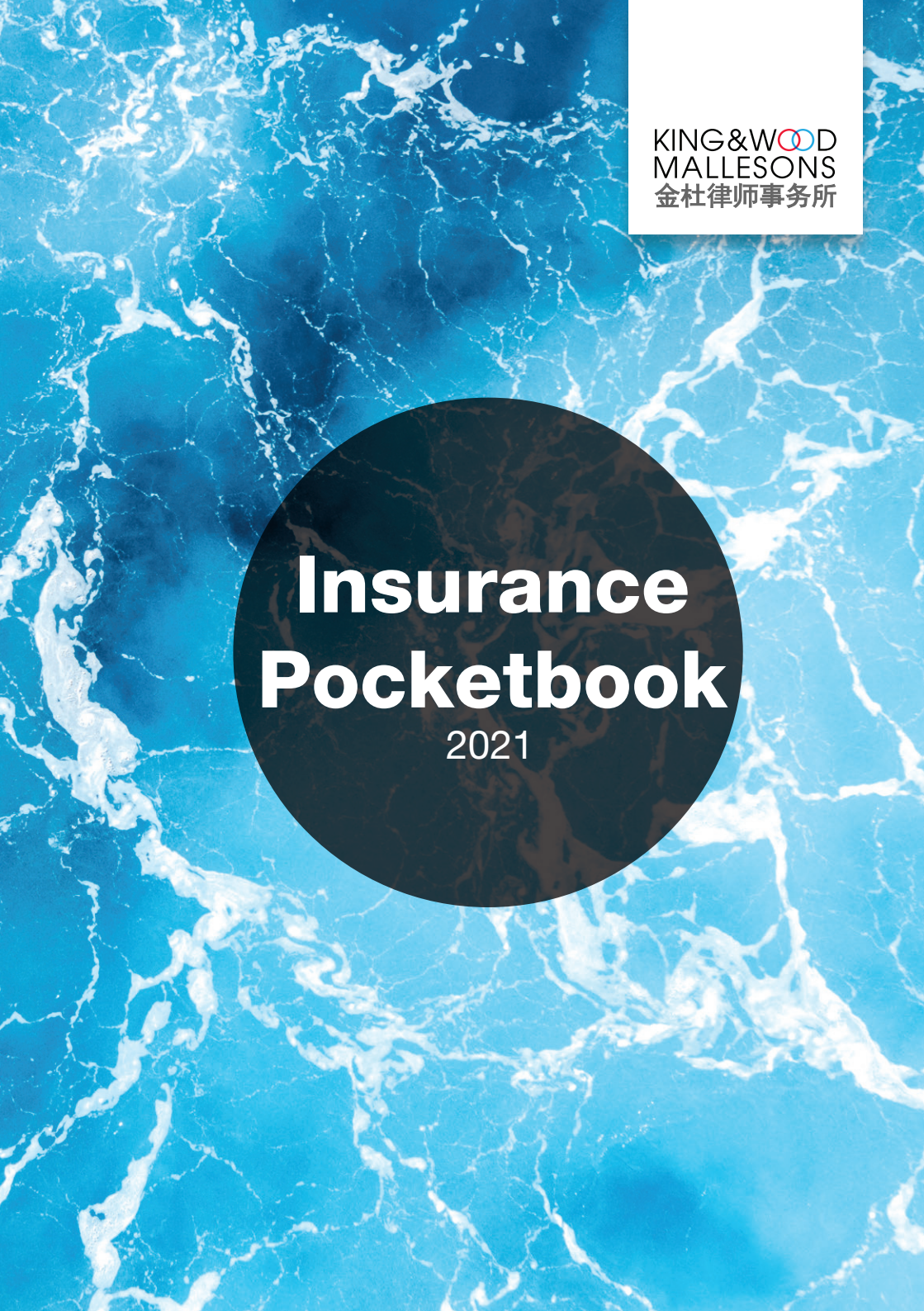
KING&WOOD
MALLESONS
金杜律师事务所
Insurance
Pocketbook
2021

Foreword

We are delighted to bring you the KWM insurance team's inaugural *Insurance Pocketbook*. We have not seen enough of each other (or you) this year, but we are excited to be able to share with you this publication. Inside you will find editorials from our team, articles on legislative reform and industry trends, and summaries of significant cases from the last year.

The insurance team at King & Wood Mallesons has broad experience and deep market insight. The inspiration for the *Insurance Pocketbook* was to improve the way we share our knowledge and experience with our clients, as well as with industry stakeholders. Our intention is to publish the *Insurance Pocketbook* on an annual basis.

The last year (2020) was a difficult year for all market participants. We anticipate that 2021 will also be a challenging year with new legislation and regulation coming into force, the possibility of further reform (including in the class action space) not to mention continued economic uncertainty both in Australia and the Asia-Pacific region, as the world continues to struggle with its COVID-19 responses and recovery plans.

Notwithstanding the challenges of the past year, industry engagement and the body of case law related to insurance in Australia continues to grow.

We encourage you to read on today, download a copy for a friend, and look out for future editions.

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Contents

2021: Regulation in the insurance industry

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Reputational challenges

The last few years have seen the insurance industry subjected to an unprecedented level of scrutiny from the Australian government and the wider community. In particular, insurers have had to meet the twin challenges of addressing the concerns raised by the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (**Royal Commission**) while also seeking to maintain their reputations (and financial standing) and in turn, the confidence of the Australian public.

In addition, there has been a notable increase in the number of regulatory investigations and other enforcement actions undertaken by the industry's regulators – some directly triggered by the Royal Commission, but many not. At the same time, the number of class actions being pursued by litigation funders and Australia's class action law firms has increased, leaving insurers increasingly exposed across various sectors.

Of course, in reflecting on the developments in the insurance industry over the last few years it is impossible not to mention COVID-19. As a result of the pandemic, the insurance industry has faced one of the largest claim events in history, with business interruption insurance coming under the spotlight across the world both in and out of Court.

Significant legislative reform

2020 saw the industry grapple with the legal, compliance and financial implications of a raft of legislative changes. The majority of these legislative changes arose as a result of the Royal Commission and were ushered into force in December.

Key reforms, including the expansion of the unfair contract terms regime to insurance contracts and the introduction of amendments to make insurance claims handling a financial service, are discussed in further detail in our article on page 19.

Attracting industry talent in an uncertain environment

In light of these developments, the need for companies to attract and retain talented decision-makers has never been more important. And yet, prevailing market conditions are making it increasingly difficult for companies to retain experienced directors and executive officers.

Key to the difficulties faced by institutions in seeking to entice appropriate candidates for leadership roles is the rapidly hardening state of Australia's directors' and officers' (**D&O**) insurance market. Indeed, such is the state of the market that Marsh described 2020 as a "watershed year" and noted that in their view, without government intervention the "Australian corporate environment would be at risk of losing its willingness to be entrepreneurial and would be unable to attract quality directors and officers for fear of exposure to personal liabilities without adequate D&O protection".[1]

During the course of the first quarter of 2020 alone, D&O premiums rose by an average of 225%, with some premiums rising by as much as 400% - 500% for the biggest ASX listed companies which are perhaps most exposed to securities class actions.[2] Increases are expected to continue, with the third quarter in 2020 proving to be the 13th consecutive quarter of double-digit increases.[3] This environment is particularly challenging for smaller listed entities, which are often caught between being unable to afford the cost of securities claim cover whilst also potentially lacking the balance sheet strength to fund a class action should it arise.

Unfortunately, the increasingly prohibitive premium rates do not reflect a corresponding expansion in the cover being afforded by D&O insurance policies – quite the opposite. In return for the payment of higher premiums, institutions are finding that the cover provided under their D&O insurance policies is drastically decreasing (whether by reason of high retentions, low limits of indemnity, narrower cover, policy exclusions or otherwise). In fact, a number of key insurers have left the D&O market entirely. Towards the end of last year, it was estimated by AON that on an aggregated basis, roughly $100 million of capacity had exited the market in 2020.[4]

This, together in particular with the perception that companies that hold cover for securities claims potentially make themselves a target for such claims, has placed some directors in the difficult position of needing to determine whether it is in the company's best interests to maintain D&O cover for securities claims (that is, what is traditionally referred to as "Side C" cover) and if so, on what terms. For some companies, these considerations are also becoming relevant to any reimbursement (or "Side B") cover that the company may hold under its D&O policy.

These developments have coincided with calls to place additional liability upon individuals and corporates within the insurance industry and to strip away certain protections which have been afforded to those persons in the past. Of particular note is the already passed and further proposed legislation to either prohibit a company from paying the premium for a D&O insurance policy which covers certain breaches (such as the Banking Executive Accountability Regime and the Financial Accountability Regime) or otherwise prohibit the provision of insurance cover altogether (for example, the recent prohibitions on the provision of insurance cover for penalties for breaches of the *Work Health and Safety Act 2011* (NSW) and the *Work Health and Safety Act 2020* (WA)).

Where to from here?

Consideration of the developments in the insurance industry over the last few years may paint a grim picture. However, it is not all bad news.

The Royal Commission has seen the insurance industry rise to the challenge of ensuring that consumer interests are central to its products and services. This has been facilitated by the industry's willingness and efforts to implement the legislative changes which have been introduced over the last year.

The difficulties in the D&O and professional indemnity insurance markets have also given rise to an increased interest in the creative use of alternative risk allocation methods. For example, in the last year KWM has seen corporates take a particular interest in the use of overseas captive arrangements (whereby a company can insure a risk through an overseas entity, which in turn cedes that risk to the reinsurance market) as an alternative solution for the maintenance of appropriate insurance cover for securities claims and professional indemnity risks.

There is no doubt that these are interesting times for Australia's insurance industry, but we look forward to working with the industry over the coming year as it continues to meet these challenges head-on. With Australia's history of finding innovative solutions to problems, we very much expect to see plenty of creativity in this particular part of the insurance market.

Life insurance in 2021

Sarah Yu, *Partner, King & Wood Mallesons* draws on her deep experience to provide some insight into 2021.

Product design

As a result of the unfair contract terms **(UCT)** legislation commencing on 5 April 2021 and the design and distribution obligations **(DDO)** commencing on 5 October 2021, fundamental changes will have to be made to the design of life insurance products in 2021. In addition, ASIC has indicated that it will be actively monitoring the design and distribution of life insurance products and in particular TPD insurance following Report 633 Holes in the safety net: A review of TPD insurance claims.

Unfair contract terms

Some of the key issues that will have to be addressed include:

- Determining what is excluded from the UCT regime as it is **the "main subject matter" of the policy.** The Explanatory Memorandum to the amending legislation suggests that the main subject matter for a life insurance policy is the description of the life insured and the sum insured. This position seems inappropriately narrow in light of the recommendation by the Royal

Commission into Misconduct in the Banking, Superannuation and Financial Services Industry that the main subject matter is the extent to which an insurance policy describes what is being insured. If a narrow interpretation is accepted by the Courts, this will result in terms that determine the scope of the cover (e.g. the definition of the insured event), the period of the cover (e.g. when the cover ceases) and the extent of the cover (e.g. jurisdictional limitations) will be caught.

- Determining **what terms are unfair** and amending those terms to remove that unfairness. This test depends on whether the term causes significant imbalance to the parties rights, it is not reasonably necessary to protect legitimate interests and would cause detriment. For life insurance this is likely to turn on whether the term is reasonably necessary to protect the insurer's legitimate interests and, as the onus of proof is reversed, whether the life insurer can prove this. The Explanatory Memorandum to the amending legislation provides some examples of terms that are reasonably necessary to protect the insurer's legitimate interests, being a term that allows a life insurer to unilaterally increase premiums (in accordance with section 9A of the *Life Insurance Act 1995* (Cth)), a term that is required for the life insurer to obtain reinsurance or a term that appropriately reflect the underwriting risk accepted by the insurer.
- **Whether guaranteed renewable policies are renewed for the purpose of the UCT regime** on or after 5 April 2021 and therefore brought within the UCT regime. We consider that generally there are strong arguments that merely because a life insurance policy is guaranteed renewable does not mean that it is renewed for the purpose of the UCT regime.
- The **disclosure of terms to policy owners** as the extent to which a term is transparent will impact an assessment of whether a term is unfair.

One of the significant ongoing challenges for life insurers will be responding to views of regulators and AFCA about the terms that they consider are unfair and ultimate to decisions of the Courts.

Design and distribution obligations

Due to the scope of these obligations, DDO will be a significant compliance project for life insurers in 2021 that will impact product design, distribution, operations, IT and governance. Some of the key issues for life insurers are:

- **How to design the target market determination (TMD)** for the insurer's retail products.
  - There is no restriction on a single document containing TMDs for multiple products. Having a separate TMD for each product may be unworkable for some insurers with multiple on sale products.
  - The target market stated in the TMD will need to be carefully crafted because an insurer will not want to inappropriately limit its market. However, ASIC considers that if it is not stated with sufficient granularity the insurer will breach its TMD obligations.
  - Although a TMD applies to each product, ASIC consider that sometimes "multiple product attributes will constitute separate products" even if they are sold as a package.
  - The impact of customisable options of a life insurance policy on the TMD.
- The **data** that the insurer will use to monitor and review the outcomes produced by the design and distribution of its financial products and consider whether changes are required to the product, to the way it is sold or to whom it is being sold (e.g. claims ratios, policy lapse or cancellation rates, penetration rates, claim duration, complaints and complaint trends).
- The **distribution conditions or restrictions** that it will impose and **amending agreements with distributors** to ensure that they comply with the distribution conditions in the TMD and comply with its record keeping and reporting obligations.
- Modifying its **breach reporting procedures** to incorporate reporting of significant dealings that are inconsistent with the TMD. Determining what will be a significant dealing. ASIC suggest a non-exhaustive list of relevant factors that include the proportion of policy owners who are outside the target market, the actual or potential harm to consumers who are not in the target market, the nature and extent of inconsistency of distribution with the TMD, the proportion of gross premium obtained from policy owners who are not in the target market and the time period over which those acquisitions occurred.

Duty of disclosure

The duty of disclosure will apply to a consumer insurance contract (being insurance that is obtained wholly or predominantly for the personal, domestic or household purposes of the insured) and to contracts of insurance that are entered into on or after 5 October 2021. For life insurance contracts which are entered into prior to 5 October 2021, the new duty of disclosure will apply as if the contract was entered into on or after 5 October 2021 if the contract is varied to increase a sum insured or to provide one or more additional kinds of cover, and any such variation was not automatic.

The new duty of disclosure requires consumers to take reasonable care not to make a misrepresentation to an insurer when entering into, varying, extending, renewing or reinstating a consumer insurance contract. The existing duty of disclosure will continue to apply to a contract of insurance that is not a consumer insurance contract.

Insurers will need to put in place new policies and procedures to address the new duty, the potentially higher risk imposed by the proposed changes and to address transition issues of applications being made on application forms that refer to the superseded duty of disclosure. Demonstrating that a consumer failed to take reasonable care will arguably be more difficult.

Distribution

DDO

The distribution obligations under DDO require, amongst other matters, distributors to implement reasonable distribution controls so that products are likely to be distributed to individuals within the target market. These arrangements must be reviewed periodically to ensure that they remain appropriate.

As stated above, life insurance companies will need to consider and review its agreements with distributors to ensure they comply with their distribution, record keeping and reporting obligations.

Commission caps

In June 2017, ASIC introduced an instrument allowing commissions to be paid for the sale of life insurance. The instrument set limits on the commissions through a commissions cap, and requires amounts to be repaid if the policy is cancelled within the first two years of the policy (clawback). Commission caps are set at 60% of the premium in the first year of the policy from 1 January 2020, with a maximum trailing commission of 20% of the premium in all subsequent years.

At the time the instrument was introduced, ASIC signalled its intention to conduct a post-implementation review in 2021 to assess the impact of these reforms. The Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Financial Services Royal Commission **(Royal Commission)**) recommended that, when ASIC conducts its review, it should consider further reducing the cap on commissions in respect of life risk insurance products and that unless there is a clear justification for retaining those commissions, the cap should ultimately be reduced to zero. ASIC has noted that it will include the factors identified by the FSRC in undertaking its post implementation review in 2021.

Further, Schedule 4 of the *Financial Sector Reform (Hayne Royal Commission Response) Act 2020* **(Royal Commission Act),** passed on 10 December 2020, gives ASIC the power to place a cap on add-on risk insurance supplied in connection with the sale or long-term lease of a motor vehicle such as consumer credit insurance for a credit facility.

Hawking provisions consolidated and broadened

In line with recommendations 3.4 and 4.1 of the Royal Commission, Schedule 5 of the Royal Commission Act consolidates the existing hawking prohibitions set out in the Corporations Act into one general prohibition with limited exceptions. The single general prohibition stipulates that a person must not issue, sell, request or invite the purchase of a financial product if the consumer is a retail client and this is made in the course of, or because of, an unsolicited contact with the consumer.

The definition of 'unsolicited contact' has been clarified and is now defined as 'contact to which the consumer did not consent which is made by telephone call, face to face meetings, or any other real-time interaction in the nature of a discussion or conversation.' Broadly, contact will only be unsolicited if the consumer did not 'consent' to the contact. Certain requirements which must be met in order for a consumer's consent to be valid have also been amended in the new Act and additional requirements have been included. For example, a consumer's consent must have been given before the start of the contact. Where previously it was proposed that a consumer's consent must be positive, the new Act requires that consent is positive and given voluntarily, and that consent must be clear such that a reasonable person would have understood that the consumer consented to the contact.

Subject to the passage of legislation, the changes in Schedule 5 are expected to come into force from 5 October 2021. Life insurance companies will have to consider their distribution models, processes and procedures.

New blackout period for sale of add-on insurance products

The Royal Commission Act also introduces an industry-wide deferred sales model **(DSM)** for the sale of add-on insurance products. Add-on insurance products are insurance products which are sold to cover risks associated with the offer or sale of a principal product or service either by the provider of the principal product or service or by a related party. Broadly, the new rules will prohibit the sale of add-on insurance products for at least four days after a consumer has entered into a commitment to acquire the principal product or service. It will be an offence for a provider or their related third parties to offer or sell an add-on insurance product to a customer who has informed the provider or any related third party that they no longer wish to receive offers, requests or invitations relating to these products. Providers and related third parties will still be permitted to respond directly to inquiries from customers about add-on insurance products at any time.

The DSM will apply to commitments to acquire principal products and services entered into on or after the commencement of the amendments on 5 October 2021. Again life insurance companies will have to consider their distribution arrangements, processes and procedures in relation to consumer credit insurance for a credit facility.

Claims handling

There are number of reforms that will impact claims handling including:

- applying for a variation to a life insurer's Australian Financial Services licence **(AFSL)** authorisations to include claims handling by 30 June 2021;
- narrowing the right to avoid life insurance policies from 1 January 2021; and
- updated complaints handling guidance released by ASIC for financial services firms to deal with consumer and small business complaints under internal dispute resolution procedures (Regulatory Guide 271: Internal Dispute Resolution).

New AFSL authorisation of claims handling

All life insurers will need to have submitted an application to be authorised under their AFSL to undertake claims handling by 30 June 2021. Any external claims managers will need to be licenced or appointed as an authorised representative under another entity's licence.

This ensures that the duty of an AFS licensee to provide financial services, honestly, effectively and fairly will apply to claims handling. In ASIC's view, this obligation will generally be satisfied if the insurer handles claims:

- in a timely way without undue delay balancing the impact of a delay on the policy owner with the insurer's reasonable requirements for handling claims;
- in the least onerous and intrusive way possible;
- fairly and transparently by informing the policy owner of the claims handling process, the reasons for requesting information and the reasons for decisions; and
- in a manner that ensures adequate support is provided for consumers.

Life insurers will need to review all claims handling operations and disclosure to ensure that they comply with the duty to act honestly, efficiently and fairly in relation to claims handling.

Narrowing the right to avoid life insurance policies

For life insurance policies entered into on or after 1 January 2021 or that are varied after that date to increase the sum insured or to provide additional types of cover, a life insurers right to avoid a life insurance policy on the basis of a non-fraudulent representation or non-disclosure will be narrowed to when the insurer can demonstrate that they would not have entered into the relevant policy on any terms if they had known the information that was omitted or misrepresented. This amendment restores the insurer's right to its pre-2013 position.

Life insurers will need to review their claims handling procedures and related disclosure (including PDSs).

Internal dispute resolution

ASIC released Regulatory Guide 271 – Internal Dispute Resolution **(RG 271)** for Australian Financial Services licensees and other financial firms. It is accompanied by a legislative instrument which sets out the enforceable internal dispute resolution **(IDR)** requirements and standards.

Some of the key changes of RG 271 include:

- **Broader definition of complaint:** the guide adopts the following definition of 'complaint:' '[An expression] of dissatisfaction made to or about an organization, related to its products, services, staff or the handling of a complaint, where a response or resolution is explicitly or implicitly expected or legally required.' The guide contains a list of expressions of dissatisfaction that constitute a 'complaint' within the meaning of the guide.
- **Reduced timeframes for responding to IDR complaints:** an acknowledged receipt of each complaint should be provided within 24 hours (or one business day) or as soon as practicable. The maximum IDR timeframe for a standard complaint is no later than 30 calendar days after receiving the complaint (previously 45 days).
- **Outline of requirements for the content of IDR response:** the written IDR response must contain the final outcome of the complaint at IDR, the right to take the complaint to AFCA if the complainant is dissatisfied, and the contact details for AFCA. The level of detail should reflect the complexity of the complaint. If the complaint is rejected, the IDR must set out the reasons by providing enough detail for the complainant to understand the basis of the decision.
- **Guidance on the identification and management of systemic issues:** the guide introduces enforceable provisions requiring boards to set clear accountabilities for complaints handling functions, including management of systemic issues identified through consumer complaints. Reports to the board and executive committees must include metrics and analysis of consumer complaints, including about how systemic issues are identified. Broadly, firms must encourage and enable staff to escalate possible systemic issues that they identify from individual complaints, regularly analyse complaint data sets to identify systemic issues, promptly escalate possible systemic issues and report internally on the outcome of investigations, including actions taken, in a timely manner.

RG 271 will apply to complaints received by financial firms on or after 5 October 2021. For complaints received before that date, Regulatory Guide 165 – Licensing: Internal and external dispute resolution applies.

Other

Mergers and acquisitions

APRA published its updated Corporate Plan 2020-24, which sets out a roadmap for reinforcing APRA's mandate of safeguarding financial stability, updated to incorporate adjustments to priorities and timelines in light of the changed external environment and financial and economic impacts of COVID-19.

Some of the strategic focus areas identified by APRA include the sustainability of insurance products and responding to material risks and issues that could impact the viability and solvency of insurers. APRA will also continue to review reinsurance arrangements by undertaking an analysis of the impact of COVID-19 and the associated economic downturn on the stability of reinsurers. APRA has noted that it will take regulatory action if required.

An example of such regulatory action occurred in December 2019 when APRA announced a range of measures aimed at intervening in the life insurance market to stem ongoing heavy losses in respect of individual disability income insurance **(IDII).** To allow life companies time to focus on responding to the pandemic, the program of work was put on hold in March 2020. However in September 2020, APRA announced that it would resume its intervention into the life insurance market as the COVID-19 market pandemic continued to exacerbate the problems with IDII. From 1 October 2020, IDII providers have been subject to upfront capital penalties until APRA is assured that they have taken adequate and timely steps to address sustainability concerns. Specifically, APRA requires IDII providers to

implement a number of measures designed to better manage riskier product features including:

- ensuring IDII benefits do not exceed the policyholder's income at the time of claim, and cease the sale of Agreed Value policies;
- avoiding offering IDII policies with fixed terms and conditions of more than five years; and
- ensuring effective controls are in place to manage the risks associated with longer benefit periods.

APRA has also asked life companies to consider and apply these underlying principles to their other insurance products.

We consider that increasing regulatory intervention in the life insurance market with APRA focusing on the sustainability of insurance products and responding to material risks and issues that could impact the viability and solvency of insurers may lead to more merger and acquisition activity in the life insurance industry.

Governance

APRA has also set out a number of governance-related policy and supervision priorities, particularly in relation to accountability, cybersecurity and remuneration.

Remuneration and FAR

On 12 November 2020, APRA released a revised draft of prudential standard CPS 511, detailing the new prudential framework to regulate remuneration in APRA-regulated entities. The draft standard has moved to a more principles-based approach that is designed to be risk based and proportionate, with more comprehensive requirements for larger and complex regulated entities (Significant Financial Institutions **(SFIs)**). Key requirements for SFIs include replacing the 50% cap on financial measures for variable remuneration with a requirement that material weight be assigned to non-financial measures, combined with a risk and conduct modifier that can potentially reduce variable remuneration to zero. Smaller (non-SFI) entities will be subject to streamlined and less onerous remuneration requirements. A key focus of this reform is transparency and entities will be subject to greater public disclosure of their remuneration practices to demonstrate compliance with APRA's requirements. The specific disclosure requirements will be subject to a consultation process, which is expected to be conducted in late 2021. SFIs should note APRA's expectation that SFIs undertake a self-assessment and develop and implementation plan from the second quarter of 2021 following the release of the finalised standard.

The consultation period for revised CPS 511 will close on 12 February 2021. It is scheduled to be finalised in mid-2021 and come into effect for SFIs that are authorised deposit-taking institutions (ADIs) on 1 January 2023, for insurance and superannuation SFIs on 1 July 2023, and for non-SFIs on 1 January 2024.

The operation of the Financial Accountability Regime (FAR) will run in parallel with CPS 511 and there is some overlap between the two regimes. It is yet to be seen exactly how these two regimes will interact, although APRA has noted that consultation with the government will occur to ensure alignment.

Cybersecurity

APRA has also outlined a new cybersecurity strategy for 2020 – 2024. As part of this strategy, APRA has noted its increased focus of ensuring full compliance with prudential standard CPS 234. Key measures announced include:

- APRA will **strengthen its supervisory approach** to cyber risk. It has noted that it is exploring new tools to enhance scrutiny and have been allocated additional Commonwealth funding for this purpose;
- APRA will **collect more data** to better understand cyber threats and share this knowledge with the industry to enable industry self-assessment and benchmarking;
- APRA will take a more **targeted approach to ensure compliance with CPS 234** and hold boards and management accountable where there are compliance failures. APRA will be asking certain boards to engage an external audit firm to conduct a thorough review of their CPS 234 compliance and report back to both APRA and the board. APRA-regulated entities that fail to comply with CPS 234 may be issued with a breach notice and required to create a rectification plan; and
- APRA will develop **stronger third-party assessment and assurance practices** to help regulated entities vet and monitor their suppliers.

Overall the strategy reflects a much more targeted and supervisory approach with greater accountability placed on boards and management.

Breach reporting

A new breach reporting regime for Australian Financial Services Licensees and Australian Credit Licensees was also introduced by the Royal Commission Act, that will replace the obligations in section 912D of the Corporations Act and insert a similar breach reporting regime for credit licensees in the *National Consumer Credit Protection Act 2009* (Cth).

Schedule 11 to the Act amends the Corporations Act to enhance the breach reporting regime for financial services licensees. Key features of the Act include:

- expanding the kinds of **situations that need to be reported** by licensees to ASIC;
- requiring licensees to **lodge breach reports** with ASIC; and
- requiring ASIC to **publish data** about breach reports on its website

Broadly, the Act requires licensees to lodge a report with ASIC if there are reasonable grounds to consider that a reportable situation has arisen. The kind of situations that need to be reported to ASIC has been expanded, although the core reportable situations largely mirror the current reporting triggers in section 912D of the Corporations Act. Relevantly, the Explanatory Memorandum provides that the obligation to act efficiently, honestly and fairly, to comply with conditions on the licence and to maintain competence to provide financial services covered by the licence are captured. Reporting must

occur within 30 days of the licensee first reasonably knowing that there are reasonable grounds to believe that there is a reportable situation. Information about breach reports are to be made to the public by ASIC within 4 months of the end of each financial year.

Failure to lodge a report with ASIC will constitute an offence with a maximum penalty of two years imprisonment and a fine may also be imposed. The new reporting obligations will apply to reportable situations that arise on or after 1 October 2021. They also apply to breaches and likely breaches that occurred before then and were not reportable under the previous Corporations Act regime.

Some key issues in considering the new regime will be:

- the scope of what has to be reported to regulators (e.g. what is a "core obligation", when does an investigation commence, what is a "gross negligence", when does the outcome of an investigation have to be reported and when does the conduct of third parties have to be reported);
- the period in which a report must be lodged (e.g. when does a licensee "reasonably know" that a reportable situation has arisen);
- how the breach report should be completed and submitted; and
- when do clients have to be notified and remediated.

2021 is shaping up as a significant year of regulatory change in the life insurance industry. Is your life insurance company ready?

Taking stock of 2020: a year of insurance regulatory reform

Consumer protection was the name of the game when it came to legislative change for the insurance industry (and indeed, the financial services industry more generally), with 2020 seeing the introduction of a number of key reforms.

Section one of this article provides an overview of those changes. Section two in turn provides an overview of their respective commencement dates.

Overview of key insurance regulatory reforms

Extension of unfair contract terms regime to insurance contracts

The *Financial Sector Reform (Hayne Royal Commission Response – Protecting Consumers (2019 Measures) Bill* 2019 **(Bill)** received Royal Assent on 17 February 2020.

The Bill:

- amended the *Australian Securities and Investments Commission Act 2001* (Cth) **(ASIC Act)** and the *Insurance Contracts Act 1984* (Cth) **(ICA)** to allow the Unfair Contract Terms **(UCT)** regime under the ASIC Act to apply to insurance contracts governed by the ICA (in addition to the existing duty of utmost good faith under the ICA); and
- extended the UCT regime to apply to those insurance contracts with some adjustments (for example, to provide that a term which defines the main subject matter of an insurance contract is only excluded from the application of the UCT regime to the extent that it describes what is being insured).

Insurance regulatory reforms arising from the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry

On 17 December 2020, the *Financial Sector Reform (Hayne Royal Commission Response) Bill 2020* **(RC Bill)** received Royal Assent. The RC Bill introduced the following key insurance regulatory reforms:

- **enforceable code provisions and mandatory codes of conduct:** the *Corporations Act 2001* (Cth) (**Corporations Act**) and the *National Consumer Credit Protection Act 2009* (Cth) were amended to give ASIC the power to make certain provisions of industry codes of conduct which are approved by ASIC (such as the General Insurance Code of Practice) "enforceable code provisions". The amendments also introduced a framework for the establishment of mandatory codes of conduct for the financial services industry (which may include civil penalty provisions). A breach of an enforceable code provision or a mandatory code of conduct constitutes a breach of law and may result in penalties or other enforcement actions;
- **narrower grounds for insurers to avoid life insurance contracts:** the ICA was amended to narrow the right of an insurer to avoid a life insurance policy for non-fraudulent misrepresentation or non-disclosure. Insurers must now demonstrate that they would not have entered into the relevant policy on any terms if they had known of the misrepresentation or non-disclosure. This restored the insurer's right to its pre-2013 position;
- **duty to take reasonable care not to make a misrepresentation to an insurer:** the insured's existing duty of disclosure was amended to create a new duty to take reasonable care not to make a misrepresentation to the insurer before entering into a "consumer insurance contract" (**CIC**). An insurance contract is a CIC if it is purchased for personal, domestic or household purposes (including general and life insurance contracts), or is purchased for a new business where the insurer gives the insured a written notice stating that the contract is a CIC prior to the contract being entered into;
- **new deferred sales model for add-on insurance products:** the ASIC Act and the Corporations Act were amended to introduce an industry-wide deferred sales model (**DSM**) for the sale of add-on insurance products. The DSM imposes a range of restrictions on the offer or sale of "add-on insurance products" (and communications in respect of such products) during certain prescribed periods. The restrictions replace the anti-hawking obligations for add-on insurance products during those periods;
- **caps on commissions:** the ASIC Act was amended to impose a cap on commissions payable in respect of the supply of add-on risk products (including insurance products and insurance-like products) which are sold in connection with motor vehicles. Criminal and civil penalties were also imposed and it is now a strict liability offence for a person to pay or receive a commission for motor vehicle add-on risk products which exceed the applicable cap. In addition, consumers now have the right to recover any commissions which exceed the applicable cap;
- **restricting the use of the terms 'insurance' and 'insurer':** the *Insurance Act 1973* (Cth) was amended to make it a strict liability offence for a person to use the term 'insurance' to describe a product or service supplied by them if the product or service is not insurance and it is likely that it could mistakenly be believed to be insurance. Similarly, it is now a strict liability offence for a person to describe themselves as an 'insurer' in connection with a product or service supplied by them if the product or service is not insurance and it is likely that it could mistakenly be believed to be insurance, or the person is not appropriately registered or authorised; and
- **claims handling as a financial service:** the Corporations Act was amended to make the handling and settling of insurance claims a financial service. As a result, insurers, insurance claims managers, claimant intermediaries, insurance brokers and other persons who provide "claims handling and settling services" (**CHS Services**) in respect of insurance products will be required to hold an Australian Financial Services (**AFS**) licence covering such services, or to otherwise become an authorised representative of an AFS licensee.

Overview of commencement dates

Change	Commencement
Extension of the unfair contract terms regime to insurance contracts	The amendments apply to insurance contracts entered into on or after 5 April 2021 (with some variations).
Enforceable code provisions and mandatory codes of conduct	The amendments commenced on 1 January 2021.
Narrowed right of insurers to avoid life insurance contracts	The amendments apply to life insurance policies which are entered into on or after 1 January 2021 (with some variations).
Duty to take reasonable care not to make misrepresentation	All amendments will apply to CICs (other than life insurance contracts) that are entered into on or after 5 October 2021. For life insurance contracts which are entered into prior to 5 October 2021, the amendments will apply as if the contract was entered into on or after 5 October 2021 if the contract is varied to increase a sum insured or to provide one or more additional kinds of cover (unless the variation was automatic). In such circumstances, the amendments will apply to the contract to the extent of the variation. The amendments will **not** apply to life insurance contracts which are entered into prior to 5 October 2021 and which are extended or reinstated on or after 5 October 2021. Any such contracts will continue to be subject to the existing duty of disclosure. An insurer can also apply the new duty to a contract of insurance if, before the contract is entered into, the insurer gives the insured a written notice that the contract is a CIC.
Deferred sales model for add-on insurance	The model will apply to commitments to acquire principal products and services which are entered into on or after 5 October 2021.
Caps on commissions	The amendments apply to commissions provided under contracts for add-on risk products which are entered into on or after 1 January 2021.
Restrictions on the use of the terms 'insurance' and 'insurer'	The new restrictions commenced on 1 January 2021.
Claims handling as a financial service	The amendments commenced on 1 January 2021. However, the amendments apply to different persons providing CHS Services and to different insurance claims at different times. The amendments do not apply to any: • providers of CHS Services before the end of 30 June 2021; or • insurance claims that were commenced before 1 January 2021. By 30 June 2021, providers of CHS Services will need to have applied for a new or varied AFS licence which covers the CHS Services (unless an exemption applies). Once a provider is granted a licence to provide CHS Services, the new amendments will apply to them in full after the later of 31 December 2021 and a later day prescribed by the Minister (which must be before 1 July 2022). The new amendments apply in turn to all claims which are commenced after the commencement date.

Good faith, not good enough?

All consumer contracts rely on a degree of trust, honesty and mutual cooperation, but the significance these values hold in the insurance relationship, even between sophisticated parties, is historically unique. While an implied duty of good faith is still struggling to find its hook in the general law of contract, it has been statutorily implied into insurance contracts for decades: a move that built upon its long history as a standalone duty in insurance law.

So far as the insurer is concerned, the reason for this was first articulated by Lord Mansfield in the seminal decision of *Carter v Boehm (1766) 97* ER 1162: *"Insurance is a contract based upon speculation. The special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only; the underwriter trusts his representation and proceeds upon the confidence that he does not keep back".*

Since that observation was made in 1766, honesty and trust have remained at the heart of the insurance relationship. The weight of the obligation, however, has experienced a gradual shift. In November 2020, ASIC Commissioner Sean Hughes described the role of good faith in insurance in similar, albeit inverse, terms: "The value of an insurance policy is in the promise—so that a consumer can feel confident and secure that they will be looked after when something goes wrong. *The community expects their insurer to be there when something does go wrong, to be treated fairly and with dignity and respect.*"[5]

The statutory embodiment of the duty of utmost good faith in section 13 of the *Insurance Contracts Act 1984* (Cth) (ICA) applies to both parties in the insurance contract, to all conduct pre- and post-contractual and, being an implied term, entitles the parties to damages and not merely avoidance of the contract.[6] Guidance to date from the High Court on the duty indicates it encompasses a broad range of behaviour falling short of community standards of fairness and decency.[7]

It is because of the unique characteristics of the insurance relationship and in particular the duties organically built up around that relationship, that the insurance industry was until only recently, carved out of other consumer regulatory regimes, notably the unfair contract term laws under the *Australian Securities and Investments Commission Act 2001* (Cth) **(ASIC Act) (UCT Regime)** and general obligations of Australian financial services licence **(AFSL)** holders in section 912A of the *Corporations Act 2001* (Cth).

In the Final Report of the Financial Services Royal Commission, Commissioner Hayne identified "*six norms of conduct*" underpinning consumer regulation which are "*all reflected in existing law. But the reflection is piecemeal". In insurance, however, "all of the norms may be seen as embodied in the duty of utmost good faith*".[8]

And yet, the Royal Commission's findings regarding the insurance industry suggest that the duty has repeatedly failed to perform its function of deterring unfair and unconscionable conduct. Is the statutory duty of utmost good faith fundamentally deficient or just misunderstood?

Underappreciated and underutilised?

The duty of utmost good faith and its statutory counterpart remain deliberately undefined. This was a point emphasised by The Honourable Chief Justice Allsop on numerous occasions last year both from the bench and extrajudicially. In *Delor Vue Apartments CTS 39788 v Allianz Australia Insurance Ltd (No 2)* [2020] FCA 588 (see our case note at page 48), Allsop CJ held: "It is not appropriate to seek to define the standard within section 13. It is a normative standard … *The expression of Gleeson CJ and Crennan J of a "commercial standard of decency and fairness" is, for these circumstances, most apt".*[9] Meanwhile, in his 2020 Geoff Masel Lecture, the Chief Justice reiterated: *"It is not to be defined because it is indefinable … One can easily (as some statutes do) fall into the trap of over-articulating and over-abstracting rules in an attempt to bring about good behaviour by companies and their employees … it is valuable that the duty of utmost good faith*

has not been over-articulated" (see further our article on unfair terms on page 19). The value in expressing norms of conduct at a level of generality is that their scope is worked out by repeated application to the real world over time.

Notwithstanding these concerns, the insurance industry faces a wave of new legislation attempting to statutorily prescribe standards of fairness, honesty and decency.[10] This includes, amongst other things, the extension of the UCT Regime to insurance contracts under the ICA and the classification of "claims handling" as a financial service under the Corporations Act.

Each of these measures was recommended in the Royal Commission's Final Report. Notably, the Commission found that a removal of the "claims handling" exemption was justified by several of the insurance case studies, in particular, CommInsure, TAL, Youi and AAI.[11] In each of those cases, the Commission found that the conduct *"fell below community standards and expectations"* (the benchmark for the duty of utmost good faith)[12] and ASIC has subsequently brought proceedings for breach for section 13 against both Youi and TAL Life.[13]

Meanwhile, another key issue arising from the case studies was the use of, and reliance upon, potentially unfair contract terms. In the discussion on this topic, no mention was made of section 14 of the ICA. As identified in the Royal Commission General Insurance Background Paper 14, section 14 is *"a very important, even remarkable, application of the duty of utmost good faith"* which prevents a party relying on a contract term if to do so would be in breach of the duty of good faith.[14] The authors of that paper describe section 14 as *"an unfair reliance contract term regime", which is arguably much wider in scope than the UCT Regime.* Their conclusion is that "section 14 appears to have been underutilised".

It is clear, from the Royal Commission's Final Report, that Commissioner Hayne considered additional protections and sanctions over and above the duty in section 13 are required to adequately prevent or deal with future conduct akin to those the subject of the Royal Commission case studies.

So, given that the statutory duty has been left deliberately flexible enough to adapt to contemporary standards of commercial decency, why has it, in the past, proved ineffective?

Reinforcing ASIC's arsenal

One significant limitation to section 13 was the scope of regulatory enforcement. Previously, by way of amendments to the ICA in 2013, ASIC could access remedies under the Corporations Act for breach of section 13 including the suspension or cancellation of the insurer's financial services licence or the imposition of licence conditions, but these proved to be blunt instruments of enforcement, often inappropriate for individual cases of (mis)conduct.

ASIC's arsenal of remedies for breach of section 13 has now been significantly supplemented by the introduction of pecuniary penalties, which introduce very real financial consequences for breach. Corporations that breach section 13 now face the greater of 10 times the prescribed penalty, three times the benefit derived and detriment avoided from the contravention, or 10% of annual turnover up to 2.5 million penalty units (currently over half a billion dollars).

2020 saw ASIC bring at least two actions for declarations of breach of the statutory duty. ASIC's media releases note that the pecuniary penalty provisions did not exist at the time of the conduct, but forewarned that penalties might be deployed in the future.

Navigating layers of regulatory compliance

With the regulatory enforcement mechanisms for section 13 now reinforced, what role will the new statutory requirements of fairness and, in particular, the duty of AFSL holders to provide services with efficiency, honesty and fairness have to play?

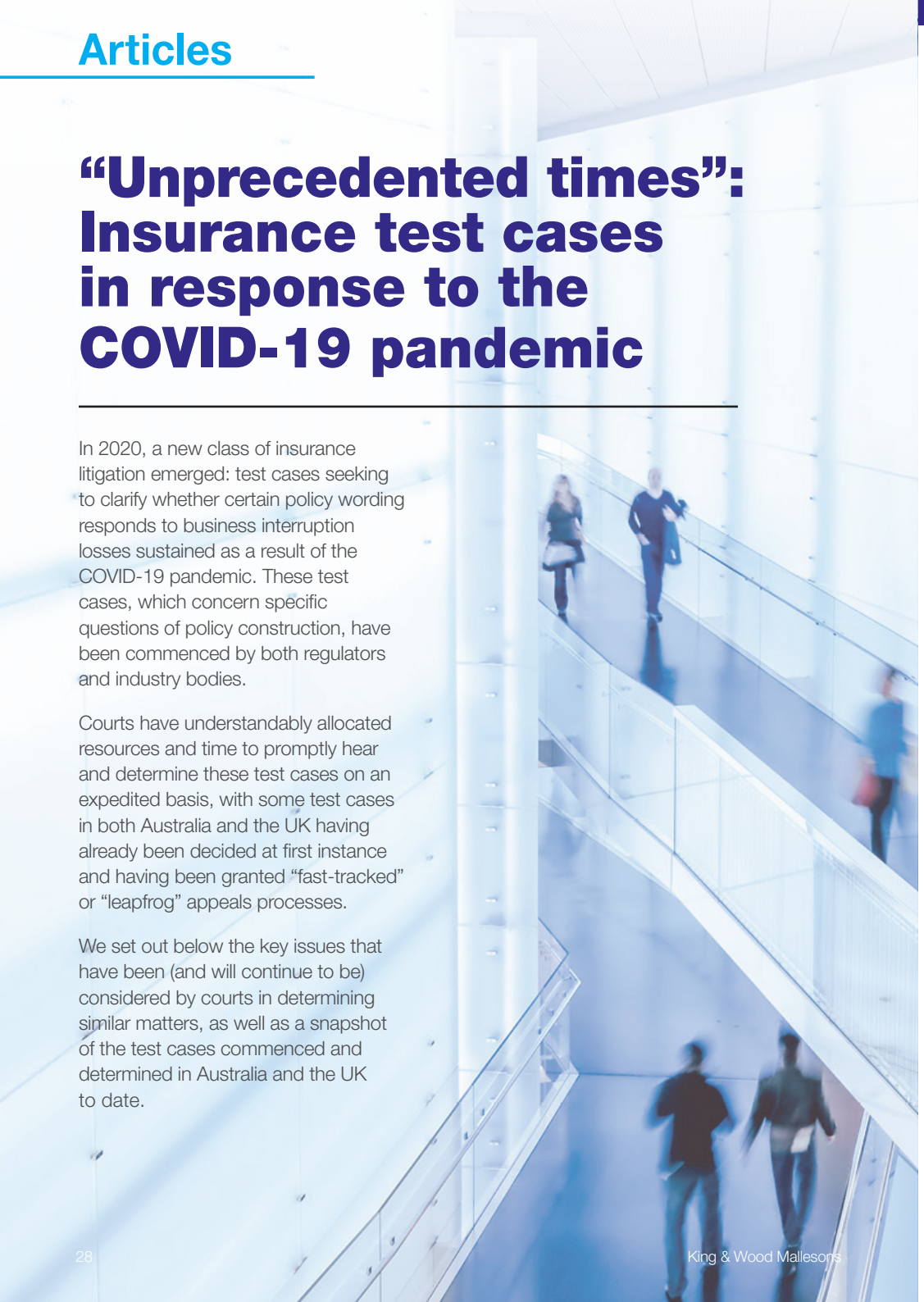
So far as the UCT Regime is concerned, remedies for reliance on unfair contract terms should, in theory in most circumstances, also be available under sections 13 and 14 of the ICA. The reality, however, is that the potential of section 14 remains unrealised. In part this may be because the statutory duty of good faith focuses on the conduct of the party (that is, the reliance on the term) rather than an objective assessment of the term itself and is therefore less appropriate for identifying systemic misconduct.

The ICA and ASIC Act have each been amended to clarify that the UCT Regime sits in parallel with, and does not affect the operation of, section 13.[15] While each regime operates independently, in situations of overlap, the court may take into account the concurrent operation of the two regimes when considering what orders to make.[16]

The duty under section 912A(1)(a) of the Corporations Act to provide financial services efficiently, honestly and fairly arguably has a more complex interaction with the duty of good faith. Section 912A(1)(a) brings with it a separate body of case law regarding norms of conduct which has been developed and applied outside the context of the insurance relationship and without regard to the duty of utmost good faith. The normative standards of honesty, fairness and efficiency, each already contained within the concept of good faith, must now be considered under two separate duties. While courts have been careful to avoid over-definition of the duty of utmost good faith to ensure that it remains flexible and adaptive, recent authority on the section 912A(1)(a) duty is moving away from treating the phrase *"efficiently, honestly and fairly"* compendiously,[17] such that insurers are likely to be subject to three more specific discrete duties.

The extension of the UCT Regime and AFSL duties to the insurance industry has been justified by lawmakers as a means of closing the gap in consumer protections and providing consistency in regulatory treatment across industries. The insurance industry, however, now faces a number of overlapping duties that add layers of regulatory compliance while importing separate bodies of case law to regulate the same normative standards. Following the Royal Commission, lawmakers were faced with two options: refocus and reinforce the primary duty of utmost good faith or supplement it with new statutory duties. The legislative response to the Royal Commission has been to do both. Whether this results in a regulatory landscape that is more "piecemeal" than before remains to be seen.

“Unprecedented times”: Insurance test cases in response to the COVID-19 pandemic



In 2020, a new class of insurance litigation emerged: test cases seeking to clarify whether certain policy wording responds to business interruption losses sustained as a result of the COVID-19 pandemic. These test cases, which concern specific questions of policy construction, have been commenced by both regulators and industry bodies.

Courts have understandably allocated resources and time to promptly hear and determine these test cases on an expedited basis, with some test cases in both Australia and the UK having already been decided at first instance and having been granted “fast-tracked” or “leapfrog” appeals processes.

We set out below the key issues that have been (and will continue to be) considered by courts in determining similar matters, as well as a snapshot of the test cases commenced and determined in Australia and the UK to date.

Key questions for consideration

Business interruption policies differ between policyholders, industries, insurers and jurisdictions, and are often tailored based on the particular type of business insured. As a result, it is difficult to adopt a “one size fits all” approach that can be taken when determining the responsiveness of business interruption policies.

While the responsiveness of an individual policy will turn on its terms, the question of whether, and to what extent, policyholders are covered for business interruption loss caused by COVID-19 usually involve (to varying degrees) the consideration of three key questions:

1. Does the policy (primarily or by extension) provide cover for non-physical loss?

2. Does the policy exclude loss caused by COVID-19 or otherwise convey a commercial intent to exclude such losses?

3. Were the alleged business interruption losses caused by an insured event?

The issues described above are relevant to many policyholders, however, the unique circumstances presented by the pandemic has made the determination of these questions difficult in the absence of analogous case law.

While the test cases in Australia have principally focussed on the first two of these questions, the UK test case has also considered how causation should be approached as a matter of principle, notwithstanding that causation will ultimately be a question that must be determined by reference to the particular facts and circumstances pertaining to individual policyholders.

Test cases in Australia

In Australia, one test case has already been determined at first instance. At the time of writing, a second test case has already been flagged and may be commenced in 2021.

Both test cases have the backing of the Insurance Council of Australia (ICA) (an Australian industry body). The first case was commenced by the Australian Financial Complaints Authority (AFCA) (a non-government ombudsman) and arose from policies submitted to it for consideration in accordance with its complaint resolution process.

AFCA and ICA test case concerning policies that refer to the Quarantine Act 1908 (Cth)

In August 2020, the AFCA and the ICA commenced a test case (in the name of the insurers of the two separate policies under consideration) in the NSW Supreme Court.

The question for determination was narrow and one that concerned Australian policies alone: whether a clause which excluded cover for “diseases declared to be quarantinable diseases under the *Quarantine Act 1908 (Cth)* and subsequent amendments” extended to diseases determined to be listed human diseases under the Biosecurity Act 2015 (Cth). If the clause did not extend in this manner, then the clause would not exclude cover for COVID-19, since it is only listed under the *Biosecurity Act* and not under the *Quarantine Act*.

The insurers argued the extension to diseases listed under the Biosecurity Act

was the proper construction for two reasons (which were framed in the alternative).

1. The words "subsequent amendment" in the exclusion clause captured the Biosecurity Act and "listed human diseases" under that Act.

2. References to the Quarantine Act must be read as references to the Biosecurity Act in order to avoid an absurd result, because:

   a) the parties could not have intended to refer to "subsequent amendments" to an Act that no longer exists; and

   b) it was clear that the insurers had intended to refer to the replacement Act, such that the insurers' construction gave effect to the objective intention of the parties.

The proceeding was "fast-tracked" at first instance to the NSW Court of Appeal, where it was heard by a five-judge bench (Bathurst CJ, Bell P, Meagher JA, Hammerschlag and Ball JJ) in October 2020.

On 18 December 2020, the Court of Appeal handed down their decision and unanimously rejected both arguments advanced by the insurers.[18] As a result, the Court made declarations that, on a proper construction of the policies, COVID-19 was not a disease declared to be a quarantinable disease under the *Quarantine Act* and the exclusion clause was therefore not enlivened under either policy.

As to the first argument, the Court held that the repeal and replacement of the *Quarantine Act* with other legislation is not within the ordinary meaning of the words *"and subsequent amendments"* and the exclusion clause does not extend to the enactment of other legislation with a different mechanism for identifying diseases.

The Court diverged on the reasons for rejecting the second argument:

- Hammerschlag J (with whom Bathurst CJ and Bell P agreed) found that the diseases declared under the Quarantine Act were still identifiable and the repeal of the Act did not affect or annul those declarations. Accordingly, the words used were not incoherent and "the exclusion still has work to do".
- Meagher JA and Ball J observed that there was no suggestion that either party knew the Quarantine Act had been repealed and replaced by the Biosecurity Act at the times the policies were issued and, accordingly, found that the repeal of the Act was not a surrounding circumstance that could be considered in construing the agreement, such that there was no "mistake" in the sense of an imperfect or incorrect expression of the parties' objective intention.

Having only been asked to determine the construction and scope of the exclusion clause, the Court was not required to determine whether the two policies otherwise responded to the losses claimed by the policyholders.

On 16 December 2020, a special leave application was filed in the High Court of Australia. As at the date of publication, this application has not been determined.

A second test case?

On 24 February 2021, the ICA announced that lawyers on behalf of participating insurers had commenced a second test case in the Federal Court to determine the meaning of policy wordings in relation to the definition of a disease, proximity of an outbreak to a business, and prevention of access to premises due to a government mandate, as well as policies with a hybrid of these types of wordings. The test case consists of nine separate small business claims lodged with AFCA as part of its dispute resolution process.

Litigation in the UK

In May 2020, a test case was commenced by the Financial Conduct Authority (FCA) in the UK High Court (equivalent to an Australian State Supreme Court) in order to obtain declaratory relief on the scope of cover afforded by a representative sample of policies issued by 17 insurers. The variance in policy wording was managed by using agreed "fact patterns" and questions for determination. The FCA was able to bring this test case under the "Financial Markets Test Case Scheme", which allows issues of "general importance" where "immediately relevant English law guidance is needed" to be heard without the usual requirement of a present cause of action between the parties.

The test case was concerned with the availability and scope of cover under certain "non-physical damage" extension clauses (in respect of which it was not disputed that cover could be available in the absence of physical damage), as well as the causation requirements of the sample policies and the operation of their respective "trends" clauses. The extension clauses for determination fell into three broad categories:

- clauses providing cover in respect of business interruption following the occurrence of a notifiable disease within a specified radius of the insured premises (Disease Clauses);
- clauses providing cover in respect of business interruption resulting from a prevention or hindrance of access to or use of the premises as a consequence of government or local authority action or restriction (Prevention of Access (POA) Clauses); and
- clauses providing cover in respect of business interruption resulting from a combination of an occurrence of a notifiable disease, government action and restrictions on access or use of the premises (Hybrid Clauses).

The test case was heard at first instance by a two judge bench of the UK High Court over the course of 2 weeks in July 2020. In its decision handed down on September 2020,[20] the Court found in favour of both policyholders and insurers to varying degrees, but did find that cover could be available under certain variants of all three types of Clauses identified above (subject to the precise policy wording and the individual facts and circumstances of the policyholder seeking indemnity). As to the applicable test for causation and the operation of the "trends" clause, the Court found in favour of policyholders on a proper construction of the "insured peril", relevantly determining that the counterfactual involved comparing the insured's losses to the losses that would have been sustained in a world without COVID-19.

On 2 October 2020, the UK High Court gave all parties permission to appeal and certified that the appeals were suitable for the "leapfrog" procedure which enables an appeal to bypass the Court of Appeal

and proceed directly to the Supreme Court in exceptional circumstances. The parties were granted permission to appeal by the UK Supreme Court (equivalent to the High Court of Australia), and both the participating insurers and the FCA filed appeals in respect of issues on which they were unsuccessful at first instance.

The appeal was heard in mid-November 2020 and, on 15 January 2021, the UK Supreme Court delivered its judgment.[21] The Court dismissed the participating insurers' appeals (but did accept some of their arguments which did not affect the outcome of the appeal) and allowed each of the FCA's grounds of appeal (albeit two were only allowed on the qualified terms set out in the judgment and in relation to specific policy wording).

In particular, the Court found that:

- where a policy provided cover for business interruption loss caused by an occurrence of disease or a particular government response, it would not be consistent with the intended scope of cover for the insurer to reject the claim on the basis that turnover would have been reduced in any event because of other consequences of the COVID-19 pandemic. Where there are two or more independent causes of loss and cover is provided for loss arising from one of those causes, so long as the other cause is not excluded, the parties do not generally intend other consequences of the same underlying event to restrict the scope of the indemnity;
- where a clause provides a mechanism for adjustment of the claim by reference to circumstances or trends that would have affected the business "but for" the insured peril **(Trends Clauses)**, the clause should generally be construed so that the loss is adjusted only to reflect "circumstances" or "trends" which are unconnected with the insured peril and do not have the same underlying cause; and
- a notable case on causation and the operation of Trends Clauses in the context of events also causing wider damage, Orient Express (which concerned a claim for business interruption losses by a hotel damaged by Hurricane Katrina),[22] was wrongly decided and should be overruled.

Testing the limits

While further test cases may continue to be commenced and determined by courts (such as the second test case foreshadowed by the ICA), these cases are not necessarily determinative of the availability and/or scope of cover available under a particular policy.

This is because the responsiveness of each policy will turn on its terms and the policy as a whole and the test cases to date have only considered the construction and effect of particular extension or exclusion clauses – not the policy as a whole, or the particular facts and circumstances of affected policyholders. As a result, individual policies will still need to be construed in light of the outcomes of these test cases, and particular policies may give rise to further policy construction questions.

While this article has considered the use of test cases by regulators and industry bodies, we are also aware of a number of cases having been commenced directly by policyholders against their insurers. In Australia, the Federal Court has already delivered judgment on a separate question in one such case.[23]

Broking: go the extra mile to avoid a breach of duty claim

Brokers can play a valuable role in a company's risk management strategy. Brokers can assist in locating cover, pricing, and acting as a client advocate and liaison during the claims process. But what do the Courts say about broking best practice and a broker's duty of care to their clients?

The duties of a broker – listing the gaps in cover is not enough

On 19 February 2020, the Federal Court (Anderson J) handed down its decision in the case of *PC Case Gear Pty Ltd v Instrat Insurance Brokers Pty Ltd* (in liq)[24] **(PCCG v Instrat)**, finding that Instrat Insurance Brokers Pty Ltd **(Instrat)** had breached its duties of care to its client, PC Case Gear Pty Ltd **(PCCG)**, by failing to properly advise PCCG on the risks facing its business and the gaps in its insurance cover for those risks.

In the decision, the Federal Court provided a helpful summary of the obligations of a broker.[25] While the obligations are not new, it is the analysis by Anderson J of the scope of those obligations and the practical application of those obligations to the facts of this case that make the decision a particularly useful reminder and resource for all brokers and lawyers.

In summary, the obligations on a broker include:

1. concurrent duties to its clients in contract and in tort (although the duty founded in tort will not impose anything additional to the scope of those in the contractual retainer);
2. the exact nature and content of a broker's duties will turn on the instructions given by the client, but there is a term implied by law into each contractual retainer that the broker will exercise reasonable skill and care in the performance of its duties;
3. a broker must use reasonable skill and care to ascertain the client's needs by instructions or otherwise, requiring the broker to be sufficiently familiar with the client's business;
4. where there is a disparity in expertise between the broker and client, it is incumbent on the broker **(not** the client) to make appropriate enquiries, including at renewal in relation to matters not previously known or inquired about in the past;

5. a competent insurance broker will have an understanding of the general principles of insurance law and agency, so that the broker can highlight the potential *"legal pitfalls"* for the client where these might arise in the course of effecting valid cover, but the broker is not expected to give legal advice;

6. where the client provides ambiguous instructions to the broker and the client would consequently be left substantially under insured if those instructions were followed, a broker has a duty to highlight the consequences of those instructions and confirm those instructions are correct;

7. a *"reasonably competent"* broker must use reasonable care and skills to procure the cover required and ensure that the policy is suitable for the purposes for which it is sought by the client. If the requested cover cannot be secured, this must be reported to the client;

8. draw the client's attention to any onerous or unusual terms, but not explain in detail the effect of each term of the policy; and

9. provide the client with "advice and assistance to enable it to make an informed decision about its insurance requirements" and to instruct the broker about what cover to procure. The Federal Court specifically noted that a broker does not owe a client a general duty to obtain a bullet proof policy.

PCCG was a supplier of computer hardware and software, focusing mainly on personal computers tailored for playing computer games but also included selling pre-installed copies of Microsoft's Windows operating system. PCCG held licences to sell Windows from a third-party distributor, but in early 2016 Microsoft alleged that PCCG's licenses, from 2009 to 2016, raised breach of copyright issues and the claim was settled.

Instrat was PCCG's broker during those relevant years and conducted PCCG's renewals each year. The insurance cover obtained expressly excluded cover for claims for copyright infringement, meaning PCCG was not covered for liabilities to Microsoft (including the $250,000 settlement sum), although it was covered for its defence costs.

PCCG sued Instrat in negligence and in breach of contract, alleging that Instrat is liable to PCCG in the amount of the $250,000 settlement sum because Instrat failed to act with reasonable skill and care by failing to advice PCCG of the availability of cover for copyright infringement.

The Federal Court held that Instrat breached its duties in contract and tort in three "key" respects:

1. Instrat failed to make adequate enquiries to understand the nature of the risks to which PCCG's business was exposed in 2009 (its first year) and on each year subsequent at renewal. Although Instrat conducted "some" investigation into the nature of the business by going on a premises tour and reviewing the business' website, Anderson J held *"it ultimately appears that [Instrat] did not ask sufficient questions…to obtain a thorough understanding of the nature of the business".* This means that Instrat did not know that PCCG's business involved the reselling of software to customers that PCCG had installed on computers;

2. Instrat failed to sufficiently identify and characterise the exposure of PCCG's business to the risk of copyright infringement. Anderson J accepted the evidence of PCCG's expert that a broker in the position of Instrat, exercising reasonable care and diligence, would have identified the major exposure of PCCG's business to the risk of copyright infringement; and

3. Instrat failed to raise with PCCG the fact that it was not covered for the risk of copyright infringement, even though copyright infringement was included as a risk in a section of the proposed insurance plan prepared by Instrat titled "Uninsured Exposures".

Anderson J held, based on PCCG's evidence, that had Instrat advised PCCG of the risks of a claim for copyright infringement, the gaps in its cover and that insurance to cover those risks was available in the market, PCCG would have elected to take out that cover and would have been covered for its $250,000 liability to Microsoft. Accordingly, Instrat was ordered to pay PCCG in the amount of $250,000.

So, what does a broker actually have to do?

It is clear from *PCCG v Instrat* (and the well-established authorities before) that the scope of a broker's duty goes well beyond collecting high level data about its client's business and forwarding that information to an underwriter. A broker must have a deep knowledge of a client's business, how it operates and what cover is available for those business risks in the market. In our experience, significant steps are often taken by the broker to understand the client's business in the first year the broker is retained but tends to ease off in subsequent years at renewal.

The broker must take the initiative to ask for an explanation of all the different business activities of the client, including those ancillary to the business' primary activities and whether the business has undergone any change to those activities year on year.

Further, a broker has to do more than recite what is insured and uninsured in proposed cover. A broker must appreciate the actual risks that the business may face and advise on whether cover is or isn't available for those risks.

As for all claims against professionals and service providers, it is also prudent to ensure that detailed file notes or records of conversations are kept. In any action by a client against a broker, written records of discussions can be crucial to defending the claim, particularly given that discussions of areas of risk and availability of cover can often occur in meetings and on telephone calls in the lead up to a renewal date where time is tight.

A year in (brief) review for W&I insurance

As may be expected, the rise of COVID-19 at the beginning of last year introduced considerable uncertainty into the Australian mergers and acquisitions and warranty and indemnity **(W&I)** insurance markets.

Despite this, healthy levels of activity continued across a range of sectors throughout the year.[26] Almost half of the deals on which KWM advised were insured, with the use of W&I insurance being particularly popular for competitive sale processes, private equity deals and larger transactions (W&I insurance was used on approximately 75% of competitive sales, 64% of private equity deals and 74% of transactions with a value of equal to or greater than $100 million).[27] As a result, notwithstanding the effects on the market of COVID-19, the use of W&I insurance experienced a dip of only 7% when compared to the use of W&I insurance on KWM-advised deals in 2019.[28]

This article summarises the key issues and trends we observed as emerging in the W&I insurance market in 2020.

Key areas of underwriting focus

The past year saw W&I insurers focus their underwriting efforts in the following key areas:

Area of underwriting focus	Comment
COVID-19	Insurers conducted COVID-19 specific underwriting and expected due diligence to address both the impact of the pandemic on the warranties to be given by the seller(s) under the sale agreement and the management by the target business of any pandemic-related risks.
Business continuity and disaster recovery plans	Insurers also sought to understand how target entities were managing risks arising as a result of the pandemic (and the associated government restrictions) from a business continuity and disaster recovery perspective.
Financial performance and stability	In light of the business risks associated with COVID-19, insurers required greater levels of visibility over the financial performance and stability of the target (or, in the alternative, any solvency risks).
Material contracts and supply chains	Insurers focused on the target's ability to perform under material contracts and the termination rights under those contracts in the event of a failure or an inability to perform. Similarly, insurers sought to familiarise themselves with any supply chain risks associated with the business of the target.
Cyber, privacy & data protection	While insurers have always been wary of cyber, privacy and data protection risks associated with the target, the potential for additional vulnerabilities to arise as a result of the pandemic caused insurers to have a heightened awareness of these risks.
Tax	Tax risks are also typically a key area of underwriting focus for insurers, and 2020 was no exception. Insurers continued to consider whether any specific tax exclusions were required (for example, in relation to fringe benefits tax, the application of transfer pricing legislation or any ongoing audits of the target group).
Compliance with laws	Always a key area of interest, insurers required a thorough understanding of the target's compliance with applicable laws.
Employment	When it came to matters of employment, insurers were particularly concerned to understand any risks relating to employee miss-classification, award compliance and, if applicable, compliance with the holiday pay laws in New Zealand.

Trends in deal-specific exclusions

Depending on the findings of the due diligence undertaken, insurers typically sought to include deal-specific exclusions for risks the subject of the above key areas of underwriting focus.

For COVID-19 risks, many insurers initially sought to include broad exclusions of cover in W&I (and other) policies for losses arising as a result of the pandemic. Broadly worded exclusions often had the effect of significantly undermining the cover otherwise available under the policy.

However, the latter part of 2020 saw insurers begin to take a more commercial and pragmatic approach. Subject to underwriting, insurers were often willing to agree to narrow the scope of any required COVID-19 exclusions (or remove them entirely).

Other common deal-specific risks which insurers sought (subject to underwriting) to exclude from cover under W&I policies included:

- breaches of duty in relation to the provision of professional services;
- defects in products and services sold, manufactured or supplied by the target group;
- pollution; and
- anti-bribery and corruption.

Developments with respect to new breach cover

The last year saw a distinct preference on the part of buyers to use deferred closings as a means to manage COVID-related risks.[29]

However, the impacts of COVID-19 also gave rise to a reluctance on the part of insurers to offer new breach cover. Indeed, even where new breach cover was offered, some insurers were only willing to provide cover on a rolling 10 business day basis (rather than the usual rolling 30 business day basis). In addition, material adverse change clauses and any mechanisms in the transaction documents which required the seller(s) to update the buyer in respect of the operations of the target's business during the period between signing and completion became subject to increased scrutiny from insurers.

As a result, there was a notable increase in buyers seeking to include a right to terminate for warranty breaches arising in the period between signing and completion in the transaction documentation.[30]

Conclusion

We expect that W&I insurance will continue to be a key component of M&A transactions in the coming year, with its use increasing in public deals.

Coffee with Craig Claughton

Craig Claughton is the Managing Director and Head of Financial and Professional Services, Pacific at Marsh (a member of Marsh & McLennan Companies, Inc.).

When KWM sat down with Craig Claughton of Marsh at a Barangaroo café for this interview, it had been almost 12 months since the COVID-19 pandemic erupted. KWM asked Craig to reflect on his almost 40 years in the insurance space, what impact a tumultuous 2020 had on insurance participants, and what we should expect in 2021. The key message? Volatility.

You've been in the insurance space for a long time now. Where did it all begin for you? What was your first job in the industry?

My first job in the industry was back in 1982, at an underwriter in Adelaide. During high school, I was one of those kids that knew I didn't want to go straight to University full time, part-time maybe, but I wanted to work – I was a bit sick of education! The father of a girl I went to school with was working at Australian Eagle. They were looking for cadets around that time, so I started there as an Office Junior, in the mailroom and doing some filing work. I moved into the claims department in the Motor Vehicle and Workers' Compensation insurance space. Not many [insurance] people start in the claims space but it gave me a really good grounding in insurance and I learnt a lot there.

After stints in domestic and commercial underwriting, I then got the prized job of an "Inspector", which was prized because it came with a company car and a company mortgage (and locked in a rate of 7.5% … which was good then).

In 1991, I moved to London for three years in an underwriting role, then came back to Australia. I moved through Adelaide, Melbourne and then ended up in Sydney.

I started at Marsh in 2002, as a broker and 19 years later I'm still here. Going into broking was a total revelation – I soon realised my skills are much more suited to broking than underwriting – I like dealing with the clients and being really hands on.

The industry has seen huge change over that time. What have been some of the biggest changes you've seen?

There are two main ones that come to mind. The first is regulation: the introduction of the Insurance Contracts Act and the Insurance (Agents and Brokers) Act in 1984 were big. That was the beginning of what we now see as industry regulation and standardisation. They also brought in this concept of prescribed classes. Up until that point, all of the rumours about that time were true – a lot of deals done on the back of coasters in pubs.

The second is the changes we've seen to the class action environment. Those huge increases in activity have had a very significant impact on D&O and PI and has been a big catalyst for a lot of change in Australia, even recently.

Other events that had significant impacts were the Royal Commission into HIH – we just didn't ever consider the collapse of someone like HIH a possibility so that was a wake-up call – and the internet. I remember for one employer I had to draft a business case to justify why we should get licenses for access!

Talking of change, the last couple of years in the financial and professional liability insurance space have been like no other. How did 2020 end up?

From a client advocate perspective, disappointing. As you say, limits were way down, self-insured retentions and premiums much higher and clients were just not able to buy the capacity they had in previous years.

From a broking perspective, we had some outstanding results being able to actually secure cover in a really, really difficult market. It was especially difficult because of COVID-19, which meant we weren't able to sit across from underwriters and negotiate. Broking still relies heavily on personal connections and networks, so that was a significant tool of ours taken away.

COVID-19 also had some other impacts not yet known: impacts to culture, training and experience of juniors in the industry who weren't able to learn by osmosis this year.

But, there were a lot of positives. Even with the pandemic, everything still got done and we proved that the technology actually worked.

What lessons have you learnt from 2020 that you'll try to take with you in the future?

I learnt not to have expectations for the next year! I say that tongue in cheek, but our clients rely on our ability to look at the environment and anticipate what could happen (especially in premiums) and that is so much more difficult in this market.

I would also say that I learnt to make sure we present all available options to the client and that we don't make any assumptions about what might be right and / or wrong for them.

How have some of your clients been dealing with those changes in capacity last year? KWM has certainly seen an increase in less traditional risk management methods like the use of captives.

The majority of issues we faced in 2020 were in the D&O space of course.

By and large, there is simply no silver bullet solution but we have seen an increase in and certainly considered captives and Protected Cell Captives, parent-owned captives, discretionary trusts, and reducing, or not taking out Side C cover.

[The current market] is probably the hardest D&O market I have seen in my career. What's unique about this hard cycle is that while the insurance market has always cycled from soft to hard, each only lasts about 3 years. The length of the soft market that preceded this hardness was 8 or 9 years, which is just unheard of. That never could have lasted – it's just not sustainable.

What are you expecting in the D&O and PI space for 2021?

Unfortunately, much like 2020 I think. The volatility will continue but it's really difficult to make any other advance observations. I don't think premiums will go backward and there may be further increases but probably not of the magnitude we have seen in the past couple of years.

I do think there will be less insurance purchased and companies will take more of a risk to their balance sheet, so I expect to see further instances of Side C cover not being taken out.

The Report of the Parliamentary Joint Committee inquiry into Litigation Funding and Regulation of the Class Action Industry could have fairly widespread impacts.

The other likely change this year is that with larger retentions, we might see some companies more willing to defend actions rather than settle.

You have historically spent a significant amount of time in London each year with London-based insurers. With the travel bans this year due to COVID-19, how has that impacted the market and renewal discussions?

The key impact was just not being able to establish or continue the relationships that we otherwise would have with underwriters and others in the industry. The industry is still so reliant on those relationships.

I think it also made it easier for underwriters to say no in negotiations, because they didn't have to do it face to face.

Did you miss the travel?

Yes, absolutely. I had six or so trips in the first half of 2020 that were cancelled.

What is one piece of advice you wish someone gave you when you were starting out?

I have two!

The first is that when I started, I was quite shy (even though no one would believe that now), but I thought the only way that I could make my career work is if I looked and acted a certain way. But authenticity is so valued here, so be yourself! It's great to see lots of younger people starting out now and being who they really are.

The second is to have an international focus. I spent 10 years working in insurance in Australia but it wasn't until I worked in London and came back that I really knew how the insurance market functioned. I was much better able to advise clients because of that experience – I had been exposed to so many other options.

William Lewis is the Head of Asia Pacific for Liberty Global Transaction Solutions (Liberty GTS) and an Executive Director of Liberty Speciality Markets Australia.

Starting his career as a tax lawyer, Will Lewis never expected to ever go into insurance but more than eight years into a journey, he has no plans of leaving. KWM asked Will to explain what 2020 was like in the world of specialty underwriting and what's next in 2021.

You didn't start your career in insurance. How did you get into the underwriting business?

That is right. I started as a tax lawyer working in New Zealand where I grew up. I worked in the UK for several years (still as a tax lawyer, but doing lots of private equity and restructuring work). When I moved to Sydney, I started working at Allen & Overy soon after it first commenced operations.

While at Allen & Overy I had the opportunity to take up a secondment with Ironshore. Ironshore was also just starting out, there would have been only two-three people in the office when I joined on secondment around 2012. I stayed with Ironshore from then on. I saw Ironshore develop from a start up in Australia to something much bigger.

Ironshore was acquired by Liberty Mutual Insurance in early 2017. I was the Managing Director of Ironshore Australia at that time so I worked with Liberty to integrate parts of the business and launch Liberty GTS in Asia Pacific.

Starting off as a tax lawyer, did you ever think you would end up in insurance?

I certainly never planned to end up in the insurance world, but I think that is probably common to a lot of people. You never know how interesting insurance can be until you're in it.

What is your current role?

I'm the Head of Asia Pacific for Liberty Global Transaction Solutions and an Executive Director of Liberty Specialty Markets Australia.

My role is largely setting the strategy for the business with some involvement in large or significant risk assessments and any particularly litigious claims. I also have marketing, finance, profitability and people management responsibilities.

In other years I also would have said I travel a lot, around Asia mostly, to build relationships and our business there, however that changed a fair bit in 2020.

Do you miss the travel?

I do miss the travel but not travelling hasn't necessarily been a bad thing. I'm sure it will resume as we come through the pandemic.

What do you miss about it?

I think when you travel you create a lot of friendships and you keep them going every time you go back to that place. Relationships are critical. I have been catching up with people on Zoom the last year but it's not quite the same. I would say I've been able to maintain and build on existing relationships but it is more difficult to create new ones.

With travel, we have really just kept trying to kick the can down the road, saying "we'll get there later this year" and postponing things but we obviously don't know when that will happen.

Interestingly, for some of my relationships, the lack of travel has meant that I am catching up more regularly via Zoom whereas in previous years I would have waited to be in country to catch up. So, actually more regular conversations with some people which is a good thing.

In terms of our business, I think Liberty GTS as a team has also probably gotten closer even though we're across the world – we are deliberately and consciously talking more.

What are some of the challenges you and the team faced in 2020?

We have spoken about maintaining business relationships already, but from a people development perspective, 2020 was also hard.

How do you mentor in this new environment? How do you make sure members of the team, particularly the more junior members, are learning? It's definitely something we are thinking about as a business.

We invest a lot of time and energy into considering the business we write. It takes time for our people to develop confidence in assessing risk and experience. That has definitely been a harder skill to replicate in the current environment.

What are some of the biggest changes you've seen in insurance since you started at Ironshore?

The hardened market in the financial lines space is a significant change and very interesting to be a part of. It's good to see a correction coming through the market.

We've also seen big changes in the aggregation of certain insurance companies and perhaps a retreat of the traditional Managing General Agents. It will be interesting to see how many MGAs re-emerge as the market continues to harden.

Are you game to make any 2021 predictions?

We are largely in the non-renewable insurance space, so our market is probably more flat than hard. The Australian and Asian businesses are doing well.

In 2021 I would expect premiums to increase on last year.

I also think our tax product will grow and I expect to see increased activity in the M&A space again. We are already seeing a number of submissions for the year. I think the number of transactions (relevant to W&I) will increase but the value of those transactions will be smaller than pre-COVID-19 and there will be less interest from China in buying into Australia.

You have spoken about the importance of relationships, and the time taken to consider risks. How worried are you about big data / AI replacing some of the human functions of underwriting in the future?

Technology can certainly be used to make a business more efficient. I certainly think increased use of data and analytics are key to getting better at what we do, but relationships, technical knowledge and expertise is still so important, particularly for a speciality lines business like Liberty GTS.

We use raters and actuaries but the assessment of risk is still first done by our underwriters.

The industry may over time get more automated but I think we are a fair way off being fully automated.

Talking about the assessment of risk, when a new client comes to see you, what are you most interested in knowing?

Two main ones, what sector they are in and how much they understand about what they're buying.

In terms of sector, we want to know what they are buying, why, and how much they plan to pay for it. What is the strategic rationale behind buying it? Why does it make sense to the company to acquire the target?

Secondly, what due diligence have they done? Do they have a broad understanding of what the target does and what are the opportunities for recovering loss outside of the policy itself?

Do you have a piece of advice you give now that you wish you had gotten in the past?

I think just to push for what you want. Get a clearly defined understanding of what you want and where you want to be – in your career the sooner the better – and articulate that to others when you're able. Doing that will take you a lot further than if you simply waited for it to come to you.

Good faith in the face of non-disclosure - *Delor Vue Apartments CTS 39788 v Allianz Australia Insurance Ltd (No 2)* (2020) 379 ALR 117

SNAPSHOT

- An insurer may lose its right to avoid a claim for non-disclosure if it confirms it will determine a claim *"notwithstanding non-disclosure issues"*, even if the grant of indemnity is conditional.
- Seeking to resile from such a confirmation can, depending on the circumstances, constitute a breach of the duty of utmost good faith by an insurer.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The content of the statutory duty of utmost good faith set out in section 13 of the Insurance Contracts Act 1984 (Cth) (ICA).
- The nature of the right to avoid a claim for non-disclosure contained in section 28(3) ICA.
- The interaction of the general law (estoppel and waiver) and the statutory duty of utmost good faith.

Facts

- A body corporate of apartments in Queensland, Delor Vue Apartments CTS 39788 **(Delor Vue)** submitted a claim under its property insurance policy, underwritten by Allianz Australia Insurance Ltd **(Allianz)** for damage to the apartment block due to cyclone damage.
- Before entry into the policy, Delor Vue failed to give proper disclosure because it failed to inform Allianz of certain roof defects (which caused or contributed to the damage) thus breaching its duty to disclose in accordance with section 21(1)(b) of the Insurance Contracts Act 1984 (ICA) **(Misrepresentation).**
- As a result of the Misrepresentation, Allianz had the right under section 28(3) of the ICA to reduce its liability for Delor Vue's claim to nil. However, by an email dated 9 May 2017 **(May 2017 Email),** Allianz confirmed to Delor Vue that it would cover the claim. The email relevantly stated:

  "Despite the non-disclosure issue which is present, [Allianz] is pleased to confirm that we will honour the claim and provide indemnity to [Delor Vue], in line with all other relevant policy terms, conditions and exclusions".

- In the twelve months following the 9 May 2017 email, Allianz:
  - took steps to hold third parties (builder and developer of the complex) responsible for defective building work; and
  - undertook an assessment of the damage according to the terms of the policy, which required the cooperation of Delor Vue and Allianz's unfettered access to the complex.
- In May 2018, Allianz sought to resile from the statements in the May 2017 Email by offering Delor Vue a "take-it-or-leave-it" lump-sum offer of settlement of the claim, stating that Allianz, due to the Misrepresentation, was entitled to rely on section 28(3) ICA **(May 2018 Offer).**
- The May 2018 Offer was expressed to be open for 21 days and if not accepted by Delor Vue, *would "lapse and [Allianz] will pay $nil pursuant to section 28 of the [ICA] on the basis of [Delor Vue's] non-disclosure as referred to in [the 9 May 2017 email] …"*
- Delor Vue commenced proceedings against Allianz, relying on arguments as to election, waiver, estoppel and the duty of utmost good faith in support of its position that Allianz was bound to honour Delor Vue's claim for indemnity.

Analysis of the court

Allsop CJ made the following findings in considering the issues in dispute:

- **As to election:** the doctrine of election was not appropriate in this case, as there were not two alternative and mutually exclusive rights available to Allianz necessitating an irrevocable choice be made. The May 2017 email was not a renunciation of a right in favour of another, incompatible alternative, but a representation that Allianz would not use the available section 28(3) remedy. The Court considered that the correct analysis to apply is whether Allianz, in all the circumstances, should be permitted to resile from that representation.[31]
- **As to estoppel:** the Court found that there was a sufficiently clear representation in the wording of the 9 May 2017 email to establish an estoppel. The Court considered the mutual obligation of utmost good faith between the insurer and the insured (and the rights to the insurer that flow from the mutuality of that obligation)[32] relevant to the circumstances of the representation, as well the Court's consideration of the remedy flowing from the estoppel. Allsop CJ rejected the notion that relief was restricted to *"removing or reversing, by the minimum equity necessary… the prejudice or detriment suffered"* on the simple basis that equity requires parties, and especially parties required to comport themselves with utmost good faith, to keep their word.[33]

Case Notes

- **As to waiver:** the Court noted that waiver (which was established), is a cognate to the estoppel argument with the substantive difference between the two being that it is the benefit obtained by Allianz, rather than detriment occasioned to Delor Vue that is the relevant consideration[34]
- **As to good faith:** the statutory obligation of good faith, in this case, prevented Allianz from resiling from its position ("in effect a promise"[35]) in the 9 May 2017 email.[36] Further, and more specifically, in the event of a dispute regarding the financial allocation of the loss, Allianz, having had the benefit of Delor Vue's cooperation and access to the site for 12 months, should have utilised the dispute resolution mechanisms within the Contract, (as Allianz had, in effect, promised to do) rather than sending the letter containing the May 2018 Offer. Although the form of relief proposed by the Court to address this particular breach was declaratory, the Chief Justice noted that damages and injunctive relief were also available[37]

Result

- Declaratory relief ordered in favour of Delor Vue against Allianz
- The declaration was to the effect that:
  - Delor Vue had breached its duty of disclosure required by section 21(1)(b) of the ICA by way of the Misrepresentation;
  - Consequently, Allianz had the right under section 28(3) of the ICA to reduce its liability for the claim relating to cyclone damage to nil. However, Allianz lost that right on 9 May 2017 when Allianz confirmed by email to Delor Vue that it would determine the claim according the policy terms under the Contract, notwithstanding "non-disclosure issues", comprising the Misrepresentation; and
  - Allianz:
    - is estopped from resiling from the 9 May 2017 email position (which it purported to do in May 2018, when, following 12 months of engagement with Delor Vue's claim, Allianz provided a take-it-or-leave-it lump-sum offer of settlement of Delor Vue's claim, on the basis that Allianz, due to the Misrepresentation, was entitled to rely on section 28(3) ICA) (May 2018 Offer);
    - waived, by the 9 May 2017 email, its entitlement to reduce Delor Vue's claim under section 28(3) of the ICA; and
    - failed, by the May 2018 Offer, to act towards Delor Vue in relation to the resolution of the claim with the utmost good faith, in breach of section 13 of the ICA

Insufficient notification & fraudulent misrepresentations: a lethal mix - *Esined No 9 Pty Limited v Moylan Retirement Solutions Pty Ltd* [2020] NSWSC 359

SNAPSHOT

- The application of the deeming provision in section 40(3) of the *Insurance Contracts Act 1984* (Cth) **(ICA)** (which permits a "circumstances notification") turns on its facts. For notifications pursuant to section 40(3) to be valid, there must be a recognisable link between the identified facts that might give rise to a claim and the claim, when made. *"Bare possibility"* of a claim is not enough.
- Knowingly making false statements about events that have occurred in a circumstances notification and/or proposal form can constitute fraudulent misrepresentation and fraudulent non-disclosure.

INSURANCE ISSUES CONSIDERED BY THE COURT

- What constitutes valid notification of "facts" under section 40(3) of the ICA?
- What constitutes fraudulent non-disclosure under section 28(2) of the ICA?
- What constitutes fraudulent misrepresentation under section 28(2) of the ICA?

Facts

Moylan Retirement Solutions Pty Ltd **("Moylan" or "the Insured")** was a financial planning firm. A number of former clients brought claims against Moylan for failed investments and misconduct, and then brought proceedings against the Insurers after Moylan was deregistered.

Three separate actions were commenced pursuant to section 601AG of the *Corporations Act 2001* (Cth) **("Corporations Act")** against the Insurers under 2012/2013 and 2013/2014 professional indemnity policies to recover losses claimed to have been sustained as a result of Moylan's advice and misconduct.

To succeed against the Insurers, the plaintiffs had to satisfy, inter alia, that the relevant PI policies responded to Moylan's liability to its clients. The Insurers denied liability for the claim on several grounds, including that the Insurers were not validly notified of any claim for civil liability during each policy year, and that Moylan had engaged in fraudulent misrepresentation and non-disclosure.

Moylan provided a notification to its Insurers on 15 January 2013 **("15 January 2013 Form")**, and the plaintiffs sought to rely on this notification as notifying of circumstances that might give rise to a claim, during the period of insurance (noting that the action and demands by the plaintiffs arose after the relevant policy of insurance had expired). The cover letter which accompanied the 15 January 2013 Form noted "In relation to the potential claim, at this stage it is just a potential possibility and no action has been brought." There was also an Appendix to the 15 January 2013 Form which stated:

"A small number of clients have invested/lent funds to property investments and/or companies that have to date been unable to repay those funds in total.

At the time of the investment all appropriate disclosures were made and clients invested/lent funds with full knowledge of the circumstances at the time.

At this stage no loss has been crystallised and no claim or complaint has been formally lodged.

We wish to advise the insurance company that there is a chance of a claim against Moylan Retirement Solutions in relation to any loss that may be incurred."

*"Where the insured gave notice in writing to the insurer of **facts that might give rise to a claim against the insured** as soon as was reasonably practicable after the insured became aware of those facts but before the insurance cover provided by the contract expired, the insurer is not relieved of liability under the contract in respect of **the claim, when made,** by reason only that it was made after the expiration of the period of the insurance cover provided by the contract." (emphasis added).*

Analysis by the court

Slattery J made the following findings in considering the issues in dispute:

- **As to what constitutes a "fact" capable of notification under section 40(3) of the Act:**
  - section 40(3) of ICA states:
  - The Court was required to consider whether a valid notification was given under the 2012/2013 policy in the 15 January 2013 Form. The Court found there was no valid notification under section 40(3) of the Act for the 2012/2013 policy year because the notification did not identify facts that might give rise to a claim against the insured. For section 40(3) to apply, there needs to be an identifiable link

between "facts that might give rise to a claim", provided in writing to the Insurer, and "the claim, when made".

- The Court considered that the 15 January 2013 Form failed to provide any information that would assist in identifying any particular claim, as opposed to "bare possibilities". The Insured failed to identify, for example, particular clients, documents, transactions or losses which could give rise to a claim.

- **As to what constitutes fraudulent misrepresentation / fraudulent non-disclosure under section 28(2) of the Act:**
  - Notwithstanding valid notifications on later policies, the Court was required to consider whether the 15 January 2013 Form constituted fraudulent non-disclosure and fraudulent misrepresentation, thus permitting the Insurers to avoid the 2012/2013 PI policy.
  - Applying the *Briginshaw* principle (effectively, that the court does not lightly make findings that, on the balance of probabilities, a party to civil litigation has been guilty of serious misconduct; the nature of what is sought affects the strength of evidence necessary to establish such findings.) the Court found that Moylan had made fraudulent misrepresentations in the 15 January 2013 Form. In particular, the Court took the following issues with the Appendix to the Form, stating that the following statements constituted fraudulent misrepresentations:

Statement	Why this was misleading
"unable to repay those funds in total" (our emphasis)	Mr Moylan, the principal of Moylan, knew that in fact no principal amounts had been repaid and almost no interest had been paid since late 2009.
"all appropriate disclosures were made and clients invested/lent funds with full knowledge of the circumstances"	Inadequate or a lack of disclosure relating to numerous matters including undisclosed conflict of interest, undisclosed financial risks associated with the investments recommended and undisclosed misapplication of funds to destinations other than those authorised by the plaintiffs.
"no loss has been crystallised"	Mr Moylan knew that by 15 January 2013, the entities were in liquidation or otherwise had no realistic prospect of repayment when assessed objectively.
"no claim or complaint has been formally lodged"	By late 2012, a group of the plaintiffs had been demanding repayment of their money, and other plaintiffs made complaints about the return of their money.

  - Given Mr Moylan possessed information which demonstrated the inaccuracy or falsehood of the above statements, the Court found that these misstatements could not have been made negligently or accidentally. Therefore, Mr Moylan was found to have been aware that the relevant statements were false, constituting fraudulent misrepresentations, when he sent the 15 January 2013 Form.
  - For similar reasons as those which led to a finding of fraudulent misrepresentations, the Court found that Moylan had engaged in fraudulent non-disclosure in the 15 January 2013 Form. The Court concluded that Mr Moylan withheld the relevant information because he had reasons to believe he would not obtain further insurance if proper disclosure was made to the Insurers.

Outcome

- The insurers were entitled to deny indemnity for the claim under the 2012/2012 PI policy because there was no valid notification of a "claim"; and
- Despite valid notification on the 2013/2014 policy, Insurers were entitled to avoid the 2013/2014 PI policy on the basis that the Insured made fraudulent misrepresentations and fraudulent non-disclosures.

King & Wood Mallesons

Knowledge is key - DIF III - *Global Co-Investment Fund LP v DIF Capital Partners Ltd* [2020] NSWCA 124

SNAPSHOT

- Where a policy of insurance permits notification of facts or circumstances which could reasonably be anticipated to give rise to a claim of which the Insured is "aware", knowledge that losses may be suffered by a third party is not by itself a matter which could reasonably be anticipated to give rise to a claim absent the disclosure of some basis on which the third party might make a claim against the insured.
- Whether the relevant Insured was "aware" will turn on the specific facts of the case.

INSURANCE ISSUES CONSIDERED BY THE COURT

- What is required to establish that an Insured was "aware of any fact, circumstance, or event which could reasonably be anticipated to give rise to a claim"?

Facts

- In September 2007, DIF III – Global Co-Investment Fund L.P **(DIF III)** entered into a management agreement **(Management Agreement)** with Babcock & Brown Direct Investment Fund Limited **(Manager)** under which the Manager would consider and approve investments presented to it by the Manager's investment officers
- The Manager had a professional indemnity policy **(Policy)** which applied "only to third party Claims first made against the Assured during the Policy Period." The Policy Period was 1 September 2008 to 1 September 2009. The Policy provided that a third party Claim was made when, relevantly, the Assured's Management (that is, the Manager) "becomes aware of any fact, circumstance or event which could reasonably be anticipated to give rise to a Claim at any future time." The Policy also contained a deeming provision deeming later Claims arising "as a direct result" of notified circumstances to be a Claim first made at the time of notice. No relevant notification was made during the Policy Period
- In November 2007, DIF III made an investment in a transaction on the recommendation of the Manager, which subsequently failed
- In 2018, DIF III pursued a number of causes of action against the Manager, including a breach of the Management Agreement for failure to exercise due diligence in carrying out its functions, powers and duties. DIF III also sued the Manager's professional indemnity insurers **(PI Insurers)**. The Manager admitted that it had breached the Management Agreement but denied there was any loss. The PI Insurers denied that they were obliged to indemnify the Manager under the Policy on the basis that the Manager had not become aware of any "fact, circumstance or event which could reasonably be anticipated to give rise to a Claim" at any time during the Policy Period
- The Supreme Court held that the PI policy did not respond because no such knowledge had accrued. Most notably, the Supreme Court found that section 54 of the *Insurance Contracts Act 1984* (Cth) **(Act)** cannot cure a restriction inherent in the claim itself and therefore cannot cure a failure to notify where there was no awareness of a notifiable circumstance
- On appeal to the NSW Court of Appeal, DIF III relied on three communications with the Manager's Investment Officer which demonstrated that (1) in November 2008, the Manager had been informed that the investment was "distressed" and the realisation of value was now "impossible" (2) the Manager was "interested in seeing [an] email trail" between parties involved in the underlying transaction agreeing the deal was "uncommercial" (there was no evidence the Officer saw the relevant chain); and (3) in February 2009, the Manager had assessed, based on a valuation in October 2008, that the equity value of the target entity in the transaction was nil
- The Supreme Court's finding that section 54 cannot cure a failure to notify where there is no awareness of the relevant fact or circumstance within the policy period was not appealed

Analysis by the court

- The Court of Appeal, upholding the below decision of Ball J, found that knowledge that losses may be suffered by a third party is not by itself a matter which could reasonably be anticipated to give rise to a claim absent the disclosure of some basis on which the third party might make a claim against the insured.[38] Specifically:
  - the first communication relied upon by DIF III contained no suggestion that the funding or capital deficiencies were not simply a consequence of the 2008 global financial crisis, that they should have been discovered earlier by the Manager or were a consequence

of inaccurate assumptions in the modelling relied upon by the Manager, nor that the Manager might be held responsible in any way for losses flowing from the investment's failure;[39]

- the second communication did not disclose a sound basis for thinking that a claim might be brought against the Manager based on the conduct of deal team members;[40] and
- the third communication was concerned with the target entity's financial position and did not indicate any party had a basis for making a claim arising out of the conduct of the Manager[41]

- In arriving at this conclusion, the Court of Appeal applied the following principles (from a 2019 UK case) regarding the construction of circumstance notification provisions:[42]
  - the provision should be construed with a view to its commercial purpose, being to provide an extension of cover "for all claims in the future which flow from the notified circumstances";
  - the requirement to notify circumstances that "may" give rise to claims is a "deliberately undemanding test";
  - a circumstance notification may notify "a 'problem' described in general terms" rather than an event, even where the quantum and character of the claim and identity of the claimant is unknown, provided the problem may, of itself, give rise to a claim;[43] and
  - while the insured must be aware of the notifiable circumstances, it need not be aware of the cause of the problem or its consequences
  - Despite the test being described as "deliberately undemanding" DIF III remained unable to meet that test on the evidence presented because the problems notified did not constitute anything that may by themselves give rise to a claim

Result

The Court of Appeal upheld the Supreme Court's decision in DIF III - *Global Co-Investment Fund LP v Babcock & Brown International Pty Ltd* [2019] NSWSC 527,[44] that the insurer is not liable for the claim because, on the evidence relied upon, the Manager did not have knowledge of the relevant facts or circumstances at the time the purported notifications of circumstances were made

Double trouble: *QBE Insurance Australia Limited v Allianz Australia Insurance Limited* [2020] FCA 589

SNAPSHOT

- The double insurance principle prevents an insurer being unjustly enriched at the expense of another and applies when each insurer insures, against the same (but not identical) risk.
- Where an insurer is able to claim an equitable contribution from another insurer, that contribution (depending on the terms of the insurance policy) may extend to the legal costs incurred by the insurer in defending legal proceedings.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Was a subcontractor an "insured" as defined within the contractor's insurance policy for the purposes of equitable contribution?
- Did the contribution required to be paid extend to legal costs?

Facts

- Pursuant to a Head Contract, a property developer retained a contractor, Southern Cross Constructions (ACT) Pty Ltd **(Contractor)** to undertake building work in Sydney
- The Contractor engaged Pile & Bucket Pty Ltd **(Subcontractor)** as subcontractor to perform excavation works on the project
- Pursuant to the Head Contract and Subcontract, the Contractor took out public liability insurance underwritten by Allianz Australia Insurance Ltd **(Allianz)** that covered the developer, the Contractor, the superintendent and any subcontractor for loss or damage to property during the course of work under a contract **(Allianz Policy)**. The Subcontractor held a broadform liability policy with QBE Insurance (Australia) Ltd **(QBE) (QBE Policy)** (and the Subcontractor was required to hold valid liability insurance as a condition of the Allianz Policy)
- The Contractor was the Named Insured (as defined) under the Allianz Policy. The word "Insured" was separately defined to include "all sub-contractors but only whilst acting in the scope of their duties as sub-contractors in relation to the Insured Contract." "Insured Contract" was defined as "the contract or agreement entered into by the Named Insured which gives rise to the Contract Works and includes any sub-contract or sub-agreement"
- Owners of a property adjacent to the relevant building work instituted an action against the Contractor, Subcontractor and others for damage to their property allegedly caused in the course of the works. The Subcontractor settled the dispute for approximately $820,000 and QBE as the insurers of the Subcontractor paid the settlement amount
- QBE sought a contribution from Allianz on the basis that the Allianz Policy would have indemnified the Subcontractor as an Insured for the claim, giving rise to dual insurance. A dispute arose between QBE and Allianz as to various issues but primarily concerned whether the Allianz Policy would have responded to a claim by the Subcontractor and whether QBE had any entitlement to contribution in respect of damages, costs and defence costs incurred by QBE in defending and settling proceedings on behalf of the Subcontractor

Analysis by the court

- In Australia, the statement of the principle of dual insurance generally cited is that of the majority in *Albion Insurance Co Ltd v Government Insurance Office of NSW*:[45]

  "There is double insurance when an assured is insured against the same risk with two independent insurers. … The insured may claim indemnity from either insurer. However, as both insurers are liable, the doctrine of contribution between insurers has been evolved … The doctrine, however, only applies when each insurer insures against the same risk, although it is not necessary that the insurances should be identical"
- Based on an analysis of the defined terms "the Insured", "Insured Contract" and the policy wording as a whole, the Court concluded that the Subcontractor was an Insured as defined in the Allianz Policy. As the Subcontractor was an insured for the purposes of the Allianz Policy, QBE could claim an equitable contribution from Allianz given that both policies would have responded to the liabilities and costs arising from the relevant proceedings
- The Court held that the requirement that the Subcontractor have a policy gave Allianz the comfort of co-insurance for any such subcontractor. This requirement did not however mean that the Subcontractor was not to be considered as meeting the definition of "the Insured" under the Allianz Policy because the definition of "the Insured" rests upon the requirement of the Allianz Policy to cover the interest of the Subcontractor, which is found

in the “Insured Contract”. In respect of whether any equitable contribution extended to the costs incurred by QBE in the defence of the Subcontractor’s underlying dispute, Allianz argued that there could be no right of contribution because QBE conducted the defence, appointed its own lawyers and spent its own money. Allianz also argued that the Subcontractor’s dispute was settled, meaning there was no liability and therefore no indemnification by QBE of the Subcontractor

- Having regard to the principles set out in *Albion Insurance*, Allsop CJ held that the duty to defend and the incurring of defence costs were together part of a policy of indemnity and were inseparable. The Subcontractor, as the insured, was entitled to its defence costs in defending the claim. The Court stated that having regard to both the principles of dual insurance and the clauses of the Allianz Policy, there was no “reason in justice or equity why the appropriate proportion of those costs should not be shared justly between the insurers, at least those costs referable to defending the claim for which both insurers were liable to indemnify the insured”

Result

- In proceedings commenced in the Insurance List, the Federal Court (Allsop CJ) applied the principle of dual insurance (also known as the doctrine of contribution) and held that a subcontractor’s insurer (QBE) could claim an equitable contribution from a contractor’s insurer (Allianz), and that such contribution extended to defence costs incurred by the subcontractor’s insurer

The conventional approach still stands: no disclosure of insurance documents unless special circumstances exist: *Evans v Davantage Group Pty Ltd (No 2)* [2020] FCA 473

SNAPSHOT

- A plaintiff will typically not be able to obtain insurance documents relating to whether a defendant will be indemnified for the plaintiff's claim unless the insurance documents are relevant to the facts in dispute. Wanting to ascertain whether the proceedings are worth continuing is not sufficient to justify a departure from the conventional approach.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Does the Court have the power to order production of insurance documents; and
- If the Court does have such a power, should it compel production of the insurance documents?

Facts

The relevant facts can be summarised as follows:

- the representative applicant, Evans, commenced class action proceedings against the respondent, Davantage Group Pty Ltd;
- investigations suggested that the Respondent did not have the means to pay the damages sought without insurance cover;
- the Respondent's professional indemnity insurers had denied indemnity;
- the Applicant sought production of the insurance documents **(Relevant Insurance Documents)** from the Respondent, including copies of insurance policies and all communications between the Respondent and insurers concerning the insurers' position on indemnity under any policy pursuant to section 33ZF(1), 37M and 37P of the *Federal Court of Australia Act 1976* (Cth) **(Act)**[46] on the basis that they were required to determine whether:
  - it was commercially viable to prosecute the proceeding to judgment;
  - it was appropriate to settle the matter and if so for what quantum;
  - an application for approval of a settlement amount (as required pursuant to section 33V of the Act) was likely to succeed; and
  - it was necessary to take action against any insurer to obtain declaratory relief as to the existence or scope of any indemnity in relation to the applicant's claims.

(Relevant Circumstances)

The Respondent and the primary and excess Insurers (as non-parties) opposed production of the policies.

Analysis by the court

Beach J's determination and analysis can be summarised as follows.

Finding 1
The Relevant Insurance Documents were not relevant to the facts in dispute

- Beach J found that the Relevant Insurance Documents were not relevant to the facts in dispute. His Honour stated that, in such circumstances, the "conventional position" is that:
  - insurance documents are not normally discoverable unless specific exceptions, such as insolvency principles, apply;[47] and
  - an applicant has no right to examine a respondent ahead of trial in order to elicit information regarding the respondent's means and whether the proceedings should be pursued[48]

Finding 2
The Court has the power to order production of insurance documents (but not in the way submitted by the Applicant)

Section 23 of the Act

- Beach J found that the Court has the power to order production of insurance documents under section 23 of the Act which states:

  > The Court has power, in relation to matters in which it has jurisdiction, to make orders of such kinds, including interlocutory orders, and to issue, or direct the issue of, writs of such kinds, as the Court thinks appropriate[49]

- Beach J did not accept that this power flowed from sections 33ZF(1), 37M and/or 37P of the Act as asserted by the applicant (discussed below)[50]

Section 33ZF(1) of the Act

- The applicant submitted that, consistent with *Simpson v Thorn Australia Pty Ltd trading as Radio Rentals (No 4)* [2019] FCA 1229 **(Simpson)**, section 33ZF(1) empowers the Court to compel production of documents relevant to the ability of an applicant to recover judgment from a respondent.[51] Beach J did not accept this submission and distinguished Evans from Simpson on a factual basis (including that in Simpson, the insurer conceded there was an

arguable case against it for indemnity) and also noted that Simpson was decided prior to the High Court decision of *BMW Australia Ltd v Brewster; Westpac Banking Corporation v Lenthall* (2019) 94 ALJR 51 **(BMW)** which provided guidance on the scope of section 33ZF(1) (discussed below)[52]

- Beach J placed significant weight on BMW, in which an order requiring production of insurance documents was deemed inappropriate because section 33ZF(1):
  - provides a supplementary or gap-filling procedural power to ensure that the pleaded issues are resolved justly between the parties;[53]
  - requires consideration of the position of all parties (not just the group members);[54] and
  - cannot be used to override the conventional position that insurance documents are not discoverable[55]

Sections 37M and 37P of the Act

- Beach J concluded that case management powers do not allow the Court to compel production of insurance documents that are not otherwise discoverable in accordance with the Court rules[56]

Finding 3:
The Relevant Circumstances did not justify production of the Relevant Insurance Documents

- Prospects of the claim and settlement approval
- Providing the applicant with information regarding the prospects of the claim and the appropriateness of settlement were not reasons to compel production because:
  - the Respondent's insufficient funds, and the question of whether it is worth pursuing a proceeding, is not compelling enough to justify production;[57]
  - mediations always occur on imperfect information;[58]
  - if production will confer a tactical advantage on the Applicant, and a corresponding disadvantage upon the Respondent, thereby creating an asymmetry in the parties' positions, facilitating such a course would not usually be appropriate to ensure that justice is done;[59]
  - an "in principle" settlement based on a foundational representation made by the Respondent can occur;[60]
  - the Applicant's lack of access to the Relevant Insurance Documents does not preclude the Court from being able to approve a settlement. For example, the Court could receive the insurance policies from the respondent on a confidential basis or defer assessment of the settlement to a special referee;[61] and
  - if settlement approval was not given by the Court, the Applicant could then decide to apply for information regarding the insurance position[62]

Involvement of insurers

- A foreshadowed application against the Insurers was not a reason to compel production because:
  - the Applicant is a stranger to the policies;[63]
  - the Respondent continued to challenge the Insurers' denials of indemnity;[64]
  - the appropriate application to determine whether to commence proceedings against a third party was instead for preliminary discovery;[65] and
  - the Insurers had denied indemnity so access to the insurance policies would be of limited benefit[66]

Result

- The applicant in a class action sought production of various insurance documents
- Beach J rejected the Applicant's application on the basis that:
  - the Relevant Insurance Documents were not relevant to the determination of any facts in issue in the class action; and
  - the circumstances of the case did not justify departing from the conventional position that:
    - insurance policies are not normally discoverable where they are not relevant to the determination of a fact in issue (save for specific exceptions dealing with an insolvency scenario); and
    - an applicant has no right to examine a respondent ahead of a trial in an endeavour to obtain information about the respondent's means "with a view to deciding whether it is worth his while to go on" (again, save for an insolvency situation)

Sorry, you'll just have to wait for your costs - *Evolution Precast Systems Pty Ltd v Chubb Insurance Australia* [2020] FCA 1690

SNAPSHOT

- An insurer's obligation to pay defence costs, and when that obligation arises, turns on the exact words of the policy.
- Under a liability policy with no advance defence costs clause, an insurer asserting that an exclusion operates to exclude liability for an underlying claim may not be required to pay defence costs until a determination on the application (or non-application) of the exclusion is obtained.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether an insurer is obliged to pay defence costs where the insurer asserts that an exclusion operates to exclude cover (but no judicial determination of the operation of that exclusion has been obtained).

Facts

- Evolution Precast Systems Pty Ltd **(Evolution)** was the insured under a Broadform Liability Insurance policy **(Policy)** with Chubb in respect of its liability for, amongst other things, property loss arising in the course of its business **(Insuring Clause)**
- Evolution was a subcontractor engaged on the "Opal Tower" development in Sydney, which sustained "not insignificant cracking" subsequent to completion. Evolution was joined as cross defendant in two separate proceedings arising out of damage sustained to the Opal Tower and sought indemnity under the Policy for costs and liabilities arising from those proceedings: including the payment of its defence costs
- The parties did not dispute the fact that costs and liabilities for both cross-claims fell within the scope of the Insuring Clause and that defence costs could have been payable prior to the determination of those proceedings. The Insurer, however, denied that the Policy provided cover in respect of those claims, by reason of a clause in the Policy that excluded liability connected with professional advice or service given by the Insured for a fee **(Exclusion Clause)**
- 'Defence Costs' were defined in the Policy as being "All reasonable legal costs and expenses incurred by Chubb or by the Insured with the written agreement of Chubb: a) in defending or appealing a claim against the Insured…"
- Regarding Defence Costs, the Policy provided that:

  "In respect of any liability for Compensation indemnifiable under this Policy, *Chubb will pay Defence Costs, subject to the following:*

  a) *Chubb is not obliged to pay any Defence Costs or to defend any suit after the Limits of Liability has been exhausted;*

  b) *If a payment exceeding the Limits of Liability has to be made to dispose of a claim, the liability of Chubb for Defence Costs is limited to the proportion that Chubb's liability to indemnify the Insured for Compensation under this Policy bears to that payment; and*

  c) *In the event of a claim being made against the Insured in any Court or before any other legally constituted body in the United States of America, Canada or their respective protectorates and territories, the total amount payable by Chubb in respect of any one Occurrence including Defence Costs will not exceed the Limit of Liability."* **(Defence Costs Extension)** (emphasis added)
- The Court was asked to decide the separate question of whether the Insurer was required to pay defence costs unless and until there was a judicial determination that the Exclusion Clause applied. This primarily required the Court determining the meaning of the words "any liability for Compensation indemnifiable under this Policy"
- Evolution argued that the Defence Costs Extension was triggered when the claims were made against it which, if they were successful, would be within the scope of the Insuring Clause. This, Evolution argued, would be sufficient to trigger Chubb's obligation to pay defence costs which would continue unless and until it was established that the Exclusion Clause relied upon by Chubb applied in the particular circumstances
- Conversely, Chubb contended that, if indemnity was denied, the Defence Costs Extension was not triggered prior to a court deciding the question of indemnity, on the basis that the Insuring Clause is qualified by the Exclusion Clause and the Defence Costs Extension is only triggered if the alleged liability is not excluded by the Policy

Case Notes

Analysis by the Court

- The Court agreed with the Insurer's construction of the Policy, and observed that confining the obligation to pay defence costs to only the defence of claims where the insured would be indemnified (on a proper construction of the policy as a whole, including any exclusion clauses) resulted in a "sensible commercial construction" pursuant to which defence costs are only "applied to support the mutually beneficial outcome of defeating the third party's claim", but only if the Insurer was liable to provide indemnity – and that had not been proven yet
- In reaching this conclusion, the Court distinguished the Defence Costs Extension and the Policy from other clauses previously held by courts to require payment in the manner contended for by Evolution. In particular, the Court drew a distinction between:
  - The "expansive" extension in *Karenlee Nominees* which was relied upon by Evolution,[67] which the Court said was triggered merely by the making of a claim for compensation and not, as required by Evolution's Policy, the existence of an "indemnifiable" liability
  - Policies in numerous other cases which referred to an obligation to "advance" defence costs and, in some cases, also imposed an obligation on the insured to reimburse those costs if it transpired that the claim was not within the scope of the policy. The Court considered the absence of such provisions in the Policy to be consistent with its conclusion
- The Court noted that its construction of the Defence Costs Extension was "far from unusual", and further stated that the fact that the Insurer's interpretation of the exclusion clause might ultimately be incorrect was not a sufficient reason by itself to require the payment of defence costs (said to be solely for the benefit of the insured) if a claim might not be covered by the Policy, as requiring this would require the Insurer to perform the Policy "despite having no legal obligation to do so". This was the case even if the Insurer's denial ultimately transpired to be incorrect and a breach of contract. In this respect, the Court stated that the Insurer was *"entitled to stand on its rights, as it sees them, and to bear the appropriate onus should the insured seek to enforce its rights, as it sees them"*
- In acknowledging that the outcome was not favourable to Evolution, the Court observed that *"There is no doubt that for Evolution the policy does not operate in a manner which best serves its interest in relation to the substantial claims now being made against it. A different policy with terms which require the advancing of defence costs by an insurer despite its denials of any obligation to do so would serve it better, but to construe the Chubb Policy in that way would amount to a substantial rewriting of the agreement"*

Result

- Applying what Derrington J described as a *"sensible commercial construction"* to the wording of the liability insurance policy in question, the Federal Court held that the Insurer, who asserted that third party claims against the Insured were not covered by the policy by reason of an exclusion clause, was not obliged to pay defence costs unless and until a Court determined the question of indemnity

Note – In December 2020, Evolution applied for special leave to appeal.

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3. Marsh Insights Article "Global Insurance Prices Rise for Twelfth Consecutive Quarter".
4. AON D&O Market Update: August 2020 "Capacity and pricing pressures continue" dated November 2020.
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8. Commonwealth, Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, *Final Report* (2019) vol 1, p 11.
9. *Delor Vue Apartments CTS 39788 v Allianz Australia Insurance Ltd* (No 2) [2020] FCA 588 at [347]
10. Commonwealth, Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Final Report (2019) vol 1, p 309.
11. Commonwealth, Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Final Report (2019) vol 1, p 309.
12. Commonwealth, Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Final Report (2019) vol 2, pp 347, 432, 443 and 454. In the case of CommInsure the Commission specifically found (at pp 330-1): "*CommInsure may have breached its obligation under section 13 of the Insurance Contracts Act 1984 (Cth) (the Insurance Contracts Act) to act towards the insured with the utmost good faith*".
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43. *See also HLB Kidsons (a firm) v Lloyd's Underwriters* [2008] EWCA Civ 1206; [2009] Bus LR 759 at [141].
44. *DIF III - Global Co-Investment Fund LP v Babcock & Brown International Pty Ltd* [2019] NSWSC 527
45. *Albion Insurance Co Limited v Government Insurance Office of New South Wales* (1969) 121 CLR 342 at 345 (Barwick CJ, McTiernan and Menzies JJ)
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