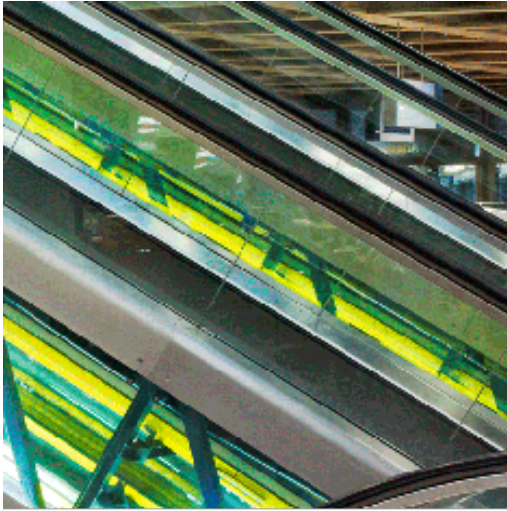




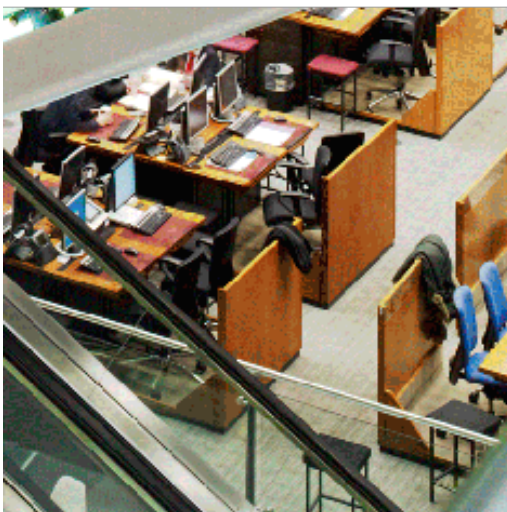
THE INSURANCE ACT 2015

**A practical guide to changes in UK Insurance
Law, prepared for members of the Lloyd's
Market Association and the International
Underwriting Association**



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Prepared in association with Clyde & Co, Cooley
LLP and Ince & Co



First published June 2015
Revised October 2016

CONTENTS

Section	Page
<u>I. INTRODUCTION</u>	2
<u>II. SUMMARY OF KEY ELEMENTS OF THE ACT</u>	4
<u>III. THE DUTY OF FAIR PRESENTATION</u>	7
<u>IV. KNOWLEDGE OF THE INSURED AND THE INSURER</u>	11
<u>V. REMEDIES</u>	16
<u>VI. WARRANTIES AND OTHER TERMS</u>	21
<u>VII. CONTRACTING OUT</u>	29
<u>VIII. FRAUDULENT CLAIMS</u>	32
<u>IX. REINSURANCE</u>	34
<u>X. LATE PAYMENT DAMAGES</u>	36
<u>XI. APPLICATION OF THE ACT</u>	52

I. INTRODUCTION

The Insurance Act 2015 (“**the Act**”) is the most significant reform of UK insurance contract law since the Marine Insurance Act 1906. It was enacted by Parliament on 12 February 2015, and came into force 18 months after that date, on 12 August 2016.¹ All contracts of insurance, reinsurance and retrocession, as well as variations to existing contracts made after that date, are governed by the Act.² The Act is intended materially to change the way in which the business of insurance governed by English Law is conducted.³

The consumer insured’s duties of disclosure are governed by the Consumer Insurance (Disclosure and Representation) Act 2012 which applies to contracts of consumer insurance entered into on or after 6 April 2013. A consumer is defined as an individual buying insurance wholly or mainly for purposes unrelated to the individual’s trade, business or profession.⁴ This guide primarily concerns non-consumer insurance, reinsurance and retrocession.⁵

The Enterprise Act 2016 introduced into the Act provisions relating to damages for late payment of an insurance claim, which will come into force on 4 May 2017.

This guide is designed to help readers to understand the principal changes embodied in the Act; the practical difference they might make; and the potential challenges which may be faced under the new law. All references to sections and subsections are to those in the Act, unless otherwise stated. The content of this guide does not constitute legal advice, and readers are advised to consult their lawyers should they require advice on any matter that is the subject of this guide.

Additional resources

Please see the following additional resources, for further information on the Act:

- [The Insurance Act 2015](#) and [Explanatory Notes](#) of HM Treasury
- [The Enterprise Act 2016](#) (see part 5) and [Explanatory Notes](#) of HM Treasury

¹ The only exception is Part 6, which amends the Third Parties (Rights Against Insurers) Act 2010 (see section 23(3)).

² Sections 14 and 21, and Part 2 of the Act apply (i) to contracts of insurance entered into after 12 August 2016, and (ii) to variations of contracts of insurance made after 12 August 2016, regardless of when the contract itself was entered into. Contrastingly, Parts 3 and 4 of the Act apply *only* to contracts of insurance entered into after 12 August 2016, and to variations of such contracts (but *not* variations of contracts entered into before 12 August 2016). See section 22.

³ The Act will also apply under the laws of Scotland, Wales and Northern Ireland (with one exception); see section 23(1).

⁴ Consumer Insurance (Disclosure and Representations) Act 2012, section 1(a).

⁵ The sections on warranties, terms not relevant to the loss and late payment damages are also relevant to consumer insurance.

- [Law Commission Paper No 353](#), *Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; and Late payment*, July 2014.

It should be noted that both reports of the Law Commission⁶ and Explanatory Notes⁷ may provide relevant and admissible evidence as to the meaning of legislation.⁸

⁶ *R v Horseferry Road Metropolitan Stipendiary Magistrate, ex parte Siadatan* [1991] 1 QB 260, Watkins LJ at 267-268.

⁷ *Flora v Wakom* [2007] 1 WLR 482, Brooke LJ at [15]-[17].

⁸ See *Bennion on Statutory Interpretation* (6th ed.) for further commentary on this matter.

II. SUMMARY OF KEY ELEMENTS OF THE ACT

❖ **Duty of fair presentation** (*Business Contracts only*)

- Insured's pre-contractual duty re-characterised as the duty of fair presentation, but retains the core elements of the duty of utmost good faith.
- New requirement for the insured's risk presentation to be reasonably clear and accessible.
- Insured may fulfil the duty of fair presentation if it discloses sufficient information to put a prudent insurer on notice that it needs to ask further questions.

❖ **Knowledge of insured and insurer** (*Business Contracts only*)

- Law governing what is known to an insured and an insurer (for the purposes of defining what must be disclosed) is substantially reformed.
- Introduction of new concept of what an insured ought to know; namely, anything that should reasonably have been revealed by a reasonable search of information. This may increase the burden on insureds.
- New exception to the insured's knowledge: confidential information obtained by the broker in its business relationship with a third party not connected to the insurance.

❖ **Remedies for breach of duty of fair presentation** (*Business Contracts only*)

- Avoidance abolished as the sole remedy for breach of the duty of utmost good faith. Avoidance still available if breach of the duty of fair presentation is deliberate or reckless.
- If breach of the duty of fair presentation is not deliberate or reckless, the remedy available will depend upon what the insurer would have done had the risk been fairly presented (namely, varying the terms of the policy, increasing the premium, or avoiding the policy).

❖ **Warranties and terms not relevant to the loss** (*Business and Consumer Contracts*)

- Breach of warranty will no longer permanently discharge insurer's liability. If the breach of warranty is remedied prior to loss, cover will remain in place.
- Breach of any term which, if complied with, would tend to reduce the risk of loss of a particular kind, or at particular location/time, cannot be relied on by insurer to reduce/extinguish liability if the insured proves that the breach could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred. This does not apply to terms which define the risk as a whole.

- Basis clauses are abolished.

❖ **Late Payment Damages** (*Business and Consumer Contracts*)

- Every insurance contract is subject to an implied term that the insurer must pay sums due in respect of a claim within a reasonable time, failing which the insurer may be liable in damages to the insured.

❖ **Contracting out** (*Business Contracts only*)

- In Business Contracts, the parties may contract out of any provisions in the Act, save for the abolition of basis clauses.
- Contracting out is subject to requirements that (i) the contracting-out clause is brought to the attention of the insured, or its agent; and (ii) that the clause is clear and unambiguous as to its effect.
- In Consumer Contracts, any attempt to contract out of the Act would be of no effect, if it would put the consumer in a worse position than under the Act.

The Act also clarifies the law relating to fraudulent claims. All of the points above are explained in more detail below.

Definitions used in this guide

For the purpose of this guide, the following definitions are used:

- **“Consumer Contract”** is a “*consumer insurance contract*” under section 1 of the Consumer Insurance (Disclosure and Representations) Act 2012. In a Consumer Contract, the insured is an individual who enters into the contract wholly or mainly for purposes unrelated to his business, trade or profession.
- **“Business Contract”** is a “*non-consumer insurance contract*” under section 1 of the Act. A Business Contract is therefore any contract of insurance which is not a Consumer Contract, for present purposes. It includes contracts of reinsurance and retrocession.
- **“Insured”** means the party to a contract of insurance who is the insured under the contract, or would be the insured if the contract were entered into.⁹ It includes reinsureds and retrocedants.
- **“Insurer”** means the party to a contract of insurance who is the insurer under the contract, or would be the insurer if the contract were entered into. It should therefore be noted that in the Act (and this guide), both the insured and the

⁹ Whether or not a person is a party to a contract of insurance is a matter of construction of the contract. It is possible that a person may be *covered* by a contract of insurance, but not a *party* to that contract.

insurer must be parties to the contract of insurance. It includes reinsurers and retrocessionaires.

- “**Old law**” means the law as it stood before the Insurance Act 2015 came into force on 12 August 2016 (or 4 May 2017, with respect to the provisions relating to Late Payment Damages).

III. THE DUTY OF FAIR PRESENTATION

1. The Act makes three important changes to the law regarding the insured's pre-contractual duty to the insurer, which will apply only to Business Contracts.¹⁰ First, section 3 renames the duty as the "*Duty of Fair Presentation*" ("**the Duty**"), and subtly re-characterises its content. Secondly, sections 4 to 6 substantially alter the law concerning what is known to the insured and the insurer, for the purposes of the Duty. Finally, section 14 abolishes the remedy of avoidance for breach of the duty of utmost good faith, and Schedule 1 introduces a new range of remedies for breach of the Duty, the availability of which depends (broadly speaking) upon whether the breach was deliberate or reckless, or not, and how the underwriter would have responded in the event that a fair presentation of the risk had been made.

What is the insured's pre-contractual duty to the insurer?

2. Under the old law, it was well known that the insured had a pre-contractual duty of utmost good faith, which (in summary) involved two separate elements: (i) the duty not to make misrepresentations to the insurer; and, (ii) the duty to disclose all material matters to the insurer. The Duty preserves these fundamental elements, though it subtly re-characterises and clarifies their content. In brief summary, the following elements of the insured's pre-contractual duty have not changed:
 - 2.1. The truth of any material representation of fact made by the insured must be "*substantially correct*". Any representation of expectation or belief must be made in good faith.¹¹ This is the same as the old law.
 - 2.2. The test for what amounts to a material matter for disclosure is codified in section 7(3) as anything which "*would influence the judgement of a prudent insurer in determining whether to take the risk and, if so, on what terms*". This mirrors the old law.
 - 2.3. The Act provides examples of things which may be material, namely: special or unusual facts relating to the risk; particular concerns which led the insured to seek insurance; and the potentially open-ended category of "*anything which those concerned with the class of insurance and field of activity would generally understand*" to be material. The presence of this latter category is designed to encourage stakeholders to formulate protocols which relate to specific classes of business, and which list those matters which an insured should disclose in the course of a risk presentation.
3. The Duty does, however, embody four changes, which are (in summary, with fuller explanation following below):
 - 3.1. The introduction of a 'second limb' to the duty of disclosure.

¹⁰ Section 2(1).

¹¹ Section 3(3)(c).

- 3.2. The requirement for the insured's disclosure to be reasonably clear and accessible.
- 3.3. The requirement for the insured to disclose matters which form the subject of a warranty, disclosure of which was previously superfluous.
- 3.4. The introduction of the concept of a "*reasonable search*" for material information, which will define what the insured "*ought to know*" for the purposes of the Duty.

(i) The second limb of the duty of disclosure

4. Under the Act, the insured may positively satisfy its duty of disclosure in one of two ways (referred to in this guide as the two 'limbs' of the duty of disclosure). Under the first limb, the insured fulfils the duty of disclosure by actually disclosing every material circumstance which it knows or ought to know.¹² That is the same as the old law (save as to the meaning of what the insured "*ought to know*", discussed below).
5. If the insured fails to fulfil the first limb, the Act introduces a fall-back position – the second limb. Under this, the insured will satisfy the duty of disclosure if it gives the insurer "*sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances.*"¹³
6. The introduction of the second limb means that an insured may positively satisfy the Duty by doing something that falls short of actually disclosing every material circumstance. If it says enough to put a prudent insurer on notice that it needs to ask further questions, the Duty has been fulfilled. In deciding whether the insured has given adequate signposts to fulfil the second limb, it should be remembered that the insured must make its disclosure in a manner which would be reasonably clear and accessible to a prudent insurer (as to which see below).¹⁴ It should also be recalled that contracts of insurance remain contracts based on utmost good faith (even though there will be no remedy for breach of that duty).¹⁵
7. In view of this, the insured will not be able to use the second limb deliberately to conceal material matters by making intentionally cryptic or elusive references to them in the risk presentation.¹⁶ If it does so, it is likely to have committed a deliberate breach of the Duty (because such reference probably does not provide "*sufficient information*" to put a prudent insurer on notice). Furthermore, the LMA/IUA consider that if an insured (or its broker) deliberately refrains from

¹² Section 3(4)(a).

¹³ Section 3(4)(b).

¹⁴ Section 3(3)(b).

¹⁵ See section 14, which amends section 17 of the Marine Insurance Act 1906 in the following way: "~~A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.~~" Accordingly, although the insurer remains subject to the duty of utmost good faith, the insured is no longer able to avoid in the event of breach of that duty by the insurer.

¹⁶ This view finds support in Law Com No 353 (July 2014), [30.23(1)].

disclosing information which it knows to be material, this will amount to a deliberate breach of the duty of fair presentation, notwithstanding the fact that the insured arguably gave the insurer sufficient 'signposts' to fulfil the second limb. That is because it is unacceptable, in a contract of utmost good faith, deliberately to withhold information known to be material.

8. By way of illustration of the way in which the second limb may operate, a financial institution crime insurance proposal form refers to the fact that the institution in question is "*under investigation by the FCA*". It so happens that the investigation relates to a suspected fraud by the management (which is a material circumstance for disclosure). The institution's disclosure may nonetheless satisfy the second limb of the Duty, since it begs an obvious question which the insurer should ask, namely: "*under investigation for what?*"
9. This represents a change of tone from the old law. Formerly, if an insured put the insurer fairly on notice that it needed to ask further questions, and the insurer did not do so, the insured had a defence of waiver.¹⁷ Under the Act, however, putting the insurer on enquiry may amount to a positive means of discharging the Duty (rather than a defence).
10. Practically speaking, insurers must therefore remain alert to matters in the risk presentation which appear to beg further questions – and should not hesitate to ask those questions if confronted with them. The Law Commissions have stated that an intention of the second limb is that underwriters should be more engaged in the disclosure process, and should ask questions during the risk presentation, rather than after loss has occurred.¹⁸

(ii) Disclosure must be reasonably clear and accessible

11. The second change embodied in the Duty is that the insured is required to give disclosure "*in a manner which would be reasonably clear and accessible to a prudent insurer*".¹⁹ Innovatively, the Act therefore prescribes the practical way in which the insured must present the risk. It should be noted that this is a self-contained requirement, which is independent of and additional to the insured's obligation to disclose what it knows or ought to know.²⁰
12. The requirement for disclosure that would be "*reasonably clear and accessible*" is intended to discourage the practice of 'data-dumping', where an insured provides vast quantities of undigested information to the insurer in an attempt to safeguard

¹⁷ This is a defence which the insured may currently satisfy if it can show that, in the course of giving a fair presentation of the risk, the insurer received information from the insured which would naturally prompt a reasonable insurer to make further enquiries, and the insurer omitted to make those enquiries (see *Synergy Health v CGU Insurance* [2011] Lloyd's Rep IR 500, Flaux J at [172]-[175]).

¹⁸ Law Com No 353 (July 2014), [7.38]

¹⁹ Section 3(3)(b).

²⁰ Section 3(3)(a) and (b).

itself against inadvertent non-disclosure.²¹ This requirement therefore places a heavier burden on the insured to give its disclosure in an ordered, digestible way. It may thereby be of benefit to insurers, who should be ready to ask the insured to re-present information which has been disclosed in an incomprehensible way.

13. It should be noted that breach of the requirement to give “*reasonably clear and accessible*” disclosure could, in certain circumstances, amount to an actionable breach of the Duty in its own right. For example, if material information was buried in a huge and impenetrable risk presentation; not mentioned elsewhere by the insured (such as in a summary); and not seen by the insurer, there may have been a failure to make disclosure in a way that would be “*reasonably clear and accessible*”. This may amount to an actionable breach of the Duty by the insured.²²

(iii) Insured must disclose matters which form the subject of a warranty

14. Under the old law, the insured did not need to disclose anything which formed the subject matter of a warranty, since such disclosure was superfluous.²³ For example, where the insured warranted that a burglar alarm would be activated whenever the building is empty, it did not need to disclose the fact that the burglar alarm had not been working properly, because the insurer was protected by the warranty, and disclosure was superfluous. As will be explained below, the Act changes the nature of warranty into a suspensory condition, meaning that the insurer will not necessarily be protected in the same way. As such, the Act abolishes the exception to the duty of disclosure by reason of superfluity,²⁴ and it will not be available as a defence to insureds.

(iv) The reasonable search

15. This matter is discussed in detail in section IV below, which addresses the knowledge of the insured and the insurer.

²¹ Law Com No 353 (July 2014), [5.28] to [5.30].

²² That is because, as explained above, the requirement to make disclosure in a way that would be “*reasonably clear and accessible*” is a self-contained and independent requirement of the Duty.

²³ Marine Insurance Act, section 18(3)(d).

²⁴ Section 21(2).

IV. KNOWLEDGE OF THE INSURED AND THE INSURER

16. Sections 4 and 6 of the Act substantially alter the law governing what an insured knows for the purposes of the Duty in the context of Business Contracts. This is a crucial area, since it dictates what the insured must disclose, and what it is excused from disclosing to the insurer. The Act does this by distinguishing between insureds who are and are not individuals. Broadly speaking, the Act is intended to make the duty of disclosure on the insured less arduous, though it is not clear that it will have this effect in practice.

What does an individual insured know?

17. An insured who is an individual (such as a sole trader, an individual partner or individual trustee buying cover) knows what is actually known to the individual; and what is actually known to the individuals who are responsible for the insured's insurance (usually the broker).²⁵ This includes matters which the individual(s) suspects, but deliberately refrains from confirming or investigating (also known as 'blind eye knowledge').²⁶ Overall, this is broadly the same as the old law, except that the knowledge of the insured's 'agent to know' will no longer be imputed automatically to the insured (unless the agent is involved in procuring the insurance).

What does an insured which is not an individual know?

18. An insured which is not an individual (such as a limited company, partnership, trust company, government organisation, unincorporated association or charity) is taken to know that which is actually known to any individual who is part of the "*senior management*"²⁷ of the insured, and that which is actually known to the individuals who are responsible for the insured's insurance (e.g. the insured's risk manager, or its broker).²⁸ Again, this includes blind eye knowledge.²⁹ All of this is broadly the same as the old law, although the concept of "*senior management*" might be more narrowly defined than the "*directing mind and will of the company*". Further, as above, the knowledge of the insured's 'agent to know' will no longer be imputed automatically to the insured (unless the agent is involved in procuring the insurance).

What ought an insured to know? Constructive knowledge

19. This area amounts to one of the most significant changes embodied in the Act, and potentially one which will increase the insured's burden of disclosure quite substantially. Whether it is an individual or not, for the purposes of what it must disclose under the Duty, an insured "*ought to know what should reasonably have*

²⁵ Section 4(2).

²⁶ Section 6(1).

²⁷ "*senior management*" comprises people who play a significant role in making decisions about how the insured's activities are to be managed and organised. Its scope and meaning is somewhat uncertain.

²⁸ Section 4(3).

²⁹ Section 6(1).

been revealed by a reasonable search of information available to the insured",³⁰ including information which is "*held within the insured's organisation or by any other person (such as the insured's agent or a person for whom cover is provided by the contract of insurance)*".³¹ The information can be revealed by "*making enquiries*", or by "*any other means*".

20. Formerly, the insured's constructive knowledge was qualified as being that which it ought to know "*in the ordinary course of business*".³² Under the Act, this is entirely replaced by the concept of information that should reasonably have been revealed by a "*reasonable search*" of a potentially broad range of sources. The "*reasonable search*" will, therefore, assume a position of importance. It seems probable that in many cases, this alteration of the law could materially increase the insured's burden of disclosure, for the following reasons:

- 20.1. Knowledge that should be revealed by a "*reasonable search*" is probably a broader category than knowledge the insured ought to know "*in the ordinary course of business*" (although this is far from certain, and remains to be seen). That is because the express language of the Act does not delimit the potential repositories of information which is to be subject to a reasonable search. The information does not need to be in the possession or control of the insured, and may include information held by the open-ended category of "*any other person*" – not merely the insured's agent. The sole parameter is that of reasonableness. This means that the scale and scope of a reasonable search is likely to vary even within the same class of risk depending upon, for example, the sum insured, since it may well be reasonable to require a wider search where the sum insured is significantly greater.
- 20.2. For example, a private bank takes out cyber insurance. Its external IT consultant knows about a latent virus in the bank's IT system, but does not tell anybody about it, and is not approached by the bank during the placing process. In those circumstances, it is possible that the insured "*ought to know*" that the virus exists, if in the circumstances of the case the court considers that it should reasonably have made enquiries of the consultant. The fact that the consultant is neither an employee nor agent of the bank is irrelevant, because the information which is subject to the reasonable search may be "*held...by any other person*".
- 20.3. Moreover, formerly the courts were able to consider the subjective characteristics of the insured in assessing what it ought to know "*in the ordinary course of business*". Thus, if the insured ran its business in an inefficient manner, it may not have been taken to have constructive knowledge of information which (by its inefficiency) it overlooked. The rationale behind the old law is that not every insured runs its business efficiently, and in certain cases the courts

³⁰ Section 4(6).

³¹ Section 4(7).

³² Marine Insurance Act 1906, section 18(1).

recognised this reality.³³ Under the Act, there is probably no such leniency, since the “*reasonable search*” test appears to be purely objective, based upon what “*should*” have been revealed by a “*reasonable search*”.³⁴ Accordingly, there is no place for consideration of the subjective qualities of the insured, and its burden may therefore be increased, because it will be held to the (higher) standard of a *reasonable* insured.

21. In view of the potential increase in the insured’s burden of disclosure, not to mention the uncertainties surrounding the concept of the “*reasonable search*”, and what it should entail, it is expected that insureds and brokers will seek to agree general guidelines on what constitutes a reasonable search with their insurers. It is also possible that they will seek to agree wordings under which the parameters of the reasonable search are set out in the contract itself, to avoid subsequent disputes on this point.

Exceptions to the insured’s knowledge

22. The Act contains an important exception of “*confidential information*” which is incapable of amounting to the insured’s knowledge.³⁵ Information which is known to the insured’s agent, but which was acquired by that agent through a business relationship with “*a person who is not connected to the contract of insurance*”, cannot amount to knowledge of the insured. This exception is itself subject to a further exception: confidential information does *not* include information which the agent acquires in a relationship with the insured, or any persons covered under the contract of insurance (even if they are not parties to the contract). In the context of reinsurance, if the broker obtains information from the underlying insured, that information will also not be subject to the confidentiality exception.
23. Although the Act does not make the point explicitly, the question as to whether something is “*confidential information*” for these purposes should be assessed objectively, rather than by reference to the broker’s subjective view as to whether the information was confidential. Otherwise, there would be scope for a potentially wide range of matters to be precluded from ever amounting to the insured’s knowledge, purely on the basis of the broker’s subjective view of them.
24. The Act also preserves the rule by which the insured is not to be attributed with the knowledge of fraud perpetrated on it by its agent, or a member of the senior management of its company.³⁶

³³ Particularly the dicta of McNair J in *Australia & New Zealand Bank Limited v Colonial & Eagle Wharves Limited* [1960] 2 Lloyd’s Rep 241, 252. See also *Simner v New India Assurance Co* [1995] L.R.L.R. 240, HHJ Diamond at 253–255. Note, however, that the opposite view is taken in *Arnould’s Law of Marine Insurance and Average* (17th ed.) [16–46].

³⁴ Law Com No 353 (July 2014), [8.83].

³⁵ Sections 4(4)–4(5).

³⁶ Section 6(2).

What does the insurer know under the Act?

25. The relevance of the law in this area is that the insured is not obliged to disclose matters which the insurer knows, ought to know, or is presumed to know. Sections 5 and 6 of the Act identify three sources of the insurer's knowledge for these purposes:

(i) Actual knowledge

26. The insurer actually knows whatever is known to any individual who participates in the underwriting decision in respect of the specific risk in question, including the insurer's agent (such as a coverholder).³⁷ As with the insured, this includes blind-eye knowledge. In all, this reflects the former state of the law.

(ii) Constructive knowledge

27. The insurer "*ought to know*" something (i.e. constructive knowledge) only if (i) an employee or agent of the insurer (such as a surveyor, or medical examiner) knows it, and ought reasonably to have passed it on to the individual(s) responsible for the underwriting decision; *or* (ii) if the information is held by the insurer, and is readily available to the individual(s) responsible for the underwriting decision.³⁸
28. As to the second category – namely information readily available to the individual(s) responsible for the underwriting decision – it appears that the Law Commissions envisage that insurers should undertake a search of information that is readily available to them.³⁹ That is a departure from the old law.⁴⁰
29. What information is likely to qualify as being "*readily available*", for these purposes? That is a question of fact. Where an insurer has written cover for an insured over a number of years, information about it, and its claims history, is likely to qualify as "*readily available*". However, if the claims history is not in fact available to the participating underwriter, because (for example) it is stored on a separate database to which the underwriter has no access, it will not be "*readily available*" for these purposes.⁴¹
30. It should also be noted that the information in question must be "*held by*" the insurer. Those words were inserted into section 5(2) in order to limit the information which is caught under that provision. In view of those words, information on the internet will not qualify, since it is not "*held by*" the insurer.⁴² Consequently, an underwriter would not be expected to carry out an internet search 'at the Box'. However, the same reasoning may not apply to information on (for example) the insurer's own intranet system, or on databases to which it subscribes.

³⁷ Section 5(1).

³⁸ Section 5(2).

³⁹ Law Com No 353 (July 2014), [10.49] to [10.54].

⁴⁰ *Mahli v Abbey Life Insurance* [1996] LRLR 237.

⁴¹ Law Com No 353 (July 2014), [10.51] to [10.53].

⁴² *Ibid.*, 10.54.

31. This point is uncertain. In one sense, information on a subscription database is not “*held by*” the insurer any more than information on the internet – because it is “*held by*” the provider of the resource. For example, the Lloyd’s Marine Intelligence Unit Seasearcher database contains information which, although accessible to its subscribers, is “*held by*” the Lloyd’s MIU itself. However, it might be argued that such information is nonetheless “*held by*” the insurer, in the sense that during the currency of its subscription, it ‘holds’ the right and ability immediately to access the information on the database, in a way that ordinary members of the public cannot do.

(iii) Presumed knowledge

32. The insurer is presumed to know things which are common knowledge. It is also presumed to know the “*things which an insurer offering insurance of the class in question to insureds in the field of activity in question would reasonably be expected to know in the ordinary course of business.*”⁴³ These provisions do not materially alter the old law.
33. In order to provide greater certainty over what might amount to something which “*an insurer offering insurance of the class in question...would reasonably be expected to know*”, insurers and insureds may work together in order to define lists of standard matters which insurers will be presumed to know for these purposes.

⁴³ Section 5(3).

V. REMEDIES

What happens if the insured breaches the Duty?

34. Perhaps the most significant change contained in the Act relates to the remedies available if an insured breaches the Duty. Under the old law, the only remedy for breach of the duty of utmost good faith by the insured is avoidance of the policy *ab initio*,⁴⁴ regardless of the severity of the breach. This was widely criticised as overly harsh, and something of a blunt instrument.
35. Under the Act, the duty of utmost good faith survives, but the sole remedy of avoidance for its breach is abolished, and is replaced with a new range of proportionate remedies which depend on whether the insured's breach of the Duty was deliberate or reckless, or not, and what the insurer would have done if the Duty had been fulfilled.⁴⁵ Although contracts of insurance remain contracts of the utmost good faith as a matter of principle, breach of that duty will have no remedy.⁴⁶ The proportionate remedies are set out in Schedule 1 of the Act (which is to be read in conjunction with section 8).

(i) Deliberate or reckless breach

36. Unlike the old law, which essentially treated all breaches of the duty of utmost good faith in the same way, the Act distinguishes between breaches of the Duty depending on their severity. If a breach is deliberate or reckless, then the insurer may avoid the policy, and need not return the premium. A breach will be deliberate if the insured knows that he is in breach of the Duty. It will be reckless if the insured does not care whether he is in breach of the Duty.
37. There may be a practical difficulty about an insurer pleading a deliberate or reckless breach of the Duty. The potential difficulty arises because, under section 8(6), the insurer has the burden of proving that the insured's breach was either deliberate or reckless. Although the Act does not say so, a deliberate or reckless breach of the Duty may well amount to fraud – and there are strict rules about when fraud can and cannot be alleged. In the light of this, even though there may have been a deliberate or reckless breach of the Duty, the insurer may be unable to allege this in its pleadings (absent clear evidence), and may therefore be deprived of seeking disclosure on this subject.

⁴⁴ Under the old law, if the policy is avoided, it is as though it never came into existence from the very beginning. See Marine Insurance Act, section 18.

⁴⁵ Section 17 of the Marine Insurance Act 1906 is amended to read: “A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.”

⁴⁶ The Law Commissions have suggested that the duty of good faith ought to remain as a “general interpretative principle”. As such, previous decisions based on the duty of utmost good faith may be used to interpret the Duty under the Act. See Law Com No 353 (July 2014), [30.5]; [30.23].

(ii) Breach not deliberate or reckless

38. If the breach is neither deliberate nor reckless, the position is entirely different, and a range of proportionate remedies is potentially available (quite unlike the old law). Which of these remedies is available depends on what the actual underwriter who wrote the risk in question would have done if there had been a fair presentation of the risk – i.e. the question of ‘inducement’. Under the Act, inducement will become an issue of even more central importance. A description of the three options available to the insurer under Schedule 1 follows below.

(i) Avoidance

39. If the underwriter in question would not have written the risk at all, then the insurer may avoid the policy, but must return the premium (contrast this with the position where the breach is deliberate or reckless). Avoidance is, therefore, still available where breach of the Duty is neither deliberate nor reckless. It will only be permitted if the insurer demonstrates (on the balance of probabilities) that, if the insured had made a fair presentation of the risk, the participating underwriter would not have been willing to write it at all. This will be proved by evidence from the underwriter responsible for writing the risk as to what he or she would have done had there been a fair presentation.

(ii) Varying the terms of the contract

40. If, in the absence of a breach of the Duty, the insurer would have written the risk, but on different terms, the contract will be treated as if it had been written on those terms.⁴⁷ That does not include terms relating to the premium. Effectively, this means that the courts will rewrite the contract – on the basis of what the underwriter would have written if he/she had received a fair presentation of the risk.

41. For example, an insured factory owner stores highly flammable chemicals on the premises which are covered by the policy, but (without being deliberate or reckless) fails to disclose this matter to the insurer. Had it done so, the insurer would have imposed an exclusion on losses caused by fire damage arising in connection with the chemicals. The insurer will therefore have a remedy if such a term would have eliminated or reduced its liability under the contract. In certain cases, this could become somewhat complex. In the same example, the insurer might have imposed a warranty requiring the chemicals to be stored in a room fitted with sprinklers. Would compliance with such a warranty have prevented the loss? Or reduced its extent? Such questions would undoubtedly require expert evidence, and may not be particularly straightforward.

42. The other notable effect of this remedy is that it might have an effect on losses which the insurer has already paid. That is because the remedy involves treating the contract “as if it had been entered into on those different terms”, thereby having a

⁴⁷ Schedule 1, paragraph 5.

retrospective effect. Accordingly, if the insurer proves that it would have contracted on different terms which would have reduced or extinguished its liability for losses which pre-date the insurer's discovery of a breach of the Duty, the insured will have to reimburse the insurer for those losses.

(iii) Proportionate reduction of the claim

43. If the insurer would have written the risk, but for a higher premium, then the insurer may proportionately reduce the claim. The reduction will be in the same proportion that the actual premium bears to the premium that would have been charged if a fair presentation had been made.⁴⁸ This proportionate reduction may work alongside the 'rewriting' of the contract described above, or may stand alone as a sole remedy. The proportionate reduction would apply to all claims, past and future, under the policy. That is because the contract is to be treated as though a higher premium had been charged from the outset, meaning that any claims paid or to be paid should be subject to the proportionate reduction.

A further example of the operation of remedies under the Act

44. Before the conclusion of a marine hull and machinery policy, the insured breaches the Duty by failing to disclose that his superyacht is in dry dock undergoing an extensive refit, including potentially hazardous hot works (welding, and the like). Subsequently, the yacht is severely damaged by an earthquake which unexpectedly occurs in the vicinity of the dry dock. The insured's breach was neither deliberate nor reckless.
45. The insurer attempts to avoid the policy, but it cannot prove that it would not have written the policy at all had there been a fair presentation, because the underwriter would have been and was generally willing to insure superyachts which were in dry dock undergoing a refit. Avoidance is consequently not possible.
46. The insurer therefore seeks to rewrite the contract so as to eliminate or reduce its liability. This, it may struggle to do. That is simply because, even if the underwriter had been told about the refit, it is not at all obvious that he would have imposed an exclusion for loss caused by earthquakes. A more obvious course would be to impose an exclusion for fire damage, which would be of no utility in these circumstances. In other words, the insurer may not be able to prove that, even if the risk had been fairly presented, it would have written cover in a way that would have excluded or reduced its liability for loss caused by earthquakes.
47. In those circumstances, the insurer would be left with the remedy of a proportionate reduction of the claim, but only if it can prove that it would have charged a higher premium for a yacht undergoing a major refit. Again, this may not be straightforward, since there may be an argument that a yacht in dry dock is in some

⁴⁸ Schedule 1, paragraph 6.

respects at a lower risk than when sailing on the open sea, leading (if anything) to a reduction in premium.

Breach in the context of a variation to the contract

48. The Act introduces a further, but important change regarding breach of the Duty in the context of a variation to a Business Contract.⁴⁹ The options available to the insurer will again depend on whether the breach is deliberate or reckless, or not.
49. If the breach is deliberate or reckless, the insurer may (by notice to the insured) treat the entire contract as having been terminated from the time of the variation (not *ab initio*), and need not return any of the premiums. Under the old law, breach of the duty of utmost good faith in the context of a variation probably allows the insurer to avoid the variation only, and not the entire contract.⁵⁰ If the breach is not deliberate or reckless, the insurer has three options (similar to those described above):
- 49.1. If the insurer would not have agreed to the variation at all were it not for the breach of Duty, the contract may be treated as if the variation had never been made. The insurer must return any extra premium paid under the variation.⁵¹
- 49.2. If the insurer would nonetheless have agreed to the variation, but on different terms, then the variation may be treated as if it were written on those terms. This is the same as the 'rewriting' of the contract described above.
- 49.3. If the insurer would have charged a higher premium in respect of the variation, it may proportionately reduce any claim which arises out of events which occur *after* the variation.⁵² That proportionate reduction will not affect claims made in respect of events occurring before the variation.

Practical effects of the new range of remedies on the business of insurers

50. The central change brought about by the introduction of proportionate remedies is an increase in the importance and complexity of inducement. The actual underwriter will, in certain cases, have to prove that he was induced to a much finer degree – including specific terms he might have imposed, or premiums charged. The importance of keeping thorough underwriting notes and records will become even more important, since often these will indicate which matters particularly influenced the underwriting

⁴⁹ Schedule 1, Part 2, paragraphs 7 to 11.

⁵⁰ The authorities on this point are inconsistent, and *obiter dicta*. In the old case of *Lishman v The Northern Maritime Insurance Company* (1875) LR 10 CP 179, Blackburn J (at 182) suggested that breach in the context of a variation vitiated the entire contract. However, in *The Mercandian Continent* [2001] 2 Lloyd's Rep 563, Longmore LJ (at [22(2)]) indicated that the right of avoidance would apply to the variation alone. This was also the approach of Potter LJ in *The Shakir III* [1997] 1 Lloyd's Rep 586, at 597.

⁵¹ Schedule 1, Part 2, paragraph 9(2).

⁵² Schedule 1, paragraph 11(1).

decision, and as to the way in which the underwriter thought about the risk. It is equally important that insurers continue to develop thorough and comprehensive methods of storing these notes safely and accessibly.

51. In seeking accurately to determine what the underwriter would have done if the Duty had not been breached, it is possible that the courts will admit evidence of previous risks written by the underwriter in question. This is currently discouraged.⁵³ It would lead to an increase in the scale of disclosure, and the likely length and costs of trial. There is also scope for an increased role of expert evidence in trials concerning breaches of the Duty, since proving inducement in these cases will become a matter of greater complexity and importance. Neither of these features, however, is likely to provide such compelling evidence as the actual underwriter's views at the time the risk was being underwritten, and insurers should seriously consider the way in which this is recorded.
52. Another potentially useful aid in cases of inducement is a comprehensive set of business plans and underwriting guidelines, which clearly set out the parameters of risks which the insurer is and is not prepared to write, as well as the basis on which premium is charged. If, for example, the insurer could demonstrate that its own internal guidelines did not permit the writing of risks involving some particular flammable chemical, that might provide persuasive evidence in favour of an avoidance remedy (in the factory scenario above). Of course, the converse may also be true, in circumstances where it can be shown that the underwriter did not adhere to the guidelines in other cases.

⁵³ *Marc Rich & Co AG v Portman* [1996] 1 Lloyd's Rep 430, Longmore J at 441.

VI. WARRANTIES AND OTHER TERMS

Section 9 - abolition of basis clauses

53. Section 9 of the Act abolishes basis clauses in Business Contracts.⁵⁴ This means that any representation made by the insured in connection with a “*proposed*” Business Contract is no longer capable of being converted into a warranty by means of any term in either the policy, or the proposal. For example, a term which says that the facts stated in the proposal form the basis of the contract will no longer be of any effect. The parties are not allowed to contract out of this provision.
54. There may be good reasons why an insurer requires the insured to warrant the truth of a particular representation. In those circumstances, the insurer might consider drafting a provision making the truth of that representation a condition precedent to its liability under the policy (or even to the inception of the policy itself).⁵⁵ Such a term may not be caught by section 9, because it would no longer be a representation in connection with a “*proposed...insurance contract*”, but a representation about an *actual*, existing insurance contract. This, however, is not certain.

Section 10 - warranties become suspensory conditions

55. A warranty in an insurance policy was formerly a term which, if breached, permanently discharged the insurer’s liability from the moment of breach, even if the breach of warranty is later remedied by the insured.⁵⁶ For example, if an insured warranted that its vessel would sail with a crew of 20, but she sailed with 18 and was subsequently lost, the insurer was not liable, even if (before the loss occurred) the insured had picked up two additional crew members. Accordingly, fulfilment of a warranty by the insured was characterised as a condition precedent to the insurer’s liability under the policy.⁵⁷
56. Section 10 transforms insurance warranties into suspensory conditions. The insurer will not be liable for losses while the insured is in breach of warranty. If, however, the insured remedies its breach of warranty, the insurer will be liable for subsequent losses, unless they were “*attributable to something happening*” before the breach was remedied. The insurer will also be liable for loss occurring or attributable to something happening before the breach of warranty.⁵⁸ The meaning of ‘remedy’ in this context is discussed below.

⁵⁴ Basis clauses have already been abolished in the context of consumer insurance contracts by section 6 of the Consumer Insurance (Disclosure and Representations) Act 2012.

⁵⁵ This is subject to the comments below, under the heading “*What if an insurer wants to preserve the former effect of warranties?*”.

⁵⁶ *Marine Insurance Act 1906*, section 33(3). This is subject to waiver and/or estoppel.

⁵⁷ *The Good Luck* [1992] 1 AC 233, Lord Goff at 262 G – 263 B.

⁵⁸ Section 10(4)(a)

57. It is important to emphasise that the Act does not redefine whether a term is or is not a warranty (which is, and remains a question of contractual construction).⁵⁹ As such, a warranty under the old law will also be a warranty under the Act. What has changed is the substantive legal *effect* of a term being designated as a warranty. Whereas under the old law, breach of warranty permanently discharged the insurer's liability, under the Act cover is merely suspended until the breach of warranty is remedied (if it can be).
58. The words "*attributable to something happening*" will catch a situation where (for example) a vessel is torpedoed while sailing in a war zone (in breach of warranty), following which she sails out of the war zone, and sinks. Ostensibly, the breach of warranty has been remedied before the loss, but the insurer will not be liable, because the loss was "*attributable to something happening*" after the warranty was breached (i.e. the torpedo attack), and before it was remedied.⁶⁰
59. It should be noted that the existing exceptions to a breach of warranty remain in place: namely, where a change in circumstances renders the warranty inapplicable; where a subsequent change of law renders compliance with the warranty unlawful; and where the insurer waives the breach of warranty.⁶¹ In view of the discussion above, there is also a new exception introduced by the Act – namely where the insured 'remedies' its breach of warranty before the loss occurs (the meaning of which is explained below).

How does an insured "remedy" its breach of warranty?

60. In view of the change outlined above, it is vital to understand what it means to 'remedy' a breach of warranty, for the purposes of section 10. That will depend upon the type of warranty in question, and the Act identifies two types:
- 60.1. The first type might be referred to as a 'time warranty'; that is, a warranty which requires that, by a particular ascertainable time, something will or will not be done, or a condition fulfilled, or something will or will not be the case.⁶² If a time warranty is breached, the breach will be remedied if the "*risk to which the warranty relates later becomes essentially the same as that originally contemplated by the parties*".⁶³
- 60.2. To take a simple example, an insured warrants that, by 1 January, it will have installed a new fire detection system. The risk to which this warranty relates is plainly the risk of fire. In fact, the insured (in breach of warranty) does not install the new detection system on 1 January, but does so on 20 January. At that later time, the insured has remedied the breach, because the risk to which the warranty relates (i.e. fire risk) has become essentially the same as originally

⁵⁹ Explanatory Notes Insurance Act 2015, [86]; Law Com No 353 (July 2014), [15.14].

⁶⁰ Law Com No 353 (July 2014), [17.27].

⁶¹ Formerly contained in section 34 of the *Marine Insurance Act 1906*.

⁶² Section 10(6).

⁶³ Section 10(5)(a).

contemplated (because the new system has been installed, and the risk of loss by fire has (presumably) diminished).

- 60.3. For “*any other case*”, the breach will be remedied “*if the insured ceases to be in breach of warranty*”.⁶⁴ It is likely that this subsection will cover the majority of warranties. For example, if the insured warrants that its vessel will not enter a war zone, but the master in fact sails there, the breach will be remedied at the moment the vessel leaves the war zone – because the insured has ceased to be in breach of warranty.
- 60.4. What if the insured repeatedly breaches a warranty, but it so happens that at the time of a loss, it is not in breach? Is the insurer liable? For example, a warranty in a motor policy provides that the car is “*only for private personal use*”, but the insured breaches this warranty by using the car for a commercial taxi service every weekend. The Law Commissions have suggested that section 10 is not intended to protect insureds who “*play the system*” in this way. They consider that the breach would only be remedied if the car’s “*use for commercial purposes was stopped entirely, or at least reduced to a level where personal use dominated*” and that “[o]nly then would the insured cease to be in breach of warranty.”⁶⁵
- 60.5. It is not clear, however, whether the Law Commissions’ stated aim is reflected in the language of section 10. That is because section 10(5)(b) provides that the insured’s breach of warranty will be taken to have been remedied “*if the insured ceases to be in breach of warranty.*” Strictly speaking, if (at the time of the loss) the car is being put to personal (rather than commercial) use by the insured, the insured has “*ceased to be in breach of warranty*”. It is not immediately obvious why the insured had not remedied its breach, purely on the basis that it might have breached the warranty the weekend after the loss occurred. This would presumably require the insurer to show that the breach was ongoing, with the intermittent personal usage being merely ancillary to the commercial one.⁶⁶ While this is a possibility, it is by no means certain. In such circumstances, the insurer may therefore wish to consider contracting out of section 10 (either altogether, or only as regards the specific warranty).
61. The Act acknowledges that it may not be possible for a breach of warranty to be “*remedied*”.⁶⁷ Take, for example, a policy insuring fine wine, in which the insured warrants that the bottles will be stored in a cool cellar at all times. During shipment, the bottles are left sitting in a hot warehouse for three months, causing unstoppable deterioration of the corks. The wine is later moved into a cool cellar. In these circumstances, there may be two reasons why the insurer is not liable:

⁶⁴ Section 10(5)(b).

⁶⁵ Law Com No 353 (July 2014), [17.39].

⁶⁶ As was held to be the case in *Murray v Scottish Automobile and General Insurance Co.* 1929 SC 48.

⁶⁷ Section 10(4)(b).

- 61.1. First, it might be argued that the breach of warranty has *not* been remedied, since “*the risk to which the warranty relates*” – namely the risk that the wine will be damaged by the wrong climatic conditions – has not and cannot be rendered essentially the same as was originally contemplated (because the corks are irredeemably damaged).
- 61.2. On another analysis, it might be said that if, after the wine has been moved to the cool cellar, it is damaged by oxidation, that damage was “*attributable to something happening*” after the warranty was breached, but before it was remedied.⁶⁸ That is because the harm (oxidation of the wine) was attributable to the fact that the wine was left in the hot warehouse, causing the corks to dry out/be damaged, and the wine (over time) to oxidise.
62. On either of the analyses above, the insurer will not be liable in view of the insured’s breach of warranty.

What if an insurer wants to preserve the former effect of warranties?

63. In spite of the fundamental reclassification of warranties, there may be circumstances in which the insurer wishes to preserve the former effect of a warranty. An obvious example might be the premium payment warranty. Formerly, such a warranty was a powerful incentive for the insured to pay its premium on time, since, if it failed to do so, it would have no cover at all. Under the Act, provided the insured has paid its premium before loss occurs, it will be covered.
64. The Law Commissions have stated that they do not intend the Act to prevent insurers from including conditions which are so fundamental that breach by the insured should discharge the insurer from all liability. Where that is necessary, they suggest that the insurer should fully set out the consequences of breach of the term, and draw the term to the insured’s attention.⁶⁹ It is not entirely clear whether this means the parties must contract out of section 10 of the Act in order for such a term to be effective. Indeed, an insurer who wishes to retain the former force of premium payment warranties (or any other kind of warranty) appears to have at least three options:
- 64.1. The first option may be to draft the premium payment warranty in the terms of a condition precedent to the very existence of the contract. This, however, may be impractical and undesirable, since the premium may be payable some time *after* the risk has attached, meaning there would be a period (before payment) when there was no contract in existence, and therefore no cover.
- 64.2. Alternatively, the insurer could redraft the premium payment warranty in the terms of a condition precedent to liability, which provides that “*Payment of the premium by x date is a condition precedent to the insurer’s liability under the*

⁶⁸ Section 10(2).

⁶⁹ Law Com No 353 (July 2014), [14.22].

contract, failing which the insurer's liability shall be discharged immediately." The potential drawback of such a term is that it may be characterised as a warranty, and therefore subject to section 10 (meaning the problem has not been solved). That is because a warranty *is* a condition precedent to the insurer's liability under the contract – so the example term described above may simply be one way of expressing a warranty.⁷⁰

- 64.3. The safest option, therefore, may be to contract out of section 10. This exclusion of section 10 could be restricted to the application of the premium payment term only, or it could be a total exclusion – but the former approach may be more acceptable to the insured. Such a restricted exclusion may read as follows:

Section 10 of the Insurance Act 2015 does not apply to the premium payment warranty (but will apply as usual to the rest of the policy). As a result, if the insured fails exactly to comply with the premium payment warranty, the insurer will irrevocably be discharged from liability from the time of such breach. Accordingly, the insured cannot avail itself of the defence that it has remedied the breach of the premium payment warranty before any loss has occurred.

Section 11 – Terms not relevant to the actual loss

65. Section 11 is intended to prevent an insurer from relying on breach of a term by the insured if that breach is entirely unconnected with the actual loss which the insured has suffered. A classic example is the insurer's reliance on breach of a burglar alarm warranty where the loss has been caused by fire – since the breach of such a warranty may have had nothing at all to do with the actual loss suffered.⁷¹ The intention of this section is to prevent unfairness. However, its application may not always be as clear as in this example, and this may give rise to disputes.

To which terms does section 11 apply?

66. The section applies to any contractual term if compliance with that term would tend to reduce the risk of loss of a particular kind, or at a particular location or time.⁷² Such terms are referred to in this guide as "Risk Mitigation Terms". Section 11 is therefore potentially applicable to a very wide range of terms, and not just warranties. The Law Commissions have suggested that this may include conditions precedent, terms which define the risk and exclusion clauses (although see the comments below on this point).⁷³ For example, if the insured warrants that it will inspect its smoke detectors monthly, that term (if complied with) would tend to reduce the risk of loss of a particular kind – i.e. loss caused by fire. It will therefore be caught by section 11, since it is a Risk Mitigation Term.

⁷⁰ *The Good Luck* [1992] 1 AC 233, Lord Goff at 262.

⁷¹ As occurred in *Sugar Hut v Great Lakes Insurance (UK) Plc* [2011] Lloyd's Rep IR 198, where the insured was in breach of a burglar alarm warranty, whereupon there was a loss caused by fire.

⁷² Section 11(1).

⁷³ Explanatory Notes Insurance Act 2015, [94]; Law Com No 353 (July 2014), [18.41].

To which terms does section 11 not apply?

67. Section 11 does not apply to a “*term defining the risk as a whole*”.⁷⁴ An example given by the Law Commissions of such a term is a warranty that a ship will remain in class (in marine insurance).⁷⁵ Similarly, the Law Commissions have suggested that the following may qualify as terms which define the risk as a whole (and are therefore not subject to section 11):

67.1. Terms which define the geographical area in which a loss must occur if the insurer is to be liable (such as the war zone warranty, described above).

67.2. Terms which define the age, identity, qualifications or experience of the operator of a vehicle, aircraft, vessel or chattel.

67.3. Terms which exclude loss which occurs while a vehicle, aircraft, vessel or chattel is being used for a commercial purpose (rather than for private/leisure use).⁷⁶

68. It is not immediately obvious why (for example) a term excluding any loss sustained while a minor is operating a quadbike should necessarily be characterised as one that defines the risk as a whole, since such a term goes to a relatively narrow and specific risk that the quadbike will be damaged whilst being operated by a minor. It should, however, be noted that a term defining the risk as a whole may also be a Risk Mitigation Term: the two are not mutually exclusive. On the contrary, the language of section 11(1) appears to acknowledge that a term might be *both* a Risk Mitigation Term, and a term defining the risk as a whole. An example may be a warranty that the insured vessel will not sail in a war zone: that term would, if complied with, tend to reduce the risk of loss at a particular location (in the war zone), but it is also (at least in the Law Commissions’ view) a term “*defining the risk as a whole*” (because it defines the geographical area in which the loss must occur if the insurer is to be liable).⁷⁷ On that basis, it would *not* be subject to section 11.

69. It may already be obvious that the meaning and application of “*term defining the risk as a whole*” is uncertain. To take an example: in view of the heightened risk of fire at an oil refinery, the insured buys bespoke fire insurance. The insured warrants that there will be a qualified fire officer on watch at all times when the refinery is operational. Would section 11 apply to such a term?

69.1. Because the specific (indeed, the only) risk being insured against is fire, one might say that the term “*defines the risk as a whole*”, because it would “*tend to affect either the whole risk, or a significant part of the risk*”.⁷⁸ However, the term is also a Risk Mitigation Term, since if complied with, it would tend to

⁷⁴ Section 11(1).

⁷⁵ Law Com No 353 (July 2014), [18.24].

⁷⁶ Law Com No 353 (July 2014), [18.33]; Explanatory Notes Insurance Act 2015, [94].

⁷⁷ *Ibid.*

⁷⁸ Law Commission Stakeholder Note on Terms not Relevant to the Actual Loss, [1.9], available through <http://lawcommission.justice.gov.uk/areas/insurance-contract-law.htm>

reduce the risk of loss of a particular type (loss caused by fire), or at a particular time (during the refinery's hours of operation).

- 69.2. Whether or not section 11 applies will turn on the overall scope of cover provided by the policy: if it is narrow (i.e. only fire risks) then section 11 may not apply, because the term will define the risk as a whole. If, however, it is broader (such as an all risks policy), the exact same term might well be covered by section 11 because, in that context, it would only affect the particular risk of a specific type of loss. In this way, the applicability of section 11 may turn not on an objective construction of the term alone, but a consideration of that term in the context of the risks insured under the policy as a whole. All of this may be fruitful ground for disputes.
70. There is some uncertainty as to whether section 11 applies to exclusion clauses. Notwithstanding the Law Commissions' suggestion that it does,⁷⁹ and the express recognition of this in section 11(2) (viz. "*the insurer may not rely on the non-compliance to exclude...its liability*"), it is unclear whether many (or any) exclusion clauses will be caught by section 11 in practice. It is arguable that all exclusion clauses define the risk as a whole, since they delimit the scope of cover provided by the policy. Moreover, it is difficult to conceive of an exclusion clause with which the insured does or does not comply. For example, a term excluding loss "*arising out of strikers, locked-out workmen, or persons taking part in labour disturbance, riots or civil commotions*" (which is common in marine policies) is not one with which the insured complies; it merely defines that which is not covered. If the term is not one with which the insured may comply, it cannot qualify under section 11(1).⁸⁰
71. If section 11 does apply to any exclusion clauses, this could have the surprising effect of reversing the burden of proof. Currently, if it is to rely on an exclusion clause, the insurer must demonstrate that the loss falls within the ambit of the exclusion. For example, it must show (in the above example) that the loss arose from a civil commotion. If, however, an exclusion clause is caught by section 11, the insured would have the burden of proving that non-compliance with the term could not have increased the risk of the loss that actually occurred, in the circumstances in which it occurred (the meaning of which is explained below).

What is the effect of section 11?

72. Where section 11 applies to a term, the insurer cannot rely on non-compliance with that term to defend a claim if the insured shows that its non-compliance "*could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred*". In the example of the warranty requiring wine to be stored in a cool cellar (above), the insured would almost certainly be unable to satisfy this

⁷⁹ Footnote 79, above.

⁸⁰ That is because section 11(1) is concerned only with terms, compliance with which would tend to reduce the risk of loss of a particular kind, or at a particular location or time. If the term is not one with which the insured may comply, it cannot qualify under section 11(1).

requirement. That is because the breach of warranty (leaving the wine in a hot warehouse) very obviously caused the loss which actually occurred in the circumstances in which it occurred (the corks deteriorated, causing the wine to become oxidised). In those circumstances, the insured could not show that the breach “*could not have increased the risk of the loss which actually occurred, in the circumstances in which it occurred*”.

73. Not every case will be this clear-cut, however, and section 11(3) is particularly uncertain in meaning and application. Take the seemingly obvious example of the burglar alarm warranty which is breached, whereupon a nightclub burns down due to a fire caused by an electrical fault:

73.1. The insured would argue that the insurer could not rely on breach of the burglar alarm warranty, because the failure to comply with it could not have increased the risk of the loss which actually occurred, in the circumstances in which it occurred (i.e. loss of the nightclub by fire). At first blush, that seems obviously right – since having a working burglar alarm could not have made any difference to the loss which actually occurred, in the circumstances in which it occurred.⁸¹

73.2. The insurer, however, might argue that compliance with the burglar alarm warranty could have increased the risk of loss of the club by fire (or at least the extent of loss), in the circumstances in which it occurred. If the insured’s burglar alarm had been working, it might have been activated by falling masonry or the movement of the fire itself, meaning the emergency services might have arrived sooner, and the loss (or its extent) might have been prevented or reduced. Therefore, the “*risk of loss which actually occurred*” could have been increased by breach of the burglar alarm warranty. In this way, section 11 essentially introduces the complexities of the law of causation into this area. Parties wishing to contract out of this section may do so, subject to section 17 (discussed below).

⁸¹ Of course, the situation would be different if the fire had been started by an intruder – who might have been frightened off if the burglar alarm had been activated. In that scenario, the breach of warranty could have “*increased the risk of the loss which actually occurred in the circumstances in which it occurred*” – because the “*circumstances*” involve a fire started by an intruder causing the club to burn down, and the risk of this could have been increased by the fact that the alarm was not working.

VII. CONTRACTING OUT

74. This section of the guide is of particular importance to any insurer who wishes to exclude certain provisions in the Act. In Consumer Contracts, any attempt to contract out of any part of the Act will be of no effect.⁸² In Business Contracts, the parties are free to contract out of any of the provisions in the Act, apart from those relating to basis clauses. However, insurers must overcome the “*transparency requirements*” in section 17 if they are successfully to contract out of any other provisions. The second of these requirements is rather onerous. The Act refers to a term purporting to contract out of any provision as a “*disadvantageous term*”. The insurer must overcome two hurdles for such a term to be effective.

First hurdle: draw the term to the attention of the insured/the broker

75. The insurer “*must take sufficient steps to draw the disadvantageous term to the insured’s attention*” before the contract (or variation) is concluded.⁸³ What will amount to “*sufficient steps*” will vary, depending on characteristics of insureds of the kind in question (an objective matter), and the (actual) circumstances of the transaction.⁸⁴ If, for example, the insurer sells insurance through a coverholder (as agent of the insurer) to a small business, without any involvement from a broker, the objective characteristics of such an insured and the circumstances of the transaction may require the insurer to take more comprehensive steps to draw the term to the insured’s attention than an insured which has arranged its cover through a broker in the open market.
76. It is not necessary that the insured has actual knowledge of the disadvantageous term, but merely that the insurer has taken sufficient steps to draw it to the insured’s attention. This is the same as existing law on incorporation of terms which involve the abrogation of rights created by statute or are otherwise onerous, which requires only that such terms are brought fairly and reasonably to the other party’s attention, rather than actual knowledge.
77. It is likely that, in the context of many Business Contracts, the onus of taking “*sufficient steps*” to draw the disadvantageous term to the insured’s attention will be on the broker. The Act makes provision for this commercial reality. If the insurer fails to satisfy the first requirement, but the insured or its agent (which will include the broker) had actual knowledge of the disadvantageous term at the time the contract or variation was concluded, the insured may not rely on the insurer’s failure – and the disadvantageous term will be effective. It should be noted that only actual knowledge will suffice, for these purposes.

⁸² Section 15.

⁸³ Section 17(1).

⁸⁴ Section 17(4).

78. In 'open market' business, it is common for wordings to be prepared by a broker. In those circumstances, it is likely that the broker will have "*actual knowledge*" of any disadvantageous term in the policy, since it will have drafted the term itself. It would therefore be surprising if it did not have actual awareness of the term. In situations which do not involve a broker, such as that of a coverholder binding risks and issuing certificates on behalf of an insurer, it is advisable that the insured is informed in writing if the policy contains a disadvantageous term.

Second hurdle: draft the term so that it is clear and unambiguous as to its effect

79. The disadvantageous term must be "*clear and unambiguous as to its effect*". This is a matter of objective construction of the words of the term in question. It is not enough merely that the term is drafted in a way that is clear and unambiguous. The effect of the term must be clear and unambiguous. For example, it may be insufficient for the term merely to provide that "*Section 10 of the Insurance Act 2015 is excluded in its entirety*", since nothing is said of the "*effect*" of this term. An acceptable form of words might read as follows:

Section 10 of the Insurance Act 2015 shall not apply to any warranty in this insurance contract. If any such warranty is breached, the Insurer's liability shall be discharged from the time of the breach of warranty, regardless of whether the breach is subsequently remedied.

80. An insurer could go even further than this, by referring (for example) to the fact that warranties remain conditions precedent to the insurer's liability, or that section 33 of the Marine Insurance Act 1906 remains in place in its un-amended form. If in doubt, the insurer should err on the side of providing too much detail of the effect of its contracting out of a particular section. That is particularly the case if the insured is less sophisticated. That is because, as with the first transparency requirement, in assessing whether the second has been complied with, the characteristics of insured persons of the kind in question should be considered, as well as the circumstances of the transaction.

81. By way of further example, if the insurer wishes to exclude section 11 of the Act ("terms not relevant to the actual loss"), an acceptable form of words might read as follows:

Section 11 of the Insurance Act 2015 shall not apply to any term of this insurance contract. Where this insurance contract contains any term which, if complied with, would tend to reduce the risk of loss of a particular kind or at a particular location or time, and such term is not complied with, the Insurer may rely upon such non-compliance to exclude, limit or discharge its liability, even if non-compliance with the term could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred.

82. From this example, it will be seen that the drafting of disadvantageous terms in Business Contracts may become somewhat laboured. This, however, is the inevitable result of the second transparency requirement.

VIII. FRAUDULENT CLAIMS

83. Section 12 of the Act clarifies the old law on what happens when an insured makes a fraudulent claim, and gives the insurer a novel option of terminating the contract in the event of such a claim.
84. If an insured makes a fraudulent claim, the insurer is not liable to pay that claim. This includes any parts of the claim which are genuine.⁸⁵ For example, if an insured has in fact suffered loss covered by the policy, yet fraudulently exaggerates the value of the claim, the insured will forfeit the entire claim, and cannot recover the non-fraudulent part.⁸⁶ Further, the insurer may recover any sums it has paid in respect of the fraudulent claim.
85. In addition, section 12 provides that if the insured makes a fraudulent claim, the insurer may give notice to the insured to terminate the contract, and may retain the premium. The termination will be effective from the time of the fraudulent act, meaning the insurer will not be liable for any “*relevant event*” (i.e. an event that gives rise to the insurer’s liability) which occurs after the termination. The insurer will, however, remain liable for any “*relevant event*” which occurs before the termination.
86. If, however, an insured makes a legitimate (non-fraudulent) claim, but deploys a collateral lie (also known as a fraudulent device) which is immaterial to the claim both as regards liability and quantum, the insured may nonetheless recover. In this context, immaterial means that the lie is irrelevant to the insurer’s liability, in the sense that, if discovered, it would make no difference to the validity of the insured’s claim.⁸⁷ For example, the insured may tell a lie to the insurer in attempt to speed up the payment of a genuine claim. Even if the lie was discovered, the insured’s claim would still be legally valid. The Supreme Court has held that, in those circumstances, the insured is trying to obtain no more than its legal entitlement, meaning it would be disproportionate to deny the claim entirely.⁸⁸ The insurer will not in those circumstances be able to terminate the contract, and must pay the claim in full.

Practical steps where a fraudulent claim is discovered

87. Although it may be relatively rare for an insurer to discover that the insured has made a fraudulent claim during the life of a policy, in the event this does occur, insurers should be alert to their ability to terminate the policy by giving notice to the insured. They should also be aware that, in circumstances where they know or ought reasonably to have known of their right to terminate the contract, but do not do so (or act in a way inconsistent with so doing), they may be precluded from doing so by waiver/estoppel.

⁸⁵ *Versloot Dredging BV and another v HDI Gerling Industrie Verischerung AG and others* (“the DC Merwestone”) [2016] UKSC 45, Lord Sumption at [25] and [26], Lord Hughes at [102].

⁸⁶ *Ibid.*, Lord Hughes at [51].

⁸⁷ *Ibid.*, Lord Sumption at [36], Lord Hughes at [92], Lord Toulson at [107].

⁸⁸ *Ibid.*, Lord Sumption at [26], Lord Clarke at [40], Lord Hughes at [100], Lord Toulson at [105].

88. There is also the possibility that an insurer may discover at some later time (including after the cover has ended) that the insured previously made a fraudulent claim under the policy. In that case, the insurer can give notice to the insured to terminate the policy retrospectively. This will mean that the contract is to be treated as having been terminated with effect from the time of the fraudulent act. The insurer could thereby recover not only any payment it made in respect of the fraudulent claim, but also any subsequent payments in respect of liabilities under the policy which post-dated the fraudulent act.
89. As far as group insurance is concerned, section 13 essentially provides that, where one person who is covered under a group insurance policy makes a fraudulent claim, the insurer can exercise the rights (summarised above) under section 12 against that person only, and not the entire group.

IX. REINSURANCE

What difference does the Act make to reinsurance?

90. It has already been explained above that what an insured ought to know for the purposes of fulfilling the Duty will, under the Act, be defined by that which should reasonably have been revealed by a reasonable search. This may have a specific effect in facultative reinsurance scenarios, where the reinsurance cover is arranged after the underlying cover.
91. An insurance company, (which is also a reinsured) will owe the Duty to its reinsurer, including the duty to undertake a reasonable search. In conducting its reasonable search, the reinsured is obliged to ask questions of its underlying insured(s) if the insured's presentation prompts it to do so,⁸⁹ and to disclose to reinsurers material information which should reasonably have been revealed by enquiries made of the underlying insured(s). This may effectively amount to the creation of a new and wide-ranging duty of care on the part of the reinsured to its reinsurer, which does not currently exist (at least, not in non-proportional reinsurance⁹⁰). That could have a significant effect on the conduct of reinsurance in the UK.
92. Take, for example, the following scenario. In the course of a risk presentation relating to an underlying insurance policy, the underlying insured (A) tells his insurer (B) something which should have prompted B to ask a further question. Had B done so, it would have revealed a material circumstance. The second limb of the Duty has therefore been fulfilled by A.
93. B then seeks reinsurance from his reinsurer (C). B, as a reinsured, is fixed with knowledge of information that should reasonably have been revealed by a reasonable search. It may be at least arguable that the information which would in fact have been revealed to B but for his failure to ask a question of A is information which "*should reasonably have been revealed by a reasonable search*". That is not least because A gave B "*sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances*" – yet B (unreasonably) failed to do so.
94. Accordingly, the material matter which would have been revealed is a matter which B "*ought to know*", and to have disclosed to C. B is therefore in breach of the duty of fair presentation to its reinsurer, C, and the reinsurer can avoid the reinsurance policy (even though the underlying insurance is intact), or claim a proportionate remedy.

⁸⁹ Paragraphs 4 to 6 above.

⁹⁰ *Bonner v Cox* [2006] Lloyd's Re IR 385.

95. This outcome may be of considerable concern to reinsureds, who may be unwilling to assume such a duty towards their reinsurers. Insofar as a reinsured is unwilling to assume such duty, it may wish to consider contracting out of the provisions in the Act dealing with knowledge.

X. LATE PAYMENT DAMAGES

96. Currently, as a matter of English Law, an insurer cannot be liable in damages for loss arising from its failure to pay a claim under an indemnity policy within a reasonable time, unless the contract expressly provides otherwise. The Enterprise Act 2016 introduces certain new provisions into the Act, under which every insurance contract will be subject to an implied term that, if an insured makes a claim, the insurer must pay any sums due within a reasonable time. This is referred to as “**the Implied Term**” in this guide. If the insurer breaches the Implied Term, it may be liable to the insured in damages (“**Late Payment Damages**”).
97. This represents a significant change in English Law (although it is noted that the current position in Scotland differs, in that damages for late payment of an insurance claim are available⁹¹). Under current English Law, if an indemnity insurer fails to pay a claim in a reasonable time, the insured has no remedy in damages for any loss it may suffer as a result. That is because under English Law, the indemnity insurer’s duty is characterised as being to hold the insured harmless against the occurrence of insured loss. As a result of this legal fiction, if the insured loss occurs, the insurer is liable in damages for breach of contract to the insured.⁹² English Law does not permit a party to claim damages for a failure to pay damages.⁹³ Hence it is currently impossible for an insured to recover damages for late payment of an insurance claim, as a result of the “hold harmless” legal fiction.⁹⁴

What is the effect of the Implied Term?

98. The “hold harmless” fiction is not abolished under the Enterprise Act 2016 or the Act. Rather, the Enterprise Act 2016 introduces a new section 13A into the Act, which provides that it is an implied term of every contract of insurance that, if the insured makes a claim under the contract, the insurer “*must pay any sums due in respect of the claim within a reasonable time.*”⁹⁵ Accordingly, every insurance contract which is concluded on or after 4 May 2017⁹⁶ will be subject to the Implied Term requiring the insurer to pay claims due under the policy within a “*reasonable time*”.
99. It is noted that the Implied Term relates only to late payment of a claim, rather than any other step, including steps which may be a prerequisite to payment of a claim. For example, under a professional indemnity policy the insurer may be required to consent to settlement of an underlying claim against the insured. The insurer is not required, under the Implied Term, to give consent within a reasonable time. If the

⁹¹ *Strachan v The Scottish Boatowners Mutual Association* 2010 SC 367, Lord Eassie at [37]-[40].

⁹² *Firma C-Trade SA v Newcastle Protection and Indemnity Association (“The Fanti”)*; *Secony Mobil Oil Inc v West of England Shipowners Mutual Association (“The Padre Island”)* [1991] 2 AC 1, Lord Goff at 35.

⁹³ *The President of India v Lips Maritime Corporation (“The Lips”)* [1988] AC 395, Lord Brandon at 425.

⁹⁴ *Sprung v Royal Insurance (UK) Ltd* [1999] 1 Lloyd’s Rep IR 111; *Apostolos Konstantine Ventouris v Trevor Rex Mountain (“The Italia Express”)* (No 3) [1992] 2 Lloyd’s Rep 281.

⁹⁵ Section 13A(1).

⁹⁶ See below on application of the new provisions on Late Payment Damages.

insurer fails or refuses to consent to the settlement, it will not thereby breach the Implied Term. That is because the liability insurer's obligation to pay a claim does not arise until the insured's liability has been established by judgment, award or settlement.⁹⁷ Accordingly, until there has been a settlement, the insurer is not required to pay any sum under a liability policy, and it cannot therefore be in breach of the Implied Term.

100. The Implied Term does not preclude an insurer from thoroughly investigating and assessing a claim before it makes any payment under the policy. On the contrary, section 13A(2) expressly provides that a "*reasonable time*" includes time to investigate and assess the claim. The Law Commissions have repeatedly emphasised the importance of insurers' having adequate time thoroughly to investigate claims,⁹⁸ a matter discussed in more detail below.
101. The Implied Term does not prevent an insurer from refusing to pay a claim if it has reasonable grounds for the refusal. In those circumstances, the insurer will not breach the Implied Term by failing to pay the claim whilst the dispute continues, provided that it acts reasonably during the dispute.⁹⁹ Moreover, even if the insurer's refusal to pay a claim is ultimately held to be wrong by a court or arbitral tribunal, it does not follow (without more) that the insurer has breached the Implied Term. On the contrary, if the insurer had reasonable grounds for the refusal and acted reasonably, there will be no breach of the Implied Term.¹⁰⁰ The new law on Late Payment Damages is not intended to prevent insurers from taking robust claims handling decisions or to engage in thorough investigation of losses; it is merely intended to catch those rare examples of bad claims handling.¹⁰¹ It is therefore expected that cases in which an insurer will be held liable for Late Payment Damages will be relatively rare.
102. The effects of the Implied Term may be illustrated by revisiting the case of *Sprung v Royal Insurance (UK) Ltd*.¹⁰² In that case, Mr Sprung owned a factory, which was insured against "*sudden and unforeseen damage*". Vandals broke in, causing severe damage which put the factory out of use. The insurer refused to pay the claim, on the basis that it was not covered under the policy. The insured was unable to raise a loan to repair the factory, and went out of business, suffering additional losses of £75,000 (which was the amount he could have obtained if he had been able to sell his business). Four years later, the insurer abandoned its coverage defence, and paid the insurance claim.
103. Under the old law, the insured was unable to recover damages for his consequential loss (i.e. the additional £75,000), for the reasons explained above. Under section 13A of the Act, when it comes into force, the insured could in theory recover this

⁹⁷ *Post Office v Norwich Union Fire Insurance Society Ltd* [1967] 2 Q.B. 363, Lord Denning MR at 373-374.

⁹⁸ Law Com No 353 (July 2014), [28.26].

⁹⁹ Section 13A(4).

¹⁰⁰ Law Com No 353 (July 2014), [27.6].

¹⁰¹ Law Com No 353 (July 2014), [27.6].

¹⁰² [1999] 1 Lloyd's Rep IR 111.

additional loss as damages. It is, however, arguable that the insured in *Sprung* would not have been assisted by the Implied Term. That is because the cause of the insured's consequential loss was his own decision not to reinstate the factory, itself a product of the insured's weak financial position, and his inability to raise a loan.¹⁰³ It is now likely that, in a tort claim, the insured's impecuniosity does not break the chain of causation,¹⁰⁴ though this is not necessarily the position in contract. In other words, the Implied Term might not have made any difference to Mr Sprung, since his claim may have foundered on causation.¹⁰⁵

104. In many cases, a claim for breach of the Implied Term will be limited to one for compound interest only. In claims involving commercial parties, it will generally be straightforward for a party to whom a debt has been paid late to establish a claim for compound interest, since such a claim reflects the costs of borrowing to which the claimant may be subject.¹⁰⁶ In view of this, it is likely that most claims for Late Payment Damages by creditworthy claimants will be for compound interest only. In certain cases it will also be open to a claimant to seek to prove that it suffered some specific loss which was, at the time of contracting, in the reasonable contemplation of the parties.

Rules on contractual damages

105. As is clear from the discussion above, if the insurer breaches the Implied Term, it does not follow automatically that it will be liable in Late Payment Damages. This will depend upon application of the usual rules of contractual damages: causation, remoteness, foreseeability and mitigation. Although a comprehensive review of these subjects is beyond the scope of this guidance, in essence, this means that an insured claiming for breach of the Implied Term could only recover losses which may fairly and reasonably be said to have arisen naturally, "*according to the normal course of things*"; or from special circumstances, but only if they were communicated to the insurer at the time the policy was concluded.¹⁰⁷
106. For example, if a small business buys insurance, and suffers a debilitating loss which the insurer unreasonably refuses to cover, it is probably foreseeable that the insured in question may struggle to raise finance elsewhere, and could go out of business due to its own impecuniosity. If, as a result of the insurer's unreasonable refusal to pay, the small business fails, the losses arising from this event may, depending on the circumstances, be foreseeable and, subject to all other matters, could be recovered as damages for breach of the Implied Term.
107. However, the position of a larger or more creditworthy business is likely to be different. Broadly speaking, it is unlikely to be in the contemplation of the parties at the time they contracted that, if the insurer fails to pay a claim, the insured would be unable to obtain finance to offset any late payment of the insurance indemnity. If

¹⁰³ Ibid., Evans LJ at 118.

¹⁰⁴ *Lagden v O'Connor* [2003] UKHL 64

¹⁰⁵ However, see further below in the discussion of contractual damages.

¹⁰⁶ *Equitas v Walsham Brothers & Co Ltd* [2014] EWHC 3264, Males J at paragraph 123(ii) and (iii).

¹⁰⁷ *Hadley v Baxendale* (1854) 9 Exch 341, Alderson B at 355.

the insured suffered loss as a result of the delayed payment, such loss might well *not* be reasonably foreseeable, and would therefore be irrecoverable.¹⁰⁸ In those circumstances, it is likely that the insured's recovery for breach of the Implied Term would be limited to compound interest.

108. The size and creditworthiness of the insured are not the only relevant factors for these purposes, however. A particular situation may arise in the case of insureds which own one or two particularly significant assets, on which they depend for all or most of their income. For example, it is not uncommon for a shipowner to own one vessel, upon which it relies for all of its income (through payments of hire for chartering the vessel). If that vessel were to be lost, and the insurer delayed in paying the indemnity for an unreasonable period, the insured would lose all of its income, and possibly its entire business. Depending upon the particular circumstances of the case, any such losses might therefore be recoverable, provided the insurer was aware, at the time it contracted, that the insured was a one-ship company which relied solely upon the income generated by the insured vessel, and was unlikely to have access to funding to replace the vessel, were it lost.

Entering into force of the new provisions on Late Payment Damages

109. As explained above, the new provisions on Late Payment Damages apply to any contract of insurance or reinsurance which is entered into on or after 4 May 2017, which is one year after the Enterprise Act 2016 was passed. For the avoidance of doubt, the relevant date is that when the insured and the insurer enter into the contract, and not the date when policy period incepts.

What is a “reasonable time”?

110. The question of what amounts to a “reasonable time” for the insurer to pay any sums due is highly fact sensitive, and will turn upon a number of considerations which will differ in every case.¹⁰⁹ The Act provides a non-exhaustive list of certain factors which may be relevant in assessing whether the insurer has exceeded a reasonable time, which is discussed below, along with other potentially relevant matters.

(i) The type of insurance¹¹⁰

111. The Act expressly provides that the type of insurance in question will influence what is a reasonable time within which to pay a claim. The essential point is that what is a reasonable time in the context of one type of insurance might not be reasonable for a different product. For example, the assessment of claims under business interruption policies is often time-consuming and difficult, because of the complexities inherent in that type of insurance.¹¹¹ Contrastingly, travel insurance

¹⁰⁸ *Hadley v Baxendale* (1854) 156 ER 145.

¹⁰⁹ Law Com No 353 (July 2014), [28.23]: “the question of whether a claim has been assessed and paid within a reasonable time must depend on all of the circumstances of the case.”

¹¹⁰ Section 13A(3)(a).

¹¹¹ Explanatory Notes Enterprise Act 2016 at [266].

provides a relatively simple form of cover which is unlikely, in most cases, to require very significant or lengthy investigation in the event of loss.

112. Relevant matters which fall within the “*type of insurance*” include the type of the insurance product (e.g. public liability, D&O, marine hull and machinery); the level of cover (which will usually be discernible by reference to the limit of indemnity); the size and complexity of the insured; and the structure of the insurance programme (for example, whether it involves multiple different insurers and/or different layers of cover). Each of these factors may influence the amount of time which is reasonably required to investigate and assess a claim.

*(ii) The size and complexity of the claim*¹¹²

113. In practice, the nature of the claim is likely to be the most relevant factor in assessing what is a reasonable time for payment in most cases. It is likely that, if the claim is of a high value, it will be reasonable to spend longer assessing the loss than if the claim is small. For example, it is to be expected that an insurer would reasonably take longer to investigate the total loss of a large vessel than it would to investigate more limited damage to the vessel's gantry.
114. However, section 13A(3)(b) makes clear that the value of the claim is not the only factor, since “*complexity*” is also a relevant factor. Even if a claim is of relatively low value, it might nonetheless involve substantial complexity, meaning it will be reasonable for the insurer to spend a longer period on investigation and assessment.
115. In *Brit UW Limited v F&B Trenchless Solutions*, there was a complex claim under a contractor's liability policy, arising from a loss involving the derailment of a train caused by construction works beneath a railway track. The insurer avoided for non-disclosure and misrepresentation relating to the performance of tunnelling works underneath the collapsed railway track. In that context, Carr J said that a period of 4-5 months in which to carry out investigations, take legal advice and decide to avoid was not unreasonable.¹¹³ The utility of this or other authorities¹¹⁴ in instructing what is a reasonable time in other cases is somewhat limited, however, since each case will turn on its particular facts. But it does illustrate that if there are complex technical or other investigations which must be performed following an insured loss, it is reasonable to expect that the process will take longer.

*(iii) Compliance with relevant statutory or regulatory rules*¹¹⁵

116. The Act provides that compliance with relevant statutory or regulatory rules may be a relevant factor in assessing whether a reasonable time had expired before the claim was paid. Below is a non-exhaustive list of some of the regulatory rules which may be relevant in determining whether the insurer has breached the Implied Term.

¹¹² Section 13A(3)(b).

¹¹³ [2016] Lloyd's Rep IR 69 at [171].

¹¹⁴ See, for example, the Australian cases which consider what amounts to a reasonable time to pay a claim: *Tropicus Orchids Flowers and Foliage Pty Ltd v Territory Insurance Office* [1997] NTSC 46 and *Moss v Sun Alliance Australia Ltd* (1990) 55 SASR 145.

¹¹⁵ Section 13A(3)(c).

However, this will always depend upon the precise circumstances of any given case. For the avoidance of doubt, it does not necessarily follow that failure to comply with any of the regulatory rules listed below, or indeed any others, will mean that the insurer has breached the Implied Term. The potentially relevant regulatory rules include:

- 116.1. Handling claims promptly and fairly.¹¹⁶
- 116.2. Providing reasonable guidance to help an insured make a claim and appropriate information on the progress of the claim.¹¹⁷
- 116.3. Settling claims promptly once settlement terms are agreed.¹¹⁸
- 116.4. Paying due regard to the interests of insureds, and treating them fairly.¹¹⁹
- 116.5. Paying due regard to the information needs of the insured, and communicating information to it in a way which is clear, fair and not misleading.¹²⁰
- 116.6. In the case of Lloyd's managing agents, having a claims management philosophy which is clearly documented, communicated and reflected in the organisation of the business.¹²¹
- 116.7. In the case of Lloyd's managing agents, having a Claims Business Plan which includes Key Performance Indicators relating to the delivery of objectives and internal performance targets for claims management.¹²²
- 116.8. In the case of Lloyd's managing agents, having appropriate claims resources and skills in each class of business,¹²³ and appropriate management control of those skills and resources.¹²⁴
- 116.9. In the case of Lloyd's managing agents, ensuring that claims are adjusted and processed in accordance with clear procedures for the management of claims.¹²⁵
- 116.10. Not requiring a consumer insured to produce documents which could not reasonably be considered relevant as to whether the claim was valid, or failing systematically to respond to pertinent correspondence.¹²⁶

¹¹⁶ FCA *Insurance: Conduct of Business Sourcebook* ("ICOBs"), 8.1.1(1).

¹¹⁷ *Ibid.*, 8.1.1(2).

¹¹⁸ *Ibid.*, 8.1.1(4).

¹¹⁹ FCA *Principles for Businesses*, 2.1.1(6).

¹²⁰ *Ibid.*, 2.1.1(7).

¹²¹ Lloyd's Minimum Standards CLM 1.1.

¹²² *Ibid.*, CLM 2.2.

¹²³ *Ibid.*, 3.1.

¹²⁴ *Ibid.*, 3.2.

¹²⁵ *Ibid.*, 4.1.

¹²⁶ *Consumer Protection from Unfair Trading Regulations 2008* (SI 2008/1277), Schedule 1, paragraph 27.

(iv) *Factors outside the insurer's control*¹²⁷

117. The final matter which the Act expressly provides may be taken into account in deciding whether there was a breach of the Implied Term is any factor outside the insurer's control. For example, where the insured or a third party (such as the broker) fails or refuses to provide information to the insurer, it may be unable to make a properly informed decision on its liability.¹²⁸ Depending upon the type of insurance, there may be many instances in which the provision of information by a third party is vital to the insurer's ability properly to investigate a claim. If, for example, sanctions are imposed mid-way through the policy period, which require the insurer to obtain a licence from a foreign government before it pays a claim to the insured, this could reasonably delay the payment of a claim for reasons which are beyond the insurer's control, meaning that the failure to pay was not a breach of the Implied Term.

Third Party Administrators

118. A Third Party Administrator ("TPA") agrees to perform claims management services on behalf of the insurer(s),¹²⁹ including the review and investigation of all claims reported to the TPA.¹³⁰ If the TPA fails to investigate or assess a claim within a reasonable time, the insurer may be liable for breach of the Implied Term. It is unlikely, in those circumstances, that the insurer's breach will be excused, because the TPA is within the insurer's control.
119. However, if the conduct of the TPA causes the insurer to be in breach of the Implied Term, the insurer is likely to have a claim against the TPA. The model TPA Agreement provides that the TPA will indemnify the insurer against "*any and all claims...based upon or [arising] directly or indirectly out of or in connection with...any actual or alleged act or omission on the TPA...unless the act or omission was at the express direction of the [insurer]*".¹³¹ In view of this, if the insurer was liable to the insured for breach of the Implied Term resulting from some act or omission by the TPA, it would have a claim against the TPA under the terms of the TPA Agreement, unless the TPA's delay was the result of following the insurer's express instructions. Alternatively, the insurer would have a claim against the TPA for breach of its duty of care to the insurer. A similar analysis would apply in respect of a coverholder, which has claims settling authority.

Claims payments made to brokers under Risk Transfer TOBAs

120. It is common practice for managing agents and London insurers to have in place Terms of Business Agreements ("**TOBAs**") with their placing brokers. The two most typical forms of TOBA are the Non Risk Transfer TOBA and the Risk Transfer TOBA.

¹²⁷ Section 13A(3)(d).

¹²⁸ Explanatory Notes Enterprise Act 2016 at [268].

¹²⁹ See LMA 9008A, model Third Party Administrator Agreement.

¹³⁰ Ibid., clause 1.1(a).

¹³¹ LMA 9008A, clause 4.1(a).

121. Under the Non Risk Transfer TOBA, the broker holds all premium and claims monies as agent for the insured.¹³² Payment to the broker under a Non Risk Transfer TOBA is therefore good payment of the claim to the insured, through its agent. Once such a payment has been made, the insurer cannot be in breach the Implied Term.
122. Under the Risk Transfer TOBA, the broker holds claims monies as agent of the insurer. If the insurer has paid claims money to a broker under a Risk Transfer TOBA, but the broker fails to pay it to the insured (for reasons other than the broker's insolvency), that is likely to be a factor outside the insurer's control, meaning there has been no breach of the Implied Term. That is because the broker remains the agent of the insured, and would be under an obligation to account for the money received, even though it held it as agent of the insurer. If the broker failed or refused to forward the money to the insured, that would be a matter over which the insurer had no control. However, if the broker's non-payment was due to its insolvency, delay by the insurer in making a second payment direct to the insured could be a breach of the Implied Term.

(v) *Other potentially relevant factors*

123. Whilst it is impossible to provide an exhaustive list of other factors which may be relevant in deciding whether an insurer has breached the Implied Term, the following is a list of factors which may be relevant, depending upon the facts and circumstances of each case:

123.1. *The time of year.* If part of the claims handling process takes place at a time when large numbers of staff are either absent from work or particularly busy (such as Christmas), payment of the claim might reasonably take longer than at other times. In *Gentry v Miller*, insurers spent two months investigating a road traffic claim, which was not unreasonable *per se*, partly because it included the Christmas period.¹³³

123.2. *The occurrence of other losses.* If there is a loss-causing event which affects a large number of policyholders simultaneously, such as flooding or other natural disasters, an insurer may come under intense pressure to handle a large number of claims. In those circumstances, it is expected that the length of time considered reasonable for payment of claims will be longer.¹³⁴ However, the insurer may be expected to take reasonable steps to ensure that if there is a sudden high volume of claims, it has adequate measures in place to handle those claims within a reasonable time.

123.3. *The non-availability of relevant staff.* If one or more of the insurer's claims handling staff with responsibility for the claim are absent for a prolonged period, it may be reasonable to expect that the claims handling process will be delayed. However, if the insurer fails to take reasonable steps to ensure that contingency

¹³² LMA/LIIBA Model Non Risk Transfer TOBA 2011 (amended May 2014), clause 6.1.

¹³³ *Gentry v Miller* [2016] EWCA Civ 141, Vos LJ at [28].

¹³⁴ Law Com No 353 (July 2014), [28.38].

plans are in place for handling claims in the absence of key individuals, this could be a relevant factor in showing that the Implied Term was breached.

123.4. *The difficulty of investigating the loss.* If the loss has taken place in circumstances which make it difficult to investigate and assess, the process will reasonably take longer. For example, if the loss occurs in a distant or remote location, it will take longer for the insurer to investigate.¹³⁵ Similarly, if the site of the loss has been secured due to risks of contamination, or because of an investigation by the police, it will be difficult or impossible for the insurer to investigate until the restrictions are lifted.

123.5. *Suspicion of fraud.* If the insurer has reasonable grounds to suspect that the insured has committed fraud, either in the course of the risk presentation or in making the claim, it is reasonable to expect that the insurer should take more time to investigate the matter fully.¹³⁶

What are “reasonable grounds” for disputing a claim?

124. If there is a dispute about the insurer’s liability to pay the claim (whether over liability or quantum), the insurer will not breach the Implied Term merely by failing to pay whilst the dispute is ongoing, provided the insurer had “reasonable grounds” for disputing the claim.¹³⁷ This is not intended to be an onerous requirement.¹³⁸ Even if the insurer ultimately loses the dispute with the insured, because (for example) a court or tribunal finds against the insurer, it does not follow that the insurer had no reasonable grounds for disputing the claim, and is therefore in breach of the Implied Term.

125. If there are reasonable grounds for disputing the claim, the insured must show something more in order to prove a breach of the Implied Term: the insurer’s conduct in disputing the claim must have been unreasonable.¹³⁹ This is clear from section 13A(4)(b), which provides that the conduct of the insurer in handling the claim may be a relevant factor in deciding whether the Implied Term was breached. For example, if the insurer is unreasonably slow and uncooperative in performing its investigation, or unreasonably ignores evidence which indicates that the loss is covered, there may be a breach of the Implied Term. But, for the avoidance of doubt, if the insurer has “reasonable grounds” for disputing the claim, there must be conduct which is otherwise unreasonable if the insured is to prove breach of the Implied Term. In practice, it is expected that such cases will be rare.

126. For example, an insured vessel is captured by pirates, set alight, and sinks. Following the loss, the insurer interviews the crew, whose answers cause the insurer to suspect that the insured had scuttled the vessel. It therefore refuses to pay the claim on the grounds of wilful misconduct. In due course, fresh evidence comes to

¹³⁵ Explanatory Notes Enterprise Act 2016 at [266].

¹³⁶ Law Com No 353 (July 2014), [28.46].

¹³⁷ Section 13A(4)(a).

¹³⁸ Law Com No 353 (July 2014), [28.85].

¹³⁹ Law Com No 353 (July 2014), [28.50] and [28.85].

light which proves that the insured did not commit wilful misconduct. In spite of this evidence, the insurer maintains its refusal to pay the claim. In those circumstances, the insurer probably did not have reasonable grounds for disputing the claim, at least not from the moment when the new evidence came to light. Moreover, the insurer's failure or refusal to alter its position on the basis of the new evidence may itself be unreasonable, meaning there was a breach of the Implied Term.

127. In the majority of cases where an insurer disputes a claim, it will do so on the basis of legal advice. In those circumstances, unless it was unreasonable for the insurer to follow the advice, the insurer will have reasonable grounds for disputing the claim. There is a question, however, as to what happens if the insurer relies upon legal advice which was both wrong and negligent. It is arguable that, in those circumstances, there are no reasonable grounds for disputing the claim.¹⁴⁰ If the legal basis which is given for disputing the claim is both wrong, and one which no reasonable lawyer would have given, then that basis must be unreasonable. There is, therefore, a risk that the insurer would be held to be in breach of the Implied Term. The insurer would in all likelihood have a remedy against its negligent legal adviser.
128. However, even if the insurer follows negligent legal advice, it is not necessarily in breach of the Implied Term. In other words, the absence of reasonable grounds for disputing a claim should not necessarily mean that the insurer's failure to pay the claim is unreasonable. That is because insurers obtain legal advice from lawyers on the reasonable assumption that the advice is non-negligent. It is not unreasonable for an insurer to follow advice on this assumption, unless (for example) there is something which ought reasonably to have indicated to the insurer that the advice was negligent (such as an obvious sign that the lawyer had misunderstood the facts). In view of this, it is arguable that even where an insurer has failed to pay a claim on the basis of legal advice which is later revealed to be negligent, it has not necessarily breached the Implied Term by failing to pay the claim within a reasonable time. This point is uncertain, however, and is likely to be tested in the courts.

Privileged advice that there were "reasonable grounds"

129. The question of whether or not an insurer had "*reasonable grounds*" for disputing a claim will be judged objectively. In view of this, the insurer will not be required to disclose privileged legal advice in order to demonstrate reasonable grounds. It will be sufficient for the insurer to explain what its grounds for disputing the claim are or were, following which a court will be able to ascertain for itself whether those grounds were, objectively, reasonable.
130. However, in view of the newfound significance of showing "*reasonable grounds*" for disputing a claim, an insurer may wish to adduce evidence of the legal effect of privileged legal advice. In other words, the insurer may wish to adduce evidence of the fact that it obtained advice that there were reasonable grounds for disputing the

¹⁴⁰ This is not a certainty, however, since there may be some alternative basis for disputing the claim, which is not the subject of the negligent advice.

claim, without disclosing the full content of the advice. There may be two related purposes to this:

- 130.1. First, although not necessary (for the reasons explained in paragraph 129 above), disclosing the effect of the advice would go some way to proving that there were reasonable grounds for disputing the claim, which is relevant under section 13A(4).
 - 130.2. Secondly, the fact that the insurer obtained legal advice at all is likely to amount to relevant claims handling conduct for the purposes of section 13A(4)(b), and will militate against a finding that the insurer's failure to pay was unreasonable.
131. If the insurer elects to disclose the effect of privileged legal advice, there is a risk that it will thereby waive privilege in that advice, and therefore be required to disclose the content of the entire advice.¹⁴¹ In order to safeguard against this risk, it is necessary that the disclosure of the effect of the advice is done on terms which are carefully drawn.¹⁴² To ensure that the insurer can rely on the effect of its legal advice without waiving privilege, insurers may include this term in the policy:

"The Insurer is entitled to adduce evidence that it obtained legal advice that there were reasonable grounds for disputing any claim under this insurance contract, for the purposes of section 13A(4) Insurance Act 2015. If it does so:

- (a) the Insurer will not thereby waive privilege in the content of that legal advice to any person;*
- (b) the existence of the advice shall be not be disclosed by any person for any purpose other than showing that the Insurer had reasonable grounds for disputing a claim under this insurance contract; and,*
- (c) the insured and the insurer shall at all times preserve confidence in the existence of the advice."*

The one-year limitation period for claims for Late Payment Damages

132. The Enterprise Act 2016 provides that a claim for breach of the Implied Term must be brought within one year from the time when payment of the sums due to the insured under the contract has been made.¹⁴³ Once the insurer has paid all sums due under the contract, therefore, the insured has one year in which to bring a claim for breach of the Implied Term. If, after the expiry of one year, the insured has not brought a claim for Late Payment Damages, it will be barred from doing so under section 5A of the Limitation Act 1980.

¹⁴¹ *Mid-East Sales Limited v United Engineering & Trading Company Limited* [2014] EWHC 892 (Comm).

¹⁴² *B v Auckland District Law Society* [2003] 2 AC 736.

¹⁴³ Enterprise Act 2016 section 30, which adds section 5A to the Limitation Act 1980.

133. Any payment which extinguishes the Insurer's liability to the insured under the contract will constitute the beginning of the one year limitation period for bringing the late payment claim.¹⁴⁴ For example, it might be made in accordance with a judgment or arbitral award, or pursuant to a binding settlement agreement.¹⁴⁵
134. In view of the shortened limitation period for claims for breach of the Implied Term, caution is needed where there is a provision altering the limitation period for claims brought under the policy. For example, it is not uncommon for policies to provide that *"No suit shall be brought upon this Contract of Insurance unless the Insured has commenced suit within twelve months after the loss occurs."* Because a claim for breach of the Implied Term is a claim brought under the insurance contract, this clause inadvertently contracts out of section 5A(1) of the Limitation Act 1980. That is because the limitation period for such a claim accrued once the claim is paid in full, not when the loss occurs.

Liability of different insurers of the same risk

135. There are many situations in which multiple insurers participate in the insurance of the same risk. This gives rise to specific issues relating to the Implied Term.
136. If, in a subscription market, the participating insurers have not put in place any claims-handling arrangements, then each of the insurers will be responsible for its own claims-handling decisions. In those circumstances, an individual insurer will be liable for breach of the Implied Term only if it fails to pay a claim within a reasonable time. Assuming the insurers are severally liable and one of them breaches the Implied Term, that insurer may (depending on all other factors) be liable to the insured, but only for the losses which were reasonably foreseeable as a result of that single insurer not paying its share of the claim within a reasonable time. If all of the other insurers have paid their shares of the claim, that loss is likely to be limited to a claim for interest only, in most cases.
137. If, however, there is a lead underwriter and following market, and the followers are bound by a "follow the lead" clause in the slip in respect of claims-handling, the situation may be different. In those circumstances, if the leader breaches the Implied Term, the following market may also be liable to the insured for breach of the Implied Term. The following insurers might in those circumstances have a claim against the leader for their liability for breach of the Implied Term. Unless the leader and followers have agreed otherwise, the leader's liability to the following market would be unlimited.
138. If the claim is subject to the Lloyd's Claims Scheme, the claims-handling decision will be made by the lead syndicate (and the second syndicate, if the claim is complex). In those circumstances, if the lead syndicate is unreasonably slow in handling the claim, it and each member of the following market is potentially liable to the insured for breach of the Implied Term. The following syndicates may have a

¹⁴⁴ Explanatory Notes Enterprise Act 2016 at [281].

¹⁴⁵ Ibid.

valid claim against the lead syndicate for breach of its duty of care, although this will be subject to the limit of liability contained in the Lloyd's Claims Scheme.

139. In view of the risk in the subscription market that an insurer could face liability for breach of the Implied Term as a result of the conduct of another insurer, careful consideration should be given to limiting liability for Late Payment Damages. In particular, it may be appropriate for an insurer in a subscription market to limit its liability for Late Payment Damages to the proportion of its risk under the insurance contract (as to which see below).

Reinsurance

140. As with the rest of the Act, the new provisions on Late Payment Damages apply to contracts of reinsurance and retrocession. Two considerations which arise in the context of reinsurance are: (i) whether the reinsurer is liable for breach of the Implied Term by the reinsured, including where the reinsurer has exercised its rights under a claims control clause; and, (ii) the reinsurer's liability for its own breach of the Implied Term.

Reinsurer's liability for breach of the Implied Term by the reinsured

141. Whether the reinsured's liability for breach of the implied term is covered by a reinsurance contract can be answered only by reference to the terms of the reinsurance contract. It should be noted that liability for breach of the Implied Term is not an extra-contractual obligation, since it arises by reason of a breach of a contractual term. It would not, therefore, be subject to an exclusion of coverage for non-contractual liability.
142. Reinsurers should consider whether they are willing to cover the reinsured for liability for breach of the Implied Term. If they are not, they should negotiate an exclusion or limitation of their liability for breaches of the Implied Term by the reinsured. Similarly, reinsurance buyers will need to consider whether their current reinsurance provides cover in the event they breach the Implied Term and, if not, whether they should negotiate such cover.
143. Many facultative reinsurance contracts contain a claims control clause or similar, which enables the reinsurer to exercise control over the handling and/or settlement of underlying insurance claims. If the reinsurer exercises its rights under such a clause, and this causes the reinsured not to pay the underlying claim in a reasonable time, is the reinsurer liable for any Late Payment Damages which the reinsured must pay to the underlying insured?
144. As a matter of contract, this question will turn upon the wording of the reinsurance policy. Unless that contract provides cover for the reinsured's liability for late payment damages, whether in general, or as a result of the reinsurer exercising its rights to control claims, there will be no such reinsurance coverage.

Reinsurer's liability for its own breach of the Implied Term

145. As for the second consideration, reinsurance contracts will be subject to the Implied Term, meaning a reinsurer which fails to pay a reinsurance claim within a reasonable time could be liable to the reinsured for Late Payment Damages. The considerations set out above are therefore relevant to payments of a claim by reinsurers.

Contracting out of the provisions relating to Late Payment Damages

146. In consumer insurance, it is not possible to contract out of the new law on Late Payment Damages. The Act provides that any term of a consumer contract which places the insured in a worse position as respects the matters in section 13A (i.e. the Implied Term) will be of no effect. Accordingly, any attempt to contract out of the Implied Term will be ineffective.
147. In non-consumer insurance, it is possible to contract out of the new law on Late Payment Damages. However, it is not possible to contract on any basis which puts the insured in a worse position than it would be in under the Act as regards deliberate or reckless breach of the Implied Term. As a result, if the insurer fails to pay a claim in circumstances where it knows or does not care whether the claim is valid, it will always be in breach of the Implied Term, regardless of any attempt to contract out.
148. There are at least two ways in which the parties could, if they agreed to do so, contract out of the new provisions on Late Payment Damages:
- 148.1. First, the parties may contract out of the Implied Term altogether, save in any case where there is a deliberate or reckless breach of that term (since this would fall foul of section 16A of the Act, summarised above). In other words, the parties would contract on the basis that the Implied Term did not apply to the contract, unless there was a deliberate or reckless breach of it. This approach is envisaged in the Explanatory Notes to the Enterprise Act 2016.¹⁴⁶
- 148.2. Secondly, the parties may agree that the insurer will not be liable in damages to the insured unless it commits a deliberate or reckless breach of the Implied Term. Similarly, the parties may agree that the insurer's liability in damages is limited (for example, to a specific amount), unless there is a deliberate or reckless breach.
149. Provided the transparency requirements are complied with, either of the approaches described above is an effective means of contracting out of the new regime on Late Payment Damages. The difference is that the second approach proceeds on the basis that the Implied Term is implied into the contract, but provides that notwithstanding this, the insurer will not be liable in damages for breach of the Implied Term, unless the breach is deliberate or reckless. In this way, it avoids the potential liability which may arise from breach of the Implied Term, save where it is

¹⁴⁶ Explanatory Notes Enterprise Act 2016 at [276]

impossible to do so. The following clause may be used in order to contract out in this way:

The Insurer shall have no liability to pay damages to the Insured for late payment of a claim under this insurance contract, unless it fails deliberately or recklessly to pay the claim within a reasonable time.

150. If the parties do not agree to exclude the insurer's liability in damages for breach of the Implied Term altogether, they may nonetheless agree that the insurer's liability should be limited, unless the breach is deliberate or reckless. For example, the parties may agree as follows:

The Insurer's liability to pay damages to the Insured for late payment of a claim under this insurance contract is limited as follows:

The Insurer's liability is limited to £10,000.

151. There are several other possibilities when it comes to limiting liability for breach of the implied term, unless the breach is deliberate or reckless, including the following:

The Insurer is not liable for any sum which, together with any claims paid by the Insurer, exceeds the limit of indemnity under this insurance contract.

The Insurer's liability is limited to a multiple of [X] times the premium charged under this insurance contract.

The Insurer is not liable for any loss of revenue, profits or goodwill on the part of the Insured.

The Insurer is not liable for any of the Insured's costs arising from the Insurer's late payment of the claim, including but not limited to legal and employee costs and management time.

The Insurer is not liable for any indirect or consequential loss.

The Insurer's liability is limited to interest on the amount which should have been paid, at a rate of 2% above LIBOR. The interest shall be payable from the date when payment should reasonably have been made until the date of actual payment.

If the Insurer has underwritten a proportion of this insurance contract, its liability for any late payment shall be no greater than that proportion of any damages suffered by the insured.

152. In any event, whichever method the parties use to contract out of the provisions on Late Payment Damages (to the extent they can do so), it is necessary to comply with the transparency requirements described in section VII above.

XI. APPLICATION OF THE ACT

153. The Act came into force on 12 August 2016, save for the provisions on Late Payment Damages, which will come into force on 4 May 2017.¹⁴⁷ All contracts of insurance, reinsurance and retrocession which are concluded on or after that date and are governed by English Law will be subject to the Act.¹⁴⁸
154. Determining whether a contract of insurance will be subject to the Act therefore involves two subsidiary questions: (i) is the contract governed by English Law? And, (ii) when was the contract concluded?

(i) Is the contract governed by English Law?

155. This may at times be a complex question, the answer to which is beyond the scope of this guide. As a very basic summary, the Act will apply to all contracts and variations that are expressly or impliedly subject to English Law.¹⁴⁹ If there is no choice of law clause in the contract,¹⁵⁰ a contract that was placed in London, or which contains a London arbitration or English High Court jurisdiction clause is likely to be governed by English Law. However, the Act may not apply where the contract provides that disputes are to be resolved outside the UK. Where uncertainties arise over the applicable law in a given case, specific legal advice should be sought.

(ii) When was the contract concluded?

156. In the majority of cases, it will be clear when a contract (or variation) is concluded: namely, when the risk is accepted by the insurer (and *not* when the cover incepts). However, care should be taken in certain situations. This is particularly true of open cover insurance and treaty reinsurance, where there may be uncertainty over *when* a contract is concluded (and therefore whether it is governed by the Act, or not). Some of the possibilities are summarised below:

- 156.1. In obligatory/obligatory contracts (and floating policies), in which the insured must cede certain risks and the insurer must take them, the contract is concluded when it is first entered into. Subsequent declarations of risks by the insured do not give rise to new contracts.¹⁵¹ Therefore, if an oblig/oblig open cover is concluded *before* 12 August 2016, but risks are ceded to the open cover *after* that date, the contract will nonetheless be governed by the old law.

¹⁴⁷ The only other exception is Part 6, which amends the Third Parties (Rights Against Insurers) Act 2010 (see section 23(3)).

¹⁴⁸ Sections 14 and 21, and Part 2 of the Act apply (i) to contracts of insurance entered into after 12 August 2016, and (ii) to variations of contracts of insurance made after 12 August 2016, regardless of when the contract itself was entered into. Contrastingly, Parts 3 and 4 of the Act apply *only* to contracts of insurance entered into after 12 August 2016, and to variations of such contracts (but *not* variations of contracts entered into before 12 August 2016). See section 22.

¹⁴⁹ Or that of the constituent parts of the UK: Scotland, Northern Ireland or Wales.

¹⁵⁰ This is never advisable, and it is recommended that all contracts should contain an applicable law and jurisdiction clause, in the interests of contractual certainty.

¹⁵¹ As in *The Beursgracht* [2002] 1 Lloyd's Rep 574, Tuckey LJ at [21].

- 156.2. This is to be contrasted with facultative/obligatory contracts, under which the insured has a choice as to what risks it cedes, but the insurer must take all of the risks ceded. In such a case, the cession of each risk by way of a declaration by the insured gives rise to an individual contract.¹⁵² Therefore, if a fac/oblig open cover is concluded before 12 August 2016, but risks are ceded after that date, those cessions will be governed by the Act. A similar analysis will be applicable to any other contract *for* insurance, which may include lineslips and coverholder binding authority arrangements. These are to be contrasted with contracts *of* insurance.
- 156.3. Finally, there is the facultative/facultative contract, under which the insured has a choice as to whether to cede risks, and the insurer a choice as to whether to take them.¹⁵³ As with fac/oblig contracts above, in such a scenario, the cession of each risk produces a fresh contract, meaning that cessions which post-date 12 August 2016 will be governed by the Act, even if the original contract was concluded before this date.
157. The fac/oblig scenario described may lead to a strange result in certain circumstances. Say that a fac/oblig open cover was concluded on 10 August 2016. At that time, the insured had a duty of utmost good faith to the insurer (under the old law). On 15 August 2016, when the Act was in force, the insured made a declaration under the open cover. This would be a new contract of insurance, and is therefore governed by the Act.
158. In spite of this, at the time of such declaration, the insured will not owe the (new) Duty to the insurer, because in a fac/oblig contract, no fresh duty of disclosure is owed at the time of each declaration (essentially because the insurer has no choice but to take the risks declared).¹⁵⁴ In view of this, it is possible that there may be a fac/oblig open cover in which the *duty* owed by the insured at placing is governed by the old law, but where other matters are governed by the Act.
159. A further scenario worth considering is the contract of [re]insurance which exists for a long period of time, such as the 'long-tail' contracts commonly seen in life insurance. In such a case, if the contract is concluded before 12 August 2016, but not renewed for (say) 10 years, it will remain subject to the old law. If, however, the contract is renewed at some point after 12 August 2016, a new contract will have been concluded, which will be subject to the Act.

¹⁵² *Glencore International AG v Alpina Insurance Company Limited (No.2)* [2004] 1 Lloyd's Rep 567.

¹⁵³ As in *Berger and Light Diffusers Pty Ltd v Pollock* [1973] 2 Lloyd's Rep 442.

¹⁵⁴ *Citadel Insurance Co v Atlantic Insurance Co SA* [1982] 2 Lloyd's Rep 543, Kerr LJ at 548.

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