Insurance Act 2015

Consumer Insurance (Disclosure and Representations) Act 2012

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Background

The need for reform in the field of insurance law was first identified as long ago as 1957. The Law Commission commenced a review of the law in 2006. It provided its recommendations as to consumer insurance law in 2009 and as to non-consumer insurance law in 2014. The recommendations were accepted by Parliament in two stages and embodied in the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA 2012") and the Insurance Act 2015 ("IA 2015").

As to consumer insurance, the Law Commission summarised the pre-2012 position as follows:

"Despite the many calls for reform, there has been no legislative change. The insurance industry did not seek to justify the principles set out in the Marine Insurance Act 1906. Instead the Association of British Insurers (ABI) argued that problems with the law could be dealt with through "market-based solutions" rather than legislation. The issue has been subject to overlapping and inconsistent layers of industry statements, FSA rules, ombudsman-discretion and codes of practice:

(1) Statements of Practice were issued in 1977 and strengthened in 1986. Insurers agreed not to rely on their strict legal rights in some circumstances.

(2) The Financial Services Authority (FSA) has incorporated some principles in the Statements of Practice into its rules. For example, the rules state that an insurer must not refuse to meet a claim on the ground of misrepresentation unless it was fraudulent or negligent. The FSA rules do not amend the law. Instead, courts are required to apply

the 1906 Act. In theory, an insurer could rely on its legal rights, win its case before a court, and then face the threat of an FSA fine.

(3) The Financial Ombudsman Service (FOS) has a statutory power to determine complaints according to what is "fair and reasonable in all the circumstances". The FOS is not bound to decide cases according to the strict law. Instead it has developed its own approach, which goes further than the FSA rules. Where the insurer failed to ask about an issue, the FOS does not require consumers to volunteer information. Furthermore, where a consumer has answered a question carelessly, the FOS does not allow the insurer to avoid the policy. Instead, the FOS applies a compensatory remedy, based on what the insurer would have done had it known the truth.

(4) In January 2008, the ABI issued formal Guidance on non-disclosure in long-term protection insurance. This responded to public disquiet about refusal rates in critical illness insurance. The industry recognised that insurers should not necessarily refuse claims for careless errors. Instead, insurers should consider what they would have done had they known the full facts. The Guidance was upgraded to the status of a Code in January 2009.

We welcome the 2008 Guidance (and its subsequent elevation to a Code). In 2006, concerns were expressed that over 10% of critical illness claims were refused for non-disclosure. Since 2007, there has been a welcome reduction in the number of complaints about critical illness and income protection reaching the FOS. However, problems about non-disclosure cover a wide range of insurance types. The ABI Code does not cover general insurance, such as household or vehicle insurance, and there is no evidence of a fall in complaints in these areas.

The different sets of rules have led to confusion. The FSA gives guidance suggesting that insurers should either ask clear questions or explain the duty to disclose material circumstances. The result is that insurers issue hundreds of warnings along the lines that "failure to disclose any material information may invalidate your insurance cover". Yet the FOS does not recognise a requirement to disclose material information: only to answer the questions asked.

We found several recent examples where insurers refused claims because the consumer failed to volunteer information, even though no question was asked. Some insurers simply fail to understand the FOS guidance on the subject.

> *Mr and Mrs D insured their house and contents with a major insurer. They were sent a policy schedule giving the last renewal date as 15 January 2007. In July 2007, they made a claim for water damage.*
>
> *The insurer refused the claim because Mr D did not disclose that he was convicted of common assault on 1 June 2007. The insurer pointed to the key facts document which described the policy as "a monthly contract". The insurer argued that this put the*

consumer under a duty to disclose material facts on a monthly basis, even though no questions were asked.

The ombudsman required the insurer to deal with the claim. She held that Mr and Mrs D had a duty to disclose the conviction only when the policy was due for renewal on 15 January 2008, and "then only in response to a clear question".

The problem is that only a minority of consumers who experience problems complain to the FOS. Where an insurer refuses a claim in contravention of FOS guidelines, the consumer may not realise that the FOS will uphold the claim.
Furthermore, many insurers continue to state that answers on proposal forms "form the basis of the contract", even though, since 1986, insurers have agreed not to use such clauses."

The rationale for the Acts

The current law in the UK is based on principles developed in the eighteenth and nineteenth centuries and codified in the Marine Insurance Act 1906 (the 1906 Act). Although the 1906 Act appears to apply only to marine insurance, most of its principles have been applied to non-marine insurance on the basis that the 1906 Act embodies the common law (which itself is mostly based on principles developed in marine cases). The Act is written in clear, forthright terms which has constrained the court's ability to develop the law.

The changes in the insurance market have meant that a market which was initially based on face-to-face contact and social bonds has developed into one based on systems, procedures and sophisticated data analysis. Furthermore, the types of risks insured have widened and the volume of information available to market participants has grown exponentially. The law has failed to keep pace with these changes. The law does not reflect the diversity of the modern insurance market or the changes in the way people communicate, store and analyse information. Nor does it reflect developments in other areas of commercial contract and consumer law.

The 1906 Act is insurer-friendly. The principles were developed at a time when the insured knew their business while the insurer did not, and were designed to protect the fledgling insurance industry against exploitation by the insured. Where a policyholder is in breach of an obligation, the law gives wide-ranging opportunities for the insurer to avoid the contract and refuse all claims, or to treat its liability as discharged, even where the remedy seems out of proportion to the wrong done by the policyholder.

The Law Commission identified a number of concerns about the current state of the law in respect of disclosure in insurance contracts and the appropriate remedies for breach of the duty of disclosure. The law was historic and outdated, the burden of

disclosure on the insured was excessive and the insurer's remedy of avoidance was excessive in many situations.

The Scheme of the Acts

The Acts are intended to ensure a better balance of interests between policyholders and insurers in the consumer and the non-consumer market.

In the consumer market the scheme creates a different duty of disclosure to that in the non-consumer market. This reflects the differing insurance requirements of the consumer and non-consumer markets, but also provides for a fairer and more realistic balance between the consumer and the professional insurer. It also creates clarity as to what is required of the consumer and as to the remedies of the insurer in the event of breach.

The reforms are mandatory for consumer contracts. Conversely, in non-consumer contracts, IA 2015 only provides a default regime, allowing non-consumer parties to contract out of the default regime or parts of it. In other words the parties are free to negotiate their own contract terms, providing the insurer satisfies the transparency principles.

The central recommendations of the Law Commission for consumer contracts were for (i) the creation of a duty of the consumer to take reasonable care not to make a misrepresentation to the insurer; and (ii) removal of the insured's right to avoid the contract ab initio following a breach of the duty save where it is proportionate.

In the non-consumer market the Law Commission recommended:

"bringing together the law of non-disclosure and misrepresentation into a single "duty of fair presentation"". The Act retains the duty on business policyholders to volunteer information, but clarified its boundaries, defining what an insured knows or ought to know. The Act also requires insurers to play a more active role, asking questions in some circumstances. Importantly, the Law Commission also recommended a new system of proportionate remedies to apply where the draconian threat of avoidance is inappropriate. This system is akin to that applicable to consumer contracts.
In respect of warranties it recommended abolition of "basis of the contract" clauses; required the insurer to pay a claim which arises after a breach of warranty has been remedied; and also recommended that where a term is designed to prevent loss of a particular type (or at a particular place or time) it should not remove the insurer's liability to pay for a different type of loss (or loss at a different place or time).
The Act provides the insurer with clear, robust remedies for fraud. The main remedy is the one already established by the courts: if a claim is tainted by fraud, the policyholder forfeits the whole claim. The Act also clarifies an area of uncertainty: the insurer may refuse any claim arising after the fraudulent act; however, previous valid claims are unaffected.

The Act requires insurers to pay any sums due in respect of the claim within a reasonable time. If they do not, insurers may be liable for losses caused by their breach, on normal contractual principles."

The Law Commission stated:

"The draft Bill is intended to develop the law rather than replace it. Many of our recommendations are based on existing judicial interpretation. Key terms (such as "insurance" and "fraudulent claim") are intended to bear their existing common law meanings, so are deliberately left undefined in the draft Bill. Instead, these terms are defined by case law, which will continue to be developed by judges. We do not wish such definitions to be preserved in aspic and become inappropriate in the future. In other cases we have retained the existing statutory language (as in "material circumstance"), signalling that the existing case law will continue to apply. We do not wish to make changes unless strictly necessary and the draft Bill is intended to operate with the structure of the existing law. It is, therefore, short and principles-based."

CONSUMER INSURANCE (DISCLOSURE AND REPRESENTATIONS) ACT 2012

Commencement and Retrospectivity

The Act applies to contracts and variations entered into after the Act came into force on 6 April 2013.

What is a Consumer Insurance Contract?

S. 1 defines a consumer insurance contract as a contract between an insurer and "an individual who enters into the contract wholly or mainly for purposes unrelated to the individual's trade, business or profession".

The insured must be "an individual" – a natural person and not a company. A car/yacht owner who puts his private car/yacht into company ownership will not be a consumer.

The main purpose of the contract must be non-business. This is a matter of fact in each case. The taxi driver primarily using a car as a taxi with occasional private use will not be a consumer. The householder insuring household contents with 10% of the value insured being business equipment will be a consumer.

The phrase "wholly or mainly for purposes unrelated to the individual's trade, business or profession" is similar to that used in the Consumer Rights Act 2015 - *""Consumer" means an individual acting for purposes that are wholly or mainly outside that individual's trade, business, craft or profession."*

The Duty of Disclosure

S. 2(2) *"It is the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer"*. This duty replaces any previous duties (s. 2(4)) and removes the duty on policyholders to volunteer information to the insurer. Instead consumers need only answer the insurer's questions carefully and honestly. However, a lack of completeness in an answer may amount to a misrepresentation. The common law will apply as to whether there has been a misrepresentation.

S. 2(3) *"A failure by a consumer to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation for the purposes of this Act (whether or not it could be apart from this subsection)"*.

S. 2(4) *"The duty set out in subsection (2) replaces any duty relating to disclosure or representations by a consumer to an insurer which existed in the same circumstances before this Act applied"*. IA 2015 s.14 effectively abolishes the obligation of utmost good faith in respect of contract formation, removes the right to avoid the contract for breach of the obligation, and s. 17 of the Marine Insurance Act 1906 has been

amended accordingly. Utmost good faith still applies, however, in respect of the making of claims.

S.3(1) *"Whether or not a consumer has taken reasonable care not to make a misrepresentation is to be determined in the light of all the relevant circumstances"*.

S.3(2) *"The following are examples of things which may need to be taken into account in making a determination under subsection (1) –*

(a) the type of consumer insurance contract in question, and its target market,
(b) any relevant explanatory material or publicity produced or authorised by the insurer,
(c) how clear, and how specific, the insurer's questions were,
(d) in the case of a failure to respond to the insurer's questions in connection with the renewal or variation of a consumer insurance contract, how clearly the insurer communicated the importance of answering those questions (or the possible consequences of failing to do so),
(e) whether or not an agent was acting for the consumer".

This list is indicative and not exhaustive.

S. 3(3) *"The standard of care required is that of a reasonable consumer: but this is subject to subsections (4) and (5)"*. The test is objective, subject to the following sub-section. The reasonable consumer denotes an average consumer with no special skills or knowledge taking into account the matters in sub-section (2).

S. 3(4) *"If the insurer was, or ought to have been, aware of any particular characteristics or circumstances of the actual consumer, those are to be taken into account"*.

S. 3(5) *"A misrepresentation made dishonestly is always to be taken as showing lack of reasonable care"*. This sub-section is necessary to cover the particular consumer who has more than the usual level of knowledge and acted dishonestly, whilst a normal, less well-informed, consumer might have made a reasonable mistake about the matter.

The duty applies pre-contract, on renewal and when making any variations during the term of an existing contract.

Qualifying misrepresentations

A breach of the duty of disclosure which gives rise to a remedy is referred to as a "qualifying misrepresentation" (s. 4(2)). For a breach to amount to a qualifying misrepresentation there must be:

(i) a breach of the duty of disclosure (s. 4(1)(a)): and
(ii) the insurer must show that in the absence of the misrepresentation, the insurer would not have entered into the contract or would have done so only on different terms (s. 4(1)(b)).

There must, therefore, be a breach of the duty AND the insurer must prove that it was induced to enter into the contract or to enter into the contract on the terms agreed. This reflects the current law following on from *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] AC 501. It is not sufficient for the insurer to show that the hypothetical prudent underwriter would have been influenced. The specific insurer must show that it relied on the misrepresentation and would have acted differently if the misrepresentation had not been made.

Remedies for breach of the duty of disclosure

Where a consumer does make a misrepresentation on an application form, the Act distinguishes between mistakes which are "reasonable", "careless" or "deliberate or reckless":

(i) For *reasonable* misrepresentations, the insurer must pay the claim.

(ii) For *careless* misrepresentations, the Act provides a proportionate remedy, based on what the insurer would have done had it known the facts.

(iii) For *deliberate or reckless* misrepresentations, the insurer may refuse the claim.

Where an insurer has been induced by a misrepresentation to enter into an insurance contract, the insurer's remedy will depend on the consumer's state of mind:

(i) Where a misrepresentation is *honest and reasonable*, the insurer must pay the claim. The applicant is expected to exercise the standard of care of a reasonable consumer, bearing in mind a range of factors, such as the type of policy and the clarity of the question. The test does not take into account the individual's own subjective circumstances (such as knowledge of English), unless these were, or ought to have been, known by the insurer.

(ii) Where a misrepresentation is *careless*, the insurer has a compensatory remedy. This is based on what the insurer would have done had the consumer taken care

to answer the question accurately and completely. If the insurer would not have entered into the contract on any terms, the insurer may avoid the contract and return the premiums. If he would have contracted but on different terms, then the contract is to be treated as if entered into on such different terms. For example, if the insurer would have added an exclusion, the insurer need not pay claims which fall within the exclusion but must pay all other claims. If the insurer would have charged more, it may pay only a proportion of the claim. It may be that a claim would be treated as if the contract included an exemption or excess clause and an increased premium.

(iii) Where the misrepresentation is *deliberate or reckless*, the insurer may "avoid the policy". In other words, it may treat the policy as if it does not exist and decline all claims. The insurer would also be entitled to retain the premium, unless it would be unfair to the consumer for the insurer to retain them. This caveat was inserted because of two particular concerns in consumer insurance: investment-type life insurance and joint lives policies, where the non-return of a premium might involve unfairness.

"Deliberate" / "Reckless"

For a misrepresentation to be considered "deliberate or reckless" the insurer must show (s. 5(4)) on the balance of probabilities that the consumer:

(i) knew that the statement was untrue or misleading, or did not care whether it was or not; and (s. 5(2)(a))

(ii) knew that the matter was relevant to the insurer, or did not care whether it was or not (s. 5(2)(b)).

Whilst it is for the insurer to show that a qualifying misrepresentation was deliberate or reckless, it is to be presumed, unless the contrary is shown, (a) that the consumer had the knowledge of a reasonable consumer, and (b) that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer (s. 5(5)).

It follows that, if a reasonable person would have known that the statement was untrue, the burden of proof would be on the consumer to show that he or she had less than normal knowledge. Similarly, if the question was clear, it would be up to the consumer to show why he or she did not think the matter was relevant.

In the event of deliberate or reckless behaviour the insurer is entitled to avoid the policy.

"Careless"

A misrepresentation is careless if it is not deliberate or reckless (s. 5(3))

The Law Commission provided a **flow chart** to identify the remedies available in any particular case.

Sections 4 and 5

"4 Qualifying misrepresentations: definition and remedies

(1) An insurer has a remedy against a consumer for a misrepresentation made by the consumer before a consumer insurance contract was entered into or varied only if--

(a) the consumer made the misrepresentation in breach of the duty set out in section 2(2), and

(b) the insurer shows that without the misrepresentation, that insurer would not have entered into the contract (or agreed to the variation) at all, or would have done so only on different terms.

(2) A misrepresentation for which the insurer has a remedy against the consumer is referred to in this Act as a "qualifying misrepresentation".

(3) The only such remedies available are set out in Schedule 1.

5 Qualifying misrepresentations: classification and presumptions

(1) For the purposes of this Act, a qualifying misrepresentation (see section 4(2)) is either--

(a) deliberate or reckless, or

(b) careless.

(2) A qualifying misrepresentation is deliberate or reckless if the consumer--

(a) knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and

(b) knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.

(3) A qualifying misrepresentation is careless if it is not deliberate or reckless.

(4) It is for the insurer to show that a qualifying misrepresentation was deliberate or reckless.

(5) But it is to be presumed, unless the contrary is shown--

(a) that the consumer had the knowledge of a reasonable consumer, and

(b) that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer."

Where the presumptions in subsection (5) apply, the burden of proof is effectively reversed. If asked whether he had suffered a heart attack, it is presumed that most people would know that they had had a heart attack, and the insurer does not have to prove that the consumer acted deliberately or recklessly in failing to answer the question in the affirmative. Instead, it is for the consumer to show that he did not know about the heart attack or did not understand the question. He might be able to argue that he had confused a minor heart attack with another condition, or might provide other evidence of lack of understanding.

Schedule 1

See the Schedule to CIDRA 2012

Termination of the Policy

Sched. 1(9) of CIDRA includes statutory termination rights for both insurers and consumers following a careless misrepresentation. Some consumer insurance contracts, particularly life and health insurance, may run for long terms. A consumer may be severely disadvantaged if they are obliged to continue to pay premiums for insurance which, because of the application of a proportionate remedy, no longer meets their needs.

Warranties

S. 6 prevents the conversion of any representation made by a consumer into a warranty by means of a basis of contract clause or otherwise. Basis of contract clauses are effectively abolished. A basis of contract clause is one where the contract or proposal states that the consumer warrants the accuracy of the answers or that the answers form the basis of the contract. A breach of the warranty would have entitled the insurer to avoid the contract even if the misrepresentation was not material and did not induce the insurer to enter into the contract.

An insurer can still include a specific warranty providing it is fair within the meaning of the Unfair Contract Terms Act 1999 and does not infringe s. 10 and the contracting out provisions.

Group Insurance

S. 7 provides that where a group member makes a misrepresentation, it has consequences only for that individual and not for others within the group.

Insurance on life of another

S. 8 provides that the insurer has a remedy where the person whose life is insured makes a careless or deliberate misrepresentation.

Agents

S. 9 provides, by Schedule 2, criteria for identifying when an intermediary / broker is an agent for the consumer or an agent for the insurer. An intermediary is considered to act for the insurer if:

(i) the intermediary is the appointed representative of the insurer;

(ii) the insurer has given the intermediary express authority to collect information as its agent; or

(iii) the insurer has given the intermediary express authority to enter into the contract on the insurer's behalf.

Otherwise the intermediary is presumed to act for the consumer unless it appears that it acts for the insurer (Sched 2(3)(1)).

The insured remains responsible for the actions of his own agent (s. 12(5)).

Contracting Out

S. 10 prevents insurers from contracting out of the scheme provided by CIDRA (see also s. 15 of IA 2015 which relates to consumer insurance contracts).

THE INSURANCE ACT 2015

Commencement and Retrospectivity

The Act comes into force on 12.8.16 and applies to all contracts made after that date and to all variations of existing contracts made after that date. It applies to England, Wales, Northern Ireland and Scotland.

Application

By s.2 the Act applies to "non-consumer insurance contracts only" and to "variations" of such contracts. In other words, all insurance contracts save for consumer insurance contracts.

The Duty of Fair Presentation

The current law

The Law Commission identified 5 primary problems with the current law in respect of non consumer contracts :

(i) the duty is poorly understood;

(ii) the duty is too onerous, particularly on medium and large companies;

(iii) the requirement to disclose every material fact encourages data dumping - that is, the presentation of huge volumes of material without distinction between the material and trivial;

(iv) the 1906 Act gives rise to too many disputes and, in particular, encourages "underwriting at claims stage"; and

(v) the single remedy of avoidance in all cases is too harsh.

The current law is set out in the Marine Insurance Act 1906. Section 17 of the Act states: *"A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party"*.

The central element is section 18, which places an onerous duty on the assured (the policyholder) to disclose to the insurer "*every material circumstance*" which the policyholder "*knows or ought to know*" before concluding a contract. Under section 18(2), a material circumstance is defined as *"every circumstance which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk"*.

The courts have over time refined the duty to being one of making "a fair presentation of the risk". In *Wise (underwriting Agency) Ltd v Grupo Nacional Provincial SA* [2004] EWCA Civ 962 the Court of Appeal affirmed what was stated in MacGillivray on Insurance Law: *"[T]he assured must perform his duty of disclosure properly by making a fair presentation of the risk proposed for insurance. If the insurers thereby receive information from the assured or his agent which, taken on its own or in conjunction with other acts known to them or which they are presumed to know, would naturally prompt a reasonably careful insurer to make further inquiries, then, if they omit to make the appropriate check or inquiry, assuming it can be made reasonably, they will be held to have waived disclosure of the material fact which that inquiry would have necessarily revealed*". Lord Justice Rix elaborated on the principle as follows: "*Ultimately, it seems, the question is: Has the insurer been put fairly on inquiry about the existence of other material facts, which such inquiry would necessarily have revealed?"*

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

Section 18(3)(c) of the 1906 Act grants an exception from the duty of disclosure where information is "waived by the insurer". Several court judgments have used this provision to protect policyholders from the full harshness of section 18(1). They have done this by giving "waiver" a much broader meaning than it has in other areas of law.

The Law Commission considered a different approach, namely a duty on the insured to disclose what the "reasonable insured" would consider to be relevant to the insurer. It accepted that it would introduce a new and unknown test which did not materially assist given the numerous different factual situations and risks. That proposal was not taken forward. Instead, the Law Commission advocated a duty to make a fair presentation of the risk.

<u>Section 3 IA 2015</u>

S. 3(1) *"Before a contract of insurance is entered into, the insured must make to the insurer a fair presentation of the risk"*.

The onus lies on the insured – contrast the obligation in consumer insurance contracts where the obligation of the insured is to answer the insurer's questions carefully and honestly.

What is a fair presentation of the risk?

S.3(3) *"A fair presentation of the risk is one:*

(a) which makes the disclosure required by subsection (4),

(b) which makes that disclosure in a manner which would be reasonably clear and accessible to a prudent insurer, and

(c) in which every material representation as to a matter of fact is substantially correct, and every material representation as to a matter of expectation or belief is made in good faith."

S.3(4) *"The disclosure required is as follows, except as provided in subsection (5) –*

(a) disclosure of every material circumstance which the insured knows or ought to know, or

(b) failing that, disclosure which gives the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purposes of revealing those material circumstances."

S. 3(4)(b) highlights the two way process in the identification of material circumstances which includes both the insured and the insurer. The outcome is not new but the Act codifies the process recognised in *Wise* and gives statutory recognition to the role to be played by the insurer. Whereas the role of the insurer had previously been based upon the principles of waiver and good faith and their uncertain application, the role is now based in statute.

S. 3(5) sets out the circumstance the insured is not required to disclose: namely, if

"(a) it diminishes the risk;

(b) the insurer knows it;

(c) the insurer ought to know it;

(d) the insurer is presumed to know it, or

(e) it is something as to which the insurer waives information.

S. 7(2) *"The term 'circumstance' includes any communication made to, or information received by, the insured*".

S. 7(3) *"A circumstance or representation is material if it would influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms*".

S. 7(4) *"Examples of things which may be material circumstances are –*

(a) special or unusual facts relating to the risk,

(b) any particular concerns which led the insured to seek insurance cover for the risk,

(c) anything which those concerned with the class of insurance and field of activity in question would generally understand as being something that should be dealt with in a fair presentation of risks of the type in question."

S. 7(5) *"A material representation is substantially correct if a prudent insurer would not consider the difference between what is represented and what is actually correct to be material*".

<u>The Insured's knowledge</u>

This is based on what the individual or the person responsible for the insured's insurance knows, or, in the case of a company, the insured's senior management or person responsible for its insurance knows (s. 4(1) – (5)).

S. 4(6) *"… an insured ought to know what should reasonably have been revealed by a reasonable search of information available to the insured (whether the search is conducted by making enquiries or by any other means)"*, and "information *"includes information 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)"* (s.4(7)).

<u>The Insurer's knowledge</u>

S. 5(1) provides that *"an insurer knows something only if it is known to one or more of the individuals who participate on behalf of the insurer in the decision whether to take the risk, and if so on what terms (whether the individual does so as the insurer's employee or agent, as an employee of the insurer's agent or in any other capacity)".*

S. 5(2) *"an insurer ought to know something only if –*

(a) an employee or agent of the insurer knows it, and ought reasonably to have passed on the relevant information to an individual mentioned in subsection. (1), or

(b) the relevant information is held by the insurer and is readily available to an individual mentioned in subsection (1)".

S. 5(3) *"an insurer is presumed to know –*

(a) things which are common knowledge, and

(b) things which an insurer offering insurance of the class in question to insureds in the field of activity in question would reasonably be expected to know in the ordinary course of business".

Knowledge

S. 6(1) addresses both the insured and the insurer's knowledge: *"references to an individual's knowledge include not only actual knowledge, but also matters which the individual suspected, and of which the individual would have knowledge but for deliberately refraining from confirming them or enquiring about them*" .

Remedies for Breach

Section 18(1) of the 1906 Act provides the only remedy for non-disclosure: avoidance of the contract. The contract is treated as if it never existed, and the insurer may refuse all claims made under it.

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

The statutory regime now seeks to ensure that a party's remedy is proportionate and that it puts the insurer back in the position it would have been in had it received a fair presentation of the risk.

For the purpose of establishing an insurer's entitlement to a remedy in the event of breach of the duty of fair representation, the insurer must show that, but for the breach:

(i) it would not have entered into the contract at all; or it would have done so only on different terms (s. 8(1)); and

(ii) the breach was deliberate or reckless, or neither of those ("a qualifying breach") (s. 8(4)).

The burden lies on the insurer to prove that it was induced to enter into the contract by reason of the representation / omission. Inducement cannot be assumed (see *Assicurazioni Generali SpA v Arab Insurance Group (BSC)* [2003] Lloyd's Rep IR 131, [2002] EWCA Civ 1642).

The nature of the remedy is dependent upon whether the breach of duty was (i) deliberate or reckless, or (ii) neither deliberate or reckless.

A qualifying breach is deliberate or reckless (s. 8(5)) if the insured –

(a) knew that it was in breach of the duty of fair representation, or

(b) did not care whether or not it was in breach of that duty.

It is for the insurer to show that a breach is deliberate or reckless (s. 8(6)).

Schedule 1 to the Act identifies the available remedies (s. 8(2)).

<u>The misrepresentation is deliberate or reckless.</u>

If the qualifying breach is deliberate or reckless then the insurer may avoid the contract and not return any premium (Sched 1(2)) .

<u>What is deliberate / reckless?</u>

The Law Commission made the following comments:
"We think a deliberate breach of the duty of fair presentation could involve intentionally:
(1) refraining from disclosing a circumstance which the insured knows to be material;
(2) making a data dump or otherwise presenting risk in a particular way in order to conceal certain information (as in the case where a summary is very misleading); or
(3) intentionally lying about a material representation, either in the initial presentation or by knowingly giving a false response to an insurer enquiry".

"Reckless" is not specifically defined in the Act and will be subject to existing case law as to its meaning – making a statement without caring whether it is true or false (*Derry*

v Peek (1889) LR 14 App Cas 337) – which is akin to the meaning which may be derived from s. 8(5).

The Law Commission deliberately did not use the words "fraud" or "fraudulent", considering that they brought a connotation of the criminal law and criminal standard of proof, which would increase the burden upon an insurer in proving deliberate or reckless behaviour. However, "deliberate" / "reckless" is intended to include fraudulent behaviour.

<u>If the misrepresentation is not deliberate or reckless</u>

If neither deliberate nor reckless, then:

(i) if the insurer would not have entered into the contract on any terms, then he may avoid the contract and refuse the claim, but must repay the premium (Sched 1(4)). This recognises that there has been no deliberate, reckless or fraudulent behaviour.

(ii) if the insurer would have entered into the contract but on different terms (other than those relating to the premium), then the contract is to be treated as if the contract had been entered into on those different terms if the insurer so requires (Sched 1(5)). The principal types of terms that insurers will seek to include are:
(a) Exclusions: if a fair presentation had been made, the insurer might have excluded liability for certain types of loss. If so, the validity of a claim will depend upon whether it falls within the terms of the exclusion.
(b) Warranties and other terms designed to reduce particular risks: knowing the full facts, an insurer might have required the insured to warrant that it would act in a certain way. If the insured's actions have put it in breach of that warranty, the insurer's liability will be suspended either entirely or in respect of the particular type of loss to which the warranty is relevant.
(c) Excesses: the insurer might have imposed an excess. The excess may cover the whole policy or particular types of loss. If the claim falls within the terms of the excess it will be reduced by the amount of the excess.

(iii) if the insurer would have entered into the contract but on a higher premium, then he may reduce proportionately the amount to be paid on a claim (Sched 1(6)). It means that the insurer need only pay X% of what it would otherwise have been under an obligation to pay, where:

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

So, if the insurer should have charged £2,000 but only charged £1,000, then the policyholder has paid only 50% of the correct charge (the premium) and the claim will be reduced by half.

Insureds are not given a right to pay the extra premium that the insurer would have charged in order to retain cover. This would under-compensate the insurer, who would thereby be forced to cover the risk after it had materialised, despite not having been given sufficient information to gauge accurately the degree of likelihood of it materialising or its extent. It would be open to insurers to decide to accept the higher premium as part of a commercial settlement.

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

How would the Insurer have reacted to an accurate statement?

Evidence of how the insurer would have acted may be derived from a number of sources, including pricing manuals and models, contemporaneous policies and oral evidence from the individual underwriter or expert witnesses. There may also be commercial reasons for similar risks being written on different terms for different policyholders. This would also be a matter of evidence in the circumstances. It may be the case that the insurer would have been willing to contract on a number of bases. For instance, the insurer might have been willing to accept the risk for a high premium, or at a lower premium level with an exclusion or warranty. The court will need to decide which offer the insurer would most likely have put to the insured. The Law Commission stated *"We believe that the courts are best placed to decide what evidence is admissible and sufficient to show how the insurer would have acted"*. The courts make similar decisions at present when deciding issues of materiality and, in particular, inducement (also see *Drake Insurance plc v Provident Insurance plc* [2003] EWCA Civ 1834, [2004] QB 601 paras 62 to 64, in which the Court of Appeal examined not only what the insurer would have done had a speeding conviction been disclosed, but also whether this would have led to discussion of an earlier accident, resulting in its reclassification in the insurer's records as being "no fault").

Termination of the Policy

Following the conclusion of the claim the insurer / insured may wish to terminate the Policy. The Act does not make any provision in respect of termination. It was thought appropriate to leave the parties to rely on the terms of the contract.

Variations

Remedies in respect of qualifying breaches arising from variations are covered in Schedule 1 Part 2. The remedies are the same as for normal qualifying breaches save that the remedy reflects the fact that the breach only occurred at the time of the variation and in respect of the variation.

Warranties

Compliance with an insurance warranty has always been of paramount importance. It is essentially a promise made by the policyholder to the insurer which, if broken, will have harsh consequences for the policyholder. The general principles of insurance warranty law are founded on the rulings of Lord Mansfield, made in the late eighteenth century. The classic case is *De Hahn v Hartley*. There, an insurance policy contained a term to the effect that a ship would leave Liverpool (for the West Indies) with "50 hands or upwards". The term was designed to guard against the substantial risk of piracy or other violent misfortune encountered on such voyages. The ship left Liverpool with a crew of only 46. Before it left the relatively safe waters around Britain, it picked up another six crew-members in Anglesey, just a few hours into the voyage and before any loss was suffered. The ship was eventually captured and lost off the coast of Africa. The insurer refused to pay the claim on the basis that the term had not been strictly complied with. The court agreed: warranties had to be complied with exactly, and the insurer would be discharged from liability where they were not. It was immaterial that the breach of warranty had been remedied within a few hours and before any loss occurred.

These principles were codified in the Marine Insurance Act 1906. Section 33(3) states that a warranty "must be exactly complied with, whether material to the risk or not". If not, then "the insurer is discharged from liability from the date of the breach of warranty". Section 34(2) confirms that once a warranty is breached, the policyholder "cannot avail himself of the defence that the breach has been remedied, and the warranty complied with, before loss". The 1906 Act applies only to marine insurance, but the common law has evolved in parallel and the same rules are said to apply to all insurance contracts. In particular, the provisions which prescribe the consequences of breach of warranty apply to all insurance.

The law of insurance warranties has been subject to major criticisms over many years. The Law Commission identified four problems with it:
(1) An insurer may refuse a claim for a trivial mistake which has no bearing on the risk.
(2) The insured cannot use the defence that the breach has been remedied.
(3) The breach of warranty discharges the insurer from all liability, not just liability for the type of loss in question. For example, a failure to install the right sort of burglar alarm would discharge the insurer from liability for a flood claim.

(4) A statement may be converted into a warranty using obscure words that few policyholders understand. For example, if a policyholder signs a statement on a proposal form that their answers form the "basis of the contract", this can have draconian consequences.

By s. 9(2) IA 2015 provides that a representation is not capable of being converted into a warranty by means of a provision of the contract, such as a "basis of contract" clause. However, an insurer can still make a representation by the insured into a specific express warranty, such as that the roof of a house is made of slate.
S. 10(1) abolishes any rule of law that a breach of warranty results in the discharge of the insurer's liability under the contract. It removes the insurer's existing remedy for breach of warranty in two ways: first, clause 10(1) removes any rule of (common) law to the effect that breach of warranty (whether express or implied) discharges the insurer's liability; and, second, clause 10(7)(a) removes the corresponding statutory provision by deleting the second sentence of section 33(3) of the 1906 Act.

These provisions ensure that there is no longer any term of an insurance contract which has the same effect as a present-day warranty (that is, an automatic discharge of liability following breach) by virtue of a rule of law.

Remediation of the breach of warranty – s. 10 IA 2015

The Law Commission considered that a breach of warranty should only be suspensory and that in the event of the breach being remedied before the loss, then the breach should not allow the insurer to avoid liability. It stated: *"Breach of warranty currently leads to an automatic discharge of the insurer's liability from that point. We recommend that, instead, the insurer's liability should be suspended rather than discharged in the event of breach, and that liability could be restored if the breach of warranty is remedied. Where the breach is remedied before a loss, the insurer should pay the claim. Where loss occurs, or is attributable to something happening, after a breach but before remedy, the insurer should not be liable for that loss"*.

A breach of warranty is remedied if the insured ceases to be in breach of the warranty, or if (in cases in which something has to be done by a certain time or a condition has to be fulfilled, and the requirement is not complied with) the risk to which the warranty relates later becomes essentially the same as that originally contemplated by the parties.

On this analysis, the Law Commission thought that the case of *De Hahn* would be decided differently. Once the ship had left Liverpool with fewer than 50 hands, as a matter of logic the "breach" could not be truly remedied: the ship could not go back in time and leave again, this time with sufficient men aboard. However, when the ship picked up another six men in Anglesey, the risk became essentially that which the parties had originally agreed; that is, a vessel crewed with no fewer than 50 hands when it made a potentially dangerous voyage. During the six hours when the ship was shorthanded, the risk was outside the scope of the policy, and the insurer's liability should have been suspended (indeed, the insurer would not yet have come on risk). When the additional hands came aboard, the risk was restored to the state in which the insurer was prepared to accept it, and the insurer's liability ought also to be restored for losses suffered after that point.

The Law Commission also considered the example of wine storage with a time specific warranty. The warranty states that the wine must be stored horizontally in a cool cellar within one month of receipt. This does not occur. The error is discovered four months later and the wine is stored correctly thereafter, but not before the corks have been compromised. Although the wine is now stored in accordance with the warranty, the breach has not been truly "remedied". This is because the wine is not "essentially the same" as that which the insurer agreed to insure. That is, the insurer did not agree to insure wine which has been permanently compromised. As the wine has not been returned to essentially the same risk, the insurer will not be liable.

The Law Commission said: *"We think that the correct approach to take when considering whether a time specific warranty has been remedied is to look at the purpose for which the warranty was inserted in the contract and ask whether that purpose has been frustrated or whether, due to the actions taken to remedy the breach of warranty, the purpose is still in substance fulfilled and the risk profile is restored to that which the insurer accepted. As above, if warranties are risk control measures, then we see no reason why an insurer should have no liability if the risk is effectively that which it agreed to accept"*.

Where a loss occurs after the warranty has been breached, and before it has been remedied, the insurer has no liability for the loss (s. 10(2)), save where the warranty ceases to be applicable in the circumstances of the contract, or compliance with the warranty is rendered unlawful by any subsequent law, or the insurer waives the breach of warranty (s. 10(3)).

Where the loss occurs before the breach of warranty or after it has been remedied, then s. 10(2) does not affect the insurer's liability (s. 10(4)).

By s. 10(5) a breach is taken to be remedied *"if the risk to which the warranty relates later becomes essentially the same as that originally contemplated by the parties"*, or *"if the insured ceases to be in breach of the warranty"*. By way of example: if a warranty states that a ship will not travel through a particular strait due to the risk of piracy and the ship passes through the strait without incident – then the insured has ceased to be in breach of the warranty (s. 10(5)(b)). If the ship went through the strait 2 days earlier than expected and then experiences a storm in which it was lost (and would not otherwise have been in the storm or lost) – then the risk has become essentially the same as that originally contemplated (s.10(5)(a)).

S. 10(7)(b) repeals s. 34 of the 1906 Act which provided that an insured could not avail himself of the defence that a breach of warranty had been remedied or complied with before the loss occurred.

<u>Terms not relevant to the actual loss – s. 11 IA 2015</u>

S. 11 of the Act provides that a breach of warranty which has no relevance to the loss does not permit the insurer to exclude, limit or discharge its liability under the contract (s. 11(1) and (2)), providing that *"the insured shows that non-compliance with the term could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred"* (S. 11(3)).

The section focuses on warranties and other terms which are designed to reduce the risk of a particular type of loss, or the risk of loss at a particular time or in a particular place. The Law Commission recommended that the insurer's remedy for breach of such a term should be that the insurer is not liable to pay claims in respect of losses caused by that category of risk, but that it should be liable in respect of other unrelated categories of risk. Thus the breach of a warranty to install a burglar alarm would suspend liability for loss caused by an intruder but not for flood loss. Similarly, a failure to employ a night watchman would suspend the insurer's liability for losses at night but not for losses during the day. This recommendation was not confined to traditional warranties, and would apply to any contract term designed to reduce particular risks.

For example, a term which requires an insured to maintain a particular type of lock on a door would tend, if complied with, to reduce the risk of break-in (and related events such as arson and vandalism). If the relevant lock was not fitted, the insurer's liability in respect of break-in would be suspended until this was remedied. The Law Commission considered that the insurer would have no liability for loss resulting from break-in, even if the break-in was through a window rather than the relevant door.

The type of term may well affect the nature of the insurer's remedy. If it is a condition precedent, liability will generally not attach until the condition is satisfied. If clause 11(1) applies, then liability *will* attach other than in respect of liability for losses of the particular type. If it is a warranty then, under s. 10, the insurer's liability will be suspended on breach. If clause 11(1) applies then liability will only be suspended in respect of that type of loss.

The Law Commission gave some examples as to the effect of s. 11(3):
(1) Breach of a term requiring a policyholder to have certain fire safety systems in place should result in suspension of the insurer's liability in respect of fire-related risks.
(2) Breach of a condition that a vessel in port must retain a night watchman would mean suspension of the insurer's liability for losses occurring while the watchman should have been present.

Importantly, a causal link between the breach and the ultimate loss is not required. The Law Commission intended that the insurer would not be liable for any loss falling within the particular category with which the warranty or other condition is concerned.

Not all warranties, conditions precedent or similar terms are about particular risks. Some address more general issues, for example those relating to a policyholder's criminal record. Some define the whole contract, such as terms restricting use of a vehicle or property to private rather than commercial use. These terms should not be affected by the reforms.

Taking vehicle insurance as an example, commercial vehicle policies will generally be subject to a higher premium than domestic use. In *Murray v Scottish Automobile and General Insurance Co* a vehicle insured for pleasure use but regularly used commercially was damaged while parked overnight in the garage, between days of hire. The court found that the overnight parking was incidental to the commercial use and therefore there could be no liability. It would frustrate the insurer's risk assessment process if a

policyholder in this position could still recover for any loss not directly related to the commercial use. The use to which a vehicle is put goes more generally to the risk the insurer was prepared to take, rather than targeting particular types of loss which might occur.

The changes should also not affect terms which have no bearing on the risk of a loss, such as premium payment warranties.

The real mischief the Law Commission intended to address is reliance by insurers on breaches of irrelevant warranties. *"We do not think it is fair that an insurer can refuse a claim on the basis of the policyholder's breach of warranty or other condition in circumstances where those terms are clearly irrelevant to the loss – that is, where the type of loss which occurred is not one which compliance with the warranty or condition could have had any chance of preventing"*.

Section 11 addresses this aspect.

<u>Interaction between clauses 10 and 11</u>

The Law Commission gave the following guidance: *"Our recommendations as set out in clauses 10 and 11 operate in different ways. Clause 10 sets out the consequences of breach of warranty, and applies only to warranties. Clause 11 has the potential to apply to warranties but also other terms which seek to exclude or limit an insurer's liability. Some contract terms will be caught by clause 11 but not by clause 10.*
All warranties will be caught by clause 10, but only some by clause 11, because not all warranties are aimed at reducing particular risks. Some address moral hazard, for example those relating to a policyholder's criminal record. Some define the scope of the contract as a whole, such as a term restricting cover to personal (and not commercial) use. Others have no bearing on risk of loss at all, such as premium payment warranties.
Nevertheless, in some cases both clauses may apply together. Clause 10 is made subject to clause 11. Where a warranty does fall within 11(1), then the insurer's liability will be suspended under 10(2) only in respect of losses of the particular kind, or loss at the particular time or location. That the two clauses can apply together is also confirmed by clause 11(4).
We think that our new remedy regime for warranties together with our "type of loss" recommendations act together to put the policyholder in a stronger legal position, which is what the courts appear to want. When enacted, the two clauses will give the courts the beginnings of substantive tools with which to tackle perceived imbalances in insurance contract law without unduly constraining them in the face of the variety of insured risks and insurance contract conditions which may pass before them. As we have previously said, we are largely aiming to minimise cases in which the insurer relies on its technical legal rights so that the draconian consequences of breach of a clearly irrelevant warranty allow it to
avoid liability".

The Law Commission provided the following examples of the interaction between s. 10 and s. 11:

1. A private individual insures a small yacht. The policy includes three warranties:
- a "premium payment" warranty, requiring payment by 1 June;
- a "lock warranty" requiring the hatch to be secured by a special type of padlock; and

- a "pleasure use only" warranty, forbidding the yacht to be used for commercial gain.

The policyholder breaches all three warranties. They fail to pay until 15 June; they install the wrong type of padlock; and they use the yacht for paid fishing trips. On 1 July the policyholder is using the yacht to transport paying customers when the yacht is damaged by a
sudden storm.

The consequences of each breach would be as follows:

(a) Under the current law, breach of a premium payment warranty discharges the insurer from liability, which is not restored if the insurer later accepts payment. Under clause 10, however, the payment on 15 June would remedy the breach and the insurer's liability would be restored. The insurer would not be permitted to reject the claim solely on this basis.

(b) Compliance with the lock warranty would tend to reduce the risk of a specific type of loss: loss caused by intruders. Under clause 11, it would not suspend the insurer's liability for other types of loss, such as loss in a storm. This would not be a good reason to refuse the claim. However, if there was a break-in, liability would be suspended even if the special
padlock would not have prevented it.

(c) The pleasure use only warranty relates to the contract generally, and suspends the insurer's liability for all losses until such time as it is remedied. Clearly in this case it has not been remedied, and the insurer may reject the claim on this basis. It does not matter whether the breach caused the loss. This would also apply where the yacht is damaged while berthed overnight as this is ancillary to the forbidden activity.

2. *Vesta v Butcher*

In *Forsikringsaktieselskapet Vesta v Butcher*, a Norwegian insurance company
provided cover for a fish farm which contained a warranty that the insured should keep a 24 hour watch at the farm. It was not complied with. After a severe storm, many fish were lost. Under Norwegian law, the insurer was liable to pay the claim. The reinsurer argued that under English law it was not liable to indemnify the direct insurer as the warranty had been breached. The court recognised this as correct, but found against the reinsurer on the basis that this particular reinsurance contract was subject to Norwegian law on this issue. Under our recommendations, the warranty for the provision of a 24 hour watch might be seen to reduce the risk of loss through theft or vandalism – or more generally loss that a watchman might have been able to do something to prevent or mitigate. The insurer's liability would only be suspended in respect of that kind of risk. The reinsurer could therefore be liable to pay a claim for storm damage even under UK law.

3. *The Bamcell II*

In *The Bamcell II,* the owners of a converted barge warranted that a watchman would be employed at night, and the barge suffered fire damage during the mid afternoon. When faced with the unfairness of denying the claim, the Supreme Court of Canada decided that the term was not a warranty, an uncomfortable finding given the clear wording used. Under our recommendations the insurer's liability would be suspended only in relation to losses occurring at night. Other losses would be paid.

4. *Printpak v AGF*

In *Printpak v AGF Insurance Ltd*, the insurer refused a claim for fire loss because the policyholder was in breach of a warranty to install and maintain a burglar alarm.

English courts reached the outcome we are proposing by construing the policy, which was set out in different sections covering different risks. Under our recommendations, a burglar alarm warranty would not suspend the insurer's liability in relation to a fire loss.

5. *Sugar Hut v Great Lakes Reinsurance (UK) plc*

Sugar Hut Group Ltd v Great Lakes Reinsurance (UK) plc in particular raises some borderline issues. An insurance policy covered four night clubs. The policyholder claimed for a fire in one of the clubs (Club X). The policy included the following warranty, headed
"kitchen warranty": "… all frying and other cooking ranges, equipment, flues and exhaust
ducting will be kept securely fixed and free from contact with combustible materials …" The kitchen flues in Club X were in contact with combustible material in four places, though this was not how the fire started. If the current law was applied strictly, then the faulty flue in Club X would discharge the insurer from liability for all claims in any of the four locations. Although in that case the fire occurred in the same premises as the breach, the judge agreed that where four premises are the subject matter of one insurance then the breach of a true warranty does indeed impact on all of them: That is however the consequence of having cover for four premises included in one policy, and it could presumably have been an option
for there to be four separate policies.
The kitchen warranty is relevant to our proposals in two ways. The warranty clearly pertained to fire risk. Further, under our recommendations concerning loss at a particular location, the warranty could be regarded as applying separately to each property, intended to
minimise risk of loss in that particular location. As it happened, the breach of warranty took place at the same location as the fire. If it had not, and the kitchen warranty had been breached at Club Y but complied with at Club X, then the insurer may not be able to escape liability for losses at Club X. This outcome depends on whether the courts would apply a single warranty to different locations. We think it is wrong that the insurer should be absolved from liability for all claims, including claims which arose in other locations. It is not helpful simply to warn policyholders to take out separate policies on each of their buildings.
Combined policies are administratively simpler for both parties.

S. 14 Good Faith

S. 14 abolishes the concept of utmost good faith and the ability of an insurer to avoid the contract for want of utmost good faith. This applies to consumer and non-consumer contracts.

Contracting out

S. 16(1) reiterates basis of contract clauses, or similar, are of no effect.

S. 16(2) restricts any other contractual term which would put the insured in a worse position than he would be under the default provisions of the Act, unless the insurer satisfies s. 17 and the "transparency requirements": namely,

(1) the insurer must take sufficient steps to draw the disadvantageous term to the insured's attention before the contract is entered into; and
(2) the term must be clear and unambiguous as to its effect.

S. 17(4) In determining whether the requirements of subsections (2) and (3) have been met, the characteristics of insured persons of the kind in question, and the circumstances of the transaction, are to be taken into account.

S 17(5) The insured may not rely on any failure on the part of the insurer to meet the requirements of subsection (2) if the insured (or its agent) had actual knowledge of the disadvantageous term when the contract was entered into or the variation agreed.

The Act allows the parties to agree warranties subject to the transparency terms.

S. 18 Contracting Out – Group insurance contracts

Section 18 deals with contracting out in respect of group insurance contracts.

S. 12-13 Fraudulent claims

The current law allows an insurer to avoid a fraudulent claim at common law and, under s. 17 of the Marine Insurance Act 1906, avoid the policy. There is an inconsistency as to the remedies available. The latter remedy would, in theory, allow the insurer to recover sums paid out previously under a non-fraudulent claim. Would a subsequent valid claim be capable of being avoided due to a previous fraudulent claim? Is an insurer entitled to claim damages for investigating a fraudulent claim?

S. 12 provides that:

"(1) If the insured makes a fraudulent claim under a contract of insurance--

(a) the insurer is not liable to pay the claim,

(b) the insurer may recover from the insured any sums paid by the insurer to the insured in respect of the claim, and

(c) in addition, the insurer may by notice to the insured treat the contract as having been terminated with effect from the time of the fraudulent act.

(2) If the insurer does treat the contract as having been terminated--

(a) it may refuse all liability to the insured under the contract in respect of a relevant event occurring after the time of the fraudulent act, and

(b) it need not return any of the premiums paid under the contract.

(3) Treating a contract as having been terminated under this section does not affect the rights and obligations of the parties to the contract with respect to a relevant event occurring before the time of the fraudulent act.

(4) In subsections (2)(a) and (3), "relevant event" refers to whatever gives rise to the insurer's liability under the contract (and includes, for example, the occurrence of

a loss, the making of a claim, or the notification of a potential claim, depending on how the contract is written).”

S. 13 applies to fraudulent claims in group insurances and provides that the group members who make fraudulent claims should be subject to the same penalties as policyholders. In other words, the insurer's remedies for fraud as set out in the Act should apply in group schemes, except that they should apply against the fraudulent beneficiary rather than the policyholder. This means that only the insurer's liability in respect of the fraudster is affected. Insurers will continue to be liable in respect of claims by non-fraudulent members of the group.

Third Parties (Rights against Insurers) Act 2010

Section 19 of the Act amends the TPA 2010 by enabling the Secretary of State to make regulations providing for changes to the circumstances in which a person is a "relevant person" under the TPA 2010. Schedule 2 amends the TPA 2010 in relation to the insured persons to whom the TPA 2010 applies.

S. 152 Road Traffic Act 1988

S. 21(4) IA 2015 amends s. 152 of the RTA 1988 (exceptions to duty of insurers to satisfy a judgment against persons insured against third party risks) so as to provide references to CIDRA 2012 and Part 2 of IA 2015.

This paper has been drafted by reference to the Law Commission reports and the Government Explanatory Notes which preceded the two Acts under consideration. The author of this paper accepts no liability for any inaccuracy or misstatement of the law in this paper.

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