breached. We think this automatic discharge operates unfairly in many cases. It leaves policyholders with no effective insurance, even though a breach of warranty may have been minor and may have been remedied before any loss took place.
- 17.2 In this chapter we recommend that the insurer's liability should be suspended from the point of breach, rather than discharged altogether. The insurer's liability under the contract of insurance should reattach once the breach has been remedied.

SUPPORT FOR THE PROPOSAL

- 17.3 In Consultation Paper 3 (CP3),¹ we argued that, where a breach of warranty has been remedied, it is unjust to allow the insurer to escape liability in respect of loss suffered after such remedy. We therefore proposed that:

- (1) the insurer's liability should be suspended from the point of breach, rather than discharged; and
- (2) liability should be restored if and when the policyholder remedies the breach.

- 17.4 We had strong support from consultees on our proposals regarding the remedies that should follow from a breach of warranty. 79% of consultees agreed with the first proposition, and 76% with the second. The Lloyd's Market Association (LMA) was "sympathetic", and the Association of British Insurers (ABI) agreed:

Some warranties should be treated as suspensive conditions so that a breach of such a warranty would suspend the insurer's liability for the duration of the breach rather than discharge it.

- 17.5 In his response to CP3, Professor Howard Bennett analysed the problem theoretically in terms of attachment of risk, and concluded that "there is no logical reason why the discharge of liability triggered by a breach of warranty need be permanent; there is no logical reason why it should be impossible to cure a breach of warranty".

¹ Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012).

- 17.6 Professor Baris Soyer commented that the proposal “is not likely to create any serious difficulty”.² We think that the reform would encourage compliance. Policyholders would be more inclined to remedy problems if they knew that the effect would be to restore cover.
- 17.7 The idea of suspending the insurer’s liability is by no means new. Several other jurisdictions treat warranties as suspensive terms. In CP3, we referred to several US cases where a suspension and restoration model is already used in respect of warranties.³ In the UK, some parties have themselves inserted terms in policies to the effect that breach of warranty will have only a suspensive effect.⁴

THE APPROACH OF THE COURTS

- 17.8 As discussed above in Chapter 13, the English courts have often found that a term, though expressed to be a warranty, is in fact a suspensory provision.⁵ That is, for the period during which the insured is in breach of the term, insurance cover is suspended. If that breach is later remedied, cover is restored.
- 17.9 In *Kler Knitwear Ltd v Lombard General Insurance Co Ltd*,⁶ an alarm inspection warranty was held to be a “suspensive condition”. Mr Justice Morland said:
- The facts that the clause is entitled "warranty" and contains the phrase "it is warranted that" are some indication that the parties intended that the clause be a warranty in the true sense of the word. Such words are frequently used in insurance policies and used in a wide variety of senses.⁷
- 17.10 Rather than the language, what had to be considered was the substance of the term. Mr Justice Morland suggested it would “be utterly absurd and make no rational business sense” if the term had the conventional effect of a warranty.⁸ He said the absurdity was evidence that the plain words of the contract were not indicative of the parties’ intentions when forming the contract, and therefore that a different construction of the words ought to apply. Since the parties could not have intended the consequences of a warranty to apply, then liability could be restored when inspection took place.

² B Soyer, “Reforming Insurance Warranties – are we finally moving forward?” in B Soyer (ed) *Reforming Marine and Commercial Insurance Law* (2008), p 127.

³ CP3, from para 13.24. See Part 13 generally for comparative law.

⁴ See *Martin Maritime Ltd v Provident Capital Indemnity Fund Ltd (The Lydia Flag)* [1998] 2 Lloyd’s Rep 652.

⁵ See B Soyer, *Warranties in Marine Insurance* (2nd ed 2006), from para 2.79.

⁶ [2000] Lloyd’s Rep IR 47.

⁷ Above, at 49.

⁸ Above, at 50.

17.11 In *Roberts v Anglo-Saxon Insurance Association Ltd*,⁹ Lord Justice Banks discussed terms which were “descriptive of the risk” as setting the boundaries of what the insurer would cover. When something was within those boundaries, the insurer’s liability attached, and when it was not, it did not. Unlike breach of a “true warranty”, the insurer’s liability is not discharged and can reattach as soon as the conditions are satisfied.

17.12 However, we think that it is more appropriate to make a change to the law in order to provide for a suspensive effect, rather than to rely on the courts to manipulate the wording of insurance contracts in order to achieve a policy aim.

THE THREE ELEMENTS OF THE RECOMMENDATION

17.13 Clause 10 of the draft Bill makes provision for our recommendations concerning the consequences following a breach of warranty by the insured.

17.14 There are three elements to our recommended reforms:

- (1) the existing remedy for breach of warranty (automatic discharge of the insurer’s liability) should be removed;
- (2) the insurer’s liability should be suspended from the point of breach of warranty; and
- (3) the insurer’s liability should reattach if and when a breach of warranty has been remedied.

17.15 We discuss each of these elements below. There are also provisions in the Marine Insurance Act 1906 which provide for excused non-compliance. These are mirrored in the draft Bill and are discussed below from paragraph 17.64.

BREACH OF WARRANTY NOT TO DISCHARGE THE INSURER’S LIABILITY

17.16 Section 33(3) of the 1906 Act currently provides that breach of warranty discharges the insurer’s liability. The common law reflects this for non-marine insurance.

17.17 Clause 10 of the draft Bill therefore removes the insurer’s existing remedy for breach of warranty in two ways:

- (1) clause 10(1) removes any rule of (common) law to the effect that breach of warranty (whether express or implied) discharges the insurer’s liability; and,
- (2) clause 10(7)(a) removes the corresponding statutory provision by deleting the second sentence of section 33(3) of the 1906 Act.

17.18 These provisions ensure that there is no longer any term of an insurance contract which has the same effect as a present-day warranty (that is, an automatic discharge of liability following breach) by virtue of a rule of law.

⁹ *Roberts v Anglo-Saxon Insurance Association Ltd* (1927) 27 Lloyd’s Rep 313 (referred to above at paragraph 13.4).

- 17.19 As well as removing discharge as the remedy for breach, it is also important that our draft Bill allows for the possibility of remedying a breach of warranty. Section 34(2) of the 1906 Act currently provides that an insured cannot avail himself of the defence that a breach of warranty has been remedied, and the warranty complied with, before loss. Clause 10(7)(b) of the draft Bill deletes the whole of section 34, including subsection (2).

BREACH OF WARRANTY TO SUSPEND THE INSURER'S LIABILITY

- 17.20 Our recommended reform to the law of insurance warranties is included in clause 10(2) of the draft Bill.

- 17.21 It provides that:

an insurer has no liability under a contract of insurance in respect of any loss occurring, or attributable to something happening, after a warranty (express or implied) in the contract has been breached but before the breach has been remedied.¹⁰

- 17.22 Whether or not a term has been breached is already a matter which parties and the courts are used to addressing. The courts also need to identify the point at which breach took place, and hence the point from which liability was discharged. We do not make any recommendations in this regard.

Clause 10(2) in detail

- 17.23 Clause 10(2) provides that, after breach of warranty, the insurer will not be liable for:

- (1) losses occurring after a breach of warranty, but before it has been remedied; or
- (2) losses that are attributable to something happening during that period of breach.

- 17.24 The first of these categories of loss is fairly straightforward.

- 17.25 Professor Baris Soyer used a similar example of a ship sailing into a war zone.¹¹ The ship suffers some damage to its propellers while in the area but is lost only after it has sailed out of that zone. Our recommendations would mean that the insurer would not be liable for any loss sustained by the ship during the period in which it is in that area, because it is in breach of the warranty. As we discuss below, we think the breach is remedied when the ship leaves the war zone.

- 17.26 The second category of loss requires further explanation. The concept of loss "attributable to something happening" caters for situations where a loss-causing event happens during a period of suspension, but the loss is not actually suffered until after the breach has been "remedied".

¹⁰ Clause 10(2) is said to be "subject to section 11" on which see Chapter 18 below.

¹¹ In his lecture, "Reforming Warranties in Business Insurance Contract Law", given at the 25 April 2013 Symposium held at the Association of British Insurers, London on the Law Commissions' proposals run by the Institute of International Shipping and Trade Law, Swansea University.

- 17.27 In Professor Soyer's example, the breach has been "remedied", in the sense that the vessel is no longer in the war zone. However, it seems clear that the policyholder should not be able to recover because the loss is attributable to an event which occurred while the ship was in the war zone.
- 17.28 Under clause 10(2), the damage to the ship is "attributable to something happening" while the warranty was being breached and before it was remedied, and therefore the insurer has no liability for it. The fact that the breach may have been remedied when the ship sailed out of the war zone is now immaterial.
- 17.29 We were given a further example illustrating a similar point. A policy insuring bottles of fine wine includes a warranty requiring the wine to be stored "horizontally in a cool cellar". In fact, the wine is initially stored upright in a warm room. The error is discovered, and the policyholder remedies the breach of warranty by placing the bottles into cool storage on their sides. However, as a result of the breach, the corks have dried out and shrunk, permanently increasing the risk that the wine will oxidise or otherwise deteriorate. Although the breach has been "remedied", the insurer would not be liable for the loss. This is because the loss was "attributable to something happening" during the period of breach.

REMEDYING A BREACH OF WARRANTY

- 17.30 In order to bring a period of suspension to an end, and therefore bring the insurer back on risk, the policyholder must remedy the breach. Whether and when a breach of warranty has been remedied are important questions.
- 17.31 Because of the conceptual difficulties inherent in these questions, the draft Bill sets out two situations in which a breach of warranty is taken to be remedied. The first situation addresses what we will call "general warranties" and the second addresses what we will call "time-specific warranties".

General warranties: when has a breach been remedied?

- 17.32 From a very literal perspective, many breaches of warranty can never be "remedied" in the sense of truly *fixed*. Consider the following example:

An insurance policy includes a warranty that the insured vessel will not travel through a certain strait, perhaps because of the risk of piracy. The ship passes through the strait without incident and emerges into safe waters.

- 17.33 By sailing out of the strait, the breach of warranty is not truly "remedied" because that breach still occurred. However, the policyholder is no longer in breach. We think the breach should be regarded as remedied for the purposes of clause 10.
- 17.34 This is provided for in clause 10(5)(b), which states that a breach of warranty is generally to be taken as remedied when the insured "ceases to be in breach of the warranty".

17.35 Continuing with the same example:

As a result of the shortcut through the strait, the vessel shaves two days off its journey. It then encounters a heavy storm and sustains damage. Had the ship taken a permitted course it would have been in a different position when the storm struck and would have avoided it altogether. The storm had not been predicted.

17.36 Our recommendations mean that the breach has been remedied and the insurer would be liable to pay the claim for storm damage. The ship that emerged from the strait represents the same risk as that which entered the strait and which the insurer had agreed to insure. It had not acquired any new characteristics. The storm was a freak occurrence which could equally have happened had the ship taken the approved course.

17.37 One analysis of warranties regards them primarily as tools which allow the insurer to define precisely the risk it is willing to underwrite.¹² That is, warranties can be viewed as risk control measures. When an insured is in breach of a warranty, the current legal consequences of that breach follow naturally (according to this theory), since the insurer had never agreed to accept a risk other than that defined (in part) by the warranties. However, where the risk is not altered following a remedy of a breach, we see no reason why the insurer should not be back on risk and liable for any loss after that point.

Murray v Scottish Automobile

17.38 We also considered an example using the facts of *Murray v Scottish Automobile and General Insurance Co.*¹³ In that case, a motor policy applied “only to a car for private personal use”. It also contained an exclusion clause in respect of losses sustained while the car was “let out for hire”. Only when the car was used for personal purposes would liability attach. When the car was used for hire purposes, it would not. In fact, the car was used almost exclusively for hire purposes. It was destroyed while parked overnight in a garage, having been let out for hire that day and most of the preceding days. The court held that the overnight parking was ancillary to the main (commercial) purpose to which the car was being put, and therefore that the loss was not covered.

¹² For a helpful exposition of this analysis see “Reflections on Values: The Law Commissions’ proposals with respect to remedies for breach of promissory warranty”, Professor Howard Bennett, in B Soyer (ed), *Reforming Marine and Commercial Insurance Law* (2008), p 155.

¹³ 1929 SC 48.

17.39 We think that our recommendations can be easily applied to this example. The fact that the car was not being let out for hire at the precise point of loss does not mean that the breach has been remedied. We wish to move the law to a more balanced position which gives the policyholder more protection than the law does at the moment. However, the insurer should not be required to pay policyholders who do not purchase the correct type of cover or who “play the system”. The overnight parking was incidental to the commercial use to which the vehicle was routinely being put, and therefore the insured had not ceased to be in breach. We think that the breach would only be “remedied” if its use for commercial purposes was stopped entirely, or at least reduced to a level where personal use dominated. Only then would the insured cease to be in breach of warranty. The broad functional test that the courts are already applying will also apply to clause 10.

Time-specific warranties

17.40 Some warranties are time-specific. Clause 10(6) describes them as warranties which must be complied with “by an ascertainable time”. This subsection applies where a warranty requires that by an ascertainable time—

(a) something is to be done, or not done,

(b) a condition is to be fulfilled, or

(c) something is, or is not, to be the case,

and that requirement is not complied with.

17.41 The clause is intended to catch breaches of warranties which include some sort of deadline. On a strict view, if a deadline is missed, that breach can never be remedied. The insured could never “cease to be in breach” because the critical time for compliance has passed.

17.42 The draft Bill includes a provision to rescue such warranties.

The risk becomes “essentially the same”

17.43 We think that breach of a time-specific warranty can be said to have been “functionally” remedied when the risk is restored to the state it would have been in had the breach not taken place.

17.44 For example, if an insured warrants that a fire alarm will be inspected every 30 days, but it is not in fact inspected until day 40 then, in a strict sense, the breach has not been “remedied” at the 40 day mark - the promise was not kept. However, the risk has been restored to the state in which the insurer accepted it: there is an alarm in place which has been inspected in the last 30 days. For 10 days, the state of affairs did not match that description, and so there can be no cover. However, at day 40 the actual state of affairs is brought back within the scope of the risk the insurer was willing to accept, and liability should be restored.

- 17.45 On this analysis, we think that the case of *De Hahn*¹⁴ would be decided differently. Once the ship had left Liverpool with fewer than 50 hands, as a matter of logic the “breach” could not be truly remedied: the ship could not go back in time and leave again, this time with sufficient men aboard. However, when the ship picked up another six men in Anglesey, the risk became essentially that which the parties had originally agreed; that is, a vessel crewed with no fewer than 50 hands when it made a potentially dangerous voyage. During the six hours when the ship was shorthanded, the risk was outside the scope of the policy, and the insurer’s liability should have been suspended (indeed, the insurer would not yet have come on risk). When the additional hands came aboard, the risk was restored to the state in which the insurer was prepared to accept it, and the insurer’s liability ought also to be restored for losses suffered after that point.
- 17.46 We also considered the wine storage example again,¹⁵ but this time with a time-specific warranty. The warranty states that the wine must be stored horizontally in a cool cellar within one month of receipt. This does not occur. The error is discovered four months later and the wine is stored correctly thereafter, but not before the corks have been compromised. Although the wine is now stored in accordance with the warranty, the breach has not been truly “remedied”. This is because the wine is not “essentially the same” as that which the insurer agreed to insure. That is, the insurer did not agree to insure wine which has been permanently compromised. As the wine has not been returned to essentially the same risk, the insurer will not be liable.
- 17.47 The remedy of time-specific warranties is addressed in the draft Bill at clause 10(5)(a). This says that, where such a warranty is breached (that is, a deadline is missed), the breach is remedied:
- if the risk to which the warranty relates later becomes essentially the same as that originally contemplated by the parties.
- 17.48 We think that the correct approach to take when considering whether a time-specific warranty has been remedied is to look at the purpose for which the warranty was inserted in the contract and ask whether that purpose has been frustrated or whether, due to the actions taken to remedy the breach of warranty, the purpose is still in substance fulfilled and the risk profile is restored to that which the insurer accepted. As above, if warranties are risk control measures, then we see no reason why an insurer should have no liability if the risk is effectively that which it agreed to accept.

Breaches which are incapable of remedy

- 17.49 Some breaches of warranty are incapable of remedy. This is acknowledged in the draft Bill.¹⁶ For example, a warranty that a house is constructed from bricks and mortar cannot be remedied if the house is actually made of wood. Similarly, a warranty relating to a duty of confidentiality can never be remedied once confidentiality has been compromised.

¹⁴ (1786) 1 TR 343, discussed above at para 12.2.

¹⁵ See para 17.29 above.

¹⁶ See draft Bill, clause 10(4)(b).

- 17.50 Where the policyholder has given a warranty as to past or present fact (as opposed to a continuing or “promissory” warranty), it is unlikely that a breach could ever be remedied if the representation was inaccurate. In many of these situations, the risk may never attach in the first place. In *The Good Luck*¹⁷ Lord Goff characterised insurance warranties as a species of condition precedent¹⁸ which could prevent insurance cover coming into existence where a condition was not complied with. In an example such as the confidentiality clause, the insurer’s liability will be indefinitely suspended after breach.

LOSSES BEFORE BREACH OR WHERE BREACH IS REMEDIED

- 17.51 Clause 10(4)(a) provides that the insurer is liable for losses occurring before the breach of warranty. This is the position under the current law and is not changed by our reforms.
- 17.52 Clause 10(4)(b) confirms that the insurer is also liable for losses after the breach of warranty has been remedied. This provision explicitly acknowledges that some warranties cannot be remedied, as we have discussed above. This was an important issue for many consultees.

OTHER CONSIDERATIONS CONCERNING CLAUSE 10

A single remedy in respect of all types of warranties

- 17.53 Clause 10 applies to warranties in insurance contracts. It applies whether a warranty is express or implied into a contract of insurance, and to all types of insurance contracts. It will therefore apply to the implied marine warranties in sections 39, 40 and 41 of the 1906 Act. The existing remedy for breach of those warranties (discharge of liability) is removed by virtue of clause 10(7), as discussed above.

Subject to section 11

- 17.54 Clause 10(2) is expressly stated to be subject to “section 11” of the draft Bill.
- 17.55 Where compliance with a warranty would tend to reduce the risk of loss of a particular type or at a particular time or place, under our recommendations in clause 11, the insurer’s liability for breach of the warranty would only be suspended in respect of losses of that type. For example, where there was a breach of a warranty designed to reduce the risk of damage caused by fire, the insurer’s liability under the contract would be suspended only in respect of fire losses. The insurance contract would continue to operate normally in all other ways. Multiple breaches of specific warranties could conceivably lead to several areas of liability being “carved out” of the policy, with the rest of the contract continuing to operate. These recommendations are discussed further in Chapter 18 below.

¹⁷ *Bank of Nova Scotia v Hellenic Mutual War Risks Association (Bermuda) Ltd (The Good Luck)* [1992] 1 AC 233 at 237 to 238.

¹⁸ See also the discussion of *De Hahn* (1786) 1 TR 343 above at paras 12.2 and 17.45, where warranties were described as conditions.

The status of an insurance contract during a period of suspension

- 17.56 Under our recommendations, a breach of warranty would suspend rather than discharge the insurer's liability under the contract. The contract would continue to operate normally in other ways. Even under the current law, there is no automatic termination or avoidance of the contract.¹⁹ The insurer will continue to be liable for losses occurring before the breach.
- 17.57 If the breach is not remedied, or indeed is irremediable, then the insurer's liability will remain in a state of suspension.

Liability for premium

- 17.58 As under the current law, the insured may remain liable to pay the premium after breach of warranty.²⁰ There is anecdotal evidence that insurers do not pursue premiums after breach of warranty for fear that taking payment will be seen by the courts as an implied waiver. However, the contract might include a cancellation clause entitling the insurer to cancel the policy and sue for any unpaid premium in the event of breach of warranty. Alternatively, it might provide that in the event of irremediable breach, cancellation or termination, the premium will be returned pro rata. These contractual arrangements already exist under the current law and would continue to be possible alongside our recommended reforms.
- 17.59 If a contract term allowed the insurer to terminate the contract if premium instalments were not kept up, the insured would need to continue making payments during a period of suspension in order to maintain the contract.

Contractual rather than a statutory right to cancel

- 17.60 It will still be open to the parties to include a term in the insurance contract providing for a right to cancel for breach of warranty, but we do not recommend a statutory cancellation right.
- 17.61 In 2007 we proposed that the insurer should have a statutory right to cancel for breach of warranty. Respondents to that consultation felt that such a right was of limited use. It was pointed out that policies often include a contractual right to cancel. A statutory right to cancel may also be overly complex, especially if it included provision for reasonable notice and pro-rata repayment, as we provisionally concluded that it should.
- 17.62 On further consideration, we suggested in CP3 that the matter is best left to the terms of the contract; consultees agreed unanimously.

¹⁹ See Lord Goff's comments in *The Good Luck* [1992] 1 AC 233, discussed above at para 13.12.

²⁰ In the case of a continuing warranty where the assured has breached a warranty during the currency of the insurance, the assured remains liable for the premium (including future instalments) despite the automatic discharge of liability (1906 Act, s 84). By contrast, where the assured has made a false statement as to present fact in the proposal form, the risk is prevented from ever attaching and therefore any premiums paid by the assured are recoverable by reason of total failure of consideration (s 84). See above at para 13.13.

17.63 The IUA said “this is best dealt with in the contractual terms.” Direct Line Group said that this accorded with current industry practice. Reynolds Porter Chamberlain LLP thought that a contractual right to cancel “allows greater flexibility to both insurer and insured; it also provides greater transparency as to the parties’ intentions.”

EXCUSED NON-COMPLIANCE AND WAIVER

17.64 As discussed above,²¹ section 33 of the 1906 Act provides that if a warranty is not “exactly complied with”, the insurer is discharged from liability from the time of breach. However, section 34 provides two instances where the breach of a warranty does not end the insurer’s liability for loss. They are:

- (1) in circumstances where, by change of circumstances, the warranty ceases to be applicable or compliance is rendered unlawful by subsequent law; and
- (2) where the insurer waives a breach of warranty.

17.65 Nearly all consultees agreed that these were helpful exclusions and should be retained.

17.66 Our draft Bill repeals section 34 (which only applies to marine insurance) and re-enacts these exceptions for all types of insurance.²² Clause 10(3) provides that clause 10(2) does not apply (that is, the insured’s liability is not suspended for breach of warranty) if:

- (a) because of a change of circumstances, the warranty ceases to be applicable;
- (b) compliance with the warranty is rendered unlawful; or
- (c) the insurer waives the breach of warranty.

17.67 Our recommendation that breach of warranty should no longer result in automatic discharge of the insurer’s liability means that the position in relation to waiver will be more intellectually coherent. There will no longer be an argument that waiver in this context must have the effect of waiving a dead contract back to life.²³

²¹ See above at paras 13.11 to 13.24.

²² See draft Bill, clauses 10(7)(b) and clause 10(3) respectively.

²³ See para 12.38 of CP3.

17.68 We think that, in these circumstances, breach of warranty could be waived by election or estoppel.²⁴ As we state above,²⁵ Scots law does not draw a distinction between waiver by election and waiver by estoppel equivalent to that in English law. Under Scots law, a party relying on the other party's abandonment of a right must demonstrate that it has conducted its affairs on the basis of the waiver – but it need not go so far as to show that it has suffered prejudice as a consequence of relying upon it.²⁶

CONTRACTING OUT

Consumer insurance

17.69 In line with our general approach for all our recommended reforms, the warranties provisions are intended to be mandatory for consumers. That is, the insurer will not be able to use a contractual term to put the consumer in a worse position than it would be in under our draft Bill. This is provided for in clause 16(1) of the draft Bill. This means, for example, that an insurer will not be able to provide that breach of warranty should have the effect of discharging its liability entirely.

Non-consumer insurance

17.70 Our recommendations in respect of warranties are only intended as a default regime for non-consumer insurance contracts. The parties should be free to agree an alternative arrangement between themselves in their contract, including providing that breach by the insured of certain fundamental terms leads to discharge of the insurer's liability. However, as we discuss in more detail in Chapter 29, we recommend two procedural requirements which must be satisfied if a provision putting the insured in a worse position is to have effect. They are:

- (1) the insurer must take sufficient steps to draw the term to the insured's attention before the contract is entered into,²⁷ and
- (2) the term must be clear and unambiguous as to its effect.²⁸

17.71 We think these requirements, discussed in more detail in Chapter 29, may be particularly important in the warranties context.

²⁴ As we discussed in CP3 at para 12.40, waiver by election is not currently possible in relation to breach of warranty.

²⁵ See para 13.23 above.

²⁶ *Armia Ltd v Daejan Developments Ltd* 1979 SC (HL) 56. Although the House of Lords referred to certain English authorities, it cautioned that the Scots law of personal bar should not be assumed to be the same as the English law of estoppel.

²⁷ See draft Bill, clause 18(2).

²⁸ See draft Bill, clause 18(3).

Other terms suspending, excluding or extinguishing liability

- 17.72 One of our main reasons for seeking to reform the law of warranties is that the consequences of breach are poorly understood: insureds and brokers appear to accept terms characterised as “warranties” without considering the draconian consequences that will follow from even a minor breach. Under our recommended reforms, “warranty” would retain a specific legal meaning within insurance law, with legally prescribed consequences attaching to it which are not spelled out in the term itself. However, the consequences will be less draconian than they currently are.
- 17.73 We do not intend to prevent parties from contracting for severe consequences where compliance with a particular term is fundamental to the bargain agreed by the parties and to the risk the insurer has agreed to take. It would remain open to insurers to insert terms in their policies which prevent liability attaching either temporarily or indefinitely in the event of breach of such a term.
- 17.74 However, even under the current law, the courts are reluctant to give effect to a term that purports to discharge liability without it being very clear that that is what the parties intended.²⁹ We would anticipate this interpretative attitude persisting under our recommendations. As we have seen, courts have re-categorised terms which appear to be “warranties” in order to avoid the harsh consequences. If our recommendations are enacted, courts might well start to find that onerous terms are warranties in order to reach the conclusion that liability is suspended rather than completely extinguished. Although it would be possible for an insurer to write a clearly worded term which would result in discharge of liability if breached (or which would prevent liability attaching if not complied with by a certain time), where there is ambiguity we would anticipate the term being treated in this way.
- 17.75 Whether or not such a term is referred to as a “warranty” in the contract, we think that insurers would be well advised to spell out the desired consequences of breach within the term itself and take sufficient steps to draw the term to the insured’s attention.

MARINE ISURANCE

Express warranties

- 17.76 We proposed in CP3 that our new rules for insurance warranties should apply to express warranties in marine insurance (covered by the 1906 Act) as well as to non-marine insurance (governed by common law which largely mirrors the 1906 Act). Nearly 90% of consultees agreed that our proposals should apply to warranties set out in marine insurance policies, largely on the basis that there was no reason to differentiate. Even though Lloyd’s Market Association (LMA) did not agree with all our proposals, it said:

if such rules are made, generally speaking we believe that insurance contract law should not differentiate between different classes of insurance business.

²⁹ See *Kler Knitwear Ltd v Lombard General Insurance Co Ltd* [2000] Lloyd’s IR 47.

17.77 As discussed above, clause 10 applies to all warranties in all contracts of insurance. Many of the existing warranties provisions in the 1906 Act are deleted or amended by our draft Bill. The new regime is designed to also apply to warranties in contracts of marine insurance.

Implied warranties

Implied warranties should be retained

17.78 The 1906 Act implies four warranties into marine insurance contracts: seaworthiness, portworthiness, cargoworthiness and legality.³⁰ In the absence of provisions to the contrary, these are implied into all marine insurance contracts by operation of law. We examined these at length in the 2007 Consultation Paper (CP1).³¹ In CP1 and in CP3, we asked whether implied marine warranties should be retained.³² Consultees' views were divided.

17.79 The LMA said "these remain important, are well understood, and should be retained. We are not aware of any problems in this area." The International Underwriting Association (IUA) described the implied marine warranties as "a useful comfort blanket underpinning the contractual provisions."

17.80 A substantial minority of consultees thought there was no reason to retain the implied warranties. It was said that if an insurer wished to impose a warranty then it should do so expressly.

17.81 However, there were no strong arguments in favour of their removal, we do not recommend any changes to the implied marine warranties.

Should breach of the implied warranties suspend the insurer's liability?

17.82 In CP3, we proposed that the implied marine warranties should operate in exactly the same way as express warranties. That is, the consequences of breach of the implied marine warranties should be consistent with breach of an express warranty, so that a breach would suspend the insurer's liability rather than automatically discharge it.

17.83 Most consultees agreed that there should be no distinction between the implied marine warranties and other warranties in this regard. The IUA said:

The arguments relating to the use of suspensive conditions is generally the same for both implied and express provisions – though the public policy arguments are even stronger for the implied provisions.

17.84 Clause 10 therefore applies to all warranties express and implied.

³⁰ See 1906 Act, ss 39, 40 and 41.

³¹ CP 1, para 8.116 and following.

³² CP 3, para 16.6 and following.

RECOMMENDATIONS

Recommendation 24: The existing remedy for breach of warranty (automatic discharge of the insurer's liability) should be removed. Instead, the insurer's liability should be suspended from the point of breach of warranty.

Recommendation 25: The insurer's liability should reattach if and when a breach of warranty has been remedied.

Recommendation 26: A breach of warranty should generally be regarded as remedied where the insured ceases to be in breach of it. For time-specific warranties which apply at or by an ascertainable time, a breach should be regarded as remedied if the risk to which the warranty relates later becomes essentially the same as that originally contemplated by the parties.

Recommendation 27: These recommendations should apply to express and implied warranties in marine insurance.

These recommendations are intended to be the mandatory regime for consumer insurance. In the non-consumer insurance context, these recommendations are intended to be a default scheme and are subject to our contracting out recommendations in Chapter 29.

CHAPTER 18

DETAILED RECOMMENDATIONS: TERMS RELEVANT TO PARTICULAR DESCRIPTIONS OF LOSS

- 18.1 As we discussed in Chapter 13, the consequences following a breach of warranty generally apply to the entirety of the insurer's liability under the contract.¹ Under the current law, the insurer's liability under the contract is discharged in full. This follows regardless of the nature of the warranty breached or the type of loss which may have been suffered, and even where the warranty breached had nothing to do with loss suffered.
- 18.2 This appears to be at odds with the purpose of warranties, which is said to be to manage risk. If a warranty is designed to reduce the risk of a particular type of loss occurring, then it should not have a bearing on the insurer's liability for a different type of loss.
- 18.3 In this chapter, we recommend that breach of a term which concerns a particular type of loss, or loss at a particular time or place, should only give the insurer a remedy in respect of that type of loss or loss at that time or place. These recommendations apply not just to warranties but potentially to all terms which seek to exclude or limit an insurer's liability.

AN OVERVIEW OF OUR POLICY

- 18.4 Some straightforward examples illustrate the point:
- (1) Breach of a term requiring a policyholder to have certain fire safety systems in place should result in suspension of the insurer's liability in respect of fire-related risks.
 - (2) Breach of a condition that a vessel in port must retain a night watchman would mean suspension of the insurer's liability for losses occurring while the watchman should have been present.
- 18.5 Importantly, a causal link between the breach and the ultimate loss is not required. Under our recommendations, the insurer would not be liable for any loss falling within the particular category with which the warranty or other condition is concerned.
- 18.6 Not all warranties, conditions precedent or similar terms are about particular risks. As we said in CP3, some address more general issues, for example those relating to a policyholder's criminal record. Some define the whole contract, such as terms restricting use of a vehicle or property to private rather than commercial use. These terms should not be affected by these recommended reforms. Nor should the recommendations affect terms which have no bearing on the risk of a loss, such as premium payment warranties.

¹ We also discussed the case of *Printpak v AGF Insurance Ltd* [1999] Lloyd's Rep IR 542 in which the court took a slightly different approach, but this was based on the construction of the particular contract.

18.7 The real mischief we are trying to address is reliance by insurers on breaches of irrelevant warranties. We do not think it is fair that an insurer can refuse a claim on the basis of the policyholder's breach of warranty or other condition in circumstances where those terms are clearly irrelevant to the loss – that is, where the type of loss which occurred is not one which compliance with the warranty or condition could have had any chance of preventing. The insurer might seek to rely on this type of “technical” get-out in order, for instance, to avoid having to prove a suspected fraudulent claim. This is not good practice and insurers tell us they do not frequently take such points.

18.8 We had strong support for these proposals. Airmic said its members were:

overwhelmingly in favour of the suggestion that in the event of a breach, the liability of the insurer should only be suspended in respect of that type of loss.

18.9 Direct Line Group was “supportive” of the proposal and said it would “bring the law into line with current practice.”

CLAUSE 11

18.10 These matters are addressed in clause 11 of the draft Bill. Clause 11 applies to any term of an insurance contract “compliance with which would tend to reduce the risk of”:

(a) loss of a particular kind,

(b) loss at a particular location; and/or

(c) loss at a particular time.²

18.11 Clause 11(2) provides that the insurer may not rely on breach of such a term in order to escape liability for loss of a different kind, or loss at a different location or time.

Compliance would “tend to reduce the risk”

18.12 When we set out these proposals in CP3, we talked about terms which were “designed” or “included” to reduce a particular type of loss. Consultees told us that it would often be difficult to show what a clause was designed or intended to do. Many insurers use standard form contract documents and therefore it is unlikely that evidence could be heard from the drafter, and insurers would be reluctant to enter into discussions about the general purpose of standard terms.

18.13 In addition, in reality, the intended purpose of these terms is to limit or exclude the insurer's liability for a particular type of loss (rather than to minimise the risk of that type of loss occurring in the first place).

18.14 Clause 11(1) therefore uses a more objective assessment, referring to clauses compliance with which would “tend to reduce” the risk of the occurrence of a particular type of loss.

² See draft Bill, clause 11(1).

18.15 This drafting is influenced by the New York code, which defines a “warranty” as:

any provision of an insurance contract which has the effect of requiring, as a condition precedent of the taking effect of such contract or as a condition precedent of the insurer's liability thereunder, the existence of a fact *which tends to diminish, or the non-existence of a fact which tends to increase, the risk of the occurrence of any loss, damage, or injury within the coverage of the contract*. The term "occurrence of loss, damage, or injury" includes the occurrence of death, disability, injury, or any other contingency insured against, and the term "risk" includes both physical and moral hazards. (emphasis added)

18.16 The consciously objective element is intended to allow the court to look at what the effect of compliance might generally be. Importantly, it 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.

18.17 Clause 11(1) makes clear that a term may relate to a particular type of loss *and* the occurrence of that kind of loss at a particular place or time.

Loss of a particular kind, or at a particular time or location

18.18 Our recommendations present contracting parties and courts with a new challenge. They will have to determine whether a term concerns loss of a particular kind or loss at a particular time or location, or whether it is designed to delimit the scope of the insurance contract more generally.

18.19 However, it is not a completely new issue. The courts already consider the purpose of particular terms in the course of their deliberations. For example, in *Amlin Corporate Member Limited & Ors v Oriental Assurance Corporation*, the judge noted when considering a warranty that:

The manifest object of the Warranty is to protect the reinsurers from liability arising from the grave danger of typhoons that can travel at varying speeds and in directions that cannot be reliably predicted.³

18.20 The real mischief this recommendation is designed to address is reliance on breach of blatantly irrelevant warranties in order to escape liability for an unconnected loss. We accept that there are many terms which do not go to the risk at all (such as terms relating to payment of the premium).

18.21 Others have a more general effect of defining the scope of the policy. Insurance is based on the insurer's ability to decide what risk to accept, and on what terms. The insurer must be in a position to calculate risks and to charge higher premiums on “riskier” risks, therefore keeping the premiums down in relation to low risk policies.

³ [2013] EWHC 2380 (Comm) at [34].

- 18.22 Taking vehicle insurance as an example, commercial vehicle policies will generally be subject to a higher premium than domestic use and this is widely accepted.⁴ In *Murray v Scottish Automobile and General Insurance Co*,⁵ a vehicle insured for pleasure use but regularly used commercially was damaged while parked overnight in the garage, between days of hire. The court found that the overnight parking was incidental to the commercial use and therefore there could be no liability.
- 18.23 It would frustrate the insurer's risk assessment process if a policyholder in this position could still recover for any loss not directly related to the commercial use. The use to which a vehicle is put goes more generally to the risk the insurer was prepared to take, rather than targeting particular types of loss which might occur.
- 18.24 Another example is a requirement in marine insurance relating to the ship's class, as this will have an impact on the insurer's overall assessment of the risk.⁶ The *Murray* case indicates that the courts are already considering these issues and by and large they are reaching the right decision with some manipulation. Under clause 11, they would address the issue more directly.

Similar approaches in other jurisdictions

- 18.25 It is helpful to look briefly at the position in New York and New Zealand. Neither system is exactly that which we recommend, but both contain similar elements which might be instructive in considering how these questions might be approached.⁷

NEW YORK

- 18.26 Our recommendations are fairly similar to the position in New York law. As stated above, that system does not require a causal connection between breach of warranty and loss; instead, the test is whether the breach "materially increases the risk of loss, damage or injury within the coverage of the contract".⁸
- 18.27 If the contract specifies two or more kinds of loss (such as fire and theft) the breach will only avoid the particular kind of loss to which the warranty relates. This does not mean that the breach must cause or contribute to the specific loss, but it must be such that would materially increase the risk of a loss of the same sort. In other words, a breach of a burglar alarm condition would not affect a claim following an electrical fire, but it would avoid a theft policy, so as to permit the insurer to refuse a claim for theft, however the thieves had entered the building.

⁴ J Birds, *Birds' Modern Insurance Law*, (9th ed 2013) at para 21.3.3.

⁵ 1929 SC 48. See discussion at paras 17.38 and 17.39.

⁶ For example, all seagoing vessels registered in the UK are assigned to a specific class, which defines their type of permitted use, determines which certification they must hold and specifies the inspection and survey regime required to comply with this certification.

⁷ See CP3, Part 13 for further comparative discussion.

⁸ 2013 New York Consolidated Laws ISC - Insurance, Article 31, § 3106(b). Under (c), most express and implied warranties in marine insurance are excluded.

18.28 As set out in paragraph 18.15 above, the New York definition of warranty seems to encapsulate an objective assessment of the purpose of a warranty. It is for the courts to determine to which “kind or kinds of loss ... such warranty relates”.

NEW ZEALAND

18.29 The position under New Zealand law is more complicated. The courts’ interpretation of it has caused concern, resulting in a review of the law by the New Zealand Law Commission (NZLC).⁹

18.30 Like our recommendations here, the relevant provisions apply not just to warranties but to any terms which exclude or limit the liability of the insurer “on the happening of certain events or the existence of certain circumstances”. The court must determine whether the “reason” for the term is that, in the view of the insurer, the circumstances or events are “likely to increase the risk of such loss occurring.”¹⁰

18.31 If the court determines that there is such a reason for the term, then the policyholder is entitled to be paid the claim unless there was a causal connection between the events or circumstances and the loss. As an aside, it is interesting to note that the burden is on the policyholder to show that there was no causative link.

18.32 Clearly, this differs from our policy in that there is a causal test. However, the New Zealand experience illustrates the difficulties of distinguishing between terms which define the risk, and those which limit liability in defined circumstances. A causal connection test or, in our case, a “type of loss” assessment which is suitable for specific warranties about locks, alarms or sprinklers may not be suitable for terms which define the nature of the business or the geographical limits of the policy.

18.33 When the NZLC reviewed the section, it expressed concern that the courts had interpreted the section to impose liability on insurers even if the policyholder was in blatant breach of a term delimiting the risk.¹¹ The NZLC thought that a causal connection test should not apply to a provision which:

- (1) defines the age, identity, qualifications or experience of a driver of a vehicle, a pilot of an aircraft, or an operator of a chattel; or
- (2) defines the geographical area in which a loss must occur if the insurer is to be liable to indemnify the insured; or
- (3) excludes 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.¹²

⁹ *Some Insurance Law Problems* (1998) NZLC R46.

¹⁰ Insurance Law Reform Act 1977, s 11.

¹¹ *Some Insurance Law Problems* (1998) NZLC R46, p 25.

¹² *Some Insurance Law Problems* (1998) NZLC R46, pp 28 and 29.

- 18.34 This suggests that the NZLC felt that these types of provisions go to the heart of the risk profile which the insurer is willing to accept, so that any breach of such a provision should allow the insurer to avoid liability. We think these types of terms would not be caught by clause 11.
- 18.35 We do not propose to identify a list of terms which should fall outside of clause 11. We think this must be left to the courts to determine. However, we think that our provisions allow insurers to include terms with a general limiting effect which do not have to be linked to a specified risk factor.

The insurer's remedy for breach

- 18.36 Clause 11(2) provides that, if a term falls within clause 11(1), then breach of that term will not cause the insurer's liability to be excluded, limited or discharged in respect of other types of loss (that is, loss of a different kind, or loss at a different location or time).
- 18.37 It therefore operates to limit the extent of an insurer's remedy where clause 11(1) is shown to apply.

No causal connection

- 18.38 We envisage that, where an insurer resists liability on the basis of breach of a policy term, it would be for the insured to raise the "type of loss" issue as a counter-argument. The scope of a term and what compliance would "tend" to achieve would be a question of fact for the courts based on the content of the term objectively assessed.
- 18.39 Importantly, the term should not be considered in light of what has actually happened. That is, when assessing the result that compliance would tend to have, whether or not breach of the term actually contributed to the loss which has occurred is not relevant. It is sufficient that the term is relevant to the particular kind, time or place of loss. If that is the case, the insurer is not liable for the actual loss. The insurer therefore retains a broader remedy than it would have under a causation test.
- 18.40 For example, a term which requires an insured to maintain a particular type of lock on a door would tend, if complied with, to reduce the risk of break-in (and related events such as arson and vandalism). If the relevant lock was not fitted, the insurer's liability in respect of break-in would be suspended until this was remedied. We think the insurer would have no liability for loss resulting from break-in, even if the break-in was through a window rather than the relevant door so that the breach was effectively irrelevant to the loss.

Different types of clauses and different types of remedies

- 18.41 This recommendation is not confined to warranties. It applies to “any term (express or implied) of a contract of insurance”¹³ the effect of which is to reduce the risk of a particular type of loss. We want to avoid technical arguments about whether the relevant provision is or is not a warranty¹⁴ and look instead to the content of the provision. Our recommendation could apply to terms including warranties (including the implied marine warranties), conditions precedent, definitions of risk and exclusion clauses.
- 18.42 The type of term may well affect the nature of the insurer’s remedy. If it is a condition precedent, liability will generally not attach until the condition is satisfied. If clause 11(1) applies, then liability *will* attach other than in respect of liability for losses of the particular type. If it is a warranty then, under our recommendations discussed in the previous chapter and set out in clause 10 of the draft Bill, the insurer’s liability will be suspended on breach. If clause 11(1) applies then liability will only be suspended in respect of that type of loss.

Interaction between clauses 10 and 11

- 18.43 Our recommendations as set out in clauses 10 and 11 operate in different ways. Clause 10 sets out the consequences of breach of warranty, and applies only to warranties. Clause 11 has the potential to apply to warranties but also other terms which seek to exclude or limit an insurer’s liability. Some contract terms will be caught by clause 11 but not by clause 10.
- 18.44 All warranties will be caught by clause 10, but only some by clause 11, because not all warranties are aimed at reducing particular risks. Some address moral hazard, for example those relating to a policyholder’s criminal record. Some define the scope of the contract as a whole, such as a term restricting cover to personal (and not commercial) use. Others have no bearing on risk of loss at all, such as premium payment warranties.
- 18.45 Nevertheless, in some cases both clauses may apply together. Clause 10 is made subject to clause 11. Where a warranty does fall within 11(1), then the insurer’s liability will be suspended under 10(2) only in respect of losses of the particular kind, or loss at the particular time or location. That the two clauses can apply together is also confirmed by clause 11(3).
- 18.46 We think that our new remedy regime for warranties together with our “type of loss” recommendations act together to put the policyholder in a stronger legal position, which is what the courts appear to want. When enacted, the two clauses will give the courts the beginnings of substantive tools with which to tackle perceived imbalances in insurance contract law without unduly constraining them in the face of the variety of insured risks and insurance contract conditions which may pass before them. As we have previously said, we are largely aiming to minimise cases in which the insurer relies on its technical legal rights so that the draconian consequences of breach of a clearly irrelevant warranty allow it to avoid liability.

¹³ See draft Bill, clause 11(1).

¹⁴ As is set out above, the distinction is often very fine and indeed the courts may determine that a provision is or is not a warranty in spite of explicit words in the term.

An illustration of clauses 10 and 11

18.47 The broad effect of these clauses can be illustrated with an example:

A private individual insures a small yacht. The policy includes three warranties:

- A “premium payment” warranty, requiring payment by 1 June;
- A “lock warranty” requiring the hatch to be secured by a special type of padlock; and
- A “pleasure use only” warranty, forbidding the yacht to be used for commercial gain.

The policyholder breaches all three warranties. They fail to pay until 15 June; they install the wrong type of padlock; and they use the yacht for paid fishing trips. On 1 July the policyholder is using the yacht to transport paying customers when the yacht is damaged by a sudden storm.

18.48 The consequences of each breach would be as follows:

- (1) Under the current law, breach of a premium payment warranty discharges the insurer from liability, which is not restored if the insurer later accepts payment. Under clause 10, however, the payment on 15 June would remedy the breach and the insurer’s liability would be restored. The insurer would not be permitted to reject the claim solely on this basis.
- (2) Compliance with the lock warranty would tend to reduce the risk of a specific type of loss: loss caused by intruders. Under clause 11, it would not suspend the insurer’s liability for other types of loss, such as loss in a storm. This would not be a good reason to refuse the claim. However, if there was a break-in, liability would be suspended even if the special padlock would not have prevented it.
- (3) The pleasure use only warranty relates to the contract generally, and suspends the insurer’s liability for all losses until such time as it is remedied. Clearly in this case it has not been remedied, and the insurer may reject the claim on this basis. It does not matter whether the breach caused the loss. In CP3,¹⁵ we argued that this would also apply where the yacht is damaged while berthed overnight, applying the case of *Murray v Scottish Automobile and General Insurance Co*,¹⁶ as this is ancillary to the forbidden activity.

¹⁵ Paras 15.18 and 15.19.

¹⁶ 1929 SC 48. See paras 17.38, 17.39 and 18.22 above. In that case, a car was destroyed while parked overnight but had been used for hire purposes, in breach of warranty, on that day and the preceding days. The court held that its being parked overnight was ancillary to the main (commercial) purpose to which the car was being put, and therefore the insurer was not liable.

CONCERNS ABOUT UNCERTAINTY

- 18.49 One of the major concerns raised by consultees about this recommendation was the lack of certainty over how it would be interpreted and applied by the courts. We accept that this is likely to become the subject of litigation particularly in the beginning before the courts have begun to build precedent. There is undoubtedly a degree of uncertainty relating to how the courts will interpret a “type of loss”, a “loss at a particular place” and “a loss at a particular time”. Often the questions will have common sense answers, but we are aware that sometimes they will not.¹⁷
- 18.50 However, there is already a large degree of uncertainty given judicial treatment of warranties and similar provisions: we have already seen that courts strain to find ways to avoid the draconian consequences of breach in the face of fairly unequivocal legislation offering few loopholes.¹⁸ This encourages litigants to present a wide range of arguments and they are then subject to the apparent discretion of the courts. We consider that overall there will be an increase in certainty for both parties. The new remedy for breach of warranty, together with the “type of loss” recommendations should channel litigants on both sides towards less speculative arguments. At the point of risk assessment, insurers will know that certain terms are to be taken to have specific purposes and will only affect certain types of risk. Insurers therefore can, where necessary, take this into account in their pricing. It will also give policyholders some confidence when making an insurance claim and defending a breach of an irrelevant condition, as they will no longer have to rely on a particularly favourable interpretation of the contract from the courts.

CONTRACTING OUT

Consumer insurance

- 18.51 In line with our general approach for all our recommended reforms, the warranties provisions are intended to be mandatory for consumers. That is, the insurer will not be able to use a contractual term to put the consumer in a worse position than it would be in under our draft Bill. This is provided for in clause 16(1) of the draft Bill. This means, for example, that an insurer will not be able to provide that breach of a condition in relation to a smoke alarm will allow it to refuse a claim for subsidence.

Non-consumer insurance

- 18.52 Our recommendations in clause 11 are only intended as a default regime for non-consumer insurance contracts. The parties should be free to agree alternative arrangements between themselves in their contract, including to provide that breach by the insured of certain fundamental conditions excludes the full extent of the insurer’s liability, no matter the relationship between the type of loss contemplated by the term and the type of loss actually suffered.

¹⁷ See the examples below which illustrate the different levels to which these provisions could be taken.

¹⁸ See Chapter 13 above and in particular the discussions of *Kler Knitwear* where a clause called a “warranty” was found to be a “suspensive condition”, and *Printpak* in which the court regarded the policy as divided into discrete sections.

- 18.53 However, as we discuss in more detail in Chapter 29, we recommend two procedural requirements which must be satisfied if a provision putting the insured in a worse position is to have effect.
- 18.54 As we discussed in the previous chapter,¹⁹ insurers should spell out the desired consequences of breach within the term itself and take sufficient steps to draw the term to the insured's attention.

EXAMPLES OF OUR RECOMMENDATIONS IN ACTION

- 18.55 Below, we use the facts of some past cases from the UK and overseas to illustrate how we think the courts might approach the recommendations set out in clause 11. These scenarios highlight some of the borderline questions which may arise.

Vesta v Butcher

- 18.56 In *Forsikringsaktieselskapet Vesta v Butcher*, a Norwegian insurance company provided cover for a fish farm which contained a warranty that the insured should keep a 24 hour watch at the farm.²⁰ It was not complied with. After a severe storm, many fish were lost. Under Norwegian law, the insurer was liable to pay the claim. The reinsurer argued that under English law it was not liable to indemnify the direct insurer as the warranty had been breached. The court recognised this as correct, but found against the reinsurer on the basis that this particular reinsurance contract was subject to Norwegian law on this issue.²¹
- 18.57 Under our recommendations, the warranty for the provision of a 24 hour watch might be seen to reduce the risk of loss through theft or vandalism – or more generally loss that a watchman might have been able to do something to prevent or mitigate. The insurer's liability would only be suspended in respect of that kind of risk. The reinsurer could therefore be liable to pay a claim for storm damage even under UK law.

The Bamcell II

- 18.58 In *The Bamcell II*, the owners of a converted barge warranted that a watchman would be employed at night, and the barge suffered fire damage during the mid afternoon.²² When faced with the unfairness of denying the claim, the Supreme Court of Canada decided that the term was not a warranty, an uncomfortable finding given the clear wording used.
- 18.59 Under our recommendations the insurer's liability would be suspended only in relation to losses occurring at night. Other losses would be paid.

¹⁹ From para 17.70.

²⁰ [1989] AC 852.

²¹ In this case, the reinsurance was considered to be "back to back" with the direct insurance, but see *WASA International Insurance Co Ltd v Lexington Insurance Co* [2009] UKHL 40, [2010] 1 AC 180 and CP3, para 9.43 and following.

²² *Century Insurance Company of Canada v Case Existological Laboratories Ltd (The Bamcell II)* [1984] 1 Western Weekly Reports 97.

Printpak v AGF

18.60 In *Printpak v AGF Insurance Ltd*, the insurer refused a claim for fire loss because the policyholder was in breach of a warranty to install and maintain a burglar alarm.²³ English courts reached the outcome we are proposing by construing the policy, which was set out in different sections covering different risks.

18.61 Under our recommendations, a burglar alarm warranty would not suspend the insurer's liability in relation to a fire loss.

Sugar Hut v Great Lakes Reinsurance (UK) plc

18.62 *Sugar Hut Group Ltd v Great Lakes Reinsurance (UK) plc*²⁴ in particular raises some borderline issues.

18.63 An insurance policy covered four night clubs. The policyholder claimed for a fire in one of the clubs (Club X). The policy included the following warranty, headed "kitchen warranty":

... all frying and other cooking ranges, equipment, flues and exhaust ducting will be kept securely fixed and free from contact with combustible materials ...

18.64 The kitchen flues in Club X were in contact with combustible material in four places, though this was not how the fire started. If the current law was applied strictly, then the faulty flue in Club X would discharge the insurer from liability for all claims in any of the four locations. Although in that case the fire occurred in the same premises as the breach, the judge agreed that where four premises are the subject matter of one insurance then the breach of a true warranty does indeed impact on all of them:

That is however the consequence of having cover for four premises included in one policy, and it could presumably have been an option for there to be four separate policies.

18.65 The kitchen warranty is relevant to our proposals in two ways.

18.66 The warranty clearly pertained to fire risk. Indeed, in CP3 we went further and said that the kitchen warranty was arguably designed to reduce the risk of a fire in the *kitchen* at Club X. Whether the courts would be willing to make such precise distinctions remains to be seen. We do not propose to introduce a causal connection test, so it is irrelevant that the fire was not started by the faulty flue.

²³ *Printpak v AGF Insurance Ltd* [1999] Lloyd's Rep IR 542, [1999] 1 All ER (Comm) 466 CA.

²⁴ [2010] EWHC 2636, [2011] Lloyd's Rep IR 198.

- 18.67 Further, under our recommendations concerning loss at a particular location, the warranty could be regarded as applying separately to each property, intended to minimise risk of loss in that particular location. As it happened, the breach of warranty took place at the same location as the fire. If it had not, and the kitchen warranty had been breached at Club Y but complied with at Club X, then the insurer may not be able to escape liability for losses at Club X. This outcome depends on whether the courts would apply a single warranty to different locations.
- 18.68 We think it is wrong that the insurer should be absolved from liability for all claims, including claims which arose in other locations. It is not helpful simply to warn policyholders to take out separate policies on each of their buildings. Combined policies are administratively simpler for both parties. The Mactavish Report shows that very few businesses understand the legal consequences of warranties, or would have borne this scenario in mind when deciding whether to take out separate or combined policies.²⁵

RECOMMENDATIONS

Recommendation 28: Where a term of an insurance contract relates to a particular kind of loss, or loss at a particular location or place, the breach of that term should only give the remedy in relation to loss of that particular kind of loss, or at that particular location or place.

Recommendation 29: Whether a term of an insurance contract relates to loss of a particular kind or at a particular type of place should be determined objectively based on whether compliance with that term would tend to reduce the risk of the occurrence of that category or those categories of loss.

These recommendations are intended to be the mandatory regime for consumer insurance. In the non-consumer insurance context, these recommendations are intended to be a default scheme and are subject to our contracting out recommendations in Chapter 29.

²⁵ Corporate Risk & Insurance -The Case for Placement Reform. The Mactavish Protocols (2011) and see Chapter 14 above where we consider the case for reform.

PART 4

REMEDIES FOR FRAUDULENT CLAIMS

CHAPTER 19

REMEDIES FOR FRAUDULENT CLAIMS: INTRODUCTION

- 19.1 Fraudulent insurance claims are a serious and expensive problem. The Association of British Insurers (ABI) reported that insurers uncovered over 118,500 fraudulent claims in 2013. The value of these claims totalled £1.3 billion.¹ The ABI have also asserted that large amounts of fraud remain undetected.²
- 19.2 As a result of fraud, all honest policyholders endure increased premiums because of the losses suffered by insurers and the investment in resources to detect it.³ Yet insurance fraud is often thought of as an “easy crime”. A recent ABI consumer survey found that 42% of respondents felt that insurance fraud was an easy way to make money quickly, and 27% believed the penalties for fraud were negligible.⁴
- 19.3 It is important for the law to set out clear sanctions to deter policyholders from acting fraudulently. Although insurance fraud is a criminal offence, prosecutions are relatively rare, meaning that the civil law has an important part to play in deterring fraud. It should also grant remedies to insurers which are principled, proportionate and reliable. However, the current law on the effect of a fraudulent claim is convoluted and confused. There is tension between the common law rule that the fraudster forfeits the fraudulent claim,⁵ and a statutory rule which allows the insurer to avoid the whole contract from the outset if the insured breaches the duty of good faith.⁶
- 19.4 We recommend a default statutory regime to the effect that, when an insured commits fraud in relation to a claim, the insurer should:
- (1) have no liability to pay the fraudulent claim; and
 - (2) be entitled to refuse all claims arising after the fraud; but
 - (3) remain liable for legitimate losses *before* the fraud.

¹ ABI, “Insurance cheats feel the heat – value of fraudulent claims uncovered by insurers hits record level” (30 May 2014) <https://www.abi.org.uk/News/News-releases/2014/05/Insurance-cheats-feel-the-heat-value-of-fraudulent-claims-uncovered-by-insurers-hits-record-level>.

² ABI report, *No Hiding Place: Insurance Fraud Exposed* (2012). The ABI estimated £2bn.

³ On average, fraud adds an extra £50 onto every insurance premium. See ABI Report (2012), p 3.

⁴ ABI Quarterly Consumer Survey 2012 Q4 (May 2013).

⁵ See the discussion in *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [62] to [67]. Forfeiture was applied in the recent case of *Versloot Dredging BV v HDI-Gerling Industrie Versicherung AG (The DC Merwestone)* [2013] EWHC 1666.

⁶ Marine Insurance Act 1906, s 17. In practice, the courts have been reluctant to apply the remedy of avoidance in the context of fraudulent claims.

- 19.5 We also recommend special provisions to address fraud committed by a member of a group policy to ensure that the insurer has remedies against the fraudster, but also so that the policyholder (usually an employer) or the other group members remain unaffected by the fraud.
- 19.6 We are not recommending a complete statutory restatement of the law on insurance fraud generally. For example, we do not seek to define fraud in the draft Bill.⁷ Instead, we recommend the introduction of targeted provisions to confirm the remedies available to an insurer who discovers a fraud by a policyholder.
- 19.7 These reforms are linked to our recommendation, discussed in Chapter 30, to remove avoidance as the remedy for breach of good faith under section 17 of the Marine Insurance Act 1906. As we discuss below, we do not think that avoidance is the appropriate remedy for fraud, but we are concerned that simply removing this remedy would lead to a gap in the law. Instead, the statute should set out clear and appropriate remedies.

A HISTORY OF THE CONSULTATION PROCESS

Issues Paper 7

- 19.8 Our initial views on the matters covered in this Part were set out in Issues Paper 7 (IP 7) on the *Insured's Post-Contract Duty of Good Faith*, published in July 2010.⁸
- 19.9 Consultees' responses to IP7 indicated that legislative reform of the remedies for fraud was supported. We developed our proposals in light of the responses we received.⁹

The 2011 Consultation Paper

- 19.10 We published further proposals on remedies for fraud in Consultation Paper 2 (CP2).¹⁰ We received 40 responses to our proposals on fraud, and in December 2012 we published a summary of the responses.¹¹
- 19.11 The clauses in the draft Bill are intended to implement those 2011 proposals.

⁷ This is discussed below from para 22.17.

⁸ Law Commission and Scottish Law Commission, *Issues Paper 7: The Insured's Post-Contract Duty of Good Faith* (July 2010). http://lawcommission.justice.gov.uk/docs/ICL7_Insureds_Duty_of_Good_Faith.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/208/107/.

⁹ See *Summary of Responses to Issues Paper 7* (December 2010). http://lawcommission.justice.gov.uk/docs/ICL7_Summary_of_Responses.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/595/107/.

¹⁰ *Insurance Contract Law: Post Contract Duties and other Issues* (December 2011) Law Commission Consultation Paper No 201; Scottish Law Commission Discussion Paper No 152. http://lawcommission.justice.gov.uk/docs/cp201_ICL_post_contract_duties.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/947/107/.

¹¹ *Summary of responses to Consultation Paper 2, chapter 2: Insurers' remedies for fraudulent claims* (December 2012). http://lawcommission.justice.gov.uk/docs/insurers-remedies-for-fraud_responses.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/1091/107/.

Limited consultation on the draft clauses

- 19.12 In January 2014, we launched a brief consultation on the draft Bill clauses covering remedies for fraud. We received 38 responses to this element of that consultation.
- 19.13 In March 2014, we also consulted on the draft Bill clause covering fraud in group insurance situations. We received 16 responses.

SUPPORT FOR REFORM

- 19.14 Support for these proposals was strong, and concerns were limited. They have been described as “a sensible exercise in distilling and, where obscure, clarifying the uncertain position left by the existing case law.”¹²

THE STRUCTURE OF THIS SECTION

- 19.15 This Part is divided into 4 further chapters:
- (1) In the next chapter, we provide a brief overview of the current law. Fuller accounts of the law are provided in IP7 and CP2.
 - (2) Chapter 21 states the case for reform and why legislation should be used to achieve it.
 - (3) Chapter 22 provides an overview of our recommendations. We also set out the issues we do not cover and the proposals we are not progressing.
 - (4) In Chapter 23, we set out our recommendations for reform and provide a detailed discussion of the statutory proposals.

¹² Simon Rainey QC, “The Law Commission’s Proposals for the Reform of an Insurer’s Remedies for Fraudulent Claims Made under Business Insurance Contracts” given at the 25 April 2013 Symposium on the Law Commissions’ proposals run by the Institute of International Shipping and Trade Law, Swansea University.

CHAPTER 20

THE CURRENT LAW

- 20.1 Where there is no express term in the insurance contract dealing with fraud, the courts must look to the general law to determine the consequences when a policyholder makes a fraudulent claim. Under the common law, the fraudster forfeits the fraudulent claim.¹ However, section 17 of the Marine Insurance Act 1906 gives the insurer a statutory remedy of avoidance of the whole contract in the event of a breach of good faith. In theory, this allows the insurer not only to refuse to pay any part of the fraudulent claim, but also to avoid the entire policy from the outset, with the parties being returned to their pre-contract position. This means the insurer could recover from the policyholder any sums previously paid out on genuine claims. Although, in practice, the courts have been reluctant to apply the remedy of avoidance, its status is still uncertain.
- 20.2 As a result, the insurer's liability to pay genuine claims for losses suffered after the fraudulent act is also unclear. Arguably, such claims could be denied on the basis that the fraudulent claim constitutes a repudiatory breach of contract giving the insurer a right to terminate. However, that termination would be prospective, leaving the insurer liable for genuine claims between the date of the fraud and its discovery and subsequent termination of contract. Insurers have strongly objected to this possibility.
- 20.3 We expand on these matters below, but further detail and analysis can be found in Issues Paper 7 (IP7) and Consultation Paper 2 (CP2). In this chapter we look only at the insurer's remedies for fraud, rather than the definition of fraud. We discussed what constitutes fraud in IP7 and concluded that the issue was best left to the courts.²

COMMON LAW: FORFEITING THE CLAIM

- 20.4 If a claim is made in the absence of a genuine loss, then clearly the insurer is not required to pay the claim. However, where only an element of a claim is fraudulent, the common law has long recognised that a fraudster should risk more than the non-payment of the fraudulent part. Since the nineteenth century, the courts have held that a person who fraudulently exaggerates a claim forfeits the whole claim, and not just the fraudulent element of it. The point was put forcefully in 1866 in *Britton v Royal Insurance Co*.³

It would be most dangerous to permit parties to practise such frauds, and then, notwithstanding their falsehood and fraud, to recover the real value of the goods consumed.

¹ See the discussions in *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [62] to [67] and *Fagnoli v GA Bonus Plc* 1997 SCLR 12, [1997] CLC 653. Forfeiture was applied in the recent case of *Versloot Dredging BV v HDI-Gerling Industrie Versicherung AG (The DC Merwestone)* [2013] EWHC 1666.

² IP7, Part 3 and paras 7.26 to 7.27. This is discussed briefly below from para 22.17.

³ (1866) 4 F&F 905 at 909.

- 20.5 Forfeiture of the entire claim was confirmed in *Galloway v Guardian Royal Exchange (UK) Ltd*,⁴ in which the policyholder made a fraudulent claim for £2,000 of damage on top of a genuine loss of around £16,000. The Court of Appeal rejected the whole claim, including the £16,000 of genuine loss. Lord Justice Millett noted that this was a “necessary and salutary rule” needed to discourage insurance fraud.⁵
- 20.6 The forfeiture rule is relatively settled. We agree that it is an appropriate remedy for an insurer and sends a clear message to the fraudster. However, this rule (which is currently only part of the common law) contrasts with the section 17 provision. It is undesirable for these two approaches to exist in conflict.

SECTION 17 OF THE MARINE INSURANCE ACT 1906

- 20.7 The central problem is the mismatch between the common law rule and the duty of good faith in section 17 of the 1906 Act. The section states:

A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.⁶

- 20.8 The duty has been held to apply to all types of insurance.⁷
- 20.9 Section 17, as currently drafted, specifies only one remedy for failing to observe utmost good faith: avoidance of the contract. This means avoiding the contract from the start, that is, returning the parties to the position they would be in had the contract never existed. In the event of a policyholder’s breach of good faith, the insurer could seek repayment of all claims paid under the policy, including genuine claims finalised and paid before the fraud arose.
- 20.10 However, finality is a core value of the law in the UK: if a valid claim is paid under a valid contract, it seems wrong to attempt to overturn that payment on the basis of subsequent events. In practice, the courts have been reluctant to allow insurers to recoup payments on valid claims which arose before the fraud took place. The courts have sought to escape the conclusion that the remedy for fraudulent claims is avoidance of the contract, but at the expense of some convoluted reasoning and uncertainty.

GOOD FAITH AND FRAUD: THE EVOLVING CASE-LAW

***The Star Sea*: reinterpreting the post-contract duty of good faith**

- 20.11 In the 2001 case *The Star Sea*,⁸ the House of Lords limited the section 17 duty of good faith in two ways.

⁴ [1999] Lloyd’s Rep IR 209.

⁵ Above, at 214.

⁶ We discuss our recommendations for the amendment of section 17 in Chapter 30 of this Report.

⁷ See for example *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501 by Lord Mustill at 518 and *Banque Keyser Ullmann SA v Skandia (UK) Insurance Co Ltd* [1990] 1 QB 665 by Steyn J at 701.

- 20.12 Firstly, it said that the duty of good faith did not continue once legal proceedings had begun. Once a writ was issued, the parties' duties were governed by the rules of court procedure, which set out disclosure requirements and appropriate sanctions for non-compliance.
- 20.13 Secondly, the House of Lords distinguished between the pre-contract and post-contract duty of good faith. Whereas the duty to disclose information pre-contract was a strict one, after the contract the duty of good faith was flexible and varied according to the context.
- 20.14 Lord Scott noted that in the context of making a claim, all that was required was "a duty of honesty".⁹ Professor Clarke suggests that "when a claim is made nothing short of fraud in the presentation of the claim will amount to a breach of the duty of disclosure and of good faith".¹⁰
- 20.15 This, however, leaves a question where the claimant does act fraudulently. If fraud is a breach of good faith, does section 17 give the insurer the right to avoid the contract? Lord Scott described this as "debatable" but refrained from deciding the point.¹¹
- 20.16 Lord Hobhouse severely criticised the remedy of avoidance.¹² He thought that avoidance may be appropriate where "the want of good faith has preceded and been material to the making of the contract". But, where the want of good faith occurs later, "it becomes anomalous and disproportionate". He noted that many traditional authorities did not use the language of avoidance, but referred to "forfeiture". Accordingly, he suggested that the appropriate remedy for fraud was forfeiture of the claim.

Applying *The Star Sea*

- 20.17 Subsequent cases have attempted to apply these principles, which has not been an easy task.
- 20.18 In *The Aegeon (No 1)*¹³ Lord Justice Mance tentatively suggested that section 17 did not apply to fraudulent claims. He thought that a solution to the "present imperfect state of the law" would be to:

treat the common law rules governing the making of a fraudulent claim (including the use of fraudulent devices) as falling outside the scope of section 17 On this basis no question of avoidance *ab initio* would arise.¹⁴

⁸ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469.

⁹ Above, at [111].

¹⁰ M A Clarke, *The Law of Insurance Contracts* (5th ed 2006), para 27-2B.

¹¹ *The Star Sea*, above, at [110].

¹² Above, at [51].

¹³ *Agapitos v Agnew (No 1) (The Aegeon)* [2002] EWCA Civ 247, [2003] QB 556.

¹⁴ Above, at [45].

- 20.19 He argued that the common law provides a separate rule that the appropriate remedy for fraud is forfeiture of the claim.
- 20.20 Academics and textbook writers have also struggled to make sense of the current law. MacGillivray takes the view that there are “two separate principles of insurance law, each of which can be invoked in defence by the insurer”.¹⁵ Thus, the common law rule referred to by Lord Justice Mance exists side by side with the remedy of avoidance under section 17. The insurer can choose which to pursue.¹⁶
- 20.21 By contrast, Professor Clarke considers there to be a single doctrine: the fraudulent claim fails entirely and the insurer may terminate the contract. Past outstanding honest claims remain enforceable, however, and the insurer cannot recover insurance money paid out in respect of other claims.¹⁷

***Axa v Gottlieb*: the insurer may not recoup previous claims**

- 20.22 The case of *Axa General Insurance Ltd v Gottlieb*¹⁸ lends support to Professor Clarke’s view. Lord Justice Mance again explained that the rule against fraudulent insurance claims was a special common law rule, distinct from section 17. Under the rule, the appropriate remedy was “to forfeit the whole of the claim to which the fraud relates”. It did not affect prior separate claims settled under the policy before the fraud occurred. He did not reach a conclusion on whether the insurer would be obliged to pay separate claims which were still unpaid at the time of the fraud. However, he saw some force in the argument that forfeiture should be confined to the fraudulent claim – although it is worth noticing that this was a consumer claim where the sums were relatively small and the policyholder less sophisticated.

***Fargnoli*: avoidance is not the appropriate remedy in Scotland**

- 20.23 The Scottish courts appear to have achieved the same result through a different route. In *Fargnoli v GA Bonus Plc*,¹⁹ Lord Penrose distinguished pre-contract fraud (where avoidance is appropriate) from post-contract fraud. Pre-contract fraud vitiates the contract. Where there is fraud in making a claim, however, there has been “a valid binding contract” up until the date the fraudulent claim was presented to the insurer: to avoid the policy from the start “would defeat that reality”.²⁰ Furthermore, avoidance was not an appropriate remedy for every want of good faith: the duty was mutual and the remedy was purely one sided.

¹⁵ *MacGillivray on Insurance Law* (12th ed 2013), para 20-057.

¹⁶ This is evident in a subsequent judgment of Lord Justice Mance in which he refers to the common law principle having a separate origin and existence to any principle which exists under section 17. See *Axa General Insurance Ltd v Gottlieb* [2005] EWCA Civ 112, [2005] 1 All ER (Comm) 445 at [20].

¹⁷ M A Clarke, *The Law of Insurance Contracts* (5th ed 2006), para 27-2C3.

¹⁸ [2005] EWCA Civ 112, [2005] 1 All ER (Comm) 445.

¹⁹ 1997 SCLR 12, [1997] CLC 653.

²⁰ 1997 SCLR 12 at 30.

20.24 Instead the remedy for fraud was forfeiture of the claim. Though “a claim tainted by fraud would be cut down as a whole”, an earlier, unconnected claim would be valid.²¹ Thus the pursuer was entitled to have his first fire claim assessed on the merits, and that earlier claim would be unaffected by the pursuer’s alleged subsequent fire-raising attempt.

THE EFFECT OF FRAUD ON SUBSEQUENT CLAIMS

20.25 In spite of section 17, the prevailing approach seems to be to apply the common law remedy of forfeiture and to find that genuine claims made in relation to losses occurring before the fraud are valid.

20.26 A further question is the effect of fraud on a subsequent genuine claim. Suppose an insured householder fabricates some aspect of a water damage claim, but the house burns down during the investigation. Does the policyholder forfeit the subsequent valid claim? There are two possible approaches:

(1) The fraud is characterised as a breach of the contract, which gives the insurer the right to terminate cover. However, the policy continues to exist until termination, and any claim arising between the date of the fraud and the date of termination must be paid.

(2) The presentation of the fraudulent claim automatically brings the contract to an end, invalidating any claim which arises after the fraud but before the fraud is discovered.

20.27 There is no definitive ruling on the issue. However, some judicial statements suggest that the first view is favoured. Normal contractual rules apply. On this basis, the fraud amounts to a repudiatory breach of contract, permitting the insurer to terminate the contract. The contract continues, however, until the insurer has exercised its right to terminate. In *Axa General Insurance Ltd v Gottlieb*, Lord Justice Mance put the point as follows:

There seems to me some force in the argument that the common law rule relating to fraudulent claims should be confined to the particular claim to which any fraud relates, while the potential scope and operation of more general contractual principles might in some circumstances also require consideration.²²

²¹ 1997 SCLR 12 at 30.

²² [2005] EWCA Civ 112, [2005] 1 All ER (Comm) 445 at [22].

20.28 In *Fargnoli v GA Bonus Plc*, Lord Penrose made a similar observation. He said that fraud would amount to a repudiatory breach of the contract, entitling the insurer to rescind in accordance with general contract principles. He added, however, that:

rescission does not absolve parties from primary obligations already due for performance at the time of rescission.²³

CAN THE INSURER SUE FOR DAMAGES?

20.29 In CP2 we discussed whether the insurer was entitled to claim damages against an insured who makes a fraudulent claim, for example to recover the costs of investigating the claim.

20.30 Generally, no claims for damages may be made. This was confirmed by *London Assurance v Clare*,²⁴ which held that the cost of investigation is not recoverable under an implied term not to commit fraud.

20.31 It remains open to an insurer, however, to argue that it is entitled to claim damages for deceit following a fraudulent claim. In *Insurance Corporation of the Channel Islands Ltd v McHugh*,²⁵ allegations of deceit were pleaded by the insurers but not pursued at trial. If they had been, Mr Justice Mance noted that an action for deceit might have been arguable in principle.²⁶

EXPRESS TERMS IN CONTRACT

20.32 Many insurance policies include express terms setting out the consequences of fraud and the courts are usually willing to enforce such terms.²⁷ Indeed, it has been held that since fraud clauses are common, there is no need to bring the clause to the insured's specific attention.²⁸ That said, the clause must be clear and unambiguous.²⁹

²³ 1997 SCLR 12 at 22. Rescission is the standard Scots law term for termination of a contract for material breach. Rescission in Scots law is, generally, prospective rather than retrospective in effect. (See W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007), paras 20-05 and 20-109 respectively.)

²⁴ (1937) 57 LI L Rep 254 by Goddard J at 270.

²⁵ [1997] LRLR 94.

²⁶ Above, at 125.

²⁷ For example, *Joseph Fielding Properties (Blackpool) Ltd v Aviva Insurance Ltd* [2010] EWHC 2192, [2011] Lloyd's Rep IR 238.

²⁸ *Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd's Rep 682 at 686.

²⁹ *Fargnoli v GA Bonus Plc* 1997 SCLR 12, [1997] CLC 653.

20.33 In consumer insurance contracts, a fraud clause is subject to the Unfair Terms in Consumer Contracts Regulations 1999. Consumers also have recourse to the Financial Ombudsman Service (FOS). In its consultation response, the FOS said it took broadly the same approach as we are recommending:

We agree that those who commit fraud should forfeit the whole claim to which the fraud relates and any claim where the loss arises after the date of the fraud – although previous claims should remain valid. This mirrors our current approach to the issue.³⁰

20.34 This means that while a clause permitting an insurer to avoid the whole contract can apply in non-consumer insurance, it may be more difficult to apply such a clause against a consumer.

Excluding liability for fraud

20.35 In the unlikely event that an insurer agreed to a clause which excluded the policyholder's liability for fraud, the courts have held that it would not be valid for public policy reasons.³¹

CONCLUSION

20.36 The area of controversy is relatively small, which is why our recommendations only target remedies for fraud. In many cases, the courts simply give effect to an express term setting out the insurer's remedies for fraud. In other cases, the insurer is only concerned with the effect of the fraud on the claim in hand: here the common law is clear that the whole claim is forfeited and any interim payments made on those claims may be recouped. Difficulty arises when this rule is contrasted with section 17 of the 1906 Act.

20.37 The uneasy juxtaposition of section 17 and the common law leaves two unresolved issues:

- (1) The effect of a fraudulent claim on a previous genuine claim under the same policy made in respect of loss suffered before the fraud; and
- (2) The effect of a fraudulent claim on a genuine claim in respect of loss suffered after the fraud but before the insurer has taken action to terminate the contract.

20.38 These issues have generated case law and debate, as the courts struggle to reconcile the apparently clear words of section 17 with principle and logic.

³⁰ See also the FOS guidance on how it deals with fraudulent claims: *Ombudsman News*, Issue 21, October 2002.

³¹ *HIH Casualty & General Insurance v Chase Manhattan Bank* [2003] UKHL 6, [2003] 1 All ER (Comm) 349. In Scots law, parties may not, by virtue of contractual terms, exclude liability for fraud; see *The Laws of Scotland (Stair Memorial Encyclopaedia)*, Obligations (Volume 15), para 683.

20.39 In the next chapter, we consider the impact of fraud on both the insurance market and policyholders and stress the need for remedies which are robust, principled and clear. We also explain why reform is needed through statute.

CHAPTER 21

THE CASE FOR REFORM

- 21.1 We do not recommend any major changes to the way in which the law is applied in practice. However, we think there is a need to clarify the law in this area and remove the problems created by section 17 of the Marine Insurance Act 1906.

THE NEED FOR A CLEAR DETERRENT

- 21.2 As we noted above, insurance fraud is a major cost to the industry.¹ Despite costly efforts invested by the industry in detecting fraud,² fraud by policyholders is a regular occurrence. The consequences of fraud must therefore be clear and strongly discourage any attempts at fraud on any scale. As Lord Hobhouse stated in *The Star Sea*:

The logic is simple. The fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing.³

- 21.3 Insurance fraud is punishable by the criminal law, under the Fraud Act 2006 in England and Wales and at common law in Scotland.⁴ However, prosecutions for this type of fraud are rare. This means that the civil remedies must play an important part in deterring fraud. We think that sanctions in the civil law should complement the existing criminal penalties.⁵
- 21.4 In *Galloway v Guardian Royal Exchange (UK) Limited*, the Court of Appeal took a robust attitude, finding that claimants should recover nothing in respect of the genuine elements of the claim. Lord Justice Millett said:

The making of dishonest insurance claims has become all too common. There seems to be a widespread belief that insurance companies are fair game, and that defrauding them is not morally reprehensible. The rule which we are asked to enforce today may appear to some to be harsh but it is in my opinion a necessary and salutary rule which deserves to be better known by the public.⁶

¹ See para 19.1.

² The ABI estimates that insurers invest about £200 million a year in identifying fraud: *No Hiding Place: Insurance Fraud Exposed* (2012) p 3.

³ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [62].

⁴ *The Laws of Scotland (Stair Memorial Encyclopaedia)*, Criminal Law (Reissue), para 360.

⁵ Although, as discussed by Katie Richards in 'Deterring insurance fraud: a critical and criminological analysis of the English and Scottish Law Commissions' current proposals for reform' (2013) 24 *Insurance Law Journal* 16, civil law is not traditionally employed as a deterrent, and there are many reasons why people act fraudulently regardless of the legal sanctions.

⁶ [1999] Lloyds Rep 209 at 214.

- 21.5 Unfortunately, the current law on insurers' remedies for fraud is confusing. We think that there is a need for a clear statement of the civil law consequences of fraud, to act as a deterrent to wrongdoers.
- 21.6 Despite the apparent robustness of section 17 and its remedy of avoidance, courts have tended not to apply it in cases of fraud. Under the common law, while forfeiture of the fraudulent claim itself is generally accepted, there is considerable uncertainty over whether insurers are required to pay genuine claims before and after the fraud. Many businesses take out combined policies covering vehicles, property and liability. In these circumstances, the differences between forfeiting the claim and avoiding the whole policy may be significant.

THE NEED FOR STATUTE

- 21.7 Removing avoidance as a statutory remedy is an important aspect of our fraud proposals. Only Parliament can change section 17 of the 1906 Act.
- 21.8 The somewhat piecemeal common law development of remedies for fraudulent claims does not provide a set of clear alternative principles, although we think the right outcomes have usually been reached. This uncertainty generates unnecessary disputes and litigation.
- 21.9 Succinct statutory remedies will empower insurers, warn potential fraudsters and generally send a message that society does not tolerate insurance fraud. This statutory confirmation is particularly important in light of our recommendation to remove avoidance as a remedy for breach of good faith under section 17, leaving no statutory remedy for fraud (albeit that section 17 is not generally used in this way). We discuss good faith in more general terms, together with our recommendations on section 17, in Chapter 30.

SUPPORT FOR REFORM

- 21.10 Support for our proposals on remedies for fraud was strong, and concerns were limited. In December 2012, we published a summary of responses to our second consultation paper regarding insurers' remedies for fraudulent claims.⁷
- 21.11 The Lloyd's Market Association (LMA) said:
- We support the concept of a clear but fair law on forfeiture as a deterrent to fraud.
- 21.12 Norton Rose LLP thought that our proposal would "provide greater clarity and certainty in relation to remedies against fraud". RSA also welcomed "statutory confirmation" of the remedy of forfeiture.

⁷ Summary of responses to Consultation Paper 2, chapter 2: Insurer's remedies for fraudulent claims (December 2012).

- 21.13 The vast majority of consultees (35 of the 38 who responded to this question, or 92%) agreed that a policyholder should forfeit a claim in relation to which there has been fraud. Further, 94% of consultees (36 of 38) agreed that any valid claim which arose *before* the insured committed an act of fraud should be unaffected by the fraud. 75% (27 of 36) agreed that the insurer should not be obliged to pay claims in respect of losses arising after the fraud.
- 21.14 RSA agreed “that s17 of the Marine Insurance Act, resulting in voidance from inception, should not apply to insurance claim fraud. Forfeiture of the tainted claim is the remedy, and forfeiture of any separate post fraud claims.” They were satisfied that “any legitimate claim prior to the fraud should be accepted and dealt with.”
- 21.15 A majority of consultees agreed with our proposal that an insured would also forfeit any claim where the loss arises after the date of the fraud. As the ABI said:

The insurer would seldom want to continue its relationship with an individual who has perpetrated fraud after the first fraudulent claim.

CONTRASTING ARGUMENTS

- 21.16 In response to CP2, we received a response from a group of judges of the commercial court⁸ who were concerned that our proposals, including the established remedy of forfeiture, were overly harsh. They said:

It is difficult to bring to mind any other area of the law in which we have a policy of penal non-damages, ie depriving a party of the damages to which they are legally entitled as a result of some deliberately false aspect of the claim or evidence advanced to support it. Yet insurers are not unique in facing exaggerated claims. Exaggerated claims are commonplace in many types of civil claim, as are fraudulent devices to support valid claims. For example personal injury claimants regularly exaggerate their injuries. One wonders why an assured whose house burns down loses his buildings and contents entitlement to hundreds of thousands of pounds because he falsely claims for extra laptops, when a personal injury claimant whose dishonesty about his injuries may be grosser and more reprehensible still gets his true entitlement.

- 21.17 The Bar Council thought “it would be unfair automatically to deprive the insured of a genuine claim which arises after the fraud”. They suggested that the loss of trust between insurer and insured “would not affect the actual merits of the subsequent genuine claim”.
- 21.18 Marsh was concerned that the remedy “should not be disproportionate, particularly for consumers”.

⁸ Mrs Justice Gloster DBE, Mr Justice Burton, Mr Justice Beatson, Mr Justice Christopher Clarke, Mr Justice Flaux and Mr Justice Popplewell.

- 21.19 It is true that the treatment of fraudsters in the insurance contract context has developed differently from that in other areas such as fraud by victims of personal injury, who tend to have the genuine part of an exaggerated claim paid.⁹ This is arguably due, in part at least, to the characterisation of the insurance contract as a contract of good faith.¹⁰
- 21.20 As we have said, our intention is only to clarify the insurer's remedies in light of our recommended removal of avoidance as a statutory remedy for breach of good faith. The reported decisions have shown no inclination to move away from the well-established forfeiture rule and, although it is arguably anomalous, we do not have a mandate to recommend more substantial change.
- 21.21 Our recommendations are intended to represent the interests of the majority of policyholders who conduct themselves honestly. We do not comment on whether the law should be changed for third party claims but we do think that insurers are particularly vulnerable to first party fraud. This is because policyholders are often the only people who know the circumstances of the claim, unlike in third party claims, where the arguments usually centre on factual disputes between the insured and the third party.
- 21.22 Moreover, the insured and the insurer have entered into a contract of good faith. Good faith does not govern the relationship in third party claims in the same way.
- 21.23 Given the moral hazard involved in fraud by policyholders, we think there is a clear case for strong remedies.

CONCLUSION ON THE CASE FOR REFORM

- 21.24 The civil law in this area has to play an important role in deterring policyholders from making fraudulent claims. Statutory confirmation of the forfeiture rule and the treatment of claims both pre and post fraud would provide much needed clarity. Such reform is supported from all sides of the insurance market and is particularly important in light of the removal of avoidance as a remedy in section 17.
- 21.25 In the next section, we provide an overview of our recommendations for reform and also set out the issues which are not covered by our reforms.

⁹ See, for example, *Summers v Fairclough Homes Ltd* [2012] UKSC 26, [2012] 1 WLR 2004. In this case, the Supreme Court held that there was power to strike out such fraudulent claims at a late stage of the proceedings, albeit one which should be exercised only in very "exceptional circumstances".

¹⁰ 1906 Act, s 17.

CHAPTER 22

OVERVIEW OF RECOMMENDATIONS

- 22.1 As we have noted above in Chapter 20, there is a tension between the common law rule that a fraudster forfeits a fraudulent claim, and the statutory rule set out in section 17 of the Marine Insurance Act that the entire policy is avoided if a party behaves in a way which is contrary to good faith. It is clearly undesirable for these two approaches to exist in conflict.
- 22.2 This uneasy juxtaposition leaves two issues which would benefit from clarification:
- (1) The effect of a fraudulent claim on the insurer's liability in respect of a genuine loss suffered before the fraud is committed; and
 - (2) The effect of a fraudulent claim on a genuine claim in respect of loss suffered after the fraud but before the insurer has taken action to terminate the contract.
- 22.3 Our aim is not to codify the law on fraudulent claims generally. Our recommendations simply provide a clear statement of the insurers' remedies for fraudulent claims. They are in line with developments at common law and go hand in hand with our recommendation to remove avoidance as a remedy for breach of good faith under section 17.¹

AN OUTLINE OF THE KEY RECOMMENDATIONS

No liability to pay the fraudulent claim

- 22.4 As explained in previous chapters, forfeiture of the claim is a well-established consequence of making a fraudulent insurance claim. We recommend confirming in primary legislation that, where an insured makes a fraudulent claim under an insurance contract, the insurer should have no liability to pay the claim.
- 22.5 We also recommend that the insurer should be entitled to retain any premiums which have already been paid.
- 22.6 What constitutes a fraudulent claim is a matter for the courts to determine in all the circumstances of a particular case.

An option to treat the contract as having been terminated at the time of the fraudulent act

- 22.7 Once a policyholder has been fraudulent, we do not think that the insurer should be bound to continue the contractual relationship. We recommend, therefore, that the insurer should be entitled to treat the contract as having been terminated at the point of the fraudulent act – that is, from the behaviour which makes a claim fraudulent. This right should be exercisable at the point at which fraud is discovered, whether or not the contract has expired before discovery of the fraud.

¹ We intend to retain the initial section 17 statement (insurance contracts as contracts of utmost good faith) as an interpretative principle. See clause 15 of the draft Bill and the discussion in Chapter 30.

- 22.8 If the insurer exercises this right, it will not be liable to pay claims in respect of losses suffered after the fraudulent act. Furthermore, it need not return any premiums which have been paid before the right is exercised. This remedies the uncertainty on this issue in the current case law.

Legitimate losses before the fraudulent act

- 22.9 We recommend that the insurer's remedies for fraudulent claims should not affect previous valid claims. We think this is the result of our recommended deletion of avoidance as the statutory remedy for breach of the duty of good faith,² but the draft Bill also provides for this explicitly. Again, this remedies the current weaknesses.

Fraud by a member of a group insurance scheme

- 22.10 In group schemes, a single policyholder takes out a policy for the benefit of a number of beneficiaries. The classic example is where an employer takes out health or life insurance for the benefit of its employees.
- 22.11 Here the insurer's remedy in the event of a beneficiary making a fraudulent claim is unclear at best. In Consultation Paper 2 (CP2), we commented that as group members are not policyholders, the normal rules of forfeiture do not appear to apply to them. We thought that the only sanction would be that the member would not receive the fraudulent element of the claim.³
- 22.12 We recommend that the group members who make fraudulent claims should be subject to the same penalties as policyholders. In other words, the insurer's remedies for fraud as set out above should apply in group schemes, except that they should apply against the fraudulent beneficiary rather than the policyholder. This means that only the insurer's liability in respect of the fraudster is affected. Insurers will continue to be liable in respect of claims by non-fraudulent members of the group.

Contracting out

- 22.13 As in our other areas of reform, parties to a non-consumer insurance contract should be able to modify the remedies available for fraud by the use of express contractual terms. We recommend a mandatory regime where consumers are concerned.

ISSUES NOT COVERED

Issues outside the scope of the insurance contract law project

Third party fraud and the criminal law

- 22.14 Our recommendations are limited to insurance contract law. This review did not look at fraudulent third party claims or at the criminal law.

² See Chapter 30.

³ CP2, para 9.25.

- 22.15 A third party may make a fraudulent claim in tort or delict, commonly for personal injury, against a party who seeks to rely on their insurance to cover any liability. The consequences of fraud in such cases have been developed quite separately from fraud by the insured party themselves.⁴ Our recommendations do not apply to fraud by a third party.
- 22.16 Fraud is punishable by the criminal law under the Fraud Act 2006 in England and Wales and the common law in Scotland. We have not reviewed the criminal law as part of this project.⁵

Issues outside the scope of our recommendations

The definition of fraud

- 22.17 In Issues Paper 7 (IP7), we suggested that fraud can be thought of as a range of behaviours. We also discussed the main cases and noted that the exact definition of fraud is not always clear-cut. However, we thought that this arose from the nature of the issues, which were better left to the courts after examining all the circumstances.⁶
- 22.18 The classic case of *Derry v Peek*⁷ held that fraud is proven when it is shown that a false representation has been made (1) knowingly, or (2) without belief in its truth, or (3) recklessly, careless whether it be true or false. Professor Clarke identified three additional elements to a fraudulent claim from his review of the case law:⁸ that the fraud must be wilful, substantial and material.⁹
- 22.19 In IP7 we asked if the definition of fraud should be left to the courts.¹⁰ Most respondents (20 out of 24, or 83%) thought this was the correct approach. We therefore did not propose any changes in CP2.¹¹

⁴ See, for example, *Summers v Fairclough Homes Ltd* [2012] UKSC 26, [2012] 1 WLR 2004. In June 2014, the Government announced measures that will require courts to dismiss personal injury claims where they are satisfied on the balance of probabilities that the claimant has been fundamentally dishonest in relation to the claim, unless the court is satisfied that the claimant would suffer substantial injustice if the claim were dismissed: <https://www.gov.uk/government/news/bogus-claims-to-be-thrown-out-as-government-steps-up-insurance-fraud-crackdown>. At the time of writing, this is being debated by Parliament: see Criminal Justice and Courts Bill 2013-14 to 2014-15 (HL Bill 30), cl 45.

⁵ The Fraud Act 2006 was introduced following a previous Law Commission report: Fraud (2002) Law Com No 276.

⁶ IP7, paras 3.63 to 3.64.

⁷ (1889) LR 14 App Cas 337 at 374. This definition has been held to apply equally to the Scots law of fraud: see *Boyd and Forrest v Glasgow and South-Western Railway Co* 1912 SC (HL) 93, [1915] AC 526; *Romanes v Garman* (1912) 2 SLT 104 and *Robinson v National Bank of Scotland* 1916 SC (HL) 154.

⁸ M A Clarke, *The Law of Insurance Contracts* (5th ed 2006), paras 27-2B to 27-2B4. The recent case of *Versloot Dredging BV v HDI-Gerling Industrie Versicherung AG (The DC Merwestone)* [2013] EWHC 1666 (Comm) at [156] and [157] confirmed that the fraudulent part of a claim has to be substantial “in the sense of not being insubstantial or immaterial or de minimis”, but said that this is “not a high threshold”.

⁹ For a more full discussion, see Part 3 of IP7.

¹⁰ IP7, para 7.27.

¹¹ CP2, para 6.5.

22.20 Several consultees to our recent limited consultation on the first available draft clauses thought that an opportunity had been missed in not clarifying what constitutes a “fraudulent claim”. Equally, however, the Law Society of Scotland told us:

We agree that it is not necessary to provide a statutory definition of fraud ...

22.21 Where the 1906 Act is overly prescriptive – in section 17 and elsewhere – it has often been bypassed by the courts. The draft Bill therefore provides a high level framework on which the courts may apply the rules to diverse and potentially complicated fact scenarios and continue to develop the common law around this framework. We do not recommend defining fraud in the draft Bill. Once there has been a finding of fraud, then our remedies would apply in providing a framework to clarify the insurers’ remedies.

THE CASE OF VERSLOOT

22.22 Although we think the definition of fraud is best left to the courts, it has been suggested that some cases have applied the law very harshly and, may have gone too far.¹² This was recognised by Mr Justice Popplewell in the recent case of *Versloot*.¹³ In that case, an untruth appeared in a letter which supported a genuine claim. Applying the current law and approach, the judge felt forced to conclude that the insurance claim was forfeited, based on the finding that the managing director of the claimant had told “a reckless untruth, not a carefully planned deceit [which] was told on one occasion, not persisted in”. He concluded, however, that, “to be deprived of a valid claim of some £3.2 million as a result of such reckless untruth is, in my view, a disproportionately harsh sanction.”¹⁴

22.23 Mr Justice Popplewell expressed regret about his conclusion and added:¹⁵

My own view would be that if the law is to extend the draconian effect of an anomalous rule, applicable only to insurance claims, and then only prior to the commencement of litigation, to striking down wholly valid claims, the policy of the law should be to require at least a sufficiently close connection between the fraudulent device and the valid claim to make it just and proportionate that the valid claim should be forfeit. The law does not provide in this context that the end always justifies the means; but nor should it say that any dishonest means which are more than de minimis should deprive a litigant of his just ends. What will be just and proportionate will depend upon the circumstances of each case, which may vary considerably.

¹² See for example, the criticisms made of *Aviva Insurance Ltd v Brown* [2011] EWHC 362 (QB): A Bugra and R Merkin, “‘Fraud’ and fraudulent claims”, *Journal of the British Insurance Law Association* (No 125, October 2012) p 3, at p 14. See also G Swaby “The Price of a Lie: discretionary flexibility in insurance fraud”, *Journal of Business Law* 2013, Issue 1, p 77.

¹³ *Versloot Dredging BV v HDI-Gerling Industrie Versicherung AG (The DC Merwestone)* [2013] EWHC 1666.

¹⁴ At [225].

¹⁵ At [177].

22.24 At the time of publication, the Law Commissions understand that the decision in *Versloot* is being taken to the Court of Appeal. We think there is an argument that the “fraudulent device” employed in that case does not satisfy the common law requirements for fraud of substantiality and materiality. We leave this issue to the courts.

Attribution of knowledge

22.25 As discussed in Part 2 of this Report, we recommend a series of rules in the context of the duty of fair presentation to determine whose knowledge is included when it comes to assessing what the prospective policyholder and the insurer knew at the time of disclosure. This is because the policyholder has to know in advance of entering into the insurance contract how far it has to go to collate information to be disclosed. In large companies, there may be material circumstances which should be disclosed to the insurer but which are not known by the “directing mind and will”. The common law rules cannot satisfactorily deal with these matters and so we recommend special rules.

22.26 In the context of post-contract fraud, however, the existing rules of attribution are relatively clear. In general, the knowledge or acts of individuals who constitute the “directing mind and will” of a company will be attributed to it.¹⁶ The courts have stressed that this is a flexible test which is intended to further the purpose behind the law.

22.27 It is appropriate and necessary that there is flexibility in the rules to suit the varied factual circumstances which may arise. We do not think that a statutory provision on this is necessary and it may prove unworkable.

PROPOSALS WE ARE NOT PROGRESSING

Costs of investigation

22.28 In CP2, we tentatively proposed that insurers should have a statutory right to recover the costs of their investigations where fraud is discovered.¹⁷ Currently, insurers cannot recover these expenses in contract,¹⁸ although they might recover under a claim for deceit.¹⁹

22.29 The responses to this proposal were mixed. There was concern at the practicality of such a right. Some consultees felt that it would be too difficult to assess the costs where the investigations are carried out internally. Insurers would instead outsource these investigations to third parties to be able to present the court with an invoice setting out the full costs of the investigation. This could have the effect of increasing overall investigation costs, which would be passed on in increased premiums if not recovered in full. Some argued that investigation of claims should be considered an inherent cost of the insurer’s business.

¹⁶ See, for example, *Lennard’s Carrying Co Ltd v Asiatic Petroleum Co Ltd* [1915] AC 705; *Meridian Global Funds Management Asia Ltd v Securities Commission* [1995] 2 AC 500; *Group Josi Re v Walbrook Insurance Co Ltd* [1996] 1 All ER 791; *Manifest Shipping & Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469.

¹⁷ CP2, from para 8.19.

¹⁸ *London Assurance Co v Clare* (1937) 57 Ll L Rep 254.

¹⁹ *Insurance Corporation of the Channel Islands Ltd v McHugh* [1997] 1 LRLR 94.

22.30 Taking these arguments into account, the Commissions do not think that there is a sufficiently strong case for reform. We do not consider that the recoverability of investigation costs will significantly disincentivise policyholder fraud. Indeed, in many cases policyholders are unlikely to be in a position to repay investigation costs. There have also been no major attempts by insurers to bring claims in deceit, nor any industry moves to include express terms in contracts to the effect that costs are recoverable in the case of a fraud investigation. Both of these options are already available to insurers.

22.31 The case for reform on this issue was therefore lacking given the practical problems identified and the apparent lack of demand. If insurers feel strongly that they ought to be able to recover investigation costs where they uncover fraud, then (in non-consumer insurance contracts) they can insert express terms to that effect in their contracts.

Co-insurance

22.32 We consulted on the situation of co-insureds, where two or more insureds are insured under the same policy, and one commits fraud or a deliberate destructive act.²⁰ A common example of co-insurance is insurance of a family home by spouses or cohabitants. Generally, an innocent insured's claim would be tainted by the fraud of their co-insured in situations where the interest is joint rather than several.

22.33 In IP7 we explained that problems might arise where policyholders start by taking out insurance together, become estranged and one acts contrary to the other's interest, for example by burning down the matrimonial home. This scenario has arisen in other jurisdictions,²¹ but has not been faced by the English or Scottish courts. Other common law jurisdictions have been sympathetic to an innocent party who has suffered from the wrongful act of a co-insured, and have found ways to allow the innocent party to recover his or her share of the loss.²²

22.34 In IP7, we tentatively proposed legislation to protect a joint policyholder who could prove that a fraud or wrongful act was carried out without his or her knowledge. While many consultees supported this proposal in principle, serious questions were raised about how it would operate in practice.

22.35 Consultees queried whether the courts would be able to distinguish between cases where co-insureds acted together and cases where their interests were no longer aligned.

22.36 Although we proposed that recovery should be limited to the innocent insured's own interest, consultees pointed out that it would be difficult to value the innocent party's share, particularly where the co-insureds were married.

²⁰ See CP2, para 9.2.

²¹ In the US, see *Klemens v Badger Mutual Insurance Co of Milwaukee* (1959) 8 Wis 2d 565, 99 NW 2d 865. In Australia, see *Holmes v GRE Insurance Ltd* [1988] TASSc 14, (1988) Tas R 147. In New Zealand, see *Maulder v National Insurance Company of New Zealand Ltd* [1993] 2 NZLR 351.

²² For discussion, see IP7, Part 5.

22.37 Further, in many of the cases we would want to catch, the claim would not actually be fraudulent. Where it is clear that one spouse set fire to the house, for example, the other is not making a fraudulent claim if they try to recover their share on the basis that they were innocent. Rather, their claim is likely to be excluded because policies usually provide that the insurer is not liable to pay if one of the insured parties, or a friend or family member, brings about the loss or damage intentionally. Disapplying the statutory remedies for fraud would therefore make no difference because it is a coverage issue.²³

22.38 In CP2 we concluded that legislation would not be appropriate unless there was evidence that this was a significant issue in practice.²⁴

22.39 We received almost no evidence from consultees that these cases are a problem in practice and the majority of consultees agreed that legislation is not needed for these cases.²⁵ RSA told us that:

There will always be difficulties where one party to insurance does something to negate a benefit otherwise owed to another joint insured. Insurers normally consider such cases on their merits, and may, where possible, act to protect the interests of the innocent. There can be no formula, and we agree that this should not be addressed in the proposed legislation. The legal position as it presently stands should remain intact.

22.40 Further, Airmic noted that:

...the effect of fraud by one joint insured on the other joint insured's claim should be the subject of a clause in the contract and not a matter for legislation.

22.41 We have decided not to address this matter in statute as part of our default rules.

22.42 In the case of consumer insurance the FOS would be able to require the insurer to pay up to £150,000 and may recommend that they pay more, so some recovery may be available.

²³ We note that, in several jurisdictions which have legislated to protect innocent co-insureds such as British Columbia, the legislation focuses on the effect of these terms rather than looking at the cases in the context of fraud. http://www.leg.bc.ca/38th4th/1st_read/gov40-1.htm (see section 28.5).

²⁴ CP2, para 9.20.

²⁵ But see G Swaby, 'Blurring Distinctions: should innocent insureds be tarred with the same brush as their fraudulent agents?' *Insurance Law Journal*, (2013) 24(60).

22.43 In addition, we think that the concepts of joint and composite insurance are sufficiently flexible to allow the courts to protect an innocent party in a suitable case. This approach has been adopted in other jurisdictions and the UK courts have begun to suggest that they might take the same approach.²⁶

²⁶ See for example *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm), in which the policy was found to be composite – although in that case the title to the house was held by one of the co-insureds. In *Direct Line Insurance Plc v Khan* [2001] EWCA Civ 1794, a husband was found to be acting as his wife’s agent in making a fraudulent claim. In that case, the couple were still together and the harm was not directed at the wife.

CHAPTER 23

DETAILED RECOMMENDATIONS

- 23.1 In the previous chapter we outlined our recommendations for introducing a scheme of statutory consequences for fraudulent insurance claims. Below, we discuss the recommendations in more detail, referring to the relevant clauses of the draft Bill.

A FRAUDULENT CLAIM BY THE INSURED

- 23.2 Clause 12 of the draft Bill implements our recommendations. Importantly, it applies when an “insured” makes a “fraudulent claim”.

A claim made by the “insured”

- 23.3 Our recommendations target claims made and frauds perpetrated by the policyholder, and not by any third party. Clause 12(1) makes this clear by stating that the remedies apply where “the insured makes a fraudulent claim under a contract of insurance”. Clause 1 of the draft Bill defines the insured as the party who enters the contract with the insurer.
- 23.4 Our provisions do not cover circumstances where a fraudulent claim is made by a third party against an insured who then claims on its liability policy.¹ Furthermore, the rules will not generally apply where a claim is made directly against an insurer by someone other than the insured. The common law will operate to determine whether parties other than the original insured are to be treated as the insured for this purpose (for example, where a policy has been novated).
- 23.5 The position is more complex where the insured becomes insolvent and the rights of the insured are transferred to a third party under the Third Parties (Rights Against Insurers) Act 1930 (the 1930 Act) or, once in force, the Third Parties (Rights Against Insurers) Act 2010 (the 2010 Act). Here the statutory provisions specifically state that the third party acquires only those rights which would be available to the insured. As the third party cannot be in a better position than the insured, a third party who fraudulently exaggerates a claim to the insurer would appear to forfeit the whole amount.²

¹ Here the consequences of fraud have developed quite separately from the treatment of first party insurance fraud with which we are concerned. See paras 22.14 and 22.15 of this Report.

² See ss 1(1) and 1(4) of the 1930 Act and s 1(2) of the 2010 Act. The courts have also stressed that the third party acquires the same rights as the insured, see *Firma C-Trade SA v Newcastle Protection and Indemnity Association (London) Ltd (The Fanti)*; *Socony Mobil Oil Co Inc v West of England Shipowners Mutual Insurance Association Ltd (The Padre Island)* [1991] 2 AC 1 at 29 and *Post Office v Norwich Union Fire Insurance Society Ltd* [1967] 2 QB 363 at 376.

What makes a claim “fraudulent”?

- 23.6 As we explained in Chapter 22, we have not sought to define fraud or a fraudulent claim; whether a claim is fraudulent will be determined by the courts applying common law principles.³
- 23.7 Inconsequential or *de minimis* dishonesty may be found not to satisfy the definition of fraud. However, we do not recommend any statutory discretion for the courts to disapply the statutory remedies once fraud has been established. Although there has been some criticism of this policy, with a small number of consultees arguing it can operate harshly, most consultees agree that there should be no leniency towards fraudsters.

NO LIABILITY TO PAY THE FRAUDULENT CLAIM

- 23.8 As we have already discussed, forfeiture of the fraudulent claim is a well-established principle of the common law.⁴
- 23.9 Clause 12(1)(a) provides that, where an insured makes a fraudulent claim under a contract of insurance, the insurer is not liable to pay the fraudulent claim. This clause effectively introduces into statute the principle of forfeiture of the fraudulent claim. As we are concerned with remedies, it is expressed from the standpoint of the insurer’s rights.
- 23.10 James Davey and Katie Richards of Cardiff Law School said in response to the January 2014 consultation:

We view clause [12] as a broad attempt to codify the ‘forfeiture rule’ as developed in recent litigation, most notably by Lord Mance. It largely confirms the assumptions made in that line of case law, that any ‘fraudulent claim’ will discharge the insurer from liability for the entirety of that claim, but leaves prior (innocent) claims untouched.

What is the fraudulent “claim” for the purposes of forfeiture?

- 23.11 The courts tend to apply the remedy of forfeiture to the “whole claim” or the “entire claim” to which the fraud relates.⁵ For example, an insured covered by buildings and contents insurance whose house burns down might exaggerate the value of their possessions when making the contents claim but claim accurately under the buildings cover. The timings of such claims may be split, with for example the exaggerated contents claim being submitted later than the buildings claim and on a separate claims form. We noted that in such situations the claim would generally be regarded as a single claim and would be forfeit in its entirety.
- 23.12 The courts have tended to give a wide meaning to the concept of a single claim or the whole claim, especially where different elements arise from the same incident. If the remedy was only applied to items on a single claim form, policyholders may escape liability by submitting a claim in a piecemeal fashion.

³ See, for example, *Derry v Peek* (1889) LR 14 App Cas 337, discussed at para 22.18 above.

⁴ See Chapter 20.

23.13 In *Aviva Insurance Ltd v Brown*, Mr Justice Eder said that “the claims for the cost of repair and alternative accommodation were part of the *same claim* arising out of the subsidence and there is ... no proper basis for dealing with them separately” (emphasis added).⁶ In *Yeganeh v Zurich Insurance* the judge referred to the “entire claim” being forfeited.⁷

23.14 Courts regularly address the question of whether related events or aspects of a claim should be treated separately or as part of the same claim having resulted from the same series of events. These questions arise not only in the context of fraud but frequently in determining whether excesses and claims limits should be applied once to a single overall claim or separately to discrete elements.⁸ Often the answer will involve interpretation of the terms of the policy and any definition of event or claim.

23.15 We suggested in Consultation Paper 2 (CP2) that there was no need to define these concepts in statute and nearly 90% of consultees agreed. The ABI said:

The definition of ‘the whole claim’ will very much depend on the individual facts and circumstances of the case and as a consequence it is not possible to have a generic definition.

23.16 Although we do not recommend any changes to this approach and agree that in most cases it must be correct, it is not without its critics. Aysegul Bugra and Rob Merkin have argued that:

...it is not obvious why the all or nothing approach should extend beyond the precise fraudulent claims and to other claims which arise from the same event but falling under different policy sections. Can it be said that that principle gives a proportional remedy, particularly where ... the innocent element dwarfs the fraudulent element?⁹

23.17 Our view is that the meaning of a “claim” (and how wide that interpretation should be) is best left to the courts to develop, based on the facts and circumstances of each case. Often the answer will involve interpretation of the terms of the policy and any definition of event or claim. We are confident that a reference to “the claim” is sufficient to allow courts to continue to develop this area of law.

⁵ See, for example, *Aviva Insurance Ltd v Brown* [2011] EWHC 362 (QB) and *Yeganeh v Zurich Plc* [2010] EWHC 1185 (QB).

⁶ [2011] EWHC 362 (QB).

⁷ [2010] EWHC 1185 (QB) by HHJ Mackie QC at [75].

⁸ See, for example, *Kuwait Airways Corp v Kuwait Insurance Co SAK* [1999] 1 Lloyd’s Rep 803 (HL).

⁹ A Bugra and R Merkin, “‘Fraud’ and fraudulent claims”, *Journal of the British Insurance Law Association* (No 125, October 2012) p 3, at p 14; see also G Swaby, “The Price of a Lie: discretionary flexibility in insurance fraud”, *Journal of Business Law* 2013, Issue 1, p 77.

Recovery of sums already paid

- 23.18 Clause 12(1)(b) of the draft Bill provides that an insurer may recover any sums already paid in respect of a claim which turns out to be fraudulent. This would include sums paid in instalments in respect of the claim.
- 23.19 This right naturally follows on from clause 12(1)(a) where an insurer has no liability in respect of the fraudulent claim. It exists irrespective of whether or not the insurer elects to treat the policy as terminated on discovery of the fraud.¹⁰
- 23.20 The draft Bill gives the insurer a right to recover sums paid on a fraudulent claim from the *insured*. As discussed above, our proposals are aimed only at first-party fraud, that is, fraud by the insured. We make no recommendation on whether the insurer should have a potentially wide-ranging right to seek recovery from third party recipients or beneficiaries of claim monies; existing common law remedies of tracing will be relevant here.

Settlement agreements

- 23.21 While voluntary settlements are generally respected by the law of restitution, settlements induced by “fraud, duress, undue influence or absence of good faith” are an exception.¹¹ Similarly, in Scots law, the courts are reluctant to undo a settlement (or compromise) on the basis of unjustified enrichment except where there is fraud or force.¹² We do not expect that the insurer will be bound by any settlement or compromise of the claim made before the fraud was discovered.
- 23.22 Some consultees were concerned about the result in *Direct Line v Fox*.¹³ In *Fox*, the fraudulent act (the use of a fraudulent invoice) was committed after the settlement agreement had been entered into and the invoice was submitted to meet a condition of the settlement agreement. As the settlement agreement itself was not a contract of insurance, it was not a contract of utmost good faith and the court found that the forfeiture rule did not apply.
- 23.23 Settlement agreements fall outside of the scope of our current recommendations, which are concerned with the relationship under the insurance contract itself.¹⁴ Insurers who are concerned about this are free to include clauses in their settlement agreements to ensure a suitable remedy.

¹⁰ This element of our recommendations is discussed below from para 23.24.

¹¹ G Virgo, *The Principles of Restitution* (2nd ed 2006) p 670. See also M A Clarke, *The Law of Insurance Contracts* (5th ed 2006) at 30-5C2 and 30-6A. The UK Supreme Court has recently held that a settlement in a personal injury case could be set aside on the grounds of the claimant’s incapacity: *Dunhill v Burgin* [2014] UKSC 18.

¹² See W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007), paras 15-24 and 15-25; R Evans-Jones, *Unjustified Enrichment*, vol 1 (2003), paras 3.116 to 3.119; Stair, *Institutions*, I, 7, 9; *Evenoon Ltd v Jackel & Co Ltd* 1982 SLT 83 at 86 by Lord President Emslie; *Assets Co Ltd v Guild* (1885) 13 R 281 at 297 by Lord President Inglis.

¹³ [2009] EWHC 386 (QB).

¹⁴ For example, our contracting out requirements do not apply to settlement agreements; see draft Bill clauses 16(3) and 17(7), and Chapter 29 of this Report.

OPTION TO TREAT THE CONTRACT AS HAVING TERMINATED AT THE TIME OF THE FRAUDULENT ACT

- 23.24 In CP2, we argued that insurers should not be bound to their contractual relationship with a fraudulent policyholder. We said that parties who commit insurance fraud should lose their entitlement to any claims relating to losses arising after the date of the fraud, regardless of when the fraud is uncovered. In CP2 we acknowledged that this was in line with current market practice.¹⁵
- 23.25 Agreeing with the proposal that claims arising after the fraud should also be forfeited and the contract effectively terminated, a number of consultees commented on how termination should be effected. There were three possible approaches:
- (1) Automatic termination of the contract on discovery of a fraud.
 - (2) Insurer's right to terminate on discovery of a fraud, with retrospective effect.
 - (3) Insurer's right to terminate with prospective effect only.

A remedy with “retrospective effect”

- 23.26 Most consultees agreed that the remedy should take effect from the time of the fraud. The BILA committee said there was “complete agreement” amongst its members that:

Because there is likely to be a time lag between the commission of a fraud and its discovery, [any] remedy would have retrospective effect, but insureds who are prepared to commit fraud must expect that insurers will not want to have any dealings with them after discovery of the fraud.

- 23.27 The Judges of the Court of Session agreed that forfeiture should happen from the date of fraud rather than from the date of rescission by the insurer. They said, further, that it:

... should be made clear in any legislation whether this forfeiture is to happen automatically, as a matter of law, or whether it will happen only if the insurer elects to terminate or rescind the insurance cover on discovery of the fraud. The latter ... is, we suggest, consistent with the need for both parties to the contract to know where they stand.

An optional remedy

- 23.28 We recommend a version of the second approach referred to in paragraph 23.25 above. Clause 12(1)(c) provides that an insurer may, by notice to the insured, treat the contract as having been terminated with effect from the time of the fraudulent act.

¹⁵ CP2, para 7.23.

- 23.29 Although we assume that insurers will not usually wish to continue the relationship after discovery of a fraud, we recommend that insurers should be able to forego this right and continue the policy should they wish to: the contract should not be terminated automatically. Where the insurer does not elect to terminate the policy, it will continue to be liable to make payment under the policy in respect of losses occurring after the fraudulent act.
- 23.30 Where the insurer elects to terminate, it may refuse to pay claims for all losses occurring subsequent to the fraudulent act. This is contained in clause 12(2)(a), which provides that the insurer may “refuse all liability ... in respect of a relevant event occurring after the time of the fraudulent act”. This is the key aspect of our policy on termination. The formulation of this provision is consistent with the formulation of avoidance under the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) and our recommended remedies for deliberate or reckless breach of the duty of fair presentation, which both state that the insurer “may avoid the contract *and refuse all claims*”.¹⁶

Subsequent or separate contracts

- 23.31 This remedy is exercisable in respect of the insurance contract under which the fraudulent claim is made. It does not allow the insurer to terminate a subsequent renewed insurance contract, which constitutes an entirely new contract.¹⁷ Nor does it affect the insurer’s liability under other policies the insured has with the insurer.
- 23.32 It does not affect claims against other insurers insuring the same loss against which no fraud was perpetrated.

The “fraudulent act”

- 23.33 Clause 12(1)(c) provides that the insurer may opt to treat the contract as having been terminated “with effect from the time of the fraudulent act”. The fraudulent act is the behaviour which makes a claim fraudulent. This concept is therefore distinct from the fraudulent claim, which, as discussed above, generally means the whole claim, even where the fraudulent element is introduced later on in the claims process.
- 23.34 For example, if a policyholder submitted a genuine claim in January, and then added a fraudulent element in March, the “fraudulent act” would take place in March.
- 23.35 There might be some doubt over when exactly the fraudulent act could be said to have taken place, and we appreciate that the fraudulent act is a new concept. However, we are satisfied that the courts have shown themselves able to resolve similar issues and we consider that this type of assessment is properly left to their analysis. We think that the courts are capable of determining this question in light of a common sense interpretation of the phrase and in accordance with the purposes for which remedies for fraud have been developed.

¹⁶ See para 2 of the Schedule to the draft Bill and Schedule 1, para 2 of CIDRA.

¹⁷ *Stockell v Heywood* [1897] 1 Ch 459. However, remedies for non-disclosure or misrepresentation may well be relevant.

23.36 For illustrative purposes only, using the five classes of fraud identified by Mance LJ in *Agapitos v Agnew*,¹⁸ we identify below what we would anticipate the “fraudulent act” to be in each case:

- (1) The insured suffered no genuine loss at all or the loss was caused by the deliberate act of the insured with fraudulent intent. In these cases, the date of the fraudulent act is the submission of the claim (in the latter case, together with the failure to admit the cause of the loss). Although it may be a step towards the fraudulent claim, the commission of a deliberate act, such as setting fire to property, is not in itself fraudulent.
- (2) The insured suffered some loss but exaggerates that loss (for example, overvaluation of property or adding additional items to the list of property genuinely lost). Here, the fraudulent act would be when the exaggerated element is communicated to the insurer. This could be at the initial submission of the claim or a later date.
- (3) The insured, having apparently sustained a loss, subsequently discovers that there is no loss or loss of a smaller amount but continues to press for the original claim. We think the fraudulent act only occurs when the party has failed to advise the insurer of the new information within a reasonable time.¹⁹ What is a reasonable time would be for the courts to decide in the circumstances.²⁰
- (4) The insured makes a claim against the insurers knowing that the insurers have a defence and fails to advise the insurers of that. It has been queried whether it is really the case that an insured has to draw a defence to the insurers’ attention if the insurers could have discovered it based upon the facts known to them.²¹ If so, the fraudulent act is the failure to disclose the defence. If the defence is known at the point of submission of the claim, the fraudulent act is at that point. If the defence is only discovered later, the fraudulent act is as in (3) above.
- (5) Use of a fraudulent means or device (for example, a false receipt) to support a genuine claim. If the courts consider the device to amount to fraud, the fraudulent act occurs when the fraudulent device is used or submitted.

¹⁸ *Agapitos v Agnew (No 1) (The Aegeon)* [2002] EWCA Civ 247, [2003] QB 556.

¹⁹ Maintenance (even by omission) of an initially innocent claim once it is discovered to be inaccurate is itself a fraudulent act. See *Agapitos v Agnew (No 1) (The Aegeon)* [2002] EWCA Civ 247, [2003] QB 556 at [15] and [16] and *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469.

²⁰ *Piermay Shipping Co SA and Brandt’s Ltd v Chester (The Michael)* [1979] 2 Lloyd’s Rep 1, the owners of a ship came into possession of information which they should have passed on to their insurer, having previously submitted a claim. They waited until their next meeting with their broker to pass on this information. The Court of Appeal found that they had not acted fraudulently in doing so.

²¹ A Bugra and R Merkin, “‘Fraud’ and fraudulent claims”, *Journal of the British Insurance Law Association* (No 125, October 2012) p 3, at p 7.

- 23.37 Where the fraud consists of a sequence of acts, such as a series of representations which, when taken together, are sufficient to taint the whole claim, we would anticipate the fraudulent act being the first of those acts.

Exercise of the right on discovery of fraud

- 23.38 Although the insurer may not discover a fraud until some time after it has been committed, at the point of discovery the insurer may exercise its right under clause 12(1)(c). This right will be exercisable whether or not the contract has expired before discovery of the fraud.
- 23.39 Some consultees wondered whether an insurer could be required to make a decision to terminate within a certain time of establishing fraud so that the policyholder would have the opportunity of seeking alternative cover rather than having post-fraud claims refused. We agree that, ideally, the insurer should make a decision as soon as fraud is discovered and let the insured know as soon as possible if the contract is to be treated as having been terminated. However, this must be balanced against the insurer's considerations given the difficulties inherent in investigating and proving fraud and questions about when a fraud is actually "discovered" rather than merely suspected.
- 23.40 We think there would be scope for an insured to claim that an insurer had waived its right to rely on clause 12(1)(c) if it had not done so as soon as it discovered fraud – or had not made reasonable attempts to confirm its suspicions until a larger, genuine claim arose which it did not want to pay. The normal rules for establishing waiver would apply.²² Further, as discussed later in this Report,²³ the requirement for good faith may operate to prevent an insurer relying on a remedy in an unfair way.

Retention of premium

- 23.41 Where the insurer elects to treat the contract as having been terminated, the policyholder should not be entitled to repayment of any premium, whether it was paid before or after the fraudulent act. This appears to be the current position²⁴ but we recommend that this be confirmed in statute. It is covered at clause 12(2)(b).

²² See, for example, *Chitty on Contracts* (31st ed 2012) paras 24-007 and 24-008. The effect of waiver by estoppel may be suspensory rather than of permanent effect. The Scots law on waiver is similar in effect though it does not draw a distinction between waiver by election and waiver by estoppel. See E C Reid & J G W Blackie, *Personal Bar* (2006), Chapter 3.

²³ From para 30.54.

²⁴ See IP7, para 4.62. See also Marine Insurance Act 1906 s 84(1), which states that although the premium is normally returnable following a total failure of consideration, this does not apply where there has been "fraud or illegality on the part of the assured or his agents".

23.42 This is in line with our recommended approach in respect of a deliberate or reckless breach of the duty of fair presentation – the insurer need not return any premium paid.²⁵ It also recalls the position in CIDRA under which a consumer is not entitled to repayment of the premium if they have made a deliberate or reckless misrepresentation.

23.43 CIDRA provides an exception to retention of the premium to the extent that it would be unfair to the consumer to retain it.²⁶ That reference to retention of a premium being “unfair” in some circumstances was included in CIDRA to deal with specific concerns in respect of (a) life insurance policies which include an investment element and (b) joint policies. Our particular concern in the context of joint policies was joint lives policies, where the premiums may have been made over many years.²⁷ We do not consider these exceptions to be relevant or appropriate in the context of fraud.

Losses occurring and claims made policies

23.44 The drafting is intended to accommodate both “losses occurring” and “claims made” policies.²⁸ Under a losses occurring policy, if the insurer exercises its clause 12(1)(c) rights, it will have no liability to pay claims in respect of any loss suffered after the fraudulent act. Under a claims made policy, we intend that the insurer would have no liability to pay in respect of any claim or circumstance notified after that time. The occurrence of the loss or the notification of a claim (as the case may be) would constitute the “relevant event” for the purposes of clauses 12(2) and (3).

23.45 Clause 12(4) defines “relevant event” as whatever gives rise to the insurer’s liability under the particular insurance contract, and includes examples to demonstrate the distinction between, for example, losses occurring and claims made policies. The definition provides examples of situations that give rise to an insurer’s liability under the contract. However, it is not exhaustive. This allows the way policies are written to develop in the market without concern that the remedies for fraud will no longer apply. We are intending to capture the event that triggers the insurer’s liability under the contract.

Payments made for genuine claims subsequent to the fraudulent act

23.46 There is a difference in the way that the draft Bill treats payments made in respect of a forfeited claim and payments made on genuine claims that occur after the fraudulent act.

²⁵ See draft Bill, clause 8 and para 2 of the Schedule. See also para 11.35 of this Report onwards.

²⁶ CIDRA, Schedule 1(1) para 2.

²⁷ See paras 6.40 to 6.53 of the Report on Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (December 2009) Law Com No 319; Scot Law Com No 219. http://lawcommission.justice.gov.uk/docs/lc319_Consumer_Insurance_Law.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/268/107/.

²⁸ Most insurance policies are written on a “losses occurring” basis. This means that the insurance in force at the time an insured peril occurs is the policy that will respond to a claim made in respect of that insured peril. Where “claims made” policies do arise, it is usually in the context of liability insurance. They provide cover for any claim that is notified to the insurer during the period of the policy, regardless of the time when the negligent act occurred (or when the insured’s liability for it is determined).

- 23.47 Clause 12(1)(b) provides that where a claim is forfeited (that is, the fraudulent claim itself), the insurer may recover from the insured any sums paid by the insurer to the insured in respect of it.
- 23.48 The option to exercise the right in clause 12(1)(c) of course depends on the insurer having discovered the fraud. If any payments have already been made in respect of relevant events occurring after a fraudulent act but before discovery of the same, the draft Bill does not give insurers a statutory right to recover those sums.
- 23.49 The draft Bill states that payments made on the fraudulent claim itself are always recoverable. However, there are other legal and policy considerations when it comes to sums paid on *later* genuine claims, including the status of the contract at the time the sums are paid and whether a policyholder may act in good faith in relying on payments made in respect of a genuine claim, if the claim arises subsequent to a fraudulent act.
- 23.50 It may be that, if the insurer were to exercise its right to treat the contract as terminated, a right to recover payments already made in respect of post-fraud events would exist. Any such right would arise at common law in both England & Wales and Scotland, by way of the law of unjust or unjustified enrichment. However, the law is uncertain and the issues complex. Consider, for example, whether the insurer's payment is valid and irreversible because it was made in accordance with a subsisting contract, or is reversible because it was made in mistake or error or because the purpose for which it was made came to an end. If it is reversible in principle, there may also be a question about whether and to what extent an insured's change of position may provide a defence to recovery. We are not aware of any such use of enrichment law in practice by insurers, however.
- 23.51 Because of the vast range of circumstances which could engage these issues and the different considerations which are at play, we do not think it is appropriate to try to formulate a statutory rule where there is common law jurisprudence which affords the necessary flexibility of response. This is consistent with our policy on fair presentation.²⁹
- 23.52 In any event, as we noted in CP2,³⁰ insurers frequently include express policy terms which specify that, following a fraud, subsequent claims will not be covered. They may also choose to provide for recovery of sums paid before discovery of the fraud. In non-consumer insurance contracts, such provisions would still have force.

²⁹ Our recommended remedies for breach of the duty of fair presentation are discussed in Chapter 11. The draft Bill does not give a statutory right to recover monies already paid by the insurer before a breach is discovered, for these same reasons.

³⁰ Paras 7.22 to 7.25.

GENUINE LOSSES PRECEDING THE FRAUD

- 23.53 We argued in CP2 that avoidance of previous claims would be unprincipled, potentially disproportionate and of little practical value because many insured parties would not be able to return monies previously received. Almost every consultee agreed with us. 94% of consultees agreed that the insured should be entitled to be paid for any previous valid claim which arose before the fraud took place.
- 23.54 We recommend that any valid claim relating to genuine loss that the insured suffered before committing the fraudulent act should be unaffected by the subsequent fraud. This is provided for in clause 12(3). The insurer will continue to be liable in respect of relevant events (usually insured losses) occurring before the time of the fraudulent act, even where it elects to treat the contract as having been terminated at the time of the fraudulent act under clause 12(1)(c).
- 23.55 Even if the claim is submitted after the fraudulent act has been committed, the insurer will still be liable to pay the claim where the relevant event (usually the loss) occurred before the fraud. The insured's right to recovery for a loss crystallises on the date of the occurrence of the relevant event and not on the date on which the claim is made.
- 23.56 A large number of consultees, particularly from within the insurance industry, thought that insurers must be able to reinvestigate previously paid claims in the light of later fraud. There is nothing to prevent insurers revisiting past claims in order to investigate whether they too were fraudulent.

THE REMEDIES APPLIED

- 23.57 The order of events will be important in determining the validity of a genuine claim submitted around the same time as a fraudulent one. Here we provide an example to illustrate how these rules will be applied.

An illustration

An insured has buildings and contents insurance, which works on a "losses occurring" basis.³¹

(1) January

A fire occurs. This is an insured event under the contract.

The insured makes a genuine claim for building damage and some contents.

(2) February

A flood occurs. This is an insured event under the contract.

(3) March

³¹ Discussed at para 23.44 above.

The insured fraudulently claims for additional contents allegedly lost in January's fire. This is a "fraudulent act".

(4) April

A burglary occurs. This is an insured event under the contract.

The insured makes a genuine claim for loss suffered in the burglary.

The insured makes a genuine claim for damage caused by February's flood.

(5) May

The insurer discovers March's fraudulent act.

The consequences

- (6) The fire claim (January and March elements) is forfeited in its entirety due to the "fraudulent act" committed in March. The insurer has no liability to pay anything in respect of this claim.
- (7) The flood claim (occurring in February; claim made in April) is valid and the insurer is liable to pay out. This is because the loss occurred before the fraudulent act and therefore before the contract is terminated.
- (8) If, on discovery of the fraud, the insurer elects to exercise its rights under clause 12(1)(c) and gives notice to the insured, the insurance contract will be treated as having been terminated at the point of the fraudulent act in March.
- (9) The burglary (occurring and claimed for in April) is after the date of "termination" of the contract and the insurer therefore has no liability to pay.

23.58 This example also demonstrates an important distinction in the trigger factors for two distinct rules:

(1) Rule 1 – forfeiture of the fraudulent claim.

The claim is forfeited when a fraudulent element is introduced. Any genuine elements of a claim which have been submitted before the fraudulent element is introduced will usually be tainted retrospectively so that the claim is forfeited from the point of first communication about the claim.³²

(2) Rule 2 – termination with effect from the date of the fraudulent act.

Once fraud has been uncovered, the insurance contract can be terminated by the insurer with retrospective effect from the date of the fraudulent act.

³² Discussed from para 23.11 above.

CONTRACTING OUT OF THE DEFAULT RULES IN CLAUSE 12

Consumer insurance contracts

- 23.59 In consumer insurance contracts, insurers will not be permitted to contract out of the statutory default rules on fraud where it would put the insured in a worse position than the provisions provided for in Clause 12. Any such clause in a consumer insurance contract will be of no effect (see clause 16(1)). This means, for example, that an insurer may not provide for harsher remedies such as avoidance.

Non-consumer insurance contracts

- 23.60 In non-consumer insurance contracts, insurers will be permitted to provide for alternative remedies provided that two transparency requirements in clauses 17 and 18 are satisfied:

- (1) The insurer must take sufficient steps to draw the term to the insured's attention before the contract is entered into,³³ and
- (2) The term must be clear and unambiguous as to its effect.³⁴

- 23.61 Our contracting out policy, and the transparency requirements, are discussed in Chapter 29.

- 23.62 In its response to consultation, the IUA noted:

Importantly, insurers also remain able to specify any remedy (including avoidance), termination rights (including termination by election) and recovery rights in the policy.

INSURERS' REMEDIES FOR FRAUDULENT CLAIMS BY MEMBERS OF GROUP INSURANCE SCHEMES

- 23.63 Group schemes are an increasingly important form of insurance. Typically, such schemes are set up by employers for the benefit of their employees and concentrate on protection insurance, such as life and health cover. By the end of 2013, nearly 11 million people were insured under group cover.³⁵

- 23.64 In our 2009 Report on Consumer Insurance, we noted that the legal principles which apply to such schemes are uncertain and under-developed. We recommended a specific provision to govern the duty of group members not to make misrepresentations to the insurer, which would have consequences for the member but not for the rest of the group. This now forms section 7 of CIDRA.

³³ See draft Bill, clause 18(2).

³⁴ See draft Bill, clause 18(3).

³⁵ Swiss Re, Group Watch 2014, p 3.

23.65 Under a group scheme, the policyholder (A) is typically the employer, who arranges the scheme directly with the insurer. The group members (C) have no specific status. Indeed, insurers are often nervous of any attempt to define the status of group members. For some purposes (such as insurable interest) it is important that they are seen as beneficiaries, while for others (such as tax) there are advantages in writing a purely discretionary scheme, in which the member has no enforceable interest.

23.66 We discussed remedies for fraudulent claims by group members in CP2.³⁶ It is often the case that the people who receive the benefit under the group insurance policy are not parties to the contract, leaving insurers with limited remedies where the person entitled to benefit under the policy acts fraudulently when making a claim. Under the current law, the normal result is that if the fraudster is not the insured, the insurer is required to pay any genuine part of the claim. This provides little disincentive to fraud. On the other hand, any consequence which had implications for all group members would be too harsh.

23.67 In CP2, we proposed that where one or more group members submits a fraudulent claim, the group member(s) concerned should be treated as if they are a party to the contract. The effect of this would be that the statutory remedies would apply: a group member who commits fraud to obtain a benefit under the group scheme would forfeit the entire benefit of the claim and, at the insurer's option, any subsequent benefit under the contract. However, only the fraudulent member should be affected; innocent group members should not be prejudiced. We received strong support. The Financial Ombudsman Service said:

We agree with the proposal that a fraudulent act by one or more group members should be treated as if the group member concerned was a party to the contract. The current law provides no remedy for the insurer in such circumstances and we would welcome the proposal provided that it does not prejudice innocent group members.

23.68 Where a fraudulent claim is made by a group member we therefore recommend that:

- (1) The fraud should have consequences only for the cover of the fraudulent group member. It should not, for example, allow termination of cover in respect of other members; and
- (2) The remedies for fraud contained in the Bill should be applied to the fraudulent group member(s) as if they were party to the contract.

23.69 The recommended provisions are intended to apply only to policies for the benefit of third parties ("group members") directly. They do not apply to policies covering the policyholder's liability to third parties such as third parties under a motor insurance policy.

³⁶ CP2, paras 9.1 to 9.9.

Definition of group insurance: consumer schemes only

23.70 Section 7 of CIDRA provides that the Act's provisions on disclosure and representations apply to a prospective group insurance member as if that group member was entering into the insurance contract directly with the insurer.

23.71 The definition of group insurance, contained in clause 13(1) of our draft Bill, follows the CIDRA definition. The provision is drafted widely. It not only covers the typical employment schemes, but may also cover block building policies taken out by landlords for tenants, or buildings insurance taken out by landlords for long leaseholders. It is possible for group insurance to cover only one member, where (for example) a freeholder takes out insurance for a single leaseholder.

23.72 To fall within the clause:

- (1) A policyholder (A) must take out a policy which is of direct benefit to a third party (C). The policy must normally do more than simply cover A's liability towards C. It must also provide some additional cover for C (such as life insurance or contents insurance).
- (2) C must not be a party to the contract.
- (3) The cover would be a consumer insurance contract if C had taken it out directly. For example, life or household contents insurance would normally be consumer insurance.
- (4) C must make a fraudulent claim. The fraudulent member is referred to as CF. If the policyholder, A, is involved in the fraud, clause 12 will apply as normal and the entire policy will be affected.³⁷

Group insurance in a non-consumer context?

23.73 We have considered whether group insurance exists in a non-consumer context. It is common for policies to be taken out by a single policyholder, such as a parent or holding company, for a number of named beneficiaries. In complex construction sites, standard forms of contract usually require the site owners, contractors and sub-contractors to take out joint insurance on the whole site. However, such arrangements do not generally appear to be treated as "group insurance" policies. Rather, the courts will regard them as bundles of individual insurance contracts.³⁸

³⁷ See the related discussion at paras 7.17 to 7.20 of the Report on Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (December 2009).

³⁸ See, for example, *New Hampshire Insurance Co Ltd v MGN Ltd* [1996] CLC 1728. However, in *Petrofina (UK) Ltd v Magnaload Ltd* [1984] QB 127, a construction site contract was found to be joint insurance for the purposes of a question about subrogation rights among the various insureds.

23.74 The nature of such insurance depends on the facts and the particular contract structure. We think that in a non-consumer context, many contracts with an apparent group structure will be analysed as composite insurance, in which each member of the group is treated by the courts as an insured. This would therefore give insurers the protection they need against fraud by the individual policyholder. We are not aware of any case in which a problem has arisen because of fraud by a claimant who was considered to be a group member rather than an insured.

23.75 In the absence of evidence of problems, we are reluctant to recommend special provisions for group insurance in a non-consumer context.

The insurer's remedy for fraud by a member of a group insurance scheme

23.76 Where a group member (C) makes a fraudulent claim under a group insurance policy, clause 13(2) provides that the provisions of clause 12 apply as if the insurer and the fraudulent member (CF) had entered into a separate insurance contract between them, with CF as the policyholder.

23.77 Where a CF makes a fraudulent claim under a group insurance contract, the insurer therefore:

- (1) has no liability to pay the fraudulent claim;
- (2) has the option to terminate their liability to pay out in respect of losses suffered after the fraudulent act, *but only as regards CF*; and
- (3) remains liable for legitimate losses suffered by CF *before* the fraudulent act.

23.78 These remedies were discussed in detail earlier in this chapter.

Operation of the remedies against the fraudulent member only

23.79 Clause 13(2)(a) provides that the insurer's remedies are only exercisable against the fraudulent member, CF. That means it may not treat its entire liability under the contract as terminated, but only its liability to CF.

23.80 Clause 13(2)(b) provides that the insurance cover provided to the other Cs (the non-fraudulent members of the group scheme) is not affected by CF's fraud.

23.81 If A and CF act in concert (including where A merely knows that CF's claim is fraudulent), or A itself makes a fraudulent claim, the insurer's remedies would affect the whole contract because A is the "insured." We think that such cases of fraud are likely to be very rare.

Recovery of sums paid in respect of the member's fraudulent claim

23.82 The arrangements for payment of insurance monies under group insurance contracts differ between contracts. The insurer may either pay insurance monies to the policyholder, A (who would pass it on to the relevant C) or may pay C directly. Clause 13(3)(a) therefore confirms the point that the insurer may reclaim sums paid in respect of the fraudulent claim from either A or CF, depending on which of them is in possession of the money.

Treating the contract as terminated from the date of the fraudulent act

- 23.83 Clause 13(3)(b) provides that an insurer exercising its right to treat CF's cover as being terminated from the date of the fraudulent act must serve notice to that effect on both A and CF.

No repayment of premium

- 23.84 Clause 13(3)(c) provides that the insurer need not repay any of the premium paid in respect of CF's insurance cover.

Contracting out of group insurance provisions

- 23.85 Our general policy is that an insurer should not be able to use a contract term to put a consumer in a worse position than they would be in under the terms of the draft Bill. This applies equally to consumer members of a group insurance scheme, who should not be put in a worse position by the terms of the policy than they would be in under clause 13.
- 23.86 We expect that the policyholder will usually be a non-consumer insured (such as an employer) and therefore the contract will usually be a non-consumer insurance contract. This is covered by clause 17(4). However, it is possible that a consumer may take out a policy for the benefit of other consumers who become group members. In this situation the contract would be a consumer contract. This is covered by clause 16(1) and 16(2)(b). Both provide that a term of a contract which seeks to put the members of a group scheme in a worse position than they would be in under clause 13 is of no effect.

RECOMMENDATIONS

Recommendation 30: Where an insured makes a fraudulent claim, the insurer should not be liable to pay the claim and should be able to recover any sums already paid in respect of it.

Recommendation 31: In addition, the insurer should have the option to treat the contract as having been terminated with effect from the time of the fraudulent act.

Recommendation 32: The insurer should remain liable for legitimate losses before the fraudulent act.

Recommendation 33: Where a consumer member of a group policy commits fraud, the insurer should have similar remedies against that fraudulent member. Those remedies should not affect the other group members who are innocent.

These recommendations are intended to be the mandatory regime for consumer insurance. In the non-consumer insurance context, these recommendations are intended to be a default scheme and are subject to our contracting out recommendations in Chapter 29.

PART 5

LATE PAYMENT

CHAPTER 24

LATE PAYMENT: INTRODUCTION

- 24.1 Where an insurer has unreasonably refused to pay a claim or paid it only after unreasonable delay, the current law in England and Wales does not provide a remedy for the insured. Notably, the insured is not entitled to damages for any loss suffered as a result of the insurer's unreasonable actions.
- 24.2 The case of *Sprung v Royal Insurance (UK) Ltd* illustrates the problems.¹ When Mr Sprung suffered damage to his factory, the insurers failed to pay his claim for four years, by which time he had been forced out of business. The judge at first instance found that, as a result of the insurer's delayed payment, Mr Sprung had suffered further losses of £75,000. The Court of Appeal held, with "undisguised reluctance", that the insurers were not liable for losses of this type.²
- 24.3 This differs from the law in Scotland and most major common law jurisdictions, where such damages are available. We think that the legal position in England and Wales is anomalous and out of step with general contractual principles. In this Part we make recommendations for its reform.
- 24.4 We consider that a policyholder should have a remedy where an insurer has acted unreasonably in delaying or refusing payment. We therefore recommend a statutory implied term in every insurance contract that the insurer will pay sums due within a reasonable time. Breach of that term should give rise to contractual remedies, including damages. In Scotland the statutory provision will serve to confirm and clarify the position already established at common law.
- 24.5 We recognise that insurers need a reasonable time to investigate claims, and that the length of time required will depend on factors such as the type of insurance and the complexity of the claim. We also understand that the speed with which a claim can be paid may depend on the insured themselves, and other factors outside the insurer's control. Furthermore, insurers have an obligation to ensure that only valid claims are paid. We therefore recommend that they should not be liable for delays caused by genuine disputes.

THE STRUCTURE OF THIS PART

- 24.6 This Part is divided into 4 further chapters:
- (1) In this Chapter, we explain the background to our project on damages for late payment.
 - (2) In the next Chapter we briefly summarise the current law governing damages for late payment.

¹ *Sprung v Royal Insurance (UK) Ltd* [1999] 1 Lloyd's Rep IR 111.

² Above at p 118.

- (3) In Chapter 26 we consider the need for reform and explain why this should be achieved by statute. We also consider the key opposing arguments.
- (4) In Chapter 27 we give an overview of our recommendations.
- (5) In Chapter 28 we discuss our recommendations in detail, with reference to the draft Bill.

A HISTORY OF THE CONSULTATION PROCESS

- 24.7 Liability for late payment of claims was included in our 2006 scoping study,³ in the context of the insurer's obligations of post-contract good faith.

Issues Paper 6

- 24.8 Our initial views on damages for late payment were set out in Issues Paper 6 (IP6), published in March 2010.⁴ We received substantial feedback which led us to modify our views.⁵

The 2011 Consultation Paper

- 24.9 We published updated proposals on damages for late payment in our December 2011 Consultation Paper (CP2).⁶ We received 39 responses to our proposals on late payment, and in December 2012 we published a summary of the responses.⁷
- 24.10 The clauses in the draft Bill are intended to implement those 2011 proposals.

Limited consultation on the draft clauses

- 24.11 In January 2014 we launched a brief consultation on the draft Bill clauses covering damages for late payment. We received 38 responses to this element of that consultation.

³ Law Commission and Scottish Law Commission, Insurance Contract Law: A Joint Scoping Paper, January 2006. http://lawcommission.justice.gov.uk/docs/ICL_Scoping_Paper.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/212/107/.

⁴ Law Commission and Scottish Law Commission, Issues Paper 6: Damages for Late Payment and the Insurer's Duty of Good Faith, March 2010. http://lawcommission.justice.gov.uk/docs/ICL6_Damages_for_Late_Payment.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/192/107/.

⁵ See Summary of Responses to Issues Paper 6, November 2010. http://lawcommission.justice.gov.uk/docs/ICL6_Damages_for_Late_Payment_responses.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/588/107/.

⁶ Insurance Contract Law: Post Contract Duties and other Issues (December 2011) Law Commission Consultation Paper No 201; Scottish Law Commission Discussion Paper No 152. http://lawcommission.justice.gov.uk/docs/cp201_ICL_post_contract_duties.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/947/107/.

⁷ Summary of responses to second consultation paper, chapter 1: Damages for late payment (December 2012). http://lawcommission.justice.gov.uk/docs/damages-for-late-payment_responses.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/1089/107/.

SUPPORT FOR REFORM

24.12 The responses to CP2 revealed widespread agreement that the law on damages for late payment in England and Wales should be reformed. Over 80% of respondents to CP2 agreed that insurers should be under a contractual obligation to pay claims within a reasonable time and that breach should trigger a liability to pay damages for any foreseeable losses which result.

24.13 The Association of British Insurers (ABI) said:

The ABI accepts that there is a need for reform in this area ... If the insurer has declined a valid claim and has acted unreasonably, we accept that the law should be brought into line with general commercial contractual principles.

24.14 The Financial Ombudsman Service (FOS), which has jurisdiction to hear complaints against insurers from consumers and micro-businesses, makes its decisions on fairness rather than strict application of the law.⁸ The FOS told us:

We have already been applying a remedy of damages for late payment for some time and there is also broad acceptance within the industry about the approach we take. However, this approach is inconsistent with the current legal position in the case of *Sprung*.⁹

24.15 There was also majority support for reform among insurance companies and insurance trade bodies. Out of the 14 insurers and insurance organisations who responded, 11 agreed that insurers should be under a contractual obligation to pay claims within a reasonable time.

24.16 We discuss the detail of the consultation responses throughout this Chapter.

⁸ The FOS is discussed in more detail in Chapter 2 of this Report.

⁹ [1999] 1 Lloyd's Rep IR 111.

CHAPTER 25

THE CURRENT LAW

- 25.1 Under the law in England and Wales, an insured who has suffered losses because their insurer has wrongly refused to pay or has delayed paying a valid insurance claim is not entitled to damages.¹ The prohibition against damages for late payment does not apply to non-indemnity insurance such as life insurance, or where the insurer has agreed to reinstate the property. In Issues Paper 6 (IP6) and Consultation Paper 2 (CP2) we argued that this is unfair, unprincipled and uncommercial. In this area, the law of England and Wales differs from that of Scotland and other major common law jurisdictions. Under Scots law, late payment of a valid claim gives rise to damages subject to ordinary contract law principles.² Furthermore, the Financial Ombudsman Service (FOS) disregards this rule when dealing with consumer disputes.³
- 25.2 Below we briefly describe the ordinary principles which apply to damages for breach of contract in general contract law. We contrast this with the special rule for insurance claims, set out in *Sprung v Royal Insurance (UK) Ltd*.⁴ There, it was held that damages are not available where an insurer delays payment or wrongly refuses to pay a claim. We explain that this situation has developed as a result of a historic legal fiction, and consider the position in Scots law which is not afflicted by this fiction. More detail on the current law is available in IP6 and CP2.

GENERAL CONTRACT LAW AND DAMAGES

Ordinary contractual damages

- 25.3 Under both English and Scots law, the general law of contract provides a remedy to a party who suffers loss when another contracting party breaches a term of the contract. The innocent party may claim damages for loss suffered as a result of the breach subject to certain limitations. Traditionally, these are:⁵
- (1) that actual loss, usually financial, was incurred;
 - (2) that the loss was foreseeable at the time the contract was entered into; and
 - (3) that the innocent party has taken reasonable steps to mitigate that loss.

¹ *Sprung v Royal Insurance (UK) Ltd* [1999] 1 Lloyd's Rep IR 111.

² *Strachan v The Scottish Boatowners' Mutual Insurance Association* 2010 SC 367.

³ See the FOS's comment quoted at para 24.14 above.

⁴ [1999] 1 Lloyd's Rep IR 111.

⁵ See *Chitty on Contracts* (31st ed 2012) Chapter 26.

- 25.4 The principle of foreseeable loss was set out in 1854 in the case of *Hadley v Baxendale*,⁶ which is applied in Scotland as well as England and Wales. Damages may be recovered if the type of loss “may reasonably be supposed to have been in the contemplation of both parties, at the time they made the contract.” This may mean losses:
- (1) which may fairly and reasonably be considered as arising naturally, “according to the usual course of things”; and/or
 - (2) arising from any special circumstances which were communicated at the time the contract was made.⁷
- 25.5 The test under *Hadley v Baxendale* has been considered many times and applied cautiously.⁸ The courts have stressed that the rule on foreseeable loss should be applied with a view to commercial reality, the context in which the contract was made and what the parties may reasonably have expected.⁹
- 25.6 The claimant’s duty to mitigate the loss is another important limitation on the contractual damages available.¹⁰ The law expects the victim of a breach of contract to act as if there is no one from whom to claim compensation. This means that the victim must take all reasonable steps to reduce the scale of the loss.
- 25.7 The general law of contractual damages therefore offers some relief to a claimant who has suffered loss as a result of another’s failure to perform their contractual obligations. However, it does so in a careful way, striking a balance between the rights of the parties.

⁶ (1854) 156 ER 145.

⁷ Above, by Alderson B at 354.

⁸ See, for example, *Victoria Laundry (Windsor) Ltd v Newman Industries Ltd* [1949] 2 KB 528; *Koufos v C Czarnikow (The Heron II)* [1969] 1 AC 350. In particular, it was noted in *The Heron II* that the test is more restricted than “reasonably foreseeable” loss in tort law, by Lord Reid at 385. See also *Parsons (Livestock) Ltd v Uttley Ingham & Co Ltd* [1978] QB 791. For Scots law see, for example, *Caledonian Property Group Ltd v Queensferry Property Group Ltd* 1992 SLT 178; *Nelson Cladding Ltd v Murray Williamson (Builders) Ltd* 1995 SLT (Sh Ct) 86; *Ogilvie Builders Ltd v City of Glasgow District Council* 1995 SLT 15; and *Alonvale Ltd v J M Ing* 1993 GWD 36-2345.

⁹ *Transfield Shipping Inc of Panama v Mercator Shipping Inc of Monrovia (The Achilleas)* [2008] UKHL 48, [2009] 1 AC 61, which has been cited on a number of occasions in Outer House cases in Scotland, for example *Donoghue v Greater Glasgow Health Board* [2009] CSOH 115, 2009 GWD 27-432; and *Upton Park Homes Ltd v Macdonalds Solicitors* [2009] CSOH 159, 2010 GWD 2-38, [2010] PNLR 12. Indeed, following *The Achilleas*, it may be that even losses that were not unlikely to occur in the usual course of things will not be recoverable if the defendant could not reasonably be regarded as assuming responsibility for losses of the particular kind suffered. There is still considerable uncertainty around this: see *Chitty on Contracts* (31st ed 2012) Chapter 26. See also IP6, paras 3.14 to 3.18.

¹⁰ *British Westinghouse Electric & Manufacturing Co Ltd v Underground Electric Railways Co of London Ltd (No 2)* [1912] AC 673.

THE UNIQUE POSITION UNDER INSURANCE CONTRACT LAW IN ENGLAND AND WALES

The “hold harmless” principle and insurance monies as damages

- 25.8 In England and Wales, by virtue of a legal fiction, a policyholder under an insurance contract is not able to claim damages from an insurer who causes further loss as a result of wrongful, late or non-payment of an insurance claim. This is because the insurer’s obligation under a contract of indemnity insurance is not, as one may expect, to pay insurance claims in return for payment of the premium. Rather, the English courts have held that the indemnity insurance contract is underpinned by the legal fiction that an insurer’s primary obligation is to “hold the indemnified person harmless against a specified loss or expense”; that is, to prevent the event which is insured against from happening.¹¹
- 25.9 In other words, an insurer’s fundamental obligation is not to pay claims but to prevent the loss occurring in the first place. English law therefore regards an insurance contract as analogous to a contract with a security firm, in which the security firm undertakes to prevent a break-in. This is a surprising position. It is worth noting that the “hold harmless” analysis has not been applied to life insurance¹² or to policies which provide for reinstatement (that is, repair or replacement of property) or where reinstatement is selected as an alternative to financial compensation.¹³
- 25.10 Importantly, in the case of most insurance policies, the “hold harmless” principle means that the law regards insurance payments not as debts due under the contract, but as damages for breach of contract. The significance of this analysis is that, while a claim can be made for damages for late payment of a debt,¹⁴ English law does not recognise a claim for damages for the late payment of damages.¹⁵ A policyholder therefore cannot claim damages for non-payment of insurance monies due.¹⁶

¹¹ *Firma C-Trade SA v Newcastle Protection and Indemnity Association (The Fanti)*; *Secony Mobil Oil Inc v West of England Shipowners Mutual Insurance Association (The Padre Island)* [1991] 2 AC 1 by Lord Goff at 35.

¹² *Blackley v National Mutual Life Association Ltd (No 2)* [1973] 1 NZLR 668, in which a claim was treated as a contract debt and the usual rules of contract law applied.

¹³ See discussion in Part 5 of IP6. See also *Colinvaux’s Law of Insurance* (9th ed 2012) at 10-44, which refers to *Ferruzzi France SA v Oceania Maritime Inc (The Palmea)* [1988] 2 Lloyd’s Rep 261.

¹⁴ *Sempra Metals (formerly Metallgesellschaft Limited) v Commissioners of Inland Revenue* [2007] UKHL 34, [2008] 1 AC 561.

¹⁵ *The President of India v Lips Maritime Corporation (The Lips)* [1988] AC 395, by Lord Brandon at 425.

¹⁶ *Apostolos Konstantine Ventouris v Trevor Rex Mountain (The Italia Express (No 3))* [1992] 2 Lloyd’s Rep 281.

An illustration: the unenviable position of Mr Sprung

- 25.11 In *Sprung v Royal Insurance (UK) Ltd*,¹⁷ Mr Sprung owned a small family business that processed animal waste. He bought insurance to protect his factory against theft and “sudden and unforeseen damage”. When vandals broke into his premises, both his factory and his plant were badly damaged. Mr Sprung submitted a claim to his insurer under the policies, and his claim was rejected.
- 25.12 Mr Sprung’s insurers contended that no theft had occurred and that the policies did not provide cover for “wilful damage”. In difficult economic conditions, Mr Sprung lacked the finance to carry out repairs, and he was unable to raise a loan. Six months later he was out of business.
- 25.13 Mr Sprung started proceedings against his insurers. Four years later, the insurers abandoned their defence, and Mr Sprung was awarded an indemnity for his lost plant and machinery, plus simple interest and costs. The judge found that the claim should have been paid four years earlier. As a result of the insurer’s failure, Mr Sprung suffered a further loss of £75,000 on top of his initial insurance claim.
- 25.14 Mr Sprung was not, however, entitled to claim this further loss. The Court of Appeal, with “undisguised reluctance”, considered itself bound by the principle that there could be no award of damages for late payment because there can be no damages on damages.¹⁸
- 25.15 Lord Justice Beldam felt that indemnity plus simple interest was inadequate to compensate Mr Sprung or an insured in his position, and called for reform of the law.¹⁹

Applying *Sprung* in subsequent cases

- 25.16 In IP6 and CP2 we discussed six cases which considered the rule in *Sprung*.²⁰ *Sprung* was followed in all except one, which was different because the claim was against a broker rather than the insurer.²¹

¹⁷ [1999] 1 Lloyd’s Rep IR 111.

¹⁸ Above, at 118.

¹⁹ Above, at 119.

²⁰ *Insurance Corporation of the Channel Islands Ltd v McHugh* [1997] 1 Lloyd’s Rep IR 94; *Tonkin v UK Insurance Ltd* [2006] EWHC 1120 (TCC), [2006] 2 All ER (Comm) 550; *Normhurst Ltd v Dornoch Ltd* [2004] EWHC 567 (Comm), [2005] Lloyd’s Rep IR 27; *England v Guardian Insurance Ltd* [1999] 2 All ER (Comm) 481; *Mandrake v Countrywide Assured Group* [2005] EWCA Civ 840; and *Arbory Group v West Craven Insurance Services* [2007] Lloyd’s Rep IR 491.

²¹ *Arbory Group v West Craven Insurance Services*, above. As we discuss at para 26.24 below, the legal question here did not involve the hold harmless principle.

- 25.17 In *Sprung*, Lord Justice Evans suggested that if the insurer could be found to have breached a separate obligation, then a claim for damages could arise.²² However, in the cases discussed the courts have felt bound to reject arguments in favour of awarding damages for loss caused by late payment. They have not been prepared to find that the precise wording of the contract creates a contractual obligation to pay,²³ or that the insurer had an implied term to pay within a reasonable time.²⁴
- 25.18 Even where an insurance policy appears to include an express term to pay claims promptly, the courts have felt unable to accept it. In *Tonkin v UK Insurance Ltd*, a household policy contained the following term:
- We will always try to be fair and reasonable whenever you have need of the protection of this Policy. We will also act quickly to provide that protection.²⁵
- 25.19 The policyholders argued that the insurers had breached this term and tried to claim damages. Citing *Sprung*, the judge said that a claim for damages for delay would effectively amount to damages on damages. The judge identified this as “just the sort of claim which the authorities noted above hold to be invalid”,²⁶ and considered that the general principle of no damages on damages was binding on him despite the wording of the clause. However, the judge did note Lord Justice Evans’ suggestion²⁷ that breach of a separate contractual obligation might allow a claim for damages. On the facts, the judge determined that the insurers had not been responsible for the delay.
- 25.20 Lord Mance has since commented on *Tonkin*.²⁸ He suggested that whilst the policy wording in that case may have been “insufficiently clear”, a more explicit requirement on the insurer to pay within a set time might be enforceable as a separate contractual obligation.²⁹

²² *Sprung v Royal Insurance (UK) Ltd* [1999] Lloyds Rep IR 111 at 116.

²³ *Normhurst Ltd v Dornoch Ltd* [2004] EWHC 567 (Comm), [2005] Lloyd’s Rep IR 27, in which the insurance policy made reference to the insurers’ liability to make payment.

²⁴ *Insurance Corporation of the Channel Islands Ltd v McHugh* [1997] 1 Lloyd’s Rep IR 94.

²⁵ [2006] 2 All ER (Comm) 550, [2006] EWHC 1120 (TCC) at [34].

²⁶ Above at [38].

²⁷ Above at [39] and see para 25.17 above.

²⁸ Lord Donaldson memorial lecture, ‘The 1906 Act, common law and contract clauses – all in harmony?’ delivered by Lord Mance to mark the Centenary of the Joint Hull Committee, in the Old Library at Lloyd’s on 10 November 2010; published [2011] *Lloyd’s Maritime and Commercial Law Quarterly* p 346.

²⁹ Such as that in clause 46.7 of the International Hull Clauses 2003 which gives the leading underwriter 28 days to make a decision on a claim.

25.21 Although there may be some lack of clarity around the edges, the High Court and Court of Appeal have generally felt bound by the decision in *Sprung*. However, in 2005, Lord Justice Rix considered that if the issue was reviewed by the House of Lords it “may well lead to some clarification and amendment of the law”.³⁰ We discuss in the next Chapter our reasons for recommending statutory intervention over other possible options, including judicial development.

LIFE INSURANCE AND REINSTATEMENT CASES

25.22 There are two significant exceptions to the prohibition on claiming damages for the failure to pay an insurance claim.

25.23 The first is for non-indemnity insurance such as life insurance: claims under life insurance policies have been characterised as contract debts so that the normal rules of contract apply.³¹

25.24 Secondly, the rule does not apply where the insurer has undertaken to reinstate property. Insurance policies often allow insurers to choose between payment or “reinstatement” (that is, repairing or replacing the damaged property). If an insurer elects to reinstate, it acquires obligations in relation to the quality of that reinstatement which are similar to the general obligations on suppliers of goods and services. In particular, the insurer may face liability in damages for the foreseeable loss caused to a policyholder if it fails to reinstate the property within a reasonable time.³²

SCOTLAND

25.25 The law of Scotland in respect of damages for late payment is different from the law of England and Wales. The hold harmless principle does not apply. The starting point for the Scots law analysis is that the insurer’s obligation is characterised as a contractual duty to pay a sum of money equivalent to the insured’s loss.³³ An insurance payment is not therefore characterised as damages, but as a debt due under the contract.

³⁰ *Mandrake v Countrywide Assured Group* [2005] EWCA Civ 840 at [25].

³¹ *Blackley v National Mutual Life Assn Ltd (No 2)* [1973] NZLR 668.

³² See IP6, paras 5.29 to 5.35.

³³ *Carrick Furniture House Ltd v General Accident Fire and Life Assurance Corp Ltd* 1977 SC 308; *Scott Lithgow Ltd v Secretary of State for Defence* 1989 SC (HL) 9; *Anderson v Commercial Union Assurance Co Plc* 1998 SLT 826; *Strachan v The Scottish Boatowners’ Mutual Insurance Association* 2010 SC 367.

- 25.26 An insurer's primary obligation is to pay a valid claim following a reasonable time for investigation. Thus, an insurer who unjustifiably delays payment or wrongfully repudiates a claim is considered to be in breach of contract. In Scots law, the normal remedy for late payment under a contract is interest on the sum from the date that it became due; however, there is no rule that interest will be the only redress for consequential loss suffered as a result of the late payment of money.³⁴ Wider recovery of damages will be open to a pursuer who can show that the loss was reasonably foreseeable in accordance with *Hadley v Baxendale* and general rules of contractual damages.³⁵ In the Scottish experience, however, the test for foreseeable loss in this context has been interpreted restrictively.³⁶
- 25.27 The Scottish approach seems more consistent with the realities of the situation. The insurer's obligation does not arise from the moment the harm occurs, but arises when the insured has made a valid claim and the insurer has had an opportunity to investigate the claim. Thus the insurer is in breach of its contractual obligations where it pays after unjustifiable delay, or where it wrongfully repudiates the claim.³⁷ The time period within which payment must be made may be specified in the insurance policy. In the absence of such an express term, the courts can imply a term that the claim should be paid within a reasonable time.
- 25.28 In contrast to the English position, the Scottish court in *Alonvale Ltd v J M Ing* accepted that there was an implied term that the insurer should assess a claim reasonably and with diligence.³⁸ When the insurer had breached this obligation, the question of potential liability for loss caused by the breach arose.³⁹

OTHER JURISDICTIONS

- 25.29 The unavailability of a remedy where an insurer unreasonably fails to pay an insurance claim is inconsistent with the position in other common law jurisdictions. In IP6 we looked at approaches taken in Australia, the USA and Canada, all of which characterised the insurer's duty as a duty to pay valid claims, rather than as a promise to hold the insured harmless. We also referred briefly to the position in Germany, Italy, Spain and China, all of which provide more generous compensation for late payment of claims than English law.⁴⁰

³⁴ *Strachan v The Scottish Boatowners' Mutual Insurance Association* 2010 SC 367.

³⁵ (1854) 156 ER 145, and see discussion from para 25.3 above.

³⁶ See for example the approach to foreseeability in *Alonvale Ltd v J M Ing* 1993 GWD 36-2345. See further IP6, paras 3.15 to 3.18.

³⁷ *Strachan v The Scottish Boatowners' Mutual Insurance Association* 2010 SC 367 by Lord Eassie at [37] to [40].

³⁸ 1993 GWD 36-2345.

³⁹ For a fuller discussion of Scots law, see Part 3 of IP6 and CP2 from para 2.62.

⁴⁰ IP6, Part 7 and Appendix A.

CONCLUSION

- 25.30 In English law, policyholders are not entitled to damages for an insurer's failure to pay an insurance claim within a reasonable time (or at all). This rule is out of line with ordinary contract principles: it is the result of a technical legal fiction that an insurer undertakes to prevent a loss from occurring. In reality, insurers do not undertake to prevent losses, but to pay defined sums of money if particular losses occur.
- 25.31 The rule also appears unique. It has not been followed in other common law jurisdictions, or in Scotland. Nor is it applied in contracts for life insurance, or where an insurer undertakes to reinstate property.
- 25.32 In the next Chapter we argue that the rule is unprincipled and unfair, and should be reformed. We briefly consider other possible routes to redress and explain why they are not an adequate substitute for law reform in this area.

CHAPTER 26

THE CASE FOR REFORM

- 26.1 In the previous Chapter we discussed the “hold harmless” principle which underpins insurance contract law in England and Wales and leads to the result that damages are not payable for late payment of insurance claims. This puts English insurance contract law at odds with general contract law, with other jurisdictions and even with itself. It is difficult to defend on a legal basis. Commercially and intuitively such justification is even more difficult, as it has no policy basis and appears to condone poor practice.
- 26.2 The current law was heavily criticised by respondents to Issues Paper 6 (IP6) and Consultation Paper 2 (CP2). The responses demonstrated widespread agreement that the law on damages for late payment in England and Wales should be reformed. A large majority of respondents to CP2 agreed that insurers should be under a contractual obligation to pay claims within a reasonable time and that breach should trigger a liability to pay damages for any foreseeable losses which result.
- 26.3 In this Chapter we discuss the main arguments in favour of reform, as well as the arguments against it.

THE CASE FOR REFORM

The law appears to lack principle

- 26.4 Malcolm Clarke has described the unavailability of damages for late payment of insurance claims as a “blot on English common law jurisprudence”.¹
- 26.5 The idea that an insurer’s primary obligation under a contract for indemnity insurance is to prevent loss occurring in the first place fails to reflect commercial reality and the parties’ understanding of the nature of their contractual obligations. As the judge put it in *Transthene v Royal Insurance*, property insurers may be surprised to discover that:
- they are, collectively, in breach of contract hundreds or thousands of times every day, wherever a fire, a flood, a road accident or other such event occurs.²
- 26.6 The majority of policyholders, whether commercial or consumer, expect that a contract of insurance gives them a contractual right to receive payment and imposes on insurers a contractual obligation to make payment. In its response to CP2, Zurich said it:

¹ See M A Clarke, “Compensation for failure to pay money due: a ‘blot on English common law jurisprudence’ partly removed” [2008] *Journal of Business Law* 291. This phrase was used by Lord Nicholls of Birkenhead in *Sempre Metals*, discussed at paras 26.16 and 26.17 below. See also C Ying, “Damages for late payment of insurance claims” (2006) 122 *Law Quarterly Review* 122.

² *Transthene Packaging Co Ltd v Royal Insurance (UK) Ltd* [1996] Lloyds’ Rep IR 32 at 40.

agrees that the decision of the English court in the case of *Sprung v Royal Insurance* is no longer tenable and that the correct interpretation of an insurance contract is of “one to pay defined sums of money if particular losses occur”.

- 26.7 Although the hold harmless principle is convenient in some respects,³ it should not operate to disappoint the legitimate expectations of insurance buyers who rely on insurance in times of crisis.

The law is unfair and unexpected

- 26.8 In the modern world we expect the law to balance the opposing interests of contracting parties. The law in England and Wales on late payment of insurance claims gives the impression of being biased against the interests of policyholders. As the British Insurance Brokers' Association (BIBA) put it:

Consumers buy insurance to protect their possessions and businesses buy to protect their assets and liabilities. Any delay in payment can negate that protection.

- 26.9 For many policyholders, from consumers to sophisticated insurance buyers, failure of the law to require prompt payment and to provide a remedy in its absence frustrates the purpose of insurance. The payment of interest on damages will not always compensate the insured for the additional loss suffered as a result of late payment of insurance monies. Where businesses suffer from fires or floods, timely payment is often crucial to their survival. This is true for both large and small businesses. We were told that the issue of timely payments has become more acute in the current financial climate. Mactavish's research has shown that far more UK companies are materially dependent on insurance than before the financial crisis,⁴ and firms will find it more difficult to obtain bridging loans from banks.⁵

³ As we discuss below from para 28.81, the hold harmless principle determines the point at which the limitation period starts to run and the point at which interest begins accruing. There is no suggestion that these are in need of reform.

⁴ That is, they could not now absorb a major loss of half or two-thirds of the insurance policy limit on a major class without severe financial and strategic consequences. Mactavish summary of recent evidence provided to the Law Commission in January 2014.

⁵ Indeed, BIBA has suggested that insurers have become stricter on paying claims as a result of the economic climate. See BIBA member research, 'Insurance brokers adding value in the claims process' (January 2013). Mactavish's anecdotal evidence supports this.

26.10 A 2005 report illustrated the importance of prompt payment when reporting the difficulties faced by small businesses following a major flood.⁶ It referred to a 2003 survey which found that the majority of small businesses affected by flooding either never re-open or cease trading within 18 months. It quoted the ABI, which reported a general loss of business as people avoided the disaster area. It said that some communities “may be blighted permanently”.⁷ However, following floods in 2007, insurers co-ordinated a quicker response, putting emphasis on prompt interim payments. The ABI reported low levels of complaints to the Financial Ombudsman Service (FOS); consumer satisfaction had increased and the long-term effects of the flooding appeared to be less severe.⁸ Insurers who deal with claims fairly and promptly can therefore make a significant difference to restoring economic activity.

26.11 Airmic emphasised the importance of timely insurance payments and the need for the law to recognise this:

Effective indemnity depends as much on the timing of payments as the adequacy of the final settlement if a business is to survive the post loss recovery period. In the event of unreasonable delays in the settlement process, there is currently inadequate opportunity for legal redress. This fact does nothing to encourage reasonable behaviour on the part of the insurer.

26.12 Bearing this in mind, Lord Mance emphasised the worst-case scenario:

The law currently allows the situation where an insurer may delay dealing with a claim to his own financial benefit, at least in cash-flow terms, and to the detriment of the insured, potentially putting him under financial pressure to settle, and possibly even out of business.⁹

26.13 Of course, most insurers do pay claims fairly and within a reasonable time. There are strong commercial pressures to do so, and there are institutional reputations at stake. Where insurers fail to act reasonably, this undermines confidence in the insurance industry generally which is not in the interests of the market.

26.14 In IP6, we considered the law on late payment of claims in seven other jurisdictions.¹⁰ All offered greater protection to policyholders than English law. In an international legal market, this perceived unfairness could affect the attractiveness of this jurisdiction. Covington and Burling LLP suggested that the current position:

⁶ Benfield Hazard Research Centre, *Flood Risk and Insurance in England and Wales: Are there any lessons to be learned from Scotland?* (March 2005).

⁷ Above at p 36.

⁸ ABI, *The Summer Floods 2007: one year on and beyond* (2008).

⁹ ‘The 1906 Act, common law and contract clauses – all in harmony?’ [2011] *Lloyd’s Maritime and Commercial Law Quarterly*, p 346 at pp 349 to 350.

¹⁰ IP6, Part 7 and Appendix A.

acts as a disincentive to international policyholders from seeking cover under English-law-governed contracts and is therefore damaging to the UK insurance industry.

An increasingly anomalous legal position

- 26.15 Fifty years ago, the rule that an insurer should not be liable to a policyholder for a failure to pay a claim may not have seemed so out-of-step with general contract principles. The decision in *Sprung*, however, is increasingly anomalous in light of contemporary developments in English common law.

Losses caused by a failure to pay money

- 26.16 In 2007, the House of Lords considered the general law of damages in *Sempra Metals v Inland Revenue*.¹¹ Lord Nicholls started with “the broad proposition of English law” that a claimant can recover damages for losses caused by a breach of contract or a tort which satisfy the usual tests for remoteness. Lord Nicholls explained that in the past this principle was thought to be subject to “an anomalous, that is, unprincipled, exception” whereby the courts were reluctant to award damages for loss of interest following non-payment of a debt.¹² However, this should not detract from the general rule that:

those who default on a contractual obligation to pay money are not possessed of some special immunity in respect of loss caused thereby.¹³

- 26.17 *Sempra Metals* involved a claim for restitution and not contract damages, and did not deal with insurance law. Nonetheless, here, it was felt that damages for losses suffered by one party due to the other’s breach ought to be effective, sufficiently compensatory, and should not be limited by common law exceptions that give rise to unjust results. In our view, it provides a robust logic that leaves the rule in *Sprung* increasingly isolated.¹⁴

Financial inability does not break the chain of causation

- 26.18 It has long been held that it is the duty of a victim of a breach of contract to mitigate the loss by taking all reasonable steps to reduce its scale. A difficult question arises when the victim, like Mr Sprung, cannot afford to take the steps necessary.

¹¹ *Sempra Metals (formerly Metallgesellschaft Limited) v Commissioners of Inland Revenue* [2007] UKHL 34, [2008] 1 AC 561.

¹² Above, [2007] UKHL 34 at [74].

¹³ Above, [2007] UKHL 34 at [93].

¹⁴ *Sempra Metals* is mentioned with seeming approval by an Extra Division of the Court of Session in *Wilson v Dunbar Bank plc* 2008 SC 457 at [32], but it does not form part of Scots law in this area.

- 26.19 In 1933, the House of Lords took the very harsh line that if a victim is unable to mitigate a loss for lack of money, the law should not compensate for “impecuniosity”, which may be regarded as “a separate and concurrent cause”.¹⁵ This is, however, no longer good law. More recently, in *Lagden v O’Connor* the House of Lords held that lack of funds should not be regarded as some extraneous factor.¹⁶ Instead the normal foreseeability test applies.
- 26.20 The central “hold harmless” fiction behind *Sprung* remains unaffected so this would not affect an insurance case. It indicates, however, that the general law now accepts the commercial reality that those who are not paid the money they are owed may not have the financial resources to mitigate their loss, leaving *Sprung* out of line.

The result in Sprung is anomalous even in the insurance context

- 26.21 As we have discussed, there are two significant exceptions to the prohibition on claiming damages for the failure to pay an insurance claim.¹⁷
- 26.22 The first is life insurance cases, where payment has been categorised as a contractual debt so that the normal rules of contract law apply.¹⁸
- 26.23 The second is where the insurer has undertaken to reinstate property rather than pay money. The insurer may face liability in damages for the foreseeable loss caused to a policyholder if it fails to reinstate the property within a reasonable time.¹⁹
- 26.24 In addition, an alternative result was reached in *Arbory Group v West Craven Insurance Services*,²⁰ although the legal question here did not involve the hold harmless principle. In this case, the claimant’s insurance brokers acted negligently and as a result the claimant’s business was significantly underinsured. After a major fire, the claimant did not receive the anticipated business interruption payments. Unable to resume trading, it suffered loss of profits and sued the brokers to recover for this. The High Court was asked to decide how much the brokers should compensate the business: should damages be limited to merely the payments the claimant would have received if it had not been underinsured, or should the brokers pay for the further loss of profits?

¹⁵ *The Liesbosch Dredger (Owners of) v Owners of SS Edition (The Liesbosch)* [1933] AC 449 at 460. See also *Sprung* [1999] Lloyd’s Rep IR 111 at 118.

¹⁶ [2003] UKHL 64, [2004] 1 AC 1067. In Scots law, it has been acknowledged that in this area “the law is changing largely as a result of” the decision of House of Lords in this case. See W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007), para 22-88.

¹⁷ See para 25.22 above.

¹⁸ *Blackley v National Mutual Life Assn Ltd (No 2)* [1973] NZLR 668.

¹⁹ See IP6, paras 5.29 to 5.35.

²⁰ *Arbory Group v West Craven Insurance Services* [2007] Lloyd’s Rep IR 491.

- 26.25 The defendant brokers argued that payment for the further loss would be “tantamount to awarding damages for the non-payment of damages” contrary to the rule in *Sprung*. The judge rejected this, and found that the brokers should pay for the further loss. He noted that business interruption cover is designed to provide funds at a vulnerable time, and without these funds it was reasonably foreseeable that the company would suffer further loss.
- 26.26 Although the legal questions in this case were quite different, the court’s approach shows the potential consequences of reversing the rule in *Sprung*. Under the ordinary rules of *Hadley v Baxendale*, the losses incurred by business failure may be regarded as foreseeable losses in the context of failure to make a timely business interruption payment.²¹

SUPPORT FOR REFORM

- 26.27 We have noted widespread support for reform. 87% of respondents (33 of 38 who answered the question) agreed that insurers should be under a contractual obligation to pay claims within a reasonable time. Furthermore, 81% (30 out of 37) agreed that a failure to meet this obligation should trigger a liability to pay damages for any foreseeable loss which results.
- 26.28 The ABI accepted there was a need for reform, and there was majority support for reform among insurance companies themselves. Out of the 14 insurers and insurance organisations who responded, 11 agreed that insurers should be under a contractual obligation to pay claims within a reasonable time:

Insurers should be obliged to pay claims within a reasonable time, provided that this is adequately defined and allows for investigation of the claim. [Hannover Life Re]

We agree that insurers should be obliged to pay a valid claim for foreseeable losses where the insurer has failed to pay a valid claim within a reasonable period. [RSA]

- 26.29 Although our proposals were aimed at reforming English law rather than Scots law, we argued that the new statute should apply to both sides of the border. The Judges of the Court of Session agreed:

Any legislation should apply to both England and Scotland, both to embed what is thought to be the Scottish position and to avoid the possible implication that the law as enacted for England and Wales may be subtly different from that in Scotland.

THE CONTRARY ARGUMENTS

- 26.30 A few consultees were concerned that awarding anything more than interest to policyholders who had suffered loss because of an insurer’s refusal or delay would expose insurers to unlimited extra costs leading to increased premiums and difficulties with capital requirements.

²¹ Above at 497.

26.31 The International Underwriting Association (IUA) said that:

allowing recourse to unlimited damages would potentially open up the claims process to increased litigation on bad faith grounds, which would be difficult to police and would inevitably drive up legal costs and the costs of insurance. The propensity for a damages award that vastly exceeds the value of the contract, policy limits and premium received will require the insurer, as a matter of good practice, to reassess their coverage and pricing structures. It will also provide difficulties for insurers in assessing their reinsurance requirements and capital holding requirements under the Solvency II requirements.

26.32 We have considered these and other arguments put forward by the few consultees who opposed the proposals in CP2. We discuss them below. We do not consider that any one argument or their cumulative effect suggests a need to reconsider the core of our recommendations, but we have accommodated certain concerns in the detail of our recommendations, as discussed in Chapter 28.

The cost of insurance

26.33 Generally speaking, we expect successful late payment claims to be relatively rare and the impact on insurers to be correspondingly limited. We recommend a specific defence where an insurer has a genuine reason for disputing a claim. The insurer will not be liable to pay damages if they are later required to pay the claim unless there is evidence of, for example, excessive delay in making the assessment. Insurers have pointed out that a combination of regulatory requirements and reputational pressures means that insurers do not routinely delay or refuse payments when there is not a good reason to do so. This being the case, the majority of insurers will be able to rely upon the defence.

26.34 As we discuss below, the level of damages will be subject to the normal limiting factors. Further, we expect judges to be cautious in their approach to assessing delays. In *Tonkin v UK Insurance Ltd* which we have discussed above,²² the judge found that the insurer should have made a payment under the policy.²³ However, he held that the delay was due to the policyholders' actions, in that they failed to provide a sufficient reinstatement scheme and further delayed the process by opting for litigation before exhausting other available avenues for resolution of the dispute. Even if damages for late payment had been available in principle, the policyholders' claim would have failed on the facts. We think this is indicative of the approach judges would take.

²² At para 25.18.

²³ [2006] 2 All ER (Comm) 550, [2006] EWHC 1120 (TCC).

- 26.35 In non-consumer insurance contracts, insurers will be entitled to exclude or limit their liability for late payment damages.²⁴ Although insurers have claimed that brokers will resist clauses which exclude liability, it is common for liability for consequential losses to be limited or excluded in commercial contracts. We expect that liability for late payment will come to form part of the negotiation process.
- 26.36 We do not foresee any significant impact on insurers and therefore would doubt that any noticeable increase in premiums could be justified on the basis of our recommendations. However, as we have commented above,²⁵ policyholders are likely to be more willing to pay a slightly increased premium if they are more confident of having claims paid timeously or additional losses compensated.

Limited damages

- 26.37 Any damages payable to compensate for late payment will be limited by the general principles applicable to contractual damages, as articulated in *Hadley v Baxendale*²⁶ and further refined and restricted in subsequent cases.
- 26.38 To obtain damages, the claimant must show that the failure to pay causes the loss: in other words, that the loss would not have occurred if the claim had been paid on time.
- 26.39 When entering into any contract, the parties recognise that their performance is important to the other party and that losses may be incurred if their performance falls below expected levels. Insurers are aware that policyholders rely on insurance monies in times of crisis. As we have said, the lack of availability of damages is the result of a legal technicality rather than a policy decision to relieve insurers of a liability to which normal contracting parties would be subject.
- 26.40 The limits on contractual damages tend to be applied strictly by the courts, and this has certainly been the case in the Scottish insurance cases.²⁷ Further, as we discussed in our impact assessment,²⁸ 90% of 65 brokers who addressed this matter in our survey estimated the average financial loss resulting from an unreasonable delay as being less than £5,000.²⁹

²⁴ See below from para 28.91.

²⁵ See para 1.40 and following, especially para 1.48.

²⁶ *Hadley v Baxendale* (1854) 156 ER 145, discussed above from para 25.3.

²⁷ See IP6, paras 3.14 to 3.18.

²⁸ Impact Assessment for CP2, para 1.25. Available at http://lawcommission.justice.gov.uk/docs/cp201_ICL_post_contract_duties_impact_assessment.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/1018/107/.

²⁹ Broking Now! In association with BIBA by FWD Research, *Research on Damages for Late Payment* (September 2011).

- 26.41 We therefore do not consider that our recommendations would expose insurers to unacceptably high levels of damages or introduce significant uncertainties for insurers in terms of calculating reserves.³⁰
- 26.42 We have not recommended the inclusion of a statutory maximum on damages; we believe the common law limitations on damages are sufficient. Any cap would be artificial and not representative of the different situations and losses which may occur. We think that this issue is best left to the parties to negotiate for themselves.

USA-style bad faith actions

- 26.43 The Lloyd's Market Association (LMA) and IUA worried about opening the floodgates to speculative claims, and in particular to standalone bad faith actions which in the USA have resulted in substantive punitive damages being awarded against insurers.
- 26.44 As we discuss below,³¹ in IP6 we suggested a cause of action based on an insurer's bad faith in delaying or refusing a claim. However, many consultees feared that, however limited the right would be initially, it would soon develop along the lines of the doctrine of good faith in the United States.³² We were persuaded that damages for bad faith would be a step too far, with unpredictable consequences.
- 26.45 We have specifically moved away from the good faith proposals as a result of grave concerns expressed by insurers. Our recommendations do not open this avenue. They do not force insurers to pay out on more claims or pay without thorough consideration. We also provide a specific defence for reasonable disputes.³³

Business interruption cover

- 26.46 The possibility of claiming such damages is not a substitute for business interruption insurance. Business interruption insurance will generally pay out when financial loss is suffered due to the occurrence of some other insured event. Damages for late payment will only be payable where an insurer has failed to pay a valid claim within a reasonable time, which will be a much rarer scenario and more difficult to prove. A business would be unwise to rely on its insurer unreasonably delaying a claim as a means of protecting its trading losses - particularly as one of the intended effects of our suggested change is to encourage the timely payment of valid claims.

³⁰ For example, in light of Solvency II Directive 2009/138/EC. Solvency II is intended to harmonise insurers' capital requirements and risk management standards across the member states of the European Union. See further: <http://www.bankofengland.co.uk/pru/Pages/solvency2/default.aspx>.

³¹ At para 26.60 and following.

³² We discuss the position in the United States in IP6, paras A.41 to A.69 and 7.11 to 7.14. See also *Whiten v Pilot Insurance Company* [2002] 1 SCR 595, in which the Supreme Court of Canada upheld an award of \$1 million in punitive damages.

³³ See draft Bill, clause 14(4); discussed below from para 28.46.

Litigation tactics and 'no win no fee'

26.47 A few consultees expressed concern that the late payment provisions would lead to abuse either as a litigation tactic or by claims farmers, leading to a large number of claims and increased costs for insurers even though they may ultimately be unsuccessful.

26.48 Catlin said:

We understand the Law Commission's point that the actual ultimate exposure to consequential loss damages may not be significant, but we believe that as drafted the provision will be widely used by insureds (particularly large insureds) as a litigation tactic to obtain information from insurers to which they should not be entitled and to increase significantly insurers' litigation risk and costs rather than as a method of seeking to obtain indemnity or genuine damages.

26.49 AXA said:

there is a further policy aim the Law Commission should take heed of, that is not to create a further field of 'claims farming' activity to the detriment of genuine claimants, the insurance industry, the courts and premium payers.

26.50 We accept that any new legal rule will need an initial period to bed-in, and during this period it is likely that policyholders will test the limits of the right to damages for late payment. However, we do not think that it will take the courts long to curb abuses. We think that any limited disruption during the bedding-in period would be substantially less than the disruption caused by judicial intervention.³⁴ It will also be less damaging than the prolonged loss of reputation of English insurance law if nothing is done. It is comforting that there have been very few Scottish cases over the last 20 years.³⁵

CONCLUSION: A STRONG CASE FOR REFORM

26.51 Following the responses we received to IP6 and CP2 and on the basis of the arguments in those papers and summarised above, we are persuaded that there is a compelling case for reform. The British Insurance Law Association (BILA) has described the decision in *Sprung* as "the principal defect in this part of English insurance law, requiring remediation as soon as possible". Consideration of the opposing arguments has not provided any compelling reason to re-think our position.

26.52 The majority of consultees supported legislative intervention to introduce an obligation on the insurer to pay sums due within a reasonable time. The majority also agreed that, if the insurer were to breach this obligation, it should give rise to damages according to the normal principles of contract law.

³⁴ See below at para 26.76.

³⁵ See IP6, paras 3.14 to 3.18.

26.53 Below we set out our reasons for recommending a statutory route.

WHY REFORM SHOULD BE ACHIEVED THROUGH LEGISLATION

26.54 In CP2 we considered three possible routes to redress which might be open to a policyholder: the general duty of good faith; statutory recourse through the Financial Services and Markets Act 2000; and complaints to the FOS. In IP6 we also considered the possibility of reform by the judiciary. As we explain briefly below, we do not think that any of these four alternatives is a suitable substitute for legislative reform.³⁶

26.55 In IP6, we explained that a policyholder also has the right to statutory interest for late payment of a debt. We are not making changes to the interest arrangements and do not discuss them here.³⁷

Damages for breach of the insurer's duty of good faith

26.56 Section 17 of the Marine Insurance Act 1906 as currently drafted imposes mutual obligations both before and after a contract is formed. It states:

A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.

26.57 In theory, it is possible that a refusal to pay a claim for no good reason would be a breach of the duty of good faith. In *The Star Sea*, the House of Lords described the post-contract duty of good faith as flexible and variable.³⁸

26.58 However, even if such behaviour does amount to a breach of the duty of good faith, the courts have held that the insured is not entitled to damages. Section 17 has been taken to mean that avoidance is the only remedy available for breach of good faith and that damages are not available.³⁹ This means that the contract is declared to be void from the start. As Lord Hobhouse of Woodborough pointed out in *The Star Sea*, the remedy is “wholly one-sided”: avoidance and return of the premium are of little or no assistance to the frustrated policyholder.⁴⁰

³⁶ We considered them in more detail in Part 5 of IP6 and Parts 3 and 5 of CP2.

³⁷ The right to statutory interest differs between England and Wales on the one hand and Scotland on the other. For more detail, see IP6, paras 5.2 to 5.15.

³⁸ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469. See for example Lord Clyde at [7].

³⁹ See *Banque Keyser Ullmann SA v Skandia (UK) Insurance Co Ltd* [1990] 1 QB 665, later approved by the House of Lords in *Banque Financiere de la Cite SA v Westgate Insurance Co Ltd* [1991] 2 AC 249. For a thorough discussion of the case, see IP6, paras 4.24 to 4.45. See also *HIH Casualty and General Insurance Ltd v Chase Manhattan Bank* [2001] EWCA Civ 1250, [2001] 2 Lloyd's Rep 483 at [68]. This point was not overturned in the subsequent appeal: *HIH Casualty and General Insurance Ltd v Chase Manhattan Bank* [2003] UKHL 6, [2003] 1 All ER (Comm) 349.

⁴⁰ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [57].

26.59 In IP6 we considered whether the law should be reformed to provide policyholders with a claim for damages against an insurer who acted in bad faith. We were persuaded that this would be a step too far. In Chapter 30, we discuss our recommendation that avoidance is abolished as the remedy for breach of good faith. We recommend that good faith will be retained as an “interpretative provision”: that is, as a principle by which other obligations in the insurance contract should be interpreted. It will not give the policyholder a right to claim damages.

The role of good faith: previous proposals

26.60 In IP6,⁴¹ we drew a distinction between insurers who fail to pay for a good reason, and those who delay payment or decline claims in bad faith. We provided an illustration of the difference:

At one end of the spectrum an insurer may refuse a claim because it genuinely believes that the loss falls outside the policy wording. It may receive legal advice to this effect, and may even win at first instance, only to be proved wrong by the Court of Appeal. Here the insurer had an honest and reasonable (though mistaken) view that the claim was not valid.

By contrast, a claims manager may know a claim to be valid, but deliberately delay payment beyond the end of the year simply to obtain a bonus. Here the delay is neither honest nor reasonable, but is made in bad faith.

26.61 We considered whether the law should be reformed to provide policyholders with a claim for damages against an insurer who acted in bad faith. Such reforms would only have applied where the insurer acted dishonestly, or so unreasonably that no reputable insurer could act in that way. We argued that an insurer should not be entitled to exclude its duty to act in good faith. As we put it in IP6:

We think this would be inimical to the nature of an insurance contract. Nor do we think such a clause would represent a genuinely negotiated bargain. No policyholder who properly considered the matter would agree that the insurer could refuse a claim in a biased or unfair way, or without properly investigating the claim. We note too that in Australia the duty of good faith cannot be excluded.⁴²

⁴¹ IP6, from para 9.3.

⁴² IP6, para 9.34.

- 26.62 A significant number of respondents, however, argued against introducing damages for breach of the duty of good faith. They expressed concern about such a development leading to US-style bad faith claims. We proposed that damages would be limited and controlled by normal contract rules. However, they feared that, however limited the right initially, it would soon develop along the lines of the doctrine of good faith in the United States, with substantial punitive damages being awarded in tort/delict claims against insurers.⁴³ Their preference was for the late payment issue to be dealt with discretely under normal contract principles: the insurer should have a duty to pay valid claims within a reasonable time, subject to the terms of the contract. Our final recommendations reflect these arguments.
- 26.63 As we discuss below,⁴⁴ we think it would be better to view the duty of good faith as a shield rather than a sword. The “shield” we provide in the draft Bill is that insurers should not be entitled to contract out of liability for deliberate or reckless failures to pay, where they know that the claim is valid or do not care whether the claim is valid. We think that an insurer should not be entitled to use exclusion clauses to hide from the consequences of its own deliberate or reckless failure to pay.

Damages for the insurer’s breach of statutory duty

- 26.64 The Financial Conduct Authority (FCA) provides detailed rules on claims handling by insurers, set out in the Insurance Conduct of Business Sourcebook (ICOBS). Rule 8.1.1 requires insurers to:
- (1) handle claims promptly and fairly;
 - (2) provide reasonable guidance to help a policyholder make a claim and appropriate information on its progress;
 - (3) not unreasonably reject a claim (including by terminating or avoiding a policy); and
 - (4) settle claims promptly once settlement terms are agreed.
- 26.65 Breaches of the FCA Rules have two possible consequences. Firstly, the FCA may take disciplinary action against the insurer in its regulatory capacity, such as imposing a fine or publishing a statement of the insurer’s misconduct.⁴⁵ This is unlikely to help an individual policyholder who has suffered loss.
- 26.66 Secondly, a policyholder may bring a claim for damages under section 138D of the Financial Services and Markets Act 2000 (FSMA). This states that:

⁴³ We discuss the position in the United States in IP6, paras A.41 to A.69 and 7.11 to 7.14. Also see *Whiten v Pilot Insurance Company* [2002] 1 SCR 595, in which the Supreme Court of Canada upheld an award of \$1 million in punitive damages.

⁴⁴ From para 28.95.

⁴⁵ Financial Services and Markets Act 2000, s 66.

A contravention by an authorised person of a rule made by the FCA is actionable at the suit of a private person who suffers loss as a result of the contravention, subject to the defences and other incidents applying to actions for breach of statutory duty.⁴⁶

The limits of section 138D

26.67 This provision is equivalent to section 150 of FSMA, now repealed, which we discussed in CP2.⁴⁷

26.68 A claim for damages under section 138D may be useful, but its predecessor section 150 was very rarely used in practice.⁴⁸ A claimant must establish that there has been a contravention of an FCA rule and that, as a result, a loss has been suffered.⁴⁹ Most problematically, redress under section 138D is only available to “a private person”. This concept appears to envisage two broad categories of claimant:

- (1) An individual. This includes both a consumer who is not acting in the course of business, and a sole trader who is acting in the course of business.⁵⁰
- (2) A legal person, such as a company or corporate body (including partnerships) which is not acting in the course of business.⁵¹

26.69 It is not surprising that the right has been so little used. Most consumers and small businesses will find it easier to complain to the FOS than bring a complex, novel action before the courts for breach of statutory duty. Most other potential claimants are excluded because they are companies and suffer losses in the course of business. Many of the cases we are concerned with involve small companies which have lost profits following catastrophic events, such as fires. These policyholders are not entitled to rely on the provision.

⁴⁶ Section 138D(2).

⁴⁷ CP2, from para 3.21. The new section 138D reflects the division of the previous regulatory body, the Financial Services Authority, into the FCA and the Prudential Regulation Authority. Insurers are part of this dual-regulatory system.

⁴⁸ IP6, para 5.18. It was considered in the recent case of *Bate v Aviva Insurance UK Ltd* [2013] EWHC 1687 (Comm) but the policyholder’s case was rejected on other grounds.

⁴⁹ See, for example, *R (BBA) v Financial Services Authority and Financial Ombudsman Service* [2011] EWHC 999 (Admin), [2011] 18 LS Gaz R 20 by Ouseley J at [71].

⁵⁰ Under this category, those losses cannot have been sustained in the course of carrying on any regulated activity under the FSA definition: Financial Services and Markets Act 2000 (Rights of Action) Regulations 2001 (SI 2001 No 2256), reg 3 (as amended).

⁵¹ See CP2 from para 3.22 for more detail.

- 26.70 Some consultees suggested that we should extend the application of section 138D to more people, rather than introducing a new cause of action. However, changing the scope of section 138D has implications far beyond insurance law. The Law Commission's recent consultation paper on Fiduciary Duties of Investment Intermediaries asked whether the rights to sue under section 138D should be extended, but this met with strong opposition.⁵²
- 26.71 We think that, as currently drafted, section 138D has limited potential to provide redress to claimants in the present context. For these reasons, we believe the need for statutory reform to reverse *Sprung* is not diminished by the availability of section 138D.
- 26.72 The new implied term which we recommend does not replace or displace the section 138D route. Recovery will be subject to the overriding principle that a claimant cannot recover twice for the same loss.

The Financial Ombudsman Service

- 26.73 The FOS regularly deals with complaints about delayed payment and bad claims handling. Importantly, the FOS decides disputes "by reference to what is in the opinion of the ombudsman fair and reasonable in all the circumstances of the case".⁵³ We are told that the FOS does not apply the rule in *Sprung*: ombudsmen are prepared to award damages for financial loss and inconvenience suffered by business and consumer policyholders. Our analysis of six sample FOS cases suggests that the FOS requires claimants to prove their losses to a high standard, but we were told that damages have been awarded up to £100,000, the maximum amount the FOS could award at that time.

Limits of the FOS

- 26.74 The FOS plays an important role in mitigating the harshness of the law in this area. We think, however, that it is unfortunate to have a law that is so far from the accepted standard of fairness that ombudsmen routinely ignore it in order to achieve a contemporary understanding of fairness.
- 26.75 Moreover, the nature of the FOS jurisdiction means it can only hear complaints from consumers and "micro-enterprises" (those with fewer than 10 staff and an annual turnover of under 2 million euros).⁵⁴ Small and medium sized businesses above this threshold will still suffer the full force of the law yet they are often the entities which suffer most dramatically from the rule in *Sprung*. Such businesses may rely heavily on prompt, sufficient payment of insurance monies after suffering a loss. The law, if unchanged, remains an unfair burden on such businesses and creates artificial distinctions between businesses.

⁵² Law Commission, LCCP 215, *Fiduciary Duties of Investment Intermediaries*, October 2013, paras 14.65 to 14.70. A summary of responses, along with a report, is due to be published shortly. See http://lawcommission.justice.gov.uk/areas/fiduciary_duties.htm.

⁵³ Financial Services and Markets Act 2000, s 228(2).

⁵⁴ The definition is found in the FSA Handbook, DISP 3.6.1. This is in line with the EU Payment Services Directive 2007/64/EC.

Development by the judiciary

- 26.76 Most consultees agreed that change should not be left to the courts. This would be time-consuming and require a case to be taken to the Supreme Court. As the General Council of the Bar commented:

We are strongly in favour of *Sprung* being reversed. Attempts have been made to do so through the courts but this has not been achieved. Our experience is that those who would wish to challenge *Sprung* do not usually have the financial means to pursue this through the appellate courts.

- 26.77 In addition, statutory intervention allows us to recommend limiting factors which would not be part of a common law cause of action. As we discuss below,⁵⁵ we recommend that an insurer who makes a reasonable but wrong decision to refuse or challenge a valid claim should not be liable for late payment damages without other evidence of unreasonableness, such as a refusal to change position when further evidence came to light.
- 26.78 Conversely, it has been suggested in Scotland that an insurer could not rely on a “reasonable but wrong” decision as a defence to a late payment claim.⁵⁶ We think that such an approach could tip the balance too far the other way (albeit that the Scottish market does not show signs of insurers being overwhelmed with claims). It is in the interest of the wider insurance market that insurers are in a position to challenge potentially invalid claims or to question the amount claimed by an insured, in order to protect the interests of other policyholders.

CONCLUSION

- 26.79 In this chapter we set out the legal and policy arguments in favour of allowing policyholders to claim damages for additional losses suffered when insurers unreasonably refused or delayed insurance payments. The current position is difficult to justify legally, commercially and intuitively, and statutory intervention is required in order to change it satisfactorily.

⁵⁵ From para 28.46.

⁵⁶ See *Strachan v The Scottish Boatowners' Mutual Insurance Association* 2010 SC 367 and *Alonvale Ltd v Ing* 1993 GWD 36-2345, discussed in IP6, paras 3.10 to 3.12 - although we are not aware that the courts have ever made such an award.

CHAPTER 27

OVERVIEW OF RECOMMENDATIONS

- 27.1 In this Chapter we give an overview of our key recommendations, discussed in more detail in the next Chapter. We also note one proposal in CP2 which we are not taking forward.

AN OUTLINE OF THE KEY RECOMMENDATIONS

An implied term to pay sums due within a reasonable time

- 27.2 We recommend that it should be an implied term of an insurance contract that insurers will pay sums due within a reasonable time. An insured who suffers loss as a result of breach of that term should be able to recover contractual damages from the insurer.

Guidance as to “reasonable time”

- 27.3 What is a reasonable time for payment will depend on all the circumstances of the particular case. However, the uncertainty surrounding this issue was a key concern for stakeholders. We therefore recommend that some guidance is provided.
- 27.4 We think that a reasonable time should always include time to investigate and assess the claim.
- 27.5 We also suggest that the following list of considerations may be relevant in determining a reasonable time for payment in a particular case:
- (1) the type of insurance;
 - (2) the size and complexity of the claim;
 - (3) compliance with any relevant statutory or regulatory rules or guidance; and
 - (4) factors outside the insurer’s control.

A reasonable but wrong refusal

- 27.6 We recommend that insurers should have a defence to a claim for late payment where they incorrectly refuse to pay a claim but can show that they acted reasonably in doing so. This protects the ability of insurers to take a robust approach to decision making where they suspect fraud or non-compliance with policy terms or where the precise circumstances of the loss are not clear. Our recommendations are intended to catch bad claims handling practices, not prevent legitimate investigations by insurers.

The normal limitation and prescription rules should apply

- 27.7 In England and Wales, the limitation period for insurance claims will continue to run from the date of the original loss, while we recommend that the period for late payment claims should run from the point at which the obligation to pay within a reasonable time is breached.

- 27.8 In Scotland, the prescriptive period for insurance claims will continue to run from the date of the casualty. For late payment claims it will run from the point at which loss flows to the insured from the insurer's failure to pay the claim within a reasonable time.

Contracting out

Consumer insurance

- 27.9 Consistent with our approach in the Consumer Insurance (Disclosure and Representations) Act 2012 and in respect of the other consumer matters dealt with by the draft Bill, we recommend that the late payment provisions should be mandatory in consumer insurance contracts. This means that an insurer may not exclude the application of the implied term in clause 14(1), nor exclude or limit its liability for breach of that term.

Non-consumer insurance

- 27.10 As with other areas of reform covered by the draft Bill, we recommend that the late payment provisions are a default regime for non-consumer insurance contracts.
- 27.11 In non-consumer contracts, this means that insurers should be able to disapply the implied term about payment, or exclude or limit their liability for breach of that term. However, we recommend that such terms should be of no effect where the insurer's breach was deliberate or reckless.

The hold harmless principle need not be removed

- 27.12 We conclude that the hold harmless principle need not be repealed in England and Wales, but it should not be extended to Scotland. Our aim is to make it possible for insureds to recover damages for late or non-payment of claims. Fundamental change to the structure underpinning insurance contract law would unnecessarily complicate these objectives, which can be achieved in England and Wales without the removal of the hold harmless principle.

PROPOSALS NOT EXPRESSLY INCLUDED IN THE DRAFT BILL

Damages for distress and inconvenience in consumer insurance

- 27.13 Where an insurer has agreed to reinstatement, policyholders have been able to obtain damages for distress and inconvenience caused by bad or slow workmanship caused by those carrying out the reinstatement.¹ However, in CP2 we reported that where an insurer fails to respond to a valid claim promptly or at all, the English courts have held that damages for distress and inconvenience are not available.² We noted that the FOS did not make such a distinction and had awarded such damages in instances of refusal or delay of payments. Such awards tend to be relatively conservative.³ In general consumer law, damages for distress and inconvenience are available for claims related to contracts entered into to give pleasure, relaxation or, importantly in the insurance context, peace of mind.⁴ Compensation may also be available where some physical inconvenience and discomfort have been caused by the breach.⁵
- 27.14 We proposed that the law should allow for such damages in consumer insurance contracts. Most consultees agreed with this proposal, although less than half thought that reform should be achieved through statute.
- 27.15 On further reflection, we do not consider that reform through statute is necessary. The creation of the implied requirement to pay claims within a reasonable time means that, under general common law principles, damages will be available for breach of this duty. Where the insurance contract is intended to provide peace of mind, this will include damages for distress and inconvenience. Use of statute to effect the introduction of such damages risks creating the impression that we are creating a special right to damages distinct from that which the general law would provide.

¹ *AXA Insurance UK plc v Cunningham Lindsey UK* [2007] EWCH 3023 (TCC).

² See CP2, para 2.72 and following, and *England v Guardian Insurance Ltd* [1999] 2 All ER (Comm) 481. See para 2.77 of CP2 for the possibility of a different approach in the Scottish courts. There is more extensive discussion in Issues Paper 6 (IP6).

³ See CP2, para 2.79 and following.

⁴ *Farley v Skinner* [2001] UKHL 49, [2002] 2 AC 732.

⁵ *Watts v Morrow* [1991] 1 WLR 1421, by Bingham LJ, cited with approval (in this respect) by the House of Lords in *Farley v Skinner* [2001] UKHL 49, [2002] 2 AC 732.

27.16 Under Scots law, damages may be awarded for trouble and inconvenience resulting from a breach of contract.⁶ Trouble and inconvenience extends beyond physical inconvenience and discomfort insofar as it can include matters such as protracted correspondence resulting from the breach.⁷ A distinct head of damages can also be awarded in Scotland where the purpose of the contract breached is to give pleasure, relaxation or peace of mind.⁸ We do not recommend any changes to this position.

⁶ *Webster & Co v Cramond Iron Co* (1875) 2R 752; *Wilkie v Brown* 2003 SC 573; *Mack v Glasgow City Council* 2006 SC 543.

⁷ *Aarons & Co Ltd v Fraser* 1934 SC 137, by Lord Murray at p 143; *Webster & Co v Cramond Iron Co* (1875) 2R 752. Note also that, in Scotland, “inconvenience” does not generally extend to emotional reaction falling short of recognised psychiatric illness. See *Simpson v Imperial Chemical Industries Ltd* 1983 SLT 601 and *Simmons v British Steel Plc* 2004 SC (HL) 94.

⁸ See Scottish Law Commission Report No 174 on Breach of Contract (1999), para 3.3 and W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007), at paras 22-104 to 22-105. Examples include *Diesen v Samson* 1971 SLT (Sh Ct) 49 and *Colston v Marshall* 1993 SCLR 43.

CHAPTER 28

DETAILED RECOMMENDATIONS

28.1 In the previous Chapter we outlined our recommendations for introducing a liability for late payment of insurance monies. Below, we discuss the recommendations in more detail, referring to the relevant clauses of the draft Bill.

A CONTRACTUAL OBLIGATION TO PAY CLAIMS WITHIN A REASONABLE TIME

28.2 We recommend that, where an insured makes a claim under an insurance contract, an insurer should have an obligation to pay sums due within a reasonable time. Clause 14(1) of the draft Bill reflects this recommendation by stating that:

It is an implied term of every contract of insurance that if the insured makes a claim under the contract, the insurer must pay any sums due in respect of the claim within a reasonable time.

28.3 There are four key elements to this clause:

- (1) The obligation takes effect as an *implied contractual term*. This means that remedies for breach, including damages, follow normal contractual principles.
- (2) It applies only to claims by *the insured*; that is, claims made by the contracting party to the contract. It does not apply to claims by third parties or by other beneficiaries.
- (3) *The sums must be due* in respect of the claim. In other words the claim must be a valid one, as agreed by the insurer or as decided by the court. Where an insurer has no liability to pay out on a claim – such as where the incident is not covered by insurance or where the claim is fraudulent – there is no implied obligation to make such assessment quickly.
- (4) The claim must be paid within a *reasonable time*. This concept is defined in clauses 14(2) and 14(3).

28.4 We discuss these elements in more detail below.

A contractual obligation giving rise to contractual damages

28.5 The reason for recommending that the obligation should take effect as an implied term (rather than as a statutory duty) is that the remedies then become contractual. Clause 14(5) confirms that damages for breach of the implied term are available, but the draft Bill deliberately refrains from stating how they are to be calculated. This means that all the normal contractual rules and limitations will apply, and will develop as contract law evolves. This means, for example, that an insured must show that:

- (1) the late payment caused actual, financial loss;

- (2) the type of loss was foreseeable at the time the contract was made in accordance with the *Hadley v Baxendale* test;¹ and
 - (3) they have taken reasonable steps to mitigate that loss.²
- 28.6 It also means that the measure of damages may be limited by contract, as discussed below.³

Claims by the insured only

- 28.7 The obligation to pay claims within a reasonable time only applies to claims by “the insured” making “a claim under the contract”. Clause 1 defines “the insured” as a party to the contract. This means that the obligation only applies to claims made by a party to the contract.
- 28.8 In particular, clause 14 does not create any new liability to a “third party”, for example where a victim of personal injury makes a claim on another’s motor or employers’ liability policy. In such cases the insured is liable to the third party for the full extent of the loss suffered as a result of the insured’s tortious or delictual act or omission.
- 28.9 In most circumstances the divide between claims made by the insured and claims made by third parties is a clear one. However, we have been asked to comment on how the divide will be applied in some complex cases.

Assignment or assignation of the policy

- 28.10 Insurance policies may be assigned in two ways. In some cases the assignee legally becomes “the insured” under the contract. Generally this amounts to a novation of the policy.⁴ In this case, clause 14 will apply.
- 28.11 In other cases, however, the assignee does not become the insured; instead, the assignment or assignation is only of the right to receive insurance monies,⁵ so the implied term would not apply.

¹ (1854) 156 ER 145.

² See discussion from para 25.6 above.

³ See discussion from para 28.91 below. We recommend that insurers should be entitled to exclude or limit their liability for late payment in non-consumer insurance contracts, but not in consumer insurance contracts.

⁴ J Birds, *Birds’ Modern Insurance Law* (9th ed 2013), para 11.4; for Scots law, see W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007), at paras 25.21 to 25.28.

⁵ See the discussion in *Birds’ Modern Insurance Law*, above, para 11.2; for Scots law, see W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007), at paras 25.21 to 25.28.

Third party rights against insurers on the insured's insolvency

- 28.12 Where an insured has become insolvent, third parties obtain certain rights directly against the insured's insurer under the Third Parties (Rights Against Insurers) Act 1930, due to be replaced by the Third Parties (Rights Against Insurers) Act 2010. Those Acts provide for the transfer to the third party of all rights which the insured had against the insurer, but not to the extent that the liability of the insurer to the insured exceeds that of the insured to the third party.⁶
- 28.13 The effect is that a third party recipient of rights against an insurer under the Act would only be able to claim for a loss if the insured would have been required to compensate the third party for the loss *and* the insurer would then have been required to compensate the insured for paying the loss. We think this would arise rarely in the context of remedies for late payment.

"Sums due"

- 28.14 The obligation only applies to "sums due" in respect of a claim. Therefore, in order to claim damages for late payment, the underlying insurance claim has to be valid. In other words, the insurer must be liable to make a payment in respect of the claim. Where an insurer has no liability to pay out on a claim – such as where the incident is not covered by insurance or where the claim is fraudulent – there is no implied obligation to make such assessment quickly.⁷
- 28.15 This also means that the insured may only claim for a loss caused by a failure to pay a sum which was actually due. To take a simple example: an insured should have been paid £50,000. Separately, it owes £100,000 to the bank. The insured is unable to pay any of the money owed and the bank puts the company into administration, leading to further losses. To claim damages for these losses on the basis of late payment, the insured would need to show that the insurer's failure to pay caused the loss. If the bank would have put the company into administration even if it had been paid £50,000, the loss was not caused by a failure to pay the sum due. It would happen in any event and therefore the late payment did not cause the loss.
- 28.16 "The sums due in respect of the claim" encompass sums which are "due" either by virtue of an agreement between the parties or because they have been determined by a court to be payable by the insurer. We discuss these issues further below.⁸

⁶ Third Party (Rights Against Insurers) Act 1930, s1(4)(a) and Third Parties (Rights Against Insurers) Act 2010, s8. A similar analysis can be made in respect of the European Communities (Rights against Insurers) Regulations 2002 SI 2002/3061, Reg 3.

⁷ See Part 4 of this Report for a discussion of our recommendations in respect of remedies for fraudulent claims.

⁸ From para 28.57.

Interest

28.17 We have considered whether “the sums due” would include interest on the substantive insurance sum.⁹ We think it would be better to allow the courts to determine this. We think that, in the absence of specific provision, the interest due would be calculated first (from the date of the loss until the ultimate day of payment). We then think that while the interest due/received would be taken into account in any award of damages (so as to prevent double recovery), damages would not be available for the late payment of interest.

DETERMINING A “REASONABLE TIME” FOR PAYMENT

28.18 The meaning of “reasonable time” was a key concern for respondents to the consultation. In Consultation Paper 2 (CP2) we acknowledged that insurers need enough time to investigate claims fully and to challenge claims which they believe to be unfounded. Insurers may be dependent upon third parties, or insureds themselves, to provide the information necessary to assess a claim fully.

28.19 In CP2 we approached the overall timescale in three stages. We proposed that:

- (1) So long as the insurer acted reasonably in asking the insured for information, the time to investigate should only begin once the insured has provided all the material information.
- (2) On receipt of a “clean claim”, the insurer should have sufficient time to carry out a full investigation, including time to seek information from third parties.
- (3) After its investigation, the insurer should assess the claim and arrive at and communicate its decision promptly.

28.20 A significant number of consultees felt that this was overly complex and could lead to artificial results. DAC Beachcroft commented that a three stage process provided “three flashpoints for disagreement and therefore costs and litigation”. A “simpler, single test” would provide less opportunity for debate.

28.21 As the City of London Law Society pointed out:

No matter what guidelines one seeks to provide, the court will be left with the question of whether a particular payment has been made within a reasonable time and that will depend on the facts in each case.

28.22 Some respondents said that the concept of “reasonable time” was too uncertain without further definition but others felt that introducing specified time periods for responses would be too arbitrary. This would be particularly difficult given that the late payment provisions cover all contracts of insurance from consumer contracts to large bespoke risks.

⁹ The right to receive interest is explicitly preserved by clause 14(5), as discussed at para 28.55 below.

28.23 While we are conscious of the need to obtain a balance between certainty and flexibility, we consider that the question of whether a claim has been assessed and paid within a reasonable time must depend on all the circumstances of the case. We think suggested timescales in particular cases are better suited to regulation than primary legislation.

28.24 However, the draft Bill does contain some guidance in this regard.

Time for investigating and assessing a claim

28.25 Clause 14(2) makes it explicit that a reasonable time will always include a reasonable time for investigating and assessing a claim.

28.26 The long-term stability of the insurance market is dependent on insurers having strong incentives to investigate claims and root out fraudulent and invalid claims. This incentive would be weakened if insurers did not feel they had adequate time to do this.

28.27 As Zurich said:

It must be appreciated that generally the insurer is playing catch up in terms of constructing the evidential material in order for them to form a view about coverage. The true facts of the loss are often known only to the policyholder who may not give a full account to insurers. The benefit of the doubt must remain with the insurer to make a legitimate enquiry to enable an informed decision to be made.

28.28 Once a claim has been investigated and valued, payment should be reasonably swift.

Factors which may be relevant in considering what is a “reasonable time”

28.29 Clause 14(3) makes clear that what is reasonable will depend on all the relevant circumstances. However, it contains a non-exhaustive list of factors which might be relevant in considering whether the insurer has acted within a reasonable time. We discuss each of these factors below.

(a) The type of insurance

28.30 Claims under business interruption policies usually take longer to value than, for example, claims for property damage. However, even this is fact-specific. One consultee gave the example of a subsidence claim under a buildings policy:

In such claims, investigations may take some considerable time, even to ascertain whether there is subsidence entitling someone to claim under the policy. There is no 'standard' time this will take, and there will be differences in investigation time between locations based on building construction, soil type and drainage issues.

(b) The size and complexity of the claim

28.31 Larger, more complicated claims will usually take longer to assess than straightforward claims.

28.32 A claim may be complicated by its location; for example, if an insured peril occurs abroad, it is likely that investigation will be more difficult.

(c) Compliance with any relevant statutory or regulatory rules or guidance

28.33 Whether an insurer has complied with relevant rules or guidance with respect to claims handling may well aid in the assessment. We have in mind, for example, the FCA Handbook and paragraph 27 of schedule 1 to the Consumer Protection from Unfair Trading Regulations 2008, which make it an offence for an insurer to ask for irrelevant information or to fail systematically to respond to correspondence.

28.34 As we discuss below, there are also a number of voluntary codes which may be of assistance.

(d) Factors outside the insurer's control

28.35 An insurer should not be penalised where, or to the extent that, its investigations are delayed because an insured or any third party fails to provide relevant information in a timely manner. This factor will also be relevant when an insurer's decision is dependent on the actions of another insurer; for example, the interaction between business interruption and property insurance.

28.36 This fourth factor was regarded as particularly important by consultees, who gave many examples of delaying factors outside the insurer's control.

28.37 The LMA said:

In addition to investigating the claim, insurers will need to carry out proportionate due diligence in respect of compliance with the Bribery Act, sanctions and export control orders. This can be time-consuming in certain cases and may involve obtaining a licence or permission from a governmental body, where turn-around can be slow.

28.38 During our consultation period, several consultees also raised the example of surges in claims due to widespread floods in particular areas. They said that, even with robust capacity planning models, there may be delays in assessing and paying claims where, for example, there are simply not enough loss assessors or surveyors available in or around the affected area. We think such circumstances may well justify a longer time for payment.¹⁰

Market practice

28.39 In CP2 we considered further factors, including market practice, which received a mixed response. Ultimately, we agreed with consultees like K&L Gates LLP and Covington & Burling LLP who took issue with reliance on market practice. K&L Gates LLP said:

¹⁰ It is worth noting that, where an insurer has undertaken to reinstate damaged property rather than to provide financial compensation, the insured is already entitled to claim damages where reinstatement is slow or defective; see discussion in Part 5 of IP6.

We are concerned at the suggestion that a concept as nebulous as "market practice" should be included within any definition of "reasonable time" as it might be used as a basis for insurers to justify delay. There may well be divergences of opinion as to what is market practice, and just because a practice has grown up in the insurance market does not necessarily mean it is right.

28.40 However, we do think that guidance or protocols drawn up by the market may help to inform the interpretation of a "reasonable time" in different contexts. Indeed, there are already a number of codes and agreements which may assist.

28.41 As we noted above, ICOBS requires insurers to handle and settle claims promptly and not unreasonably reject claims.¹¹ The ABI said:

We agree that insurers should pay valid claims within a reasonable time, a requirement that, it could be argued, is already set out in ICOBS 8.1.1.

28.42 The LMA said:

Paying claims in a reasonable time is at the core of the FSA's conduct of business supervision (eg obligations under ICOBS to handle claims promptly and fairly and under the FSA's principles for Treating Customers Fairly); and the FCA, as a successor body, has said that it will have consumer protection and conduct of business at the heart of its regime.

28.43 In addition, Airmic referred us to the speed of settlement agreement they reached with several large insurance companies in the London market in 2009 to provide a set of principles that would govern the timing of settlement of large claims.

28.44 One consultee referred to the International Hull Clauses, which say a decision must be made by the insurer within 28 days of receipt of the loss adjuster's final adjustment or, if no adjuster is appointed, a fully documented claim presentation sufficient to enable the insurer to determine their liability.¹²

28.45 We hope that the industry will continue to develop voluntary codes which will give some more guidance surrounding what is generally to be regarded as a "reasonable time" for payment in different contexts. As we have said, we do not think that primary legislation is the correct place for detailed requirements about time for payment because the provisions cater for the full breadth of insurance policies.

¹¹ From para 26.64.

¹² International Hull Clauses 2003, clause 46.7.

A REASONABLE BUT WRONG REFUSAL

- 28.46 There may be circumstances in which an insurer genuinely and for good reason considers that it is not liable to pay a claim. This might occur where, for example, there is some evidence that the claim is fraudulent, the insurer believes there has been a non-disclosure or misrepresentation at placement which allows it to avoid the policy or the insurer believes the damage to have been caused by an event which the policy does not cover.
- 28.47 Consultees were concerned that our proposals might never allow an insurer in these circumstances to dispute a claim all the way to court without becoming liable for consequential losses as a result. As we have already said, it is in the interest of the wider insurance market that insurers are in a position to challenge potentially invalid claims or to question the amount claimed by an insured.¹³ We accept that there may be an apparently legitimate reason for an insurer to question the validity or value of a claim which ultimately turns out to be payable, and we do not consider that late payment claims should be a regular occurrence in such cases.

Clause 14(4)

- 28.48 Clause 14(4) reads:

If the insurer shows that there were reasonable grounds for disputing the claim (whether as to the amount of any sum payable, or as to whether anything at all is payable)—

(a) the insurer does not breach the term implied by subsection (1) merely by failing to pay the claim (or the affected part of it) while the dispute is continuing, but

(b) 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.

- 28.49 Clause 14(4)(a) therefore says that, if the insurer had reasonable grounds for disputing the validity or quantum of a claim, failure to pay the claim (or the disputed part)¹⁴ while the dispute is continuing is not itself enough to show a breach of the implied term.
- 28.50 Rather, under clause 14(4)(b), something more must be shown before an insurer who makes a reasonable but ultimately wrong refusal can be found to be in breach.

¹³ There is extensive case law examining the extent to which an insured may deliberately exaggerate or enhance a claim before that claim becomes fraudulent. Innocent or mistaken overvaluations of a claim, not amounting to fraud, would have no effect on the “validity” of a claim.

¹⁴ See below, from para 28.63, for a short comment on payments on account.

28.51 An insurer who has a reasonable basis for disputing a claim or at least conducting further investigations may still therefore be in breach of the obligation to pay within a reasonable time if, for example, it conducts its investigation unreasonably slowly, or is slow to change its position when further information confirming the validity of the claim comes to light.

28.52 Under the current Scots law, it has been suggested that late payment damages could be awarded on the basis of a reasonable but wrong decision to refuse a claim even where the insurer's conduct was also reasonable.¹⁵ We are not aware, however, that the courts have ever made an award in such circumstances.

REMEDIES FOR BREACH OF THE IMPLIED TERM

28.53 Clause 14(5) makes specific reference to remedies being available for breach of the term implied by clause 14(1). Because the obligation to pay claims within a reasonable time is a contractual one, the normal range of remedies for breach of contract will be available. We envisage that damages will be the most important remedy in the event that an insured has suffered further loss due to an insurer's failure to pay sums due within a reasonable time. Any damages for breach of the implied term will be calculated according to the general calculation of contractual damages, based on the *Hadley v Baxendale*¹⁶ requirements of actual loss, foreseeability at the point of contracting, and mitigation.¹⁷

28.54 A few consultees were concerned that the concept of "foreseeable losses", for which an insured may be compensated in the event of an insurer's late payment, should be defined narrowly. We are satisfied that the general law of calculation of contractual damages is sufficiently well developed and well understood as to require no definition in statute.¹⁸ It would be undesirable to add qualifications such as "reasonable damages" or "foreseeable losses" into statute as such drafting risks creating an impression that a new right to damages is being created rather than a right to damages calculated according to existing legal principles.

CLAIM FOR LATE PAYMENT SEPARATE FROM MAIN INSURANCE CLAIM AND CLAIM FOR INTEREST

28.55 Clause 14(5) preserves the distinction between claims for breach of the implied term in clause 14(1) and claims for (a) the substantive insurance claim and (b) interest, whether contractual, statutory or otherwise. Breach of the implied term must be argued and proved separately.

¹⁵ See *Strachan v The Scottish Boatowners' Mutual Insurance Association* 2010 SC 367 and *Alonvale Ltd v Ing* 1993 GWD 36-2345.

¹⁶ (1854) 156 ER 145.

¹⁷ See brief discussion from para 25.3.

¹⁸ As we note in para 25.5, the test under *Hadley v Baxendale* has been applied cautiously.

28.56 This provision makes clear that insureds will still be entitled to claim interest on their payments if they have a contractual right to do so, or where they are entitled to enforce a statutory right to interest. An example is section 35A of the Senior Courts Act 1981 (power to award simple interest on debt and damages claims). In Scotland, the common law on interest on damages, and the statutory development of that by the Interest on Damages (Scotland) Act 1958 as amended by the Interest on Damages (Scotland) Act 1971,¹⁹ will continue to apply.

The value of the underlying insurance claim

28.57 Although the underlying insurance claim and any claim for late payment are separate, the value of the former will affect the latter. As we said above, for a late payment claim to succeed, the insured must show that the delay or failure to pay the “sums due” caused the loss suffered. This means that the “sums due” must be determined first.

28.58 We have said that we envisage “sums due in respect of the claim” to encompass sums which are “due” either by virtue of an agreement between the parties or because they have been determined by a court to be payable by the insurer.²⁰

28.59 Where there is a written settlement agreement, it is likely to provide that the insured has no more rights against the insurer in respect of the claim. As well as preventing the insured from claiming further sums for the underlying insurance claim, this would tend to preclude a late payment claim by the insured. It is worth noting that, in both consumer and non-consumer contracts, an insurer may include a term excluding a future late payment claim in its settlement agreement.²¹ Timing of payment would often be dealt with by the settlement agreement, taking any late payment claims outside the remit of our proposals.

¹⁹ See *Wilson v Dunbar Bank Plc* [2008] CSIH 27, 2008 SC 457 for a discussion of the development of this area of the law.

²⁰ At para 28.16.

²¹ See clauses 16(3) and 17(7) and the discussion in Chapter 29.

28.60 However, in many cases there will be no settlement agreement as such. “Settlement” is a tricky term as most payments of insurance claims will not be by way of settlement, through a contract of settlement, but pursuant to the insurance contract itself.²² Even where the language of settlement is used by the insurer in paying a claim, this will not by itself amount to a true settlement:

In most cases, the settlement of a claim is no more than the customary language of the insurance world for the normal routine, whereby the insurer considers the claim presented in the light of the evidence and of the terms of the policy concerned, before “clearing the desk of the file” by payment. Something more than this is implied by a contract of compromise or settlement.²³

28.61 Professor Clarke emphasises that even a claimant’s acceptance and cashing of a cheque does not necessarily amount to a final settlement unless this intention is clear in all the circumstances.²⁴ Professor McBryde confirms a similar position in Scots law.²⁵ There is therefore a question about whether an insured can sue the insurer for further sums for the underlying insurance claim.²⁶ The “sums due” for the purposes of clause 14(1) will depend on the answer to this question.

28.62 Putting aside settlement agreements which deal with these matters expressly, there may still have been a breach of the clause 14(1) obligation where a binding agreement as to quantum has been reached between the parties. The delay in reaching agreement, or delay in making the agreed payment, or both, may have been unreasonable.

Payments on account

28.63 There is no general requirement for insurers to make payments on account. However, insurers frequently make such payments either under contractual arrangements or in a voluntary capacity.

28.64 As Geoffrey Lloyd noted:

Even when dilatory insurers do eventually pay up it is often too late to save the business because the damaged business has been starved of capital.

²² M A Clarke, *The Law of Insurance Contracts* (5th ed 2006) 30-6; see also W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007) at 6-84 and *Evenoon Ltd v Jackel & Co Ltd* 1982 SLT 83 by Lord President Emslie at 86. Also consider whether insurance payments in England and Wales are truly made under the contract in any situation, given that they are characterised as damages rather than a contractual debt.

²³ M A Clarke, *The Law of Insurance Contracts* (5th ed 2006) at 30-6.

²⁴ Above at 30-6.

²⁵ W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007) at 6-84.

²⁶ N H Andrews, ‘Mistaken settlements of disputable claims’, 1989 *Lloyd’s Maritime and Commercial Law Quarterly* p 431 contains an interesting discussion of the policy and legal arguments in favour of respecting “settlements”.

28.65 Even where an insurer is still investigating or disputing part of a claim, making payments towards the undisputed part(s) may make a significant difference to the policyholder's cash flow situation. We envisage that making payments on account in these circumstances could reduce the likelihood of a policyholder having a claim for damages under clause 14.

LIMITATION AND PRESCRIPTION

28.66 We do not recommend any special provisions in relation to the limitation and prescription of actions, so the general rules will apply.

28.67 The law, in England and Wales, requires that a claim is brought with six years of a breach of contract and,²⁷ in Scotland, within five years of the date of the loss flowing from a breach of contract.²⁸

The underlying insurance claim

28.68 In English law, under the "hold harmless" principle, the insurer is considered to be in breach of its obligations under the insurance contract as soon as the harm occurs. The limitation period for the substantive insurance claim therefore begins to run from the date of the loss.²⁹

28.69 In Scotland, where the law operates on the basis that the insurer is a debtor obliged to pay a debt and claims are subject to prescription rather than limitation, it is generally thought that the prescriptive period of five years runs from the date of the occurrence of the loss to which the insurance cover relates.³⁰

28.70 We do not recommend any changes to the existing limitation and prescriptive periods.

A claim for breach of the implied term in clause 14(1)

England and Wales

28.71 The issue of limitation periods in England and Wales has been a difficult one since the inception of the proposals for this new cause of action. We asked consultees specific questions in CP2 about limitation periods for damages for late payment claims and received no majority verdict.

²⁷ Limitation Act 1980, s5.

²⁸ Prescription and Limitation (Scotland) Act 1973, s6.

²⁹ *Callaghan v Dominion Insurance Co Ltd* [1997] 2 Lloyd's Rep 541 (QBD).

³⁰ D Johnston, *Prescription and Limitation* (2nd ed 2012), para 4.14.

28.72 Since we recommend the creation of an independent contractual duty to pay claims on time, the legal position in England and Wales without specific statutory intervention is that limitation on a late payment claim will run from the time of breach of the implied term. This is the last point at which an insurer could have paid a claim and still been within the reasonable time period. In CP2 we commended this option for its logic and its reliance on the general law, despite the fact that it would result in different limitation periods for the substantive insurance and late payment claims.³¹

28.73 In general, the Law Commissions are critical of any suggestion to create another special limitation or prescriptive period and there must be very good arguments in favour of it in order to dislodge the presumption in favour of following the general law. Importantly, we do not think that a late payment action will allow an insured to resurrect a time-barred substantive insurance claim.

28.74 We considered the key arguments against relying on the Limitation Act 1980 to determine the limitation period and concluded that on balance they do not justify a departure from the general law.

(1) Difficulty in determining the end of the limitation period.

Some stakeholders argued that insurers and insureds would have difficulty identifying the point at which the limitation period would start to run (that is, the point at which the insurer should have paid a claim after having had a reasonable time to investigate and assess it) and thus when it would expire. However, it is often the case that the point at which a cause of action accrued is uncertain where it is claimed that there has been a breach of an obligation to do something within a reasonable time. We do not consider that this is a sufficient justification for introducing a special limitation period.

(2) Limitation period for late or non-payment claim subsisting when underlying insurance claim is time barred.

Relying on the default limitation rules means that in some situations a claimant will be in time to bring a claim for late or non-payment but out of time in respect of the underlying insurance claim. Again, we consider this insufficient justification for departing from the usual rules of limitation. We would expect that the insured's own delay would be taken into account by the court in determining whether the insurer had unreasonably delayed, and we are confident that it will not be available to an insured to tack an out of time substantive insurance claim onto a damages claim.

A specific legislative provision starting the limitation period in respect of a late payment claim at the point of the initial loss would mean that the limitation period would begin before the cause of action accrued. In a complex case, that could result in a very substantial abbreviation of the limitation period for the claim for breach of the implied term.

³¹ CP2, from para 5.38.

- (3) Uncertainty for insurers who want to close their books and calculate budgets.

Some consultees said that this approach would introduce uncertainty into an industry where accurate auditing and future planning are paramount. However, as we have discussed,³² we do not accept that the introduction of damages for late payment will have any significant impact upon insurers' ability to forward plan or calculate reserves.

28.75 We therefore recommend that the limitation for claims for damages for late payment of insurance claims should run in line with the existing statutory provisions.

28.76 This requires no explicit provision on the face of the draft Bill. This approach also has the advantage of keeping the English and Scottish positions comparable.

Scotland

28.77 In respect of the recommended independent contractual duty to pay claims within a reasonable time, in Scotland the normal rules of prescription will apply. The prescriptive period for late payment claims will run from the point at which the loss flows to the insured from the insurer's failure to pay the claim within a reasonable time (which may or may not be concurrent events).

28.78 It will be recalled that the damages claim already exists in Scots law. The insurer's liability for breach of the duty to pay a valid claim within a reasonable time will be, for the purposes of the Prescription and Limitation (Scotland) Act 1973, one of reparation. Thus the prescriptive period of five years will run from the date of loss, damage or injury arising from the insurer's breach (rather than the loss covered by the insurance policy).³³ In most cases, the date of loss for these purposes is likely to be contemporaneous with the date of the breach, and it does not matter that the loss actually to be recovered later on may not be fully determinable at that point in time. The loss must also be reasonably discoverable by the party suffering it before the prescriptive period begins to run, so that the beginning of the prescriptive period may perhaps be delayed where the insured has no reason to suspect dragging of feet by the insurer.³⁴

³² See Chapter 26.

³³ Prescription and Limitation (Scotland) Act 1973, s 11(1).

³⁴ Prescription and Limitation (Scotland) Act 1973, s 11(3).

28.79 There is the further possibility that the insurer's breach of duty may be seen as a continuing wrong rather than as a single wrongful event, in which case the prescriptive period would not start to run until the cessation of the continuing act, neglect or default (even if loss was incurred before that cessation).³⁵ Little authority exists on this latter possibility, perhaps because in cases where the parties were in dispute about whether or not there had been a breach of duty it could mean that prescription never begins to run at all. For this reason we think the courts are likely to interpret the concept of continuing act, neglect or default narrowly and to exclude the insurer's wrongful delay in payment from the category.³⁶

NO REMOVAL OF "HOLD HARMLESS" PRINCIPLE IN ENGLAND AND WALES

28.80 In CP2 we criticised the "hold harmless" fiction as being unprincipled and compared it unfavourably with the Scots law position, where the insurer's obligation is to pay valid claims within a reasonable time.³⁷ However, we did not directly propose to remove the hold harmless principle, although a number of consultees suggested that we should do so.

28.81 Our aim is to provide a remedy for late payment. We do not consider that we need to remove the hold harmless principle in England and Wales in order to achieve this. We have not consulted on its removal and, if we were to make this more fundamental change to the insurance law framework, there is a danger that it would have unintended consequences in other areas. From a brief review, we have identified two key issues which would be affected by such change:

- (1) Interest: Changing the hold harmless principle would have an impact on the calculation of interest when an insured is suing for an insurance payment. In his response to CP2, Lord Justice Longmore considered that most insureds would think they should get interest from the date of loss, and also that using any other date would introduce an unwelcome difficulty and degree of uncertainty. He therefore advocated maintaining the status quo, such that interest would be calculated from the date of loss.

³⁵ See Prescription and Limitation (Scotland) Act 1973, s11(2); *Fergus v McLennan* 1991 SLT 321. In England and Wales, some breaches may be regarded as continuing wrongs rather than single wrongful events. In such a case, the breach continues until the obligation is performed or becomes impossible to perform; see for example *Midland Bank Trust Co Ltd and another v Hett, Stubbs & Kemp (A Firm)* [1979] Ch 384. Arguably it is no longer possible to comply with the obligation to pay within a reasonable time once that point has passed. See further A McGee, *Limitation Periods* (6th ed 2010) from para 10-022 and *Chitty on Contracts* (31st ed 2012) para 28-035.

³⁶ See further D Johnston, *Prescription and Limitation* (2nd ed 2012), para 4.64 et seq.

³⁷ CP2, Part 2.

- (2) Limitation period: As discussed above, the hold harmless principle means that the limitation period currently starts running in respect of substantive insurance claims at the date of loss: the cause of action accrues at this point because this is the insurer's breach of its obligation to the insured. If we removed the hold harmless principle, the insurer's obligation would likely be characterised as a contractual duty to pay money to compensate the insured's loss. The cause of action would therefore accrue only when the insurer could be said to have breached that duty. In terms of the limitation period, the options would be to: (a) abandon the policy of starting limitation at the date of loss and allow it to start running at the date at which a cause of action accrued (ie a reasonable time after the claim is made); or (b) legislate specifically to counter the presumptive position that limitation would start running at the date the cause of action is accrued. There is no demand among any stakeholder group to change the limitation period for the main insurance claim, and the Commissions are generally loath to legislate to create special limitation rules which would be needed in order to preserve the current position. Neither option is therefore attractive, nor have we consulted on them as alternatives.

28.82 The IUA said:

As a general comment on legal principle, we agree that the 'hold harmless' concept is anomalous in the context of first party property claims – the main focus of the consultation paper. However, we would reiterate that there continues to be relevance for third party liability claims where the insurer essentially stands alongside the insured in defending against a third party claimant. In such circumstances, where there is a successful defence funded by the insurer, the insured is essentially held harmless by the insurer from the loss occurring.

28.83 We do not recommend removing the hold harmless principle. Our policy aim can be achieved in other ways, as demonstrated above.

BURDEN OF PROOF

28.84 It will be for the policyholder to show that the insurer has breached the implied term by failing to pay within a reasonable time. In law, the burden naturally falls on the claimant to substantiate a claim for damages.

28.85 If the insurer wishes to rely on reasonable grounds for disputing the claim (clause 14(4)), it will have to show that it had reasonable grounds for disputing the claim. However, as we have discussed above, this is not intended to be an onerous requirement. If the insurer establishes that it had reasonable grounds, it has not breached the implied term unless its conduct can also be shown to be unreasonable.

CONTRACTING OUT

Consumer insurance contracts

28.86 Consistent with our approach in the Consumer Insurance (Disclosure and Representations) Act 2012 and in respect of the other consumer matters dealt with by the current draft Bill, we recommend that our late payment provisions should be mandatory in consumer insurance contracts.

28.87 Consultees agreed. The Bar Council said:

We are strongly of the view that insurers should not be able to exclude or limit their liability. The tenor of most insurance literature aimed at consumers is that the latter can look to insurers to pay their claims promptly.

28.88 The late payment provisions in a consumer context are covered by clause 16, which provides that a contractual term is of no effect if it would put the consumer in a worse position than they would be in under the provisions of the draft Bill.³⁸

28.89 This means that an insurer may not exclude the application of the implied term in clause 14(1), nor exclude or limit its liability for breach of that term.

28.90 Even without this, we think that the FOS would ignore any attempt by an insurer to deny a consumer a right to claim for late payment. The Unfair Terms in Consumer Contracts Regulations 1999 might also apply to any such term.³⁹

Non-consumer insurance contracts

28.91 As with other areas of reform covered by the draft Bill, we recommend that the late payment provisions are a default regime for non-consumer insurance contracts.

28.92 Many consultees supported this approach, emphasising the importance of freedom of contract. Some said that there should be no limits on the ability to contract out. Others noted that even in the non-consumer context, many policyholders have a very weak bargaining position. Norton Rose LLP said:

We agree that in the interests of freedom of contract, business policies (ie non-consumer) should be able to exclude the duty to pay damages for late payment. We believe that for large commercial practices, freedom of contract should be unhindered but acknowledge that, in cases such as *Sprung* or for small/micro businesses, limitation of the duty could have catastrophic consequences.

³⁸ Clause 16 is discussed in more detail in Chapter 29.

³⁹ To be replaced by Consumer Rights Bill, Part II. The 1999 Regulations are revoked by paragraph 34 of Schedule 4 of that Bill.

28.93 In order to balance these interests, we recommend certain procedural requirements which must be satisfied before a contracting out provision will have effect. They are contained in clauses 17 and 18 of the draft Bill, which provide that parties to a non-consumer insurance contract can contract to put the insured in a worse position than they would be in under the default provisions, provided that the following transparency requirements are satisfied:⁴⁰

- (1) the insurer must take sufficient steps to draw the disadvantageous term to the insured's attention before the contract is entered into; and
- (2) the disadvantageous term must be clear and unambiguous as to its effect.⁴¹

28.94 In non-consumer contracts, this means that insurers will be able to disapply the implied term about payment contained in clause 14(1), or exclude their liability for breach of that term. Alternatively, they may cap their liability for breach at a specific amount or, for example, at a percentage of the value of the substantive insurance claim.

Deliberate or reckless breaches of the implied term about payment

28.95 In the context of damages for late payment, we recommend a further restriction on parties' ability to contract out of the default regime. We recommend that insurers should not be able to exclude or limit their liability for breaches or exclude the application of the implied term where their failure to pay within a reasonable time is deliberate or reckless.

28.96 In CP2 we described this as a "shield" of good faith which ought to protect insureds from insurers seeking to rely on an exclusion clause to avoid liability for late payment.

28.97 This limitation is contained within clause 17(1) and 17(2)(b), which provide that any attempt to contract out of liability for a deliberate or reckless breach of the implied term about payment will be of no effect.

28.98 Under clause 17(5), a breach is "deliberate or reckless" if the insurer knew it was in breach of the term or did not care whether or not it was in breach. This will cover circumstances in which the insurer refused a valid claim (or failed to pay) within a reasonable time either knowing or not caring that it was doing (or failing to do) so. This is intended to target insurers who knowingly delay payment, as where claims handlers delay or reject a claim they know to be valid in order to secure a bonus payment or with a view to any internal budgets or quotas. It is also intended to catch insurers whose approach to a claim is blameworthy to the point of recklessness.

⁴⁰ Clauses 17 and 18, including the transparency requirements, are discussed in more detail in Chapter 29.

⁴¹ See draft Bill, clauses 18(2) and 18(3) respectively.

Giving reasons for the delay or rejection

- 28.99 The burden of proving that an insurer acted deliberately or recklessly must naturally fall on the policyholder. This is consistent with general legal principles.
- 28.100 In CP2 we suggested that where an insurer sought to rely on an exclusion or limitation of its liability for late payment, it should have to explain why the payment was delayed or rejected. However, it is not clear what practical sanctions could be imposed, either for failure to give reasons or where weak or cursory reasons were provided in order to fulfil the requirement.
- 28.101 Where an insured makes a late payment claim against an insurer and alleges deliberate or reckless behaviour, the insurer will in any defence have to explain its behaviour. We do not consider that a specific statutory obligation to give reasons would provide any additional practical benefit.

Settlement agreements

- 28.102 Our restrictions on parties' ability to contract out of the default provisions do not apply to settlement agreements in either the consumer⁴² or the non-consumer insurance context.⁴³ This is discussed further in Chapter 29.
- 28.103 We would not wish to prevent valid settlements, or call their validity into question, even if the insured settles on less favourable terms than a court would have awarded.⁴⁴
- 28.104 This means that it will be possible for insurers to exclude future late payment claims by a term in the settlement agreement, even where entered into with a consumer. If a payment is made in full and final settlement, we agree that this should be capable of applying to any claims for late payment as well as further sums for the substantive insurance claim. Similarly, the restriction on excluding or limiting liability for deliberate or reckless breaches would not apply to a term in a settlement agreement.

RECOMMENDATIONS

Recommendation 34: It should be an implied term of every insurance contract that, where an insured makes a claim under the contract, the insurer must pay sums due within a reasonable time.

Recommendation 35: A reasonable time should always include a reasonable time for investigating and assessing a claim.

Recommendation 36: Although what is a reasonable time will depend on all the relevant circumstances, the following are examples of things which may need to be taken into account:

- (1) The type of insurance.

⁴² See draft Bill, clause 16(3).

⁴³ See draft Bill, clause 17(7).

⁴⁴ See above from para 28.59.

- (2) The size and complexity of the claim.
- (3) Compliance with any relevant statutory rules or guidance.
- (4) Factors outside the insurer's control.

Recommendation 37: If the insurer can show that it had reasonable grounds for disputing the claim (whether as to the amount payable, or whether anything at all is payable), the insurer does not breach the obligation to pay within a reasonable time merely by failing to pay the claim while the dispute is continuing.

Recommendation 38: In those circumstances, the conduct of the insurer in handling the dispute may be a relevant factor in deciding whether the obligation was breached and, if so, when.

Recommendation 39: Normal contractual remedies for breach of contract should be available for breach of the implied term to pay sums due within a reasonable time.

Recommendation 40: In England, the normal rules of limitation will apply in respect of claims for breach of the new term. In Scotland, the normal prescriptive period will continue to apply.

Recommendation 41: The hold harmless principle need not be removed, nor extended to Scotland.

Recommendation 42: In consumer insurance contracts, the insurer should not be able to contract out of the obligation to pay sums due within a reasonable time.

Recommendation 43: In non-consumer insurance contracts, the insurer should be permitted to exclude or limit its liability for breach of the obligation to pay sums due within a reasonable time, unless such breach was deliberate or reckless. In other cases, its right to contract out will be subject to satisfying the transparency requirements.

PART 6

GENERAL ISSUES

CHAPTER 29

CONTRACTING OUT

- 29.1 Much of the draft Bill applies to both consumer and non-consumer insurance, though the clauses on fair presentation and the provisions of clause 9 apply only to non-consumer insurance.¹
- 29.2 Insofar as the draft Bill applies to consumer insurance, we recommend that its provisions should be mandatory, so that insurers cannot use a contract term to put the consumer in a worse position than it would be in under the provisions of the draft Bill. This follows the approach in the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA).
- 29.3 In the non-consumer context, our recommendations apply to a wide range of insurance, from micro-business policies to reinsurance. We believe that in most cases they strike a suitable balance between the interests of the insurer and the non-consumer insured. However, given the range of risks covered, parties may need freedom to agree bespoke arrangements in their contracts.
- 29.4 For non-consumer insurance, we do not generally propose to place any restrictions on the *extent* to which the regime can be altered (or excluded) by contract. Parties may opt out of most of proposed changes entirely, provided they meet two procedural requirements:
- (1) the insurer must take sufficient steps to draw the relevant term to the insured's attention before the contract is entered into;² and
 - (2) the term must be clear and unambiguous as to its effect.³
- 29.5 These requirements are referred to in the draft Bill as the "transparency requirements".⁴ The way in which they operate in specific cases will depend on the characteristics of the insured.
- 29.6 In this chapter we discuss the policy behind our recommendations on contracting out. We then explain the transparency requirements. We also outline the two exceptions where contracting out will not be permitted: basis of the contract clauses, and deliberate or reckless late payment of claims. Finally we illustrate the recommendations with some examples.

¹ See Part 2 and Chapter 16 of this Report respectively. The equivalent matters in respect of consumer insurance were addressed in the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA).

² See draft Bill, clause 18(2).

³ See draft Bill, clause 18(3).

⁴ See draft Bill, clause 18.

CONSUMER INSURANCE CONTRACTS

- 29.7 When entering into a contract of insurance, the consumer is very unlikely to be in a position to obtain more favourable terms for themselves than those that appear in the insurer's standard contract. Around 35% of consumer insurance is purchased directly from the insurer,⁵ without the help or advice of a broker, and much of it will be purchased online where there is no opportunity to discuss particular provisions. To some extent, therefore, our recommendations in respect of consumer insurance are designed to protect consumers and ensure that standard contract terms are fair.
- 29.8 In each of our Consultation Papers, we have suggested that it should not be possible to contract out of the default regimes we propose, except in favour of the consumer.⁶ Almost everyone who responded on these matters agreed that this was appropriate.
- 29.9 One consultee thought that this was "an important safeguard for consumers who have limited, if any, negotiating power with insurers over the core terms of their policies." The International Underwriting Association (IUA) noted that our proposals for contracting out in consumer insurance were "consistent with the widely accepted approach adopted in the Consumer Insurance (Disclosure and Representations) Act."
- 29.10 CIDRA provides that its rules are mandatory. An insurer may not use a contract term to put the consumer in a worse position than it would be in under the provisions of CIDRA.⁷
- 29.11 We have included a similar provision preventing contracting out in the draft Bill. Clause 16(1) renders a contract term of no effect if it would put the consumer in a worse position than they would be in under Parts 3 or 4 of the draft Bill.⁸

⁵ Association of British Insurers, *UK Insurance Key Facts 2013*, p 14.
https://www.abi.org.uk/~/_media/Files/Documents/Publications/Public/2013/industry%20data/UK%20Insurance%20Key%20Facts%202013.ashx.

⁶ Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (June 2007) (CP1), para 12.24; Post Contract Duties and other Issues (December 2011) (CP2), paras 5.25 and 8.30; and The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012) (CP3), para 15.59.

⁷ CIDRA, s 10.

⁸ Part 3 of the draft Bill addresses warranties and other terms; Part 4 addresses fraudulent claims and late payment.

- 29.12 The new provisions on warranties, remedies for fraudulent claims, late payment of insurance claims and good faith will therefore apply to all consumer insurance contracts as a mandatory regime.⁹ Any clause of a consumer insurance contract which seeks to change the default rules will be subject to scrutiny. If the result of the term is that a consumer is worse off than he or she would have been under the default regime, the term will be of no effect.
- 29.13 Clause 16(1) applies not only to terms of the insurance contract itself, but also to terms contained in connected or ancillary contracts. However, in clause 16(3), the draft Bill makes an exception for agreements to settle claims. We would not wish to prevent valid settlements, even if the consumer settled on less favourable terms than a court would have awarded. Again, this follows the approach in CIDRA.¹⁰

Consumer members of a group insurance scheme

- 29.14 The restriction also applies to consumers who are beneficiaries of a group insurance contract caught by clause 13, which deals with fraudulent claims by group members. Consumer members of such a scheme should not be put in a worse position by the terms of the policy than they would be in under clause 13.
- 29.15 We expect that the policyholder will usually be a non-consumer insured (such as an employer) and therefore the contract will usually be a non-consumer insurance contract. This is covered by clause 17(4). However, it is possible that a consumer may take out a policy for the benefit of other consumers who become group members. In this situation the contract would be a consumer contract. This is covered by clauses 16(1) and 16(2)(b). Both provide that a term of a contract which seeks to put the members of a group scheme in a worse position than they would be in under clause 13 is of no effect.

NON-CONSUMER INSURANCE

A single regime for non-consumer insurance

- 29.16 Our consultees were very clear that they wanted a single regime for non-consumer insurance.¹¹ Our recommendations therefore have to cover a very wide range of risks and contracts, from micro-businesses, small and medium enterprises (SMEs) and charities to multinational corporations, large risks, marine insurance and reinsurance.

⁹ See draft Bill, clause 16(1). As we have said, Part 2 of the draft Bill (the duty of fair presentation) does not apply to consumer insurance contracts. This is also true of clause 9, which deals with basis of the contract clauses. Both of these matters are dealt with in the consumer insurance context by CIDRA.

¹⁰ CIDRA, s 10(4).

¹¹ We consulted on micro-businesses in 2009 and found no call for the consumer regime to be applied to them. Consultation and summary of responses available at <http://lawcommission.justice.gov.uk/consultations/micro-businesses.htm> and <http://www.scotlawcom.gov.uk/law-reform-projects/joint-projects/insurance-law>. See Appendix A of CP3 for a discussion of our conclusions.

29.17 In contrast to the consumer position, it is generally less appropriate to seek to protect non-consumer insurance buyers. Instead, we seek a workable law which strikes a balance between the interests of insurers and policyholders. We believe that the proposals represent a fair balance. They are supported by the majority of consultees from all sides of the market.

Freedom of contract

29.18 Consultees strongly supported freedom of contract where policyholders have the experience, resources and bargaining power to negotiate alternatives to the default regime. We fully accept this principle. Many large policyholders are sophisticated, commercially aware insurance buyers with a strong negotiating position. They may wish to pay more for better terms, or pay less for worse terms, or balance improvements in some areas against reductions in others. We think that they should be given full freedom to do so.

29.19 There was, however, considerable debate about how far SMEs are able to bargain freely. Some consultees noted that most SMEs use brokers. They said it was the broker's job to negotiate the best possible deal for their client (the insured). Brokers should be aware of all aspects of the market that they are operating in, and it is part of their duty to their client to advise properly on all adverse terms that an insurer is seeking to insert into a policy.

29.20 However, other consultees thought that freedom of contract in this market was an illusion. BIBA thought that there was no true freedom of contract between businesses and insurers due to their "unequal bargaining position[s]". K&L Gates commented:

In many cases policy terms are imposed on business policyholders through their lack of understanding or for commercial reasons.

29.21 The Bar Council and BILA argued that while large businesses could be allowed to contract out, insurers should be prevented from contracting out of proportionate remedies when dealing with SMEs. The Faculty of Advocates expressed concern that contracting out "might readily become the industry standard".

29.22 In many parts of the market, policyholders are unaware of their rights, and lack the bargaining power to secure a favourable deal. We accept that the problem is mitigated somewhat by the use of a broker, but even then small businesses may not fully understand the implications of what they are signing. Anecdotal evidence suggests that even brokers (and insurers) are not always aware of, for example, the harsh impact of a warranty or the meaning of a "basis of the contract" clause. Even larger insurance buyers may find it difficult to convince an insurer to change its standard terms, and small businesses may find it very difficult to do so.¹²

¹² Mactavish summary of recent evidence provided to the Law Commission in January 2014.

29.23 One advantage of insurance is that it is quick and easy to buy: there are rarely lengthy negotiations and the parties do not use lawyers to check contracts before signing. While this is a strength of the market, it also makes it more difficult for buyers to question or change the insurer's standard terms.

Our views

29.24 We think our recommended regime strikes a balance between the interests of both parties, so we wish to discourage boilerplate clauses which opt out of the default regime as a matter of routine. This is especially the case for mainstream business insurance. The parties to an insurance contract should consider whether contracting out of any or all of the default provisions is appropriate in their particular circumstances. The reality is, however, that some small non-consumer buyers are much like consumers, with very little ability to negotiate better terms for themselves.

29.25 On the other hand, in sophisticated markets including the marine insurance market, we expect that contracting out will be more widespread. The enormous value of the UK insurance market depends on the existence of a flexible legal regime which allows non-standard risks to be written. Given the range of risks which may be covered by the non-consumer regime, parties may need freedom to agree bespoke arrangements in their contracts.

29.26 In Consultation Paper 3 (CP3),¹³ we considered whether it is possible to distinguish between different types of insurance buyer at the point of sale, but the market is too diverse to allow for separate categories of buyer.¹⁴ We have therefore attempted to strike a balance in a different way. Below we recommend that the parties will be free to contract out of the default regime, but only if they do so in a transparent way.

¹³ Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155.

¹⁴ See CP3, Appendix A.

Procedural requirements

- 29.27 In CP3 we proposed that the parties should be entitled to contract out of the default regime, but only if the term is written in clear, unambiguous language and specifically brought to the attention of the other party before the contract is formed. Most respondents supported including procedural requirements,¹⁵ but there was also concern about them. It was thought that they would introduce uncertainty into insurance contracts and that insurers would find it difficult to know whether they could rely on a term until it had been tested in court. Some consultees, particularly at the more sophisticated and high-value end of the market, were sceptical of any approach that sought to impose restrictions on what they put in their contracts.
- 29.28 There are a number of important but competing concerns: the insurers' need for certainty; the principle of freedom of contract; and the interests of insurance buyers whose negotiating power and understanding of insurance law may be limited. This is especially true for micro-businesses and SMEs purchasing off-the-shelf insurance online.
- 29.29 The requirements proposed are intended to balance those interests and achieve the following aims:
- (1) To encourage insurers to consider whether opting out of the default regime is necessary or appropriate in the circumstances.
 - (2) To enable policyholders to make an informed decision (with or without the aid of a broker) about whether to agree to the alternative position, to negotiate for the default position or to seek an alternative insurance provider.
 - (3) To ensure that the contracting out provisions are not so onerous as to interfere with the smooth running of the insurance market, particularly at the more bespoke and sophisticated end of the market.
 - (4) To give the courts room to differentiate between different scenarios, from well-advised, commercially aware insurance buyers to smaller insureds buying "off the shelf" and, increasingly, online.

¹⁵ We consulted on each issue separately. On disclosure, for example, out of 36 respondents, 23 (64%) supported the transparency test. See the Summaries of Responses for Disclosure, p 37; Warranties, p 18; and Remedies for fraudulent claims, p 17. <http://lawcommission.justice.gov.uk/areas/insurance-contract-law.htm> and <http://www.scotlawcom.gov.uk/law-reform-projects/joint-projects/insurance-law>.

- 29.30 As we have outlined above, we do not propose to place any general restrictions on the *extent* to which the regime can be altered (or excluded) in a non-consumer insurance contract. We do not, therefore, recommend a requirement for substantive “fairness”, such as is found in the Unfair Contract Terms Act 1977 (and the Unfair Terms in Consumer Contracts Regulations 1999).¹⁶ Parties may opt out of most of the proposed changes entirely, provided they meet the “transparency requirements” outlined below.
- 29.31 Insurers will have to take some steps to bring their terms to the attention of buyers, and this will impose some (albeit limited) administrative work. To some extent, this is deliberate. We think that it is right that insurers should pause and consider whether the benefits of contracting out are worth the administrative and reputational costs involved. We do not wish to see insurers routinely contract out of the default regime in the general insurance market for little reason.
- 29.32 However, contracting out may well be appropriate for large or unusual risks. Because of this, the transparency requirements are intended to operate flexibly, so among sophisticated parties little or no additional administration will be required. We illustrate this with some examples at the end of the chapter.

THE TRANSPARENCY REQUIREMENTS

- 29.33 Clause 17(3) provides that a contractual term (or terms) which puts the non-consumer insured in a worse position than it would be in under the terms of the draft Bill (a “disadvantageous term”¹⁷) is of no effect unless the requirements of clause 18 are satisfied.
- 29.34 Clause 18 contains the transparency requirements, which are:
- (1) the insurer must take sufficient steps to draw the term to the insured’s attention before the contract is entered into;¹⁸ and
 - (2) the term must be clear and unambiguous as to its effect.¹⁹

A subjective application of the transparency requirements

- 29.35 Clause 18(4) provides that, in determining whether the transparency requirements have been met, the characteristics of insured persons of the kind in question should be taken into account, as should the circumstances of the transaction.

¹⁶ Section 3 (s 17 in Scotland) and Reg 16 respectively. The 1999 Regulations are due to be replaced by the Consumer Rights Bill, Part II. The 1999 Regulations are revoked by paragraph 34 of Schedule 4 to that Bill.

¹⁷ See draft Bill, clause 18(1).

¹⁸ See draft Bill, clause 18(2).

¹⁹ See draft Bill, clause 18(3).

29.36 The transparency requirements are not intended to be too onerous, or to force commercially aware insureds, insurers and brokers to behave artificially. However, at the other end of the scale (right down to what might be termed quasi-consumer insurance) insurers should think carefully about how they present information to their insureds. We think that the draft Bill gives courts (and indeed those operating in the market) the opportunity to draw appropriate distinctions where necessary. We illustrate this in our examples at the end of this chapter.

Drawing the insured's attention to the disadvantageous term

29.37 This requirement, in clause 18(2), aims to ensure that insureds are given a reasonable opportunity to know that the disadvantageous term exists. A term which puts the insured in a worse position than the default regime should not generally be buried in a policy document without any further reference to it.

29.38 This requirement for “notice” of the provision goes slightly further than the common law. In the well-known case of *Interfoto Picture Library Limited v Stiletto Visual Programmes Limited*, Lord Justice Dillon said:

... if one condition in a set of printed conditions is particularly onerous or unusual, the party seeking to enforce it must show that that particular condition was fairly brought to the attention of the other party.²⁰

29.39 However, such conditions only apply where a term is “particularly onerous or unusual”. We intend our transparency requirements to apply in every instance of contracting out. The (over) use by insurers of alternative regimes should not be capable of disapplying the requirements.²¹ In addition, a recent case upheld the incorporation of terms which were not known to the insured upon conclusion of the contract and were only available on request.²²

29.40 We therefore consider it important to include the requirement on the face of the draft Bill. The insurer must take sufficient steps to draw the term to the insured's attention before the contract is entered into. For the insured to know about a disadvantageous term only after the contract has been concluded would not advance the aims we set out above.

²⁰ [1989] QB 433 at 439. In Scotland, see *Montgomery Litho Ltd v Maxwell* 2000 SC 56 and *Brandon Hire Plc v Russell* [2010] CSIH 76.

²¹ See, for example, *Allen Fabrications Limited v ASD Limited* [2012] EWHC 2213 (TCC) in which the court stressed that whether an exclusion clause was onerous or unusual would depend on the context: if a particular type of clause was in common use, it is less likely to be regarded as onerous as between two commercial parties.

²² *Brown-Quinn and Another v Equity Syndicate Management Ltd and Another* [2012] EWCA Civ 1633.

- 29.41 As we have said, the requirement for bringing a term to the insured's attention must be interpreted flexibly to take account of the full range of participants in the insurance market. This is also implied in the word "sufficiently". What is sufficient for one type of insured may not be sufficient for another. The extent to which a term should be brought to the attention of a policyholder will vary considerably depending on whether the policyholder is, for example, a sole trader buying standardised retail public liability insurance or a charterer purchasing a voyage policy at Lloyd's using a broker.
- 29.42 Where the insured is using a broker, we think drawing the broker's attention to the disadvantageous term would be sufficient. In many instances there will be little or no direct contact between the insurer and the insured, with everything being done through intermediaries. In such a situation, it is the broker's responsibility to ensure the insured is aware of the term. This is not specified in the draft Bill, but is a matter of general agency law.
- 29.43 As we discuss in the examples below, there may be situations in which very little must be done in order to satisfy this requirement.

Actual knowledge of a disadvantageous term

- 29.44 Clause 18(5) makes clear that an insured may not rely on any failure by the insurer to draw a disadvantageous term to its attention if the insured had actual knowledge of the term at the time the contract was entered into.
- 29.45 Although a key concern is to ensure that the insurer acts transparently, it would be disingenuous for an insured to obtain an advantage from an improper process when it was aware of the clause.
- 29.46 Again, through the operation of agency laws, this clause might also apply where the broker was actually aware of the disadvantageous term.²³ This may become an important issue, so brokers should be sure to specifically discuss with the insured any terms which contract out of the default regime.
- 29.47 Where there are joint policyholders, we think it would be sufficient to bring the disadvantageous term to the attention of one of them.

Term to be clear and unambiguous as to its effect

- 29.48 Clarity and a lack of ambiguity are basic requirements and are already well established in common law.
- 29.49 The requirement should not be equated with the *contra proferentem* rule, under which any ambiguity in a term will be construed against the party seeking to rely upon it. The requirement applies not only where a term is ambiguous (see the example below) but to all disadvantageous terms. If a clause fails to meet the transparency requirements, it will be of no effect and the default rules will be applied instead.

²³ It is worth noting that our recommendations in respect of agents' knowledge in the context of the duty of fair presentation, discussed in Chapter 9, do not apply here,

- 29.50 The requirement in clause 18(3) goes slightly further. It requires the *consequences* of the disadvantageous term to be clear and unambiguous. For example, it would not normally be sufficient to say that “section 14 of the Insurance Contracts Act 20XX does not apply to this contract”, despite the fact that this is clear and unambiguous in itself. Rather, an insurer wishing to contract out of the requirement to pay sums due within a reasonable time might have to say that “Section 14 of the Insurance Contracts Act 20XX does not apply to this contract, meaning that we shall have no liability to you in respect of any loss or damage suffered by you as a result of our failure to pay sums due to you under this contract within a reasonable time”.
- 29.51 Again, how far the term has to spell out the consequences will depend on the nature of the insured party and the extent to which they could be expected to understand the consequences of the provision.

TWO EXCEPTIONS FROM CONTRACTING OUT

Basis of the contract and similar clauses

- 29.52 Our recommendations in relation to basis of the contract clauses are contained in clause 9 of the draft Bill and discussed in Chapter 16. By the very nature of the prohibition of basis of the contract clauses, it will not be possible to contract out of this. This is addressed in clauses 17(1) and 17(2)(a).
- 29.53 Insurers will not be able, by any formulation of words, to provide that any or all of the pre-contractual representations made by a (prospective) insured automatically become warranties. If an insurer wants a warranty in respect of any particular matter, this must be specifically agreed between the parties.

Deliberate or reckless late payment of insurance monies

- 29.54 Our recommendations in relation to late payment of insurance claims are contained in clause 14 of the draft Bill and discussed in Part 5. In non-consumer insurance contracts, insurers will generally be able to contract out of the implied obligation, contained in clause 14(1), as to payment within a reasonable time. That is, insurers will be able to exclude or limit their liability for breach of the duty to pay within a reasonable time, or provide that the implied term does not apply to a particular insurance contract, provided they comply with the transparency requirements.
- 29.55 However, insurers may not limit/exclude liability for breaches or exclude the application of the implied term where their failure to pay within a reasonable time is deliberate or reckless.²⁴ This limitation is contained within clauses 17(1) and 17(2)(b), which provide that any attempt to contract out of liability for a deliberate or reckless breach of the implied term about payment will be of no effect.

²⁴ See also para 28.95 and following.

- 29.56 Under clause 17(5), a breach is “deliberate or reckless” if the insurer knew it was in breach of the term or did not care whether or not it was in breach. This will cover circumstances in which the insurer refused a valid claim (or failed to pay within a reasonable time) either knowing or not caring that it was doing (or failing to do) so.

SETTLEMENT AGREEMENTS

- 29.57 Our contracting out provisions do not apply to settlement agreements. We would not wish to prevent valid settlements, or call their validity into question, even if the insured settles on less favourable terms than a court would have awarded.
- 29.58 This means that, where a settlement has been reached in the consumer insurance context, the prohibition on less favourable terms than the default rules does not apply. In the non-consumer context, there is no requirement to meet the transparency requirements in the context of settlement agreements.
- 29.59 This is provided in clauses 16(3) (consumer) and 17(7) (non-consumer).

CANCELLATION RIGHTS

- 29.60 We do not wish to hinder the ability of parties to make provision for cancellation. Cancellation clauses are currently used by insurers in many contracts and generally allow the insurer to terminate the contract upon giving a specified period of notice. Depending on the detail of the term, the right may be exercisable in specified circumstances or for any reason. As such clauses operate prospectively, an insured is not put in a worse position than they would be in under the new rules: the insured will be aware that they no longer have insurance cover and will be able to take out new insurance. The right to cancel is usually tied to an obligation to return any paid premiums on a pro-rata basis. The policyholder’s past claims will still be payable (unless the insurer has a remedy for non-disclosure or some other breach).
- 29.61 We therefore do not think that the transparency requirements would apply to cancellation clauses.

EXAMPLES APPLYING THE TRANSPARENCY REQUIREMENTS

Example 1: Small business purchasing standard form insurance online

- 29.62 **Scenario 1:** The owner of a small business (B) visits an insurance company’s (C) website to purchase public liability insurance. B fills in the requisite forms online, is given an automatically generated quote and is then asked to indicate whether or not he wishes to proceed. At this stage there is a large box on screen showing the key terms of the policy: premium, extent of coverage, etc. B has to tick a box stating that he agrees to the standard terms and conditions attached to the insurance policy. There is a link next to the box which, if clicked, opens a window showing all of the standard terms. A term excluding liability for damages for late payment — that is, excluding liability for breach of the implied term in clause 14(1) — is included at paragraph 24. There is no other reference to the term.

We do not think the transparency requirement in clause 18(2) has been satisfied here. The policy would still exist but the term purporting to exclude liability for damages for late payment would be of no effect.²⁵

- 29.63 **Scenario 2:** As above, but this time the box detailing the key terms also states: “The insurer will not be liable to pay you damages if you suffer loss as a result of a delayed or wrongly refused claim. Please see paragraph 24 of our standard terms and conditions for further details”. That wording is one of only five points appearing in the “key terms” box.

We think this would be sufficient (assuming paragraph 24 is appropriately worded) to exclude liability for late payment of claims. C has taken active steps to draw B’s attention to the specific term that excludes liability. B was presented directly with this term, and had the option of purchasing the insurance, investigating further, or abandoning the purchase. There was little more the insurer could do in the context to bring the clause to B’s attention.

Example 2: Medium-sized enterprise buying insurance through a regional/non-specialist broker

- 29.64 **Scenario 3:** The managing director of a medium-sized enterprise (M) visits an insurance broker (IB) to discuss purchasing a bespoke liability policy to cover any liabilities arising from the manufacture, sale and use of a new product. IB discusses M’s needs and agrees a set of requirements. IB then telephones a number of underwriters. Underwriter U offers the best price. IB and U discuss and negotiate certain terms of the insurance policy including price and coverage, and U states that the policy will, other than the negotiated terms, be on its standard terms and conditions. U emails a scanned copy of those conditions to IB. These include, at paragraph 24, a term stating that if any of M’s employees have given a dishonest answer to M’s “reasonable search” for information conducted under the fair presentation requirements, U is entitled to avoid the contract *ab initio*. This provision has the effect of modifying the fair presentation duty and U’s remedy for breach. U did not mention this on the telephone. Paragraph 24, along with a handful of other terms, is marked with an asterisk. IB consults with M, not mentioning paragraph 24. M is pleased with the price and instructs IB to purchase the policy. IB relays this to U, who asks if IB has had a chance to go through the standard terms. IB replies in the affirmative and arranges for the policy to be entered into.

²⁵ It is worth noting that the transparency requirements do not apply to any attempt to contract out of liability for deliberate or reckless late payment, because any such attempt is of no effect regardless. We do not therefore think that an explicit “saving” provision would be required where the insurer otherwise sought to exclude or limit its liability for late payment.

This would be at the limit of what was sufficient to bring the term to the notice of the insured (through its agent), but nevertheless we think this term would be effective. U has taken steps to draw IB's attention to the clause (which sets out relatively clearly the consequences of an employee's dishonesty). Although U did not do a lot, they acted knowing that they were dealing with a broker. This would be a question of evidence, but we think that U should be entitled to assume that the broker had actually read the terms, or at least those that U had marked out for special attention.

This is also an example of the way in which our reforms would treat the relationship between broker and insured: U has done enough by telling the broker, and does not have to go directly to the insured. Naturally, if IB does not advise M of paragraph 24 and M suffers loss as a result, M might seek to bring a claim against IB for failing to identify and explain the term.

29.65 **Scenario 4:** As above, but M deals directly with U, without the benefit of a broker.

In this scenario, we do not think that U has done enough to satisfy clause 18(2). Unlike during their dealings with IB, U cannot assume that M will go through the standard terms, even when some were highlighted. Had they mentioned it to M on the phone, or in the covering sheet or email with the scanned standard terms, we think they would have satisfied the requirement. U should consider whether there is evidence that M had actual knowledge of the term.

Example 3: Sophisticated insurance buyer purchasing cover through Lloyd's

29.66 **Scenario 5:** One year after the coming into force of the new Insurance Contracts Act, Lloyd's underwriters and brokers have developed standard wordings to disapply the Act's reforms on warranties (so that breach results in discharge of all liability) and late payment (complete exclusion of liability). These standard wordings are assigned codes of LC1 and LC2 respectively. When a broker is negotiating a policy, if it is agreed that any of those will apply, the broker jots the code down on the slip, and this is taken as evidence that the terms are agreed and incorporated into the insurance policy.

S has just chartered a ship to carry cargo. S calls its broker (IB) in London and asks IB to arrange cover for the voyage, which must be in place by the time the ship sails in 24 hours' time. IB negotiates with several underwriters at Lloyd's before finding one (U) who agrees to underwrite the voyage on favourable terms. However, U insists on excluding liability for damages for late payment and is particularly keen that if S's ship strays from its proposed course (which S will need to warrant it will not) the policy should be permanently terminable, so wishes to exclude the warranties reforms. IB, with authority to bind S, accepts this, and writes LC1 and LC2 on the slip which is stamped by U.

This assumes that the standard wordings agreed in the market are clearly drafted as to their effect. We think U's exclusions are effective, and they have satisfied the transparency requirements. This is a fast-paced market, and we would not want to interfere unnecessarily with its operation. The provisions have been discussed with IB who ought, as a broker, to know what LC1 and LC2 mean or to find out before binding his or her client.

29.67 **Scenario 6:** As above, but U does not mention LC1 or LC2, or its desire to exclude certain portions of the Insurance Contracts Act 20XX. Instead, it refers to its standard voyage conditions (coded U1VOY1). Those conditions have recently been updated to include terms substantively the same as LC1 and LC2. The broker writes a reference to the U1VOY1 conditions on the slip and the policy is concluded.

We think these exclusions could be held to be ineffective if the matter was to come before a court. U has not done anything at all to bring IB's attention to the inclusion of the terms in its own standard terms. However, it would depend on the exact circumstances of the case: for example, the extent to which the detail of U1VOY1, as recently modified, was known by brokers generally; the availability of U1VOY1 for inspection; and the extent to which other standard sets of voyage conditions would be known by brokers to include such exclusions. We think an insurer in such a situation would be well advised to mention the specific provisions to the broker, perhaps in an email or by having them specifically noted on the slip.

RECOMMENDATIONS

Recommendation 44: In a consumer insurance contract, it should not be possible to put the consumer in a worse position than the consumer would be in by virtue of the provisions of the draft Bill.

Recommendation 45: Similarly, it should not be possible to put consumer members of a group insurance scheme in a worse position with regards to remedies for fraudulent claims by group members than they would be in by virtue of the draft Bill.

Recommendation 46: Subject to recommendation 48, any term in a non-consumer insurance contract which would put the insured in a worse position than the insured would be in by virtue of the provisions of the draft Bill should be of no effect unless:

- (1) the insurer has taken sufficient steps to draw the relevant term to the insured's attention before the contract is entered into; and
- (2) the term is clear and unambiguous as to its effect.

Recommendation 47: In considering whether the above requirements have been satisfied, the characteristics of insured persons of the kind in question, and the circumstances of the transaction, should be taken into account.

Recommendation 48: In a non-consumer contract, it should not be possible to put the insured in a worse position than the non-consumer would be in by virtue of the provisions of the draft Bill in relation to:

- (1) basis of the contract clauses; or
- (2) deliberate or reckless breaches of the duty to pay sums due within a reasonable time.

CHAPTER 30

GOOD FAITH

30.1 Section 17 of the Marine Insurance Act 1906 (the 1906 Act) imposes a duty of good faith on both parties. It states:

A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.

30.2 Section 17 is said to reflect the common law for all types of insurance.¹

30.3 The characterisation of an insurance contract as a contract of “the utmost good faith” lies at the heart of insurance contract law. The mutual duty of good faith imposed on the parties to an insurance contract is a significant differentiator of insurance from general commercial law.²

30.4 The main problem with section 17 is that it only provides one remedy: avoidance of the contract.

30.5 In this chapter we discuss our recommendation to remove avoidance as a remedy for breach of good faith. We think that the duty of good faith is important as a general interpretative principle.

PREVIOUS CONSULTATIONS

30.6 In the course of our review, we have considered section 17 on many occasions. As we noted in Consultation Paper 1, sections 18 and 20 of the 1906 Act are specific pre-contract examples of the duty of good faith in relation to non-disclosure and misrepresentation.³

¹ See for example *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501 by Lord Mustill at 518 and *Banque Keyser Ullmann SA v Skandia (UK) Insurance Co Ltd* [1990] 1 QB 665 by Steyn J at 701.

² This may be less pronounced in Scots law than in English law; see Issues Paper 6: Damages for Late Payment and the Insurer’s Duty of Good Faith, March 2010, paras 4.11 to 4.13. Outside of insurance contract law, there is some debate as to whether there exists an implied duty of good faith in English contract law. See *Yam Seng Pte Limited (A company registered in Singapore) v International Trade Corporation Limited* [2013] EWHC 111 (QB) at [119] to [154], but note its failure to attract support in subsequent decisions: see for example *Mid Essex Hospital Services NHS Trust v Compass Group UK and Ireland Ltd (Trading As Medirest)* [2013] EWCA Civ 200 at [105] and *TSG Building Services Plc v South Anglia Housing Limited* [2013] EWHC 1151 (TCC) at [45] and [46].

³ See Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured (July 2007) Law Commission Consultation Paper No 182; Scottish Law Commission Discussion Paper No 134, paras 2.6 to 2.11. See also Part 2 of this Report.

- 30.7 In Issues Paper 6 (IP6) we looked at the insurer's duty of good faith, particularly in respect of the late payment of claims.⁴ In Issues Paper 7 (IP7) we considered the insured's post-contract duty of good faith, of which the clearest example is the duty not to make a fraudulent claim.⁵ We reported on the results of these two consultations in Consultation Paper 2 (CP2).⁶
- 30.8 We returned to the duty of good faith in Part 10 of Consultation Paper 3 (CP3).⁷ We proposed that it should continue as an interpretative principle but should not in itself give either party a cause of action. As we reported in the summary of responses, there was strong support for this proposal. Of 38 respondents, 27 (71%) supported it. Only 3 (8%) expressly disagreed, and 8 respondents (21%) were classed as "other".⁸

⁴ Issues Paper 6: Damages for Late Payment and the Insurer's Duty of Good Faith (March 2010) above.

⁵ Issues Paper 7: The Insured's Post-Contract Duty of Good Faith (July 2010). However, in recent years the courts have not tended to apply the section 17 remedy of avoidance in the event of fraudulent claims. See Part 4 of this Report, especially Chapter 20.

⁶ Insurance Contract Law: Post Contract Duties and other Issues (December 2011) Law Commission Consultation Paper No 201; Scottish Law Commission Discussion Paper No 152. See, in particular, the discussion of damages for insurer's breach of good faith at paras 3.3 to 3.18; and the discussion of why forfeiture rather than avoidance is the appropriate remedy for fraudulent claims at paras 6.25 to 6.55 and 7.9 to 7.16.

⁷ Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties (June 2012) Law Commission Consultation Paper No 204; Scottish Law Commission Discussion Paper No 155.

⁸ Summary of responses to third consultation paper, Chapter 1: The business insured's duty of disclosure (March 2013).

THE NATURE OF THE DUTY

- 30.9 The duty of good faith is reciprocal: it must be observed by both the insured and the insurer. It operates throughout the life cycle of the insurance contract, emerging pre-contract and ceasing only once the contract ends or the parties enter into litigation.⁹
- 30.10 There has been substantial discussion by commentators as to the situations in which good faith arises. Many of these suggested instances are controversial. Despite section 17 being the source of both pre- and post-contract duties of good faith, it has been held that there exists a significant distinction between the two.¹⁰ The broad scope of the pre-contractual duty is not reflected in the post-contractual duty.¹¹ A reluctance to extend good faith substantially in the post-contractual context is clear from the authorities.¹²
- 30.11 At the end of this chapter, we summarise some of these instances and the impact of our recommendations on them.

AVOIDANCE AS THE SOLE REMEDY

- 30.12 The doctrine of avoidance has been subject to widespread criticism. Although the duty of good faith is reciprocal, the remedy is capable of operating with considerable harshness against policyholders and is generally favourable to insurers.
- 30.13 Where an insurer has acted in bad faith, avoidance of the policy is generally an inappropriate remedy for the insured who usually wants their claim paid. Where the insured is at fault and the insurer seeks a remedy, avoidance is often a harsh and disproportionate consequence which over-compensates the insurer.
- 30.14 A key aim of our fair presentation recommendations is to replace the singular remedy of avoidance for non-disclosure or misrepresentation with a scheme of proportionate remedies where the policyholder's conduct is not dishonest.¹³
- 30.15 In respect of fraudulent claims, we wish to codify the common law remedy of forfeiture. Claims under the policy which are tainted by fraud would be forfeited, but previously valid claims would not be affected. The continued existence of avoidance in section 17 would be inconsistent with our objectives and would undermine these reforms.¹⁴

⁹ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469.

¹⁰ See *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469, especially Lord Hobhouse at [57].

¹¹ Above.

¹² Although for Scots law see *Fagnoli v G A Bonus Plc* 1997 SCLR 12, discussed in IP6, paras 4.20 to 4.21 and IP 7, paras 4.52 to 4.56.

¹³ See Part 2 of this Report.

¹⁴ See Part 4 of this Report.

OUR RECOMMENDATIONS

Removing avoidance as the remedy for breach of the duty of good faith

30.16 We propose an amendment to section 17 of the 1906 Act to remove the following statement:

...and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.

30.17 Following this reform, section 17 would simply state that “a contract of marine insurance is a contract based upon the utmost good faith”. In other words, good faith would remain as a general principle, with section 17 and the common law still providing that insurance contracts are based upon the utmost good faith.

30.18 The amendments to the doctrine of good faith in insurance contracts are contained in clause 15 of the draft Bill.

30.19 Clause 15(1) abolishes any legal rule allowing a party to avoid an insurance contract where the other party has not acted in good faith. This catches the common law rule. Clause 15(3)(a) makes the consequential amendment to section 17 of the 1906 Act to remove the statutory remedy of avoidance.

30.20 Clauses 15(2) and 15(3)(b) provide that the common law good faith rule and section 17 are subject to the provisions of the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) and the draft Bill. This is to take into account the specific recommendations we make in respect of, for example, fair presentation and remedies for fraudulent claims.

30.21 Clause 15(4) makes a consequential repeal of section 2(5) of CIDRA, because clause 15 of the draft Bill does for all insurance contracts (including consumer insurance contracts) what section 2(5) of CIDRA does for consumer insurance contracts. Section 2(5) will therefore become superfluous if clause 15 is implemented.

Good faith as an interpretative principle

30.22 Utmost good faith represents an important difference between insurance contracts and other commercial contracts. Consultees from all sides of the market were keen to see it retained. We think it will be valuable as an interpretative principle. As the Faculty of Advocates said:

We believe that this concept should continue to inform the approach of the courts in this field. The further advantage to retaining this as an interpretative principle is that resort may continue to be had to the substantial and well developed jurisprudence on the subject.

30.23 While we have proposed specific provisions covering the principal examples of good faith in the form of fair presentation and remedies for fraud, a general statement is still useful. We envisage three roles for such a principle:

- (1) To interpret the duty of fair presentation. Both parties are expected to act in good faith in exchanging information. For example, if a court were to find that an insured had intentionally disclosed only the bare minimum of information, hoping that the insurer would fail to make further enquiries to reveal the full picture, the insured would not have acted in good faith and would therefore be in breach of the duty of fair presentation.
- (2) To inform the need to imply contractual terms into the policy under the traditional “business efficacy” test.¹⁵ Good faith provides a background when considering whether it is necessary to imply a particular term.
- (3) To leave some room for judicial flexibility. It is possible that the principle of a mutual duty of good faith could provide a solution to an especially hard case or emergent difficulty. Although we think such cases would be extremely rare, it is possible that the courts could develop the concept to prevent an insurer from relying on a right to deny a claim where it would be manifestly unfair to do so.

30.24 In IP6 we noted that the courts did not award damages against an insurer for breach of its duty of good faith.¹⁶ As we discussed in CP2, there was substantial opposition to the idea that damages should be made available for breach of the duty,¹⁷ and we do not make any recommendation along these lines.

Good faith or utmost good faith?

30.25 In CP3, we sought views on whether the duty should continue to be expressed as one of “utmost good faith”, or simply “good faith”.¹⁸ Consultees’ views were split on whether the concepts were interchangeable or whether “utmost” had a role to play in distinguishing the relationship in insurance contracts from other commercial contracts. There was also a lack of consensus on any need for change. Given the division of views here, there is no decisive argument in favour of changing the law and we do not make any recommendation to do so at this stage.

IMPACT OF OUR RECOMMENDATIONS ON OTHER INSTANCES OF GOOD FAITH

30.26 Below, we briefly consider other situations in which the duty of good faith is said to arise. We conclude that our recommended removal of the right to avoid for breach does not interfere with such situations.

30.27 As we have already identified, there is a marked difference between the emphasis on pre-contractual good faith and its treatment during the life of the contract.

¹⁵ Referred to below at para 30.58.

¹⁶ *Banque Keyser Ullmann SA v Skandia (UK) Insurance Co Ltd* [1990] 1 QB 665. This is discussed in IP6, Part 4.

¹⁷ CP2, paras 4.31 to 4.41.

¹⁸ CP3, paras 10.23 to 10.27.

Pre-contractual

Duty on the insured

- 30.28 It is clear that section 17 is not merely an introduction to the later provisions of the 1906 Act.¹⁹ Section 17 has an independent force, which appears to operate alongside the specific duties in the pre-contractual context. The section may also operate as an interpretative principle to the later duties.²⁰
- 30.29 A logical corollary of section 17's independent status is that it may apply to actions not caught by the specific instances set out by the statute. This was suggested by Lord Justice Parker in *CTI v Oceanus Mutual Underwriting*:

Finally it is necessary to mention at this stage that the duty imposed by s17 goes, in my judgment, further than merely to require fulfilment of the duties under the succeeding sections. If, for example, the insurer shows interest in circumstances which are not material within s18, s17 requires the assured to disclose them fully and fairly. Again, if the assured or his broker realized in the course of negotiations that the insurer had made a serious arithmetical mistake or was proceeding upon a mistake of fact with regard to past experience he would, under s17, be obliged to draw attention to the matter.²¹

- 30.30 Real usage of section 17 in this manner is rare to non-existent. The same considerations which lead to our desire to remove the remedy of avoidance also apply here. It is not desirable for there to be a possibility that an insurer could side-step the proportionate remedies regime by avoiding under section 17 for a non-material non-disclosure. Indeed it is doubtful that this should attract any remedy at all. Where the insured realises that the insurer is operating on the basis of an error, the contractual doctrines of unilateral mistake (England and Wales) or unilateral error (Scotland)²² may provide a remedy. The failure to inform the insurer of the mistake could also itself be a non-disclosure.²³

Duty on the insurer

- 30.31 Section 17 also imposes a duty of good faith on the insurer pre-contract, stated in *Banque Keyser Ullmann SA v Skandia (UK) Insurance Co Ltd* to encompass disclosure of:

¹⁹ *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [81].

²⁰ See *CTI Inc v Oceanus Mutual Underwriting Assn (Bermuda) Ltd* [1984] 1 Lloyd's Rep 476 by Stephenson LJ at 525.

²¹ Above at 512.

²² *Chitty on Contracts* (31st ed 2012), para 5-014. W W McBryde, *The Law of Contract in Scotland* (3rd ed 2007), paras 15-40 to 15-41.

²³ M A Clarke, *The Law of Insurance Contracts* (5th ed 2006), para 21-4.

all facts known to him which are material either to the nature of the risk sought to be covered or the recoverability of a claim under the policy which a prudent insured would take into account in deciding whether or not to place the risk for which he seeks cover with that insurer.²⁴

- 30.32 Lord Mansfield in *Carter v Boehm* gave as an example of a failure to comply with this duty an insurer agreeing to cover a ship for a voyage which the insurer knows has already been safely completed.²⁵
- 30.33 This particular usage of section 17 could occur when an insurer knowingly sells a worthless policy. Although this is one of the few situations in which avoidance could be a suitable remedy for the insured, real examples of its use are rare.²⁶ In particular, section 17 was not used by policyholders to avoid worthless policies in the PPI mis-selling scandal.
- 30.34 We raised the issue of worthless policies in our original Scoping Paper. There was a strong view from those respondents who considered the issue to be a problem that it should be dealt with by the Financial Services Authority (and its successors)²⁷ or the Financial Ombudsman Service, rather than through law reform. We concluded in our response to the Scoping Paper that there was evidence of a problem but that regulators may be better placed to deal with these issues. This is especially true where, as can often be the case, the policy is not entirely worthless. Issues of “value for money” are fine judgements driven by individual risk aversion; avoidance is too blunt an instrument here.

Post-contractual

- 30.35 In *The Mercandian Continent*,²⁸ Lord Justice Longmore listed the situations in which it had been suggested that good faith arose after the conclusion of a contract:
- (1) variations to the risk and “held covered” clauses;
 - (2) renewals;
 - (3) insurer having right of cancellation;
 - (4) insurer asking for information during the policy;
 - (5) fraudulent claims;
 - (6) other situations where good faith may be implied; and

²⁴ [1990] 1 QB 665 by Slade LJ at 772.

²⁵ (1766) 3 Burr 1905 at 1909.

²⁶ H Bennett, *The Law of Marine Insurance* (2nd ed 2006) at para 4.153.

²⁷ Now the Financial Conduct Authority.

²⁸ *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] EWCA Civ 1275, [2001] 2 Lloyd's Rep 563.

(7) litigation.

- 30.36 This list can be divided into those incidents which concern the post-contract conduct of the insured, and those affecting the conduct of the insurer. Litigation is an area which concerns both parties, although it is now clear that the duty of good faith ceases once the parties enter into litigation.²⁹
- 30.37 Where the insured is being asked to make a further underwriting decision, the duty of good faith is justified in the same way as it is in respect of the pre-contractual duty of disclosure: the asymmetry of information between the parties. Where there is no underwriting decision to be made, it is less clear why the insurance relationship should be underpinned by a duty of good faith not imposed on other contractual relationships. This is reflected in the case law.

Variations and held-covered clauses

- 30.38 Good faith operates whenever an insurance contract is varied, to require disclosure of circumstances “material to the additional risk being accepted by the variation”.³⁰ The specific pre-contract provisions cannot apply to variations; both sections 18 and 20 apply only “before the contract is concluded.”
- 30.39 Held-covered clauses are similar in many ways to variations, as the insured risk changes, but the insured remains covered provided any conditions imposed on the occurrence of a specified event are fulfilled.³¹ The insurer will generally need to perform an underwriting decision in order to fix any additional premium due, so the duty of good faith attaches.³² The duty applies in its limited post-contractual form, requiring only information material to the new underwriting decision to be disclosed, if any.³³
- 30.40 There is a general assumption that, although the remedy for breach is avoidance, “the right of avoidance only applies to the variation not to the original risk”.³⁴ Similarly for held covered clauses, “it is never suggested that lack of good faith ... avoids the whole contract of insurance”.³⁵

²⁹ See *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [77].

³⁰ By Lord Hobhouse, above at [54].

³¹ H Bennett, *The Law of Marine Insurance* (2nd ed 2006) at para 18.111.

³² *Black King Shipping Corp v Massie (The Litsion Pride)* [1985] 1 Lloyd's Rep 437 at 511.

³³ *Arnould's Law of Marine Insurance and Average* (17th ed 2008) at para 18-32.

³⁴ *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] 2 Lloyd's Rep 563 by Longmore LJ at [22]. See also H Bennett, *The Law of Marine Insurance* (2nd ed 2006) at para 4.197 and *Colinvaux's Law of Insurance* (9th ed 2013) at para 6-106.

³⁵ *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] 2 Lloyd's Rep 563 by Longmore LJ at 571.

30.41 As discussed in Part 2, we recommend that the new duty of fair presentation should explicitly attach before a contract of insurance is varied. This is included in the draft Bill at clause 2(2). This provides that the duty to make a fair presentation of the “risk” relates only to the risk “relevant to the proposed variation”. We think held-covered clauses will be treated as variations for this purpose. Specific remedies, based on the principle of proportionate remedies, are also specified for breach of the duty of fair presentation in respect of a variation. Section 17 will no longer need to be relied upon in this context.

Renewals

30.42 In contrast to variations, the full duty of disclosure attaches to policy renewals.³⁶ As a renewal constitutes a new contract, it is better analysed as an aspect of pre-contract good faith.³⁷

30.43 As under the current law, our recommended pre-contractual duty of fair presentation and scheme of proportionate remedies should apply to renewals. Section 17 will not need to be relied upon in this context.

Insurer’s information and cancellation rights

30.44 There is no duty on the insured arising from the doctrine of good faith to volunteer material information after the conclusion of the contract outside situations where a further underwriting decision is required.³⁸ Nor does the presence of a cancellation clause introduce a duty to disclose to the insurer circumstances which may allow its operation.³⁹

30.45 The position may be different where the contract contains an express term giving the insurer a right to information from the insured.⁴⁰ However, as Lord Justice Longmore has noted:

It is not usually suggested that breach of any such term gives rise to a right to avoid the contract rather than a claim to damages.⁴¹

This strongly suggests that these terms do not engage section 17.

30.46 We agree with the court’s restrictive approach to any requirements for post-contractual information, and agree that there should be no right of avoidance for any breach. Removal of avoidance from section 17 will therefore provide a useful clarification of the law here.

³⁶ *Arnould’s Law of Marine Insurance and Average* (17th ed 2008) at para 15-37.

³⁷ H Bennett, *The Law of Marine Insurance* (2nd ed 2006) at para 4.198.

³⁸ *Niger Co Ltd v Guardian Assurance Co Ltd* (1922) 13 LI L Rep 75 at 82.

³⁹ *New Hampshire Insurance Co v MGN Ltd* [1997] LRLR 24.

⁴⁰ We discuss the interpretation of these terms in IP7, paras 6.15 to 6.47. We note that the courts have tended to interpret such terms narrowly. See *Kausar v Eagle Star Insurance Co Ltd* [2000] Lloyd’s Rep IR 154.

⁴¹ *K/S Merc-Scandia XXXXII v Certain Lloyd’s Underwriters (The Mercandian Continent)* [2001] 2 Lloyd’s Rep 563 by Longmore LJ at [22].

- 30.47 A term requiring the insured to supply information to the insurer may still attract an implied term requiring the information to be provided in good faith. This would be implied under general contractual principles and not section 17, however, and breach of the term will not result in avoidance of the policy.

Fraudulent claims

- 30.48 There is undoubtedly a duty on the insured not to put forward a fraudulent claim. This may also be described as a duty of honesty at the claims stage.⁴² As we discussed in Part 4, whether or not this duty comes from section 17⁴³ or from a common law source⁴⁴ is unclear. This means that the insurer's remedies where a policyholder makes a fraudulent claim – in particular whether section 17 operates to allow avoidance – are also unclear.
- 30.49 In Part 4 we recommend enacting specific remedies for fraudulent claims. The removal of avoidance from section 17 will provide further clarification in this area.

Litigation

- 30.50 *The Star Sea* conclusively determined that the section 17 duty of good faith ceases once the parties engage in litigation.⁴⁵ The parties are no longer required to act in good faith towards each other, but are instead governed by the rules of litigation. Section 17 is therefore not relevant here.

A right to damages?

- 30.51 The right of the insured to claim damages for an insurer's breach of section 17 was considered by the Court of Appeal in *Banque Keyser*.⁴⁶ The claim for damages was rejected on the basis that the only remedy specified by section 17 was avoidance, which gave rise to the clear inference that Parliament did not intend a breach to give rise to damages.

⁴² *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [111].

⁴³ In *The Star Sea*, Lord Hobhouse appeared to consider the insurer's defence that the insured had put forward a fraudulent claim to be based on section 17; see [74] to [75].

⁴⁴ In *Agapitos v Agnew (The Aegeon) (No 1)* [2002] EWCA Civ 247 at [45], Mance LJ advanced, albeit tentatively, the view that the fraudulent claims rule fell outside section 17. In their recent book *Insurance and the Law of Obligations* (2013), Rob Merkin and Jenny Steele say that insureds' fraudulent claims and insurers' late payments "would generally not be classified as 'good faith' issues" at p 52 note 80.

⁴⁵ [2001] UKHL 1 at [77].

⁴⁶ [1990] 1 QB 665. The Court of Appeal's decision was upheld on appeal to the House of Lords [1991] 2 AC 249.

- 30.52 In IP6 we tentatively proposed that damages should be available for breaches of good faith by the insurer.⁴⁷ There was widespread opposition to this proposal, and we are not proceeding with a general right to damages. Instead, we have recommended more selective reform, targeting the giving of a right to damages to policyholders for the late payment of claims by insurers.⁴⁸
- 30.53 We do not envisage that the courts will readily regard the removal of avoidance as an opportunity to find that damages are payable for breach of good faith, having showed no such appetite in the past. However, judicial intervention may be appropriate in an extreme case.

Restriction on exercise of rights

- 30.54 In CP2 we summarised a series of cases in which the courts have prevented an insurer from exercising an apparent right because the remedy was not exercised in good faith.⁴⁹
- 30.55 For example, whether the duty of good faith under section 17 is capable of restricting the avoidance of policies by insurers is an open question⁵⁰ on which commentators are split.⁵¹
- 30.56 The law in this area is uncertain and does not yet support a general doctrine restricting the exercise of the right of avoidance or any other right. We intend that the courts should be able to continue to develop the duty of good faith in this way, where it is appropriate to do so. Certainly, the removal of avoidance from section 17 would not affect this line of cases.

⁴⁷ IP 6, paras 9.26 to 9.30.

⁴⁸ See Part 5 of this Report.

⁴⁹ CP2, paras 3.11 to 3.15. See, for example, *Strive Shipping Corp v Hellenic Mutual War Risks Association (Bermuda) Ltd (The Grecia Express)* [2002] EWHC 203 (Comm), [2002] 2 All ER (Comm) 213 and *Drake Insurance Plc v Provident Insurance Plc* [2003] EWCA Civ 1834, [2004] QB 601.

⁵⁰ The editors of *Arnould's* summarise the case law at paras 15-156 to 15-165, *Arnould's Law of Marine Insurance and Average* (17th ed 2008).

⁵¹ The editors of *Colinvaux's Law of Insurance* (9th ed 2012) believe that the cases show that it does (at para 6-129). *MacGillivray on Insurance Law* (12th ed 2012) asserts the converse (at para 17-097). Bennett occupies a middle ground, stating that the right may be lost where the insurer was aware of the non-disclosure: H Bennett, *The Law of Marine Insurance* (2nd ed 2006) at para 4.171.

Implied terms

- 30.57 A number of cases have considered whether section 17 can be the source of implied terms requiring insurers to operate contractual rights in good faith or perform responsibilities reasonably. In *The Mercandian Continent*, Lord Justice Longmore stated that good faith would be required where the insurer takes over the insured's defence of a claim.⁵² Whether this is an aspect of section 17 is questionable, however, for the judge suggested that avoidance alone was not a suitable remedy.
- 30.58 It appears that good faith in this context should be regarded as a component of, or factor in, business efficacy where the contractual relationship is one of good faith, rather than provided by section 17 specifically.⁵³
- 30.59 This approach may provide a solution to reconciling the reluctance of the courts to allow avoidance for breach of good faith with their desire to see that the contract is performed in good faith.
- 30.60 Furthermore, this approach grants the courts flexibility to temper contractual terms in a manner consistent with general contract law. Identifying good faith as a component of business efficacy recognises the unique nature of insurance contracts, and allows the courts to imply terms which would not be considered necessary outside the field of insurance. This has allowed the implication of positive rights as well as restrictions.
- 30.61 Our recommended amendment to section 17 should not alter the law in this area.

RECOMMENDATIONS

Recommendation 49: Avoidance should be removed as a remedy for failure to observe good faith. Specific remedies for the main examples of obligations based on good faith should be provided.

Recommendation 50: Good faith should be retained as an interpretative principle.

⁵² *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters (The Mercandian Continent)* [2001] 2 Lloyd's Rep 563 at [22] and [27].

⁵³ See, for example, *Gan Insurance Co Ltd v Tai Ping Insurance Co Ltd (No 2)* [2001] Lloyd's Rep IR 667; *Goshawk Dedicated Ltd v Tyser & Co Ltd* [2007] Lloyd's Rep IR 224; *Bonner v Cox* [2005] EWCA Civ 1512, [2006] Lloyd's Rep IR 385. See also the following commentaries: *Arnould's Law of Marine Insurance and Average* (18th ed 2013) at para 18-19 and fn 28; *Colinvaux's Law of Insurance* (9th ed 2012) at para 6-111; *MacGillivray on Insurance Law* (12th ed 2012) at para 17-003.

CHAPTER 31

COMPULSORY INSURANCE

- 31.1 The label “compulsory insurance” typically refers to motor insurance and employers’ liability insurance, which are made compulsory by the Road Traffic Act 1988 and the Employers’ Liability (Compulsory Insurance) Act 1969 respectively. These are the only statutes which require insurance of a certain form to be taken out and restrict the terms which may be included by the insurer.⁵⁴
- 31.2 Other requirements to insure are found in statute or made under statutory authority.⁵⁵ Insurance is also required by the rules of some professions.⁵⁶
- 31.3 Several consultees have asked for clarification as to how proportionate remedies for disclosure failures would operate in the context of compulsory liability policies, particularly motor insurance and employers’ liability insurance. Similar questions have arisen in the context of our proposed remedies for fraudulent claims and, in particular, the insurer’s right to terminate the insurance contract with effect from the fraudulent act. This chapter considers these issues.
- 31.4 We also consider the need to update section 152(2) of the Road Traffic Act 1988 in consequence of our fair presentation recommendations.

MOTOR INSURANCE

The scheme for compulsory motor insurance

- 31.5 Motor insurance has been compulsory since 1934. The scheme is complex, as it has been amended over the years and it now implements a series of European Directives.⁵⁷

⁵⁴ J Birds, *Birds’ Modern Insurance Law* (9th ed 2013) para 22.2.

⁵⁵ For example, Riding Establishments Act 1964; Merchant Shipping Act 1995; Chiropractors Act 1994; Civil Aviation (Insurance) Regulations 2005; Tenements (Scotland) Act 2004. See further *Birds’ Modern Insurance Law* (9th ed 2013) para 22.2 and *Colinvaux’s Law of Insurance* (9th ed 2012) paras 20-001 to 20-005.

⁵⁶ See, for example, the *Solicitors’ Regulation Authority Indemnity Insurance Rules 2012* (part of the SRA Handbook) and, for Scotland, *The Law Society of Scotland Practice Rules 2011*.

⁵⁷ These have been consolidated in the EU Motor Insurance Directive 2009/103/EC, and are discussed briefly from para 31.25 below.

- 31.6 It is now set out in the Road Traffic Act 1988 (RTA). Under Part VI of the RTA, it is compulsory for motorists to either insure against liability for death or bodily injury to third parties and for damage to property belonging to third parties (though property damage is limited to £1 million) or to have a security in respect of these risks.⁵⁸
- 31.7 The RTA gives third parties wide-ranging protection. For example, section 148 states that various exclusions of liability in an insurance contract are of no effect against the third party. This means that the insurer may not refuse to pay the third party because the insured has breached, for example, a policy term relating to the condition of the vehicle or the age of the driver. Moreover, under section 151(5), the insurer (or issuer of the certificate of security) is obliged to pay the third party even when it is entitled to avoid or cancel the policy as against the insured, or has already done so.
- 31.8 However, the insurer's obligation to pay third parties is qualified by section 152. That section sets out various exceptions under which the insurer is not required to satisfy a judgment in favour of a third party. Most of the exceptions are procedural in nature. For example, section 152(1)(b) provides that the insurer will not be liable while execution of the judgment is stayed pending an appeal.

Disclosure and representations

- 31.9 Section 152(2), however, deals with non-disclosures and misrepresentations by the policyholder. It provides that no sum is payable by an insurer under section 151 if "he has obtained a declaration that, apart from any provision contained in the policy or security he is entitled to avoid" the policy. The policy may be avoided either under the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) or, where that does not apply, if it was obtained:

- (i) by the non-disclosure of a material fact; or
- (ii) by the representation of a fact which was false in some material particular.⁵⁹

This echoes the language of sections 18 and 20 of the Marine Insurance Act 1906. It appears to be intended to mean that the insurer can obtain a declaration (and does not have to pay the third party) if the policyholder has made a non-disclosure or misrepresentation under the 1906 Act.

⁵⁸ An exception is made for vehicles whose owner maintains a deposit of £500,000 with the Accountant General of the Senior Courts, so long as the vehicle is being driven under the owner's control. See Road Traffic Act 1988, s 144.

⁵⁹ This has been modified in consumer insurance, as discussed below.

The reform for consumer insurance

- 31.10 We previously reviewed section 152(2) as part of our project on consumer insurance.⁶⁰ We found that the practical significance of the section was reduced greatly by the operation of the Motor Insurers' Bureau (MIB) scheme. Generally speaking, where an insurer is entitled to obtain a declaration under section 152(2), the third party victim will be able to claim its compensation through the MIB.⁶¹ Under Article 75 of the MIB's Articles of Association,⁶² liability is passed back from the MIB to the insurer who was providing insurance at the time of the accident, notwithstanding that the policy was obtained by misrepresentation or non-disclosure of a material fact. The insurer must then pay the third party's claim as an "Article 75" insurer.
- 31.11 We concluded that in most cases there is little point in an insurer using section 152(2) to avoid a policy because it will still have to pay the claim under Article 75. Section 152(2) only becomes useful to an insurer when another insurer is connected to the accident, and we identified only three types of relatively rare situations in which this may happen.⁶³ In each case, the dispute is between two insurers about how the loss will be allocated. The third party is always compensated.
- 31.12 After consultation with the MIB and ABI, we recommended that section 152(2) be amended in relation to consumer insurance to bring it in line with our reforms. We said that the insurer should only get a declaration under clause 152(2) when the insurer would be entitled to *avoid* the policy, rather than apply another proportionate remedy. CIDRA implemented this.⁶⁴ The result is that for consumer insurance, an insurer may obtain a declaration under section 152(2) only where the misrepresentation was deliberate or reckless, or where it was careless and the insurer would not have entered into the policy at all. This limits the exception to serious cases.

⁶⁰ Consumer Insurance Law: Pre-Contract Disclosure and Misrepresentation (2009) Law Com No 319; Scot Law Com No 219 (Consumer Report), paras 9.26 to 9.35. <http://lawcommission.justice.gov.uk/consultations/misrep-breach-warranty.hm> and http://www.scotlawcom.gov.uk/index.php/download_file/view/268/107/.

⁶¹ See J Birds, *Birds' Modern Insurance Law* (9th ed 2013), from para 21.7.

⁶² Available at <http://www.mib.org.uk/NR/rdonlyres/32A4AB2C-5B4A-43A8-8610-1A629B7A933B/830/ArticlesofAssociation070612.pdf>.

⁶³ Consumer Report, para 9.28.

⁶⁴ CIDRA, s 11.

Aligning section 152(2) with our recommendations on non-consumer disclosure and representations

- 31.13 We have now considered section 152(2) in the light of our recommendations for non-consumer disclosure, which are set out in Part 2. We believe that the section should be aligned with our recommendations in a similar manner as for consumer insurance. An insurer should be able to obtain a declaration of entitlement to avoid in respect of non-consumer insurance contracts only where the insurer would be able to *avoid* the contract under our draft Bill. This means that the grounds for a declaration are limited to deliberate or reckless failures to make a fair presentation of the risk and cases where the insurer would not have entered into the policy at all had it received a fair presentation.
- 31.14 We do not think that section 152(2) should apply where the insurer would be liable, but only for a proportionate sum. The policy behind the compulsory insurance scheme is that an insurer should be liable in full to a third party, even if the insured has made a mistake or breached a policy term.⁶⁵ The insurer may, however, recover any overpayment from the policyholder under section 151(7) of the RTA.
- 31.15 Clause 19 of the draft Bill makes these amendments. The following text shows section 152(2) as it would be affected by the amendments in clause 19 (additions are shown in italics).

(2) Subject to subsection (3) below, no sum is payable by an insurer under section 151 of this Act if, in an action commenced before, or within three months after, the commencement of the proceedings in which the judgment was given, he has obtained a declaration—

- (a) that, apart from any provision contained in the policy or security, he is entitled to avoid *the policy under either of the relevant insurance enactments, or the security* on the ground that it was obtained—
- (i) by the non-disclosure of a material fact, or
- (ii) by a representation of fact which was false in some material particular, or
- (b) if he has avoided the policy *under either of the relevant insurance enactments, or the security* on that ground, that he was entitled so to do apart from any provision contained in [the policy or security].

[and, for the purposes of this section, “*material*” means of such a nature as to influence the judgment of a prudent insurer in determining whether he will take the risk and, if so, at what premium and on what conditions.]

⁶⁵ *Motor and General Insurance Co Ltd v Pavy* [1994] 1 Lloyd's Rep 607 at 615.

(3) An insurer who has obtained such a declaration as is mentioned in subsection (2) above in an action does not by reason of that become entitled to the benefit of that subsection as respects any judgment obtained in proceedings commenced before the commencement of that action unless before, or within seven days after, the commencement of that action he has given notice of it to the person who is the plaintiff (or in Scotland pursuer) in those proceedings specifying *the relevant insurance enactment or, in the case of a security, the non-disclosure or false representation on which he proposes to rely.*

(4) A person to whom notice of such an action is so given is entitled, if he thinks fit, to be made a party to it.

(5) *In this section, “relevant insurance enactment” means the Consumer Insurance (Disclosure and Representations) Act 2012 or Part 2 of the Insurance Contracts Act 2014.*

RECOMMENDATION

Recommendation 51: For non-consumer motor insurance, an insurer should only be entitled to a declaration under section 152(2) of the Road Traffic Act 1988 if it would be entitled to avoid the policy under the draft Bill.

Contractual rights to avoid

- 31.16 As we discuss in Part 2, our recommendations for the duty of fair presentation and scheme of proportionate remedies for non-consumer insurance are a default regime. Parties may still agree alternative arrangements, including avoidance of the policy for any breach. Insurers should only be able to obtain a declaration under section 152(2) where they would be entitled to avoid under the default remedies in our draft Bill or CIDRA. The current reference in section 152(2) to “apart from any provision contained in the policy” already ensures that such a contractual provision does not give rise to the right to obtain a declaration under section 152(2).

Proportionate remedies and remedies for fraudulent claims

- 31.17 The obligation to satisfy judgments under section 151 applies regardless of any entitlement of the insurer to avoid or cancel the policy as against the policyholder⁶⁶ (unless a declaration is obtained under section 152(2) as discussed above – and a declaration cannot be obtained on the basis of a fraudulent claim).

⁶⁶ *Churchill Insurance Co Ltd v Wilkinson* [2012] EWCA Civ 1166 at [18].

- 31.18 The courts have held that the reference to “avoid or cancel” is illustrative only: in other instances where the insurer is entitled to evade liability under the policy the insurer continues to be obliged to pay the third party.⁶⁷ Any contrary interpretation would defeat the object of Part VI of the 1988 Act.
- 31.19 The introduction of proportionate remedies for breach of the duty of fair presentation would be an instance of the insurer potentially being able to evade liability for a claim without “avoiding or cancelling” the policy. Any right of the insurer to apply a proportionate reduction to claim payments or to treat the policy as having been made on different terms would apply only as against the policyholder. Third party claims should still be paid in full.
- 31.20 Where the incident was not covered by the policy as a result of an additional term, the insurer is not liable under the policy. The insurer must, however, still meet third party claims for compulsory liabilities as an Article 75 Insurer under the MIB scheme.⁶⁸
- 31.21 Under our recommended remedies for fraudulent claims, set out in Part 4, the insurer’s right to treat the contract as terminated from the date of a fraudulent act is another example of “avoiding or cancelling”. The insurer must still satisfy a third party judgment under section 151.

Securities under section 152(2)

- 31.22 Section 152(2) also applies to securities issued as an alternative to motor insurance. Securities appear to be extremely rarely used. We were informed by the Department for Transport that they were aware of only one company with an issued security.
- 31.23 At present, the issuer of a security may obtain a declaration under section 152(2) in order to escape liability to satisfy third party judgments on the same basis as for insurance policies; that is, the security was obtained by non-disclosure or misrepresentation. These grounds appear ill-suited to securities, which are a form of guarantee. Contracts of guarantee are not contracts of the utmost good faith,⁶⁹ and there is no requirement for both parties to make full disclosure of all material facts.⁷⁰

⁶⁷ See, for example, *Motor and General Insurance Co Ltd v Pavy* [1994] 1 Lloyd’s Rep 607 at 615.

⁶⁸ MIB Articles of Association, Article 75: <http://www.mib.org.uk/NR/rdonlyres/32A4AB2C-5B4A-43A8-8610-1A629B7A933B/830/ArticlesofAssociation070612.pdf>.

⁶⁹ *Royal Bank of Scotland Plc v Etridge (No 2)* [2001] UKHL 44 at [185] by Lord Scott of Foscote.

⁷⁰ J O’Donovan and J Phillips, *The Modern Contract of Guarantee* (English ed 2003) p 156. For Scotland see Gloag & Henderson, *The Law of Scotland* (13th ed 2012) para 16.06 (although note also para 16.17).

31.24 Neither CIDRA nor the draft Bill makes any change to an insurer's right to obtain a declaration in respect of a security. Although securities are very rarely used, and in any case it appears that it would not be possible to avoid them for non-disclosure, it is beyond our remit to recommend changes. The draft Bill is limited to insurance law and it would not be appropriate to use it to amend provisions about securities.

General concerns surrounding Part VI of the RTA

31.25 EU law is of prime importance in this area. The European Union has sought to harmonise the compulsory coverage of motor insurance across member states through a series of directives.⁷¹ These are now consolidated in the 2009 Motor Insurance Directive.⁷² Part VI of the Road Traffic Act 1988 and the Government's agreements with the Motor Insurers' Bureau in respect of untraced and uninsured drivers⁷³ are part of the UK's implementation of the directives.⁷⁴

31.26 This is a sensitive area. The extent of the obligation to satisfy judgments under section 151 has been the subject of recent litigation⁷⁵ and some commentators have called for a full review of the compulsory insurance regime.⁷⁶ These commentators express doubts that the UK regime adequately implements Article 3(1) of the EU Motor Insurance Directive, as broadly interpreted by the CJEU.⁷⁷

31.27 A full review and consultation would be required in order to consider such issues properly. That is beyond the remit of this project, and we make no comment in this regard. The changes we recommend to section 152 are strictly limited to those required to update the provision in line with the reforms to the duty of fair presentation.

⁷¹ Namely Directives 72/166/EEC, 84/5/EEC, 90/232/EEC, 2000/26/EC and 2005/14/EC.

⁷² European Parliament and Council Directive (EC) 2009/103.

⁷³ Currently the Uninsured Drivers' Agreement England, Scotland and Wales 1999 and the Untraced Drivers' Agreement 1998.

⁷⁴ Other measures which implement the directives include the European Communities (Rights against Insurers) Regulations 2002, the Motor Vehicles (Compulsory Insurance) (Information Centre and Compensation Body) Regulations 2003 and the Financial Services and Markets Act 2000 (Motor Insurance) Regulations 2007.

⁷⁵ *Bristol Alliance Limited Partnership v EUI Ltd* [2012] EWCA Civ 1267.

⁷⁶ The New Law Journal ran a four-part series "On the right road?" beginning 1 February 2013.

⁷⁷ See Case C-129/94 *Bernaldez* [1996] ECR I-1829, [1996] All ER (EC) 741; and Case C-442/110 *Churchill Insurance Company and Evans* 2011 ECR I-0000, [2012] Lloyd's Rep IR 544 respectively.

Criminal liability under the RTA for lack of insurance

- 31.28 The RTA contains two offences relating to insurance. Firstly, by section 143 it is a criminal offence to use a motor vehicle on a road or other public place unless there is a policy of insurance “in force”. Secondly, under section 144A, the registered keeper of the motor vehicle commits an offence if it is not covered by a policy of insurance. Again, this requires an insurance policy to be “in force” in relation to the use of the vehicle. We do not consider that any of our recommendations would affect an insured’s criminal liability under the RTA, as discussed below.

Fair presentation

- 31.29 A motor insurance policy susceptible to avoidance for pre-contractual conduct remains “in force” until the insurer takes steps to avoid under section 152(2) of the RTA. This is because the insurer is obliged to satisfy third party judgments for compulsory liabilities by section 151(5) despite being otherwise entitled to avoid the policy.⁷⁸ As such, the policyholder complies with the requirement to hold insurance until the insurers obtain a declaration and become liable under Article 75.
- 31.30 Obtaining a declaration does not appear to impose retrospective criminal liability, though the point has not been finally decided. The authors of *The Law of Motor Insurance* state that the declaration does not, but both cases cited concerned drivers whose insurers had *not* sought to obtain a declaration.⁷⁹ Where avoidance remains available to insurers under our proposals and the insurer obtains a declaration, we think it is unlikely that criminal liability would be imposed retrospectively. Our recommendations do not affect this either way.
- 31.31 The ability of an insurer to impose a proportionate reduction on claim payments does not stop the policy being “in force”. The policy continues and third party claims for compulsory liability must be met in full. We do not think that any offence is committed in this case.
- 31.32 In some situations, an imposed additional term could mean that the vehicle was used outside the scope of cover (unless it is a section 148 prohibited term).⁸⁰ Given our analysis that an insurer’s right to avoid under a declaration would be unlikely to result in criminal liability, we think that same analysis must apply here.⁸¹

⁷⁸ See, for example, *Durrant v Maclaren* [1956] 2 Lloyd’s Rep 70 at 73.

⁷⁹ R Merkin and J Stuart-Smith, *The Law Of Motor Insurance* (2004) at para 5-19. The cases are *Adams v Dunne* [1978] RTR 281 and *Durrant v Maclaren* [1956] 2 Lloyd’s Rep 70.

⁸⁰ For example, sections 143 and 144A require there to be an insurance policy “in force in relation to the use of the vehicle”.

⁸¹ But see *R (on the application of Singh) v Solihull Metropolitan Borough Council* [2007] EWHC 552 (Admin) in which the High Court found criminal liability for a private hire driver who was found “plying for hire” in breach of a policy limitation (and therefore driving without insurance). We think there are also policy considerations here.

Fraudulent claims

- 31.33 The making of a fraudulent claim by the policyholder will not entitle the insurer to obtain a declaration under section 152 and the insurer will be bound to pay third party claims for compulsory liabilities as a contractual insurer. The policy therefore remains “in force” irrespective of any right to terminate the policy as against the policyholder.⁸² As a result, the policyholder should not be criminally liable for lack of insurance by reason of the insurer’s entitlement to treat the policy as having terminated at the time of the fraudulent act.

EMPLOYERS’ LIABILITY INSURANCE

The scheme for compulsory employers’ liability insurance

- 31.34 Employers carrying on a business in Great Britain must insure against their liability for personal injury to their employees as a result of the Employers’ Liability (Compulsory Insurance) Act 1969.⁸³
- 31.35 The employers’ liability legislation does not provide for an extensive scheme of third party protection in the same manner as the road traffic legislation, although there is some prohibition of certain terms.⁸⁴ Employees have no right to bring proceedings directly against their employer’s insurer, save for where they inherit their employer’s rights under the Third Parties (Rights against Insurers) Act 1930.⁸⁵ Where employees do inherit rights as a result of their employer’s bankruptcy or insolvency, they are subject to any defences that the insurer had against the policyholder, including misrepresentation or non-disclosure.⁸⁶
- 31.36 This means that, under the current law, an employee may not be able to recover from the insurer as a result of its employer’s pre-contractual conduct. The employee may of course continue their claim against their employer regardless of the status of the insurance policy, but without insurance the chances of recovery may be significantly reduced.

Impact of our recommendations

- 31.37 Our recommendations do not change the employers’ liability insurance scheme. We have, however, been told that there is a strong general understanding among insurance practitioners that employers’ liability policies should not be readily avoided, and that claims should be paid in order to ensure compensation of employees.

⁸² This would be in line with the reasoning in *Durrant v Maclaren* [1956] 2 Lloyd’s Rep 70.

⁸³ The minimum amount of cover which employers must hold is set by secondary legislation and currently stands at £5 million for any one occurrence (including costs and expenses). See Employers’ Liability (Compulsory Insurance) Regulations 1998, Regulation 3.

⁸⁴ For example, Employers’ Liability (Compulsory Insurance) Regulations 1998, Regulation 2.

⁸⁵ To be replaced by the Third Parties (Rights against Insurers) Act 2010, which has yet to come into force.

⁸⁶ See the comment in the Employers’ Liability Policy Trigger Litigation [2010] EWCA Civ 1096 at [171]. See also the earlier comments of David Richards J in *Re T&N Ltd (No 3)* [2006] EWHC 1447 (Ch) at [104].

31.38 We think our recommendations in respect of non-consumer disclosure would deliver indirect benefits to employers and their employees. As a result of the introduction of proportionate remedies, fewer policies should be susceptible to avoidance. Our reforms to the disclosure duty itself should also help employers to fulfil their obligations, leading to greater policy security.

Criminal liability for lack of employers' liability insurance

31.39 An employer who on any day carries on a business in Great Britain without liability insurance commits a criminal offence and is punishable by a fine.⁸⁷ This is an offence of strict liability.⁸⁸ Additionally, where the employer is a corporation, its officers and managers will also be guilty of an offence if the company's failure was facilitated by their neglect or committed with their consent or connivance.⁸⁹

31.40 The nature of the requirement to insure and the criminal sanction for failure were discussed in *Re T&N Ltd (No 3)*.⁹⁰ The case was very fact-dependent, and the matter was not entirely clear, but the judge supported the argument that:

The 1969 Act does not prohibit insurers from avoiding policies, but avoidance may deprive an employer of insurance for which no replacement is available. Parliament cannot have intended the employer to be thereafter guilty of an offence in such circumstances
...⁹¹

31.41 Given this, none of our proposals providing for the insurer to be entitled to avoid the contract (for example, for deliberate breach of the duty of fair presentation), or treat the contract as terminated (from the date of the fraudulent act for fraudulent claims) should lead to the employer being criminally liable. The judge's reasoning should be equally applicable where other proportionate remedies (ie additional terms and proportionate reductions) are available to the insurer which put the insured in breach of the minimum requirements.

OTHER COMPULSORY INSURANCES

31.42 As we identified in the introduction to this chapter, there are a number of contexts in which insurance cover for third party liabilities is required. These requirements arise in a number of ways, some by primary legislation, but many more under statutory authority or as a condition of licensing for certain activities.

⁸⁷ Employers' Liability (Compulsory Insurance) Act 1969, s 5.

⁸⁸ *Re T&N Ltd (No 3)* [2006] EWHC 1447 (Ch) at [101] by David Richards J.

⁸⁹ Above.

⁹⁰ [2006] EWHC 1447 (Ch).

⁹¹ Above at [123]. The "1969 Act" is the Employers' Liability (Compulsory Insurance) Act 1969, referred to at para 31.34 above.

31.43 It is already possible for insurers to avoid insurance policies taken out to meet these requirements for disclosure failures, and potentially for fraudulent claims under section 17 of the 1906 Act. We have not identified any instances in which a right to avoid has caused difficulties. In particular, we have not identified any reported decisions on the consequences of avoidance for the policyholder's criminal liability under these requirements. Given that we recommend minimising the circumstances in which an insurer will be entitled to avoid, we do not consider that our recommendations in respect of fair presentation or remedies for fraudulent claims will affect these issues.

CHAPTER 32

LIST OF RECOMMENDATIONS

FAIR PRESENTATION

The duty of fair presentation

Recommendation 1: For non-consumer insurance, the current law set out in sections 18 to 20 of the Marine Insurance Act 1906 should be replaced with a new statutory duty of fair presentation. The new duty should reflect the current law subject to the following recommendations.

Recommendation 2: The disclosure duty should have two limbs. The insured should either:

- (1) disclose every material circumstance which the insured knows or ought to know; or
- (2) failing that, disclose sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those circumstances.

Recommendation 3: The statute should include an indicative and non-exhaustive list of circumstances which may be material, taken from the case law, namely:

- (1) special or unusual facts relating to the risk;
- (2) any particular concerns which led the insured to seek insurance; and
- (3) anything which those concerned with the class of insurance and field of activity would generally understand as something that should be dealt with in a fair presentation of risks of the type in question.

Recommendation 4: The insured should disclose information in a manner which would be reasonably clear and accessible to a prudent insurer.

Recommendation 5: The duty of fair presentation should also include the existing duty not to make misrepresentations.

Insured's knowledge

Recommendation 6: The legislation should provide greater certainty by defining both what an insured "knows" and what an insured "ought to know" for the purposes of the duty of fair presentation.

Recommendation 7: An insured should be taken to know what is known to the following specified individuals:

- (1) Where the insured is a natural person, the specified individuals should be the insured, and those responsible for the insured's insurance.

- (2) Where the insured is not a natural person, the specified individuals should be the insured's senior management and those responsible for the insured's insurance.

Recommendation 8: "Senior management" for these purposes should mean those who play significant roles in making decisions about how the insured's activities are to be managed or organised.

Recommendation 9: "Those responsible for the insured's insurance" for these purposes should mean those who participate on behalf of the insured in the process of procuring the insured's insurance (whether the individual does so as the insured's employee or agent, or as an employee of the insured's agent, or in any other capacity).

Recommendation 10: For these purposes, an insured "ought to know" that which should reasonably have been revealed by a reasonable search of information available to the insured (whether within its own organisation or held by others, for example its agent), including by making reasonable enquiries.

Agent's knowledge

Recommendation 11: In non-consumer insurance, there should be no specific provisions requiring an agent to disclose information to the insurer. Instead, before entering into an insurance contract, the insured should be obliged to disclose two types of information known to its agents:

- (1) information known to those individuals who participate in the process of procuring its insurance;
- (2) information which should reasonably have been revealed by a reasonable search of information available to the insured.

Insurer's knowledge and other exceptions to the duty of fair presentation

Recommendation 12: In the absence of enquiry by the insurer, the insured should not have to disclose information which:

- (1) the insurer knows;
- (2) the insurer ought to know;
- (3) the insurer is presumed to know;
- (4) diminishes the risk; or
- (5) is something as to which the insurer has waived disclosure.

Recommendation 13: An insurer should be taken to know something only if it is known to one or more of the individuals who participate in the underwriting decision (whether as the insurer's employee or agent, or as an employee of the insurer's agent, or in any other capacity).

Recommendation 14: The insurer “ought to know” something only if:

- (1) an employee or agent of the insurer knows it, and ought reasonably to have passed it on to the particular underwriter(s); or
- (2) the relevant information is held by the insurer and is readily available to the particular underwriter(s).

Recommendation 15: The insurer should be presumed to know:

- (1) things which are common knowledge; and
- (2) things which an insurer offering insurance of the class in question to proposers in the field of activity in question would reasonably be expected to know in the ordinary course of business.

Knowledge: general

Recommendation 16: The recommendations concerning the knowledge of the insured, the agent and the insurer should be subject to the following general rules:

- (1) An individual’s knowledge should include not only their actual knowledge but also their blind eye knowledge.
- (2) References to an individual’s knowledge should not include confidential information acquired by an agent through a business relationship with someone other than the insured or the insurer, as relevant.
- (3) The insured or insurer should not be taken to know that its employee or agent has perpetrated a fraud against it.

Fair presentation: remedies

Recommendation 17: The inducement test developed by the courts should be set out in statute. The statute should provide that the insurer has a remedy against the insured for a breach of the duty of fair presentation only if the insurer shows that, but for the breach, the insurer:

- (1) would not have entered into the contract at all, or
- (2) would have done so only on different terms.

Recommendation 18: Where a breach of the duty of fair presentation is deliberate or reckless, the insurer should be entitled to avoid the contract and refuse all claims. The insurer should also be entitled to keep the premiums.

Recommendation 19: A breach should be considered deliberate or reckless if the insured:

- (1) knew that it was in breach of the duty of fair presentation, or
- (2) did not care whether or not it was in breach of that duty.

Recommendation 20: In other cases, we recommend a scheme of proportionate remedies which aim, as far as practicable, to put the insurer in the position it would have been in had the insured fulfilled its duty to make a fair presentation. In particular:

- (1) if the insurer would not have entered into the insurance contract at all, it may avoid the contract.
- (2) if the insurer would have entered into the contract on different terms (other than the premium), the contract is to be treated as if it included those terms.
- (3) if the insurer would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim (which may be additional to the inclusion of other terms).

Recommendation 21: Proportionate remedies should also apply in the event of a breach of the duty of fair presentation in the context of a variation.

WARRANTIES

Basis of the contract clauses

Recommendation 22: Basis of the contract clauses in non-consumer insurance contracts should be of no effect. Representations should not be capable of being converted into warranties by means of a policy term or statement on the proposal form.

Recommendation 23: This proposed reform should not be capable of being avoided by the use of a contract term.

Remedy for breach of warranty

Recommendation 24: The existing remedy for breach of warranty (automatic discharge of the insurer's liability) should be removed. Instead, the insurer's liability should be suspended from the point of breach of warranty.

Recommendation 25: The insurer's liability should reattach if and when a breach of warranty has been remedied.

Recommendation 26: A breach of warranty should generally be regarded as remedied where the insured ceases to be in breach of it. For time-specific warranties which apply at or by an ascertainable time, a breach should be regarded as remedied if the risk to which the warranty relates later becomes essentially the same as that originally contemplated by the parties.

Recommendation 27: These recommendations should apply to express and implied warranties in marine insurance.

Terms relevant to particular descriptions of risk

Recommendation 28: Where a term of an insurance contract relates to a particular kind of loss, or loss at a particular location or place, the breach of that term should only give the remedy in relation to loss of that particular kind of loss, or at that particular location or place.

Recommendation 29: Whether a term of an insurance contract relates to loss of a particular kind or at a particular type of place should be determined objectively based on whether compliance with that term would tend to reduce the risk of the occurrence of that category or those categories of loss.

REMEDIES FOR FRAUDULENT CLAIMS

Recommendation 30: Where an insured makes a fraudulent claim, the insurer should not be liable to pay the claim and should be able to recover any sums already paid in respect of it.

Recommendation 31: In addition, the insurer should have the option to treat the contract as having been terminated with effect from the time of the fraudulent act.

Recommendation 32: The insurer should remain liable for legitimate losses before the fraudulent act.

Recommendation 33: Where a consumer member of a group policy commits fraud, the insurer should have similar remedies against that fraudulent member. Those remedies should not affect the other group members who are innocent.

LATE PAYMENT

Recommendation 34: It should be an implied term of every insurance contract that, where an insured makes a claim under the contract, the insurer must pay sums due within a reasonable time.

Recommendation 35: A reasonable time should always include a reasonable time for investigating and assessing a claim.

Recommendation 36: Although what is a reasonable time will depend on all the relevant circumstances, the following are examples of things which may need to be taken into account:

- (1) The type of insurance.
- (2) The size and complexity of the claim.
- (3) Compliance with any relevant statutory rules or guidance.
- (4) Factors outside the insurer's control.

Recommendation 37: If the insurer can show that it had reasonable grounds for disputing the claim (whether as to the amount payable, or whether anything at all is payable), the insurer does not breach the obligation to pay within a reasonable time merely by failing to pay the claim while the dispute is continuing.

Recommendation 38: In those circumstances, the conduct of the insurer in handling the dispute may be a relevant factor in deciding whether the obligation was breached and, if so, when.

Recommendation 39: Normal contractual remedies for breach of contract should be available for breach of the implied term to pay sums due within a reasonable time.

Recommendation 40: In England, the normal rules of limitation will apply in respect of claims for breach of the new term. In Scotland, the normal prescriptive period will continue to apply.

Recommendation 41: The hold harmless principle need not be removed, nor extended to Scotland.

Recommendation 42: In consumer insurance contracts, the insurer should not be able to contract out of the obligation to pay sums due within a reasonable time.

Recommendation 43: In non-consumer insurance contracts, the insurer should be permitted to exclude or limit its liability for breach of the obligation to pay sums due within a reasonable time, unless such breach was deliberate or reckless. In other cases, its right to contract out will be subject to satisfying the transparency requirements.

CONTRACTING OUT

Recommendation 44: In a consumer insurance contract, it should not be possible to put the consumer in a worse position than the consumer would be in by virtue of the provisions of the draft Bill.

Recommendation 45: Similarly, it should not be possible to put consumer members of a group insurance scheme in a worse position with regards to remedies for fraudulent claims by group members than they would be in by virtue of the draft Bill.

Recommendation 46: Subject to recommendation 48, any term in a non-consumer insurance contract which would put the insured in a worse position than the insured would be in by virtue of the provisions of the draft Bill should be of no effect unless:

- (1) the insurer has taken sufficient steps to draw the relevant term to the insured's attention before the contract is entered into; and
- (2) the term is clear and unambiguous as to its effect.

Recommendation 47: In considering whether the above requirements have been satisfied, the characteristics of insured persons of the kind in question, and the circumstances of the transaction, should be taken into account.

Recommendation 48: In a non-consumer contract, it should not be possible to put the insured in a worse position than the non-consumer would be in by virtue of the provisions of the draft Bill in relation to:

- (1) basis of the contract clauses; or
- (2) deliberate or reckless breaches of the duty to pay sums due within a reasonable time.

GOOD FAITH

Recommendation 49: Avoidance should be removed as a remedy for failure to observe good faith. Specific remedies for the main examples of obligations based on good faith should be provided.

Recommendation 50: Good faith should be retained as an interpretative principle.

COMPULSORY INSURANCE

Recommendation 51: For non-consumer motor insurance, an insurer should only be entitled to a declaration under section 152(2) of the Road Traffic Act 1988 if it would be entitled to avoid the policy under the draft Bill.

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3 July 2014

APPENDIX A

DRAFT BILL AND EXPLANATORY NOTES

The draft Insurance Contracts Bill begins over the page with a Contents section. The provisions of the draft Bill are then set out. The Explanatory Notes on each clause of the draft Bill follow.

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TO

Make provision for a duty of fair presentation in relation to non-consumer insurance contracts and for remedies for breach of that duty; to amend the law relating to representations and warranties in connection with non-consumer insurance contracts, and relating to breach of warranty and certain other terms in contracts of insurance; to make provision in connection with remedies for fraudulent insurance claims and late payment of insurance claims; to amend the law relating to the remedies for a breach of the duty of good faith in connection with contracts of insurance; and for connected purposes.

BE IT ENACTED by the Queen’s most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

PART 1

MAIN DEFINITIONS

1 Main definitions

In this Act—

- “consumer insurance contract” has the same meaning as in the Consumer Insurance (Disclosure and Representations) Act 2012;
- “non-consumer insurance contract” means a contract of insurance that is not a consumer insurance contract;
- “insured” means the party to a contract of insurance who is the insured under the contract, or would be if the contract were entered into;
- “insurer” means the party to a contract of insurance who is the insurer under the contract, or would be if the contract were entered into;
- “the duty of fair presentation” means the duty imposed by section 3(1).

PART 2

THE DUTY OF FAIR PRESENTATION

2 Application and interpretation

- (1) This Part applies to non-consumer insurance contracts only.
- (2) This Part applies in relation to variations of non-consumer insurance contracts as it applies to contracts, but—
 - (a) references to the risk are to be read as references to changes in the risk relevant to the proposed variation, and
 - (b) references to the contract of insurance are to the variation.

3 The duty of fair presentation

- (1) Before a contract of insurance is entered into, the insured must make to the insurer a fair presentation of the risk.
- (2) The duty imposed by subsection (1) is referred to in this Act as “the duty of fair presentation”.
- (3) A fair presentation of the risk is one—
 - (a) which makes the disclosure required by subsection (4),
 - (b) which makes that disclosure in a manner which would be reasonably clear and accessible to a prudent insurer, and
 - (c) in which every material representation as to a matter of fact is substantially correct, and every material representation as to a matter of expectation or belief is made in good faith.
- (4) The disclosure required is as follows, except as provided in subsection (5)—
 - (a) disclosure of every material circumstance which the insured knows or ought to know, or
 - (b) failing that, disclosure which gives the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances.
- (5) In the absence of enquiry, subsection (4) does not require the insured to disclose a circumstance if—
 - (a) it diminishes the risk,
 - (b) the insurer knows it,
 - (c) the insurer ought to know it,
 - (d) the insurer is presumed to know it, or
 - (e) it is something as to which the insurer waives information.
- (6) Sections 4 to 6 make further provision about the knowledge of the insured and of the insurer, and section 7 contains supplementary provision.

4 Knowledge of insured

- (1) Subsections (2) to (4) provide for what an insured knows or ought to know for the purposes of section 3(4)(a).
- (2) An insured who is an individual knows—
 - (a) what is known to the individual, and

- (b) what is known to one or more of the individuals who are responsible for the insured's insurance.
- (3) An insured who is not an individual knows only what is known to one or more of the individuals who are –
 - (a) part of the insured's senior management, or
 - (b) responsible for the insured's insurance.
- (4) Whether an individual or not, an insured ought to know what should reasonably have been revealed by a reasonable search of information available to the insured (whether within its own organisation or held by others, for example its agent, and whether the search is conducted by making enquiries or by any other means).
- (5) In this section –
 - (a) an individual is responsible for the insured's insurance if the individual participates on behalf of the insured in the process of procuring the insured's insurance (whether the individual does so as the insured's employee or agent, or as an employee of the insured's agent, or in any other capacity),
 - (b) "senior management" means those individuals who play significant roles in the making of decisions about how the insured's activities are to be managed or organised.

5 Knowledge of insurer

- (1) For the purposes of section 3(5)(b), an insurer knows something only if it is known to one or more of the individuals who participate on behalf of the insurer in the decision whether to take the risk, and if so on what terms (whether the individual does so as the insurer's employee or agent, or as an employee of the insurer's agent, or in any other capacity).
- (2) For the purposes of section 3(5)(c), 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 mentioned in subsection (1), or
 - (b) the relevant information is held by the insurer and is readily available to an individual mentioned in subsection (1).
- (3) For the purposes of section 3(5)(d), 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.

6 Knowledge: general

- (1) Subsections (2) and (3) apply for the purposes of sections 3 to 5.
- (2) References to an individual's knowledge include not only actual knowledge, but also matters which the individual suspected, and of which the individual would have had knowledge but for deliberately refraining from confirming them or enquiring about them.

- (3) References to an individual's knowledge do not include confidential information acquired by –
 - (a) the insured's agent, through a business relationship with someone other than the insured (for the purposes of section 4), or
 - (b) the insurer's agent, through a business relationship with someone other than the insurer (for the purposes of section 5).
- (4) Nothing in this Part affects the operation of any rule of law according to which knowledge of a fraud perpetrated by an individual ("F") either on the insured or on the insurer is not to be attributed to the insured or to the insurer (respectively), where –
 - (a) if the fraud is on the insured, F is any of the individuals mentioned in section 4(2)(b) or (3), or
 - (b) if the fraud is on the insurer, F is any of the individuals mentioned in section 5(1).

7 Supplementary

- (1) A fair presentation need not be contained in only one document or oral presentation.
- (2) The term "circumstance" includes any communication made to, or information received by, the insured.
- (3) A circumstance or representation is material if it would influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms.
- (4) Examples of things which may be material circumstances are –
 - (a) special or unusual facts relating to the risk,
 - (b) any particular concerns which led the insured to seek insurance cover for the risk,
 - (c) anything which those concerned with the class of insurance and field of activity in question would generally understand as being something that should be dealt with in a fair presentation of risks of the type in question.
- (5) A material representation is substantially correct if a prudent insurer would not consider the difference between what is represented and what is actually correct to be material.
- (6) A representation may be withdrawn or corrected before the contract of insurance is entered into.

8 Remedies for breach

- (1) The insurer has a remedy against the insured for a breach of the duty of fair presentation only if the insurer shows that, but for the breach, the insurer –
 - (a) would not have entered into the contract of insurance at all, or
 - (b) would have done so only on different terms.
- (2) The remedies are set out in the Schedule.
- (3) A breach for which the insurer has a remedy against the insured is referred to in this Act as a "qualifying breach".

- (4) A qualifying breach is either –
 - (a) deliberate or reckless, or
 - (b) neither deliberate nor reckless.
- (5) A qualifying breach is deliberate or reckless if the insured –
 - (a) knew that it was in breach of the duty of fair presentation, or
 - (b) did not care whether or not it was in breach of that duty.
- (6) It is for the insurer to show that a qualifying breach was deliberate or reckless.

PART 3

WARRANTIES AND OTHER TERMS

9 Warranties and representations

- (1) This section applies to representations made by the insured in connection with –
 - (a) a proposed non-consumer insurance contract, or
 - (b) a proposed variation to a non-consumer insurance contract.
- (2) Such a representation is not capable of being converted into a warranty by means of any provision of the non-consumer insurance contract (or of the terms of the variation), or of any other contract (and whether by declaring the representation to form the basis of the contract or otherwise).

10 Breach of warranty

- (1) Any rule of law that breach of a warranty (express or implied) in a contract of insurance results in the discharge of the insurer's liability under the contract is abolished.
- (2) Subject to section 11, an insurer has no liability under a contract of insurance in respect of any loss occurring, or attributable to something happening, after a warranty (express or implied) in the contract has been breached but before the breach has been remedied.
- (3) But subsection (2) does not apply if –
 - (a) because of a change of circumstances, the warranty ceases to be applicable to the circumstances of the contract,
 - (b) compliance with the warranty is rendered unlawful by any subsequent law, or
 - (c) the insurer waives the breach of warranty.
- (4) Subsection (2) does not affect the liability of the insurer in respect of losses occurring, or attributable to something happening –
 - (a) before the breach of warranty, or
 - (b) if the breach can be remedied, after it has been remedied.
- (5) For the purposes of this section, a breach of warranty is to be taken as remedied –
 - (a) in a case falling within subsection (6), if the risk to which the warranty relates later becomes essentially the same as that originally contemplated by the parties,
 - (b) in any other case, if the insured ceases to be in breach of the warranty.

- (6) A case falls within this subsection if –
 - (a) the warranty in question requires that by an ascertainable time something is to be done (or not done), or a condition is to be fulfilled, or something is (or is not) to be the case, and
 - (b) that requirement is not complied with.
- (7) In the Marine Insurance Act 1906 –
 - (a) in section 33 (nature of warranty), in subsection (3), the second sentence is omitted,
 - (b) section 34 (when breach of warranty excused) is omitted.

11 Terms relevant to particular descriptions of loss

- (1) This section applies to any term (express or implied) of a contract of insurance compliance with which would tend to reduce the risk of one or more of the following –
 - (a) loss of a particular kind,
 - (b) loss at a particular location,
 - (c) loss at a particular time.
- (2) Breach of such a term may not be relied upon by the insurer to exclude, limit or discharge its liability for, respectively –
 - (a) loss of a different kind,
 - (b) loss at a different location,
 - (c) loss at a different time.
- (3) This section may apply in addition to section 10.

PART 4

OTHER MATTERS

Fraudulent claims

12 Remedies for fraudulent claims

- (1) If the insured makes a fraudulent claim under a contract of insurance –
 - (a) the insurer is not liable to pay the claim,
 - (b) the insurer may recover from the insured any sums paid by the insurer to the insured in respect of the claim, and
 - (c) in addition, the insurer may by notice to the insured treat the contract as having been terminated with effect from the time of the fraudulent act.
- (2) If the insurer does treat the contract as having been terminated –
 - (a) it may refuse all liability to the insured under the contract in respect of a relevant event occurring after the time of the fraudulent act, and
 - (b) it need not return any of the premiums paid under the contract.
- (3) Treating a contract as having been terminated under this section does not affect the rights and obligations of the parties to the contract with respect to a relevant event occurring before the time of the fraudulent act.

- (4) In subsections (2)(a) and (3), “relevant event” refers to whatever gives rise to the insurer’s liability under the contract (and includes, for example, the occurrence of a loss, the making of a claim, or the notification of a potential claim, depending on how the contract is written).

13 Remedies for fraudulent claims: group insurance

- (1) This section applies where –
- (a) a contract of insurance is entered into by a person (“A”) in order to provide cover for one or more other persons (“C”),
 - (b) none of the Cs is a party to the contract,
 - (c) so far as the cover for each C is concerned, the contract would have been a consumer insurance contract if entered into by that C rather than by A, and
 - (d) a fraudulent claim is made under the contract by or on behalf of one of the Cs (“CF”).
- (2) Section 12 applies in relation to the claim as if the cover provided for CF were provided under an individual consumer insurance contract between the insurer and CF as the insured; and, accordingly –
- (a) the insurer’s rights under section 12 are exercisable only in relation to the cover provided for CF, and
 - (b) the exercise of any of those rights does not affect the cover provided under the contract for anyone else.
- (3) In its application by virtue of subsection (2), section 12 is subject to the following particular modifications –
- (a) the reference to “the insured” in subsection (1)(b) of that section, in respect of any particular sum paid by the insurer, is to whichever of A and CF the insurer paid the sum to; but if a sum was paid to A and passed on by A to CF, the reference is to CF,
 - (b) the reference to “the insured” in subsection (1)(c) is to both CF and A,
 - (c) the reference in subsection (2)(b) to the premiums paid under the contract is to premiums paid in respect of the cover for CF.

Late payment

14 Implied term about payment

- (1) It is an implied term of every contract of insurance that if the insured makes a claim under the contract, the insurer must pay any sums due in respect of the claim within a reasonable time.
- (2) A reasonable time includes a reasonable time to investigate and assess the claim.
- (3) What is reasonable will depend on all the relevant circumstances, but the following are examples of things which may need to be taken into account –
- (a) the type of insurance,
 - (b) the size and complexity of the claim,
 - (c) compliance with any relevant statutory or regulatory rules or guidance,
 - (d) factors outside the insurer’s control.

- (4) If the insurer shows that there were reasonable grounds for disputing the claim (whether as to the amount of any sum payable, or as to whether anything at all is payable) –
 - (a) the insurer does not breach the term implied by subsection (1) merely by failing to pay the claim (or the affected part of it) while the dispute is continuing, but
 - (b) 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.
- (5) Remedies (for example, damages) available for breach of the term implied by subsection (1) are in addition to and distinct from –
 - (a) any right to enforce payment of the sums due, and
 - (b) any right to interest on those sums (whether under the contract, under another enactment, at the court’s discretion or otherwise).

PART 5

GOOD FAITH AND CONTRACTING OUT

Good faith

15 Good faith

- (1) Any rule of law permitting a party to a contract of insurance to avoid the contract on the ground that the utmost good faith has not been observed by the other party is abolished.
- (2) Any rule of law to the effect that a contract of insurance is a contract based on the utmost good faith is modified to the extent required by the provisions of this Act and the Consumer Insurance (Disclosure and Representations) Act 2012.
- (3) Accordingly –
 - (a) in section 17 of the Marine Insurance Act 1906 (marine insurance contracts are contracts of the utmost good faith), the words from “, and” to the end are omitted, and
 - (b) the application of that section (as so amended) is subject to the provisions of this Act and the Consumer Insurance (Disclosure and Representations) Act 2012.
- (4) In section 2 of the Consumer Insurance (Disclosure and Representations) Act 2012 (disclosure and representations before contract or variation), subsection (5) is omitted.

Contracting out

16 Contracting out: consumer insurance contracts

- (1) A term of a consumer insurance contract, or of any other contract, which would put the consumer in a worse position as respects any of the matters provided for in Part 3 or 4 of this Act than the consumer would be in by virtue of the provisions of those Parts (so far as relating to consumer insurance contracts) is to that extent of no effect.

- (2) In subsection (1) –
 - (a) references to a contract include a variation,
 - (b) references to the consumer include any person referred to as “C” in section 13.
- (3) This section does not apply in relation to a contract for the settlement of a claim arising under a consumer insurance contract.

17 Contracting out: non-consumer insurance contracts

- (1) A term of a non-consumer insurance contract, or of any other contract, which would put the insured in a worse position as respects the matters set out in subsection (2) than the insured would be in by virtue of the sections mentioned there is to that extent of no effect.
- (2) The matters referred to in subsection (1) are –
 - (a) representations to which section 9 applies, and
 - (b) deliberate or reckless breaches of the term implied by section 14(1).
- (3) A term of a non-consumer insurance contract, or of any other contract, which would put the insured in a worse position as respects any of the other matters provided for in Part 2, 3 or 4 of this Act than the insured would be in by virtue of the provisions of those Parts (so far as relating to non-consumer insurance contracts) is to that extent of no effect, unless the requirements of section 18 have been satisfied in relation to the term.
- (4) A term of a non-consumer insurance contract, or of any other contract, which would put any person referred to in section 13 as “C” in a worse position as respects the matters dealt with in that section than C would be in by virtue of section 13 is to that extent of no effect.
- (5) For the purposes of subsection (2)(b), a breach is deliberate or reckless if the insurer –
 - (a) knew that it was in breach, or
 - (b) did not care whether or not it was in breach.
- (6) In this section, references to a contract include a variation.
- (7) This section does not apply in relation to a contract for the settlement of a claim arising under a non-consumer insurance contract.

18 The transparency requirements

- (1) In this section, “the disadvantageous term” means such a term as is mentioned in section 17(3).
- (2) The insurer must take sufficient steps to draw the disadvantageous term to the insured’s attention before the contract is entered into or the variation agreed.
- (3) The disadvantageous term must be clear and unambiguous as to its effect.
- (4) In determining whether the requirements of subsections (2) and (3) have been met, the characteristics of insured persons of the kind in question, and the circumstances of the transaction, are to be taken into account.
- (5) The insured may not rely on any failure on the part of the insurer to meet the requirements of subsection (2) if the insured had actual knowledge of the

disadvantageous term when the contract was entered into or the variation agreed.

PART 6

GENERAL

19 Provision consequential on Part 2

- (1) The provision made by this section is consequential on Part 2 of this Act.
- (2) In the Marine Insurance Act 1906, sections 18 (disclosure by assured), 19 (disclosure by agent effecting insurance) and 20 (representations pending negotiation of contract) are omitted.
- (3) Any rule of law to the same effect as any of those provisions is abolished.
- (4) Section 152 of the Road Traffic Act 1988 (exceptions to duty of insurers to satisfy judgment against persons insured against third-party risks) is amended in accordance with subsections (5) to (7).
- (5) In subsection (2) –
 - (a) in paragraph (a), for “it either under the Consumer Insurance (Disclosure and Representations) Act 2012 or, if that Act does not apply,” substitute “the policy under either of the relevant insurance enactments, or the security”,
 - (b) in paragraph (b), for “or security under that Act or” substitute “under either of the relevant insurance enactments, or the security”.
- (6) In subsection (3), after “specifying” insert “the relevant insurance enactment or, in the case of a security,”.
- (7) After subsection (4) add –
 - “(5) In this section, “relevant insurance enactment” means the Consumer Insurance (Disclosure and Representations) Act 2012 or Part 2 of the Insurance Contracts Act 2014.”
- (8) In section 11 of the Consumer Insurance (Disclosure and Representations) Act 2012 (consequential provision), subsections (1) and (2) are omitted.

20 Short title, commencement, application and extent

- (1) This Act may be cited as the Insurance Contracts Act 2014.
- (2) This Act comes into force at the end of the period of 18 months beginning with the day on which this Act is passed.
- (3) Part 2 (and section 19) and section 15 of this Act apply only in relation to –
 - (a) contracts of insurance entered into after this Act comes into force, and
 - (b) variations, agreed after this Act comes into force, to contracts of insurance entered into at any time.
- (4) Parts 3 and 4 of this Act apply only in relation to contracts of insurance entered into after this Act comes into force, and variations to such contracts.
- (5) This Act extends to England and Wales and to Scotland.

SCHEDULE

Section 8(2).

INSURERS’ REMEDIES FOR QUALIFYING BREACHES

PART 1

CONTRACTS

General

- 1 This Part of this Schedule applies to qualifying breaches of the duty of fair presentation in relation to non-consumer insurance contracts (for variations to them, see Part 2).

Deliberate or reckless breaches

- 2 If a qualifying breach was deliberate or reckless, the insurer –
 - (a) may avoid the contract and refuse all claims, and
 - (b) need not return any of the premiums paid.

Other breaches

- 3 Paragraphs 4 to 6 apply if a qualifying breach was neither deliberate nor reckless.
- 4 If, in the absence of the qualifying breach, the insurer would not have entered into the contract on any terms, the insurer may avoid the contract and refuse all claims, but must in that event return the premiums paid.
- 5 If the insurer would have entered into the contract, but on different terms (other than terms relating to the premium), the contract is to be treated as if it had been entered into on those different terms if the insurer so requires.
- 6 (1) In addition, if the insurer would have entered into the contract (whether the terms relating to matters other than the premium would have been the same or different), but would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim.
(2) In sub-paragraph (1), “reduce proportionately” means that the insurer need pay on the claim only X% of what it would otherwise have been under an obligation to pay under the terms of the contract (or, if applicable, under the different terms provided for by virtue of paragraph 5), where –

$$X = \frac{\text{Premium actually charged}}{\text{Higher premium}} \times 100$$

PART 2

VARIATIONS

General

- 7 This Part of this Schedule applies to qualifying breaches of the duty of fair presentation in relation to variations to non-consumer insurance contracts.

Deliberate or reckless breaches

- 8 If a qualifying breach was deliberate or reckless, the insurer –
- (a) may by notice to the insured treat the contract as having been terminated with effect from the time when the variation was made, and
 - (b) need not return any of the premiums paid.

Other breaches

- 9 (1) This paragraph applies if –
- (a) a qualifying breach was neither deliberate nor reckless, and
 - (b) the total premium was increased or not changed as a result of the variation.
- (2) If, in the absence of the qualifying breach, the insurer would not have agreed to the variation on any terms, the insurer may treat the contract as if the variation was never made, but must in that event return any extra premium paid.
- (3) If sub-paragraph (2) does not apply –
- (a) if the insurer would have agreed to the variation on different terms (other than terms relating to the premium), the variation is to be treated as if it had been entered into on those different terms if the insurer so requires, and
 - (b) paragraph 11 also applies if (in the case of an increased premium) the insurer would have increased the premium by more than it did, or (in the case of an unchanged premium) the insurer would have increased the premium.
- 10 (1) This paragraph applies if –
- (a) a qualifying breach was neither deliberate nor reckless, and
 - (b) the total premium was reduced as a result of the variation.
- (2) If, in the absence of the qualifying breach, the insurer would not have agreed to the variation on any terms, the insurer may treat the contract as if the variation was never made, and paragraph 11 also applies.
- (3) If sub-paragraph (2) does not apply –
- (a) if the insurer would have agreed to the variation on different terms (other than terms relating to the premium), the variation is to be treated as if it had been entered into on those different terms if the insurer so requires, and
 - (b) paragraph 11 also applies if the insurer would have increased the premium, would not have reduced the premium, or would have reduced it by less than it did.

Proportionate reduction

- 11 (1) If this paragraph applies, the insurer may reduce proportionately the amount to be paid on a claim arising out of events after the variation.
- (2) In sub-paragraph (1), “reduce proportionately” means that the insurer need pay on the claim only Y% of what it would otherwise have been under an obligation to pay under the terms of the contract (whether on the original terms, or as varied, or under the different terms provided for by virtue of paragraph 9(3)(a) or 10(3)(a), as the case may be), where –
- $$Y = \frac{\text{Total premium actually charged}}{P} \times 100$$
- (3) In the formula in sub-paragraph (2), “P” –
- (a) in a paragraph 9(3)(b) case, is the total premium the insurer would have charged,
 - (b) in a paragraph 10(2) case, is the original premium,
 - (c) in a paragraph 10(3)(b) case, is the original premium if the insurer would not have changed it, and otherwise the increased or (as the case may be) reduced total premium the insurer would have charged.

PART 3

SUPPLEMENTARY

Relationship with section 84 of the Marine Insurance Act 1906

- 12 Section 84 of the Marine Insurance Act 1906 (return of premium for failure of consideration) is to be read subject to the provisions of this Schedule in relation to contracts of marine insurance which are non-consumer insurance contracts.

EXPLANATORY NOTES

PART 1: MAIN DEFINITIONS

Clause 1: Main definitions

- A.1 Some provisions of the draft Bill apply to both “consumer insurance contracts” and “non-consumer insurance contracts”. Others only apply to one or the other. Clause 1 defines these important terms.
- A.2 Clause 1 provides that a “consumer insurance contract” has the same definition as in the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). Section 1 of CIDRA defines a “consumer insurance contract” as an insurance contract between an insurer¹ and:
- an individual who enters into the contract wholly or mainly for purposes unrelated to the individual's trade, business or profession.
- A.3 Under this definition, a “consumer” must:
- (1) be an individual – that is a natural rather than a non-natural person; and
 - (2) enter into a contract “wholly or mainly” for purposes unrelated to their trade, business or profession, if any.
- A.4 In “mixed use” policies, where the insurance covers some private and some business use, one must look at the main purpose of the insurance to classify it as one or the other.
- A.5 Clause 1 defines “non-consumer insurance contract” as any contract of insurance which does not fall within the CIDRA definition of consumer insurance contract.
- A.6 An insurance contract may be “non-consumer” for two reasons: either the policyholder is not an individual, or they have entered into the contract wholly or in significant part for trade, business or professional reasons. In many cases, both reasons will apply: the policyholder will be a company or other corporate entity taking out insurance for commercial reasons. However, either reason is sufficient in itself.
- A.7 Clause 1 also defines “insurer” and “insured”. Each is described as being a “party to a contract of insurance”. The definitions also capture the parties who would be the “insurer” and “insured” under a contract of insurance if the contract were entered into. This part of the definitions caters for Part 2 of the draft Bill, which addresses pre-contractual requirements and therefore applies to persons who are not yet parties to the relevant insurance contract.
- A.8 The draft Bill does not define insurance. The common law definition of insurance continues to apply. It is expected that contracts of reinsurance and retrocession would be treated as contracts of insurance.
- A.9 For further discussion of these matters, see paragraphs 2.5 to 2.21.

¹ Defined by section 1 of CIDRA as “a person who carries on the business of insurance and who becomes a party to the contract by way of that business (whether or not in accordance with permission for the purposes of the Financial Services and Markets Act 2000)”.

PART 2: THE DUTY OF FAIR PRESENTATION

Clause 2: Application and interpretation

- A.10 Clause 2(1) states that Part 2 of the draft Bill, which addresses the duty of fair presentation, “applies to non-consumer insurance contracts only”. This is because the law in this area as it applies to consumer insurance contracts was reformed by the Consumer Insurance (Disclosure and Representations) Act 2012.
- A.11 The definitions of consumer insurance contract and non-consumer insurance contract are addressed in clause 1 of the draft Bill.
- A.12 Clause 2(2) provides that the duty of fair presentation, set out in the remainder of Part 2, applies in the event of a variation to a non-consumer insurance contract as well as upon the initial agreement of the contract. Clause 2(2)(a) follows the current law by stating that the duty to make a fair presentation of the “risk” relates only to the “changes in the risk” which are “relevant to the proposed variation”.²
- A.13 The duty of fair presentation as it applies in the context of a variation to a non-consumer insurance contract is discussed at paragraphs 7.11 to 7.12.

Clause 3: The duty of fair presentation

- A.14 Clause 3 is central to the proposed reforms. Clause 3(1) introduces a requirement on the insured (at this stage, the person or party who would be the insured if the contract were entered into) to make to the insurer a “fair presentation of the risk” before the contract is entered into. Clause 3(2) identifies this as the “duty of fair presentation”.
- A.15 The duty of fair presentation replaces the existing duties in relation to disclosure and representations contained in sections 18, 19 and 20 of the Marine Insurance Act 1906 (the 1906 Act).³ However, it retains essential elements of those provisions. Insurers need potential insureds to provide them with the information they require to decide whether to insure a risk, and on what terms.
- A.16 Like the current law, the duty of fair presentation attaches “before a contract of insurance is entered into”. Since the law regards renewals as new contracts, the duty also applies when an insurance contract is renewed. This is in accordance with the current law.
- A.17 The duty falls on “the insured”, defined in clause 1. In some situations, one party may enter into a contract on behalf of others. Who is “the insured” in such cases is, and will continue to be, a question of construction of the particular contract. This is discussed from paragraph 7.15.
- A.18 Clause 3(3) sets out the three elements of a “fair presentation of the risk”.

² See, for example, *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469, by Lord Hobhouse at [54]. There is no requirement to disclose information relating to the rest of the original policy; see *Lishman v Northern Maritime* (1875) LR 10 CP 179.

³ Sections 18, 19 and 20 of the 1906 Act are repealed by clause 19(2) of the draft Bill.

- A.19 The first element of a fair presentation is a duty of disclosure, introduced in clause 3(3)(a) and further defined in clause 3(4), which provides two ways to satisfy the duty of disclosure. Clause 3(4)(a) effectively replicates the disclosure duty in section 18(1) of the 1906 Act. Its key features are that the insured must disclose “every material circumstance”⁴ which the insured “knows or ought to know”.⁵
- A.20 The second way to satisfy the duty is intended to operate where the insured has failed to satisfy the strict duty in clause 3(4)(a) but has nevertheless disclosed enough information. Under clause 3(4)(b), the insured has satisfied the disclosure duty if it has disclosed sufficient information to put a prudent insurer on notice that it must make further enquiries which, when answered, would reveal material circumstances which the insured knows or ought to know. This reflects the approach already taken by the courts in some cases.⁶ The duty in clause 3(4)(b) must, like the rest of the draft Bill, be read subject to the overriding duty of good faith in section 17 of the 1906 Act. Deliberately withholding information from the insurer that the insured knows to be “material” would not satisfy the duty of fair presentation. The second element of the duty of fair presentation, concerning the form of presentation, may also be breached where a policyholder is deliberately opaque in the hope that an insurer will not detect a point and ask further questions about it.
- A.21 Clause 3(3)(b) relates to the form of presentation rather than the substance. It requires that the presentation must be reasonably clear and accessible to “a prudent insurer”; that is, an insurer who is acting prudently to understand and evaluate risks. It is intended to target, at one end of the scale, “data dumps”, where the insurer is presented with an overwhelming amount of undigested information. At the other end of the scale, it is not expected that this requirement would be satisfied by an overly brief or cryptic presentation.
- A.22 The third element of the duty of fair presentation, contained in clause 3(3)(c), is based on section 20 of the 1906 Act. It comprises a duty not to make misrepresentations. As under the 1906 Act, where a material representation⁷ concerns a matter of fact, it must be “substantially correct”.⁸ Where it concerns a matter of expectation or belief, it must be made in good faith. The courts’ approach to this distinction is discussed from paragraph 7.49.
- A.23 The duty of fair presentation is discussed in more detail in Chapter 7.

Exceptions to the duty of fair presentation

- A.24 As in section 18(3) of the 1906 Act, clause 3(5) of the draft Bill provides exceptions to the insured’s duty of disclosure. The exceptions do not apply to the requirement to make the disclosure in a clear and accessible manner, or to the duty not to make misrepresentations. Anything which is the subject of an exception does not have to be disclosed by the insured to the insurer, unless the insurer makes enquiries about that matter.

⁴ Defined in clause 7(3).

⁵ Defined in clause 4.

⁶ For example, *CTI v Oceanus* [1984] 1 Lloyd’s LR 476; *Garnat Trading and Shipping v Baominh Insurance Corporation* [2011] EWCA Civ 773.

⁷ Defined in clause 7(3).

⁸ Defined in clause 7(5).

- A.25 Exceptions (a) and (e) replicate the relevant provisions in the 1906 Act almost exactly. The rest of the exceptions relate to circumstances which the insurer “knows”, “ought to know” and “is presumed to know”. They replace similar provisions in the 1906 Act. Each of these categories of “knowledge” is expanded on in clause 5.
- A.26 The exceptions are discussed in more detail in paragraphs 10.34 to 10.74.

Clause 4: Knowledge of insured

- A.27 Clause 4 defines what the insured “knows” and “ought to know” for the purposes of the duty of disclosure in clause 3. It is based on the insured’s duty under section 18 of the 1906 Act to disclose every material circumstance known to them, including everything which “in the ordinary course of business, ought to be known” to them.
- A.28 Clause 4(2) addresses the position of an insured who is an individual (such as in the case of a sole trader or practitioner). As well as their own knowledge, the insured will also be taken to “know” anything which is known by the person or people who are “responsible for the insured’s insurance”.
- A.29 Clause 4(3) sets out the individuals whose knowledge will be directly attributed to the insured where the insured is not an individual (for example, in the case of a company). They are the insured’s senior management and the people responsible for the insured’s insurance. These categories reflect important decisions on the common law rules of attribution in the insurance context. However, the intended effect of the phrase “knows only” is that the common law is replaced by the terms of the draft Bill.
- A.30 Clause 4(5)(a) defines a person “responsible for the insured’s insurance”. It is expected to catch, for example, the insured’s risk manager if they have one, and any employee who assists in the collection of data or negotiates the terms of the insurance. It may also include an individual acting as the insured’s broker.
- A.31 Clause 4(5)(b) defines “senior management”. It is intended to include (and be more or less limited to) board members or their equivalent in a non-corporate organisation.
- A.32 Clause 4(4) defines what an insured “ought to know”. It states what has been suggested by some recent cases:⁹ that insureds have a positive duty to seek out information about their business by undertaking a reasonable search, whether by making enquiries of its staff and agents or by other means.
- A.33 What is “reasonable” will depend on the insured’s size, nature and complexity. Clause 4(4) is to be interpreted in light of existing case law. For example, a search may not be expected to evince an admission by a servant of their own negligence.¹⁰ In contrast, the knowledge of an “agent to know”, who has a duty to communicate the relevant information to their employer or principal, may well be included.¹¹ Clause 4(4) explicitly states that a reasonable search may include a search of information held by the insured’s agents.
- A.34 The insured’s knowledge is discussed in paragraphs 8.45 to 8.91.

⁹ See, for example, *Aiken v Stewart Wrightson Members Agency Ltd* [1995] 3 All ER 449.

¹⁰ See, for example, *Australia & New Zealand Bank Ltd v Colonial & Eagle Wharves Ltd* [1960] 2 Lloyd’s Rep 241.

¹¹ See, for example, *Proudfoot v Montefiore* (1867) LR 2 QB 511.

- A.35 Unlike section 19 of the 1906 Act, the draft Bill does not include a separate duty on the agent to disclose information to the insurer. The agent's knowledge or other information held by the agent may be caught under clause 4, as discussed above and in more detail at paragraph 9.25 and following.

Clause 5: Knowledge of insurer

- A.36 Clause 5 defines what the insurer "knows", "ought to know" and "is presumed to know" for the purposes of the clause 3(5) exceptions to the duty of disclosure. These provisions are based on the exceptions contained in section 18(3) of the 1906 Act and the case law interpreting them. This is discussed in Chapter 9.
- A.37 Clause 5(1) sets out the individuals whose knowledge will be directly attributed to the insurer, being what the insurer "knows". This provision is intended to capture the person or people involved in making the particular underwriting decision – essentially the underwriter(s). The relevant individual(s) may be, for example, employees of the insurer or of the insurer's agent. Again, the intended effect of the phrase "knows... only" is that the common law is replaced by the terms of the draft Bill.
- A.38 Clause 5(2) sets out two types of information which an insurer "ought to know".
- A.39 The first, in clause 5(2)(a), is information which an employee or agent of the insurer knows and ought reasonably to have passed on to the underwriter(s). This is intended to include, for example, information held by the claims department or reports produced by surveyors or medical experts for the purpose of assessing the risk.
- A.40 The second category, at clause 5(2)(b), is intended to require the responsible underwriter(s) to make a reasonable effort to search such information as is available to them within the insurer's organisation, such as in the insurer's electronic records.
- A.41 Clause 5(3) defines what the insurer is "presumed to know".
- A.42 The reference to common knowledge in clause 5(3)(a) replicates the language of the 1906 Act. The reference to "common notoriety" has not been retained, because the meaning of that phrase appears to have changed since 1906. At the time the 1906 Act was drafted, "notoriety" appeared to mean the state of being "well known", whereas now it suggests an element of infamy.
- A.43 Clause 5(3)(b) is intended to be a modernisation of the reference in section 18(3)(b) of the 1906 Act to "matters which an insurer in the ordinary course of his business, as such, ought to know". The clause explicitly references different classes of insurance and different fields of activity. Many underwriters work by class of business (such as property or professional indemnity insurance) rather than by industry sector (such as oil and gas). An insurer ought to have some insight into the industry for which it is providing insurance, but this insight may reasonably be limited to matters relevant to the type of insurance provided. Thus an employers' liability insurer should know something about the range of industries they insure such as the usual rates of injury in construction or off-shore marine business. It is unrealistic to suppose that they will have a detailed knowledge of all the industries they provide cover for.
- A.44 The current law, and our recommendations, are discussed in Chapter 10.

Clause 6: Knowledge: general

- A.45 Clauses 4 and 5 respectively set out the categories of individual whose knowledge will be directly attributed to the insured and insurer. These rules are intended to replace the common law in the context of the duty of fair presentation. This leaves questions around exactly what an individual “knows”, and whether their knowledge should in all cases be attributed to the relevant entity. In this regard, there are useful rules to be drawn from the common law. Clause 6 sets out three further rules about an individual's knowledge.
- A.46 Clause 6(2) provides that what an individual knows includes not only what it actually knows but also “blind eye” knowledge. The courts have consistently interpreted knowledge to include cases where someone has deliberately failed to make an enquiry in case it results in the confirmation of a suspicion.¹²
- A.47 Clause 6(3) makes further provision about the knowledge of an individual acting as an agent of the insured or insurer. Where the insured's agent knows confidential information which it acquired through a business relationship with someone other than the insured, that information will not be attributed to the insured. The same rule applies as regards the insurer's agent and the insurer.
- A.48 This provision will be particularly relevant to the insured's broker. Clause 6(3) is intended to mean that they are not required to break their obligation of confidentiality to one client in order to assist another client with its duty to make a fair presentation. The insured would not be taken to “know” the information and would not have to disclose it. Clause 6(3) also applies in the case of confidential information held by the *insurer's* agent. The insurer would not be taken to know the relevant information and therefore it would not be the subject of an exception to the insured's duty of disclosure. This is discussed at paragraphs 9.41 to 9.46.
- A.49 Clause 6(4) concerns the situation in which an individual (an employee or agent) perpetrates fraud against his or her principal (whether the insured or the insurer). It is intended to capture a common law exception to the general rules of attribution, known as the *Hampshire Land* principle, which broadly means that a company or other principal is not fixed with knowledge of a fraud practised against it by an agent or officer.¹³ However, the exact scope of the principle is far from clear and the Law Commissions did not consider it desirable to legislate prescriptively to constrain it.
- A.50 Clause 6(4) therefore preserves “any rule of law” according to which the knowledge of a fraudster is not attributed to the party on whom the fraud is practised. This is discussed in more detail at paragraphs 8.67 to 8.76.

Clause 7: Supplementary

- A.51 Clause 7 makes further provision about the duty of fair presentation, including definitions of some terms used in earlier provisions.

¹² See, for example, Lord Scott in *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at [112].

¹³ From *Re Hampshire Land Company* [1896] 2 Ch 743. For Scotland, see L Macgregor, *The Law of Agency in Scotland* (2013), para 13-24.

- A.52 Clause 7(1) states that a “fair presentation” does not have to be made in a single document or oral presentation. The draft Bill is intended to recognise that the insurer may need to ask questions about the information in the initial presentation in order to draw out the information it requires to make the underwriting decision. All information which has been provided to the insurer by the time the contract is entered into will therefore form part of the presentation to be assessed.
- A.53 Indeed, as is set out in clause 7(6), an insured may withdraw or correct any information provided, or representation made, to the insurer, before the contract is entered into. Once the contract has been entered into, the presentation will “crystallise” for the purposes of assessing whether the insured has complied with the duty of fair presentation.
- A.54 Clause 7(2) concerns the scope of the term “circumstance”, which is the language used in the 1906 Act. Clause 7(2) repeats the terms of section 18(5) of the 1906 Act in order to make clear that the terms are used in the same way in both pieces of legislation.
- A.55 Clause 7(3) contains a definition of material circumstance and material representation, used in clause 3. It is based on sections 18(2) and 20(2) of the 1906 Act. It provides that something is “material” if it would influence the judgement of a prudent insurer in determining whether to take the risk and, if so, on what terms. The term “prudent insurer” is also taken from the 1906 Act, and it is intended that existing case law will be used to interpret it. The retention of the “prudent insurer” test means that whether there has been a “fair presentation of the risk” is still assessed principally from the perspective of an insurer.
- A.56 Clause 7(4) sets out three examples of things which may constitute “material circumstances”. Whether circumstances falling within these examples are in fact “material” will depend on the facts of each case. Of the examples, (c) has particular potential for development by the market. It is intended to recognise that the type of information which should be disclosed may vary significantly depending on the “class” of insurance being purchased (for example, employers’ liability, property) and the “field of activity” in which the insured operates (for example, shipping, financial auditing). It would be helpful for insurers, brokers and policyholder bodies to work together to develop guidance setting out what a standard presentation of the risk should include in particular circumstances.
- A.57 Clause 7(5) makes further provision about the duty in clause 3(3)(c) not to make misrepresentations. It defines “substantially correct” in the context of a representation as to a matter of fact. This definition is based on section 20(4) of the 1906 Act.

Clause 8: Remedies for breach

- A.58 This clause sets out the circumstances in which an insurer will be entitled to a remedy for an insured’s breach of the duty of fair presentation.

- A.59 Clause 8(1) requires the insurer to show that it would have acted differently if the insured had not failed to make a fair presentation; that is, that the insurer would not have entered into the contract at all, or would have done so only on different terms. This “inducement test” reflects the current law as developed following the decision in *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*.¹⁴
- A.60 Before the insurer can claim a remedy for breach of the duty of fair presentation, it must therefore show that it was induced to enter into the policy on the relevant terms by the proposer’s breach. Clause 8(3) gives the label “qualifying breach” to a breach for which the insurer has a remedy.
- A.61 Clause 8(4) distinguishes between qualifying breaches which were “deliberate or reckless”, and all other breaches. As under CIDRA, an insurer has different remedies depending on whether or not the proposer’s breach of the duty of fair presentation was deliberate or reckless.
- A.62 Clause 8(5) defines a “deliberate or reckless” qualifying breach. An insured acted deliberately or recklessly if it knew that it did not make a fair presentation of the risk or did not care whether or not it was in breach of that duty. In this context, “not caring” is intended to be more culpable than acting “carelessly” in the sense of not taking sufficient care. “Deliberate or reckless” is particularly intended to include fraudulent behaviour.
- A.63 The deliberate or reckless definition echoes that in CIDRA. However, in CIDRA a “qualifying breach” must be either deliberate/reckless or careless, since the consumer’s duty is to take reasonable care not to make a misrepresentation to the insurer. In non-consumer insurance, breaches do not have to be careless or deliberate/reckless in order to be actionable. “Innocent” breaches of the duty will also give an insurer a remedy if the insurer can show inducement. This reflects the current law for non-consumer insurance.
- A.64 Clause 8(6) states that the onus of proving that a qualifying breach is deliberate or reckless is on the insurer. This follows normal legal principles that the party alleging wrongdoing must substantiate it.
- A.65 Clause 8(2) provides a signpost to the details of the remedies available for breach of the duty of fair presentation, which are set out in the Schedule.
- A.66 For a further discussion of the matters addressed in this clause, see Chapter 11 and Appendix B.

¹⁴ [1995] 1 AC 501.

PART 3: WARRANTIES AND OTHER TERMS

Clause 9: Warranties and representations

- A.67 This clause abolishes “basis of the contract” clauses in non-consumer insurance. “Basis of the contract” clauses in consumer insurance were abolished by section 6 of the Consumer Insurance (Disclosure and Representations) Act 2012.
- A.68 Under the current law, an insurer may add a declaration to a non-consumer insurance proposal form or policy stating that the insured warrants the accuracy of all the answers given, or that such answers form the “basis of the contract”.¹⁵ This has the legal effect of converting representations into warranties. The insurer is discharged from liability for claims if the insured made any misrepresentation, even if it was immaterial and did not induce the insurer to enter into the contract.
- A.69 Clause 9(2) prevents a term in the policy or on the proposal form turning representations into warranties in this way.
- A.70 The clause is limited in scope. It remains possible for insurers to include specific warranties within their policies. A warranty may deal with an issue that is covered by a question on the proposal form or is otherwise part of the presentation. However, insurers cannot employ a device that purports to convert a representation into a warranty.
- A.71 For further discussion of this clause, see Chapter 16.

Clause 10: Breach of warranty

- A.72 Clause 10 replaces the existing remedy for breach of a warranty in an insurance contract, which is contained in section 33(3) of the 1906 Act. Under that section, the insurer’s liability under the contract is completely discharged from the point of breach. Section 34(2) makes clear that remedying a breach of warranty does not change this. Clauses 10(1) and 10(7) repeal these existing statutory rules, and any common law equivalent.
- A.73 However, the draft Bill does not make any change to the definition of warranty. Warranties are defined in section 33(1) of the 1906 Act with regard to marine warranties, and the common law has developed in parallel in regard to other types of insurance. It is still the case that a warranty “must be exactly complied with, whether it be material to the risk or not”.¹⁶
- A.74 The effect of clause 10(2) is that breach of a warranty by an insured *suspends* the insurer’s liability under the insurance contract from the time of the breach, until such time as the breach is remedied. The insurer will have no liability for anything which occurs, or which is attributable to something occurring, during the period of suspension.
- A.75 Clause 10(4)(b) makes explicit that the insurer will be liable for losses occurring after a breach has been remedied. It acknowledges, however, that some breaches of warranty cannot be remedied.

¹⁵ *Dawsons Ltd v Bonnin* [1922] 2 AC 413, 1922 SC (HL) 156; *Genesis Housing Association Ltd v Liberty Syndicate Management Ltd for and on behalf of Liberty Syndicate* 4472 at *Lloyd’s* [2013] EWCA Civ 1173, [2013] WLR (D) 368.

¹⁶ 1906 Act, s 33(3).

- A.76 The “attributable to something happening” wording is intended to cater for the situation in which loss arises as a result of an event which occurred during the period of suspension, but is not actually suffered until after the breach has been “remedied”. This may be relevant where, for example, a warranty in a policy covering fine wines requires the bottles to be stored on their sides. The insured mistakenly stores them upright, with the effect that the corks shrink and the wine becomes oxidised. Although the insured may “remedy” the breach by laying the bottles on their sides, the permanent loss of quality is “attributable to something happening” during the period of breach so the insurer is not liable.
- A.77 Generally, a breach of warranty will be “remedied” where the insured “ceases to be in breach of warranty”. This is set out in clause 10(5)(b). However, some warranties require something to be done by an ascertainable time. If a deadline is missed, the insured could never cease to be in breach because the critical time for compliance has passed. Clauses 10(5)(a) and 10(6) are intended to mean that this type of breach will be remedied if the warranty is ultimately complied with, albeit late.
- A.78 Clause 10 applies to all express and implied warranties including the implied marine warranties in sections 39, 40 and 41 of the 1906 Act.
- A.79 For further discussion of this clause, see Chapter 17.

Clause 11: Terms relevant to particular descriptions of loss

- A.80 Clause 11 concerns warranties and other terms which are designed to reduce the risk of a particular type of loss, or the risk of loss at a particular time or in a particular place. In the event of breach of such a term, it is intended that the insurer’s liability will only be excluded for losses of that type, or at that particular time or place.
- A.81 Clause 11(1) refers to contractual terms which, if complied with, “would tend to reduce the risk” of loss of a particular kind, or loss at a particular location or time. This is intended to enable an objective assessment of the “purpose” of the provision: if the term were to be complied with, what sorts of loss might be less likely to occur as a result?
- A.82 Clause 11(1) does not apply only to warranties and may catch other types of contractual provision such as conditions precedent and exclusion clauses. However, not all such terms will be caught, because some do not relate to particular types of loss or losses at a particular location or time.
- A.83 Clause 11 is not intended to apply where a clause goes to the entirety of the nature of the risk (such as a requirement that a ship remains in class, or that a vehicle is not used commercially).
- A.84 Clause 11(2) is intended to mean that, if a term falls within clause 11(1), breach of that term will only affect the insurer’s liability in respect of losses of the particular type, or at the particular location or time. The insurer will remain liable for other kinds of loss, or losses at a different place or time.
- A.85 For example, breach of a warranty requiring a policyholder to have a fire safety system in place would result in suspension of the insurer’s liability in respect of fire-related losses, but not in respect of flood losses. Breach of a condition that a building must retain a night watchman would mean that the insurer will have no liability for losses occurring at night, while a watchman should be present.

- A.86 A direct causal link between the breach and the ultimate loss is not required. That is, it is not relevant whether or not breach of the term actually caused or contributed to the loss which has been suffered. The clause is intended to provide that the insurer will not be liable for any loss falling within the particular *category* of loss with which the warranty or other term is concerned.
- A.87 Clause 11(3) provides that clause 10 and clause 11 may apply together. This will only arise where the relevant term is found to be a warranty, because clause 10 only applies to warranties. Breach of a warranty would suspend the insurer's liability under the whole contract, under clause 10(2), unless it is found that the warranty is caught by clause 11(1). If that is the case, then the insurer's liability will only be suspended for losses of the relevant type, or at the relevant location or time. If the breach is remedied, the insurer's liability will be restored.
- A.88 For further discussion of this clause, see Chapter 18.

PART 4: OTHER MATTERS

Clause 12: Remedies for fraudulent claims

- A.89 This clause sets out the insurer's remedies where the insured makes a fraudulent claim. It does not apply where a third party commits a fraud against the insurer or the insured, such as where a fraudulent claim is made against an insured, who seeks recovery from its insurer under a liability policy.
- A.90 The clause does not define "fraud" or "fraudulent claim". The remedies will apply once fraud has been determined in accordance with common law principles.¹⁷
- A.91 Clause 12(1)(a) puts the common law rule of forfeiture on a statutory footing. Where the insured commits a fraud against the insurer, the insurer is not liable to pay the insurance claim to which the fraud relates. Clause 12(1)(b) makes explicit that, where the insurer has already paid out insurance monies on the claim and later discovers the fraud, the insurer may recover these sums from the insured.
- A.92 Clause 12(1)(c) provides the insurer with a further remedy. It gives the insurer an option to treat the contract as if it had been terminated at the time of the "fraudulent act". This is dependent on the insurer giving notice of their election to do so to the insured.
- A.93 The "fraudulent claim" is, in clause 12(1), to be distinguished from the "fraudulent act", which is intended to be the behaviour that makes a claim fraudulent, which may be after the initial submission of the claim. The timing of the "fraudulent act" is relevant in determining when the liability of the insurer ceases for the purposes of clause 12(1)(c). For example, if an insured submits a genuine claim in January and adds a fraudulent element in March (for example, adding an additional, fabricated, head of loss), the "fraudulent act" takes place in March. This is the point at which the contract may be treated as having been terminated, and from which the insurer's liability ceases.
- A.94 Clause 12(2) sets out the consequences if the insurer elects to treat the contract as terminated under 12(1)(c). It can refuse to pay claims relating to "relevant events" occurring after the time of the fraudulent act. It does not have to return any premiums already paid by the insured.
- A.95 "Relevant event" is explained in clause 12(4). It refers to any event that would trigger the insurer's liability under the particular insurance contract. Usually, this will be the occurrence of loss or damage which is insured under the contract. However, some insurance contracts, such as professional indemnity insurance contracts, are written on the basis of a "claims made" policy. In such cases, the "relevant event" may be the notification of a claim against the professional, even where no loss has actually occurred.
- A.96 Clause 12(3) makes clear that the insurer remains liable in respect of relevant events that took place before the date of the fraudulent act.
- A.97 For further discussion of this clause, see Chapter 23.

¹⁷ For example, see the test for fraud in *Derry v Peek* (1889) LR 14 App Cas 337.

Clause 13: Remedies for fraudulent claims: group insurance

- A.98 Group schemes are an important form of insurance. Many schemes are set up by employers to provide protection insurance for their employees. The policyholder is typically the employer, who arranges the scheme directly with the insurer. The group members (typically employees) have no specific status. As they are not policyholders, if a group member makes a fraudulent claim, the insurer's remedies are uncertain.
- A.99 This clause is intended to give the insurer a remedy against a fraudulent group member, while protecting the other members who are covered by the insurance.
- A.100 Clause 13(1) defines a group scheme to which this clause applies. It follows the definition in section 7 of CIDRA. It covers not only the typical employment scheme, but may also cover block building policies taken out by landlords for tenants, or buildings insurance taken out by landlords for long leaseholders. It is possible for group insurance to cover only one member, where (for example) a freeholder takes out insurance for a single leaseholder.
- A.101 To fall within the clause:
- (1) A policyholder (A) must take out a policy which is of direct benefit to a third party (C), rather than simply covering A's liability towards C.
 - (2) C must not be a party to the contract.
 - (3) It would have been a consumer insurance contract if C had taken out the cover directly.
 - (4) One of the Cs (CF) must make a fraudulent claim. (If A is fraudulent, clause 12 will apply as normal and the entire policy will be affected.)
- A.102 Clause 13(2) provides that the insurer has the same remedies against the fraudulent group member (CF) as it would have against a policyholder who makes a fraudulent claim. These remedies are set out in clause 12. This means that the insurer is not liable to pay the fraudulent claim. It may retain any premiums paid by, or on behalf of, CF. It may also treat CF's insurance cover as having been terminated at the time of the fraudulent act. To exercise this option, it must serve notice on both the policyholder A and CF.
- A.103 Importantly, the insurer may not treat its entire liability under the contract as terminated, but only its liability to CF. Clauses 13(2)(a) and (b) provide that the remedies are only exercisable against, and can only affect the rights of, that fraudulent member.
- A.104 The arrangements for payment of insurance monies under a group insurance contract differ. The insurer may either pay insurance monies to the policyholder, A (who would pass it on to the relevant group member) or may pay the group member directly. Clause 13(3)(a) provides that the insurer may reclaim any sums paid in respect of the fraudulent claim from either A or CF, depending on which of them is (or was last) in possession of the money.
- A.105 For further discussion of this clause, see paragraphs 23.63 to 23.86.

Clause 14: Implied term about payment

- A.106 Under the current law, the courts in England and Wales have found themselves unable to say that the insurer has an implied obligation to pay valid insurance claims within a reasonable time.¹⁸ Clause 14(1) implies this obligation into all contracts of insurance. In the interests of certainty, this applies also to Scotland. Because it is a contractual term which is created, breach of the term will give rise to the usual remedies for breach of contract, including damages.
- A.107 Clauses 14(2) and 14(3) make further provision about a “reasonable time”. Under clause 14(2), this will always include time to investigate and assess the claim. Clause 14(3) contains a non-exhaustive list of factors which might be relevant in considering whether the insurer has acted within a reasonable time.
- A.108 The type of insurance involved may be relevant because, for example, claims under business interruption policies usually take longer to value than claims for property damage. In terms of size and complexity, larger more complicated claims will usually take longer to assess than straightforward claims. A claim may be complicated by its location, for example: if an insured peril occurs abroad, it is possible that investigation will be more difficult.
- A.109 The reference to relevant statutory or regulatory rules or guidance might include, for example, rule 8 of the Financial Conduct Authority’s Insurance: Conduct of Business sourcebook (ICOBS), and paragraph 27 of Schedule 1 to the Consumer Protection from Unfair Trading Regulations 2008.
- A.110 A number of factors beyond the insurer’s control might delay payment. For example, investigations may be held up because the policyholder or a third party fails to provide relevant information in a timely manner. An insurer’s decision may also be dependent on the actions of another insurer. This may arise as a result of the interaction between business interruption and property insurance, or in the subscription market where a follower may be dependent on the lead insurer.
- A.111 Clause 14(4) gives the insurer a defence to a claim for breach of the implied term where it had reasonable grounds for disputing the validity or quantum of a claim. In such a case, more must be shown before an insurer who makes a reasonable but ultimately wrong refusal will be found to be in breach.
- A.112 Clause 14(4)(b) provides that the insurer’s conduct in handling the claim may be a relevant factor in deciding whether the term was breached and, if so, when. An insurer who has a reasonable basis for disputing a claim or at least conducting further investigations may still be in breach of the implied term if, for example, it conducts its investigation unreasonably slowly, or is slow to change its position when further information confirming the validity of the claim comes to light.
- A.113 Clause 14(5) preserves the distinction between claims for breach of the implied term in clause 14(1) and claims for (a) the substantive insurance claim and (b) interest, whether contractual, statutory or otherwise. Breach of the implied term must be argued and proven separately.
- A.114 For further discussion of this clause, see Chapter 28.

¹⁸ *Insurance Corporation of the Channel Islands Ltd v McHugh* [1997] LRLR 94. This is not the case in Scotland; see for example *Strachan v The Scottish Boatowners’ Mutual Insurance Association* 2010 SC 367.

PART 5: GOOD FAITH AND CONTRACTING OUT

Clause 15: Good faith

- A.115 Section 17 of the Marine Insurance Act 1906 provides that insurance contracts are contracts based upon the utmost good faith. It also provides that, “if the utmost good faith be not observed by either party, the contract may be avoided by the other party.” The common law mirrors this provision in relation to non-marine insurance.
- A.116 Clause 15 is intended to remove avoidance as a remedy for breach of good faith. Clause 15(1) abolishes any legal rule allowing a party to avoid an insurance contract where the other party has not acted in good faith. This addresses the common law. Clause 15(3)(a) removes the statutory reference to the remedy of avoidance from section 17 of the 1906 Act.
- A.117 Clauses 15(2) and 15(3)(b) provide that the common law good faith rule and section 17 of the 1906 Act are subject to the provisions of the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) and this Bill.
- A.118 Clause 15(4) repeals section 2(5) of CIDRA, which is superseded by the provisions of this clause.
- A.119 The intention of clause 15 is that good faith will remain an interpretative principle, with section 17 of the 1906 Act and the common law continuing to provide that insurance contracts are contracts of good faith.
- A.120 For further discussion of this clause, see paragraphs 30.16 to 30.24.

Clause 16: Contracting out: consumer insurance contracts

- A.121 This clause applies to all consumer insurance contracts.
- A.122 Clause 16(1) prevents insurers from contracting out of the provisions of the draft Bill to the detriment of the consumer. A policy term, or a term in any other contract, is rendered void to the extent that it would put the consumer in a worse position than the provisions in the draft Bill on:
- (1) Breach of warranty (clause 10);¹⁹
 - (2) Terms relevant to particular descriptions of loss (clause 11);
 - (3) Remedies for fraudulent claims (clause 12);
 - (4) Remedies for fraudulent claims: groups (clause 13); and
 - (5) Implied term about payment (clause 14).
- A.123 Clause 16(1) applies, not only to any term of a consumer insurance contract, but also to “any other contract”. This makes provision for situations where there may be a contracting out agreement that is separate from the insurance contract.
- A.124 Clause 16(2)(a) makes explicit that the restriction on contracting out also applies to variations to a consumer insurance contract.
- A.125 Clause 16(2)(b) applies to consumers who are beneficiaries of a group insurance contract caught by clause 13. The policyholder in this situation will usually be a non-consumer insured (such as an employer) and therefore the contract will usually be a non-consumer insurance contract. This is covered by clause 17(4) and discussed below. However, it is possible that a consumer may take out a policy for the benefit of other consumers who become group members. In this situation the contract would be a consumer contract. This is covered by clauses 16(1) and 16(2)(b). The effect of these provisions is that a term of such a contract which seeks to put the members of a group scheme in a worse position than they would be in under clause 13 is, to that extent, of no effect.
- A.126 Clause 16(3) states that clause 16 does not apply to contracts to settle claims. A settlement of a claim will therefore continue to provide certainty for the parties. It would not be possible for a consumer to go behind a settlement by alleging that it was less favourable than their entitlement under the draft Bill.
- A.127 For further discussion of this clause, see paragraphs 29.7 to 29.15.

Clause 17: Contracting out: non-consumer insurance contracts

- A.128 This clause applies to all non-consumer insurance contracts. It concerns the situations in which an insurer can use a term of the non-consumer insurance contract to put the insured in a worse position than it would be in under the default rules contained in the draft Bill.

¹⁹ Clause 9 does not apply to consumer insurance contracts; an equivalent provision for consumer insurance contracts appears at section 6 of CIDRA.

- A.129 Clause 17(3) provides that, generally speaking, parties can agree to contract terms which are less favourable to the insured than provisions of the draft Bill. Such terms may appear in the insurance contract itself or any separate contract. However, such terms will only be valid if the insurer has complied with the “transparency requirements”, contained in clause 18 and discussed below.
- A.130 There are only two situations in which the insurer cannot contract out to the detriment of the insured. These are set out in clauses 17(1) and 17(2). They are:
- (1) the prohibition on “basis of the contract” and similar provisions, in clause 9; and
 - (2) deliberate or reckless breaches of the insurer’s duty, contained in clause 14(1), to pay claims within a reasonable time. Clause 17(5) defines “deliberate or reckless” in this context.
- A.131 Clause 17(4) addresses the situation in which a non-consumer policyholder, such as an employer, takes out a group insurance policy for the benefit of members who are consumers. The contract is a non-consumer insurance contract but the real beneficiaries are consumers and should be protected from contracting out as they are under clause 16. Clause 17(4) therefore provides that an attempt to put the consumer members in a worse position than they would be in under the provisions in the draft Bill on fraudulent claims in group insurance (contained in clause 13) is to that extent of no effect.
- A.132 Clauses 17(6) and 17(7) repeat clauses 16(2)(a) and 16(3) but for non-consumer insurance. Clause 17(6) makes explicit that the provisions on contracting out also apply to variations to a non-consumer insurance contract. Clause 17(7) states that clause 17 does not apply to contracts to settle claims. A settlement of a claim will therefore continue to provide certainty for the parties. It would not be possible for an insured to go behind a settlement by alleging that it was less favourable than their entitlement under the draft Bill.
- A.133 For further discussion of this clause, see paragraphs 29.16 to 29.59.

Clause 18: The transparency requirements

- A.134 As discussed above, clause 17(1) provides that a contractual term which puts the non-consumer insured in a worse position than it would be in under the terms of the draft Bill is of no effect unless the requirements of clause 18 are satisfied. Such a term is referred to in clause 18(1) as a “disadvantageous term”.
- A.135 The clause 18 conditions (the “transparency requirements”) are set out in clauses 18(2) and 18(3).
- A.136 The requirement, in clause 18(2), that the insurer take sufficient steps to draw the term to the insured’s attention is intended to ensure that the insured is given a reasonable opportunity to know that the disadvantageous term exists before it enters into the contract.
- A.137 Under the general law of agency, this requirement could also be satisfied by taking sufficient steps to draw the term to the attention of the insured’s agent. If the insured (or its agent) has actual knowledge of the disadvantageous term, clause 18(5) makes clear that an insured may not claim that the insurer has failed to draw the term sufficiently to its attention.

- A.138 The requirement should be interpreted flexibly to take account of the full range of participants in the insurance market. This is implied by the phrase “sufficient steps” in clause 18(2).
- A.139 In addition, clause 18(4) makes explicit that in determining whether the transparency requirements have been met, the characteristics of insured persons of the kind in question should be taken into account, as should the circumstances of the transaction. What is sufficient for one type of insured may not be sufficient for another. It is intended that the extent to which a term should be brought to the attention of a policyholder could vary considerably depending on whether the policyholder is, for example, a sole trader buying standardised retail public liability insurance or a charterer purchasing a voyage policy at Lloyd’s using a broker.
- A.140 Under clause 18(3), the term must also be clear and unambiguous as to its effect. This is intended to require the *consequences* of the disadvantageous term to be clear and unambiguous. For example, it would not normally be sufficient to say that “section 14 of the Insurance Contracts Act 20XX does not apply to this contract”, despite the fact that this is clear and unambiguous in itself. Rather, an insurer wishing to contract out of the requirement to pay sums due within a reasonable time might have to say that “Section 14 of the Insurance Contracts Act 20XX does not apply to this contract, meaning that we shall have no liability to you in respect of any loss or damage suffered by you as a result of our failure to pay sums due to you under this contract within a reasonable time”.
- A.141 Again, how far the term has to spell out the consequences will depend on the nature of the insured party and the extent to which it could be expected to understand the consequences of the provision.
- A.142 For further discussion of this clause, see paragraphs 29.33 to 29.51 and 29.60 to 29.67.

PART 6: GENERAL

Clause 19: provision consequential on Part 2

A.143 This clause affects:

- (1) the Marine Insurance Act 1906, sections 18, 19 and 20;
- (2) the Road Traffic Act 1988, section 152; and
- (3) the Consumer Insurance (Disclosure and Representations) Act 2012, section 11.

Marine Insurance Act 1906, sections 18, 19 and 20

A.144 Part 2 of the draft Bill now provides the content of the duty imposed on the non-consumer insured in the pre-contractual phase of the relationship between insurer and insured. Clause 19(2) therefore omits sections 18 to 20 of the 1906 Act, which currently govern the pre-contractual relationship between insured and insurer. Clause 19(3) abolishes any rule of law to the same effect as those provisions.

A.145 The combined effect of the relevant provisions of the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) and of this draft Bill is to replace sections 18, 19 and 20 of the Marine Insurance Act 1906.

Road Traffic Act 1988, section 152

A.146 The Road Traffic Act 1988 (RTA 1988) provides for a scheme of compulsory motor insurance. Motor insurers generally have an obligation to satisfy judgments obtained by third parties, even if the insured has breached the insurance contract. There is a limited exception in section 152(2) of the RTA 1988, by which an insurer may obtain a declaration that it is entitled to avoid a policy because the insured has made a non-disclosure or misrepresentation. However, the effect of this section is much more limited than first appears. Under an agreement between the Motor Insurance Bureau and the Government, insurers have undertaken to ensure that the third party is compensated.

A.147 Section 11(3) of CIDRA amended section 152(2), so that an insurer is only entitled to avoid a consumer insurance policy under section 152(2) if it may avoid the policy under the provisions of CIDRA.

A.148 Clauses 19(4), 19(5), 19(6) and 19(7) further amend section 152, so that an insurer is only entitled to avoid a non-consumer insurance policy under section 152(2) if it may avoid the policy under Part 2 of this draft Bill.

A.149 For further discussion, see paragraphs 31.5 to 31.15.

Consumer Insurance (Disclosure and Representations) Act 2012

A.150 As a result of the amendments to the 1906 Act and the RTA 1988 set out in clause 19, sections 11(1) and 11(2) of CIDRA, which deal with the points in relation to consumer insurance, are now superseded and are omitted.

Clause 20: Short title, commencement, application and extent

- A.151 Under clause 20(2), the lead-in time for the coming into force of the Act (once passed) is 18 months, to enable insurers to prepare for the new regime.
- A.152 Clauses 20(3) and (4) set out which insurance contracts and variations the Act will apply to once it is in force.
- A.153 The draft Bill extends to England and Wales and to Scotland (clause 20(5)). Neither the Law Commission nor the Scottish Law Commission has the requisite mandate to make recommendations or draft legislation to cover Northern Ireland, the Channel Islands or any other jurisdiction.

SCHEDULE: INSURERS' REMEDIES FOR QUALIFYING BREACHES

Part 1: Contracts

- A.154 Part 1 of the Schedule sets out the remedies available for qualifying breaches of the duty of fair presentation made before the contract is entered into. This would include breaches of that duty in relation to renewals.

Deliberate or reckless breaches

- A.155 Paragraph 2 specifies the remedies for qualifying breaches that are deliberate or reckless, as defined in clause 8. Under paragraph 2(a), the insurer is entitled to avoid the contract. Under paragraph 2(b), the insurer may keep the premiums paid.

Other breaches

- A.156 If the breach of the duty of fair presentation was not deliberate or reckless, the remedy is based on what the insured would have done if the insured had not made the qualifying breach; that is, if the insured had made a fair presentation of the risk. The remedies are as follows:

- (1) Where an insurer would have declined the risk altogether, the policy may be avoided, the claim refused and the premiums returned (paragraph 4).
- (2) Where the insurer would have contracted on different terms (except for those relating to the premium), those terms are applied to the claim. Thus if the insurer would have excluded a particular type of claim, the insurer should not be obliged to pay claims that would fall within the exclusion. Similarly, if an insurer would have imposed a warranty or excess, the claim should be treated as if the policy included the warranty or excess (paragraph 5).
- (3) Where an insurer would have increased the premium, the claim should be reduced proportionately to the under-payment of premium. For example, if an insurer only charged £10,000 but should have charged £15,000, the insured would receive two thirds of the claim (paragraph 6).

In some cases, both paragraphs 5 and 6 will apply: if the insurer would have entered the contract on different terms (other than terms relating to the premium) and would have charged a higher premium, the different terms may apply to the claim and, in addition, the claim may be reduced proportionately.

- A.157 These issues are discussed in the Report, in paragraphs 11.35 to 11.96.

Part 2: Variations

- A.158 Part 2 of the Schedule sets out the remedies available for qualifying breaches of the duty of fair presentation made when an insurance contract is being varied. Variations are discussed at paragraphs 11.97 to 11.104.

Deliberate or reckless breaches

- A.159 Paragraph 8 specifies the remedies for qualifying breaches that are deliberate or reckless in the context of variations. Under paragraph 8(a), the insurer is entitled to treat the contract as having been terminated with effect from the time the variation was made. Under paragraph 8(b), the insurer may keep the premiums paid.

Other breaches

- A.160 If the breach of the duty of fair presentation was not deliberate or reckless, the remedy is based on what the insurer would have done had the insured made a fair presentation of the additional or changed risk on variation.
- A.161 In some cases, the draft Bill makes a distinction between variations involving a reduction in premium (paragraph 10), and all other variations (that is, where the premium was increased, or not changed, as a result of the variation) (paragraph 9). This is intended to reflect the fact that, where the overall premium is reduced, the overall bargain between the parties is affected. The variation therefore goes to the heart of the insurance policy.
- A.162 In either case, if the insurer would not have agreed to the variation on any terms, the insurer may treat the contract as if the variation was never made. If the premium was increased, the insurer must return the additional premium paid for the variation (paragraph 9(2)). If the premium was reduced, the insurer may pay a proportionate reduction of claims after the variation (paragraphs 10(2) and 11).
- A.163 Again, in either case, if the insurer would have included additional terms relating to the variation (for example a warranty relating to the new risk), the insurer may treat the variation as if it contained those terms (paragraphs 9(3)(a) and 10(3)(a)).
- A.164 If the insurer would have charged a different premium for the variation, or would not have changed the premium when in fact it has increased or reduced it, any claims arising after the variation may be reduced in proportion to the premium that the insurer would have charged (paragraphs 9(3)(b) and 10(3)(b)). Paragraph 11(3) makes further provision about the formula, depending on whether the insurer increased or reduced the premium or did not change it.
- A.165 Examples of how these provisions operate are given in Appendix B.

Part 3: Supplementary

- A.166 Section 84 of the Marine Insurance Act 1906 sets out an insurer's duties to return premiums. Section 84(3)(a) states that where the policy is avoided by the insurer from the commencement of the risk, the premium is returnable, provided that there has been no fraud or illegality on the part of the assured. Under paragraph 12, this is to be read subject to the provisions of the Schedule, which allows the insurer to retain premiums in some cases.

APPENDIX B

PROPORTIONATE REMEDIES ON VARIATIONS

INTRODUCTION

- B.1 Under the current law, when a policyholder seeks to vary a contract of insurance, only information relating to the variation must be disclosed; there is no requirement to disclose information relating to the rest of the original policy.¹
- B.2 When considering a change to an insurance policy, the court must determine whether it is a variation or whether it “amounts in law to the discharge of the original insurance and its replacement by a new contract”.² The answer depends on the intention of the parties as deduced from the new terms, supplemented by an objective view of the nature of the change.³ If the alteration actually discharges the original contract then the insured is subject to the pre-contractual duties in relation to disclosure and representations. The current remedy for breach is avoidance of the whole new contract.⁴ If the alteration is a variation, then the remedy at present is avoidance of the variation.⁵
- B.3 The insurer’s remedy for a non-disclosure or misrepresentation by the insured in relation to a variation of the policy is currently given by section 17 of the Marine Insurance Act 1906 (the 1906 Act). The courts have interpreted this as an entitlement to avoid the variation itself. That is, the insurer is entitled “to avoid the agreement by which the policy was amended, not the entire contract”.⁶ The language of “avoiding the variation” arises from the courts’ manipulation of section 17 to achieve this result.
- B.4 In Chapter 7, we recommend that the duty of fair presentation should apply to variations. Clause 2(2) of the draft Bill requires the insured to make a fair presentation of the changes in the risk “relevant to the proposed variation”. As under the current law, we recommend that an insurer’s remedy for a breach of the duty of fair presentation under the new regime should generally only affect the variation and not the entire contract. Further, in line with our general policy regarding breaches of the duty of fair presentation, we recommend in Chapter 11 that the single remedy of avoidance (of the variation) should be dispensed with in favour of a scheme of proportionate remedies. We took a similar approach in the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA).
- B.5 In this Appendix we consider how proportionate remedies should apply to a breach of the duty of fair presentation in the context of a variation.

¹ We also discuss this at para 4.11 and from para 11.97.

² *MacGillivray on Insurance Law* (12th ed 2012) at para 17-026.

³ *MacGillivray*, above, citing *Kensington v Inglis* (1807) 8 East 273; *Royal Exchange Assurance Co v Hope* [1928] 1 Ch 179; *Cornhill Insurance Co v L&B Assenheim* (1937) 58 Lloyd’s Rep 27 at 29.

⁴ See, for example, *Cornhill Insurance Co v L&B Assenheim* (1937) 58 Lloyd’s Rep 27.

⁵ See, for example, *Limit No 2 v Axa* [2008] EWCA Civ 1231.

⁶ *MacGillivray on Insurance Law* (12th ed 2012) at para 17-026.

DELIBERATE AND RECKLESS BREACHES

- B.6 As for other breaches of the duty of fair presentation, we make a distinction between deliberate or reckless breaches of the duty of fair presentation upon variation, and all other breaches. We discussed the definition of deliberate or reckless in this context in Chapter 11.⁷

Remedies for breach

- B.7 Where there has been a deliberate or reckless breach in the context of a variation, we recommend that the insurer should be entitled to treat the contract as having been terminated from the time when the variation was made and retain premiums already paid.⁸
- B.8 This will protect rights accrued under the original unamended contract, before the deliberate or reckless behaviour.

Example

- B.9 An insured has buildings insurance for several licensed premises. The insurer agrees to extend the policy to cover a further establishment, for an additional premium of £8,000. However, when presenting the risk in relation to the new premises, the insured deliberately misrepresents the extent of the fire safety arrangements at the premises.
- B.10 The insurer can, at its option, treat the contract as having been terminated at the point of the variation, retaining the original premium and the additional £8,000. Any claims which have been paid, or rights which have accrued (even if a claim has not been made), under the contract before the variation was made will not be affected.

BREACHES WHICH ARE NOT DELIBERATE OR RECKLESS

- B.11 We make a distinction between variations involving a reduction in premium, and all other variations. As we recognised when working on CIDRA, where a variation has had the effect of reducing the overall premium charged for the policy, this affects the overall bargain between the parties. In such situations, the variation goes to the heart of the insurance policy because the overall bargain of the parties has been changed. The insured has benefitted from an overall reduction in the cost of their insurance while the insurer has potentially been exposed to additional risk. It would under-compensate the insurer to simply “unravel” the variation.

Remedies for breach of the duty of fair presentation on a variation which did not change the premium or which increased the premium

- B.12 Where an insured has breached the duty of fair presentation in the context of a variation which did not affect the premium or which resulted in an increase in premium, we recommend a scheme of proportionate remedies similar to those for new contracts.

⁷ From para 11.41. See also draft Bill, clause 8(5).

⁸ See draft Bill, Schedule Part 2, para 8.

B.13 To illustrate them, we use the following example:

X LLP, an engineering consultant, buys professional indemnity insurance at a premium of £2 million. During the term of its policy it acquires a small consultancy firm of 5 people (Z and partners), which it subsumes into its business. X's insurer agrees to vary the policy to cover accrued liabilities of the firm for an additional premium of £200,000.

Where the insurer would not have agreed the variation on any terms

B.14 If the insurer would not have agreed to the variation on any terms had it received a fair presentation, the insurer is entitled to treat the contract as if the variation had never been made. The insurer must, however, return any extra premium paid for the variation (but not for the original policy).⁹

EXAMPLE 1

X LLP unintentionally failed to disclose that Z has undertaken a small amount of work in the oil and gas industry (X is not insured for this type of work). If this had been disclosed, the insurer would not have agreed to underwrite Z's liabilities because it does not underwrite risks in the oil and gas industry.

The insurer is therefore entitled to treat the contract as if the variation was never made, under Part 2 of the Schedule, paragraph 9(2). It must return the additional £200,000.

A client brings a claim against X on one of its own previous projects, and X is found to have acted negligently. Because only the variation (and therefore the cover for Z's liabilities) is "avoided", the contract remains in force on its original terms. The insurer's liability for claims relating to X's projects (whether relating to events before or after the variation) will be determined in accordance with the terms of the original policy.

Where the insurer would have agreed to the variation on different non-premium terms

B.15 If the insurer would have agreed to the variation on different non-premium terms, the insurer may treat the variation as having been made on those terms.¹⁰

EXAMPLE 2

As in Example 1 above, X fails to disclose the oil and gas element of Z's work. Rather than saying it would not have agreed to the variation, the insurer says it would have agreed to underwrite Z's accrued liabilities (including any in relation to oil and gas) but not any future oil and gas liabilities. It would therefore have included a term excluding all liability for future oil and gas work performed by X (including by the previous members of Z).

⁹ See draft Bill, Schedule Part 2, para 9(2).

¹⁰ See draft Bill, Schedule Part 2, para 9(3)(a).

The insurer can elect to treat the variation as if that exclusion clause had been included. Therefore, if X has taken on any new oil and gas work after the date of the variation, that would not be covered by the insurance. It is not open to X to argue that it would not have taken on any oil and gas work if it had known about the exclusion clause, or that it would have transferred its insurance to a different provider in order to obtain cover for such works.

Where the insurer would have charged an increased premium

- B.16 If the insurer would have charged a higher premium for the variation (or, where it did not increase the premium, it would have done so), the insurer may apply a proportionate reduction to claims arising out of events after the variation.¹¹ The reduction will be made in accordance with the following formula, so that the insurer must pay Y% of the value of a claims where:

$$Y = \frac{\text{Total premium actually charged}}{P} \times 100$$

If the insurer would have charged a higher premium for the variation (or, where it did not increase the premium, would have done so), P is the total premium it would have charged.¹²

EXAMPLE 3

X failed to disclose a previous negligence action against Z which resulted in a settlement. Had it known, the insurer would have agreed to the variation to underwrite Z's liabilities, but would have charged an additional £500,000 rather than £200,000.

The insurer can apply a proportionate reduction to all claims arising out of events after the variation. On such claims, the insurer should pay $(2,200,000/2,500,000) \times 100 = 88\%$ of the value of each claim.

Remedies for breach of the duty of fair presentation on a variation which resulted in a reduction in the premium

- B.17 Where an insured has breached the duty of fair presentation in the context of a variation which resulted in the premium being *reduced*, we recommend a separate scheme of remedies which recognise that the overall bargain between the parties has been changed.
- B.18 Again, to illustrate them, we use a single example:

Policyholder B has products liability insurance, for which it pays £20,000. B negotiates with the insurer to reduce the premium in exchange for increasing its excess from £1,000 to £5,000 for each claim. It negligently (but not deliberately) produces incorrect evidence that 50% of its past claims have been for between £1,000 and £5,000, so that this change means substantially less liability for the insurer overall. The insurer agrees to reduce the premium by £4,000 as a result of this unfair presentation, so that the new premium is £16,000.

¹¹ See draft Bill, Schedule Part 2, para 9(3)(b) and para 11.

¹² See draft Bill, Schedule Part 2, para 11(3)(a).

Where the insurer would not have agreed the variation on any terms

- B.19 If the insurer would not have agreed to the variation on any terms, the insurer is entitled to treat the contract as if the variation had never been made *and* may apply a proportionate reduction to any claim in accordance with the paragraph 11 formula.¹³ Because the insurer has been on risk while being under-remunerated, simply “unravelling” the variation is insufficient compensation.
- B.20 In this case, “P” in the paragraph 11 formula is the original premium, which is what the insurer would have continued to charge.¹⁴

EXAMPLE 4

If it had received a fair presentation so that it understood the extent of its risk, the insurer would not have agreed to the variation (that is, it would not have reduced the premium or increased the excess). We recommend that:

- (1) The contract continues on original non-premium terms, with the original excess of £1,000; and
- (2) The insurer can apply a proportionate reduction to claims relating to events after the variation, based on the original premium. The insurer pays $(16,000/20,000) \times 100 = 80\%$ of any claim.

Where the insured would have agreed to the variation on different non-premium terms

- B.21 If the insurer would have agreed to the variation on different non-premium terms, the insurer may treat the variation as having been made on those terms.¹⁵

EXAMPLE 5

The insurer would still have reduced the premium to £16,000, but would have increased the excess to £8,000 instead of £5,000. The contract would proceed as if the new increased excess of £8,000 had applied from the time the variation was entered into.

Where the insurer would have charged a different premium

- B.22 If the insurer would have charged a higher premium for the variation, would not have reduced the premium or would have reduced it by a lesser amount, the insurer may reduce the amount paid for any claim in accordance with the paragraph 11 formula.¹⁶
- B.23 “P” will vary depending on what the insurer would have done, as illustrated below.

¹³ See draft Bill, Schedule Part 2, paras 10(2) and 11.

¹⁴ See draft Bill, Schedule Part 2, para 11(3)(b).

¹⁵ See draft Bill, Schedule Part 2, para 10(3)(a).

¹⁶ See draft Bill, Schedule Part 2, paras 10(3)(b) and 11.

EXAMPLE 6

The insurer would still have agreed to increase the excess to £5,000, but would only have reduced the premium by £2,000 (to £18,000). That is, it would have reduced the premium by a lesser amount.

“P” is the total (reduced) premium the insurer would have charged.¹⁷ The insurer pays $(16,000/18,000)*100 = 88.9\%$ of any claim, after the first £5,000. Nothing is paid below £5,000 because the new excess applies.

EXAMPLE 7

The insurer argues that it would have agreed to increase the excess to £5,000 as requested, and *increased* the premium. The insurer cannot use the variation to escape an original bad bargain. The most it should generally be able to claim it would have charged, where there is no overall increase in the risk, is the original premium so that P is the original premium. The insurer pays $(16,000/20,000)*100 = 80\%$ of the value of each claim.

EXAMPLE 8

We think the insurer would only be able to show that it would have *increased*, rather than reduced, the premium in very rare cases. We think the insurer would have had to show that the variation had resulted in an *increase in the risk*, which the insurer did not know about because of the breach of the duty of fair presentation. In that rare case, P would be the increased premium.¹⁸

¹⁷ See draft Bill, Schedule Part 2, para 11(3)(c).

¹⁸ See draft Bill, Schedule Part 2, para 11(3)(c).

APPENDIX C

LIST OF CONSULTEES

RESPONDENTS TO CONSULTATION PAPER 2

Association of British Insurers (ABI)
ACE
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Professor John Birds
British Insurance Brokers' Association (BIBA)
British Insurance Law Association (BILA)
British Vehicle Rental & Leasing Association
Browne Jacobson LLP
BTO Solicitors
Richard Buttle
CIFAS
City of London Law Society Insurance Law Committee
Professor Malcolm Clarke
Covington & Burling LLP
DAC Beachcroft LLP
Direct Line Group (formerly RBS)
Faculty of Advocates
Financial Ombudsman Service (FOS)
Financial Services Authority (FSA)
Financial Services Consumer Panel
Mrs Justice Gloster DBE, Mr Justice Burton, Mr Justice Beatson,
Mr Justice Christopher Clarke, Mr Justice Flaux and
Mr Justice Popplewell
Group Risk Development (GRiD)
Hannover Life Reassurance (UK) Limited (Hannover Life Re)
Investment and Life Assurance Group (ILAG)
International Underwriting Association (IUA)
Judges of the Court of Session
Keoghs LLP
K&L Gates LLP
The Law Reform Committee of the Bar Council of England and Wales
The Law Society of Scotland
Dr Kate Lewins
Geoffrey Lloyd
Lloyd's Market Association (LMA)
London & International Insurance Brokers Association (LIIBA)
Marsh Ltd
Miller Insurance Services Limited
Munich Re United Kingdom Life Branch
NFU Mutual Insurance Society Ltd
Newman Martin and Buchan LLP (NMB)
Norton Rose LLP
QBE European Operations (QBE)
RGA UK
The Right Honourable Lord Justice Longmore
Royal & Sun Alliance Insurance plc (RSA)
Dr Caroline Sijbrandij
Naomi Talisman

David Turner QC
Mark Wibberley
Zurich Financial Services (Zurich)
Two confidential responses

We are also very grateful for the helpful articles submitted by Gerald Swaby.

RESPONDENTS TO CONSULTATION PAPER 3

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Allen & Overy LLP
ABI
AXA Corporate Solutions Assurance, UK Branch
The Bar Council
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Berrymans Lace Mawer LLP
Professor John Birds
BIBA
BILA
British Property Federation
Browne Jacobson LLP
Catlin Underwriting Agencies UK Ltd, Catlin Insurance Company (UK) Ltd
Chartered Insurance Institute (CII)
Chartis Europe Limited
Mr Philippe Chennaux
Claims Against Professionals (CAP)
Direct Line Group
Faculty of Advocates
FOS
Forum of Insurance Lawyers (FOIL)
Mr Steve Goodacre
Group Risk Development (GRiD)
Mr John Habergham, Myton Law Ltd
Mr David Hunter
IUA
Investment & Life Assurance Group (ILAG)
Judges of the Court of Session
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Law Society of Scotland
Mr Geoffrey H. Lloyd
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London & International Insurance Brokers' Association (LIIBA)
Mactavish
Marsh Limited
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NFU Mutual Insurance Society Ltd
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RWA Group
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Ms Heather Thomas

Zurich Insurance Group
Two confidential responses

RESPONDENTS TO LIMITED CONSULTATION ON THE DRAFT BILL

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FJM Wakefield
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Griffin Managers
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